The Open Journal of Occupational Therapy

Volume 11
Issue 3 *Summer 2023*

Article 12

July 2023

The Canadian Occupational Performance Measure (COPM): Critiquing its Applicability With Indigenous Peoples and Communities

Tara Price
Dalhousie University - Canada, tara.price@dal.ca

Tara Pride
Dalhousie University - Canada, tarapride@dal.ca

Recommended Citation

Price, T., & Pride, T. (2023). The Canadian Occupational Performance Measure (COPM): Critiquing its Applicability With Indigenous Peoples and Communities. *The Open Journal of Occupational Therapy, 11*(3), 1-10. https://doi.org/10.15453/2168-6408.2085

The Canadian Occupational Performance Measure (COPM): Critiquing its Applicability With Indigenous Peoples and Communities

Abstract

Indigenous Peoples experience significant health inequities that must be understood in relation to historical and ongoing colonialism, racism, and discrimination. The occupational therapy profession has claimed commitment to addressing the Truth and Reconciliation Commission (TRC) calls to action, however, the profession is firmly grounded in Euro-Western epistemologies, including its assessments. The purpose of this paper was to assess the Canadian Occupational Performance Measure (COPM) for use with Indigenous clients and communities. Although the COPM uses flexibility through semi-structured interviews and the exclusion of standardized score comparisons, it is mired in colonial underpinnings and has hierarchical therapist-client power dynamics threaded throughout. The COPM has potential given its semi-structured nature and client-led approach. However, acknowledgement of the assessments' Euro-Western roots and biases are necessary. This assessment may be modified for improved use, which should occur in collaboration with Indigenous clients, communities, and leaders.

Comments

The authors declare that they have no competing financial, professional, or personal interest that might have influenced the performance or presentation of the work described in this manuscript.

Keywords

indigenous peoples, health care, occupational therapists, cultural safety, collaborate, reflexivity

Cover Page Footnote

The authors would like to thank Dr. Brenda Beagan for her insightful contributions on earlier versions of this manuscript.

Credentials Display

Tara Price, MSc(OT), O.T. Reg(NS)

Tara Pride, MSc(OT), O.T. Reg(NS), PhD Candidate

DOI: 10.15453/2168-6408.2085

For centuries, Indigenous Peoples on Turtle Island have been living sustainably with the world around them, practicing their traditional, cultural, ceremonial, and health practices while maintaining harmony with all living and non-living entities. The lives of Indigenous Peoples were significantly impacted upon first contact with Europeans (settlers) several hundred years ago. Since then, settlers to the region have attempted to eliminate Indigenous Peoples and their ways of knowing through segregation, assimilation, and genocide (Smith, 2018) using practices such as the Residential School system, the implementation of reserves, and the 60's Scoop/Child welfare system, which removed children from their families and communities to foster them with white families (Allan & Smylie, 2015). These practices have led to notable health disparities among Indigenous Peoples across Turtle Island, with colonization constituting as a distal determinant of health for Indigenous Peoples (Reading & Wien, 2009).

Colonialism has formed the foundation of mainstream Canadian society, resulting in a dominant worldview that is in stark contrast to the ways of knowing, being, and doing of Indigenous Peoples. The health professions in Canada, including occupational therapy, have been created and advanced from a Euro-Western worldview (Gerlach et al., 2014; Grenier, 2020; Hunter & Pride, 2021), resulting in inequities when working with Indigenous clients in health care systems. As such, there is a need to critically evaluate the assessments, models, and tools used in occupational therapy to work toward better serving Indigenous Peoples and closing the gap in health equity. This paper explores the Canadian Occupational Performance Measure (COPM), examining its value when working with Indigenous clients and communities.

Colonialism: A Distal Determinant of Indigenous Peoples' Health and Well-being

The social determinants of health (SDH) are factors that influence health that are non-medical, such as where people are born and the external forces that shape the conditions of everyday life (World Health Organization [WHO], 2021). SDHs may be categorized into proximal (educational attainment, income), intermediate (social networks and supports, health care access), or distal (historical, political, legal, social, and economic) factors that impact health (Reading, 2015). Distal social determinants operate at a greater distance, more indirectly, and are generally more stable and less amenable to change (Arah et al., 2005). Indigenous Peoples experience numerous health inequities relating to the SDH, situated in the context of the contemporary colonial Canadian society. Headlines outlining high rates of substance use or misuse (Toombs et al., 2019), high levels of poverty (National Collaborating Centre for Aboriginal Health [NCCAH], 2009–2010), lower socioeconomic status (Allan & Smylie, 2015), inadequate housing and water supply (National Collaborating Centre for Aboriginal Health, 2017), and inadequate access to care services and programs (Reading & Wien, 2009) are ubiquitous. However, what is often lacking in the description of these health inequities is an analysis of their root causes. It is well established that the inequities experienced by Indigenous Peoples result from colonialism and colonization (Nelson, 2012), causing colonialism to be deemed a distal determinant of health for Indigenous Peoples today (Reading, 2015).

