College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

Culture, Equity, and Justice

in Occupational Therapy Practice

Note to Reader

This document is written to complement the *Competencies for Occupational Therapists in Canada* ACOTRO, ACOTUP & CAOT, 2021), Domain C: Culture, Equity, and Justice. It serves to outline specific expectations for how occupational therapists can provide services that are **culturally safer** while upholding the **human rights** of all clients and the people that occupational therapists work with. These expectations are not restricted to registrants in clinical roles; they apply to all occupational therapists, regardless of practice area, setting, or job title. Those in macro-level roles, such as leading and teaching, will be especially influential in actioning this work.

This document is a starting point for the College as it begins to help occupational therapists to best apply principles of **culture, equity,** and **justice** in practice. Because occupational therapists in Ontario serve diverse populations, it is not possible to outline specifically how registrants should approach every practice situation. Instead, the College has created this document to educate and empower occupational therapists to develop the knowledge and tools to move toward culturally safer, **anti-oppressive** work. The glossary in Appendix A provides definitions of the bolded terms used, but it in no way represents every concept, definition, or group that deserves mention and understanding.

The content of this document can be heavy. Some may read it all at once, and others may come back several times as the concepts are digested. As they read, occupational therapists are encouraged to think about how the concepts relate to clients and colleagues in their practice, and where change can begin or continue to evolve. Appendix B has some questions to help structure this self-reflection.

Readers will notice that the terms used to identify racialized groups, including "Black," "Indigenous," and "White" have been capitalized in this document. While capitalizing "White" has not been universally adopted, some feel that writing "white" may perpetuate **White supremacy** by inferring that whiteness is neutral and objective. The College has made the decision to capitalize "White".

Introduction

Clients benefit when their healthcare providers are sensitive to their unique needs and experiences. The process of deepening our understanding of how to best to provide service to clients requires the hard work of self-reflection, insight, and learning about the emerging trends in practice that are driving change. This document is intended to explain to occupational therapists how culture, equity, and justice impact practice, and to inform registrants about what they can do to provide culturally safer practices. The College recognizes that the process of questioning personal and professional views can be difficult, but also knows that occupational therapists can be champions of this work.

Background

Like most Western healthcare, the profession of occupational therapy was founded on, and remains grounded in, White, Western ideologies. It continues to include mainly female-identifying clinicians and students. This has resulted in historically excluded **equity-deserving groups** being unintentionally and unknowingly disadvantaged and discriminated against when receiving services.

Changing the reality that equity and justice are not always present in practice is the responsibility of us all. The College, in its own position of power and **privilege**, has the important role of protecting the public from injustices by setting the expectations for competent, safe, and ethical occupational therapy practice in Ontario.

While data is lacking to indicate the type of **diversity** that may exist amongst those practising the profession, the College acknowledges that diversity does exist. A survey and conversations with self-identified Indigenous and equity-informed registrants revealed that occupational therapists are at different stages of learning, understanding, and applying the concepts of this document. Those with lived/living experience as members of equity-deserving groups may be more knowledgeable than others about injustices in practice, but they should not be tasked with explaining or having to “fix” them. If real change is to be made, the responsibility of learning and growing must be shared amongst us.

Intersectionality as a Guiding Framework

The framework of **intersectionality** is a useful foundation for understanding culture, equity, and justice, and how these concepts can be applied to practice. Intersectionality explains that people view and experience the world from unique **social locations** (that is, social positions, positionalities). Social locations are shaped by both the identities an individual holds and the contexts in which they live. These are intersecting and interdependent identities, outlined as follows. When practising, occupational therapists should be aware of the positionality, values, and beliefs both they and their clients hold, as these will influence a client's experience with the therapeutic process.

What Occupational Therapists Need to Know

Oppression is systemic and is reinforced and challenged in everyday practice

The dynamic intersections between social identities and contexts over time compound to create systems of privilege and **systems of oppression**. Institutions and organizations may uphold and perpetuate systems of oppression through legislation, policies, and other structures. There are many examples of how these systems may influence an individual's experiences with health and occupation. For example, the **social determinants of health** are intrinsically linked to social identities and positionalities. Lower socioeconomic status is correlated with many social identities due to systems that create privilege and disadvantage through law, policy, and other institutions. Importantly, occupational therapists working in Canada must recognize that ongoing legacies of "colonization and **colonialism** cross-cut and influence all other social determinants of health of First Nations, Inuit and Métis individuals, families and communities" (National Collaborating Centre for Indigenous Health, 2021, para. 2, emphasis added).

