Jennifer Kathleen Clarke, candidate for the degree of Master of Social Work, has presented a thesis titled, *Indigenous Professionals’ Experiences of Interprofessional Collaboration in Health Contexts*, in an oral examination held on December 15, 2016. The following committee members have found the thesis acceptable in form and content, and that the candidate demonstrated satisfactory knowledge of the subject material.

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*Via tele/videoconference*
Abstract

This qualitative study explores Indigenous experiences of interprofessional collaboration in health settings within Saskatchewan. The study adopts a transformative phenomenological approach, using a critical theory perspective, to generate rich descriptions of the experiences of five Indigenous professionals in multidisciplinary practice. Data was collected through interviews with each participant and a reflective journal and field notes completed by the researcher. Study findings highlight Indigenous ways of knowing; multiple meanings of the term professional; dynamics of power and status; relationships required for collaboration; policy and program factors impacting collaboration; and the suggestions offered by study participants to create a way forward. This study contributes to current research by developing the essence of Indigenous understandings of interactional, organizational, and systemic environments that augment and impede interprofessional collaboration.
Acknowledgement

I wish to acknowledge my thesis committee Dr. H. Monty Montgomery, Dr. Darlene Chalmers, and Dr. Nora McKee. My appreciation is extended to each of you for your insight, guidance, and support. Your contributions have enhanced this work.

I would like to express my deepest gratitude to my family for their love, encouragement, and sacrifice throughout this process. I have been remarkably blessed by each of you.

I extend my sincere appreciation to each of the participants. Thank you for your openness in sharing your experiences and vision with me. It is an honor to carry your knowledge on my journey forward.
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I offer gratitude to Dr. Tara Turner for her willingness to Chair the defense process. Your organization and thoroughness are appreciated.
Dedication

This thesis is dedicated to my grandmother, Greta Clarke. She inspired me to create space for learning in every experience. Her legacy sparked the beginning of this work.
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List of Abbreviations

**IPC**: Interprofessional Collaboration

**IPE**: Interprofessional Education

**CIHC**: Canadian Interprofessional Health Collaborative

**CAIPE**: Centre for the Advancement of Interprofessional Education

**AIPHE**: Accreditation of Interprofessional Health Education

**CASWE**: Canadian Association for Social Work Education


**Definition of Terms**

**Indigenous Peoples**

The United Nations Indigenous Peoples, Indigenous Voices Factsheet (n.d.) estimated there are more than 370 million Indigenous people within 70 countries. Indigenous populations are socially, economically, politically, and culturally distinct from the dominant societies in which they live. Indigenous populations have historical continuity and experiences of colonization. Identification occurs at the individual level and is acknowledged by their community. For the purpose of this study, criteria regarding Indigenous ancestry is determined by participant self-identification as is consistent with Indigenous social science literature and the Canadian Institutes of Health Research Tri-Council Policy. Purposive sampling using self-identification challenges colonialist practices of classification of Indigenous peoples (Baskin, 2005; Hart, 2014; Porter, 2005).

**Indigenous Professionals**

For the purpose of this study, professional criteria is inclusive of Indigenous cultural understandings of professional roles (i.e. Elders, knowledge keepers). Additionally, professionals and paraprofessionals within Western understandings of discipline-specific competencies and licensing accreditation are included in the study (i.e. nurses, social workers). Student-learner roles are not included in this category.

**Interprofessional Collaboration (IPC)**

The Canadian Interprofessional Health Collaborative (2010) defined an interprofessional team as “occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care” (pg. 24). For the
purpose of this study, interprofessional collaboration is expanded to include three or more professions to elicit the complexities of collaborative practice.

**Interprofessional Education (IPE)**

The Centre for the Advancement of Interprofessional Education (CAIPE) uses the term interprofessional education (IPE) to include all learning in academic and experiential settings while intending an inclusive view of "professional" (CAIPE, 2002). Interprofessional education requires purposeful interaction amongst the learners. It is insufficient for students to attend the same seminar or receive training from another profession (Accreditation of Interprofessional Health Education (AIPHE), 2009).
Chapter One: Introduction

Since 1988, interprofessional collaboration (IPC), interprofessional education (IPE), and integrated service delivery models have become more frequently utilized by social systems, including child welfare, justice, education, and health (World Health Organization, 1988). Collaboration amongst professionals is presented as a vital method for cultivating positive outcomes, client safety, and service delivery cohesion while addressing human and economic resource deficits (Baldwin, 1996; Reeves & Freeth, 2002; Wee, Hillier, Coles, Mountford, Sheldon, & Turner, 2001). However, there has been limited theoretical and empirical examination of power inequalities within interdisciplinary teams. Power exists not only within disciplinary hierarchies, but is also contained within gender, race, class, academia, and institutions impacting interprofessional relationships (Baker, Egan-Lee, Martimianakis, & Reeves, 2011; Hall, 2005). Current frameworks of IPE and IPC implemented by academic institutions offer hierarchical approaches. Thus, established IPE and IPC models have had very limited inclusion of Indigenous populations. Under-representation has also emerged in relation to recognition and acceptance of Indigenous epistemology, immersion within community, and teams led by Indigenous professionals, community appointed experts, and traditional healers.

A gap exists in understanding the experiences of Indigenous professionals in the context of interprofessional collaboration. This study aims to increase understandings of the experiences of Indigenous professionals in interdisciplinary health practice within Saskatchewan. The next section will provide the purpose of the study and connect the study to social work practice.
Purpose of the Study

This study aims to explore interprofessional collaboration frameworks. Specifically, this will include an examination of the dynamics of power and socialized professionalism within multidisciplinary collaboration in health care settings in Saskatchewan in 2016. The voices of Indigenous professionals provide meaning to the essence of their lived experience in interprofessional contexts. As such, the research question guiding the proposed study asks: “What is the experience of Indigenous professionals with interprofessional collaboration in health contexts?” This question is explored using qualitative research methods.

Relevance to Social Work

In Canada, the population of Aboriginal people was 1.4 million in 2011, comprising 4.3% of the total population (Statistics Canada, 2011). Statistics Canada (2011) identified Aboriginal people within three categories. Of the three Aboriginal categories, the largest was First Nations (851,560), followed by Métis (451,795), and Inuit (59,445). The Aboriginal population is growing at an increased rate over non-Aboriginal people. The Aboriginal population growth of 20.1% between 2006 and 2011 surpassed non-Aboriginal population growth of 5.2%. This highlights the importance of Indigenous contributions to human service contexts. In Saskatchewan, 157,740 Aboriginal people resided in seventy-five Indigenous communities. Métis peoples comprised almost half that population (Statistics Canada, 2011). In addition, six Indigenous languages add to the diversity of cultures, traditions, beliefs, and values of Indigenous peoples in Canada (Statistics Canada, 2011). The National Household Survey (Statistics Canada, 2011) identified disparity in socioeconomic status between Aboriginal
and non-Aboriginal people in Canada. Socioeconomic disparity, racism, and colonization place Indigenous involvement in support services at greater proportion.

Ongoing effects of colonization produced various results that include poverty, high unemployment rates, lack of education, inadequate or lack of affordable housing, family violence, dependence on social services, and substance abuse (Shah, 2004). In view of this, many Indigenous peoples experience severe social and health inequities as compared to other Canadians (Campaign 2000, 2005) (Baskin, 2011, p. 5).

Indigenous peoples should be “afforded additional consideration, in part because of the unique Constitutional rights and distinct legal status of Aboriginal Peoples in Canada” (Schnarch, 2004, p. 13). The voices of Indigenous professionals provide comprehensive understanding of Indigenous worldviews to advance collaboration.

Advantages of interprofessional collaboration for social workers include enriched interprofessional communication, utilization of community resources, activism, client empowerment, authority within public policy to effect social change, role definition, and problem solving approaches (Berg-Weger & Schneider, 1998; Karuza, Calkins, Duffey, & Feather, 1988; Quattrin, Aronica, & Mazur, 1990; Valentine, Williams, & Tafoya, 1990; Dunn & Janata, 1987; Casto, 1987; Andrews, 1990). Social workers receive academic training specific to communication skills and approaches to problem solving.

Field education opportunities facilitate knowledge acquisition of community resources. The CASW Code of Ethics (2005) requires social workers to engage in activism, empower clients, and advocate for social policy change. In addition to micro practice benefits, interprofessional collaboration “may increase the generalizability and impact of findings” (Berg-Weger & Schneider, 1998, p. 105) in social work research. Collaborative research approaches, such as participatory action research, assist in identifying other social, political, or economic applications for research findings. The next chapter
provides a literature review conducted to examine existing research regarding interprofessional education frameworks, Indigenous education, concepts of power within interprofessional collaboration, and collaboration with Indigenous peoples.
Chapter Two: Literature Review

Overview and Introduction

The following section outlines the current and social contexts of IPE and IPC. Current interprofessional models and challenges in IPE and IPC develop the background to the study subsequently forming the research question. This is followed by a literature review exploring collaboration with Indigenous populations and highlighting how dynamics of power intersect with IPE and IPC, impacting collaborative outcomes.

Interprofessional Education

IPE was launched in 1988 via the World Health Organization’s acknowledgement that collaboration in a multidisciplinary education setting resulted in enriched collaborative aptitudes for students in community settings (World Health Organization, 1988). The Centre for the Advancement of Interprofessional Education (CAIPE) provides the most widely agreed upon definition of interprofessional education. The definition states, “Interprofessional Education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care” (CAIPE, 2002). CAIPE uses the term interprofessional education (IPE) to include all learning in academic and experiential settings while intending an inclusive view of "professional" (CAIPE, 2002). Interprofessional education requires purposeful interaction among the learners. It is insufficient for students from different disciplines to attend the same seminar or receive training from another profession (AIPHE, 2009).

One of the primary keys to effective interprofessional education is the active engagement of students from different professions in interactive learning – something must be exchanged among and between learners from different professions that changes how they perceive themselves and others. These changes must positively affect clinical practice in a way that enhances interprofessional collaboration, client involvement in care, and ultimately improves health.
Interprofessional education outcomes are strengthened when opportunities for collaboration are integrated throughout the curriculum increasing in complexity as the student advances within their professional program (AIPHE, 2009).

In 2009, Canadian accreditation standards and principles for IPE among medicine, nursing, pharmacy, physical therapy, occupational therapy, and social work academic programs were developed with the intention for each accrediting body to frame them in their own language (AIPHE, 2009). The Canadian Association for Social Work Education (CASWE) Commission on Accreditation has established standards to ensure the curriculum provides undergraduate students with the necessary knowledge of associated disciplines to guide interprofessional collaboration (AIPHE, 2009).

**Challenges in Interprofessional Education**

Notwithstanding the frameworks for interprofessional education put forward by AIPHE and the Canadian Interprofessional Health Collaborative (CIHC), the integration into accreditation standards by the CASWE, and the importance of multidisciplinary collaboration to research and service delivery; social work programs have dedicated nominal or token resources to the advancement of effective interprofessional education pedagogy (Andrews, 1990; Berg-Weger & Schneider, 1998). Credit for the progress in interprofessional education is often owed to the few champions who dedicate their time in addition to their academic roles (Hall, 2005).

Challenges to IPE, IPC, and problem-based learning involve subdivided institutional structure, academic requirements, and resources. It can be difficult to coordinate IPE opportunities across disciplines that address each discipline’s curriculum
outcomes and determine equal allocation of funding, academic, and administrative resources. Further complicating factors include scheduling alignment, methods of evaluation, tuition payments, education and practice skill levels, faculty policies, professional language, academic competencies, socialized professionalism, and human resources (AIPHE, 2011; Barwell, Arnold, & Berry, 2013; McPherson, Headrick, & Moss, 2001). Dynamics and challenges of socialized professionalism will be explored later in this chapter. Additionally, Clark (2006) proposed “much of the literature on interprofessional education (IPE) is descriptive, anecdotal, and atheoretical” (p. 577) and further exploration is needed into the theoretical foundations of interprofessional education.

**Theoretical Approaches to Interprofessional Education**

The strength-based model is a foundational approach within social work practice. It acknowledges clients’ strengths as a resource in overcoming adversity. Berg-Weger and Schneider (1998) pointed out the strength-based approach commonly referenced in social work provides an opportunity to highlight interdisciplinary collaboration, the advantages of interdisciplinary practice, and the assets of each profession. Strength-based frameworks in IPE could create space for student collaboration and problem based learning modules to complement the unique competencies of each discipline. The principles of strength-based practice are consistent with foundational frameworks for interprofessional education and collaboration. The strength-based approach within IPE recognizes each person/profession has distinctive proficiencies that define their perspectives, proposes that capacity building transpires in the milieu of authentic relationships, and envisions effective transformation as a collaborative, inclusive, and
participatory process (Hammond, 2010).

Bandura (1977) proposed that learning takes place in a social context and occurs through observation, imitation, and modeling. Social learning theory is recognized within IPE because collaborative learning environments encourage reciprocal interactions between students to develop observations, reproduction of skills, and accuracy of feedback and communication with other disciplines. Collaborative, strength-based, and social learning frameworks are predictable correlations to interprofessional education (Clark, 2006). These theoretical approaches mirror IPE competencies such as role clarification, leadership, and shared decision-making (CIHC, 2010). These competencies will be explored later in this chapter. Social and experiential processes are integral components to interprofessional education, but may not expose the power disparities or exclusionary practices within professional collaboration.

**Indigenous Education**

The wealth of Indigenous knowledge is an uncultivated resource (Scribe, 2014). Indigenous communities are laboring to rebuild the knowledge of the past and engaging in re-valuation of knowledge the ancestors possessed (Scribe, 2014). Indigenous literature speaks of Indigenous programs, education settings, and the challenges for Indigenous students within mainstream classrooms (Baskin, 2005; Gair, Miles, & Thompson, 2005; Gray, Coates, & Yellow Bird, 2008; Sinclair, 2004; Vine Deloria Jr. & Wildcat, 2001). There seems to be limited research or exploration of “indigenization” of mainstream education, specifically post-secondary education in the field of social work. Porter (2005) defined “indigenization [as] the personal and collective process of decolonizing Indigenous life and restoring true self-determination based on traditional Indigenous
values” (p. 286-287).

Sinclair (2004) spoke to the need for mainstream social work programs to become culturally relevant through incorporation of Indigenous history and epistemology not only through curriculum, but also within the “daily workings” (p. 53) of the institutions. Gair, Miles, and Thompson (2005) emphasized the significance of collaborative development of curriculum to include multiple knowledges; specifically integrating Indigenous lived experience, storytelling, ceremony, and practice skills. Baskin (2005) put forth the importance of:

- inclusiveness of Aboriginal world views and ways of helping throughout the social work curriculum;
- awareness of the history of colonization;
- insight into the assumptions, values and biases of the profession, educators, and students;
- understanding of the client’s cultural context; and an emphasis on decolonization (p. 56).

Gray, Coates, and Yellow Bird (2008) critiqued mainstream social work programs’ focus on intellectual knowledge with limited integration of cosmology. Vine Deloria Jr. and Wildcat (2001) underlined the profound difference between “Indigenous professionals who live in the world with relatives and focus on relations [and]… professionals who study resources (objects) and focus on control” (p. 121). It is ‘all my relations’ epistemologies juxtaposed with ‘the other’ approaches. This juxtaposition is also evident in current models of interprofessional education and collaboration.

Vukic and Keddy (2002) and Purden (2005) asserted that cultural considerations are a primary element in the efficacy of health and social program development in Indigenous communities, however many professionals do not acquire the necessary knowledge as cultural topics receive token attention during the intense process of professional education.
Interprofessional education is currently a top-down approach, implemented by academic institutions. In the same way “you can’t volun-tell someone to teach Indigenous content in the classroom” (Scribe, 2014) interprofessional engagement and collaboration cannot be obligatory. Community development frameworks are essential to interprofessional education and collaboration. A shift towards community-led, student-led, bottom-up, grassroots, and inclusive partnership is needed.

Minore and Boone (2002) go further in their recommendations specifying that course content should be expanded to include the roles and responsibilities of aboriginal paraprofessionals – in order to focus on the entire team. Students in the health sciences need to be made aware of aboriginal paraprofessionals’ contributions to patient care, and how to work more collaboratively with them. A future direction for interprofessional education may involve creating some opportunities for shared instruction in the classroom and the clinical setting between aboriginal paraprofessional and health professional programs (Purden, 2005, p. 232).

Examination beyond textbooks and into the experiential understanding of ‘place’ and ‘knowing’ is imperative. Incorporation of Indigenous ways of knowing and cumulative impacts of colonization into all education levels is the missing component. Connection to place, language, and customs need to be foundationally embedded throughout the academic milieu through storytelling, Indigenous knowledges, life stories, and oral tradition. Creating culturally responsive, Indigenously infused school environments that promote the revitalization of the past generates opportunities for success in the future (Scribe, 2014). The complex intersectionality of social determinants of health surpasses the proficiency of individual disciplines thus requiring collaborative patient-centered care (Freeth, 2001).

Current Interprofessional Model

The Accreditation of Interprofessional Health Education (AIPHE) developed
benchmark principles for IPE in health contexts. The benchmark principles focused on student-led IPE opportunities; IPE embedded in curriculum; consistent accreditation standards and support for IPE and IPC across disciplines; specific knowledge, aptitudes, and core competencies for collaborative practice; relationship-focused approaches to collaboration; and client-centered care practices (AIPHE, 2009). The Canadian Interprofessional Health Collaborative (CIHC) identified six competency domains for IPC and created the National Competency Framework (see Figure 1).

Figure 1

*The National Competency Framework*
Within the National Competency Framework, the six competency domains include interprofessional communication, patient/client/family/community centered care, role clarification, team functioning, collaborative leadership, and interprofessional conflict resolution (CIHC, 2010). A core competency statement delineates each domain and the descriptors associated with it. The National Competency Framework provides a guideline for disciplines engaging in IPC and for evaluation of student competencies following IPE modules. In 2011, the AIPHE Project developed the Accreditation Standards Guide, which contains five domains to establish IPE criteria within each discipline. The domains for accreditation standards include organizational commitment, faculty/academic unit, students, educational program, and resources (AIPHE, 2011). Each domain contains context, suggested standards for language and criteria, and examples of evidentiary outcomes.

Evident in the literature on IPC are three conceptual areas of relevance to this study. These are concepts of power; mainstream perspectives of collaboration with Indigenous populations and professionals; and Elders perspectives of IPC. These areas will now be discussed.

**Concepts of Power**

Power is a basic component of any relationship. It can be based within legal, social, political, economic, or institutional constructs (Foucault, 1983). Foucault (1983) identified three types of power struggles

…either against forms of domination (ethnic, social, and religious); against forms of exploitation which separate individuals from what they produce; or against that which ties the individual to himself and submits him to others in this way (struggles against subjection, against forms of subjectivity and submission) (p. 209).
In addition to power within domination, exploitation, and subjection Foucault (1972) identified power exerted through language. Language and communication are critical components within IPE and IPC; however there has been limited exploration of discourse analysis in these settings. Orchard, Curran, & Kabene (2005) identified several barriers to the goals of interprofessional collaboration including organizational structuralism, power relationships, and role socialization. Orchard et al. (2005) characterized these barriers as follows:

organizational structuralism is defined as the administrative organization and decision making processes adopted within institutions; power imbalances as the ability to exert pressure on another by virtue of formal or informal positions; and role socialization being development of behaviors, and attitudes deemed necessary to fit into a cultural group (p. 2).

Organizational structuralism can influence power dynamics within IPE and IPC when decision-making or administrative processes are implemented unilaterally without consultation with stakeholders. Imbalance in power relationships can be created through hierarchical roles or position structures (i.e. employee, supervisor, manager) that do not create flexibility for collaboration. Professional role socialization occurs when undergraduate students are taught the norms, values, beliefs, and behaviors specific to their discipline. Autonomous undergraduate education models can result in decreased knowledge concerning the “scope of practice, expertise, responsibilities, and competencies of other disciplines” (Orchard et al., 2005, p. 4). Orchard et al. (2005) and Clark (1997) assert that professional cultures and personal beliefs inform teamwork and group processes within interprofessional education settings.

Baker, Egan-Lee, Martimianakis, and Reeves (2011) used Witz’s Model of Professional Closure as a lens through which they examined power dynamics within
interprofessional education. Witz’s *Model of Professional Closure* (1992) examines four categories of closure strategies and the interactions between them. The strategies are identified as exclusionary, demarcationary, inclusionary, and dual closure. Table 1 outlines how professional power corresponds with Witz’s model.

**Table 1**

*Definitions of professional closure strategies*

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusionary</td>
<td>Exclusionary strategies involve a downward use of power by a dominant profession in order to control entry to their profession and create a monopoly over their skills and knowledge.</td>
</tr>
<tr>
<td>Inclusionary</td>
<td>Inclusionary strategies are used by subordinate professions to challenge exclusionary strategies and involve an upward push of power in order to achieve entry into the ranks of the dominant profession.</td>
</tr>
<tr>
<td>Demarcationary</td>
<td>Demarcationary strategies involve a downward use of power by a dominant profession in order to control boundaries between related professions to secure their position of power on the professional hierarchy.</td>
</tr>
</tbody>
</table>
| Dual closure   | Dual closure strategies are used by subordinate professions in response to demarcationary strategies and involve a two-way use of power:  

  - Usurpationary strategies push upward and are used not to gain entry to the ranks of the dominant profession, but to challenge demarcationary strategies and change the structure of the hierarchy.  
  - Exclusionary strategies push downward and are used to secure their place in the hierarchy. (Baker et al., 2011, p. 99) |
Exclusionary closure is also referenced as boundary-work (Hall, 2005) and is criticized for promotion of professional ideologies, professional authority, and siloed service delivery. Boundary-work fosters exclusion of paraprofessionals, community appointed experts, traditional Indigenous healers, and clients within interprofessional teams. Figure 2 provides Witz’s (1992) diagram of the Model of Professional Closure.

Figure 2

Witz’s Conceptual Model of Strategies of Closure

(Witz, 1992, p. 4)

This visual illustrates directional power between the professions to further illustrate the hierarchy between disciplines in professional practice.

Baker et al. (2011) suggested, “interprofessional interactions within an IPE
context can be seen to mirror closure strategies” (p. 102) and proposed that such strategies fortify power imbalances and impair collaborative care. Additionally, Baker et al. (2011) contended some professions, especially those in subsidiary stations such as social work, nursing, and allied health professions, are prone to engage in interprofessional collaboration as a means to experience augmented power and status.

Dahlgren (2006) explored the interconnectedness of the social facets of interprofessional education models with Piaget’s concept of “decentering”. Decentering encompasses awareness of perspectives independent of one’s own. This shift in perception through interprofessional learning can be linked to epistemological changes (Clark, 2006). Clark (2006) and Perry (1970) outlined students’ progression through stages of professional dualism, relativism, and ultimately develop a commitment to interdisciplinary collaboration. Wenger (1998) and D’Eon (2005) described this process as socialization within parallel communities of practice. Multidisciplinary socialization may also change professional cognitive maps. Cognitive maps are the result of role socialization whereby “quite literally, two opposing ‘disciplinarians’ can look at the same thing and not see the same thing” (Petrie, 1976, p. 35). In response to some of these challenges, pedagogical foundations of IPE should include “openness, mutual respect, inclusiveness, responsiveness and understanding one’s roles” as these characteristics are central to the provision of holistic care in culturally diverse communities (Purden, 2005, p. 224).

Socialized professionalism is reinforced through systemic economic, social, and political protection of exclusive knowledge and roles (Baker et al., 2011; Schroeder, Morrison, Cavanaugh, West, & Fache, 1999). Larkin (1983) argued that accreditation and
licensing bodies further fortify professionalization. Hall (2005), in reference to Witz’s

Model of Professional Closure (1992), stated

through exclusionary closure, the profession limits the number and type of entrants into its fold, thus enhancing the market value of the service. The profession then begins to monitor and regulate the labour of other occupations that provide related services to protect its market niche (p. 189).

This exercise of authority also limits the recognition of informal or community appointed experts, traditional healers, Elders, and Indigenous professionals.

Systemic power disparities affect collaborative processes. To prevent siloed approaches to practice, praxis - or reflective practice - is critical during the process of professionalization and professional socialization. Organizational structures that are conducive to IPC facilitate open and direct communication and shared decision-making through a less hierarchical leadership configuration. The organizational philosophy must champion inherent values and work climate that facilitates collaborative practice. It is the responsibility of management to model leadership styles that are supportive of collaborative practice and establish realistic objectives for interprofessional tasks.

