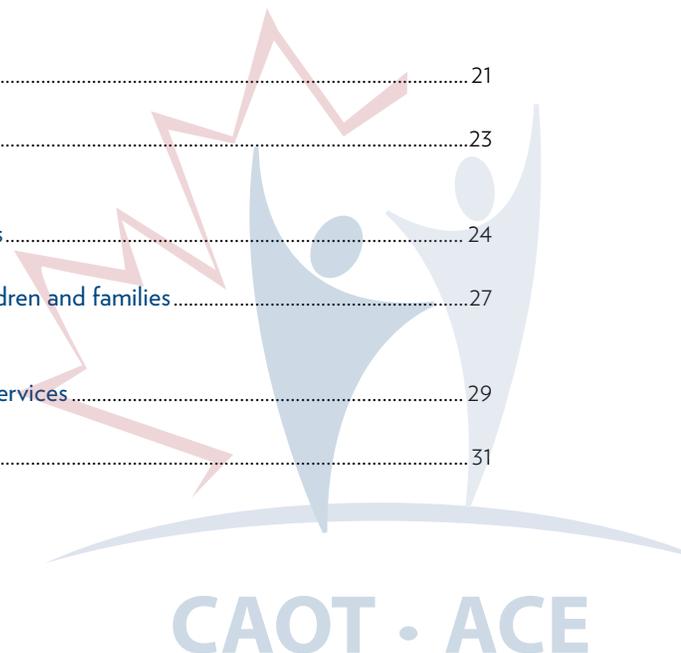


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Impacting lives, communities and systems: Occupational therapists as change agents

Lori Cyr

If I had a penny for every word written about change in popular or professional literature, I'd be rich. It's the new normal. Change management is the leader's critical survival skill. Change can elicit feelings of excitement, fear, anticipation, anxiety, energy, inevitability and, ultimately, hope that things will be better than the current state.

Occupational therapists, with their expertise in enabling participation in valued activities and roles (also known as occupations), are ideally positioned to be change agents in our health, social and education systems. The Canadian Association of Occupational Therapists' (CAOT) *Profile of Practice of Occupational Therapists in Canada* (2012) identifies change agent as one of the six roles that are key to the occupational therapy approach:

Occupational therapists advocate on behalf of, and with clients, working toward positive change to improve programs, services, and society, within health and other systems.

Practitioners work for population and community change in the funding, management, policy, and other systems that impact occupations in daily life. Occupational therapists collaborate with those inside and outside the system, and draw on strategies to enable the empowerment of populations (CAOT, 2012, p. 3).

The Canadian Model of Client Centred Enablement (CMCE; Townsend, Polatajko, Craik, & Davis, 2007) points to four key skills of occupational therapists that support the change agent role – adapt, advocate, design/build and educate. The strengths of occupational therapists are often considered in relation to affecting change with clients. Occupational therapists support change to help clients live the lives they want to live, participating in everyday activities and occupations that give life quality and meaning. However, change agency does not stop there. Occupational therapy solutions and approaches can be equally applied to addressing individual, population and systems issues, leading to individual and social change.

This issue explores occupational therapists' successes as change agents on individual, population and system levels in some of the most complex issues facing our challenged health, education and social systems: partnerships with Indigenous peoples, caregiver supports, poverty, end-of-life care, health in the military and access to pediatric services. Read more about:

- Pages 4-6: Advocacy and lobbying are powerful tools. Learn about CAOT's recent activities influencing decision-makers,

as well as a model that can be followed for crafting an effective message.

- Pages 7-9: A conversation between an Indigenous scholar and a non-Indigenous occupational therapist explores how to build meaningful partnerships with Indigenous communities.
- Pages 10-13: As health-care services continue to be stretched, more is required of Canadian families as they care for loved ones. Reports in this section of the issue explore occupational therapy contributions to programs and interventions aimed at the varied needs of caregivers and their environments.
- Pages 14-17: Occupational therapists are called to action to address the devastating impact of poverty on individuals' and populations' basic right to occupational opportunities. These pages highlight successful occupational therapy interventions targeting housing, unemployment, social exclusion and occupational engagement, and provide concrete tips for occupational therapy practice.
- Pages 18-22: Perhaps no issue creates more debate than end of life, and in particular the recent Supreme Court ruling on physician-assisted suicide. Reports in this section of the issue address end-of-life issues and the important role that occupational therapists can have in contributing to quality of life, and present an ethical framework to use when considering this highly charged and emotional topic.
- Pages 23-26: Physical and operational stress injuries have far-reaching impact of on members of the military, their families and their communities. In this section, learn more about trauma-informed care, how occupational therapists are working with veterans and current service members, and the importance of further research into this increasingly recognized area of need.
- Pages 27-30: Creative occupational therapy service delivery models that aim to provide earlier, more equitable and more accessible services for children with special needs are profiled here. For example, in a program called Partnering for Change, occupational therapists work with schools in a consultative role to address needs identified by educators, allowing for an impact that is timely and builds capacity within schools.

In the words of C. S. Lewis (1996), "it may be hard for an egg to turn into a bird. It would be a jolly sight harder for it to learn to fly while remaining an egg" (p. 170). As occupational therapists, we have the tools for transformation, to support individuals and societies alike, to enable flight.

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The change agent role of occupational therapists: Influencing policy with ideas that stick

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To optimize access to health-care services and promote health, occupational therapists are expected to act as change agents (Canadian Association of Occupational Therapists, 2012), an important yet challenging role. A core skill for change agents is the capacity to synthesize, integrate and communicate knowledge to decision-makers, practitioners and stakeholders in organizations and policy-making arenas. To do so, important lessons can be learned from communication theory, cognitive psychology and political science. This brief report describes core principles in communication that can optimize knowledge translation, following the SUCCEs Model described by Heath and Heath (2007; Table 1).