Distal determinants of health are those that impact health indirectly through structures such as underlying historical, legal, and economic contexts that, in turn, shape institutions, policies, and programs (Arah et al., 2005). In the context of Indigenous health, it is clear that Indigenous Peoples are not afforded the same opportunities or resource investment compared to settler populations in Canada (Allan & Smiley, 2015). This inequitable allocation of resources and opportunities for Indigenous Peoples, combined with historical and current experiences of racism, discrimination, exclusion, and deliberate acts of genocide on behalf of settlers, are the root causes of Indigenous struggles to thrive and survive today. Policies such as

the Indian Act (Henderson, 2006) and the 60's Scoop (Truth and Reconciliation Commission of Canada [TRC], 2015a), or more subtle acts of exclusion, discrimination, and assimilation, such as those embedded in colonial education and health care systems, are directly related to the contemporary context of Indigenous health. These systems and their policies, programs, and procedures serve to alienate Indigenous Peoples while enacting white supremacy and reinforcing the superiority of white people over the original occupants of these lands (Smith, 2012). Recognizing the root causes of health and social inequities can inhibit blaming Indigenous Peoples or reducing complex, socially-constructed issues to "cultural differences."

Health care is but one system that creates significant inequities in health and well-being for Indigenous Peoples. The system itself is derived from colonial ideologies and operates under the frame of Euro-Western knowledge (Burnett et al., 2020), resulting in both inadequate access to health care services for Indigenous Peoples accessing care (National Collaborating Centre for Indigenous Heath [NCCIH], 2019) and experiences of exclusion, racism, and discrimination when they do access health services (Allan & Smylie, 2015; White & Beagan, 2020). In recent years, Canadian health care has been deadly to many Indigenous Peoples, such as Brian Sinclair, who sought services in Winnipeg and waited over 34 hr to receive care (Geary, 2017), and Joyce Echaquan, who experienced overt racism and was restrained, given a sedative, and left alone as she sought services in an emergency room in Québec (Page, 2021). Although these experiences are extreme cases, versions of these events happen routinely, and they must be examined in the context of a country and health care system that boasts about its universal access to care and commitments to equity, diversity, and inclusion (e.g., Alberta Health Services, n.d.). A clear link can be drawn between notions of white supremacy, colonialism, and the inequities Indigenous Peoples experience (Smith, 2018).

Influential reports, such as the Final Report for the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG2S, 2019) and Canada's Truth and Reconciliation Commission Report (TRC, 2015a), have clearly outlined the need for immediate action to move toward redressing harms and building respectful, equitable relationships with Indigenous Peoples. Calls to Action and Calls to Justice have been deliberately structured and written in a way to ensure that recommendations are implemented in a timely manner. Yet, to date, Federal and Provincial governments have largely failed to turn recommendations and declarations of intent into action, with fewer than ten Calls to Action from the TRC being implemented since its release in 2015 (Martens, 2019) and the National Action Plan to address the Calls to Justice for the MMIWG2S being heavily criticized for falling short of what is needed and taking too long to come to fruition (Macyshon, 2021). This is yet another failure in truly addressing the inequities experienced by Indigenous Peoples (Martens, 2019) and building mutual, nation-to-nation relations.

The TRC Calls to Action (TRC, 2015b) outlines broad areas for change in both the heath care and education systems. It outlines the need to put into place culturally appropriate curricula (#10); to increase and ensure the retention of Aboriginal health care professionals, along with ensuring cultural safety training is in place (#23); and the need for courses on Aboriginal health issues and the history of Residential Schools for medical and nursing schools (#24). As such, there is a need to work toward these Calls to Action in all health professions, including rehabilitation professions, such as occupational therapy.

Occupational Therapy: A Euro-Western Profession

The profession of occupational therapy was created around the time of the First World War, with therapists working through vocational training with veterans to help them transition back to their lives and

duties after the war (Canadian Association of Occupational Therapists, 2016). Over the past century, the profession has significantly expanded its scope of practice. The profession currently can be seen in rehabilitation centers, hospitals, and communities, with therapists working across diverse contexts to support clients in engaging in their needed and desired occupations. However, the profession has been critiqued extensively in the past few decades for its claims to universality (Hammell, 2009), given that the profession is dominated by and grounded in a Euro-Western worldview (Grenier, 2020; White & Beagan, 2020), including prevalent theories, assessments, and interventions (Hammell, 2019; Hunter & Pride, 2021). This is particularly problematic given the diverse clients with whom occupational therapists may work. The importation of Eurocentric theories, assessments, and interventions for use in diverse contexts raises issues of suitability, lack of cultural safety, and inability to truly be "client-centered."