Occupational therapists have an opportunity to model the change needed in systems of oppression where a power imbalance exists. Occupational therapists should be mindful that practice tools reflect the worldviews of those that developed them and that these tools are not always normalized with a representative sample. Therefore, it would be

incorrect to assume that all practice theories, assessment tools, and therapeutic approaches are applicable to all clients.

Further, occupational therapists are to understand that language used in practice and the workplace can also affect oppression. When talking to or about their clients and colleagues, occupational therapists should refer to others respectfully. This includes learning about, avoiding, and not silently condoning **microaggressions** in the workplace.

Bias is inevitable and harmful

Biases refer to the views that individuals consciously and/or unconsciously hold toward diverse groups of people because of their own unique social location. Biases can be emotional (causing prejudice), cognitive (causing stereotypes), and behavioural (causing discrimination). **Implicit biases** are views that an individual holds unconsciously, whereas **explicit biases** are views that an individual is aware they hold. All people, including occupational therapists, have biases that inform their actions, behaviours, and judgements. Occupational therapists' biases can intentionally and/or unintentionally impact clinical decision-making and client interactions, at times perpetuating discrimination. While it is difficult to completely remove all biases, occupational therapists can take steps to identify and challenge their biases to reduce the impact these have on their practice.

"Available" and "Accessible" are not synonymous

The World Federation of Occupational Therapists (2019) has clearly articulated that **occupational rights** are human rights. Specifically, all people have the right to participate in occupations that are meaningful, necessary for survival, and contribute to personal and community well-being; to **"[c]hoose occupations** without pressure, force, coercion, or threats"; and to **"[f]reely engage in necessary and chosen occupations** without risk to safety, human dignity, or equity" (p. 1, emphasis in original).

Occupational therapists can promote occupational rights by facilitating equitable access to both participation and services. But practitioners must understand that the availability of occupational opportunities

and services does not guarantee accessibility for all clients. Barriers to access may be systemic (for example, affordability of services) or practical (for example, culturally insensitive or inappropriate). Considering the barriers that may impact access and taking steps to mitigate or alleviate them contributes to improved client outcomes.

Trauma is prevalent

Occupational therapists in Ontario should have a basic understanding of the prevalence of trauma and its potential effects on the clients and communities they work with. Research demonstrates that individuals of equity-deserving groups are more likely to experience both interpersonal and systemic trauma and violence. This can affect the services they require and receive, and occupational therapists need to know how to properly manage client trauma experiences and responses.

Occupational therapists have human rights too

It is important to remember that just as the College expects occupational therapists to provide culturally safe and justice-oriented services to the public they serve, registrants also have the human right to work in environments and with clients and colleagues that are not racist or discriminatory. If an occupational therapist experiences unsafe or inappropriate behaviour from a client, they may choose to transition services to another provider. If the workplace or those in it are creating an unsafe situation, the employer should be informed, and solutions developed and implemented.

What Occupational Therapists Can Do

The College recognizes the practice challenges of delivering services in ways that are culturally safer and anti-oppressive. There is immense diversity within the population served by occupational therapists in Ontario, and all clinical situations are different. However, occupational therapists can employ several tools and strategies in their practice, including the following:

Critical reflexivity

+ Employ critical reflexivity to bring awareness to positionality and the perspectives brought into each therapeutic relationship.
+ Recognize and respect that clients enter the therapeutic relationship from their own social location and may have worldviews, values, beliefs, and traditions that differ from those of the occupational therapist.
+ Critically examine the traditions and knowledge they have, and the tools and approaches used.
+ Use the list of reflective questions in Appendix B to support their process.