To make their ideas “stick” in their targets’ minds, occupational therapists should first *simplify* ideas to their bare bones. Proverbs are good examples of simplified yet profound ideas. Second, occupational therapists should present their ideas in an *unexpected* and counterintuitive way. A powerful idea may use surprise but interest and curiosity will generate enduring “stickiness.” Third, ideas should be conveyed using *concrete* language and images. Fourth, for people to believe them, ideas need to be *credible* on their own, connecting with underlying knowledge. Fifth, an enduring idea makes people feel; occupational therapists must find the relevant *emotions* for their target audience. Finally, ideas must be told in a story-like fashion because *stories* incite us to act quickly and effectively (Heath & Heath, 2007). Following as many of these principles as possible will enable occupational therapists to communicate knowledge more effectively.

Table 1. Applying SUCCEs Principles

Principles	Description	Example
Simple	Provide a one-sentence statement inspired by proverbs.	Evidence-based medicine motto: “Less is more”
Unexpected	Generate interest and curiosity; do not limit yourself to surprise.	First sentence of Gøtzsche, Young, & Crace 2015 article: “We could stop almost all psychotropic drug use without deleterious effect” (p. 1).
Concrete	Use images, concrete language and experience.	Training to limit use of restraints: strap professionals to a bed
Credible	Present your idea so it carries its own credentials; use symbols’ implicit power.	Health ads: show nurses and doctors wearing stethoscopes
Emotional	Make your target audience feel.	Drug companies lobbying for drug approval: place sick kids at the forefront
Stories	Tell a story.	Can you remember stories in the media about patients harmed by poor care?

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Lobbying and advocacy for occupational therapy in Canada. Why? Because occupational therapy solutions work!

Havelin Anand and Nicolas McCarthy

The vision of the Canadian Association of Occupational Therapists (CAOT) is that occupational therapy will be valued and accessible across Canada. In order to make that vision a reality, CAOT, through its own advocacy initiatives and by supporting the efforts of occupational therapists in Canada, helps deliver the message of the importance of occupational therapy. This article describes CAOT's advocacy efforts on behalf of all occupational therapists in Canada.

What are lobbying and advocacy? How do lobbying and advocacy relate to an organization's promotional efforts?

Lobbying and advocacy are terms that are often used interchangeably in general discourse and sometimes in the literature because both involve forms of promotion and influence.

- Promotion entails all methods of communication used to provide information to different audiences about an organization's products or services and includes public as well as government relations.
- Public relations can be characterized as the "art and science" of disseminating information between an individual or an organization and the public.
- Government relations is about initiating and establishing relationships with government(s) to influence current or proposed policies, programs, projects, initiatives and other instruments such as budgets, statements, motions, petitions, etc. Government relations includes lobbying and advocacy. These promotional efforts facilitate:
 - sharing knowledge, expertise and innovative or promising practices
 - advocating for clients
 - gaining recognition for the profession of occupational therapy as an essential health-care service
 - demonstrating the return on investment of occupational therapy and, most importantly, how enabling occupation contributes to an individual's physical, mental, emotional and spiritual well-being
 - influencing public policy orientation and decisions
 - calling for the expansion of occupational therapists' scope of practice and the inclusion of occupational therapists in various health-care teams
 - advocating for universal access to occupational therapy services through public and private insurance plans

Lobbying

In the strict legal definition, lobbying refers to a set of activities designed to influence government policy, which includes legislation, regulation, programs, services or other instruments such as budgets or speeches from the throne (Lobbying Act, 1985). People outside government influence government officials such as federal parliamentarians, provincial members of legislative assemblies or city councilors by:

- presenting points of view or perspectives
- registering opposition or support for specific policies, programs or projects
- presenting research or evidence that substantiates particular positions or points of view or encourages government(s) to take a particular course of action (Lobbying Act, 1985)

In Canada, the federal Lobbying Act, along with comparable legislation in several provinces, is based on the principles of:

- free and open access to government
- the legitimacy of lobbying public office holders in a democratic society
- the general public's right to know who is engaged in lobbying activities
- the legal requirement for the registration of paid lobbyists (Lobbyists Registration Act, 1998)

Legislation requires disclosure of specifics about the lobbyists:

- whether they are former holders of a public office
- description of the nature of businesses and its office holders
- information about funding sources, including government funding in particular
- the number and nature of contracts awarded for lobbying government(s)
- targeted ministries
- strategies and tactics (lobby days or petitions) used and frequency and type of communication (e.g., phone calls, emails, face-to-face meetings, presentations at standing committees) with government(s) and reports outlining these activities (Lobbying Act, 1985)

Advocacy

Advocacy is a more general term and entails activism in support of an issue that is very often linked to the greater public good, such as health promotion and disease prevention or equal pay for work of equal value. Advocacy also involves promotional activities targeted at the general public (League of Women Voters, 2011).

Examples of advocacy efforts include working with:

- clients who want occupational therapy
- the insurance industry to encourage them to expand benefits to include occupational therapy
- employers who would see benefits accrued from subsidizing health plans that include occupational therapy
- unions who would include occupational therapy as part of their collective bargaining (Northeast Ohio Medical University, 2015)

Both lobbying and advocacy can be undertaken at the individual, organizational, provincial, regional, national or international levels. They can also be undertaken in concert with coalitions, as there is strength in numbers. For example, CAOT belongs to a number of coalitions, including the Health Action Lobby, the Canadian Coalition for Public Health in the 21st Century, the Group of Eight Health Care Professions (G8) – just to name a few. CAOT, on its own and in collaboration with coalition partners, registers its position and perspectives on legislation, regulations and motions in the House of Commons, and works with colleagues in the provinces to support them in their efforts at the provincial level.