A Euro-Western worldview and the underpinnings of the profession have been documented as problematic in relation to efforts to diversify and expand the profession into diverse communities (Hunter & Pride, 2021). For example, the way occupational therapy structures self-care, productivity, and leisure may not resonate with communities that hold differing worldviews. The importance of and emphasis on time and linear, measurable progress stem from a Euro-Western worldview (Gerlach et al., 2014; White & Beagan, 2020). Another example, from pediatric occupational therapy, is guiding assessments for child development milestones derived solely from norms found in Euro-Western populations (Gerlach, 2018). Standardized assessments are a key feature of the profession, yet the biases and assumptions underlying these assessments used in everyday practice are rarely acknowledged (White & Beagan, 2020). Failing to acknowledge the colonial underpinnings and ideologies of the profession and how this impacts work with diverse communities is halting meaningful progress toward critically interrogating the profession and making meaningful changes (Hammell, 2015). In relation to work with Indigenous Peoples specifically, occupational therapy must consider the unique and complex experiences of colonialism, discrimination, and genocide in this country and determine concrete ways to address the ongoing domination of a Euro-Western worldview.

The profession of occupational therapy in Canada has declared a commitment toward reconciliation with Indigenous Peoples, communities, and organizations (CAOT, 2018). This responds to efforts stemming directly from Indigenous Peoples and communities to gain access to health care services that are supportive, available, and free of discrimination and racism (TRC, 2015b). To date, the profession in Canada has created an Occupational Therapy and Indigenous Health Network (OTIHN), as well as a TRC Task Force, with a mandate to "facilitate actions that will create sustainable occupational therapy research, clinical practice, and education that fosters reconciliation and decolonization within the profession" (CAOT, 2019, p. 2). These efforts include both Indigenous and non-Indigenous occupational therapists working toward a goal of improving the profession to better work with Indigenous Peoples and communities. There is a long way to go, given that the profession has entirely excluded Indigenous ways of knowing, being, and doing from its knowledge base until recently. Determining how best to integrate, use, and center Indigenous ways of knowing, being, and doing into the profession is a work in progress.

Efforts to center Indigenous ways of knowing and worldviews in the profession have been underway in recent years. Given that Indigenous Peoples and communities are incredibly diverse, knowledge and practice tools are unlikely to have universal application, but rather there is a need for occupational therapists to work with individual Indigenous communities and to partner and co-create what is needed in that specific context. Examples include the development of a cognitive assessment for dementia for Indigenous Australians and Torres Strait Islanders (Westphal, 2013) and exploring the use

of the Australian Therapy Outcome Measure (ATOMIC) with Indigenous clients (Sheahan et al., 2019). In the Canadian context, there has been an assessment developed from Indigenous knowledges to address substance use and mental health issues, the Native Wellness Assessment (Thunderbird Partnership Foundation, 2015), as well as a cognitive assessment developed for use with older Anishinaabe adults in Ontario (Jacklin et al., 2020). Finally, a recent article published by Hunter and Pride (2021) explored the applicability of the Canadian Model for Client-Centred Enablement (CMCE) for use in Indigenous contexts. These are important steps toward decentering the Euro-Western worldview that dominates occupational therapy, opening spaces for culturally safe therapy with Indigenous Peoples.

Without a deeper consideration of how colonialism is perpetuated by and within the profession, any work toward reconciliation and decolonization will be superficial, at best, with limited efforts to address the root causes of Indigenous health inequities. Occupational therapists have the skills and abilities to transform the profession toward something that is truly representative of the diverse clients with whom we work. This means drawing on efforts from the profession (e.g., TRC Task Force & OTIHN) as well as the knowledges of Indigenous Peoples, communities, and organizations to pave the way toward a profession grounded in critical reflexivity (Beagan & Chacala, 2012) and cultural safety (Papps & Ramsden, 1996).

The COPM

The COPM is an outcome measure designed for occupational therapists to identify and prioritize issues restricting or impacting client performance in everyday living. This assessment tool is considered a reliable, valid, and responsive measure of client performance, and several studies have concluded that the measure has widespread use across diverse clinical situations (COPM, 2020). It includes a semi-structured interview that focuses on identifying occupational performance issues categorized within a productivity, leisure, and self-care framework, plus structured scoring methods, resulting in two calculated scores: performance and satisfaction. Clients are asked to respond with a ranking between 1 and 10 for each identified issue and their corresponding satisfaction with current performance levels for up to five individual occupational performance issues. The COPM is designed to be highly client-centered, encouraging a dialogue between the client and the therapist to uncover issues and goals, which the client has the final authority to determine.

Because the COPM is an assessment tool based on and developed in a Euro-Western context, it is important to critically examine its suitability for use with diverse client populations, recognizing both how it may support positive health outcomes as well as limitations of the assessment. While the ideal for assessments in Indigenous contexts would employ tools co-developed in collaboration with Indigenous Peoples and grounded in Indigenous knowledge and ways of knowing, the COPM is so widely used that it demands scrutiny. This paper examines the use of the COPM critically when working with Indigenous clients to determine its appropriateness and applicability for culturally safe care with this population.

Positionality

This paper emerged from a project completed by the first author for an Advanced Practice Issues course. As authors, our experiences and identities in society, as shaped by social and political contexts, influence our understanding of the world and, inevitably, our work. We are both occupational therapists trained in Canadian colonial frameworks. The first author is a white settler of Irish-Scottish descent who grew up in a largely homogenous white rural community in Southwestern Ontario. Throughout her childhood and early adolescence, she was exposed to social justice issues surrounding Indigenous communities, such as the Ipperwash Crisis of 1995, through her mother's interest and commitment.