Relational accountability

+ Consider how their practice embodies (or could embody) the four Rs of relational accountability: respect, relevance, reciprocity, and responsibility (see the glossary for an example).
+ Recognize that they are accountable to the people they work with, including individuals, families, communities, groups, and populations.
+ Avoid making assumptions that a client will or will not benefit from a given tool or approach based on presumptions about the client's social identities and contexts.
+ Strive to create ethical spaces and collaborative dialogue when determining which approaches and tools are appropriate for a given client.

+ Strive to foster a culture of belonging when working with clients, communities, and colleagues, as true inclusion can occur only when the people they are working with feel valued, seen, and heard.
+ Speak and write about clients as they wish to be described and referred to. When completing documentation, write notes with the assumption that clients will read them. Reflect on how notes might make them feel.

Consider what it means to be evidence informed

+ Recognize that tools and approaches found in scholarly literature are not normalized or validated with a sample that represents the diverse clientele served.
+ Understand that scholarly evidence, while valuable in many contexts, is only one type of evidence, and it usually reflects Western knowledge and methodologies.
+ Respect and continue to learn about different ways of knowing, including Eastern, Global Southern, and Indigenous perspectives on health and occupation.
+ Be mindful of **cultural appropriation** when integrating knowledge and traditions from cultures that are not their own.

Strive for cultural humility and culturally safer practices

+ Recognize that **cultural competency** is unattainable as no one can fully be "competent" in the culture of another. Instead, strive to have **cultural humility** and culturally safer practices.
+ Commit to learning about the historical and ongoing social and political contexts that affect clients' experiences with health, healthcare, well-being, and healthcare professionals.

+ Understand the ongoing legacies of colonialism and its impact on Indigenous Peoples in Canada. This includes how colonialism, including the residential school system, has systematically disadvantaged indigenous peoples and resulted in **intergenerational trauma**, creating ongoing barriers to health, well-being, and access to health services and occupational participation. Know that intergenerational trauma has been experienced by many other groups and cultures as well.

+ Recognize and honour the resiliency of equity-deserving groups, and commit to amplifying their voices and undertaking actions that promote **reconciliation** and **self-determination**.

+ Understand that while culturally safer experiences for clients are obtainable, it is the clients who ultimately determine whether a setting or experience is comfortable and safe for them. Be prepared to open this dialogue and respond sensitively to feedback.

+ Expand awareness and understanding of trauma and violence, including historical and ongoing contexts, consequences of trauma across lifespans and generations, and the relationship of trauma with other physical and mental health concerns. This may require obtaining additional information on t**rauma- and violence-informed approaches** in service delivery.

Commit to lifelong learning

+ Recognize that the information presented in this document is far from exhaustive and the process in learning about culture, equity, and justice will be different for everyone.

+ Identify learning and knowledge gaps and commit to addressing them as part of Professional Development Plans, workplace goals, and personal commitment to improving knowledge and understanding about anti-oppressive and culturally safer practices.

Summary

Culture, equity, and justice are represented in occupational therapy practice in ways that are complex and varied by settings and roles. Navigating this requires openness, reflection, and flexibility. Successfully handling the challenges of practice and meeting the needs of the diverse public seen in practice will require occupational therapists to critically and continuously reflect on how to provide equitable access to their services. Occupational therapists can create inclusive and welcoming environments for clients, and in workplaces that promote belonging and respect for all human rights. Despite the changing conversations and language used around culture, equity, and justice, occupational therapists should view this learning as an ongoing process. Unlearning biases while relearning how to be truly open to the uniqueness of the client in front of them will contribute to safe, effective, and ethical care.

For questions about this content, please contact the College's practice team at **practice@coto.org**.

If you would like to provide feedback to potentially be incorporated into future versions of this material, please complete the **survey here**.

Appendix A: Glossary with Practice Examples

Note: This glossary is intended to provide education and information on the terms used in this document. The descriptions listed may not fully explain all concepts and ideas, and language use is likely to change in time. Practice examples have been added where most appropriate to contribute to understanding, but these do not represent all situations or scenarios that may apply.