Universities also receive criticism for reinforcing the siloed approach through specialization and departments (Dauphiné & Martin, 2000; Hall, 2005; Kerr, 1982). Academic institutions are charged with the task of initiating links between disciplines to create foundations in collaborative education and practice (Hinton Walker, Baldwin, Fitzpatrick, Ryan, Bulger, DeBasio, Hanson, et al., 1998; Liedtka & Whitten, 1998). It is my opinion that IPE through field education and experiential learning that includes paraprofessionals, community appointed experts, traditional Indigenous healers, and clients is indispensable at the undergraduate level before silos and socialized professionalism are solidified.
Inclusionary Interprofessional Education

Orchard, et al. (2005) asserted interprofessional education and practice models identify the professionals as decision-makers. Review of the literature and practice experience leads me to assert authentic participatory, collaborative practice should include clients, students, and non-traditional experts. One of the principles of interprofessional education is shared decision making and, as such, should include service-users. In education settings this would include students. In multidisciplinary collaborative practice clients should be included. If we argue an inclusive approach students, clients, and non-traditional community experts may perceive the term ‘interprofessional’ as exclusionary (Orchard et al., 2005). It is important to consider a term that encompasses the collaborative team participants. From a social work standpoint more comprehensive practice and terminology would be consistent with anti-oppressive practice approaches. I would suggest a more general term, such as collaborative or cooperative teams.

Community development initiatives and program implementation are more successful when introduced, guided, and executed by students and clients (Jones & Black, 2008). Few IPE models incorporate clients in experiential and academic settings (Furness, Armitage, & Pitt, 2011). The Trent Universities Interprofessional Learning in Practice (TULIP) Project developed two case studies to research interprofessional education with clients. The TULIP Project emphasized direct contact between clients, professionals, and students. The research validated previous literature that conveyed all participants benefited from these activities (Furness et al., 2011). Clients are motivated to participate in interprofessional education to improve service delivery, develop personal
skills, demonstrate individual competencies, advocate for social change, and improve the professional-client relationship (Telford & Faulkner, 2004).

I think shared decision-making, client inclusion, and interprofessional collaboration must occur throughout the academic milieu and community practice. Orchard et al. (2005) acknowledged this shift will require change within the distribution of client care responsibilities and management.

The patient will have, as a team player, to share responsibility about his/her health. The patient cannot be both the center of the new care delivery model and independent from it. The inclusion of the patient in the model will require a real balance in decision-making processes (Orchard et al., 2005, p. 8).

Hoffman, Rosenfeld, Gilbert, & Oandasan (2008) offered “student leadership in IPE suddenly becomes especially important as it encourages the nurturing of student champions, which enables a cultural change to take place among the youngest clinicians, who have the longest careers ahead of them” (p. 656). In Canada, the IPE stakeholders support student leadership in the areas of participant engagement, public education, and advocacy within macro realms (Hoffman et al., 2008). Appendix J provides the research outcomes of Hoffman et al.’s (2008) study considering student-initiated IPE. The challenges in student-directed models are consistent with those identified earlier within faculty-led approaches.

Student leadership is consistent with student-centered approaches to education maintained by most institutions (Hoffman et al., 2008). Interprofessional education also provides a practical, efficient, economical, and sustainable model for universities facing reductions in government funding (Hoffman et al., 2008). Institutions can leverage student-directed education models for additional resources from government funders. Student, client, and Indigenous voices add to the diversity of perspectives in IPE and IPC.
Mainstream Perspectives of Collaboration with Indigenous Populations and Professionals

In reviewing the literature I found inclusive collaboration could be hindered by ambiguity surrounding the role of Indigenous paraprofessionals. This is sometimes perceived as a “lack of confidence professionals have in the knowledge, skills and judgment of their paraprofessional colleagues” (Purden, 2005, p. 228). This lack of confidence may also be reflective of racism, hierarchical structures, and power imbalances within Western society. dé Ishtar (2004) identified the fear of disrespecting Indigenous peoples and the fear of yielding white privilege. In my experience, non-Indigenous professionals may refrain from asking questions about the roles of Indigenous professionals to avoid being viewed as lacking appropriate cultural understanding or asserting white privilege within IPC contexts. Challenges related to cultural considerations are likely present whenever participants’ values and beliefs differ from Western societal norms (Purden, 2005).

Jackson, Brady, and Stein (1999) used an exploratory descriptive design and feminist approach to identify the tensions between nurses and Aboriginal health workers. Participants in the study indicated that professional relationships are essential within knowledge sharing, skill development, and systemic equality. Nurse participants expressed a limited understanding of hierarchical, cultural, power, status, and educational experiences of the Aboriginal health workers.

Barr (2007) used a community-based participatory research approach to create reciprocity between student learning and community development and explore the improvement of quality of life in communities through IPE. Barr challenged the
shallowness of IPC through comprehending the distinctions in marginalized and dominant cultures. Barr (2007) examined the strategies for recruiting Indigenous health professionals through IPE as outlined in the example taken from Baldwin, Baldwin, Edinberg, and Rowley (1980) that put forth Indigenous populations must be provided "clinical experience" to "heighten Indian motivation to pursue careers in health care" (Barr, 2007, p. 45). I think these are hegemonic and stereotypical views of Indigenous populations that circumscribe Indigenous worldviews, perspectives of community and reciprocity, and assume the need to legitimize Indigenous care through Western academic systems.

Kickett, Hoffman, and Flavell (2014) reported the outcomes of a mixed methods survey in an IPE course examining students’ perceptions of supports to the achievement of learning outcomes. The pedagogical approach to the course was theoretical conceptualization of culture. The course outline identified the use of video podcasts to allow diverse Indigenous people to communicate the impacts of colonization, policies, practices, and racism on health and well being (Kickett et al., 2014, pg. 39). Student evaluations clearly articulated cultural incongruence in the areas of oral tradition, cosmology, and reciprocity. Kickett et al. (2014) offered an exploration of student experience within cross-cultural education; further research still needed is the examination of the experiences of the Indigenous tutors, Instructors, and Indigenous contributors to the development of this IPE course.

Lindeman, Taylor, Kuipers, Stothers, and Piper (2012) identified the need for holistic approaches to care that are considerate of cultural contexts, poverty, and competing priorities for practitioners and clients. The qualitative study foregrounded the
perceptions and experiences of clinic health care providers, and recognized the importance of cultural factors, but did not incorporate the voices of the Indigenous community.

Berg-Weger et al. (1998) recognized the opportunity for “cross-listed courses, multidisciplinary team-taught courses, and joint or dual degree programs” (p. 105) as well as the development of “multidisciplinary, community-based programs in such settings as schools, health care centers, housing projects, and community centers” (p. 106). Experiential learning or community-based programs create opportunities beyond problem-based learning modules and field education to develop relationships. I think experiential learning led by Indigenous community partnerships would be of value to interrupt hegemonic collaboration and disciplinary exclusivity. I believe Indigenous communities must initiate, create, and sustain the program and/or interprofessional team. The community needs to have the leadership role instead of involvement, or secondary, roles (Baldwin, Baldwin, Edinberg, & Rowley, 1980; Barr, 2007).

Oelkel, Thurston, and Arthur (2013) outlined a cultural competency framework for IPC. Oelkel et al. proposed that cultural competency could ensure effective collaboration through cultural safety, advocacy, addressing systemic barriers, valuing cultural knowledge, and developing cross-sectoral partnerships. I suggest this framework proposes solutions to common barriers in IPC; however it is founded on the abilities of health care providers (those with power) to be critically reflective of their practice and recognize systemic, hierarchical, power, and colonialist dynamics. Practitioners may not be able to adequately identify relevant factors. Therefore, it is necessary for the voices of Indigenous professionals to be heard within IPE and IPC.
Elders’ perspectives of interprofessional collaboration

Stevenson’s thesis (2009) contributed to Indigenous voices in IPC through a phenomenological approach and narrative inquiry with Elders in southern Saskatchewan. The study highlighted the Elders’ beliefs that collaborative Western and Indigenous health systems offer diversity in treatment options and beneficial health outcomes for all people. Inclusion of Elders in facilitating traditional healing within mainstream systems is crucial to developing “the ethical space between two knowledge systems” (Stevenson, 2009, p. 83).

Summary

This review of the literature identifies a gap relating to the experiences of Indigenous professionals in collaborative practice. The IPE and IPC literature provides comprehensive documentation of the models of collaboration; the experiences of scholars, professionals, and students; and the perceptions of Western society on the engagement of Indigenous professionals, but it does not offer first-person perspectives from Indigenous professionals. The next chapter will outline the methodology, social location, and interests in interprofessional education and collaboration. It will also identify the research design for the study, including data collection, data storage, data analysis, limitations, and ethical considerations.
Chapter Three: Research Design

Overview and Introduction

Qualitative research is appropriate when the area of study requires exploration of participants’ experience in commonplace contexts. This method provides rich, thick description of lived experience. “Phenomenology is rooted in questions that give a direction and focus to meaning, and in themes that sustain an inquiry, awaken further interest and concern, and account for our passionate involvement with whatever is being experienced” (Moustakas, 1994, p. 59). Participants’ perspectives are captured to develop understanding of the processes of change and create meaning in relationship to the phenomenon (Creswell, 2013). There is little research exploring the experiences of Indigenous professionals in the context of interprofessional collaboration. However, qualitative methods have been successful in creating understanding of the experiences of other contributors to interprofessional education and practice, such as students, clients, and health science professionals (dé Ishtar, 2004; Jackson, Brady, & Stein, 1999; Kickett, Hoffman, & Flavell, 2014; Lindeman, Taylor, Kuipers, Stothers, & Piper, 2012).

The purpose of this phenomenological study was to answer the research question: “What is the experience of Indigenous professionals with interprofessional collaboration in health contexts?” Transformative research frameworks, self-reflection, and critical theory are incorporated to acknowledge bias and partiality and challenge hegemonic research. Transformative phenomenology incorporates the essence of participant experience with the acknowledgement that transformation occurs for researchers, personally and professionally, through the process of engaging in research. The study attempts to frame research outcomes through activism and offer solutions to oppression in societal and institutional structures (Creswell, 2013). The next section will expand on
the transformative phenomenological approach I employed for this study.

**Methodology**

Transformative phenomenology developed from the work of philosophers Husserl, Schutz, Merleau-Ponty, Heidegger, and Gadamer (Rehorick & Bentz, 2008). Husserl (1931), and later Moustakas (1994), considered our consciousness of everyday occurrences and started to uncover the essential structures of a phenomenon. Schutz (1970) theorized that our experiences and lifeworlds are connected to social and cultural contexts. Merleau-Ponty (1962) examined the mind-body connection and Heidegger (1977) highlighted the relationship between technology and nature. Both of these phenomenon are long-understood by Indigenous peoples. Gadamer (1975) revealed the significance of interactions, relationships, and social organizations in data collection.

Douglass and Moustakas (1985) identified distinctions between heuristic and phenomenological research stating,

(1) Whereas phenomenology encourages a kind of detachment from the phenomenon being investigated, heuristics emphasizes connectedness and relationship. (2) Whereas phenomenology permits the researcher to conclude with definitive descriptions of the structures of experience, heuristics leads to depictions of essential meanings and portrayal of the intrigue and personal significance that imbue the search to know. (3) Whereas phenomenological research generally concludes with a presentation of the distilled structure of the experience, heuristics may involve reintegration of derived knowledge that itself is an act of creative discovery, a synthesis that includes intuition and tacit understanding. (4) Whereas phenomenology loses the persons in the process of descriptive analysis, in heuristics the research participants remain visible in the examination of the data and continue to be portrayed as whole person. Phenomenology ends with the essence of experience, heuristics retains the essence of the person in experience (pg. 43).

Rehorick and Bentz (2008) linked hermeneutics to phenomenology by claiming that phenomenology can be transformative. The transformative phenomenological approach incorporates the philosophy of phenomenology while highlighting the transformative
experiences that occur for researchers and participants through the research process. The new perspectives and understanding that emerge through the research process can lead to advocacy for social change. For the researcher, transformative phenomenology blends academic research with practice experience (Rehorick and Bentz, 2008).

Transformative phenomenology entails examining of the essential structures of the phenomena and understanding of the social context and relationships. The approach balances researcher integration of epistemology, ontology, and axiology through bracketing. Bracketing is a process developed by Husserl (1931) where the researcher suspends prior knowledge and experience. The researcher must learn to “recognize, then set aside, the myriad assumptions, filters, and conceptual frameworks that structure our perceptions and experiences. This process can never be complete as each new situation and horizon embodies change” (Rehorick & Bentz, 2008, p. 11). Bracketing is believed to increase the researcher’s ability to “describe the phenomenon in its pure, universal sense” (Wojnar & Swanson, 2007, p. 173). Bentz shares “I more routinely examine the preconceptions I bring to a situation, am more aware of the particularity of my point of view, or the way my mood may affect what I perceive” (Rehorick & Bentz, 2008, p. 9). Researchers are encouraged to develop reflexive practice and an openness to change, or transform, over time. This transformation includes our typifications, or the “mental constructs” of characteristics about a phenomenon “based on judgments from prior knowledge” (Rehorick & Bentz, 2008, p. 18). The intent of the transformation is toward the alteration of society and the human condition (Rehorick & Bentz, 2008). “Phenomenological inquiry displays how typifications can help and hinder professional practice” (Rehorick & Bentz, 2008, p. 19). This research approach is consistent with
social work ethics to pursue social justice (Canadian Association of Social Workers, 2005).

In Canada, social workers are required to examine the client’s lived experience through understanding of social, emotional, physical, and spiritual contexts. In doing so, we effectively use ourselves to reflect neutrality and filter, or bracket, personal values and bias especially with individuals, groups, and communities for whom we are providing professional services. “Phenomenology is a return to direct experience as a source of knowledge while rejecting the received knowledge of authority (teachers, preachers, books, parents, history, science, and others)” (Rehorick & Bentz, 2008, p. 6). Advocacy in support of social transformation is created through the understanding of the lived experience of another and connecting that knowledge to collective human need.

Understanding the lived-experience of others is key to transformative phenomenology, social work, and interprofessional collaboration. Interprofessional teams have the potential to engage in social justice by moving members’ focus on internal factors to engagement in a discourse of social action and advocacy (Ratts & Santos, 2010). Social workers are uniquely positioned to engage team members in inclusive, social justice focused work given their knowledge, skills, and ethical foundations (Pullen-Sansfaçon & Ward, 2012).

**Social Location**

Within qualitative inquiry, stating the philosophical assumptions and social location of the researcher is imperative to the trustworthiness of the study (Creswell, 2013). This is because epistemology, ontology, and axiology are connected to the formation of the selected research methodology and therefore influence the process and interpretation of
disciplined inquiry. “The self of the researcher is present throughout the process and, while understanding the phenomenon with increasing depth, the researcher also experiences growing self-awareness and self-knowledge. Heuristic processes incorporate creative self-processes and self-discoveries” (Moustakas, 1990, p. 9). Within qualitative research, the researcher is often described as an “instrument” of data collection (Denzin & Lincoln, 2003). All qualitative data is filtered through the researcher. Dwyer and Buckle (2009) explore “the space between” being part of or not part of the group or area of research study. They propose there is opportunity to be both an insider and an outsider. This resonates with me as a professional engaged in interprofessional practice, but not an Indigenous professional with experience in health settings. Dwyer and Buckle (2009) proposed,

…as qualitative researchers we have an appreciation for the fluidity and multilayered complexity of human experience. Holding membership in a group does not denote complete sameness within that group. Likewise, not being a member of a group does not denote complete difference. It seems paradoxical, then, that we would endorse binary alternatives that unduly narrow the range of understanding and experience (p. 60).

My social location offers a critical reflection of the biases, assumptions, and experiences connected to the research study.

I collaborate to obtain perspectives from others who do not share my lived experience. These consultations have allowed me to identify linkages and communicate shared outcomes to effectively advance collaboration. I noticed that in academic and practice settings the experiences of Indigenous professionals, Elders, and community-identified experts were rarely heard. I believe IPC challenges personal assumptions, which are rooted in our professional training and role socialization and are reinforced by the scholarly community in which we work (Creswell, 2013). This research study seeks
to add to current knowledge of interprofessional collaboration, by focusing on the experiences of Indigenous professionals.

As a white woman from Saskatchewan, I benefit from racism maintained through power, privilege, and inequality. I contribute to racism in our society through my privilege to contribute to knowledge construction founded on my Western-based postsecondary education. Within my roles in academic institutions and government systems I inform others about how to behave, succeed, and interpret information. I am successful in these contexts because my cultural background, socioeconomic status, and religious beliefs align with the dominant groups.

As a social worker, I am employed in and contribute to social institutions that apply token understandings of Indigenous worldview and engage in the legitimization of Indigenous knowledge within the characterization of social justice. I am developing resistance toward interpersonal, organizational, and systemic milieus that fostered my contributions to and acceptance of racism through unexamined privileges and covert acceptance. I strive to alter the belief that I am excluded from the oppressive mainstream because I am attempting to understand the experience of marginalized populations. Exploration of the experiences of Indigenous populations converges with my desire to transform the partiality of my perspective through critical reflection.

According to Mertens (2003) transformative philosophical assumptions and interpretive frameworks propose, “knowledge is not neutral but is influenced by human interests, that all knowledge reflects the power and social relationships within society, and that an important purpose of knowledge construction is to help people improve society” (p. 139). Critical theory focuses on the hegemony contained within social
institutions and challenges traditional theories used to describe individual experiences (Brookfield, 2014). Thus, critical theory corresponds well with the examination of the social constructs within IPC. Transformative approaches and critical theory are positioned within liberal philosophical orientations and the Canadian welfare state model. IPC within health settings assumes the involvement of government social programs, interventions, and professionals. IPC takes a reformist approach toward social program service delivery that is consistent with liberal political positions. IPC intends to reform the service delivery of current social programs and in the case of Canada’s healthcare system, programs that are delivered primarily through the government. IPC and intervention requires acknowledgement of service gaps and progressive views for greater government involvement in providing social programs. Decolonization theory highlights that Indigenous knowledges and self-governance were excluded when academic and healthcare systems were first established (Baskin, 2011; Kohn & McBride, 2011; Tuhiwai Smith, 1999). I believe this perspective is a foundational construct for this study.

The next section will identify the research design for the proposed study. It will include data collection, data storage, data analysis, limitations, and ethical considerations.

**Overview of the Research Design**

This qualitative study utilized transformative phenomenological research methods to gain insight into the experiences of Indigenous individuals working within interprofessional teams in health settings. Qualitative data collection methods include a literature review, participant interviews, field notes, and a reflective journal. Five Indigenous individuals who fit the approved selection criteria participated in two semi-structured interviews. Data analysis was conducted using the descriptive
phenomenological approach outlined by Moustakas (1990) and incorporated the transformative analytic method offered by Rehorick and Bentz (2008). Ethical considerations, credibility, and trustworthiness of the study are also explored within this chapter.

Participants

The participants for this study were identified through a purposeful sampling approach, which includes criterion, convenience, gatekeeper, and snowball sampling strategies. This method elicited rich data and comprehensive individual narratives from which to explore the essence of the phenomenon. Dukes (1984) recommended interviews with three to ten participants. Utilizing my approved recruitment strategy, I received responses from eight interested persons and ultimately five Indigenous professionals participated. Following successful recruitment of individual participants, I consulted by phone and in person with culturally-informed individuals with whom I already have established relationships including an Elder, my thesis supervisor, and an Indigenous colleague within health service delivery. This process was important for me, as a non-Indigenous person, as it enabled me to receive guidance and information about protocols unique to Indigenous culture. It was paramount for me to ensure appropriate protocols were followed and Indigenous knowledge was respected.

Phenomenological inquiry requires participants to experience and articulate the phenomenon (or criteria) being studied (Moustakas, 1994). In the case of this research project, recruiting participants with common experience in interprofessional collaboration in a Saskatchewan health setting was imperative. The participants were chosen from the health services sector because it can be more difficult to examine the essence of the
phenomenon when diversity in characteristics occurs (Creswell, 2013). Additionally, IPE frameworks were developed to focus on health sciences and current literature examines IPC primarily within health contexts. For the purpose of this study, criteria for participation in IPC included teams where three or more professions formed to provide health services within Saskatchewan.

Criteria regarding Indigenous ancestry were achieved through participant self-identification, as this is consistent with Indigenous social science literature and the Canadian Institutes of Health Research Tri-Council Policy. Purposive sampling using these criteria challenges colonialist practices of classification of Indigenous peoples (Baskin, 2005; Hart, 2014; Porter, 2005). Professional criteria are inclusive of Indigenous understandings of traditional helping roles (i.e. Elders, knowledge keepers) although these roles do not fit Westernized conceptions of professional disciplines. Additionally, professionals and paraprofessionals who met established Western understandings of academic competencies and licensing accreditation are also included in the study.

The participants were recruited by advertising through posters (Appendix A) and email (Appendix B) to Saskatchewan health regions and health centres in Indigenous communities. The sample for this study was also obtained through convenience, gatekeeper, and snowball strategies. I utilized professional contacts with gatekeepers within health regions, community based organizations, and Indigenous health centres in Saskatchewan. Utilizing a gatekeeper strategy, I asked these key informants to forward the request for research participants to fellow colleagues. Several participants also referred colleagues, forming a snowball effect.
Eight interested participants contacted me via email, were provided additional details about the study (Appendix C), and given the option of scheduling an interview in the location of their choosing or to participate via telephone. One participant declined to proceed, due to significant employment demands. Two participants determined they did not meet the Indigenous selection criteria. Of the eight interested participants, five proceeded with the study.

The participants reflect a diverse demographic sample. Four participants were female and one was male. Pseudonyms were used to provide confidentiality for the participants. The participants are employed within health regions and/or Indigenous community based organizations within central and southern Saskatchewan. This allowed for diversity in experience within workplace settings and geographic locations. The participants range in age and professional experience. Each participant identified a different professional background and one participant preferred to self-identify as a helper, as opposed to the Western definition of professional.

Data Collection

The interviews were conducted at a date, time, and location most comfortable and convenient for the participant. Each participant was interviewed individually. The initial interviews were approximately 60 minutes. Three participants opted to attend the interview in-person at my office space in Saskatoon and two chose to participate via telephone. Phenomenological researchers typically engage in multiple in-depth interviews with each participant (Dukes, 1984); therefore an additional interview was completed. Three participants chose to complete the supplementary interview by phone and one chose to complete the interview in person. The in-person interview was
completed at the participant’s office space. One participant was unable to complete a supplementary interview due to work constraints. Member-checking sessions were conducted at times suitable to each participant, in-person and via telephone. Notes from these sessions were recorded and incorporated into the data set associated with each participant. Each interview was audio-recorded with my personal computer and I created field notes immediately following the interactions to ensure accurate data reporting. A semi-structured interview guide was used to form the discussion.

An initial interview guide (Appendix D) was developed for this study. The guide consisted of eight questions and prompts that were used, as needed. The flexibility of semi-structured interviews allows the researcher to ask probing questions to respond to topics raised by participants to provide further depth to the response (Creswell, 2013). The questions were open-ended and focused on the experiences, meaning, and contexts of Indigenous professionals’ involvements with IPC. The interview began with grand tour questions to develop rapport and gather broad data in relation to IPC. It concluded with an opportunity for the participant to contribute additional thoughts and bring closure to the discussion. Space was created for the participant to move forward from any difficult topics eliciting strong emotions that may have arisen during the interview. As suggested by Creswell (2013), the interview questions were assessed for fieldwork suitability. In conjunction with my graduate coursework, I conducted an informal pilot test of the interview guide with two Indigenous professionals in November 2014. A supplementary interview guide was developed and approved by the University of Regina Research Ethics Board for the secondary interviews with each participant. This interview guide
was developed to obtain richer more descriptive data for further analysis and to ensure emerging themes were reflective of the participants’ experiences.

**Field Notes and Reflective Journal**

The field notes are descriptive documentation of participant characteristics and the interview environment. I created field notes during the interviews and immediately following the interactions to ensure accurate data reporting. The field notes recorded my observations including location surroundings, pauses in conversation, tone, and inflection of the participants. These notations provided additional data, especially for the analysis of the telephone interviews.