CAOT lobby and advocacy efforts in 2014 and 2015

CAOT advocates for occupational therapy services in Canada. Recently, CAOT presented to the House of Commons Standing Committee on Health and provided written submissions to the Standing Committee on Finance (a pre-budget submission) and the Standing Committee on Health (regarding health-care innovation – best and promising practices).

In 2014/2015, as part of a larger strategy, CAOT board members met with 17 members of Parliament (MPs) at their respective constituency offices. The board members' discussions were focused on the theme of "Solutions for an Aging Canada." MPs were presented with information about older adults and health, older adults and the workforce and older driver safety, and were provided with CAOT National Occupational Therapy Month resources, such as calendars, facts sheets about specific areas of practice and e-cards. As a follow-up event, CAOT hosted a reception on Parliament Hill to showcase occupational therapy and the CarFit educational program (<http://www.caot.ca/default.asp?pageid=3963>). This event was well attended, allowing CAOT to meet with 17 MPs and their staff. The following morning, CAOT Executive Director Janet Craik and Director of Government Affairs & Policy Havelin Anand met with the Prime Minister's Office. We were able to discuss not only the importance of occupational therapy interventions with individuals, but also occupational therapists' roles in health promotion and literacy.

CAOT subsequently held meetings with the Canada's chief public health officer and the assistant deputy minister responsible for health promotion. These were opportunities to discuss ways of collaborating on a number of initiatives with the Public Health

Agency Canada. CAOT also met with the National Association of Federal Retirees to discuss the importance of occupational therapy interventions to the association's membership.

To have a strong and unified national voice, CAOT's engagement with coalitions has included work with the Health Action Lobby (HEAL), which released a public document supported by CAOT on the federal role in health and health care (HEAL, 2014). Another example of CAOT involvement is the Canadian Coalition on Public Health in the 21st Century (CCPH21), in which CAOT is actively engaged in the Working Group on the 2015 Federal Election. CAOT staff and volunteer representatives attend meetings and participate in working groups of some additional 20 coalitions, which provides CAOT opportunities for proactive outreach, particularly in interprofessional health and health-care teams in both the research and practice arenas. Over the next two years, CAOT's executive director, Janet Craik, will be chairing the Group of Eight Health Care Professions (G8). G8's mission is to promote health-care services (outside of services provided by doctors and nurses) that are integral to the health-care system.

Building on its work to date and in preparation for the October 19, 2015, federal election, CAOT has developed an Election 2015 Playbook to support occupational therapists in their advocacy efforts in cities, towns and communities across Canada. The Playbook (which can be accessed at: <http://www.caot.ca/default.asp?pageid=1449>) consists of a sample advocacy letter, an elected officials' meeting guide, documents that highlight issues and provide questions and answers that can be used to ask candidates questions, and a number of tweets occupational therapists can post. CAOT will host a Water Cooler Talk Webinar on October 1, 2015, to discuss the Election 2015 Playbook.

CAOT is committed to continuing to foster a culture that supports occupational therapists in their individual as well as collective efforts to act as change agents in communities across the country, allowing all of us to advance excellence in occupational therapy and contribute to improving the health and well-being of all people who live in Canada.

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INDIGENOUS PEOPLES AND
OCCUPATIONAL THERAPY IN
CANADA



COLUMN EDITORS: ALISON GERLACH
AND JANET JULL

“Walking side by side”: Being an occupational therapy change agent in partnership with Indigenous clients and communities

Alison J. Gerlach and Monique Gray Smith

What does it mean to be a change agent in the context of Indigenous individuals, families and communities in Canada?

In this paper, we hope that our conversation exploring this question adds to the perspectives on being an occupational therapy change agent presented in this special issue. Monique is a mixed heritage woman of Cree, Lakota and Scottish ancestry who is formally trained as a psychiatric nurse and has worked in Indigenous communities, both on and off reserve, for over 25 years. Alison has British ancestry and is an occupational therapist and doctoral candidate who has worked with Indigenous communities, families and colleagues for the past 15 years. Together, we have worked on numerous projects primarily related to Indigenous early child development. Our work and writing integrates Indigenous and western worldviews with a shared vision for creating changes that foster the health and wellness of Indigenous peoples.

Alison: From your perspective, Monique, what does it mean to be a change agent?

Monique: For me, a change agent is someone who has a powerful intrinsic motivation to be a lifelong learner, to have the courage to explore their own values and beliefs, and to rarely settle for the status quo. In the context of this article, I see change agents as individuals who are committed to supporting the wellness and thriving of Indigenous peoples. I think this can be done in a variety of ways, and will be unique to each and every occupational therapist. Occupational therapists as change agents need to be willing to learn with and from, and not only about, Indigenous peoples in Canada, and then consciously find ways of weaving this learning into their personal and professional ways of being in the world.

Being a change agent does not just happen when we are at work; it often requires us to be this way in all aspects of our lives, and I think that is where the potential vulnerability of being a change agent lies. I think of being a change agent like being a parent. I am not only a mother when I am in my home; being a mother truly influences every decision I make, how I respond in conversations and how I respond emotionally in particular situations. When we are true change agents, it is not just 8 a.m. to 4 p.m., but an integral part of who we are, and how we show up with our friends and family, and in our community. That is when and how change happens.

Alison: What do you think occupational therapists need to learn from Indigenous peoples in order to be a change agent?