Anti-oppressive Practice

Behaviours and actions in practice that challenge oppression and discrimination against equity-seeking and deserving groups (groups that have been historically and systematically excluded and/or marginalized because of their social, cultural, economic, or political identities). This may include anti-ableism, anti-colonialism, and anti-racism and anti-racist and anti-hate movements.

Example of anti-ableism: Finding solutions for client participation if the client cannot follow certain policies or complete activities necessary to receive services (for example, they cannot complete an online screen or sign a document digitally).

Example of anti-colonialism: Modifying consent processes for an Indigenous person who indicates that consent for services must involve a Band Leader, Elder, or Knowledge Keeper.

Example of anti-racism: Holding colleagues accountable if bias, racist language, and/or stereotypes are used within the workplace and welcoming ongoing critical dialogue.

Biases

Views, beliefs, and attitudes that individuals consciously and/or unconsciously hold toward diverse groups of people and which are informed by the unique experiences and worldviews that an individual holds because of their unique social location. Bias can be divided into explicit (views that an individual is aware they hold) and implicit (views that they are unaware they hold).

Examples of explicit bias: Assuming some clients will have more supports available at discharge because of their culture or described living situation (for example, a multifamily home). Or assuming a client of a visible minority may have a language barrier.

Example of implicit bias: Hiring males to complete roles or tasks that may require more physical demands, such as lifting or transfers.

Colonialism

According to the National Inquiry into Missing and Murdered Indigenous Women and Girls (2019),

> the attempted or actual imposition of policies, laws, mores, economics, cultures, or systems and institutions put in place by the settle governments to support and continue the occupation of Indigenous territories, the subjugation of Indigenous individuals, communities, and Nations, and the resulting internalized and externalized ways of thinking and knowing that support this occupational and subjugation. These impositions are race-and gender-based. (p. 77)

Of note, colonial violence stems from colonialism

> and relies on the dehumanization of Indigenous peoples […] perpetuated through a variety of different strategies, including depriving people of the necessities of life, using public institutions and laws to reassert colonial norms, ignoring the knowledge and capacity of Indigenous peoples, and using constructs that deny the ongoing presence and dignity of Indigenous peoples. It is also linked to racism. (p. 76)

Example: Government laws and policies determine who is eligible to receive "status" as an Indigenous person.

Critical Reflexivity

The process of reflecting on, questioning, and challenging socially constructed identities and personal assumptions and beliefs.

Example: Challenging the assumption of the clinical team that certain people will have access to specific resources even if not yet known (for example, assuming that insurance funding will be available when it is not in place yet, or that someone of a certain age does not need assessments for returning to work or would not fit into a group made up of younger participants). Or reflecting on standardized assessment tools or initial assessment forms created by institutions, to ensure that the content is relevant in the current context and inclusive in language (for example, if gender is to be specified on the form, are the only options male and female?).

Cultural Appropriation

"The unacknowledged or inappropriate adoption of the customs, practices, ideas, etc. of one people or society by members of another and typically more dominant people or society" (Lexico, n.d.).

Examples: Wearing clothing, jewellery, or symbols without knowing or understanding the meaning and significance of these for the culture from which they originated. Or a non-Indigenous occupational therapist working in mental health using "spirit animals" as part of a therapeutic exercise while disregarding their significance and sacredness to many Indigenous cultures.

Cultural Competency

The ability to interact with and understand people of all cultures. This concept has been criticized through the growing understanding that it is not possible to be competent in the experiences and worldviews of another person or community.

Example: Understanding a culture or group may extend beyond taking a course or travelling to work in another country.

Cultural Humility

A lifelong commitment grounded in empathy and respect in which individuals are conscious of their own culture and positionality, and are open to others' preferences, experiences, and worldviews.

Example: Asking questions about the culture and experience of others to gain knowledge and understanding. If a colleague tells you they are fasting, asking them about this to learn about their belief system. Sometimes, simply saying, "Can you tell me more about that?" Or during a kitchen assessment, asking a client about the type of food they typically eat or prepare at home without making assumptions about what they eat based on culture or race, or assuming they eat a standard Western diet.