I maintained a reflective journal throughout the research process. The reflective journal records my reactions, assumptions, expectations, and biases about the research process. This document created a space to engage in bracketing my experiences from the research (Moustakas, 1994). I engaged in reflexive journaling weekly throughout the research process, immediately following each participant interview, and spontaneously as thoughts about the research emerged. Assumptions, values, and biases were noted in the reflective journal to assist in separating that information from the research. This allowed for a deeper appreciation of participants’ experiences. During the study, I consulted by phone and in person with culturally-informed individuals (e.g. an Elder, thesis supervisor, and community identified expert) with whom I already had established relationships to inform myself about general Indigenous protocols, traditions, or customs unique to the participant’s community and Indigenous culture. Teachings emergent from these interactions were recorded in my reflective journal. The reflective journal also provided
data to analyze my transformation as a researcher and practitioner through the process of research (Rehorick & Bentz, 2008). These dynamics are explored in chapter five.

**Data Storage**

Interview audio files, field notes, reflective journal, transcripts, and documents pertaining to the research were stored electronically on my personal computer. Each individual file was password protected. Additionally, the user login to the personal computer was password protected. Duplicates of the electronic transcripts were securely stored online with Dropbox file hosting service, accessible to my Thesis Supervisor and me. All consent forms and other paper documents were submitted to the Thesis Supervisor to be securely stored in a locked cabinet in the Supervisor’s office at the University of Regina and will be destroyed after five years. All information will remain strictly confidential and available to only the researcher, the thesis committee, and members of the University of Regina Research Ethics Board that reviewed this protocol, and other regulatory authorities for the purpose of monitoring this study, unless required by law.

**Data Analysis Procedures**

The data was analyzed following the descriptive phenomenological approach outlined by Moustakas (1990) and incorporated the transformative analytic framework offered by Rehorick and Bentz (2008). The seven steps for data analysis were (Creswell, 2013; Rehorick & Bentz, 2008):

1. Organize data into files,
2. Create margin notes in the text,
3. Describe personal experiences through bracketing,
4. Identify significant statements and group them into themes,

5. Describe “what” the participants experienced and “how” it was experienced,

6. Describe the essence of the phenomenon, and

7. Describe personal transformation through the research process.

The practice of transformative phenomenology occurs in all stages of research inquiry, including the data analysis process identified above. Within transformative phenomenology, researchers are called to explore the ways in which interpreting the meaning of a phenomenon adds to their practice and scholarly wisdom. This new knowledge is then to be experienced as profound intrinsic change in self-perception and way of being in the world (Rehorick & Bentz, 2008).

Before the data was analyzed, I transcribed interviews, reflective journal entries, and field notes verbatim. Personal transcription allowed for enhanced familiarity with the data and enabled notation-making in the margins about emerging thoughts and perceptions. Assumptions, values, and biases were noted in the reflective journal to assist in separating that information from the research. This allowed for a deeper appreciation of participants’ lifeworld. Data from the reflective journal were analyzed and compared with the initial thoughts on the topic contained in the social location. Personal transformation through the research process is captured in chapter five. Coding was completed by hand, without the use of software. It began word-by-word and line-by-line to identify significant statements, or meaning units (Creswell, 2013). I practiced horizontalization to view all items as equal in value to consider its essence (Moustakas, 1994; Rehorick & Bentz, 2008). I looked within and between the transcripts to combine similar meaning units into themes or categories. Eight preliminary themes emerged as:
Broken Policies and Programs; Ways of the People; Walking a Tight Line; Knowing; Team; Spirituality; Relationship; and Way Forward. The emerging themes and keywords were generated in a visual representation to show the interconnectedness of the data (Appendix F). The preliminary themes and keywords were explored with the participants during the supplementary interview and member-checking to ensure the accurate reflection of their experiences.

Following the supplementary interviews, additional data was transcribed verbatim from the interviews, reflective journal entries, and field notes. Coding was repeated word-by-word and line-by-line within the secondary interviews to highlight significant statements. I looked within and between supplementary interviews and began to group similar significant statements into the emerging thematic framework, and considered additional themes during the process. As thick, rich descriptions began to emerge within each theme I looked within and across all data sets. Some significant statements were coded in multiple themes due to their interconnected nature.

Significant statements and emerging themes were reviewed. I observed that overlap occurred between the Relationship theme and all other themes. Additionally, I observed that Walking a Tight Line and Knowing themes had the most overlap in significant statements (n=20). I again reviewed significant statements and emerging themes to determine if significant statements could be coded in only one theme to reduce overlap or if the themes could be refined. I observed there were eight emerging themes that overlapped in thirty-three areas. I continued the analysis and the eight themes were collapsed to five themes. The five themes are: Knowing; Walking a Tight Line; Relationship; Broken Policies and Programs; and Way Forward.
The textural description was developed through analysis of participant statements of their experiences in interprofessional collaboration. The textural description “includes thoughts, feelings, examples, ideas, [and] situations that portray what comprises an experience” (Moustakas, 1994, p. 47). Structural description was explored through the structures participants’ identified as being significant or relevant to the context in which they experienced the activity under observation (Creswell, 2013; Rehorick & Bentz, 2008; Schutz, 1970). The textural and structural descriptions came together to form the essence of the phenomenon. The essence of the phenomenon can also be described as the core, or typical, experience of participants in the study (Creswell, 2013). “The essences of any experience are never totally exhausted. The fundamental textural-structural synthesis represents the essences at a particular time and place from the vantage point of an individual researcher following an exhaustive imaginative and reflective study of the phenomenon” (Moustakas, 1994, p. 100). Thematic analysis, structural descriptions, textural descriptions, and essence of the phenomena were presented to the participants for further member-checking and feedback through telephone and in-person conversations. Member-checking was completed following initial thematic analysis and after the secondary interview and data analysis.

**Ethical Considerations**

Ethical issues must be critically considered in qualitative research. Ethical issues including informed consent, participant-researcher relationships, participant recruitment, confidentiality, and anonymity must be examined. An application to the University of Regina Research Ethics Board was made and the research did not commence until approval was received for the research project. The University of Regina Research Ethics
Board collaborated with the Regina Qu’Appelle Health Region, University of Saskatchewan, and Saskatoon Health Region in assessing the ethics application. All parties provided approval for the study (Appendix G). Additionally, I reviewed the Canadian Institutes of Health Research Tri-Council Policy (2010), specifically as it relates to research with Aboriginal and Métis People. I received a certificate of completion for the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Course on Research Ethics (TCPS 2: CORE) on October 26, 2015 (Appendix H).

This research project engages participants who view the topic of study to be of personal or social interest (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Science and Humanities Research Council of Canada, 2010). The Research Ethics Board assessed the study to have low risk of harm to participants. Additionally, the project is unlikely to impact the health, safety, or prosperity of discrete geographic or cultural community members. Following successful recruitment of individual participants, I consulted by phone and in person with culturally-informed individuals (e.g. an Elder, thesis supervisor, and community identified expert) with whom I already have established relationships to inform myself about general Indigenous protocols, traditions, or customs unique to the participant’s community and Indigenous culture. This process was important for me, as a non-Indigenous person, to ensure appropriate protocols were followed and Indigenous knowledge was respected. At all times, all identifying information provided by the participant remained confidential during such consultations. Teachings emergent from these interactions are recorded in my reflective journal. It is important to recognize the
diversity in customs for each participant and engage in an ethical way. In recognition and reciprocity of participants’ knowledge sharing, each participant received a small gift of appreciation of a value not exceeding fifteen dollars.

The Participant Consent Form (Appendix I) was verbally reviewed with the participants before the interview commenced. Ongoing consent was verbally sought with participants during the supplementary interview, member-checking, and during the review and approval of initial thematic analyses. The consent form informed participants that they are welcome to inquire about any part of the study. Participants were informed that they may withdraw from the study at any point without any repercussions. The participant had the right to withdraw their transcribed interview from the study until the initial thematic analysis process is complete. Participants were provided opportunities to ask questions, understand the voluntary nature of their participation, understand the purpose and scope of the study, and determine with autonomy their desire to participate in the study. There are no known or anticipated risks for participants engaging in the study. The participants are practicing professionals in health settings and are familiar with the elements of consent, voluntary participation, and protection of confidentiality and anonymity. However, consistent with social work practice, participants were offered a resource list in the event they may require counseling or support services. Four participants self-selected a pseudonym and one participant requested a pseudonym be assigned. Additionally, identifying information has been redacted in the thesis to provide confidentiality. Direct quotes of participants are used to contribute depth and authenticity to the study. As such, anonymity cannot be guaranteed.
The Canadian Association of Social Workers (CASW) oversees the practice of accredited Social Workers in Canada. The CASW created the Code of Ethics (2005) that outlined the requirement of Social Workers to uphold “service in the interests of others, consistent with social justice, as a core professional objective” (CASW, 2005, p. 5). In accordance with this criterion, this study upheld the interests of participants over the potential interests of government and community health service agencies.

**Credibility and Trustworthiness**

Validity can be enhanced through extended involvement with the participants and multiple interviews within a phenomenological study (Creswell, 2013). Triangulation, or the use of multiple sources, is helpful to corroborate data received through the primary interviews (Creswell, 2013). Phenomenological approaches rely heavily on interview data to create rich description of participants’ lived experience to understand the essence of the phenomenon. The researcher’s repeated review of the raw data through “a rigorous and disciplined series of steps” (Moustakas, 1990, p.33) aims to “achieve repeated verification that the explication of the phenomenon and the creative synthesis of essences and meanings actually portray the phenomenon investigated” (Moustakas, 1990, p. 33).

Debriefing was utilized during the process through in-person discussions and academic feedback from the thesis supervisor and thesis committee. I met monthly with the Thesis Supervisor and met during the proposal, thematic analysis, and pre-defense stages with the Thesis Committee. Member checking and rich, thick description have been employed during data analysis and conclusion drawing to verify the authenticity of the findings (Moustakas, 1990).
Authenticity and trustworthiness of the data is achieved through an audit trail, reflexive journaling, member-checking, and field notes. During the interview process, I used a semi-structured interview guide to direct the process. The semi-structured nature of the interview process encouraged the participant and I to ask questions, allowing the participant to provide additions or corrections. The interview questions were open-ended and leading questions were avoided. “The trustworthiness of the questions put to study participants depends on the extent to which they tap the participants’ experiences apart from the participants’ theoretical knowledge of the topic” (Streubert Speziale & Rinaldi Carpenter, 2007, p. 97). Questions posed during the interview were specific to the experiences of participants (Appendix D). Observations within the telephone interviews were limited, as visual information was not available. However, observations including pauses in conversation, tone, and inflection were included in the field notes. Images, artifacts, journals, or interviews with additional participants would have enhanced the reliability or dependability of the study.

Following the initial interview, the data were analyzed and emerging themes were assessed to ensure the views of the participants were represented authentically (Moustakas, 1990; Rehorick & Bentz, 2008). An audit trail was recorded and used to outline the processes of raw data, analysis, and interpretations of the findings (Creswell, 2013). I communicated regularly with my thesis supervisor and thesis committee to discuss these processes. Rigor was established through critical thinking and analysis of the data and interpretations. The cyclical process of emersion in the data; looking within, between, and across data sets; identifying patterns of meaningful connection; and interpretation of the data as a whole also contributed to rigor within the study. Engaging
in additional interviews with participants and allowing for further cyclical analysis of the
data could have enhanced the study. This was not completed as participants’ advised
during member-checking that they had no further comments on the topic at this time;
therefore I assessed that thematic saturation had been achieved.

Moustakas (1994) suggests that bracketing should be viewed as a process through
which we “abstain from or stay away from the everyday, ordinary way of perceiving
things” (p. 33). Through bracketing I have been able to identify significant statements
made by participants, accept them "naively" (p.33), and challenge my assumptions to
develop new knowledge and understandings of the experiences of Indigenous
professionals in IPC in health settings. This process was assisted in that I do not have
experience within health settings and, as such, have limited pre-conceived notions about
the practice experiences. The bracketing process assisted in creating space to document
my understandings of IPC and experiences of collaboration with Indigenous professionals
in other settings. Additionally, as a non-Indigenous woman I cannot speak to the
experiences of Indigenous professionals in IPC.

Summary

The research design, role of the researcher, and data collection process provide a
foundation on which to present the emergent themes and interpretation. The next chapter
will reveal findings from interviews with five Indigenous professionals who shared their
lived experience of IPC in Saskatchewan health settings. The structural and textural
descriptions will provide context to the experiences and collectively develop the essence
of their experiences.
Chapter Four: Findings

Introduction

The study occurred within an eight-month timeline from October 2015 to June 2016. Data sources included reflective journal entries, field notes, and transcriptions from nine interviews with five participants. From verbatim transcripts of the five initial interviews and four secondary interviews, 2426 significant statements emerged. The significant statements formed the preliminary thematic grouping. The clustering of associated meanings resulted in eight emerging themes. Each theme was provided a code. These eight themes overlapped in thirty-three areas. The cyclical process of emersion in the data; looking within, between, and across data sets; identifying patterns of meaningful connection; and interpretation of the data as a whole continued and the eight themes were collapsed to five themes. From the participants’ words the five themes are: Knowing; Walking a Tight Line; Relationship; Broken Policies and Programs; and Way Forward. From these five themes and structural and textural descriptions, the essence emerged, that of The People, meaning the experiences of Indigenous professionals’ engagement with clients.

Findings

As noted above, five themes emerged from the data. Those being: Knowing; Walking a Tight Line; Relationship; Broken Policies and Programs; and Way Forward. Each of the themes contains subthemes, or details of a specific aspect of the theme. The themes are presented via direct quotations provided by the participants. Emerging themes were relayed to participants during member-checking to increase the trustworthiness of the study. The participants accepted my interpretation of the emerging
themes. Participants found the findings to be reflective of their experience. Additionally, participants were able to recognize their experience in the voices of other participants.

Participants provided the following feedback during member-checking. Maggie states,

Everything sounded good to me. They were my understandings also. Nothing came back to me as that didn’t sound right or I don’t know that. Everything did sound good with me. When you read that I thought, “Is this all me talking?” [laughs]. Because that’s how much it was my understanding. It’s amazing to me when I have sat with other Indigenous people and I hear them speak that it’s very similar. That, to me, talks about that we’re all connected (Maggie – 2, 2016, L 144-153).

I think you have done a very good job of reaching a lot of what we would like to say, and there is always so much more but, you know, I think we have done a lot, you have done a lot, the people have done a lot too, so I think it’s a good way forward (Maggie – 2, 2016, L 725-729).

Grace states, “Everything that you said. Everything that you said. I don’t know what more I could add. [laughs]” (Grace -2, 2016, L 125-127). “I really like what you shared. I think you get the essence of everything. You must have had some really powerful speakers if you only had five. That’s amazing. [laughs] (Grace-2, 2016, L 520-523).

Grace’s comments also speak to the validity of the study through rich, thick description of experiences. Karl also acknowledges the emerging themes resonated with him. “Yeah, it does. It fits with what I said before. All of it” (Karl-2, 2016, L 131). Lynne clarifies the following experience regarding dynamics within interprofessional teams. “Yes, I think you did a really good job summarizing” (L 140); “I think the only thing that was missing was that when we are developing those relationships with people that we consider to be allies, there is a lot of humor involved and that’s a piece that I think is really important” (L 175-179); “I think you did a really good summation” (Lynne-2, 2016, L 254). The concept of humor is integrated into the presentation of findings to ensure a thorough description of participants’ experiences. These comments address the authenticity,
trustworthiness, and validity of the study. Following is a co-created interpretation of the
data, as presented to me by Indigenous professionals who engage in interprofessional
collaborative practice in health settings.

**Theme One: Knowing**

One of the themes emerging from the words of the participants is that of *knowing*. Within this theme participants spoke of the learning processes, cultural competency and cultural safety, Indigenous teachings, spiritual aspects of human health, and Westernized ways of health care practice.

**Learning Processes.**

Developing an understanding of health care settings, identifying key stakeholders in the communities, and understanding complex professional roles are competencies required of all professionals in interprofessional health contexts. The learning curve for study participants within these settings is difficult due to the disparity between western knowledge acquisition and traditional Indigenous ways of knowing. One participant describes it in this way,

> It took a very long time. It was very overwhelming when I first started in [name of program]. I never had a true understanding of what rural health care looked like. Even coming, well, I came from my reserve, but the closest town was [name of city] and it is a larger town so our health services weren’t really rural. They were more of a city-based, you go and make an appointment with the doctor that’s where you get seen. So, I had no real understanding of what rural health care looked like and how it was made and how those systems actually worked, and the reliance on partnerships from so many community partners to make is successful. So that was a huge learning curve, also learning different professions and the roles that they play within clinics and their communities in order to make any change. Cause you can’t just come in and try and implement change and they’ll all come at you like ‘you have no idea what we do’ (Cole, 2015, L 212-231).
The participants reveal the structured, and often fragmented, learning process within Western health care settings. Many Indigenous and non-Indigenous professionals would likely describe the learning process in a new role as Cole does here, “Learning their processes over the last [number] of years is overwhelming” (Cole, 2015, L135-136). Another participant identified transitions and thought processes that may be unique as an Indigenous professional. Karl discusses the transition from rural to urban settings. “I am learning all about the ins and outs of working in the city” (Karl, 2015, L 291-292). Karl connects his experiences in collaborative practice to attending school as a child. “I was just a kid off the street when I went to school. It was really hard for me because I didn’t understand the language and when I look back, giving structure to children, I didn’t know what that was” (Karl, 2015, L 420-424). The structured nature of collaborative practice mirrors, for him, the requirements of his elementary academic environments. Language is also a considerable consideration for Karl, as he navigates IPC in an environment that primarily utilizes his secondary language.

**Cultural Competence and Cultural Safety.**

Another participant spoke of cultural competency and cultural safety. Lynne defines these terms in the following way:

Cultural competency means having a skill set and an awareness and a knowledge base about what a different culture is about. Your skill set really develops and evolves with your ability to understand the way our different cultural backgrounds impact health (Lynne, 2016, L 96-101).

Cultural competence speaks to congruence between thoughts, attitudes, and behaviors of individual professionals that are continuously evolving to encourage effective cross-cultural service delivery (Campinha-Bacote, 2002). “Cultural safety is more of an outcome so it is invested in making the person that you are working with feel safe”
Cultural safety is the observable outcome when cultural competence is achieved. Cultural safety outcomes emerge through co-created policies, procedures, and practices that result in client engagement in program evaluation and service delivery. Lynne recognizes that introducing new terminology is an adequate beginning, but does not necessarily equate to implementation in practice.

The only problem with that is that the ways in which we approach people haven’t changed so much so we have these new words, cultural competency and cultural safety, but until our style and the modes and the policies adapt to fit the people we serve then it’s still not cultural competent or culturally safe. We have the language, now we have to move it towards the way we practice (Lynne, 2016, L 123-130).

Maggie acknowledges that public education campaigns can be helpful to highlight linkages between traditional knowledge keepers and physicians.

If you look at a poster that was released last year during the Aboriginal AIDS awareness week campaign, from the Canadian Aboriginal AIDS Network, [they] have an infectious disease doctor along with our own doctor standing together talking about “live holistically, healthier and longer”. Traditional knowledge keepers and doctors creating cultural safety. So, we have our own doctors. It needs to be working together making the way forward for Indigenous people, for any people (Maggie – 2, 2016, L 199-2010).

Collaborative public education campaigns can advance cultural competence and cultural safety mandates. They can also create awareness that collaborative practice and Indigenous health knowledge is applicable to all people, not only Indigenous populations.

Training professionals to examine personal values, biases, attitudes, and behaviors related to cultural competence can be difficult.

[Doctors] are trained that all people are the same because biologically we are all made up the same. For them to see us as anything but the same and that everybody should be treated the same and they should give some of their personhood. An oncologist who is giving breast cancer surgery is going to wonder what his cultural competencies need to be. Why do I need to bring my person into the work that I do? They don’t see the value of that relationship. It
actually saves lives when they treat people like human beings (Lynne, 2016, L 380-390).

Critical reflection of personal values, bias, attitudes, and behaviors requires an openness to explore one’s own characteristics in the context of professional roles. Co-creation of cultural safety with clients requires the development of a mutual relationship to explore health outcomes. Personal values influence professional practice, which affects client health outcomes. There is interconnection between aspects of IPC, personal values, professional roles, client experience, and health outcomes.

For us, it is our understanding as we move forward that we have to begin to model this type of cultural safety, cultural competency and a way forward that is grounded in our own theories as Indigenous people (Maggie – 2, 2016, L 293-298).

Spiritual Aspects of Human Health.

Often included in Indigenous theory (King, Smith, & Gracey, 2009; National Aboriginal Health Organization, 2011) is recognition of the spiritual aspects of human health.

Spirit is the one that’s missing. In cultural competency training we talk about integrating the spiritual into the work, but try and say that to people who are hired for food service. They would be like “well, what do I need to…” It’s not an easy road. (Lynne, 2016, L 392-396).

Spirit is often misconstrued as structured religion. Indigenous understandings of spirituality refer to the interconnectedness between people, animals, and the land.

I think if people would study their culture back to its origins, before Christianity, they look very similar to First Nations culture. If people would just go back to their original roots the same way that First Nations people are doing they would see these interconnections and earth-based ways are found in their cultures as well and it’s been lost with the introduction of science. We’re getting there. I see all the new age things and I’m like “oh” (Lynne, 2015, L 402-410).

Grace feels it is the spiritual connection to the land, living creatures, and one another that fortify relationships. “I’m not saying that they’re traditional or that they’re Catholic or
that they’re Christian, just a really basic human form of being connected to something spiritually. No label. Just having that faith; that belief. It strengthens everything” (Grace – 2, 2016, L 199-203).

**Learning Journey.**

Indigenous teachings are connected to the spirit, to ancestors, and incorporate holistic health models. Each of the participants speaks of learning within the framework of “we don’t know what we don’t know” (Maggie, 2016, L 850-851).

There’s lots of stuff, lots and lots of things, lots of lessons, lots of teachings. They come to you as you need them. I have a grasp on some of them and some of them I just know because I know. An Elder told me, told us, that we don’t know what we don’t know. To me that means whatever my ancestors is alive in me, but I don’t know it yet, but I do know it, and when it comes, it comes at the right timing. You ask for it. Pray for it (Maggie, 2016, L 846-854).

Maggie speaks of the recognition that each person is on a learning journey. Each experience offers the opportunity for new teachings and new learning. Maggie believes that learning can come through spiritual connection and prayer, through ancestral teachings, and an openness to new learning in each experience.

How an Indigenous person sees what’s going on through our eyes because Caucasian people don’t know. And I’m not saying that in a derogatory way, sincerely, you don’t know what you don’t know and that’s just the way it is. It’s not right. It’s not wrong. It’s just the way it is (Grace, 2016, L 211-216).

Karl describes himself in this way, “I’m a gatherer” (Karl, 2016, L 83). He acknowledges collaboration as an opportunity to gather new knowledge that can be carried forward for future use.

I just go and we collaborate and I take the information that they have given us, we hold on to it, and when it comes time to use it, we can use it. I take what I hear and what I learn from the other people and I know I’m going to use it if and when I leave this field (Karl, 2016, L 228-235).
“All this information I’m gathering I’m going to use that in another place” (Karl, 2016, L 443-444). The gathering of knowledge can be used in personal or professional settings. It can be used in reciprocity as Grace explains, “I’m giving back what I was given, what people gave to me (Grace, 2016, L 100-101). Lynne acknowledges the similarities between her personal experience and those of clients. “Being able to help people that are in situations that are similar to my own, where I came from. Using that to give back what was given to me (Lynne, 2016, L 338-341). Learning provides an opportunity to connect spiritually, gather knowledge, and offer it in reciprocity. Maggie describes her experience of knowing as,

When I am being pushed forward to stand up and speak I need to honor that because my ancestors are wanting me to say something and when it comes out it comes out the way it’s supposed to and that’s the great mystery that I have come to know as an Indigenous woman. When that voice comes I need to stand up and speak and I can’t sit back anymore and be quiet and when I do that it’s not honoring my purpose in life and what my truth is (Maggie - 2, 2016, L 396-405).

Theme One Discussion

The theme knowing encompasses the study participants’ experiences of learning processes, cultural competence and cultural safety, spiritual aspects of human health, and the learning journey. For study participants, learning processes are impacted by transitions from rural Indigenous communities to urban settings. Language barriers can further compound the tremendous learning required when understanding new roles, collaborative relationships, and health contexts. Structured training of new employees offered by organizations may incorporate concepts of cultural competence and cultural safety, but often fail to effectively implement these objectives into practice. This professional training requires individuals to consistently engage in critical reflection of
personal thoughts, feelings, and behaviors and openness to incorporate new knowledge that challenges their practices.