Through undergraduate and graduate studies, she gained a broader perspective of the socio-cultural and political issues facing Indigenous communities and the larger impacts of colonialism on Canadian society. The second author is of mixed Mi'kmaw and settler ancestry who grew up outside of her Indigenous community and away from her extended family due, in large part, to practices of colonialism. Her journey over many years has been to understand better her own Indigenous ancestry and reclaim her Indigenous identity through creating new community and family connections. It is in this context that her work is positioned and shaped.

Discussion

The COPM is a client-centered outcome measure designed to be administered at the beginning of a client interaction and at various intervals throughout the therapeutic relationship to evaluate client-perceived changes over time. Several aspects of the structure and intended application of the COPM position it as a suitable assessment tool for use in diverse contexts and with diverse cultures (COPM, 2020), which may include work with Indigenous populations. Such features include using a semi-structured interview and the exclusion of standardized score comparisons of satisfaction and performance, allowing the therapist to adapt to different clients and cultural contexts. However, inherent power dynamics, the therapist's own level of cultural awareness, and Indigenous experiences with the health care system may undermine these potential benefits. In addition, the concept of numerical rankings and activity categorizations further limits the COPM's suitability across cultural backgrounds, including for use with Indigenous clients.

The goal of the COPM is to establish occupational performance issues, goals, and rankings during the preliminary assessment, which often occurs during the initial client-therapist interaction. The existence of a metric-oriented and bureaucratic care-provision system puts pressure on the occupational therapist to deliver on these expectations (Hammell, 2019). Yet, building a trusting relationship that encourages open dialogue takes time, as noted in a recent integrative review of literature on occupational therapy in Indigenous contexts:

> After centuries of European colonization, the power inequity between European settlers and Indigenous peoples results in a barrier that is exceptionally difficult to break. The first few meetings should be focused on letting the client speak and building a trusting relationship prior to beginning any formal therapy . . . [which] ill-suits
> many agency mandates. (White & Beagan, 2020, p. 204)

The urgency associated with getting results, embedded in the Euro-Western health care system, limits the potential effectiveness of the COPM as a tool for use in Indigenous contexts.

A Eurocentric Approach

A strength of the COPM is that, unlike many assessment tools, it does not compare individual performance metrics to standardized scores, which reduces the likelihood of "perpetuating colonial discourses that marginalize and inferiorize" Indigenous Peoples by comparing them to "the norm" (Gerlach, 2018, p. 22). Assessments have been employed in a colonial agenda to justify actions, such as child apprehension. Nonetheless, the notion of categorizing, numerically ranking, and scoring activities and their respective performance is present with the COPM and rooted in Euro-Western epistemologies, or knowledge systems, that fail to translate across cultures. The COPM is explicitly a "process which measures individual, client-identified problem areas in daily function" (Law et al., 1990, p. 82). This focus on deficits (occupational challenges), goals, and results embodies a Eurocentric biomedical and individualistic view, which contrasts with the strengths-based approach that is more common in

Indigenous epistemologies (Gerlach, 2018). Imagine assessment beginning from how a client contributes value to their community and how family and community view, perhaps even value, their disability, injury, or illness.

Further, the requirement of identifying performance issues in three established categories (productivity, leisure, and self-care) may not translate well for Indigenous clients. While the categories are considered general enough to allow for client-defined issues, they are still wrought within Euro-Western assumptions of what occupations matter most and what legitimately comprises each category. For example, Gerlach and Suto (2014) discuss the concept of play in children across Indigenous and Western cultures, noting that often these may not align as definitions of what constitutes play are largely based on "[w]hite, middle-class, and urban perspective[s]" (p. 248). Imagine assessment starting from relationality rather than productivity, leisure, and self-care. What shifts in worldviews would be needed to assume (for example) that the most central occupations were relationship to others, spirit, self, land, and ancestors?

The COPM defines the client as the individual seeking change. In Indigenous cultures, however, there is often a strong focus on collectivity and community rather than individualism. The biomedical model approach to health care has been criticized for favoring Western perspectives of health with little space to integrate the diversity of knowledges from Indigenous cultures (Gerlach, 2018) or perspectives from other individuals in the client's life, such as community leaders or Elders. Euro-Western assessments are typically conducted with the individual, precluding contributions from family or community members. What shifts in worldviews would be needed to envision assessment starting with sharing tea with a client's family, friends, neighbors, and community Elders, simply listening? Or starting with traversing the land with community members? The exclusion of the community in assessment is compounded for Indigenous Peoples, where traditional roles have been disrupted because of colonialism (MacDonald & Steenbeek, 2015). Building partnerships within Indigenous communities has been purported to support positive health outcomes for both the client and the community (White & Beagan, 2020) and also appeals to the collective well-being that is fundamental in many Indigenous cultures (Gerlach, 2018).