Culturally Safer Practice

A form of practice that involves acknowledging that as healthcare providers, occupational therapists hold a position of power in therapeutic relationships. Culturally safer practice also recognizes that due to historical and ongoing mistreatment within healthcare systems, individuals from marginalized groups may never feel safe in therapeutic spaces. Occupational therapists must continuously work toward practising in culturally safer ways, but it is ultimately the individual or group receiving services that determines what they consider to be safe.

Example: Recognizing that culturally safer practice is a process, not necessarily a destination. It may include the following: creating

an environment of comfort for clients based on their preferences; seeking feedback on ways to improve the services or the environment where they are provided; having a gender-neutral washroom, prayer room, or adequate seating in the waiting and treatment rooms for a client who brings others to appointments; and adding other, non-Western materials, images, or decor to service spaces.

Culture

A collection of beliefs and behaviours shared by a group of people and that are influenced by languages, values, institutions, and customs.

Example: A workplace may set expectations that work is only to be completed during certain days or hours. This is an element of workplace culture.

Diversity

Differences amongst individuals in a variety of visible and non-visible areas which may include culture, gender, race, sex, and socioeconomic status. These areas intersect with broader contexts and influence an individual's beliefs, experiences, and values.

Equity

The process of ensuring fair access to resources and services for all people based on diverse factors and circumstances. While "equality" refers to providing everyone with the same resources, "equity" involves giving people what they need to reach the same benchmarks. Equitable distribution involves removing avoidable or remediable differences between groups and providing fair and just access to resources.

Examples: Advocating early for more visits or more time than typically provided or allowed to address a client-specific need that falls outside of a typical service criterion. Or if three people have a mobility impairment, not suggesting that they all purchase the same single-point cane because it is inexpensive and easily accessible. Or being up to date on alternative resources and funding sources for people to access therapy.

Equity-Deserving Groups

Those who have been historically excluded, marginalized, or "constrained by existing structures and practices […] who […] are made to feel that they do not belong" (Tettey, 2019, para. 38) Equity-deserving groups include Black, disabled, and Indigenous peoples, and racialized, religious, and sexual minorities. The term "equity-

deserving" is preferred to "equity-seeking" because [t]hose on the margins of our community, who feel or are made to feel that they do not belong, deserve equity as a right. They should not be given the burden of seeking it and they should not be made to feel that they get it as a privilege from the generosity of those who have the power to give it, and hence the power to take it back. (Tettey, 2019, para. 39)

Ethical Spaces

A concept developed by Indigenous researcher Willie Ermine (2007) and that describes the process of individuals or groups who hold different worldviews coming together to create a space that promotes an openness to learning from one another.

Example: Hosting webinars or learning experiences with content experts about how to include and encourage comfortable conversations about culture, diversity, privilege, race, and social locations with colleagues to promote sharing and understanding.

Human Rights

The United Nations Universal Declaration of Human Rights (1948) states that "[a]ll human beings are born free and equal in dignity and rights" (Article 1) and outlines 30 articles that apply to all people around the world "without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" (Article 2).

Example: Recognizing that all clients have the right to healthcare, and no person can be denied services because of their identities. Or recognizing that all clients have the right to be able to physically access services.

Inclusion

Providing all people with access to the same rights, resources, services, and opportunities regardless of their social identities. The creation of inclusive environments promotes a sense of value and belonging for all individuals.

Example: Providing options for group sessions to be at different times or locations, or delivered virtually if appropriate, to accommodate those that may not be able to participate if only one option exists.