For study participants, *knowing* is a lifelong journey. Every experience offers an opportunity for new learning. Learning in a social context, as recognized by Bandura (1977), encourages interactions between team members in IPC. Study participants acknowledge that learning comes in many forms which can include, but is not limited to, Westernized education settings, traditional Indigenous knowledge through storytelling, life experiences, and collaborative relationships. They highlight the interconnections between humans, animals, and the environment. Study participants drew connections between the balance within social, physical, mental, emotional, and spiritual environments and holistic health models. Each of these environments engages the individual in the process of *knowing*. Key for participants is knowledge received through spiritual connections. These spiritual connections create opportunity to receive teachings from their ancestors, carry knowledge for future use, and offer this knowledge in reciprocity and acknowledgement of ancestors who have come before them.

Study participants shared views on cultural competency, cultural safety, and collaborative treatment options within Western and Indigenous health systems with the Elders within Stevenson’s study (2009). Both groups maintain collaboration between traditional Indigenous healers and Western physicians can create cultural safety for clients. Study participants suggest that collaborative public education initiatives and developing linkages between traditional helpers and health care professionals would create understanding that Indigenous health knowledge is applicable to all populations. I
would assert that these initiatives would also assist in solidifying respectful collaborative relationships.

**Theme Two: Walking a Tight Line**

The theme of *walking a tight line* emerges from the data and contains the participants’ views of themselves as Indigenous people and the professional roles they hold in the community. The textural description, or “what”, the participants experience is outlined most concretely within the *walking a tight line* theme. Tension between family connections and employment responsibilities; the multiple meanings of the term professional; power and status; isolation and tokenism; and the integration of personal experience and professional practice are explored within this theme.

**Tension Between Family Connections and Employment Responsibilities.**

The majority of the participants are not employed within their home communities. They speak of their connections to family in their home communities and the pull between family and work. Employment in a community outside your home community can create feelings of isolation. Cole describes these feelings as,

> I don’t have anyone – I have some cousins that live here in the city, but all my family, my mom, my brother, my sister, my grandma, my aunts and my uncles, most of my cousins all live back home on the reserve so I go home a lot. I have very strong ties back home to the reserve (Cole, 2015, L 34-41).

Karl describes the additional travel and requirements of maintaining that family connection and parenting his children. “My kids moved to [name of city] so I go back and forth and back and forth” (Karl, 2016, L 243-244). When considering full-time employment and a potential pay increase, his mind turns to the additional day away from his children “And this 5 days, that means it’s an extra 24 hours” (Karl, 2016, L 245).
Even in circumstances where an Indigenous community does not feel like home, establishing belonging can be challenging. “I don’t say I’m from a reserve because in the beginning when reserves were created we were put on them, in that little section of land to die” (Grace, 2016, L 18-21) “there’s no opportunity for success, employment, or anything there” (Grace, 2016, L 25-26). Lynne shares her perspective as an urban-Indigenous woman and the inferences of this experience.

I grew up in urban settings so really represent that urban-Indigenous identity and finding culture in different kind of ways. Some people grew up with their home community, whereas I grew up in urban settings where the Elders were really community based Elders from organizations and those were the ones that provided the teachings. Sometimes there are negative connotations because you’re urban as opposed to living on reserve so getting some “you’re not cultural enough” “you’re not submersed in the culture” “you don’t have the language”. I represent a generation of kids that grew up disconnected from a community, but really found community in [name of city] (Lynne, 2016, L 14-31).

Grace and Lynne acknowledge that Indigenous experiences cannot be homogenized and that understandings of place, community, and belonging can be varied. Lynne also exposes the repercussions of colonialist categorization of Indigenous peoples. This process has resulted in tiered understandings of what it means to be Indigenous.

**Multiple Meanings of Professional.**

Additionally, the term professional can carry multiple meanings. Karl shares his observations of his role as a helper, rather than a professional, in the community. “I don’t really see myself as a professional, until actually somebody called me that” (Karl, 2016, L 27-28). Karl’s understanding of professional is disconnected from his view of his role in health settings.

A professional is someone that has a degree, has been in school many, many, many years and me, I just lucked out that I had friends and this program that they developed, [name of program], a branch of the [organization] was Indigenous focused, I guess you could say (Karl, 2016, L 40-45).
Without Western academic recognition, Karl feels he does not qualify for the professional role. He attributes his employment to relationship, connections, and “luck” that the agency was interested in indigenization. Karl prefers to see himself as a “go-between” (L 119), “middle guy” (L 256), and a “helper” (L 390). Likewise, Lynne describes an Indigenous professional as a “role model”. The position functions as an opportunity to demonstrate variance in future possibilities for her family.

Mostly, an Indigenous professional is being a good role model for my kids so that they see where we came from and what we created. So, for me, the professionalism is rooted in family. Being that foundation for my kids and breaking through some of the dysfunction that we came from. That’s the piece that is my primary focus (Lynne, 2016, L 331-338).

**Power and Status.**

Study participants also discuss perceptions of power and status in relation to their professional roles. Karl describes the experience of wearing a professional identification badge,

Anywhere I go I always carry this, my tag. It gives me a lot of respect because I have been here for five years. When I first started out I was kind of shy, but as soon as I have this tag I get respect. I don’t get pushy. I go in there and I ask how I can help them (Karl, 2016, L 204-209).

Karl connects the identification badge to respect from community members, other professionals, and his personal identity as a “helper”.

If you see a badge or a tag like that the people know that you have authority to do something. Most people they don’t have these tags. They just go in there and you don’t know who they are, but then if I wear this I am identified as a professional, I guess you could say (Karl, 2016, L 213-218).

Karl recognizes that with his professional role comes power. He is conscious of the power imbalance inherent in helping roles. “Not power-tripping on my little tag [laughs], but I like it. They know that I’m there to help them as best as I can” (Karl, 2016, L 220-
The study participants recognize the dynamics of power that can impede collaboration, development of relationships, and service delivery that is co-created with clients.

Even our doctors, our medical systems are broken. They don’t know how to treat people as humans. They, themselves, have been put on these god-like pedestals as doctors, but doctors are just other human beings giving you a really good guessimate (Grace -2, 2016, L 365-370).

Study participants shared personal experiences of power dynamics within interprofessional collaboration.

When you are the one with less power you have to make sure you establish personal relationships and acknowledge that there’s power and privilege in the Western spaces. At the end of the day, what they say goes, so I have no real power. The only thing I have to do is to make that relationship real so they will use their power to allow particular things to happen. We know these ways work, but we have to be granted permission, still, to do those ways in Western institutions. Those collaborations, that piece, is critical and acknowledging that we are not on the same…where they’re not true collaborations (Lynne, 2016, L 288-300).

Collaboration allows professionals to use their power and status to influence change. This can be a positive outcome in collaborative practice, as one professional may be able to influence the decisions of others to effect change. It can also be a contentious issue in collaborative practice. As Karl identifies, critical reflection by professionals is necessary for collaboration. Without self-reflection, authority and influence can hinder collaborative practice by constructing mezzo, macro, and micro barriers to service delivery.

We had to collaborate on certain items. Some people put a paper on the wall asking what can we do and how can we do it. Some people wrote all their stuff down and me, I didn’t know what to do ‘cause I didn’t understand some of the wording they chose plus some of the stuff I do is real easy. It doesn’t require a lot of brainpower. I was looking at them, looking at everyone else, and I was thinking wow! I am not qualified to even be here, but then I am. That’s the organization, but when I look at myself and where I came from, the [name of
community] people, then I’m kind of up there because of all the other stuff that I have done. It’s interesting (Karl, 2016, L 496-509).

Karl touches on the importance of accessible language. As described in the literature review, language has an element of power within collaborative relationships (Foucault, 1972). Language is a component of communication and is an important consideration when collaborating cross-culturally and across disciplines. Language should be clear, recognizing that English may not be the principle language, and acronyms and terminology may be specific to each discipline.

I think I have to be careful not to divulge too much information to my managers. There’s something that I will tell him and there’s a lot I don’t say. When we go to meetings, I don’t say nothing. I just listen. When [name of doctor] is there I just listen cause I know he’s at a different education level than I am. I speak through my boss, he speaks to him. Like the hierarchy (Karl - 2, 2016, L 176-184).

Karl’s experience also touches on the internalization of power and status. He shares feelings of doubt, second-guessing his qualifications and value to the collaborative process. Karl connects his professional value to his personal experiences and ancestry; recognizing his contributions and perspective are unique and significant. Lynne sees that personal connections are vital to authenticity in collaborative practice. Mutually beneficial personal connection dissuades inequality and creates foundations for communication. Lynne and Cole also acknowledge the power held by Indigenous peoples to share teachings and shift opinions.

In my mind, people are people. I see people as being human so they are not any better or less than me. My perception is that we are on the same level when it’s personal. So, just because the world grants them power based on their status, I use that status in the best way that I know how. I also use my own status. Getting into these spaces and really representing the teachings of the Elders and the things that I have learned and I do that in a good way. I have to acknowledge that I have some power to shift things around and also that it’s not a real, genuine, collaboration because they still hold the power (Lynne, 2016, L 304-316).
I think that’s the most difficult part of being an Indigenous health professional working with people is getting them to shift their thought. It’s one of those challenging pieces of work, but you recognize that it’s almost like a start (Cole, 2015, L 639-644).

Indigenous worldviews are provided marginal significance within education settings (Gair et al, 2005; Gray et al, 2008; Sinclair, 2004). Consequently, the responsibility to educate colleagues descends to Indigenous professionals, in addition to their professional roles within interprofessional teams. Although the experiences are varied, each participant identifies relationship building as a key strategy to provoke insight and counter inequity.

**Isolation and Tokenism.**

The perceptions of their colleagues impacted the professional identity of each participant. These perceptions included tokenism of their position, feeling siloed in their work, and experiencing the homogenization of Indigenous people. Participants identify working as “the only Native person that works on my team” (Cole, 2015, L 240-241) or working within an indigenized program or organization. Feelings of tokenism were key components of the experiences of participants, as voiced in the following statements.

I think it is one of the most difficult positions to be in. I exist as a token position in my team. I am seen kind of like that, too. My title is the only one that has Aboriginal in it. Nobody else’s does (Cole, 2015, L 626-629).

There is a lot of humor involved and that’s a piece that I think is really important because you know, when you are talking about tokenism, I just think about hearing them say “you’re our token Indian” and like as a joke, making fun of some of the realities. There’s a level of truth to all humor. So, when you’re the only person there, and I don’t necessarily see it as being tokenism, but, I mean, we work in an environment that doesn’t promote employment equity. So, are we really committed to having more people like me in this work environment? That’s just systemically speaking. There isn’t very many (Lynne, 2016, L 177-194).
Lynne questions the systemic motivations for limited Indigenous positions. Employment equity is linked to dismantling systemic barriers and creating accommodations for the unique needs of underrepresented populations (Government of Canada, 2014). Therefore, it is not only about the creation of positions for Indigenous professionals. Racial discrimination, systemic barriers, and accommodation needs can be difficult to identify within organizational structures and processes. However, study participants were able to describe their experiences related to employment equity initiatives within their interprofessional teams.

I am often looked at as very young, naïve a little bit, but also they treat me very well, but working as a [role] in comparison to others who do have more experience than I do it’s challenging sometimes to implement some of the change and follow-up in some of the teams because of that. I know that’s a personal reflection of mine. My managers might say something different, like they don’t think that’s as true, but that’s what I’ve experienced in some ways. People responding either quicker or better or listening more to what others have to say when I have said the exact same thing. There’s different levels, I understand, of why people do that. I can say social constructs that build their views of who I might be, their judgments that they have on what abilities I can bring to their team and the successes that we can build together (Cole, 2015, L 244-261).

Cole identifies multiple factors that may impact the perceptions of her colleagues. These factors include age, gender, professional experience, communication skills, social constructs, and service delivery outcomes. When Cole discusses these factors with the leadership team, the managers may not observe or acknowledge these barriers. Thus, it would be difficult for management to implement remedial processes or accommodations. This speaks to the need for Indigenous professionals voices within IPC contexts. Lynne shares some reasons why Indigenous professionals may be reluctant to speak,

Sometimes, it’s scary because when you don’t grow up submersed in the culture in some Indigenous peoples’ eyes you’re not cultural enough and you’re not the one that should be talking about the particular issues that you’re talking about.
There’s some hesitation in that regard. Am I the right person to do this? Am I cultural enough? Some second-guessing myself (Lynne, 2016, L 319-326).

As the following statement indicates, inclusion may disguise tokenism within professional teams.

Sometimes I laugh because people are excited they have an Indigenous person on part of the professional team. So there is a level of tokenism sometimes. People want you on their research grants, people want to say they talked to you because you are Indigenous (Lynne, 2016, L 326-331).

The Tri-Council Policy Statement (2010) provided ethical principles to guide research with Indigenous populations. The spirit and intention is to create meaningful collaboration with Indigenous populations through trust and reciprocity. Unfortunately, as Lynne states, the respectful engagement is not mandatory.

Participants experience expectations that as an Indigenous professional they are responsible for resolving the concerns of all Indigenous clients. Positions are created “with that specific Aboriginal title and they are siloed to do that work on their own” (Cole, 2015, L 635-637).

I know when people have good intentions and when they don’t. If I don’t know you and you are just tokenizing me then I don’t feel that great, but if you approach me in a good way, which you know because you have been speaking with an Elder, and you ask in a good way and in a proper way things are done in a more balanced nature than just asking “come fix this” or “you address this” (Cole, 2015, L 874-882).

Given the unrealistic nature of this task to resolve issues and provide support services to all Indigenous clients and colleagues, it can be difficult to discern the effectiveness of their professional role.

At the end of the training session we get evaluated and we get the negative comments so it looks like we’re not doing our job. It makes us feel bad that we’re going in and doing the same training every two weeks and get the same negative feedback. We get frustrated because it has nothing to do with the delivery of what we’re delivering. It has to do with the way that people perceive it and their own attitudes, but those attitudes become part of a written document that’s a reflection...
on us. You get tired of getting up and saying the same thing to have the same response (Lynne, 2016, L 177-189).

Cole describes the opposition from colleagues and systems when Indigenous ways of knowing or healing theories are suggested.

It’s always a challenge to find out what people actually think of the position at the end of the day or think of the work that you want to achieve. So I know people in different organizations who try to challenge their systems and have been denied moving in that direction or “that’s not why we hired you”, “that’s not where we want to go with this”. I am thankful because I work with a team that is very open to the things that I share and also want to have that work and don’t resist change in that way (Cole, 2015, L 645-655).

She reiterates the importance of teams who are open to collaborative decision-making, understanding Indigenous teachings, and consensus building. At times, study participants described being required to provide services within their professional roles, while balancing their perspectives of race and privilege that are integrated into collaborative practice. Cole describes it in this way,

I’m wearing both my Indigenous woman activism advocate, I have knowledge about race and privilege and our different roles but I am also [role] and I need you guys to work better as a team, but I need to also address that your concerns around safety are thoughts around race and privilege and not around giving the best service to your clients. It’s hard its like walking a tight line and I know that my managers very specifically put me in those roles to make those challenges apparent and to not let people off the hook and say that’s the way it’s going to be. They put me there strategically to address those things (Cole, 2015, L 819-831).

Cole appreciates the strategic implementation of Indigenous professionals to challenge attitudes of race and privilege. She also raises concern that the lack of awareness of cultural differences among Indigenous peoples in Saskatchewan can create barriers to service delivery.

I am a Cree Native woman from [name of First Nation] [Treaty territory]. I know nothing about Dene people from northern Saskatchewan. Their ways of life, culture, language, I know nothing. So when people were to approach me “can you help me with this situation” I’d be like “uh, I can try and find somebody who
can translate Dene”. You know, things like that. That’s when ignorance comes in. I always say, you grew up in Saskatchewan, you don’t know how many reserves are in Saskatchewan, how many Indigenous languages are in Saskatchewan, those things that I thought were common knowledge and are not with so many people (Cole, 2015, L 856-870).

Culture, language, and territory are diverse within Indigenous populations, in much the same way that Caucasian populations may be connected to German or Francophone communities. Every Caucasian person would not be expected to translate French language, as each Caucasian person is recognized as a unique individual. Unfortunately, in Canada, Indigenous and other minority populations have not been afforded this same distinction.

Integration of Personal Experience and Professional Practice.

The participants speak of integration between personal experiences and professional roles. Grace shares that her personal life experiences are connected to her competencies as a professional. “I am where I am based on my experience in life” (Grace, 2016, L 69-70). Grace acknowledges that these personal experiences are not always perceived as positive and can often lead to experiences of discrimination.

I don’t think that I’m treated as an equal because of my personal history and not only that, racism and discrimination is alive and well in [name of city], in Saskatchewan, in society as a whole. Because of where I come from and the experiences that I’ve had I’m not treated as an equal and I don’t mean by my own people (Grace, 2016, L 75-81).

Employment in spaces that integrate cultural safety and cultural competence for employees and clients is crucial for Lynne, Grace, Maggie, Karl, and Cole. Spaces that create opportunities to openly share personal histories, experiences of discrimination and trauma without negative repercussions are important within IPC (Epstein, 1999).

[Working] in a western world is way different. I worked for a First Nations organization for most of my career where people are very well aware and people
are very open that we have issues and different backgrounds and we talk very openly about healing and getting better. It’s no secret that I could say I’m an alcoholic, I’m a drug addict, I come from the streets, I’ve been in-and-out of jail. When you say that in these new spaces you get a lot of comments like “I can’t believe you just said that”. It makes me very uncomfortable to talk about my personal life so the personal and the professional are very separate. Trying to talk about the ways in which Indigenous people see things as more of a whole, the personal and the professional are of a whole. It is so different. I laugh at some of the organizational structure they have to it. You have [a form] for this, and you have a policy for this. Everything is so standardized that it takes away from some of the personal aspect. Feeling safe enough to talk about the personal aspects of where I come from (Lynne, 2016, L 204-225).

Especially in social work, professionals are socialized to create dissonance between personal and professional selves. Disciplinary insistence upon the creation of boundaries moves beyond ethics and confidentiality to rigid restrictions that impact our abilities to create relationship with one another. Grace acknowledges a balance between relationships and ethical professionalism. “There is etiquette that needs to be followed. There is privacy and confidentiality. It’s key in both, for our client, in both [of my] work settings” (Grace – 2, 2016, L 194-196).

In some cases it’s very rewarding where I can go and provide my personal story and share my personal success, show people where they were at and where they could be – if that’s what they chose. And then, in another sense I can share with other professionals that, you know what, sometimes, people who are addicted they’re gonna die that way and that’s not right, it’s not wrong, and it’s just the way it is. People don’t want to deal with their hurt and their pain. So, I get different opportunities at different levels to share my experience, my insight, and my expertise (Grace, 2016, L 257-268).

For the study participants, their personal experiences and professional knowledge unify as they engage with clients. Grace, Karl, Maggie, Cole, and Lynne shared their experiences of gathering the stories of clients. “When they’re sharing their story it’s almost like an echo of my own” (Grace - 2, 2016, L 280-282). To hear clients speak of
experiences so similar to ones’ own can be very impactful for some Indigenous professionals.

It’s about helping people. If I can help them in any way, show them a path to their addictions or send them to a certain place to get a meal, where they can go if they have garbage in their yard or building and I can send the health inspector there and help them that way. That really is very emotional when I do stuff like that, help somebody (Karl - 2, 2016, L 219-225).

Instead of responding from a place of empathy, some Indigenous professionals may truly sympathize and understand the internal distress of their clients because of their own past experiences. “I think watching people not feel safe to talk about their struggles. I get that” (Lynne, 2016, L 155-156). Karl shares, “I walked out of the [name of agency] many times with a lump in my throat” (Karl- 2, 2016, L 262-263) after working with clients whose experiences were similar to his own.

Grace highlights boundaries that are a continuation of oppressive practice.

It’s because it’s…it feels like being…it’s like…it’s like oppression! If I really get to the root of it it’s like being oppressed because I see the girls and I think to myself if I could tell you everything that I learned now that I wish I would have known I would give it to you freely so that you don’t make the same mistakes that I did, I see them going through it, I see them making these mistakes, I see them being co-dependent on men, I see them experiencing life and it is their journey and I know that, but I really do feel oppressed at some times because you have to be careful (Grace - 2, 2016, L 290-301).

Indigenous professionals are not the only ones who have life experiences that resonate within their work. The experiences of non-Indigenous professionals may seep into their work, as well.

I just had a gentleman, just recently tell me, he just went in for surgery and he said, “I sat there for 3 days and I listened”. The nurses weren’t necessarily coming to him, but he just listened to the conversation, things that were going on in the hallways and he said there’s so many of them that are house broke. He said literally they bought a property that cost too much money when prices were up and now the prices are down, they’re house broke. Them and their husbands are working just to maintain this mortgage and they’re probably never going to pay it
and they can’t sell it now. So they have outside life pressures that are affecting their jobs and how they respond to people (Grace – 2, 2016, L 406-420).

Personal experiences continue external to professional roles. However, professionals carry those experiences and they can become integrated into the work in healthy or unhealthy ways.

Life goes on outside of work. That there’s crises that happen with our people because our families, the people that are surrounding us, are still dealing with trauma that they’ve had forever. I really believe that we get trauma passed on through generations, even through blood memory. I completely believe that. Having somebody that has that knowledge and has that faith it makes it really, I don’t want to say easy, but it makes a much more relaxed atmosphere. I’m more comfortable. I speak freely. I don’t hold anything back. Everything is based on respect, as well (Grace - 2, 2016, L 209-220).

Provisions of support, respect, and encouragement by colleagues and leadership in professional settings can allow for these human experiences to be incorporated into practice in safe and beneficial ways.

The minute that one person starts getting overworked or burnt out that’s when you need to take a step aside and say “listen, I need a break. I need a break because I’m going to start hurting people” (Grace – 2, 2016, L 398-402).

Being able to be myself and having my history respected and my family being able to be involved in certain things and events and their expertise being used and validated and valued. It’s built my career. It’s built the foundation of where I am and it’s kept me here (Grace - 2, 2016, L 180-185).

Study participants feel it is important for supervisors or managers to create opportunities for Indigenous professionals to choose professional development opportunities connected to their individual gifts or areas of expertise, to speak freely about personal experience, and to engage in spiritual ceremonies.

I can share my personal experience when I am facilitating a training session. I can be bold and not be reprimanded for it and not worry about it getting to my employer because my employer knows my story. She’s heard it. Whereas on the other hand, management at a different place doesn’t know it, isn’t familiar with it, but are working with people who could relate to it, but because it’s working with
a portion of the box, let’s call Social Services the box, the colonized box, one of the broken systems, it’s not encouraged to share your personal. You have to be careful there (Grace - 2, 2016, L 263-275).

Work environments and leadership that promote such opportunities can increase retention of Indigenous professionals and challenge stereotypes and hegemonic beliefs that Indigenous peoples do not want to work or are ineffective employees. The study participants create understanding of the systemic policies that require change to create healthy, collaborative, work environments with Indigenous professionals.

Keeping the personal and business separate we have to do that a lot. The extended family, like my extended family, nieces and nephews and they know people or they have lived with people and then now those people are now connected to me. In the work I do I actually have to be friends with everybody because of the work that I have to do. So, I have to use all my connections to do my work properly (Karl - 2, 2016, L 149-158).

Holistic integration of personal experience and professional roles is challenging. It requires professionals to be intentional and critically reflective. Culturally competent spaces or organizations are also necessary. “I haven’t been able to make it come together for me yet because it’s such a novelty where I work to talk about the personal and it’s so different” (Lynne, 2015, L 231-233). Grace adds, “I’m guarded. I’m very conscious of what I say. I’m very conscious of not thinking out loud. I’m careful. I’m careful. I stay within the parameters that I’m allowed to” (Grace – 2, 2016, L 306-309). Additionally, teaching colleagues to recognize and share personal experiences within professional contexts can be challenging. Study participants provide the following examples:

I asked “say something personal about yourself” and people would say “I’m not comfortable sharing”. It’s not a big secret. They could say “my toenails are painted pink”, but they got really standoffish, which was sad for me because you don’t feel safe enough to be who you are in your work environment. I miss that part of working with just a First Nations organization because you’re free to be yourself and be messy (Lynne, 2016, L 236-245).
I just feel like I am in a foreign land where people are very robotic. I almost feel sorry for them. You’re so disconnected from who you are as a person, at work, and that must suck to think you have to separate those two things. I don’t necessarily feel unsafe. I feel more sympathy for people who have a more fragmented sense of self. Which is what Western education really strives for (Lynne, 2016, L 259-266).