Monique: The historical and ongoing influence of the government on Indigenous peoples' lives. It sounds simple, but it is complex, intergenerational and can at times be painful to learn about. A few examples of our history that can influence occupational therapy with Indigenous clients include: the residential school system, Indian day schools, the “Sixties Scoop” and the tuberculosis hospitals (sometimes also known as Indian Hospitals). Our history has resulted in many Indigenous peoples being reluctant, or even fearful, of sharing any information with “government.” There are many Indigenous people who do not feel safe using the health-care system and occupational therapists may be viewed as part of this system. To be effective change agents, occupational therapists have to learn about the history and understand how it can potentially influence their ability to work with Indigenous clients and in Indigenous communities.

Alison: Why is learning about the historical context of Indigenous clients' lives so important in being an effective change agent?

Monique: Once occupational therapists learn about the history of Indigenous peoples and communities, they cannot go backwards if they wish to be change agents because this understanding becomes part of who they are. Occupational therapists have to know about the history in order to move forward and to be able to say: “I understand differently now and, therefore, I will act differently.” Also, a key element for all change makers is taking time for self-reflection. It is important to reflect on what you have learned, and perhaps unlearned, and to question: “How does what I have learned about Indigenous history in Canada influence my practice?” or “How does it influence my approach or the questions I might ask of the clients I serve?”

Alison: Given the history and ongoing aftermath of colonization in Canada, do occupational therapists need to be careful about the notion of “empowerment” that is sometimes associated with being a change agent?

Monique: As occupational therapists engage more with Indigenous communities and individuals, they will find that there are Indigenous clients who do not know what an occupational therapist can offer. Being a change agent involves giving a client information about

the different ways in which occupational therapy can support his or her health and then on a following visit helping the client to make a choice as to what he or she wants to do. Choice is really important because colonial policies and practices frequently eliminated Indigenous peoples' choices. This requires occupational therapists to take the time necessary to build relationships, provide information in ways that are understandable to clients and possibly members of their family (we are often unaware of the jargon terms we use that clients may not understand) and create opportunities for clients to choose how they want to work with the occupational therapist and what they want to work on. Ensuring that a client can make a choice is in and of itself an integral part of the healing process.

Alison: Is there a risk that in working toward being a change agent, occupational therapists could inadvertently do more harm than good?

Monique: Yes, if they do not understand trauma-informed practice. It is like getting in the car without the keys; understanding history needs to be accompanied by an understanding of trauma and trauma-informed practice. Trauma-informed practice helps to avoid unintentionally triggering an individual's trauma response or misinterpreting how trauma is manifested in people's health and health-care behaviors. Occupational therapists need to pause and consider how some of their ways of being and practicing may be a trigger for some Indigenous clients. Examples of this might include wearing a uniform, focusing on paperwork, asking lots of questions, or rushing in and doing an assessment rather than spending time building a trusting relationship and listening and learning from clients.

Alison: So we need to have both in order to avoid doing more harm than good: an understanding of history and an understanding of trauma-informed practice?

Monique: I see them as two concentric circles that overlap. Where they come together is where occupational therapists need to bring their authentic self and consider how this influences who they are and how they practice (see Figure 1).

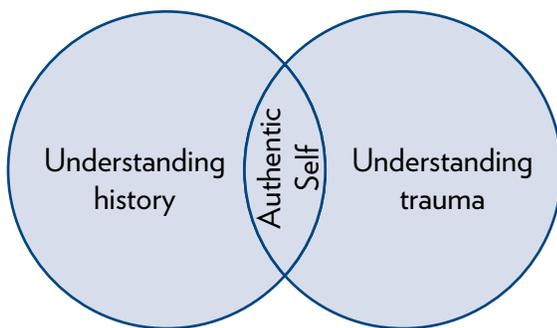


Figure 1. Partnerships for change.

Alison: I think you are talking about the need for occupational therapists to not only develop their understanding and skills, but also to reflect on who they are as a person as well as an occupational therapist in relation to Indigenous peoples in this country.

Monique: Who an occupational therapist is as a person is integral to the healing process. How you “show up” with those you have the privilege to work with is absolutely critical. Being a change agent comes back to building relationships. One of the most important elements for occupational therapists in working with our people is to be willing to share their authentic, gentle, genuine selves.

Alison: I agree and that has certainly been my experience. I also think that being a change agent, in the context of Indigenous clients, requires occupational therapists to understand how current political and socio-economic policies and structures can negatively impact Indigenous peoples' occupational engagement and opportunities. We then need to step up and get political in partnership with Indigenous colleagues, communities and organizations.

Monique: I think that the word you chose, partnership, is critical. We are at an interesting time in our country, a time when we have the potential for significant and profound change in the relationships between Indigenous and non-Indigenous peoples. The work of the Truth and Reconciliation Commission has been instrumental in this process. In raising the awareness of the atrocities that occurred in residential schools and their continued impact on families, there seems to be a greater empathy amongst non-Indigenous Canadians, as well as a desire to support and assist in creating change. This is a general statement as it does not include all non-Indigenous Canadians and perhaps never will. However, I think that is why it is critical that those working with Indigenous peoples, wanting to work with them, or whose hearts draw them to being allies, understand how current government decisions and policies impact Indigenous peoples. When we know different, we act different, and I think that is a significant reason to learn about our history, current challenges and the resilience that is also very present in our history and today. In being authentic, empathic and informed, there is great potential to create partnerships that can significantly influence the lives of all involved. I encourage occupational therapists who are reading this article to reflect on where in their lives and work their opportunities for partnership can be found; it does not have to be a formal partnership. I think of you and me, Alison; at no point in our work together have we sat down and said, “Okay, now we are going to form a partnership.” Instead, through our common interests and deep desires to support and create change, we have created an informal partnership. We have shared information and had conversations that I know take me to a very deep and reflective place, and often shift my thinking. At times, we have taken risks by providing each other with feedback that has caused us to grow and learn about ourselves. To me, that is a partnership, where there is trust, respect, a shared desire to learn

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and contribute, and the ability to invite each other to look at ways of thinking, being and working together.