An additional consideration is Indigenous perspectives of interconnectedness, balance, and harmony among all aspects of life, both spiritual and physical (Williams & Snively, 2016), which may not align with the COPM's focus on categorization and identifying specific, measurable goals in these categories. Identifying an issue in one aspect of life presents a challenge when the interconnectedness of all things is paramount. Spirituality and the human-Earth connection are also components of Indigenous ways of knowing and world views (Williams & Snively, 2016) that are neglected in the COPM's structure. Although the COPM is designed to provide flexibility in its categories for client-centeredness, it is still weighed down by Eurocentric definitions that continue to encumber cross-cultural utility.

Rooted in Colonialism

An additional challenge of this individualistic perspective that warrants particular attention when working with Indigenous contexts is the lack of acknowledgment of the larger impact of colonialism. The biomedical model focuses on the individual as the source of the issue and as the agent of change. What this fails to capture are the widespread and longstanding impacts that colonialism has had on Indigenous Peoples and cultures. Colonialism has resulted in significant inequities in terms of educational attainment, income, housing, and health for Indigenous groups (MacDonald & Steenbeek, 2015). Colonialism is still so pervasive that addressing these issues with an individual client is not likely to yield outcomes. Recognizing that poor housing and living conditions, as a result of colonial policies and structures, may

significantly limit an Indigenous client's ability to participate in what is considered typical interventions or therapy automatically disadvantages them in terms of performing according to expectations; therefore, it reduces the likelihood that the therapist will be able to justify continued service. Addressing individual issues (such as depression) without looking at the larger cause (such as poverty, hunger, and unstable housing because of colonialism) fails to tackle the primary issues, and the COPM's individual focus restricts the ability of the therapist to acknowledge these larger issues. As noted by Reading and Wein (2009), the roots of colonialism need to be addressed to support meaningful change for Indigenous clients.

Power Dynamics

One of the major features of the COPM that increases its utility across cultures and communities is the reliance on a semi-structured interview. This gives the therapist flexibility when obtaining information and facilitates dialogue between therapist and client, providing space for the client to lead the interaction. Inherent power dynamics that exist in a client-therapist relationship and a settler-non-settler relationship may reduce the realization of the intended benefits of this approach, namely the identification of client-centered performance issues. These inherent power dynamics are also more likely to surface when there is misalignment between the client and the therapist, which may result in poor performance on scoring metrics and assumptions by the therapist that the client is not engaged or not able to improve. Since decisions regarding discharge and access to benefits and services are based on the therapist's assessment, the institutional power structure often favors the therapist (McColl, 2005); this may lead to the removal of benefits or services, further contributing to inequitable access to health care services that are often experienced by Indigenous Peoples (Reading & Wein, 2009).

This lack of acknowledgment of structural barriers to client-centered practice negatively impacts Indigenous self-determination, which is cited as one of the primary distal social determinants of Indigenous health (Reading, 2015). The importance of self-determination and health outcomes is often cited at the structural level; however, connections have been found at the individual level, wherein a limited sense of control over one's life is linked with instances of depression (Reading & Wein, 2009).

The Importance of Cultural Awareness

The semi-structured interview intends to remove or, at minimum, mitigate the potential for cultural influence or bias on behalf of the therapist when identifying or defining client performance issues. It also encourages the integration of client and therapist knowledge and expertise, opening up possibilities for the client to bring in their own ways of knowing (Martin, 2012). However, the potential for this integration of worldviews through semi-structured dialogue relies heavily on the therapist's cultural awareness. Indigenous experiences with health care providers and the health care system have often been negative, including the removal of children from families (Gerlach, 2018) and blatant disregard and mistreatment as a result of structural racism when seeking services (McGibbon & Anderson, 2017). Such previous experiences are directly tied to the experience of colonialism. Elder members of Indigenous communities have lived through Residential Schools, the 60's Scoop, and numerous practices of oppression; subsequent generations have experienced intergenerational trauma that continues to permeate Indigenous cultures and experiences (MacDonald & Steenbeek, 2015). This may limit the willingness of Indigenous clients to share and converse openly with a therapist during the semi-structured interview portion of the COPM assessment for fear of unfair judgment or treatment (Gerlach, 2018). Sharing from an Indigenous worldview may be risky business in health care systems dominated by Euro-Western perspectives. Without the establishment of a trusting client-therapist relationship through culturally safe practices on

the part of the therapist, there is a risk that the dialectical goal of the semi-structured interview will not be realized.

Moving Toward True Client-Centeredness

In the absence of assessment tools collaboratively constructed for use in Indigenous contexts, there are several opportunities to modify and adapt the COPM to increase its suitability. Ideally, these modifications will be Indigenous-led through consultation with Indigenous therapists, clients, communities, and organizations to ensure the integration and consideration of Indigenous ways of knowing. Modifications may include but are not limited to addressing the individualistic nature of the COPM assessment tool, the deficit-focused approach, the numerical scoring guide, and the occupational performance issue categories. Such amendments, along with integrated cultural safety training for all occupational therapists certified to use the COPM, and modifications to practice mandates that require completion of the tool in the first client visit, can further support client-centered care that is the foundation of occupational therapy practice.