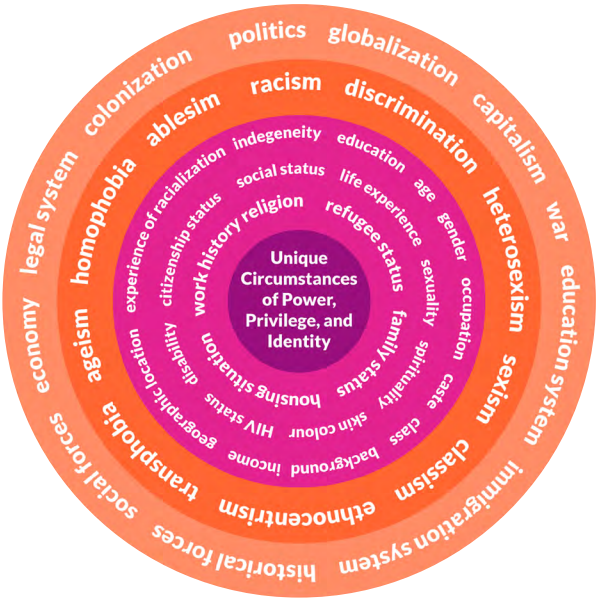
Intergenerational Trauma

Shared trauma experienced by members of an identifiable group over multiple generations and that "incorporates the psychological and social aspects of historical oppression" (Aguiar & Halseth, 2015, p. 9) in addition to other biological and psychological processes. The term

is often used to describe the trauma experienced by Indigenous peoples because of colonial policies and processes, including the residential school system. It is imperative to recognize both the historic and ongoing legacies of colonialism that reinforce and perpetuate intergenerational trauma. Notably, Mitchell et al. (2019) have also coined the term "colonial trauma" to describe the "complex, continuous, cumulative, and compounding interaction of impacts related to the imposition of colonial policies and practices which continue to separate Indigenous peoples from their land, languages, cultural practices, and one another" (p. 75). Notably, other racialized groups are also subjected to intergenerational trauma. For example, Black communities may experience intergenerational trauma from slavery and racist post-slavery policies; likewise, asylum seekers, immigrants, and refugees may experience intergenerational trauma associated with forced migration. See also **trauma- and violence-informed care**.

Intersectionality

A framework developed by Kimberlé Crenshaw (1989) and that describes how all people have multiple, connected social identities that interact with broader contexts to create privileges and/or disadvantages. The Canadian Research Institute for the Advancement of Women has developed a visual aid depicting intersectionality. In this diagram, "the innermost circle represents a person's unique circumstances, the second circle aspects of the individual identity, the third different types of discrimination and attitudes that affect identity, and the outer circle larger forces and structures that work to reinforce exclusion" (Women Friendly Cities Challenge, n.d.).



Intersectionality Displayed in a Wheel Diagram [Digital Image]. Women Transforming Cities. https://www.womentransformingcities.org/intersectional-feminism. (Adapted from the Canadian Research Institute for the Advancement of Women, 2009). Reprinted with permission.

Justice

The principle that individuals should be treated fairly and equitably and receive what they deserve. It involves altering, replacing, and/or disposing of policies and practices that systematically disadvantage certain groups.

Examples: Promoting justice may involve changing consent forms or clinical record templates to allow for people to use a preferred name (when legally able) instead of a birth/legal name that they may no longer identify with. Or advocating for adapting policies for late or missed visits to accommodate clients who have circumstances that make their attendance unpredictable.

Microaggressions

Verbal or behavioural indignities, comments, slights, and slurs aimed at historically excluded, equity-deserving groups in everyday life. Although microaggressions are often thought of as harmless comments or even jokes, they are not, and they contribute to hostile, unsafe, and oppressive environments.

Example: Making comments like the following: "You are so well spoken / articulate for a [insert racialized group]." "I am not racist. I have a [insert racialized group] friend." Another example is saying "All Lives Matter." This is a microaggression to the Black Lives Matter movement, which is trying to communicate until Black lives matter, all lives cannot matter.

Occupational Rights

The rights that all individuals have to freely choose, participate in, and engage in occupations that are meaningful, and contribute to personal and community well-being.

Example: Not having only predetermined benchmarks of function (for example, full range of motion) when the client's preference may be to do other things regardless of full physical capability. Or advocating for a client with multiple sclerosis or a spinal cord injury to receive care for their morning routine (even if they can perform this routine themselves), because they would prefer to save their energy to be used throughout the day for other meaningful activities (for example, work or childcare).

Privilege

An advantage or right that is enjoyed by people of some groups but not others.

Examples: Some people can afford things that others cannot, such as better or more equipment, a private room, specialized services or treatments after public funding ends, or items or services not available to others. Or some occupational therapists may advance in their career more quickly based on financial privilege that provides them access to additional education and training.