Unfortunately, everything is really based on being a professional. A lot of places expect you not to be personal, but if you’re not personal you’re never going to make it. You’re never going to reach people. You have to show your humanness sometimes (Grace 2, 2016, L 249-254).

Creation of personal relationships is central to the experiences of Indigenous professionals in health settings. This concept will be explored within the next theme.

**Theme Two Discussion**

The theme *walking a tight line* contains the participants’ views of themselves as Indigenous people and the professional roles they hold in the community. The textural description incorporates experiences of the tension between family connections and employment responsibilities; determining what it means to be Indigenous and the colonialist categorization of Indigenous peoples; understanding the multiple meanings of the term professional; dynamics of power and status; experiences of isolation and tokenism; and integrating personal experiences into professional practice.

The study participants’ experiences of place, community, and belonging vary from Indigenous communities to urban settings. Each participant acknowledges the desire for connection to family and belonging to a community. For four of the study participants, their community is not in the same geographical location as their workplace. They describe how this can create feelings of isolation and disconnect. I assert that further isolation occurs through the colonialist categorization of Indigenous peoples. As discussed in chapter one, the Canadian government requires Indigenous peoples to
identify as First Nations, Métis, or Inuit as outlined by federal definitions (Statistics Canada, 2011). Indigenous peoples are required to conform to a category to receive health care services, as the funding can be divided between federal and provincial jurisdictions. One study participant questions whether she is “cultural enough” (Lynne, 2016, L 27) as an urban-Indigenous woman to share Indigenous teachings within collaborative contexts. Through colonialist practices such as residential schools, the sixties scoop, and foster care Indigenous peoples are displaced from Indigenous communities. This creates, as Lynne identified, urban-Indigenous populations and people with varying understandings of what it means to be Indigenous peoples. I would assert that the colonialist categorization of Indigenous peoples and colonialist practices such as residential schools, 60’s scoop, and apprehension of Indigenous children furthers the isolation from community contributing to the study participants’ reluctance and/or inability, at times, to share Indigenous knowledge and their experiences within IPC. The history of Indigenous populations in Canada is a strong contributor to the exclusion of Indigenous professionals within IPC. Study participants focus on helping clients and creating visibility for Indigenous professionals as ways of “breaking through some of the dysfunction that we came from” (Lynne, 2016, L 338) as a result of colonialism.

For study participants, the term professional has multiple meanings. It is primarily associated with “helper” (Karl, 2016, L 390), “go-between” (Karl, 2016, L 119), and “role model” (Lynne, 2016, L 331). Exclusionary closure, or boundary-work, as framed by Witz (1992) and described by Hall (2005) and Baker et al. (2011) is experienced by study participants within health settings. I suggest the term ‘professional’ along with western academic requirements create barriers for Indigenous inclusion in collaborative
teams. Through the literature review and personal experience in collaborative practice I have noted that IPC teams rarely include individuals who do not fit within western academic disciplines. For example, clients, Elders, traditional healers, community appointed experts, or helpers are not typically included within the core collaborative teams. At times, these people may be included in a pre or post meeting, but rarely hold the power or authority to make decisions within the core interprofessional team. I assert the importance of addressing barriers to collaboration, such as the requirements of western academic recognition for inclusion in collaborative teams.

Study participants discuss identification badges worn within health settings as a symbol of power and status. The identification badges are used to identify those with power, status, knowledge, and solutions. I assert the use of identification badges can hinder or limit the voices of traditional Indigenous helpers within IPC teams. Traditional healers, Elders, or community experts may not be connected to an agency and therefore not have identification badges. I would be curious if, as study participants inferred, without the identification badge Indigenous professionals or traditional healers would experience power and status within interprofessional teams. Additionally, identification badges provide at-a-glance information regarding a person’s role and agency association. With the role and agency association comes each team member’s knowledge, understanding, and potential biases about that role and agency. The bias or assumptions may positively or negatively impact collaboration between team members. As discussed above and shared by study participants, critical reflection is necessary for collaboration. I would assert that critical reflection could challenge professional role socialization and deconstruct ideas, beliefs, and attitudes connected to racism, privilege, power, and status.
within IPC. Increased critical reflection would assist in creating authentic personal connections and opportunities for communication to shift perspectives within interprofessional teams.

Power and status not only impact collaborative practice, but study participants share that the experiences of power and status can be internalized on an individual level. Power imbalances as offered by Orchard et al, (2005) connect to Karl’s experiences. Karl shared feelings of being unqualified to engage in discussion and as a result he provided input through a hierarchical process with his managers. He acknowledged that his contributions were limited, as he sometimes chose not to say anything at all. I would suggest that Karl’s input might be misconstrued or misinterpreted as it navigates multiple channels before being presented. Additionally, Karl may not be present within the meeting to clarify his comments, provide additional information, or answer questions.

IPC spaces require accessible language, for example avoiding jargon or discipline specific acronyms and terminology, and create opportunities for each team member to contribute. Enhanced understandings of the discursive power inherent within professionalized communication (Foucault, 1972) may also be beneficial to identify power within language in IPE and IPC.

Study participants experience isolation from their home communities and also feel solitary in their professional roles, at times. They recognize that inclusion within interprofessional teams can disguise tokenism, ulterior motives for research funding, or service delivery models. Study participants observe the expectations within their organizations and interprofessional teams to provide solutions for all Indigenous clients. Siloed approaches to service delivery are contrary to Freeth’s (2001) research which
indicates that collaborative practice is required to address the complex intersectionality of social determinants of health. However, study participants encounter resistance to the implementation of Indigenous healing practices. Effective IPC requires acknowledgment of the diversity within Indigenous culture, language, approaches to and understandings of health, healing, and wellbeing.

Organizations and professional disciplines offer standardized ways to determine when, where, and how it is acceptable to share personal experience within professional practice contexts. As the study participants shared above, this standardization impacts the ability of team members to create relationships in IPC. The study participants suggest that support, respect, encouragement, and validation by colleagues and agency leadership can allow for human experience to be incorporated safely into practice. Understanding one another’s strengths and personal history can assist in identifying where they can most effectively contribute within the interprofessional team. Once identified, the strengths, gifts, and personal experiences of an individual can be correlated to roles within the interprofessional team. These dynamics can also pinpoint areas where an individual would be an asset to patient care. This correlation is consistent with strength-based approaches to social work practice, Berg-Weger and Schneider’s (1998) research highlighting strength-based approaches to IPC, and Hammond’s (2010) research proposing authentic relationships as a mechanism to achieve IPC. The integration of personal experiences and professional practice requires individual critical reflection, culturally competent spaces, and collaborative teams that are open to connecting on a personal level.
Theme Three: Relationship

The theme relationship is woven into the interprofessional collaborative experiences of Indigenous professionals in health settings. Cole characterizes, “Interprofessional means working with different areas of expertise so I feel that almost every single piece of my work is an interprofessional collaboration” (Cole, 2015, L 403-406) and “Interprofessional collaboration means working together as a bunch of teams of professionals to achieve better access to health care” (Cole, 2015, L 446-448). Another participant’s reflections on IPC were similar:

It means taking a lot of different ideas and a lot of different disciplines and coming together to look for a common ground. So for us, the common ground is health equity and reducing health disparities among populations of people. For me, it’s working together with these different disciplines, but being on the same page towards a common goal (Lynne, 2016, L 193-199).

Cole echoes the World Health Organization’s rationale for the development of IPE and IPC through her experiences in health settings: “Because people who have come before us have seen a need for [collaboration] and they have installed roles like mine and the rest of my coworkers to help fill that gap and build those relationships and to connect people” (Cole, 2015, L 454-458). For the study participants, IPC in health settings is created through acknowledgement and integration of each discipline’s area of expertise working together to a common goal of increased health outcomes for clients. This dynamic was expanded in the words of one participant who described how collaborative relationships are developed,

True collaboration is really about two different worldviews side-by-side, as opposed to integration. So, we say we want to collaborate which means we want to maintain our autonomy, the way that we do things. Integration means that they become a melting pot so we really like the word collaboration (Lynne, 2016, L 151-157).
Lynne adds, “I think where two things are merged together to come up with a new understanding of something else that is a perfect balance of both ideas. So that would be ideal for me” (Lynne, 2016, L 208-211). Lynne’s comments may suggest that autonomy is important in collaborative relationships because it allows for each professional to share their area of expertise. The comments of the participants indicated it is additionally important for Indigenous professionals, as the power dynamics inherent to collaborative practice can be reflective of assimilation and appropriation.

Team dynamics.

The individual traits of professionals impact the overarching team dynamics within collaboration. Team dynamics can shift with the introduction of new members.

It’s really the team dynamics whether or not collaborations come easy or they come really hard. Some people really love working together and they cannot work alone, like they need to work in a team setting and some others would probably, could go their entire careers without any sort of collaboration and they would just be just fine. So, it’s always interesting finding those dynamics out and finding out peoples’ personalities. It takes some time. It takes some patience (Cole, 2015, L 50-59).

There’s always professional issues always ongoing whether people like each other or don’t like each other at the office. Things like that always exist. They’re outside where my expertise lies with race and relations issues. Sometimes its just “I don’t like you. You’re a jerk” (Cole, 2015, L 781-787).

Study participants suggest that frequent critical reflection on an individual level and as a team holds an important role in IPC. “I ask that a lot. Why is this team far more accepting and I’m willing to far more openly challenge people in a very respectful way” (Cole, 2015, L 803-805). Role clarification and education are important components within IPC. “One of the things we talk about as partners is that we’re on equal status when we’re talking” (Maggie, 2016, L 175-177).
I’m able to begin a relationship with a group, or with a system, or institution and start talking about Indigenous people and getting them to understand us as Indigenous people. The way forward for us, we have the solutions, but we need to develop partnerships that are equal, on equal status, in terms of addressing what we’re faced. So, whether it’s going to a housing meeting or a health meeting or going to whatever kind of meeting I’m invited to and even this process of being part of research is that we have to have a relationship before we can begin to talk about what the solutions are for Indigenous people (Maggie, 2016, L 456-468).

Development of partnerships and effective teams are necessary before collaborative service delivery can occur.

**Community engagement.**

Cole clearly connects characteristics required for IPC and service delivery.

Service providers are required to be “visible” and “present” in community to engage with clients to effectively communicate understanding and promote engagement in programs.

Without being visible and being present in the community no one is going to truly know who you are and participate in programming. That’s kind of where we started. I continually challenged them to come to events, come to community, be present, do whatever that takes. And they did for a little bit, they would come to one or two events and I thought okay, this is a start, this is where we are going. I thought this is going to be good, we are going to get somewhere. I was like it’s going to take time and I was really motivated or super excited. I was like yes! (Cole, 2015, L 513-524).

Community engagement and professional relationships create opportunity for innovative service delivery. Cole shares, “I know that they know me, that’s why they came to me. I thought this is going to be great, this is going to be an easy win” (Cole, 2015, L 528-531).

Relationships are also identified by Lynne as a key component of IPC in health settings.

I really built a relationship with the director and the people that were in charge and once they developed a sense of trust for me they really included me in the case planning and all of the different aspects that go with working with the kids, which was really super helpful (Lynne, 2016, L 283-288).
Negative outcomes are evident when care is not taken to establish IPC foundations of role clarification, consensus building, relationship, community engagement, and co-created service delivery models.

It became like this cycle of lies and my heart got broken because I really believed in it when the project first started. I was like this is going to be amazing and I was congratulating everyone in my mind like you guys are awesome for pinpointing the weakness in your program and wanting to fix it, but it was also just really hard. They recognized there was a problem, but they weren’t actually willing to do anything about it. I don’t understand the reasons why. They never really, truly, shared that with me (Cole, 2015, L 542-552).

“So I went, over the course of years, I was so excited about the project to where I realized there was no traction because one side of the partnership didn’t actually exist” (Cole, 2015, L 599-602). “So, it’s disappointing, I guess. I’m disappointed” (Cole, 2015, L 605-606). Negative outcomes in IPC can collapse relationships and result in reluctance and aversion to future collaborations.

I don’t know if I would, if they ever approached me to do anything again, if I would participate or not. I also have to be a professional, to have that professional courtesy, okay maybe I can share this, but I’m not going to commit to any more work like this. I have wasted enough hours trying to support your team and it doesn’t seem like you guys are giving that support back and wouldn’t talk about those things that have happened (Cole, 2015, L 608-616).

Ongoing effective communication assists in developing long-standing relationships in multiple sectors to ensure health care services meet the needs of Indigenous populations.

We worked closely with the Indigenous community making sure that they were on side and knowing what we were doing here in the city. We wanted to continue to work with them and are still continuing to work with them to understand what the results of the survey meant and what they meant for [name of city] and what it means for the responsibility of the [name of health region], the city of [name of city], the province of Saskatchewan, the country of Canada, how they need to help people in the city now to move forward and address the multitude of health and social issues that are impacting them at the greatest numbers here. It was a great opportunity to partner and work more closely together in addressing what we’re seeing (Maggie, 2016, L 187-202).
Continuous and mutually-beneficial relationships are crucial to IPC and human service work.

**Kinship.**

Relationships for the participants move beyond professional collaborations in the workplace to recognition of kinship and interconnection, healing, and reconciliation.

We talk about kinship. We’re all related and what that relationship meant. There’s so much broken in Indigenous kinship right now, but we can reestablish that. That’s one of our solutions as we work our way forward is to reestablish kinship within our families, within our structures of our communities, our nations (Maggie, 2016, L 271-277).

Maggie shares that the kinship relationship has to be developed within IPC.

That relationship has to be developed. I want to know where you’re from. I want to know, cause you’re not from Canada, the only people from Canada are Indigenous people, this is where my ancestors have been forever, but your ancestors came from someplace else so let’s talk about that. Tell me where your ancestors came from and then we can start to tell truths. This is my truth; I’m from here. You’re from where you’re from. Okay, now have you forgiven your ancestors for what they did to Indigenous people when they came to this land called Canada because whether you can forgive your ancestors for that then cause I’ve forgiven my ancestors I’ve had to forgive my ancestors for where I am today so that forgiveness is very real to us. That’s our truth, right. We can start reconciliation now. Okay, so that forgiveness is real. Okay, so now you and me can forgive one another for what has happened. Let’s work together now in a real way. This way forward is you won’t try to save me anymore ‘cuz you can’t save me. I have to save myself. I’m an Indigenous person. I have the solutions that live inside of me. My ancestors are alive and well and pushing me forward to do the work that I need to do here on earth and Canada. So that way we can work closely together (Maggie, 2016, L 475-501).

To work together in a culturally-inclusive way, components of relationship, forgiveness, and truth need to be incorporated into IPE and IPC. Questions of self-reflection should be asked by non-Indigenous professionals in practice to assist in determining if we are working toward building a relationship or working in a “privileged way” (Maggie, 2016, L 586).
Then they got to know that I wanted to know where they were from so that was developing relationship with them. I told them where I’m from, who I was, and my Indigenous name and asked a bit about them, why they were there, so there’s questions. That’s about relationship building, about understanding us as human beings, a little bit about your family and the work that you do. That was really a good foundation for me to begin working with them (Maggie, 2016, L 559-568).

Then I went on and really worked on establishing relationships because I think that’s the important part is having those relationships and making them personal. When I work with people I make sure I know them on a personal level so that those collaborations become strengthened and that’s worked well (Lynne, 2016, L 50-56).

They have to understand that we are coming at it from an Indigenous way and our lens is very different than theirs. They have to respect our way forward and work with us as we have respected them all along and will continue to do that. So there’s no us or them, it’s us together that needs to work together, but it needs to be done in a respectful manner so that the people will benefit from the work that we’re going to do in our communities (Maggie - 2, 2016, L 269-278).

IPC foundations for the study participants are human connections, understanding of each other on a personal level, with a focus on clients within the community. Lynne describes what IPC can look like when those foundations are in place.

It feels safe. You feel respected. You feel a lot of hope that you’re going to make a difference and there is actually people in the world that aren’t from our background saying the same things. They are saying the same things that we are. You feel like you can create change, organizational change, very very quickly and that’s because there’s some great leaders. You have to give them credit because they set the bar for what’s going to happen. Really valuing those relationships (Lynne, 2016, L 167-176).

**Connection to nature.**

For the participants, relationships are not exclusive to human interpersonal connections. “Indigenous people are connected to nature in so many different ways and because a lot of us are urbanized we don’t know that” (Grace, 2016, L 221-224). Indigenous teachings continue to be integral to knowledge acquisition for Indigenous and non-Indigenous professionals.
Our relationship we have not only with human beings, with the land, the animals, with the plants, with everything. We have a relationship with everything. Indigenous people, that’s our understanding. We can share that with the rest of society. … We have relationships with many things and those are our ways forward (Maggie, 2016, L 810-816, L 819-820).

Our relationship is not only with the land but it’s with the animals, it’s with humans, it’s just everything. So, things that are alive or seem to be not alive, we have relationship with everything and we have these understandings and these teachings that I am still being awakened to (Maggie, 2016, L 107-112).

The relationships with the land, animals, and plants are included in the study participants’ experiences of IPC. Maggie provides two examples of incorporating multiple relationships into the work of IPC in health settings.

Before they begin meeting, before they begin gathering, they acknowledge the land, they acknowledge the people of the land. That’s what has to happen here in the province of Saskatchewan. I always take every opportunity that I have in a meeting to stand up and acknowledge this is Indigenous land. This is the land of Indigenous people. It doesn’t mean that we have any ownership because our ownership isn’t like in a colonized way, it’s more honoring the land that our ancestors were on and to begin to move forward in that manner. It’s a different way of thinking (Maggie - 2, 2016, L 526-538).

Before we go and get a plant that we are going to use for medicine we have to pray to that plant and thank it because it’s going to help us. How many people do that, right? [laughs] To harvest that plant in a good way; to prepare that medicine in a good way, and how you give that medicine to a person and how they can also take care of that medicine and pray while they’re taking that medicine and when they’re done taking that medicine, if it’s a tea, then they get rid of that plant in a good way so that’s it’s given back to the Mother Earth and it’s thanked for what it’s done, the time that you were able to use it for medicine (Maggie, 2016, L 833-846).

For the study participants, it is important to honor the land and the caretakers of the earth, not to acknowledge ownership. Maggie creates understanding of how land, animals, and plants are part of the reciprocal relationship and highlights the significance of using these items in a good way and offering thanksgiving for their contributions. Maggie draws a
parallel between our acknowledgement and appreciation for one another in IPC to the ways we should provide gratitude to the land, animals, and plants.

When reciprocal relationships with all things are created in a good way, IPC can “look like a very meaningful friendship” (Lynne - 2, 2016, L 214-215) with “no biases, or no stigma, or no discrimination” (Grace – 2, 2016, L 396). “Collaboration would have absolutely no judgment. No judgment. Everybody would be treated equal” (Grace -2, 2016, L 393-394). Study participants further identify relational characteristics that can enhance interprofessional practice.

If you were going to look at a collaborative setting where it would have to be an open, honest communication, based on respect. It would have to be there. With no judgments, but with policies in place that protected all (Grace – 2, 2016, L 422-426).

Well, respect is the first one. Understanding, sense of humor, reciprocity, kindness, compassion. I think humor is one of the big ones. A willingness to learn and be self-reflective on both sides. Because I am not always right in some of the judgments or ideas that I have. I like when people challenge me (Lynne – 2, 2016, L 231-236).

Interprofessional collaborations that incorporate characteristics of respect, honest communication, humor, reciprocity, compassion, and critical reflection can inspire holistic health service delivery. “It’s just so easy and that’s what I love about my work, when it becomes like really easy and like you don’t have to struggle to convince people that this is the right piece of work that we should be doing” (Cole, 2015, L 124-128).

I feel inspired because collaborations can work. I have heard on both sides, you can’t collaborate with white people, you can’t collaborate here, and so I’ve seen these divisions. So, knowing that it’s not always the case, that those divisions don’t always have to take place. I think that’s inspirational (Lynne -2, 2016, L 221-226).
When balance is created “It’s very rewarding” (Karl, 2016, L 95) and we “have the opportunity to work with other professionals in hope of making people understand and provide better services to Indigenous people” (Grace, 2016, L 178-180).

**Theme Three Discussion**

The theme *relationship* encompasses the study participants’ understandings of interprofessional collaboration and their experiences of team dynamics, community engagement, kinship, and connections to nature. The study participants describe interprofessional collaboration as the process of working together to reduce health disparity and improve health care access for clients. They suggest this is achieved through building relationships to connect people. Autonomy for the study participants in collaborative relationships allows for individual contributions in a cooperative environment to achieve a common goal. Collaborative relationships are influenced by many factors including personalities of individual team members and their readiness to engage in critical reflection. The study participants assert that the partnerships must be created within a framework of status equality. Team members must exude patience and a willingness to navigate the challenges within IPC. As noted in the literature review and echoed by study participants, team dynamics such as interprofessional conflict resolution, team functioning, and collaborative leadership influence IPC outcomes.

Study participants suggest that community engagement is key to IPC. Community work is consistent with mezzo level social work practice. Community engagement requires integration of input from the community and transparency in service delivery models. Micro, mezzo, and macro impacts of health care services must be identified and incorporated into interprofessional teams and health care services. Client inclusion (micro
level), community engagement (mezzo level), and systemic dynamics (macro level) are identified within the literature and by participants as interrelated within collaborative practice (CAIPE, 2002; AIPHE, 2009; CIHC, 2010).

IPC includes the recognition of kinship relationships and interconnections between team members, community, environment, and all nations. Orchard et al. (2005) and Clark (1997) assert professional cultures and personal beliefs inform teamwork and group processes. Therefore, understanding past history assists in creating interprofessional relationships in the present to develop holistic health services for future generations. Cole’s comments regarding her perceptions of partnership resonate with me in the context of colonialism. In speaking of the treaty relationship, Indigenous leaders often share feelings that the Western intention was not to create partnership, but to assimilate Indigenous populations. Study participants assert resolution within these relationships as the way forward for Indigenous peoples in reconciliation. I would assert it is also a way forward in IPC.

Study participants incorporate traditional teachings to honor all living things, including the land, within IPC. The social work profession is beginning to explore the relationship between humans and the environment (Besthorn & Saleebey, 2003; Zapf, 2010). Environmental social work moves beyond social work explorations of person-in-environment that address the social, political, or environmental impacts on the person. Environmental social work recognizes relationships with animals, stewardship of natural resources, and advocacy for environmental sustainability (Dewane, 2011). Indigenous understanding differs from Western conceptions and asserts that “those who seek to
understand the reality of existence and harmony with the environment by turning inward
have a different, incorporeal knowledge paradigm” (Ermine, 1995, p. 103).

**Theme Four: Broken Policies and Programs**

The study participants’ experiences of IPC are given meaning through the context,
or structural, elements which include interactional, organizational, and systemic
environments that augment and impede IPC. The structural elements are highlighted
under a theme I ascribed to *broken policies and programs*.

Many different areas of concern for me as we move forward and looking at what’s
happening within our systems, our institutions, and our agencies that are there to
address what we are seeing within the people, but yet, you know there is
something broken and it’s not the people. It’s the systems, institutions, agencies,
have broken promises, broken policies, broken programs that aren’t meeting the
needs of the people that are walking through their doors so the work that we’re
doing is really partnering with those groups and saying “hey, you know, let’s get
real here. Let’s move forward and do some reconciliation so
we can really help the people to address what they’re faced with on a daily basis”
(Maggie, 2016, L 54-69).

**Resources.**

The study participants indicated that time, resources, and workload produce barriers to
service delivery and IPC.

[They] didn’t want to give them any time to do that work so they wanted the
project to exist, and they wanted it to happen, and be a success, but they weren’t
willing to give any time and they weren’t willing to give any resources to the
project (Cole, 2015, L 533-538).

But they don’t think that far ahead. They’re worried about their policies all the
time or how much money. To me it’s just excuse after excuse for why they can’t
provide a good service in a good way (Maggie, 2016, L 777-781).

Because they have such a huge waitlist they put barriers in place. They
intentionally put barriers in place. They acknowledge that they do that, but they
tell us they do that to keep their sanity because there is no way they could provide
the service that the community needs (Cole, 2015, L 674-679).
Barriers to service delivery may not be specific to Indigenous clients, but intentionally designed to alleviate pressures within the workplace.