Integrating an opportunity to gather insight and knowledge from community members and key individuals in the client's life, as directed by the client, could help to support the collective orientation that is commonplace in Indigenous cultures. In addition to the inclusion of a section gathering information from others, gaining an understanding of disability from a community perspective (Gerlach, 2018) could also help to support effective practice and use of the COPM in Indigenous contexts. Occupational performance issues may be understood very differently in the community and may not be a concern or a priority for the client, the family, or the community. This aligns well with a strengths-based approach, ensuring that conversations with Indigenous clients center on balance and harmony, which is a key component of Indigenous perspectives of health and wellness. A focus on collective and community well-being, building on individual and communal strengths rather than remediating 'deficits', would be an important move away from assessing performance and satisfaction. Removal of or modification to the numerical scoring format, such as using pictures or simply oral communication to indicate experiences and changes (White & Beagan, 2020), may increase the applicability of the COPM in Indigenous contexts.

Therapists need to proactively address program expectations and mandates established in a Euro-Western health care system focused on efficiency and measurable productivity (Hammell, 2019). Such approaches are not culture-neutral and are unlikely to be effective in Indigenous contexts. Altering practice so that therapists can take the time needed to establish a trusting relationship before completing the COPM assessment could help mitigate some of the identified issues with the tool, including power dynamics and possible client hesitation or the inability to engage actively in the semi-structured interview. This building of a therapeutic relationship and sharing of knowledge centers on the Indigenous concept of Two-Eyed Seeing, which is the acknowledgment and valuing of differing worldviews (Bartlett et al., 2012). It could help facilitate positive change in the health care system and, ultimately, the health and well-being of Indigenous clients. This understanding may also help mitigate some of the limitations that are housed in the COPM occupational performance issue categories, enabling the therapist to gain an understanding of the values of the client and eliciting occupational meanings that may be more culturally relevant. Spirituality and human-earth connection are vital components of most Indigenous cultures. Acknowledging this and allowing space for conversations about this may enable more culturally safe practice.

Conclusion

The COPM may be used in conjunction with other approaches to assessment and as part of a thorough process of practice; thus, the COPM alone is neither the whole of the problem nor the whole of the solution regarding colonial influences in therapy. It is a single illustration of the ways Euro-Western ways of knowing permeate the profession. As an assessment tool for use in Indigenous contexts, the COPM has potential, given its semi-structured nature and client-led approach. The benefits of this approach, however, can only be realized with proper training and culturally safer practices on the part of the therapist. Widespread training of occupational therapists on adopting culturally safe methods, along with education regarding the impacts of colonialism, can help to increase the suitability of this tool. Additional prompts within the assessment tool that can be accessed when working with Indigenous communities would also be beneficial. These suggestions and modifications to the model should be collaboratively developed with Indigenous clients, organizations, therapists, and communities, which may include the addition of a category addressing spirituality, an additional section for community input, and modification of the scoring to be non-numerical or removed altogether to focus more on strengths. Of primary importance is the recognition that the assessment has been developed according to a Western, Eurocentric perspective and embodies that bias. Acknowledging therapists' personal and professional limitations can help support relationship-building and positive change toward improved service provision in Indigenous contexts.

References

Alberta Health Services. (n.d). *Diversity and inclusion*. https://www.albertahealthservices.ca/about/Page13880.aspx

Allan, B., & Smylie, J. (2015). *First peoples, second class treatment: The role of racism in the health and well-being of Indigenous Peoples in Canada*. Wellesley Institute and Well Living House. http://caid.ca/FirPeoSecClaTre2015.pdf

Arah, O. A., Westert, G. P., Delnoij, D. M., & Klazings, N. S. (2005). Health system outcomes and determinants amenable to public health in industrialized countries: a pooled, cross-sectional time series analysis. *BMC Public Health 5*, 81. https://doi.org/10.1186/1471-2458-5-81

Bartlett, C., Marshall, M., & Marshall, A. (2012). Two-eyed seeing and other lessons learned within a co-learning journey of bringing together indigenous and mainstream knowledges and ways of knowing. *Journal of Environmental Studies and Sciences*, *2*(4), 331–340. https://doi.org/10.1007/s13412-012-0086-8

Beagan, B. L., & Chacala, A. (2012). Culture and diversity among occupational therapists in Ireland: When the occupational therapist is the ''diverse'' one. *British Journal of Occupational Therapy*, *75*(3), 144–151. https://doi.org/10.4276/030802212X13311219571828

Burnett, K., Sanders, C., Halperin, D., & Halperin, S. (2020). Indigenous Peoples, settler colonialism, and access to health care in rural and Northern Ontario. *Health & Place*, *66*, 102445. https://doi.org/10.1016/j.healthplace.2020.102445

Canadian Association of Occupational Therapists [CAOT]. (2016). *Who we are and what we do*. https://www.caot.ca/site/wwa/whoweare?nav=sidebar