Reconciliation

An ongoing individual and collective process of establishing and maintaining respectful relationships (Truth and Reconciliation Commission of Canada, 2015). Reconciliation requires commitment from all parties and may occur between any of the following groups: First Nations, Inuit, and Métis former Indian Residential School students, their families, their communities, religious entities, former school employees, governments, and the people of Canada.

Example: The first National Day for Truth and Reconciliation on September 30, 2021, was a government initiative to continue the process of publicly recognizing the tragic and painful history that residential schools had on Indigenous culture, Indigenous children, their families, and their communities.

Relational Accountability

A principle in ethical Indigenous research methodologies which states that people are dependent on and related to everyone around them. All people have a responsibility to nurture and maintain relationships with their collaborators and are accountable to the communities they live and work in. Relational accountability is demonstrated by practising the four Rs: respect, relevance, reciprocity, and responsibility.

Example: When working with Indigenous people, occupational therapists can keep the four Rs at the forefront of their practice by, for example, doing the following: respecting the need to cocreate a service plan with the client, codeveloping service plans that are relevant to the client's culture, recognizing and acknowledging clients and communities as equal partners in the therapeutic relationship, creating space for continued open and reciprocal dialogue about the nature of services, and taking responsibility by following through on promises and commitments made to the client and community.

Self-Determination

The right to self-governance and autonomy amongst Indigenous populations. It is important to recognize that the process of self-determination will be different across Indigenous communities.

Example: While occupational therapists are self-regulated and govern their own profession, Indigenous populations and communities also have the right to self-govern and be autonomous in the decisions they make, especially those related to the delivery of healthcare services.

Social Determinants of Health

Defined by the World Health Organization (2021) as

the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. (para. 1)

Commonly cited social determinants of health can include childhood development, culture, dis/ability, education, employment status, gender, geographic location and origin, housing, income, living and working conditions, migration status, natural and built environments, quality and accessibility of health and social services, race/ethnicity, social inclusion, social safety nets, and transportation.

Social Location

A position that one holds within society based on factors that include dis/ability, gender, race, sex, and socioeconomic status. An individual's social location affects their experiences and can create certain privileges and/or disadvantages.

Systemic Oppression

The cultural, economic, political, and social structures (for example, policies, legislation, or institutional practices) that deny one or more groups equitable, barrier-free access to certain rights and privileges that are afforded to other groups based on one or more social identities. To illustrate, people of many equity-deserving groups, including Indigenous, LGBTQ2S+, and racialized people, are less likely to receive or have access to quality healthcare services than are those with higher degrees of privilege. Examples of systemic oppression include ableism, ageism, classism, heterosexism, and sexism.

Examples of ableism: Assuming disability is inherently negative and/or that all disabled people want to or would be better off if they did not have a disability. Or unconditionally promoting "independence" as part of occupational goals or treatment plans.

Examples of ageism: Dismissing the COVID-19 pandemic as something that affects only older adults who are already unwell or otherwise nearing the end of their lives. Or limiting occupational opportunities based on age (for example, assuming that older adult clients are unwilling or unable to participate in activities such as recreational sport leagues).

Example of classism: Assuming everyone has the social and economic means to participate in certain occupations (for example, survival occupations like obtaining and consuming healthy foods, obtaining and paying for medications, or purchasing equipment).

Trauma- and Violence-Informed Care (TVIC)

A therapeutic approach that aims to reduce the potential for harm and traumatization. The high prevalence of trauma in historically marginalized groups warrants the use of TVIC when required.

Example: Learning about the high prevalence of trauma and its biological, economic, psychological, and social impacts on individuals and communities, to provide appropriate and responsive care to clients who may have a trauma history.

White Supremacy

The deeply rooted belief in society that White people are superior to people of other races. White supremacy is systemic and present in most, if not all, social structures, and institutions. It maintains systems of privilege and oppression and causes racialized people to face harm, discrimination, inequity, and injustice.

Appendix B: Reflective Questions

Positioning Yourself as a Citizen & Clinician

+ Who am I? What identities do I hold, and how do these affect my personal values, beliefs, and experiences?
+ What cultural, economic, historical, political, and social contexts am I embedded in? How do these intersect with my identities to shape my worldviews?
+ What is my social location? How does it differ from those of my clients?
+ What systems of privilege and oppression do I simultaneously experience?