You don’t actually have to go through a [program] to receive therapies, but they have created this as an intentional barrier because they can say, they can check mark, they can say you need therapy, there’s a timeslot available, you’re available to do this, oh – you haven’t taken the [program]. They can push you down the list until you’ve taken the [program] because there’s 50 more of you guys waiting and those families have completed the [program] (Cole, 2015, L 701-710).

That’s one situation where people have barriers and things that are intentionally built to limit access, that I challenge with them all the time and it might not always be specifically barriers that relate only to First Nations people but I think it’s just a community barrier in and of it’s own self (Cole, 2015, L 724-730).

**Racism.**

Racism, stigma, and discrimination can impact client engagement with services.

“We have to talk about racism and how that affects people’s care treatment and support” (Maggie, 2016, L 389-390). There is “A lot of racism that way, a lot of prejudice, a lot of stigma, ignorance and discrimination associated with the work that we are doing” (Maggie, 2016, L 412-415).

So much discrimination going on – racism and ignorance around people who are presenting with the greatest need. Society has a lot to change around their understandings of human beings. We have moved away from really looking at people as human beings and looking at them as whatever way you’ve been raised to look at people, whatever you’ve been trained at universities or colleges, or institutions to treat people the way that you treat them (Maggie, 2016, L 431-440).

Cole suggests, “It’s trying to challenge them to think outside their system” (Cole, 2015, L 716-717). Lynne notes racism, stigma, and discrimination not only impact client experiences, but influence Indigenous professionals’ experiences of cultural safety within their workplace.

Right now, language has become an issue in my organization. Having people speaking different languages on the job is not deemed as appropriate and our department, of course, says we have to allow people to speak their own languages.
at work. We’re struggling through trying to get people to see that is a form of oppression. They listen to what we say and then carry on thinking that it’s perfectly okay not to allow people to speak their languages. We are a First Nations department and we say that’s not a part of reconciliation (Lynne, 2016, L 76-86).

If staff want to speak another language because that’s what they feel most comfortable speaking in having a little bit of faith that they are not speaking about you, but using policies which is a form of systemic racism to create policies that forbid people from speaking their language (Lynne, 2016, L 106-112).

Personal relationships described in the previous theme are integral to reducing barriers for clients. “We develop a relationship. They’re not just a client. They’re not a number. They don’t have an appointment. These are things that create barriers for accessing programs” (Maggie, 2016, L 377-380).

A lot of times there is no personal relationships developed with service providers and that needs to happen. It’s not just the privileged way where you’re the social worker and I’m the client and I won’t look you in the eye, but I’ll tell you what you have to do and I won’t ask you any other questions other than what I need to know here on this piece of paper because this is what the policies say and how I’ve been trained. You can’t work with anyone that’s in need of many things if you’re not truthful with them and treating them with respect and treating them as a human being. You’re never going to get anywhere with them. You’re not going to help them. They’re not going to come back and be part of that. They’re not going to participate in that. They need to know that it’s coming from a good place, that you’re trying to help them, not a place of “I’m going to follow this policy and this is the rule and that’s it. If you don’t to this you can’t pass go and collect 100 [laughs]” (Maggie, 2016, L 585-604).

Service delivery is not about having all the solutions. As outlined in chapter two, strength-based approaches highlight the importance of developing a relationship with a client to empower them to develop solutions. “Just stop trying to save us because there’s no salvation anymore. Those days are over. [laughs]” (Maggie, 2016, L 784-786).

Professional socialization and cultural norms can lead to the “privileged way” of service delivery, offered by Maggie.
We always say there is three different kinds of white people. There’s ones that think they are going to come in and they get trained, and this is the scariest ones, and they think that they are going to save us from something and that we need their help. They come in with a savior model. Then there’s people, like yourself, that are genuine allies. They question everything and they want to help, but they want to know what their place is. Training people like this we try to build this allyship in a good way so that people use what they have. The third is the people that think they become Indian. So they adopt our culture and our ceremonies and they’ve found the path. It just looks funny. You’re in the middle. The first one is very dangerous. You can pick them out right away. They have an answer to our problems (Lynne, 2016, L 350-366).

Hegemonic, colonial, and assimilative practices need to be identified, challenged, and addressed within health services. IPC is promoted through inclusive, reciprocal partnerships.

They are still coming at it from a very colonized way and for us to deal adequately with [health issues] in this province there has to be zero colonization so when we partner and work with health regions, or with the province of Saskatchewan, or any institution or system they have to understand that we are coming at it from an Indigenous way and our lens is very different than theirs (Maggie – 2, 2016, L 264-272).

It’s just an inclusiveness for our Aboriginal people to participate in the health system. For accessibility, specifically for health, proper access to health and health care when you need it, where you need it, and willingness to meet Aboriginal people where they are in the health system and not force their system upon them (Cole, 2015, L 662-668).

There’s politics in the health region. The tribal council and the health region, I guess they had a little falling out years back. I don’t know the whole story, but it’s true that we need to keep them separate because the health region and sorry to say this but if they put their rules onto the tribal council then that would be colonization all over again. I have to remind myself to keep that and that away from each other (Karl, 2016, L 582-590).

Barriers and protocol can have significant impact for study participants when implementing services from an Indigenous framework. In the words of one participant, “It’s a very tough job. We do what we can with what we have” (Karl, 2016, L 136-137).

Restricted resources and limited understandings of Indigenous protocols regulate the
ways Indigenous professionals can provide services. “We’re trying to expand, but then we try to do nice stuff, we get slapped on the wrist, we get reminded what the rules are” (Karl, 2016, L 294-297).

When we wanted to bring the Elders in they’re like, oh, our policies, we have to check with the labor, the union, because we can’t bring people in that, you know, they have to be unionized. There was a bunch of really, okay, well, that’s a barrier. That’s an example. They need to change their policies and their procedures around how they’re working with Indigenous people (Maggie – 2, 2016, L 517-524).

I have another story about protocol. We did the fire keepers. We were on schedule. With protocol the people know that you’re supposed to put that tipi at the bottom of the hill and when it was really cold and windy and then they put the tipi at the top to, I guess you could say, to please whoever was running [name of agency]. It ended up burning. It burnt down because it’s top of the hill, it’s colder, it’s windy so you got to turn up the heat and it actually burnt down. Sometimes you got to let protocol go (Karl, 2016, L 652-664).

Indigenous service delivery needs to be led by Indigenous professionals to ensure protocols are followed. Legislation, policies, and processes require ongoing evaluation by Indigenous professionals to ensure they are not creating inflexible barriers. “We can’t always have everything written in stone. It’s good to bust them out and explore new things” (Karl, 2016, L 366-367). Maggie speaks of barriers to inclusion of Indigenous professionals in collaborative conferences and meetings.

There was 150 people in that room, 5 of us were Indigenous. Openly, openly Indigenous. There might have been some that sit back and don’t say they’re Indigenous, right? [laughs] But, openly and viewing, when you look for Indigenous people in a crowd, and 5 that stood up and spoke and we’re not on the agenda to speak. We put ourselves on the agenda. That in itself says a lot about Saskatchewan and the movement forward and our opportunities to be on equal status in terms of the professionals, meaning the clinical professionals, understanding that Indigenous people we have our own clinical way (Maggie – 2, 2016, L 187-199).

They’re talking about Indigenous people in Saskatchewan, but yet none of our leaders were there. The only leaders that I seen were community leaders of myself, [name] [name of organization], people that I had brought, last minute
invited because I felt they needed to be there, Indigenous people. It’s very sad to see that (Maggie -2, 2016, L 213-219).

She also explores her experiences of marginalization of community-based organizations noting, “they don’t include community based organizations, the longtime funded groups were missing” (Maggie – 2, 2016, L 222-224).

Hierarchy and power are evident not only in interprofessional relationships. It is apparent within the status, classification, and funding of government organizations and community based agencies.

Community based organizations they rise up from the call or the voice of the people who are not getting care, treatment, or support from an institution or a system and that’s why these organizations rise up and have been around here for 20 years plus, but yet they weren’t invited (Maggie, 2016, L 229-234).

Maggie also notes that when Indigenous professionals put themselves on the meeting agenda and contribute to discussions, the input is disregarded or appropriated.

So, we made those points at this meeting, but it’s very disheartening to see that in the 30 years that we’ve been working in this province that, yes, they are still not being acknowledged for the work that they’ve done since day one (Maggie -2, 2016, L 236-241).

That’s very disheartening to hear and see when they are trying to reinvent work that we have been doing for many, many years in this province and not including us in their work is very detrimental to the people. As community organizations we come from the other way, where we include the people (Maggie -2, 2016, L 254-260).

**Client inclusion.**

The study participants assert that client inclusion is foundational for Indigenous professionals. Collaboration begins with the voices of clients. Indigenous professionals identify the privileged assumptions of race, gender, and socioeconomic status. “I’m not even talking about systemic racism when you’re going in for care, treatment, and support and you’re treated like you’re less than” (Maggie, 2016, L 402-404).
So I kind of challenge them right now to think about why do you have these perceived thoughts of safety. Is it your stereotypes that you are coming to work with? Is it your judgments around the neighborhood? Has anyone actually violated your space? (Cole, 2015, L 301-306)

Yes, you are providing care to those who might be drug users. Yes, you’re providing care to people who are living in poverty. And yes, you’re providing care to minorities. And if you have a race-based assumption of judgment of other people then we are never going to be able to work (Cole, 2015, L 331-337).

If you’re going to open the door and greet a white mom really happily and “oh, hey, how’s it going” and “we’ll be with you in 10 minutes” and you open the door and there’s a Native guy there who looks like he might have been using today and the first question you ask is “are you using today” and you shut the door. When I see that happening I get mad. That is not fair. You do not treat one person better than the other, based on what you see. You don’t even know what they are both presenting with, but yet you treated one with more care than you did with the other. So it’s those perceptions that I am trying to challenge and I know exactly where they’re coming from. They’re coming from ideas of racism, of privilege, of all those places of power, and they don’t necessarily see the way their attitude affects the way the community reacts to the [name of program] (Cole, 2015, L 339-356).

We are working with a hurt people. Our people are very hurt. They have been traumatized. They’re walking around traumatized. When they walk into places and someone says no to them or treats them in a negative way they’re not going to go there no more. They can feel it. They know when they’re not welcome (Maggie, 2016, L 422-428).

As noted in chapter one, the AIPHE and CIHC highlighted client-centered care as a benchmark for effective IPE and IPC. Client inclusion provides opportunities for diversity in perspective (Jones & Black, 2008; Orchard et al, 2005). Clients can identify barriers to service delivery that may not be apparent to professionals working within the team. Cole describes the shift in perspective that can occur for professionals when the client is incorporated into the IPC team.

It’s always amazing when a patient advisor comes to the table and the conversation changes from “I can’t do this”, “I’m not going to do this” “I’m not going to do that”. Then as soon as they get to the table, the doctors are like “YES!” and they’re like “okay, yeah, we can do that” and their tune changes
automatically from being defensive to actually listening to what they say (Cole, 2015, L 413-421).

We always talk about the patient experience and we always talk about is this patient-centered care or are you choosing to do this because it’s better for you, for your work space, or is it actually making their experience better (Cole, 2015, L 421-425).

Cole connects the client experience to the experiences of all people. This perspective can be helpful in shifting the professional response to health care services. When the client experience shifts from race-based assumptions it becomes a human experience for which the response is compassion. Study participants indicated that interprofessional teams need to be “working with the community and asking what their needs are” (Maggie, 2016, L 206-207).

So, we always challenge our teams to change the way in which they’re thinking and that patient experience it can be very generic. Everybody can be a patient. Everybody has been a patient at one time or another. We also challenge them to think even further. The patient experience based on their economic status, the social determinants of health, their race, their language. It’s always a great way to phrase things with our teams and get them to think about things more outside the box of how they can provide health care, rather than their traditional – and this this the thing – their very traditional forms of service that they’re used to do (Cole, 2015, L 425-438).

The participants loaned their voice to IPE and IPC frameworks through their experiences and offer suggestions for advancement.

**Theme Four Discussion**

The theme *broken policies and programs* examines barriers to IPC from the perspectives of Indigenous professionals. Study participants highlight the concerns with health care services that stem from broken policies and programs. They clearly articulate that clients are not the hindrance to effective service delivery and positive health outcomes.
As noted in the literature review, IPC requires ongoing commitment, time, and adequate resources. I believe there is a strong misconception that IPC comes easily within teams. Systemic barriers can often pose significant issues when developing an interprofessional model of service delivery. When multiple agencies or disciplines are involved in IPC, consideration must be given to policies, program mandates, and outcomes to alleviate barriers to service delivery. Organizational structuralism (Orchard et al., 2005) is evident within the study participant’s experiences of the decision-making structures within organizations. Grace notes this is especially evident when collaboration is sought between Indigenous organizations and government agencies. “Two totally different settings, but both really mean well. Both really want to help people, just that one of them is literally linked to a system that’s broken” (Grace – 2, 2016, L 331-334). Maggie shared her observations of exclusion of community-based organizations from interprofessional conferences, meetings, or service delivery models. While this does not relate directly to IPC, it does indicate that tokenism, power dynamics, and exclusionary practices are evident outside of IPE and IPC. Additionally, research offered by Baldwin et al. (1980) and Barr (2007) concluded that community leadership is essential within IPC. The need for power, to move upwards in the health care hierarchy, and specialization may be reasons for the increasing shift from community development to clinical focus within social work practice.

The experiences of Indigenous professionals may also connect to experiences of other marginalized populations of professionals. This is especially significant given the increasing populations of immigrants, newcomers, and refugees to Canada engaging in the health care system as clients and professionals. Reconciliation with Indigenous
populations may offer opportunities to discontinue power-over relationships, create understanding of multicultural experiences, and generate awareness of homogenization within other marginalized populations, including clients. This is likely to be an area of future study within IPE and IPC.

**Theme Five: Way Forward**

Within the fifth theme, the study participants identify the *way forward* for Indigenous professionals in IPC. The *way forward* includes discussion about truth and reconciliation, family relationships, Indigenous teachings and ceremony, and waking up the people.

**Truth and reconciliation.**

The truth for Indigenous peoples is acknowledgement of Canada’s history of colonization and the creation of systems to assimilate Indigenous people. The Truth and Reconciliation Commission of Canada generated multiple *Calls to Action* (2012) germane to the helping professions.

It’s a cycle. We see it. We acknowledge it. And, you know, we talk about it; the truth and reconciliation. And what is the truth? The truth is this system’s not working. It’s not doing any good for the people. You want to talk about reconciliation, well let’s talk about the truth first (Maggie, 2016, L 259-264).

And yet, they don’t know anything about the residential schools, what happened in Canada, and their ancestors are part and parcel of putting those places in place here in Canada so to move forward we talk about the truth and the truth has to be revealed (Maggie, 2016, L 303-308).

Discussions about truth allow for understanding of the experiences of Indigenous peoples resulting in health, social, and economic disparities.

People like to talk about all the addictions and institutions and correctional systems and the foster care systems and all of those. They talk about those. They give statistics, but do they ever get to the root of what caused people to be
involved in those institutions and systems? No, you never hear that and that’s what we need to talk about. The truth (Maggie, 2016, L 530-537).

To tell the truth about Indigenous people here in this land called Canada so that people can understand why it is that we are at the highest numbers and why we need to work together now to address what we are being faced with as Indigenous people. This is for the generations to come so that there will be no more of the health, social, disparities that are taking place with Indigenous people in Canada. The way forward is being paved and I’m excited to be part of that time (Maggie, 2016, L 319-329).

Study participants suggest that non-Indigenous people need to first understand Canada’s history of colonization before reconciliation and collaboration can effectively occur. “The way forward is better when we can work with those systems and institutions so they can change the way they are doing the work and help us” (Maggie, 2016, L 282-285).

As Indigenous people we have the solutions. You have to help us, to work closely with us, to be familiar with what our teachings are and have our understandings and understand what happened in Canada, here, with colonization and residential schools. It’s kind of amazing to me to sit in meetings sometimes with non-Indigenous people and they don’t know what the residential schools were about in Canada (Maggie, 2016, L 285-293).

Currently, conversations about reconciliation with Indigenous peoples are in the forefront of political, academic, and practice communities.

I’m thankful that the new Prime Minister of Canada [Justin Trudeau] talks about truth and reconciliation and looking at the 94 recommendations that have come out, that are going to be implemented now in Canada and so that’s important because now our children will learn about residential schools in school (Maggie, 2016, L 308-314).

You’re seeing a group of young people coming out of the First Nations University of Canada who are going to be in those institutions and systems and be the policy makers and changers and you’ll see things begin to change (Maggie, 2016, L 805-810).

Study participants suggest personal reflection is necessary to determine how our personal experiences impact our work. It is important to develop an understanding of how it feels to carry our ancestors’ strengths and transgressions. “Our ancestors are never
gone, they are still here with us, we live and breathe them everyday. They come with us when we do the work (Maggie -2, 2016, L 326-329).

As someone who has come here, who’s ancestors were the colonizers so sometimes the individuals that are here now that are working towards solutions they don’t understand that they haven’t dug deep enough within themselves to understand that they can’t carry this guilt and shame of what their ancestors done to Indigenous people. When they come to the point of their working in these institutions, in these systems, or these agencies that are in place to provide care, treatment, and support to Indigenous people that they’re making these decisions based on guilt and shame that they carry, which they have not acknowledged. So when it comes down to them they are very controlling. They are very authoritative, it’s their way or no way, they have that thought that we’re saving Indigenous people and so they’re coming at it strongly that way. That’s a spiritual battle that Indigenous people are always working on because for us as Indigenous people it’s not just sitting down in an argument between [name of agency] and the province of Saskatchewan, it’s a spiritual battle that we know first and foremost. When we change the way that things are happening in a spiritual realm then things on earth will happen in the way that they should. For me, that’s a way forward that’s comforting and more peaceful for me to acknowledge it in that manner (Maggie -2, 2016, L 656-683).

Maggie explores the impacts of colonialism on interprofessional practice and connects this to a spiritual battle. This connection moves the conversation from interpersonal or interprofessional contexts to a broader understanding tied to the ancestral histories carried by humans into their work.

So it’s challenging to know that and it’s sad to see them because I see that and I feel pity for them because they don’t see that. They don’t understand why they’re acting the way they are because they are not respecting Indigenous peoples and they want to push their way (Maggie – 2, 2016, L 685-690).

Maggie’s assertion expands on Vine Deloria Jr. and Wildcat’s (2001) views that non-Indigenous professionals can “focus on control” (p. 121) within service delivery with clients.

They say things like ‘if they could just get over what happened in residential schools, that was long ago’. Those kind of comments talk to me a lot about the way an individual is thinking. They still have that guilt and that shame that they’re carrying. That’s why they overcompensate trying to help people,
Indigenous people, and trying to be controlling, control the situation. That’s the same for Indigenous people. When I sit with people, Indigenous people, they are still carrying the guilt and shame from our ancestors, too. The way forward takes a lot to understand and I have opportunity to sit with some of our leaders, some of our people living with HIV and I have been able to share with them that when they are sitting across and being challenged from Social Services or by a doctor or a nurse or whoever that you should pray for them and have pity on them because they don’t know (Maggie – 2, 2106, L 692-710).

Maggie connects the similarities between the guilt and shame carried by Western peoples and the feelings experienced by Indigenous populations. Consensus building and collaboration are bolstered by identifying shared feelings, values, and beliefs. Recognition of shared feelings or experiences can elicit suggestions for shared outcomes. It may be through each party’s recognition of guilt and shame from the past; we acknowledge that we tried to control the situation and each other as a way to overcome the negative emotions. Addressing the truth, understanding the history, and engaging in forgiveness and healing are opportunities to build consensus moving forward. “Today, it’s changing and that’s good” (Maggie, 2016, L 318).

“As we move forward it’s time to work together. That’s reconciliation” (Maggie, 2016, L 518-519). Maggie highlights the importance of reconciliation in IPC. The CIHC National Competency Framework (Figure 1) for IPE highlighted core competency domains of role clarification, conflict resolution, collaborative leadership, and team functioning. These four competency domains and descriptors could also provide a framework for reconciliation. Role clarification between Indigenous and non-Indigenous populations and creating understanding of collaborative leadership within government could be useful in creating opportunities for conflict resolution and increased functioning between Indigenous and non-Indigenous populations. The National Competency Framework also provides suggestions for possible ways forward in the areas of
communication, community-centered care, and contextual issues. The participants’ contributions regarding community engagement and historical contexts are consistent with my understanding of the *National Competency Framework*.

**Waniska.**

Maggie incorporates Indigenous spirituality into the reconciliation process.

We are starting to wake up and our young people say it very well. In Cree it’s *waniska* “rise” “wake up now”. We’re saying that’s what’s happening in our communities for Indigenous people. It’s time to rise, to wake up, and bring the solutions forward for what we’re faced with today. That’s very heartfelt and inspirational to Indigenous people to talk about our way forward. The things forward that have happened to us since colonization, since residential schools, are no more. We are putting a stop to them. It’s time to *waniska* to rise, to wake up and to live in a good way now. We talk about that and it’s some of our teachings, our understandings around what it is to live a good life (Maggie, 2016, L 692-706).

Indigenous teachings of *waniska* are resonating with emerging professionals, as well. Maggie asserts this will provide assistance in the years to come.

We have some strong people coming up, that are already present, and that are coming up and are being trained and mentored to speak this way and to do things in this manner. It’s important to me because that’s what bringing life is (Maggie – 2, 2016, L 584-588).

The spiritual awakening of Indigenous youth, students, and emerging professionals is crucial, as Hoffman et al. (2008) pointed out, they have the “longest careers ahead of them” (p.656) and are able to create cultural change.

What we’re faced with today is going to take a lot of Indigenous people to wake up, to *waniska, waniska*, to wake up and to address what’s really true, what the truth is, what we’re addressing here in Saskatchewan. If we can wake up non-Indigenous people, well so be it, but they need to respect our ways. If they don’t believe it, they have to respect it, because that’s our way forward. It’s very real to us (Maggie -2, 2016, L 437-445).

Maggie suggests the way forward is also for people who do not believe in the spiritual aspects of Indigenous understandings. This way forward is through respect. Respect for
Indigenous understandings of truth, reconciliation, and service delivery. “If we can drop that guard and the barriers that have been placed because society in general has dumbed us down and it’s turned us against one another” (Grace, 2016, L 404-406). As enunciated through the words of one participant, it is my opinion that for Indigenous professionals the way forward is offered through spiritual connections with ancestors and the Creator. It comes through recognition that professionals are also spiritual beings.

When I sit among professionals I am speaking from a way that is going to help Indigenous people and I am confident that the words that I speak are the words that are supposed to be said and the work that we do is the work that is supposed to happen for the people and I am speaking on behalf of the people. I am speaking in a way that I understand is a gift that the Creator has given me. It’s not my own intellect because I went to university for 7 years and have a [graduate] degree. No, it’s because I understand people as human beings. I ask the Creator to help me. I am spiritually awake. Sometimes we forget as professionals, we are also spiritual beings (Maggie, 2016, L 674-686).

Maggie and Grace endeavor to create opportunities for spiritual connection through IPC, especially with non-Indigenous professionals.

I took them through a visual and I gave them an opportunity to, in their own mind and with their spirit and their emotion, ask somebody for something or say something that needed to be said that they didn’t get to say, whether it was somebody that had passed on, it was their choice. I could see the majority of the Caucasian people just not impressed and I don’t…I’m not saying that in a…I have the utmost respect for the people that were in that room; I still do, but they weren’t raised the way I was raised, they don’t understand the spiritual side…very connected. Now, that’s not true in all cases, I know a 70-something, if not an 80 year old nun, who is the most spiritual woman that I know, but follows the Bible. Whenever I am near her I am spiritually connected. I’m just at ease and I have this trust and almost a, I guess, a love feeling. She doesn’t do it my way, but she’s connected spiritually. A lot of people are not, so when we were part of that team and we were asked to provide an Indigenous perspective, so to help them understand what it was like, they didn’t get it. There was people that got it, like Caucasian people and Indigenous people in the room. When we were done the visual I asked everybody how it was. People were in tears. They went to a place with a grandmother or a mother that had died and they were so thankful. Everybody has that capability, they just don’t know how. They don’t know what they don’t know. But, the people that weren’t connected didn’t care for the exercise (Grace, 2016, L 224-254).
Grace speaks of being asked to attend meetings to provide an “Indigenous perspective” (Grace, 2016, L 208). This request is connected to siloed approaches to service delivery and the assumption that Indigenous professionals are responsible to provide all services to all Indigenous peoples. The expectation is that Indigenous professionals should “fix” (Cole, 2016, L 882) the problems of Indigenous people without regard for the complexity of this task.