Alison and Monique: We hope that reading this article inspires you to learn more about Indigenous peoples and their unique history in Canada and in the communities in which you work. We also hope that this article provokes reflective thinking about your current understanding of trauma and its potential influence on Indigenous clients and taken-for-granted occupational therapy policies and practices. Finally, we hope that you take away an understanding of the importance of developing equitable partnerships with Indigenous clients, communities and organizations in order to be a change agent in working toward the health and wellness of Indigenous peoples.

Suggested resources

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What's new



Find an occupational therapist: Helping Canadians find the occupational therapy services they need

The Canadian Association of Occupational Therapists (CAOT) has developed Find an OT, a new dynamic search tool to help people find occupational therapists in Canada. Find an OT is an easy-to-use resource that allows anyone, including referral agents, clients and health-care professionals to find the occupational therapy services that are right for them, their clients or their families. Find an OT has several features, including:

- Map-based search results that help clients find individual occupational therapists across Canada
- Multiple search fields, including area of practice, city and other keywords
- Customizable profiles that may include a personal photo, logo and a short biography
- Open access to your profile with a personal login and password

- Three listing options so you can choose the package that best suits your needs

To celebrate the launch of this new product, CAOT is offering a one-time only free trial of Find an OT that commences on October 1, 2015 and expires December 31, 2015. This offer will only be available to CAOT members during the 2015/2016 renewal period.

Find an OT will be the best resource for finding and contacting an occupational therapist in Canada! Be sure to sign up at renewal so the one-time offer of the introductory trial is not missed! To learn more about this new CAOT product, visit: www.caot.ca/findanot

Meeting family caregivers' changing support needs across the care continuum

Jill I. Cameron

Family members who provide care to individuals with disabilities are essential to the sustainability of our health-care system. In Canada, their unpaid labour annually saves our health-care system over \$25 billion (Hollander, Lui, & Chappell, 2009). Essentially, they coordinate medical care and services and support care recipients' basic and instrumental activities of daily living, transitions across care environments, ongoing rehabilitation, emotional well-being and community re-integration. Unfortunately, it is not standard clinical practice to prepare or support these family caregivers, and, as a result, caregivers across disability populations often experience stress and decrease their engagement in personally valuable activities. Both stress and decreased engagement contribute to caregivers experiencing poor mental health (Pinquart & Sorensen, 2003).

Canadian Caregiver Strategy

Recognizing the valuable and important roles played by family caregivers and the negative impact providing care can have on caregiver health, the partner organizations of the Canadian Caregiver Coalition (CCC) created a Canadian Caregiver Strategy (2013). This document highlights five interrelated priority areas: 1. Safeguard the health and well-being of family caregivers, 2. Minimize the financial burden placed on family caregivers, 3. Enable access to user-friendly information and education, 4. Create flexible workplace and educational environments that respect caregiving obligations and 5. Invest in research on family caregiving as a foundation for evidence-informed decision making (CCC, 2013). The CCC highlights the close link between caregiver and patient well-being. As a result, occupational therapists, who consider caregivers as part of patients' care environments to inform therapy, can be change agents by considering the needs of caregivers, enhancing caregiving situations, and, ultimately, improving patient and caregiver well-being.

Understanding caregivers' changing needs

To date, related to the first and third priority areas, available research has used both quantitative and qualitative methods to identify factors and care contexts that influence caregiver

health outcomes. Researchers are beginning to understand situations in which caregivers are more likely to need education and support to minimize the negative impact on their health and well-being. Caregivers who have limited experience with the health-care system, have low levels of social support and personal mastery (i.e., sense of control over life) and are caring for individuals with higher care needs, including those related to cognitive impairment, are more likely to need support from the health-care system (Cameron et al., 2014b).

As researchers and practitioners have begun to characterize family caregivers' needs, the research literature has identified four crucial areas of support, including informational, emotional, instrumental (e.g., training, arranging services) and appraisal (i.e., providing feedback about caregiving abilities). In addition, researchers are beginning to recognize that support needs change over time and are influenced by the care recipient's place in his or her illness trajectory (Cameron & Gignac, 2008). Illness trajectories can vary significantly depending on the onset of the disability, be it sudden or gradual. Researchers aim to understand common phases that care recipients and caregivers experience and how their support needs change across these phases. This will allow researchers to target interventions and programs more effectively and optimize the use of therapists' time.

In the case of caregiving associated with gradual onset of the caregiving role, such as with general aging or dementia, caregivers may experience common phases and changing needs for support. For example, adult children may begin to consider care options prior to the existence of any care needs. In this phase, they may primarily need information about how to access the care and services that their parents may need in the future. As parents' care needs begin to increase, caregivers' needs may also progress to include learning how to provide care, and lead to their engaging more support from community services. Ultimately, when care demands reach the maximum a family can manage, families may need to place a parent in a long-term care facility. More research is needed to understand how caregivers' needs evolve as parents age or develop progressive conditions.