Canadian Association of Occupational Therapists [CAOT]. (2018). *CAOT Position statement: Occupational therapy and Indigenous peoples*. https://www.caot.ca/document/3700/O%20-%20OT%20and%20Aboriginal%20Health.pdf

Canadian Association of Occupational Therapists [CAOT]. (2019). *Synopsis of CAOT TRC Task Force Action Plan*. https://caot.in1touch.org/document/7539/TRC%20Board%20Report%202019_final%5B2%5D.pdf

COPM: The Canadian Occuptional Performance Measure. (2020). *About the COPM*. http://www.thecopm.ca/

Geary, A. (2017, September 18). *Ignored to death: Brian Sinclair's death caused by racism, inquest inadequate, group says*. CBC News. https://www.cbc.ca/news/canada/manitoba/winnipeg-brian-sinclair-report-1.4295996

Gerlach, A. (2018). *Exploring sociality-responsive approaches to children's rehabilitation with Indigenous communities, families, and children*. Prince George, BC, CA: National Collaborating Centre for Aboriginal Health. http://inuuqatigiit.ca/wp-content/uploads/2018/04/RPTChildRehabGerlach.pdf.pdf

Gerlach, A., Browne, A., & Suto, M. (2014). A critical reframing of play in relation to Indigenous children in Canada. *Journal of Occupational Science*, *21*(3), 243–258. https://doi.org/10.1080/14427591.2014.908818

Grenier, M.-L. (2020). Cultural competency and the reproduction of white supremacy in occupational therapy education. *Health Education Journal*, *79*(6), 633–644. https://doi.org/10.1177/0017896920902515

Hammell, K. W. (2009). Sacred texts: A sceptical exploration of the assumptions underpinning theories of occupation. *The Canadian Journal of Occupational Therapy*, *76*(1), 6–22. https://doi.org/10.1177/000841740907600105

Hammell, K. W. (2015). Client-centred occupational therapy: The importance of critical perspectives. *Scandinavian Journal of Occupational Therapy*, *22*(4), 237–243. https://doi.org/10.3109/11038128.2015.1004103

Hammell, K. W. (2019). Building globally relevant occupational therapy from the strength of our diversity. *World Federation of Occupational Therapists Bulletin*, *75*(1), 13–26. https://doi.org/10.1080/14473828.2018.1529480

Hunter, C., & Pride, T. (2021). Critiquing the Canadian Model of Client-Centered Enablement (CMCE) for Indigenous contexts. *Canadian Journal of Occupational Therapy*, *88*(4), 329–339. https://doi.org/10.1177/00084174211042960

Henderson, W. B. (2006, February 6). Indian Act. *The Canadian Encyclopedia*. https://www.thecanadianencyclopedia.ca/en/article/indian-act

Jacklin, K., Pitawanakwat, K., Blind, M., O'Connell, M. E., Walker, J., Lemieux, A., & Warry, W. (2020). Developing the Canadian Indigenous cognitive assessment for use with Indigenous older Anishinaabe adults in Ontario, Canada.

Innovation in Aging, *4*(4), igaa038. https://doi.org/10.1093/geroni/igaa038

Law, M., Baptiste, S., McColl, M., Opzoomer, A., Polatajko, H., & Pollock, N. (1990). The Canadian occupational performance measure: An outcome measure for occupational therapy. *Canadian Journal of Occupational Therapy*, *57*(2), 82–87. https://doi.org/10.1177/000841749005700207

Macdonald, C., & Steenbeek, A. (2015). The impact of colonization and western assimilation on health and wellbeing of Canadian Aboriginal people. *International Journal of Regional and Local History*, *10*(1), 32–46. https://doi.org/10.1179/2051453015Z.00000000023

Macyshon, J. (2021, June 3). *Long-awaited national action plan on MMIWG falls short, critics say*. CTV News. https://www.ctvnews.ca/politics/long-awaited-national-action-plan-on-mmiwg-falls-short-critics-say-1.5454171

Martens, K. (2019, December 17). *Canada has made 'dreadful progress' in fulfilling TRC's calls to action*. APTN National News. https://www.aptnnews.ca/national-news/canada-has-made-dreadful-progress-in-fulfilling-trcs-calls-to-action/

Martin, D. (2012). Two-eyed seeing: A framework for understanding Indigenous and non-Indigenous approaches to Indigenous health research. *Canadian Journal of Nursing Research*, *44*(2), 20–42.