Spirituality is incorporated within Indigenous research. As Maggie highlights, this approach is innovative within research methodologies (Kovach, 2009; Tuhiwai Smith, 1999; Wilson, 2008).

I think that some of the Indigenous researchers in Canada are really pushing the limits of the Canadian Institute of Health and Research and pushing the limits of researchers and academics in Canada in terms of doing research in a way that is Indigenous led, Indigenized research, especially if they are looking at groups of people that says that the research is affecting a high majority of Indigenous people. I think that’s a good movement forward (Maggie – 2, 2016, L 575-584).

Maggie provides an example of what Indigenized research can look like.

We took [the research project] to a sweat lodge and we asked for good things here on the prairies, for the women, and for the work of how that project happens. We are asking for good things, for good things to happen. So we want all of the research team members to enter into the lodge with us and to pray in that manner. That’s different than how research would take place in Canada. There’s no spiritual content in some of the way research takes place, but for us that’s very real. That research project is living and some people wouldn’t say it’s alive. It’s all intellect. It’s all written. Paper. It’s not alive. But to us our research is alive and that’s something we talk about – animate and inanimate objects that are things that are alive. All things have life to them. There’s nothing that we say that doesn’t have life. Everything has life. A different way of thinking, right (Maggie – 2, 2016, L 557-575).

One of the first research projects that we did, we led that forward and Indigenized. At times it was challenging to help the [agencies], but we stood by our ground that this is the way that it has to unfold for the people, for life to come, for the project that we’re doing and it was surveillance so it was numbers. It was very interesting. We were taking the blood from the people, too and how
that was to be protected and how that was to be used. We had to put it in a document, right, in a living document, research. The Elder gave the [study a] name, gave it a name in Cree, [name of project]. The way forward there is very interesting. We had our challenges because we went up against the intellects. This is our way forward as Indigenous people. We are not going to do this unless they agreed to come into our sweat lodge ceremony, this is a good way forward. I believe it changes the hearts and minds and spirits of some of the non-Indigenous people who had never been part of an Indigenous ceremony. So it was good (Maggie -2, 2016, L 588-611).

Maggie highlights the dissonance between intellectual, structured, colonized, and privileged ways of research and Indigenous ways that incorporate spiritual understandings and holistic perspectives. Grace appreciates the opportunity to create spiritual experiences for colleagues.

I like providing hope. I don’t provide it, I touch a spot in people, and in a professional level I’m speaking. I’ve had people cry in my workshops because I’ve touched something that they weren’t in touch with in a long time and to me that’s rewarding. Someone got to go somewhere they haven’t been in a long time within themselves, mentally, emotionally, spiritually, and it shows physically (Grace, 2016, L 275-283).

These opportunities in IPC for spiritual experiences allow for richer understandings and holistic solutions for clients.

The way forward for Indigenous people, myself, my community, and for all nations has got to come from a place of my understanding as an Indigenous person so it’s just a bit more, the vision is wider as we begin to speak, even the fact around [health issues] is not the problem in our community. That it’s so much more, that we are dealing with that has to be addressed. We get stuck in that way of thinking as a colonizer that this is [a health issue], this is all this is, no, this is so much more than that. It’s so much broader than that and it’s so much deeper in our understandings of how to deal in a way that’s going to bring life to the people, not just Indigenous people, but all nations (Maggie -2, 2016, L 116-129).

For us, it’s important that we begin to understand that it’s not a pill that’s going to help Indigenous people, it’s so much more than a pill. A pill is a small amount in the circle of care. If we look at a circle of care, a pill, taking medication, even taking traditional medicines, is a small piece of the circle of care that needs to happen when we’re working with someone who is sick (Maggie - 2, 2016, L 286-293).
Maggie speaks to a broader holistic circle of care that includes examination of the social, emotional, physical, spiritual, and cognitive health care needs.

We use the medicine wheel as a teaching so we don’t look at HIV as strictly a physical disease and how it affects people holistically so their emotional side, their mental side, their spiritual side. Then we don’t only look at the person who’s infected we also look at the people who are affected, including front line workers and we use the medicine wheel as a visual to teach people how to see where they are in each aspect of themselves, sort of the four quadrants and if they have a visual they can see where there strong in, what may need more attention (Grace – 2, 2016, L 53-64).

As we move forward we are going to be able to talk, care, and help Indigenous people; all nations. I’m saying that our way forward is not only for Indigenous, it is for all nations that want to take part. It’s a very vice way forward (Maggie - 2, 2016, L 298-302).

Maggie identifies the contrast between Western or colonized ways of service delivery with Indigenous ways forward. Western IPE, IPC, and service delivery models include classification and hierarchy based on race, class, gender, and economic status. “We can help those that came. Those ones that came here to this land, the other nations that came to this land. We can help them to find their ancestry, to find their way forward in that manner” (Maggie – 2, 2016, L 352-356). This is a shift in perspective to begin to acknowledge that no one needs “saving”. We can learn from one another. This perspective is consistent with the CIHC definition of collaborative practice to “learn with, from, and about each other” (2010, p. 24). “That’s a spiritual ceremony that takes place, truth and reconciliation, to reconcile” (Maggie, 2016, L 501-503).

Study participants assert that Indigenous professionals are equipped with unique skills to contribute to IPC. Their experiences incorporate more than professional practice competencies. “I’m equipped with many tools as an Indigenous woman. Spiritually
awake. As an Indigenous person I understand that prayer is important. Ceremony is so important when we are beginning to do work together” (Maggie, 2016, L 664-668).

Spiritual connections within IPC contexts are integral for Indigenous professionals, as Lynne and Maggie explain. “We talk about integrating the spiritual into the work” … “It’s not an easy road” (Lynne, 2016, L 393-394, 396). “We incorporate our teachings, our understandings, our medicines, our ceremonies, our traditions” (Maggie, 2016, L 513-515). Maggie highlights the seven sacred teachings, which are sacred Indigenous concepts, based on natural laws. They are guideposts for living in a good, holistic, way.

Some of our values that we look at are the seven sacred teachings. Those are very current. You will see them all over the place here at [name of agency]. You’ll see them in different areas of our living documents. Those are important teachings to understand, but it’s to walk your talk, to understand, and to do ceremony, to be part of ceremony. What does that mean to you? How does your day begin? Every day here at [name of agency] there’s prayer that happens every day for the people, with the people, and by the people (Maggie, 2016, L 710-720).

We can use some of our sacred items and our tools and our ceremonies that have been given to us. As we move forward in doing things in a good way we’re honoring, we’re praying, and we’re asking, we’re being humble about it and it’s for the people, again, I can’t say that enough and that’s why we’re here (Maggie, 2016, L 746-752).

Ceremony and prayer are central to “move forward in good ways” (Maggie – 2, 2016, L 364-365).

In essence our belief, our Indigenous belief, is that our ancestors are always with us. So even when you and me are talking on the phone here, my ancestors are here, and your ancestors are there and they’re happy about what we are talking about because it’s going to bring life to the people cause it’s all about the people (Maggie, 2016, L 740-746).

Maggie, Lynne, and Grace highlight the importance of ancestral teachings, ceremony, and prayer in reconciliation and IPC.
Theme Five Discussion

Study participants suggest the way forward for IPC is through truth and reconciliation, spiritual awakening, ceremony, and prayer. For the study participants, truth and reconciliation means developing an understanding within interprofessional teams of the colonialism within Canada. They believe this will lead non-Indigenous professionals to an understanding of client experiences within health care settings and assist in the development of culturally appropriate support for clients. I agree with the study participants that interprofessional teams, working in health care environments where a significant percentage of the clients are Indigenous, need to understand historical and current contexts for Indigenous peoples to adequately assess interventions and co-create service delivery models with Indigenous professionals. Gair, Miles, Thompson (2005) and Baskin (2005) also emphasize inclusion of multiple knowledges, focusing on ceremony and decolonization, within IPE and IPC. Maggie believes that unmasking colonialism within Canada will create opportunities for non-Indigenous professionals to uncover guilt and shame and reconcile authoritarian and salvation-based approaches to client engagement, service delivery, and IPC. The study participants share that IPC encompasses spiritual connections with one another. I believe that an Indigenous model of IPC requires ceremony and prayer for the work, as service delivery and research also have life, and require the same respect and relationship offered to individual team members. Maggie’s example of Indigenized research and incorporation of ceremony into research methods may also increase the universality of research findings as suggested by Berg-Weger & Schneider (1998). The vision offered for IPC by study participants is
wider than team dynamics and service delivery outcomes. It creates opportunities for healing and restoration spiritually for individuals, communities, the land, and all nations.

**Interpretation of the Data**

The textural description, or “what”, the participants experienced are outlined most concretely within the *walking a tight line* theme. The participants experience connection to family, connection to community, merging of personal experience and professional role, and power, status, race, and privilege in IPE and IPC.

The structural elements are highlighted within the theme *broken policies and programs*. The study participants’ experiences of IPC are given meaning through the context in which they were experienced. The participants experience IPC within health settings and acknowledge commitment, time, resources, hegemonic practices, professional socialization, cultural norms, systemic and intentional barriers, and marginalization of community based organizations as impacting factors on IPE and IPC.

**Essence: The People**

The five themes emerged as consistent understandings across the participants’ varied, although interconnected, experiences. Reflecting on what the study participants experienced and the context in which they experienced IPC emerged for me as the lens through which they viewed the experiences, which is *the people*. Within each theme, participants connect their experiences to *the people*. *The people* refers to clients. The participants acknowledge that their roles would not exist if services were not needed. “We need to talk to the people and see what we need to do for the people because we wouldn’t be here if it wasn’t for the people” (Maggie, 2016, L 112-114). Providing
support for the people is not only a role in interprofessional practice. For the participants, it is a role for all people.

Our Elders tell us that the work that we do is about building people. It’s not about building a building or an organization. It’s about building people and that’s what we have to remind ourselves. We wouldn’t be here if we didn’t have the people. You can’t be a leader, you can’t do work unless you are working in a good way with the people. That’s what our understanding is (Maggie, 2016, L 336-343).

As previously mentioned in theme three, developing a meaningful connection with the people is necessary. “To me, that’s sitting with somebody and developing a relationship with them. You know who they are. It’s easy for me to talk this way because I’m Indigenous” (Maggie, 2015, L 347-350).

I can relate to them. First of all, we’re Indigenous. We’re both the same. We look the same. We talk the same. We have the same understanding. We start talking about who our parents are, what community we’re from, start talking about our children, our parents, whoever – our relationships and then we find a way how we are possibly related or we possibly know the same people or some of our relatives are related. Developing that relationship with one another, treating each other with respect. Our Elders talk to us about…we’re very spiritual people so we talk about the same spirit that lives in them, lives in us, lives in our Creator and so we have that understanding. It’s about waking up the people, waking the spirit up, and understanding them and treating them as human beings first and foremost is very important (Maggie, 2016, L 353-370).

Maggie asserts waking the people to recognize the spiritual connections created within each one of us is essential to developing kinship relationship, or love, as the Elders would say. It allows professionals to connect with clients on a deeper level, creating empathy and compassion.

They are a human being first and foremost. Treat them in that manner. Greeting them in that manner. Telling them good morning. Offering them a cup of coffee or whatever we have to feed people down there. Mentally, emotionally, physically, spiritually. We develop a relationship (Maggie, 2016, L 372-377).
The people require holistic care services to assist with cognitive, emotional, physical, and spiritual balance. The relational connection creates opportunities to discuss holistic healing.

They are treated as human beings and that’s the most important piece of teaching that we have. We treat everybody with respect, with dignity. If they choose to use drugs and alcohol for the rest of their life, so be it; that’s their choice, but they’re still going to live and die with dignity and with respect because they are a human being (Maggie, 2016, L 380-387).

The study participants approach the people with tolerance, recognizing that unhealthy choice does not remove their humanness. Grace implores professionals to “start treating one another more humane. We are, after all, just people. We are human” (Grace, 2016, L 181-183). Karl adds, “I can only guide the clients” (Karl, 2016, L 387). “That is important to understand because we live in a world where people see that we should be treated equally, whereas we say no, equity. Infusing the right services for the right people and addressing those things” (Lynne, 2016, L 101-105). Using a humble approach, as Maggie describes, moves IPC forward in a good way to help the people. “As we move forward in doing things in a good way we’re honoring, we’re praying, and we’re asking, we’re being humble about it and it’s for the people, again, I can’t say that enough and that’s why we’re here” (Maggie, 2016, L 748-752).

Summary

The participants provided rich, thick descriptions of their experiences within IPC in health contexts. The voices of Indigenous professionals provide new insights into the complexities of race, privilege, power, spirituality, and kinship relationships within IPE and IPC. The cultural competency framework proposed by Oelkel et al. (2013) appears to me to be consistent with recommendations and experiences of participants within this
study. Additionally, the study participants’ offer the importance of team members to engage in critically reflective practice within IPC. The final chapter will explore the limitations and contributions of the study to social work, theoretical frameworks, and the broader community. I will also examine the transformations for me as a researcher and practitioner as a result of this study.
Chapter Five: Discussion

Introduction

The study examined dynamics of power and socialized professionalism within multidisciplinary collaboration in health settings in Saskatchewan. My review of the literature presented regarding IPE and IPC brought to question the experiences of Indigenous professionals. The research question guiding the study asked: “What is the experience of Indigenous professionals with interprofessional collaboration in health contexts?” The research suggests incorporation of Indigenous worldview, cultural safety, systemic equality, and cross-cultural relationships are key to achieving IPC outcomes. The voices of Indigenous professionals in collaborative practice within social systems are essential to cultivating positive outcomes, client safety, and service delivery cohesion. Their experiences have the potential to challenge current hierarchical practice models of collaboration.

Contributions of the Study

Through a transformative phenomenological methodology, the voices of five Indigenous professionals offer an opportunity to better understand the lived experiences of Indigenous professionals, particularly in IPC in health settings. The study stimulates dialogue regarding Indigenous perspectives in IPE, IPC, and health settings; the development of academic curriculum; and IPC teams led by Indigenous professionals. Decolonizing research acknowledges the value and involvement by Indigenous communities. The voices of Indigenous professionals in IPC allow for understanding of fundamental aspects of Indigenous worldviews that can be applied to all people.
Interprofessional education.

Baskin (2011) stated “how crucial it is to include multiple knowledges within our classrooms” as “education can be healing and decolonizing for both Indigenous and non-Indigenous learners and educators” (p. 203). Creating opportunities in the classroom to understand Indigenous world views and experiences of IPC is relevant to working in Saskatchewan. Much like IPC, Indigenous perspectives encourage equality and focus on the importance of learning from one another. This connects to participants’ comments that “we don’t know what we don’t know”. It is about honoring that everyone is on a journey. It is important for academics, students, and professionals to engage in critical reflection and stay current in research and multiple ways of knowing by engaging in less traditional, or Westernized, forms of professional development.

Power and professional socialization.

The participants offer a unique view of professional power and status. They see professional power as an opportunity develop respect, engage in relationship, and provide a helping role to clients. Power is identified as a positive aspect of the professional role as it creates opportunities to shift perspectives within IPC teams and effect policy change to support clients. This perspective is explored in literature from Baskin (2011):

There is a continuum of power and privileges at one end of the spectrum and of oppressions at the other end. The majority of us live somewhere along the continuum. Power is neither good nor bad, and there are many kinds of power. Social work might want to consider assisting both learners and practitioners to tap into their own personal power and use it to make positive change (Baskin, 2011, p. 265).

This viewpoint is in contrast to the negative connotation associated with perceptions of power offered within the literature review, specifically relating to Witz’s Model of Professional Closure.
Social work profession.

The CASW *Code of Ethics* (2005) and *Standards for Ethical Practice* do not acknowledge Indigenous autonomy, ways of knowing and approaches to healing (Baikie, 2009). Further work is needed in this area to incorporate the voices of Indigenous social workers and their approaches to ethical practice. Silence around hegemonic approaches to collaboration and service delivery perpetuates the practice. It also creates and sustains the isolation felt by study participants. Pullen-Sansfaçon & Ward (2012) suggest that social workers are uniquely positioned to engage collaborative teams in social justice. In Saskatchewan, the University of Regina Social Work program could collaborate with First Nations University of Canada, Indigenous Social Work program in the area of IPE. There is opportunity for co-created curricula and resource development, co-taught courses, and interlocking practicum placements. Both programs are operated within the University of Regina, which may alleviate some of the logistical and resource barriers often faced by IPE courses.

The CASW *Guidelines for Ethical Practice* (2005) addresses ethical responsibilities to colleagues stating,

> When collaborating with other professionals, social workers utilize the expertise of other disciplines for the benefit of their clients. Social workers participate in and contribute to decisions that affect the well-being of clients by drawing on the knowledge, values and experiences of the social work profession (p. 13).

I believe this guideline compels social workers to engage Indigenous professionals in collaborative practice to develop service delivery methods that incorporate Indigenous ways of knowing and healing practices. This guideline also centralizes clients, which is consistent with the perspectives of study participants. The *Guidelines for Ethical Practice* (2005) also encourages social workers to “co-operate with other disciplines to promote
and expand ideas, knowledge, theory and skills, experience and opportunities that improve professional expertise and service provision” (p. 14). The CASW acknowledges theoretical knowledge and service delivery is bolstered by IPC. This includes challenging policies, processes, and programs that “are in any way oppressive, disempowering or culturally inappropriate; and demonstrate discrimination” (p. 16). The experiences of the participants in this study indicate that there is further work to do in this area.

**Society.**

Transformative ontological assumptions outline that diverse viewpoints exist (Ermine, 1995). The viewpoints need to be contextualized within cultural, historical, social, political, and economic value systems to allow the researcher to determine which perspective will be favored (Mertens, 2003). Within this study, the purpose is to highlight the experiences of Indigenous professionals to create understanding of their experiences within IPC. Given that Indigenous voices are absent from current IPE and IPC research, their perspectives are provided privilege. The study participants’ highlight collective, holistic, interconnections between all living things. This Indigenous worldview stimulates the understanding that each living thing is valuable, not one more than another, as each is entwined with another. The balance between all things is required for universal health and wellness. Collective responsibility is required for the balance, health, and wellness of all things to be maintained.

**Links to Theory**

In addition to theoretical frameworks in IPE discussed in chapter two, the study can be linked to holistic theory, anti-oppressive practice, critical theory, and strength-based approaches.
Indigenous holistic theory focuses on the viewing the person in relationship with everything around them. It approaches healing through understanding balance within four aspects of the person. This is particularly relevant for Indigenous peoples in Saskatchewan, but this particular worldview may not be consistent with Indigenous peoples across Canada who hold different cultural understandings. According to Baskin (2011), the first aspect is knowing and understanding their purpose in life. Maggie discussed this when she shared about her gift to “wake up” the people. She understands that her gift is to bring life to Indigenous people. Karl understands that his purpose is to be a “helper” to others. The second aspect is relationships and connections to all things (Baskin, 2011). This aspect is explored thoroughly in theme three where participants described the importance of relationship in the development of IPC teams. The third aspect is about emotions and releasing the traumatic life experiences (Baskin, 2011). Participants spoke of releasing their hurts to engage with clients. The voices of clients “echo” (Grace -2, 2016, L 281) for study participants and allow them to build connection and relationship to help clients move forward. The fourth aspect is nutrition and exercise (Baskin, 2011). Baskin (2011) noted that if any of the four quadrants are unbalanced it would impact another area, as well as the whole person.

Sinclair (2004) provided a critique of anti-oppressive practice stating that identification or “theoretical grasping of issues” (p. 36) is not sufficient, or truly, anti-oppressive practice, without action. Participants in this study voice their experiences with oppression, racism, and privilege while offering a way forward through connection on a human level to create understanding, kinship, and a desire to support one another.
Critical theory corresponds well with the examination of the social constructs within IPC including issues of power, racism, discrimination, and privilege. Critical theory explores the social problems and offers practical responses to them. It allows exploration of the truths embedded within IPE and IPC. The questions posed to Indigenous professionals within this study focus on the individuality of the participant in determining their experiences in IPC and specifically, understanding how being an Indigenous professional impacts their experience. Critical theory also explores how the individual experiences of power, racism, discrimination, and privilege correlate with IPE and IPC research and broader themes.

Strength-based approaches to service delivery focus on identifying the client’s strengths and using them as a foundation for change. The participants’ focus on trusting, meaningful relationships; empowering leadership in clients; working collaboratively toward shared outcomes; drawing on personal resources; and creating change through experiential learning. Each of these strategies can be considered strength-based approaches to IPE, IPC, and service delivery. Trusting, meaningful relationships; drawing on personal experience and understanding; and collaborating toward shared outcomes were identified by participants as elements of the relationship and walking a tight line themes. Empowering clients to take a leadership role creates experiential opportunities for change. Grace and Maggie describe broken systems, not broken people, to highlight the strength and resilience of clients. Additionally, participants share examples of ways in which they lead colleagues through training sessions to assist them in understanding the strengths of Indigenous professionals.
Transformations and Implications

Research inquiry is “an essential educational mission” for the scholar-practitioner (Rehorick & Bentz, 2008, p. 26). The process of engaging in research with Indigenous participants and allowing the emergence of their experience within my consciousness has been transformative. I humbly hold their stories and integrate them with my own experiences to shape my practice moving forward. I take with me the knowledge that if Indigenous professionals are asked about their experiences in a good way, in consultation with Elders and from a place of trust, respect, openness and humility, they will likely share their experiences with candor.

The transformative phenomenological methodology that I employed during the research allowed me to integrate my own experiences with IPE and IPC into the study. Engaging in reflective journaling created a tangible chronology of the transformation within my thoughts, insights, and connections to professional practice. My insider knowledge of IPE and IPC, my experiences personally and professionally in these contexts, my understanding of language and terminology was difficult to bracket. It was difficult to achieve complete naivety to engage participants in providing comprehensive explanations of all aspects of their experience (Moustakas, 1990). As a non-Indigenous professional, I recognize I cannot truly feel or experience IPE and IPC in the same way Indigenous professionals do. This allowed me to separate my understanding and open myself to hearing the voices of Indigenous professionals as they shared what the experience was like for them. This created opportunity for new knowledge to be revealed.

I approached this research with some hesitancy as a non-Indigenous professional. I recognize my experience is influenced by privilege afforded to me by my race, culture,
education, and socioeconomic status. I struggled with questions about the appropriateness of engaging in this research as a non-Indigenous woman. I wondered if I would be perceived as attempting to appropriate Indigenous knowledge. I have worked with Indigenous professionals and in Indigenous communities for nearly twenty years. So, I took my questions to my Indigenous colleagues and to an Elder I have come to work closely with. I was encouraged to continue with this work. As I began participant recruitment, Indigenous peoples and Indigenous organizations embraced me. They expressed excitement about the study, requested summaries of the outcomes, and encouraged me to continue the work in a good way. I have prayed over this research, I have asked many questions, and I have been humbled by the openness and candor with which the participants have shared their experiences.

I have always understood personal and professional boundaries to mean separation. I described it as “keeping the personal, personal and the professional, professional” while physically moving my hands to signify compartments on opposite sides of my body to ensure the two parts did not touch. I have been intentional about remaining silent about my personal experiences. I have experienced awkwardness when clients or colleagues have asked personal questions, never knowing quite how to respond without creating a rift in the relationship. I have also felt desire to share these personal parts of myself, feeling the pull of a deeper connection, but thoughts of ethical boundaries and organizational policies to the contrary prevailed. The participants have reminded me that spirituality is not something to hide. It is within each of us, a necessary part of holistic health. We need to nurture it, speak of it, acknowledge it, and bring it to work with us and use it to awaken the spirits of those we are cosmically connected to. Maggie
recognized this shift in me during our second interview. She said, “Waniska – you have woken up and have an opportunity to wake up many other people that are in your circle of influence in the work that you are doing right now with this project” (Maggie – 2, 2016, L 632-635). Grace also identified spiritual transformation during our second interview stating, “I hear the growth in your spirit and your words from first speaking with you. This has changed you” (Grace -2, 2016, L 541-542). “You are awake. Your spirit is awake” (L 546).