In the case of a sudden onset medical condition, such as stroke, the caregiving situation begins unexpectedly

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(Cameron, Naglie, Silver, & Gignac, 2013). Caregivers' needs may initially centre on understanding what is happening in the emergency situation, then on the medical tests a family member is having as well as the results of these tests. After the diagnosis is confirmed, families want to understand the diagnosis and the reason behind it. The rehabilitation phase can arrive quickly for individuals who experience a mild stroke and are discharged home from an acute care hospital, or extend over a longer period of time for those receiving short- or longer- duration in-patient rehabilitation. During this phase, caregivers can benefit from engaging in the rehabilitation process and gaining assistance in preparing for their family member's return home. To assist with adjustment to living at home, families often want to make use of home and community care services. Caregivers can experience stress at this time, as primary care of the person with stroke often becomes the caregiver's responsibility. After adjusting to living in the home environment, both the person with stroke and caregiver gradually return to engaging in valued activities and interests. This is an important step in their community re-integration. Caregivers can benefit from receiving support that is sensitive to the phase of care their family member is experiencing.

The Timing it Right Stroke Family Support Program

A recent intervention developed for families dealing with stroke, the Timing it Right Stroke Family Support Program, aims to meet the evolving needs of families as individuals transition from acute care, through rehabilitation and ultimately reintegrate into the community (Cameron et al., 2014a). The program is delivered by a "stroke support person," commonly an occupational therapist, who meets with families starting during acute care, at first in person and then by telephone, for approximately the first six months post-stroke. In addition to enhancing continuity of care, these practitioners aim to provide the four previously mentioned elements of support: informational, emotional, instrumental and appraisal. They also tailor the content of the intervention to the specific needs of each family and account for how these needs evolve over time. Every time they meet with families, they ask how they are coping and provide emotional support. As caregivers often cannot anticipate what life post-stroke may look like, stroke support persons provide suggestions regarding possible discussion points, based on insight gained from other caregivers. They provide guidance on how to access services and needs-specific training. Caregivers also receive feedback about how they are managing the care situation, as previous research suggests that this can put their minds at ease. Findings to date suggest caregivers who need and receive the intervention show improvements in their emotional well-being (Cameron et al., 2014b). In addition, caregivers who receive the intervention are able to access more community services for the person with stroke than caregivers who do not receive the program. Analysis of data from this study also suggests that it would be beneficial for the stroke support person to be a core member of the care team so that the intervention can

be timely and they can have access to the individual's medical information and care needs.

Conclusions

Research that will help to meet the objectives of the Canadian Caregiver Strategy is progressing. As much of the observational and interventional research has been conducted with caregivers who tend to be English-speaking middle-aged women caring for a spouse, more research is needed in emerging caregiving populations. Specifically, further research is needed with caregivers representing culturally diverse populations, different age groups (e.g., young adult caregivers) and males. Understanding their experiences can inform adaptation of existing or development of new interventions to meet their unique needs.

Occupational therapists are in a prime position to be champions to meet the needs of family members supporting the care of individuals with a variety of disabilities. As they care for patients or clients in various care contexts, they commonly consider the environment to inform therapy, and this includes the family as an essential element. To enhance the health and well-being of clients and their caregivers, research and clinical practice will continue to identify and address the needs of caregivers.

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Snapshots of occupational therapists as change agents: Caregiver support

The Fitness-to-Drive Screening Measure®: Enabling caregivers to detect at-risk older drivers

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Adults 65 years of age and older represent the fastest-growing segment of the Canadian population (Sinha, 2013). Age-related declines in visual, cognitive, motor and sensory functions impact older adults' fitness to drive. Caregivers, who are sharing the lived experiences of the older adults, are primary stakeholders in helping to identify at-risk older drivers. Early identification of at-risk older drivers can help drivers access timely services, resources and recommendations (Classen, Velozo, Winter, Bédard, & Wang, 2015). The Fitness-to-Drive Screening Measure® (FTDS) is a valid and reliable tool enabling caregivers to detect driving deficits and suggesting next steps (Classen, Winter, Velozo, Hannold, & Rogers, 2013).

The FTDS is an online tool (www.fitnessdrivescreening.com) that takes 20 minutes to complete. Caregivers, who have observed the driver in the last three months, can rate drivers' difficulty on 54 items. Upon completion, the tool classifies the driver as an *at-risk* (safety concerns needing immediate attention), *routine* (early signs needing intervention) or *accomplished driver* (driving is acceptable) (Classen et al., 2015). The driver classification is summarized via a key form and Canadian resources and recommendations are suggested as logical next steps for decision-making. The FTDS provides plausible opportunities for supporting caregivers to help older drivers in their fitness-to-drive decisions. For example, results can prompt caregivers to take precautionary measures, such as starting a conversation about alternative transportation options, making an appointment with the physician to discuss driving cessation or arranging an on-road assessment with a driver rehabilitation specialist. As such, the tool may help increase driver awareness of driving deficits, allow for timely intervention and decrease caregiver burden. Furthermore, professionals such as occupational therapists can co-administer the assessment with the caregiver and use the

results as an entry point for intervention (Classen et al., 2015). The FTDS can be used by all caregivers who have access to the internet, and it can be completed in the privacy of their own homes. By using the FTDS to help detect at-risk older drivers, Canadian caregivers can help them maintain their autonomy, while decreasing their own stress in the realm of fitness-to-drive decisions.

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Psychoeducational support group for caregivers of people with dementia: A holistic toolkit

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Caregiving for people with dementia may be one of the most challenging occupations an individual can face emotionally and physically. The occupational therapist in the Geriatric Psychiatry Community Service (GPCS) at Baycrest, a geriatric health science center, responded to the needs of caregivers encountered at that facility by developing a resource guide and specialized group program as an adjunct to the assessment and case management of clients with dementia.