Identifying & Challenging Personal Biases

+ How might the **biases** I hold affect my interactions with clients and the services that I provide?
+ Am I prepared to challenge my biases? What are some steps I can take to do so?
+ Do I view alternative perspectives, **cultures**, and worldviews as equally valid to my own?
+ What positive and/or negative assumptions do I make about specific groups? What stereotypes do I subscribe to? What informs these assumptions and stereotypes?

Critically Analyzing Evidence & Practice Tools

+ Where does my prior learning about health and occupation originate from? How is this reflected in the practice tools and approaches I use?
+ What do I consider to be evidence? Do I privilege Western knowledge over other ways of knowing?

+ Do I consider my client's experiences, worldviews, contexts, and beliefs about health and occupation when selecting practice tools and approaches?

+ Do I use assessments in my practice that have relevant items, norms, and purposes for the clients that I service? Do I provide a rationale for the assessments and interventions that I use?

Creating Culturally Safer & Accessible Practice Environments

+ Who is likely to feel welcome in my practice setting? Do the values, philosophies, and goals of my practice setting align with those of the current population that I am providing service to?

+ How do I determine whether my clients feel welcomed, valued, safe, and comfortable?

+ In what ways do I create **ethical spaces** in my practice? How can I use ethical spaces to better understand my client as a person, including their unique social location, worldviews, beliefs, and values?

+ What barriers exist to accessing the services I provide? Are there cultural, economic, physical, political, or social obstacles that should be addressed? How can I help to make available services more accessible?

+ Is my employer/organization committed to providing **culturally safer, anti-oppressive, equitable**, and accessible services? How can I work with my colleagues to foster a workplace culture that values **diversity, equity, inclusion**, and belonging?

+ Based on my own experiences, do I feel culturally safe at work? Have I experienced discrimination, inequity, or oppression because of my social identities? Do I have a plan to manage these experiences if they occur with my clients, workplace, or colleagues?

+ Will my workplace support me in standing up for my **human rights** and those of my clients?

Facilitating Collaborative, Relationship-Focused Practice

+ Have I created time and space to understand my clients' lived experiences, values, beliefs, preferences, and worldviews?
+ How can I work with my clients to develop a service plan that is meaningful and relevant to them?
+ Do I practise **relational accountability** in my record keeping? Do I write my reports and notes with the assumption that my clients will read them? Have I unintentionally created or reinforced barriers/inequities through what I have written or not written?
+ How do my clients want to be addressed and described (for example, name, gender, pronouns, and ethnic group)? Do I honour their identities and rights to **self-determination** in all aspects of my practice?
+ Do I model culturally safer, anti-oppressive, and equitable practices for others in my workplace, including colleagues and students?
+ Have I witnessed or participated in **microaggressions**? Do I know that these are harmful, and am I prepared to identify and rectify these in myself and others when they occur?

Navigating Systemic Barriers

+ What are the broader cultural, economic, historical, political, and social factors that may be creating inequitable barriers to health and occupation for my clients?
+ How might I unintentionally be reinforcing or perpetuating systemic barriers in my practice? What steps can I take within my practice to mitigate and/or alleviate these barriers?
+ What community stakeholders and partners can I engage to address barriers and inequities in health and occupation? How can I build and/or strengthen these relationships?
+ How can I use my knowledge, skills, and partnerships to advocate at systems levels for equitable and sustainable access to occupational opportunities and participation?

Commitment to Lifelong Learning

+ What are my learning and knowledge gaps? What strategies and resources can I use to address these gaps?
+ Do I understand that promoting anti-oppressive, culturally safer practices is a career-long commitment?
+ Do I appreciate that I will never fully understand or become “culturally competent” in the experiences of another person?
+ Do I understand that I will always hold biases and it is my responsibility to challenge them to mitigate their impacts on my practice?
+ Am I willing to or can I create space to diversify and contribute to the current body of practice knowledge for the profession? If not, can I commit to the ongoing personal learning that is required?

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