This study raised in me a desire to co-create an IPE social work course to develop an understanding of IPE and IPC challenges from diverse professionals. The course could allow students an opportunity to practice collaborative skills and explore dynamics of interpersonal, community, and systemic issues related to diversity in a safe and mentored space. The course could create stronger connections between Indigenous and mainstream social work programs, allow students to create stronger relationships with Indigenous peers, and create opportunities for students to hear Indigenous voices. The course could engage community-based organizations, provide opportunities for IPC outside of health sciences, and co-create new collaborative programs for service delivery. My hope is that moving forward professionals can be trained to work collaboratively in a way that includes the voices of Indigenous professionals. This study has also reaffirmed my desire to engage in collaborative practice as a primary service delivery model. The study participants reminded me to engage in regular critical reflection to ensure diverse perspectives are included in interprofessional teams.
Suggestions for Future Research

The available literature requires further scholarly critique and research in the areas of uneven power relations, deconstructing systemic barriers, impacts on social change, and client inclusion in interprofessional milieus. Current research has explored the perspectives of students, clients, Elders, IPE leadership teams, and professionals within these contexts. The study addressed the questions regarding Indigenous professionals’ experiences of interactional, organizational, and systemic milieus to provide a new perspective on the factors that enhance and inhibit interprofessional collaboration.

Future research to determine the best ways to incorporate Indigenous understandings into IPE and IPC must ensure that Indigenous peoples retain control and ownership of the knowledge and that non-Indigenous peoples do not appropriate the knowledge. The responsibility and control must stay with Indigenous peoples (Baskin, 2011). “World views and knowledges can be learned as they are general” (Baskin, 2011, p. 11). Indigenous worldview can include concepts such as respect for the land, holistic approaches to healing, and inclusive rather than individualistic perspectives (Baskin, 2011). Indigenous culture and spirituality cannot be taught, as they are expressed through languages, ceremonies, governance, clan systems, and, yes, food. Complex, ever evolving, and adapting to environments and circumstances, cultures make little sense out of context, and unless one lives that culture, can easily be misunderstood (Baskin, 2011, p. 12).

As the participants share, there are opportunities to teach other professionals in the contexts of IPE and IPC about Indigenous worldviews and knowledges and their
applications to professional practice. Barriers to IPC for Indigenous professionals in health settings need to be deconstructed to allow opportunities for meaningful collaborations to occur.

But it saddens me to think that both groups are supposed to live separately forever. I picture more of an interconnected relationship, a sharing of knowledges, a discovering of commonalities, and a desire to reach consensus when it came to differences. Each group could take up whatever they saw as valuable from each other’s values and ways of doing things, and be able to blend what might be equally beneficial for all (Baskin, 2011, p. 275).

Baskin was speaking of relationship between Indigenous and non-Indigenous peoples; however her comments resonate with me in the context of interprofessional relationships. Lynne echoes these comments in theme three. Additionally, research regarding IPE and IPC outside of health sciences would be beneficial. The study participants noted IPC could be utilized more effectively in areas of justice, education, and social services. The perspectives of Indigenous professionals could contribute outside of the human service field to IPE and IPC in the contexts of environment, economic development, resource management, agriculture, government relations, and historical preservation.

**Conclusion**

Working collaboratively is not an innovative idea at its core; communities have been working collaboratively to address complex needs. More recently, interprofessional structures have been implemented within professional practice as an organizational approach to achieve economic and efficiency outcomes. Systemic approaches to collaboration expose the power disparities and exclusionary practices within IPC.

The literature presented regarding IPE and IPC brings to question the experiences of Indigenous professionals. The research suggests incorporation of
Indigenous worldview, cultural safety, systemic equality, and cross-cultural relationships are key to achieving IPE and IPC outcomes. The voices of Indigenous professionals in collaborative education and practice within social systems are essential to cultivating positive outcomes, client safety, and service delivery cohesion. Cultural values of autonomy, individualism, and specialization are significant as they relate to the perception of collaborative work. Educational and organizational systems that suppress values of professional pluralism and the sharing and integration of knowledge and practices can stimulate autonomous service delivery models and practice. I believe the experiences of Indigenous professionals have the potential to challenge current hegemonic education and practice models of collaboration to create an authentic, culturally inclusive, model of care.
References


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doi:10.1093/acprof:oso/9780195399578.001.0001


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Tuhiwai Smith, L. (1999). Decolonizing methodologies Research and Indigenous
Indigenous Voices: Who are Indigenous peoples? (Fact Sheet). Retrieved from
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Palliative care: A suitable setting for undergraduate interprofessional education.
Palliative Medicine, 15(6), 487–492.
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PARTICIPANTS NEEDED FOR RESEARCH IN INTERPROFESSIONAL COLLABORATION

We are looking for volunteers to take part in a study of Indigenous professionals experiences of interprofessional collaboration in health settings.

As a participant in this study, you would be asked to participate in one 60-minute interview. An additional interview may be completed, as necessary. Following the interview(s) you will be provided an opportunity to review and provide feedback on the initial thematic analysis.

For more information about this study, or to volunteer for this study, please contact:

Jennifer Clarke
Graduate Student, University of Regina, Faculty of Social Work
at
Email: Jennifer.Clarke@uregina.ca

This study has been reviewed and received approval through the Research Ethics Board, University of Regina.
Appendix B: Participant Recruitment Email

Hello,
My name is Jennifer Clarke and I am currently conducting research toward the completion of my Master of Social Work thesis through the University of Regina. I would appreciate your assistance in sharing my request for research participants, below, with your colleagues. I would also appreciate your willingness to display the attached recruitment poster within your organization.

Indigenous Professionals’ Experiences of Interprofessional Collaboration in Health Contexts

Are you an Indigenous professional with experience working in health contexts? Do you work with three (3) or more colleagues from professions different than your own? You are invited to participate in a research study conducted by Jennifer Clarke, from the University of Regina.

I am conducting this research as part of the requirements for my Master of Social Work. My research seeks to understand your experiences of interprofessional practice. I would welcome the opportunity to meet with you. I would appreciate your participation by answering several questions that would take no more than one (1) hour of your time. Kindly review the attached poster for more information. Please feel free to extend this invitation to your colleagues.

If you would like to participate, please contact me at Jennifer.Clarke@uregina.ca.

Thank you for your time and interest in this study.

Kind regards,
Jennifer Clarke
Jennifer Clarke, BSW RSW (SK)
Graduate Student
University of Regina
Appendix C: Participant Recruitment Supplementary Email

Thank you for your interest in my thesis research on the experiences of Indigenous professionals with interprofessional collaboration in health contexts. I value the unique contribution that you can make to my study and am excited about the possibility of your participation in it. The purpose of this email is to respond to your inquiry and to request your signature on the consent form, which you will find attached.

The research model I am using is a qualitative one through which I am seeking comprehensive depictions or descriptions of your experience. In this way I hope to illuminate or answer my question: What is the experience of Indigenous professionals with interprofessional collaboration in health contexts?

Through your participation, I hope to understand the essence of the phenomenon as it reveals itself in your experience. You will be asked to recall specific episodes, situations, or events in which you experienced interprofessional collaboration in a health setting. I am seeking vivid, accurate, and comprehensive portrayals of what these experiences were like for you: your thoughts, feelings, and behaviors, as well as situations, events, places, and people connected with your experience. You may also wish to share personal logs or journals with me or other ways in which you have recorded your experience – for example, in letters, poems, or artwork.

I value your participation and thank you for the commitment of time, energy, and effort. If you have any further questions before signing the consent form, please do not hesitate to contact me.

Kind regards,
Jennifer Clarke
Appendix D: Initial Interview Guide

Interview Guide

Thank you for agreeing to take part in this interview. The overall goal of this study is to understand the experiences of Indigenous professionals within interprofessional collaboration. Your experiences and perspective will be very helpful. The information that you provide will contribute to a thesis.

You will be asked to read a consent form, and sign if you agree to participate. The interview will be audio-recorded with your consent and the audio files will be destroyed five years after the study has been completed.

Guiding Questions:

1. Please tell me about yourself.

   Prompts:
   - Describe your identification as an Indigenous person.
   - Describe your professional background.

2. Tell me about your experiences in interprofessional collaboration.

   Prompts:
   - What is your collaborative work?

3. Please describe the experience of interprofessional collaboration in health contexts.

   Prompts:
   - You mentioned ______ tell me what that was like for you.
   - You mentioned ______ describe that in more detail for me.

4. What does your participation in interprofessional collaboration mean to you?

   Prompts:
What is it like for you to do it?

5. Think of a time when you experienced interprofessional collaboration and describe that in as much detail as possible.

Prompts:

You mentioned ______ tell me what that was like for you.

Can you give a more detailed description of what happened?

6. As an Indigenous professional, what is the experience like for you?

Prompts:
Could you say something more about that?

Do you have further examples of this?
- contexts/situations in which it was experienced
- feelings, sensations, memories, stream of consciousness

7. Is there anything that I missed, that you want to say or add?

Summary

Thank you for participating in this interview. Your responses will help to provide a better understanding of the essence of Indigenous professionals understandings of interactional, organizational, and systemic environments that augment and impede interprofessional collaboration.

If you feel that our discussion today has raised any difficult issues for you, or if you feel that you would like to pursue any additional support about the topics discussed today, feel free to talk to the staff at the agencies provided below.

HealthLine: dial 811

STC Health & Family Services, Living Well Program: 306-956-6100

* These references will be expanded to include services in geographic proximity to the participant, as needed.
Appendix E: Supplementary Interview Guide

Supplementary Interview Guide

Thank you for agreeing to take part in this supplementary interview. I would like to share with you some of the themes and key words emerging from my conversations with the participants. Your perspective and contribution continue to be very helpful.

Guiding Questions:

1. Do these emerging themes, as I have described them, resonate with you?

   Prompts:

   Do they accurately reflect your experience?

2. Do you have further examples of situations in which it was experienced?

   Prompts:

   Please describe that experience in as much detail as you can.

   Can you describe your stream of consciousness during that experience?

   How did you feel at the time?

   How has that impacted you?

3. Please describe what the ideal environment for collaboration would look like.

4. Are there experiences, feelings, descriptions, or details that could be added or are missing?

5. Is there anything that you would like to add?
Appendix F: Emerging Thematic Analysis Visual Representation
Appendix G: University of Regina Research Ethics Board Certificates of Approval

University of Regina
Research Ethics Board
Certificate of Approval

REB #
2015-127 U of R
REB 15-104 RQHR
Beh 15-259 U of S

Investigator(s): Jennifer Clarke
Department: Social Work
Funder: Unfunded
Supervisor: Dr. Monty Montgomery

Title: Indigenous Experiences of Interprofessional Collaboration in Health Contexts

APPROVED ON: October 29, 2015-10-29
RENEWAL DATE: October 29, 2016
APPROVAL OF:
Application for Behavioural Research Ethics Review
Recruitment Poster (Appendix A) Participant Consent Form (Appendix B) Interview Guide (Appendix C) Transcript Release Form (Appendix D)
REB Application 3.2

FULL BOARD
DELEGATED REVIEW _X_
MEETING ____

The University of Regina Research Ethics Board has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol, consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS
In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for

Dr. Larena Hoeber, Chair
University of Regina Research Ethics Board

Please send all correspondence to:
Research Office
University of Regina
Research and Innovation Centre 109
Regina, SK S4S 0A2
Telephone (306) 585-4775
Fax: (306) 585-4893
research.ethics@uregina.ca
Research Ethics Board
Certificate of Amendment Approval

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<th>DEPARTMENT</th>
<th>REB#</th>
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<td>Social Work</td>
<td>2015-127 U of R</td>
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SUPERVISOR
Dr. Monty Montgomery

TITLE
Indigenous Experiences of Interprofessional Collaboration in Health Contexts

AMENDMENT APPROVAL OF
Approval of the Supplementary Interview Guide (Appendix C-1)

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<th>NEXT RENEWAL DATE</th>
<th>Date of Amendment Approval</th>
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<td>October 29, 2015</td>
<td>October 29, 2016</td>
<td>March 16, 2016</td>
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Full Board Meeting  □
Delegated Review   ☑

AMENDMENT CERTIFICATION
The University of Regina Research Ethics Board has reviewed the changes to the above-named research project as outlined in your memo dated March 16, 2016, and they are approved.

ONGOING REVIEW REQUIREMENTS
In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month of the current expiry date each year the study remains open, and upon study completion. Please refer to the following website for further instructions: [http://www.uregina.ca/research/for-faculty-staff/ethics-compliance/human/forms1/ethics-forms.html](http://www.uregina.ca/research/for-faculty-staff/ethics-compliance/human/forms1/ethics-forms.html)
Certificate of Completion

This document certifies that

Jennifer Clarke

has completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Course on Research Ethics (TCPS 2: CORE)

Date of Issue: 26 October, 2015
Appendix I: Participant Consent Form

University of Regina

Participant Consent Form

Project Title: Indigenous Experiences of Interprofessional Collaboration in Health Contexts

Researcher(s): Jennifer Clarke, Graduate Student, Faculty of Social Work, Graduate Studies and Research, University of Regina, 306-384-3555, Jennifer.Clarke@uregina.ca

Supervisor: Thesis Supervisor: Dr. H. Monty Montgomery, Faculty of Social Work, 306-664-7379, H.Monty.Montgomery@uregina.ca

Purpose(s) and Objective(s) of the Research:
- The purpose of this research is to explore Indigenous professionals’ experiences of interprofessional collaboration in health contexts using qualitative research methods.
- A thesis will be written that will include a discussion on how the data from the interviews was managed and the presentation of findings and outcomes. The thesis will also include initial exploration of the limitations of the project, and how the findings may relate to social work practice and future research.

Procedures:
- If you volunteer to participate in this study, you will be asked to take part in an interview. During the interview you will be asked to discuss your experience related to the research question “What is the experience of Indigenous professionals with interprofessional collaboration in health contexts?” An interview guide will be used by the researcher to guide the discussion. The results of the interviews will be used to write a thesis for a Masters in Social Work program at the University of Regina.

- The entire interview will take approximately 60 minutes and will be conducted at a time and a location that is convenient for you. An additional interview may be completed, as necessary. Any follow-up sessions for member-checking will also be conducted at times and locations suitable to you, including via telephone if requested. The interview will be audiotaped and the researcher

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may take notes during the interview process to ensure that the data gathered will be reported accurately. Please feel free to ask any questions regarding the procedures and goals of the study or your role.

- Your participation in this project is voluntary. You are free to decide to not answer any question during the interview. No negative repercussions will occur if you decide to terminate the interview, do not want your interview to be used, or decide not to participate in this project. You are able to request that the audio-recorder be turned off at any point during the interview.

**Potential Risks:**
- There are no known or anticipated risks to you by participating in this research. There is no physical risk from taking part in the interview. However, if you need help dealing with issues raised during the interview, you will be given a resource list with contact information for a variety of telephone crisis resources available to you at no cost. You may contact these service providers in the event that you could benefit from discussing these issues with a professional counselor. If you choose to be referred by the crisis service to a counseling agency or program in your community, you are responsible for any costs that may be incurred upon accessing these services.

- The researcher will not provide any information to authorities unless required by law. For example, if anything you tell the interviewer indicates that a person under the age of 18 is in need of protection, the interviewer shall have to report this to Child Welfare authorities.

**Potential Benefits:**
- There are no direct benefits to you by taking part in this study. However, your participation may help with advancing the researcher’s learning through the completion of a thesis as part of the requirements for the Master of Social Work program through the University of Regina.

**Compensation:**
- In recognition and reciprocity of your knowledge sharing, you will receive a small gift of appreciation of a value not exceeding fifteen dollars.
**Confidentiality:**

- All of the data collected will be kept in strict confidence. The digital audio recording and any other data will be kept in computer files that are protected by a password and a firewall on a secured computer. All of the paper data will be kept in a locked filing cabinet in the researcher’s office.

- Your name or other information that could tell others who you are will not be recorded on the interview digital audio recording, computer or paper files. Only the researcher, thesis supervisor, and the two thesis committee members will be allowed to view the transcript data. The computer files will be labeled with a number code that only the researcher will see. The consent forms will be stored separately from other data collected so that it will not be possible to associate a name with any given set of responses. Please do not put your name or other identifying information on any documents except the consent form.

- When the thesis is written, your name or any other information that could tell others who you are will not be used. Although direct quotations from the interview may be used, you will be given a pseudonym, and all identifying information such as the name of your workplace and position will be removed.

- Because the participants for this research project have been selected from a small group of people, it is possible that you may be identifiable to other people on the basis of what you have said.

- All consent forms, documents, electronic files, and audio files will be securely stored in a locked cabinet in the office of the Thesis Supervisor at the University of Regina and will be destroyed after five years. The University of Regina Research Ethics Board and the University of Saskatchewan have reviewed this protocol.

- The final thesis will be accessible to participants, the thesis committee, and the general public via the University of Regina library. All information will remain strictly confidential and available to only the researcher, the thesis committee, and members of the University of Regina Research Ethics Board that reviewed this protocol, and other regulatory authorities for the purpose of monitoring this study, unless required by law.
There are several options for you to consider if you decide to take part in this project. You can choose all, some or none of them. Please put a check mark on the corresponding line(s) that grants me your permission to:

I grant permission to be audio taped:  
Yes:____  
No:____  
The pseudonym I choose for myself is:  
______________________________________
You may quote me using only my pseudonym:  
Yes:_____  
No:_____

**Right to Withdraw:**
- You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort. Should you wish to withdraw, your data will be deleted from the project and destroyed, if desired.
- Your right to withdraw data from the study will apply until two weeks following the initial interview. After this point, it is possible that some of the data will have been analyzed and written into the thesis and it may not be possible to withdraw your data.

**Questions or Concerns:**
- Contact the researcher using the information at the top of page 1;
- This project has been approved on ethical grounds by the U of R Research Ethics Board on October 29, 2015 and the University of Saskatchewan Research Ethics Board on October 29, 2015.
- Any questions regarding your rights as a participant may be addressed to the committee at (585-4775 or research.ethics@uregina.ca). Out of town participants may call collect.

**Consent:**
Your signature below indicates that you have read and understand the description provided; I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

______________________________________  
Name of Participant  Signature  Date
<table>
<thead>
<tr>
<th>Researcher’s Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

A copy of this consent will be left with you, and a copy will be taken by the researcher.
Appendix J: Perceived benefits, effectiveness and challenges of student-initiated interprofessional education

<table>
<thead>
<tr>
<th>Questionnaire Items</th>
<th>% Agree (1–5 versus 6–7)</th>
<th>Mean (1–7)</th>
<th>Standard deviation</th>
<th>Single-sample t test (value = 4)</th>
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<tr>
<td><strong>Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge of health professional roles</td>
<td>92% (n = 34)</td>
<td>6.41</td>
<td>0.725</td>
<td>20.183 &lt; 0.001</td>
</tr>
<tr>
<td>Perceptions of the importance of collaborative care</td>
<td>97% (n = 36)</td>
<td>6.49</td>
<td>0.559</td>
<td>27.064 &lt; 0.001</td>
</tr>
<tr>
<td>Attitudes related to mutual trust between health professions</td>
<td>81% (n = 29)</td>
<td>6.22</td>
<td>0.760</td>
<td>17.541 &lt; 0.001</td>
</tr>
<tr>
<td>Ability to communicate effectively with other health professionals</td>
<td>95% (n = 35)</td>
<td>6.41</td>
<td>0.798</td>
<td>18.338 &lt; 0.001</td>
</tr>
<tr>
<td>Willingness to collaborate</td>
<td>84% (n = 31)</td>
<td>6.32</td>
<td>0.818</td>
<td>17.277 &lt; 0.001</td>
</tr>
<tr>
<td>Behaviours that allow students to collaborate with other health professionals</td>
<td>92% (n = 34)</td>
<td>6.43</td>
<td>0.647</td>
<td>22.860 &lt; 0.001</td>
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<tr>
<td>Ability to work in teams</td>
<td>78% (n = 29)</td>
<td>6.08</td>
<td>0.795</td>
<td>15.922 &lt; 0.001</td>
</tr>
<tr>
<td>Interest in practising in a collaborative setting in students’ future clinical work</td>
<td>89% (n = 33)</td>
<td>6.30</td>
<td>0.661</td>
<td>21.140 &lt; 0.001</td>
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<tr>
<td><strong>Effectiveness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Knowledge of health professional roles</td>
<td>49% (n = 18)</td>
<td>5.41</td>
<td>1.142</td>
<td>7.488 &lt; 0.001</td>
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<tr>
<td>Perceptions of the importance of collaborative care</td>
<td>51% (n = 19)</td>
<td>5.62</td>
<td>1.010</td>
<td>9.769 &lt; 0.001</td>
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<tr>
<td>Attitudes related to mutual trust between health professions</td>
<td>68% (n = 25)</td>
<td>5.84</td>
<td>0.958</td>
<td>11.671 &lt; 0.001</td>
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<tr>
<td>Ability to communicate with other health professionals</td>
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<td>5.84</td>
<td>0.958</td>
<td>11.671 &lt; 0.001</td>
</tr>
<tr>
<td>Willingness to collaborate</td>
<td>68% (n = 25)</td>
<td>5.84</td>
<td>0.958</td>
<td>11.671 &lt; 0.001</td>
</tr>
<tr>
<td>Behaviours that allow students to collaborate</td>
<td>70% (n = 26)</td>
<td>5.89</td>
<td>0.966</td>
<td>11.918 &lt; 0.001</td>
</tr>
<tr>
<td>Ability to work in teams</td>
<td>68% (n = 25)</td>
<td>5.84</td>
<td>0.888</td>
<td>12.450 &lt; 0.001</td>
</tr>
<tr>
<td>Interest in practising in a collaborative setting in students’ future clinical work</td>
<td>62% (n = 23)</td>
<td>5.76</td>
<td>0.895</td>
<td>11.945 &lt; 0.001</td>
</tr>
<tr>
<td><strong>Challenges</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of funding</td>
<td>65% (n = 24)</td>
<td>5.68</td>
<td>1.454</td>
<td>–</td>
</tr>
<tr>
<td>Lack of IPE clinical placements</td>
<td>57% (n = 21)</td>
<td>5.41</td>
<td>1.572</td>
<td>–</td>
</tr>
<tr>
<td>Lack of opportunities to influence curricula</td>
<td>57% (n = 21)</td>
<td>5.30</td>
<td>1.697</td>
<td>–</td>
</tr>
<tr>
<td>Lack of institutional and/or administrative support</td>
<td>51% (n = 19)</td>
<td>5.05</td>
<td>1.632</td>
<td>–</td>
</tr>
<tr>
<td>Lack of student interest in leading IPE activities</td>
<td>49% (n = 18)</td>
<td>5.00</td>
<td>1.886</td>
<td>–</td>
</tr>
<tr>
<td>Lack of IPE research opportunities</td>
<td>46% (n = 17)</td>
<td>5.11</td>
<td>1.542</td>
<td>–</td>
</tr>
<tr>
<td>Lack of faculty mentorship and/or guidance</td>
<td>41% (n = 15)</td>
<td>4.92</td>
<td>1.656</td>
<td>–</td>
</tr>
<tr>
<td>Lack of student interest in participating in IPE</td>
<td>38% (n = 14)</td>
<td>4.84</td>
<td>1.864</td>
<td>–</td>
</tr>
<tr>
<td>Lack of student leadership opportunities</td>
<td>22% (n = 8)</td>
<td>3.57</td>
<td>1.772</td>
<td>–</td>
</tr>
</tbody>
</table>

The questionnaire used a 7-point Likert scale and was analysed by item using single-sample, two-tailed t-tests that used “neither agree nor disagree” (value = 4) as the hypothesised comparative value. The dataset was also dichotomised into “agree” and “disagree” variables for summary purposes. Results show that student-initiated IPE may hold comparative advantages in some areas (e.g. attitudes and behaviours) and not others (e.g. knowledge and value). Student responses also point to several ways in which educators, researchers and policymakers can assist students in their efforts. Although funding (65%) and institutional support (51%) both ranked high as challenges, a lack of opportunities to actually experience interprofessional collaboration in the practice setting (57%) and influence its development (57%) are also perceived as obstacles. Fewer leaders identified a lack of student leadership opportunities (22%) or interest in IPE as a barrier (38%).

IPE = interprofessional education

(Hoffman, Rosenfeld, Gilbert, & Oandasan, 2008, p. 658)