The program is delivered in a six-week, psychoeducational support group format. It is co-led by an occupational therapist and a social worker, and includes up to 15 non-spousal family caregivers. The program is offered two to three times per year. The six weekly topics include: Understanding Dementia, Communication, Managing Challenging Behaviour,

Navigating the System, Caring for Yourself and an open session for which the group chooses from options including Legal Issues, Activities of Daily Living and Care Issues, and Home Safety.

All group participants are given fact sheets from a caregiver resource guide that includes clear, practical and easy-to-read information on dementia care. The “Caring for Your Loved One” dementia education guidebook, now in its third edition, was originally compiled through a continuous quality improvement initiative that included a review of the literature and development of resources, and was ultimately reviewed by community caregivers. The final product was released in both book and fact sheet formats. Unlike other resources, caregivers felt it targeted care issues in a manner that made them easy to digest, offering both education and management strategies.

Once the guide was developed, the occupational therapist developed a program to start using this information in a more structured psychoeducational model. It was noted that other lectures on dementia and care issues were available in the community, but none were combined in a supportive educational format. Caregivers reported having had to shop around for the information as well as find support from a variety of health professionals.

The Caring for Your Loved One psychoeducational group is now in its 14th year. It has received recognition for its positive effect on learning, peer support and the caregivers’ emotional, relational and practical capacity. Over the years, research collaboration with the University of Toronto Department of Occupational Science and Occupational Therapy has allowed for better understanding of the impact the group has on the caregiving community. Most recently, research has been focused on male caregivers, a group whose role has not been studied well in this context. As a result of this research, the group leaders are revising interventions to address the unique needs of this group. As the prevalence of dementia increases, so does the need to address caregiver issues in a creative and comprehensive manner in our health-care system.

Overlooked and invisible: The experiences of young adults caring for stroke survivors

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Young caregivers (e.g., aged 18-25) account for 12-18% of familial caregivers, however, few studies have explored their experiences (Levine et al., 2005). Although they may have similar caring responsibilities to older caregivers, they face unique challenges due to their transitional life course stage (Levine et al., 2005). We undertook an exploratory study to understand the caregiving role from the perspective of young caregivers who were caring for a family member with stroke. This report highlights the results of our study and its implications for occupational therapists, who have the ability to

act as change agents in supporting young caregivers.

Interviews were conducted with ten young caregivers in an Ontario city. All were female, spoke English and provided care to a family member with stroke without financial compensation. Young caregivers undertook a variety of tasks with the stroke survivor (e.g., supervision, emotional support, housekeeping, assisting with activities of daily living) and provided support not only to that individual, but also to others (e.g., siblings, spouse of survivor). Several described providing respite to their parent who was the primary caregiver, or as one participant described, “taking on the night shift.” Many experienced challenges with maintaining participation in their own valued activities (e.g., schooling, work, social). For example, one caregiver decided not to take summer school as it would interfere with her ability to continue providing care to her mother. Another reported participating less in social activities with friends. Caregivers also discussed experiencing strain and negative emotions as a result of caregiving. For example, some discussed feeling guilty about wanting to have respite from their caregiving responsibilities or wanting to move on in their own lives. Participants also reported feeling isolated from their peers and friends, whom they believed didn’t understand their circumstances and couldn’t be relied on for support. As one participant explained, “I think people my age didn’t know how to deal with it . . . we all don’t know what it means [to be a caregiver].”

As occupational therapists support their clients with stroke, they need to also assist the client’s familial caregivers who provide an important source of support. Our study suggests that young adult caregivers may experience challenges and that caregiving may negatively impact their educational and professional opportunities, as well as their relationships with others. They may be particularly vulnerable and may need access to psychoeducation that specifically addresses their unique needs. Occupational therapists can effect lasting change for young caregivers and their families by providing them with this needed support.

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If human health is impacted by occupational opportunities (and it is), what are we doing about poverty?

Karen Whalley Hammell

A substantial body of evidence demonstrates a clear connection between people's occupational engagement, their health and the quality of their lives (Hammell, 2009); it is this knowledge — that human health and well-being are impacted by the occupations in which people have the ability and opportunity to engage — that informs the occupational therapy profession. "Occupation" in this context refers to anything that people *do* in their daily lives.

Reflecting its origins within the health-care system, the occupational therapy profession has been preoccupied since its inception with evaluating and augmenting individuals' abilities. However, this is an inadequate response to disabled people's lives, because abilities are of little value without opportunities. Teaching people how to manoeuvre a wheelchair, for example, is of little value if their homes do not have ramps, their local streets are unpaved or lack curb cuts and snow removal is tailored for the privileged population who drive and not for those who must endeavour to wheel their chairs over the resultant snow banks (up to 30% of disabled Canadians have no accessible transportation; Stienstra, 2012).

The intent of this article is to encourage occupational therapists and their funding agencies to acknowledge, challenge and address structural barriers to equitable occupational opportunities, and to resist those boundaries that conspire to confine occupational therapy practices to the enhancement of individual abilities and preservation of the status quo. For the past four decades, disability activists have denounced individualistic, impairment-focused approaches to the needs of disabled people and have asserted their conviction that people with impairments are "disabled" (disempowered, disadvantaged, incapacitated) by the ways in which they are excluded from full participation in society (Union of the Physically Impaired Against Segregation, 1976). Recognizing that social determinants, such as poverty, shape the occupational opportunities, participation and well-being of disabled and other people (and that these outcomes are interconnected), there have been calls for occupational therapists to commit to addressing the "occupational rights" of both individuals and populations (Hammell & Iwama, 2012).