Mccoll, M., Law, M., Baptiste, S., Pollock, N., Carswell, A., & Polatajko, H. (2005). Targeted applications of the Canadian Occupational Performance Measure. *Canadian Journal of Occupational Therapy*, *72*(5), 298–300. https://doi.org/10.1177/000841740507200506

McGibbon, E. & Anderson, M. (2017, October 26). *Indigenous health equity: Examining racism as an Indigenous social determinant of health*. Indigenous Cultural Safety Collaborative Learning Series. https://www.icscollaborative.com/webinars/indigenous-health-equity-examining-racism-as-an-indigenous-social-determinant-of-health

Missing and Murdered Indigenous Women, Girls, and Two-Spirit People. (MMIWG2S). (2019). *Reclaiming power and place – The final report on the National Inquiry into Missing and Murdered Indigenous Women and Girls.* Gatineau, QUE: The Commission. https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1a-1.pdf

National Collaborating Centre for Aboriginal Health. (2017). *Housing as a social determinant of First Nations, Inuit and Métis health*. National Collaborating Centre for Aboriginal Health. https://www.ccnsa-nccah.ca/docs/determinants/FS-HousingSDOH2017-EN.pdf

National Collaborating Centre for Aboriginal Health [NCCAH]. (2009-2010). *Poverty as a social determinant of First Nations, Inuit and Métis health*. Prince George, BC.: National Collaborating Centre for Aboriginal Health. https://www.ccnsa-nccah.ca/docs/determinants/FS-PovertySDOH-EN.pdf

National Collaborating Centre for Indigenous Health. (2019). *Access to health services as a social determinant of health for First Nations, Inuit and Métis health*. Prince George, BC.: National Collaborating Centre for Indigenous Health. https://www.nccih.ca/docs/determinants/FS-AccessHealthServicesSDOH-2019-EN.pdf

Nelson, S. (2012). *Challenging hidden assumptions: colonial norms as determinants of Aboriginal mental health*. Prince George, BC.: National Collaborating Centre for Aboriginal Health.

Page, J. (2021, May 19). *Hospital orderly, caught on video mocking Joyce Echaquan before she died, tells inquest she meant no harm*. CBC News. https://www.cbc.ca/news/canada/montreal/joyce-echaquan-coroner-inquest-may-19-1.6032387

Papps, E., & Ramsden, I. (1996). Cultural safety in nursing: The New Zealand experience. *International Journal for Quality in Health Care*, *8*(5), 491–497. https://doi.org/10.1093/intqhc/8.5.491

Reading, C. (2015). Structural determinants of Aboriginal peoples' health. In M. Greenwood, S. De Leeuw, N. Lindsay, & C. Reading (Eds.), *Determinants of Indigenous Peoples' health in Canada* (1st ed., pp. 3–15). Toronto: Canadian Scholars' Press.

Reading, C., & Wien, F. (2009). *Health inequalities and the social determinants of Aboriginal peoples' health.* Prince George, B.C.: National Collaborating Centre for Aboriginal Health. http://www.nccah-ccnsa.ca/docs/social%20determinates/nccah-loppie-wien_report.pdf

Sheahan, N., Harrington, R., Nelson, A., Sheppard, L., Potgeiter, A., Bartlett, A., White, R., Copley, J., Hill, A., Quinlan, T., McLaren, C., & Castan, C. (2019). Evaluating the clinical utility and responsiveness of the Australian Therapy Outcome Measure for Indigenous Clients (ATOMIC). 13th National Allied Health Conference, Brisbane, AU, August 2019. http://www.nahc.com.au/wp-content/uploads/2019/08/WED-1400_1-Nicholas-Sheahan.pdf

Smith, A. (2012). Indigeneity, settler colonialism, white supremacy. In D. M. Hosang, O. LaBennett, & L. Pulido (Eds.), *Racial Formation in the twenty-first century* (pp. 66–94). University of California Press. https://doi.org/10.1525/9780520953765

Smith, L. T. (2018). *Decolonizing methodologies: Research and Indigenous peoples* (2nd ed.). Zed Books Ltd.

Thunderbird Partnership Foundation. (2015). *Native Wellness Assessment*. https://thunderbirdpf.org/about-tpf/scope-of-work/native-wellness-assessment/

Toombs, E., Marshall, N., & Mushquash, C. J. (2019). Residential and nonresidential treatment within Indigenous populations: A systematic review. *Journal of Ethnicity in Substance Use*, *20*(1), 316–341. https://doi.org/10.1080/15332640.2019.1622478

Truth and Reconciliation Commission of Canada (TRC). (2015a). *Honouring the truth, reconciling for the future: Summary of the final report of the truth and reconciliation commission of Canada*. http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Exec_Summary_2015_05_31_web_o.pdf

Truth and Reconciliation Commission of Canada (TRC). (2015b). *Truth and reconciliation commission of Canada: Calls to action.* https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf

Westphal, A. (2013). Cognitive dementia and memory service (CDAMS) literature review. *Victoria Department of Health*. https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Cognitive-Dementia-and-Memory-Serviceliterature-review

Williams, W. L., & Snively, G. (2016). "Coming to know": A framework for Indigenous science education. In G. Snively & W. L. Williams (Eds), *Knowing home: Braiding indigenous science with western science* (pp. 32–47). PressBooks. https://pressbooks.bccampus.ca/knowinghome/chapter/chapter-3/

White, T., & Beagan, B. L. (2020). Occupational therapy roles in an Indigenous context: An integrative review. *Canadian Journal of Occupational Therapy*, *87*(3), 200–210. https://doi.org/10.1177/0008417420924933

World Health Organization (WHO). (2021). *Social determinants of health*. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1