Occupational rights are defined as "the right of all people to engage in meaningful occupations that contribute positively to their own well-being and the well-being of their communities" (Hammell, 2008, p. 62). It is because human health and well-being are influenced by the occupations in which people have the ability and opportunity to engage that occupational rights are associated with human rights (Hammell & Iwama, 2012), and it is why poverty is

an issue of occupational rights.

Poverty rates in Canada are among the highest of the world's wealthiest industrialized nations (Organisation for Economic Co-operation and Development, 2008). There is an inordinately high prevalence of poverty among certain groups, including children, First Nations people, recent immigrants, people with mental illnesses and disabled people (Canadian Medical Association [CMA], 2013). People with mental illness experience high rates of persistent poverty (Benbow, Rudnick, Forchuk, & Edwards, 2014), and, with one in five disabled Canadians living in poverty, disabled people are among the most poor, excluded and disenfranchised people in Canada (Stienstra, 2012).

Identified as both a cause and a consequence of both impairment and disability, poverty is Canada's most important social determinant of health (CMA, 2013), negatively impacting children's neurological development and contributing significantly to stress, substance abuse, anxiety, depression and other forms of mental illness, as well as to physical illnesses and impairments (CMA, 2013). Canadians who are poor are accorded a devalued social status, which has detrimental consequences for both their mental health and their occupational opportunities. Moreover, intersections of socially-devalued statuses — constructed on the basis of class, race, gender, age, sexuality and dis/ability — conspire to magnify poverty and marginalization, such that occupational opportunities for poor disabled First Nations people, for example, fall below the already dismal standard experienced by many other poor disabled Canadians (Stienstra, 2012).

Sherry (2010) observed that "in situations of poverty, environmental factors may be more disabling than impairments themselves" (p. 40), noting that occupational rights may be violated due to social, political and economic factors. For example, a nine-floor building in Vancouver's downtown east side houses some of the city's marginalized citizens. In 2015, the only elevator in the building broke down. Ten days later it had still not been repaired, leaving many people with mobility impairments — including John, a man with quadriplegia — stranded on the upper floors. This had repercussions for John's occupational opportunities: he was unable to shower because the only wheelchair accessible shower was on the ground floor, he was unable to work because he could not get to his job (thus also losing his opportunity to earn an income) and he was unable to go outdoors and participate in his community (Canadian Broadcasting Corporation, 2015). John will have discovered that ability is of little use without opportunity, that the occupational choices people make are dependent upon the choices

they have the opportunity to make and that opportunities are severely constrained for people who are both disabled and poor.

Poverty is not simply a problem of inadequate financial resources, but comprises a matrix of social exclusion that includes limited access to education, employment, housing and transportation (Sakellariou & Pollard, 2009). Because poverty constitutes a barrier to the opportunity to lead a healthy life (CMA, 2013), researchers characterize poverty as a restriction of opportunities that diminishes people's "capabilities" — their abilities to act and to do (Frohlich & Abel, 2014). Thus, poverty constitutes a limitation of capabilities: a deprivation of options and opportunities for engaging in occupations (acting and doing) that contribute to health, to well-being, to dignity and to quality of life. This is why occupational therapists ought to be engaged in addressing inequities of occupational opportunities for all those people whose abilities to act and to do are constrained by poverty.

With our specific knowledge — that human health and well-being are impacted by the occupations in which people have the ability and opportunity to engage — occupational therapists are ideally situated to work with and for governments, policy-makers and non-governmental organizations in order to facilitate engagement in productive occupations and meaningful roles, to assist marginalized communities to identify and develop income-generating opportunities, and to advocate for the elimination of systemic barriers that violate the occupational rights of those who are poor. Using occupation-based interventions, occupational therapists have assisted economically disadvantaged at-risk youth to acquire skills and envision a future of healthy and fulfilling occupational engagement (Shea & Jackson, 2015). Some other examples of occupational therapy interventions that have successfully addressed poverty may be found on pages 16-17 of this issue.

Clearly, such endeavours have both fiscal and social benefits. People who are poor have strengths, abilities and tenacity to engage in occupations that can improve their lives, but they require opportunities to do so.

Improvements in human health and well-being can occur if barriers to occupational opportunities are addressed. Occupational therapists have the ability to make a difference, but we need opportunities to do so. In light of the substantial weight of evidence documenting the negative impact of poverty on the abilities and opportunities of entire populations of Canadians to engage in occupations that contribute positively to well-being, it is frustrating that the majority of occupational therapists are still working almost exclusively with individuals, focusing primarily on their abilities and mostly doing so from within the constraining parameters of the health service. We require new modes of funding that enable us to fulfill our potential in wider arenas. If we are to take seriously the assertion of the World Federation of Occupational Therapists (2006) that access to occupational participation is a right, we must recognize that opportunity is a right for everyone, and we

must insist that occupational therapists have opportunities to help achieve these rights.

Indeed, if ability is of little value without opportunity, then conditions such as poverty that constrain the opportunities and violate the occupational rights of so many people ought to be of fundamental concern to Canadian occupational therapists (Hammell & Iwama, 2012). Occupational engagement — ability and opportunity — is *our* area of ability. We can do this!

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Snapshots of occupational therapists as change agents: Poverty

Tips for a poverty-aware practice

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In Andrea Perry's first occupational therapy fieldwork placement, she found herself entering the homes of people who lived in poverty, which made her realize: "I've been so unaware and naive." In her first job, she learned that it was counterproductive to try to help stabilize clients' mental health through traditional biomedical means while ignoring the poverty that constituted a precipitant to many of their health concerns. Moreover, in undertaking home safety assessments, Andrea pondered: "Why am I assessing if you are "safe" to cook or to live in your own apartment if you don't have access to food and there are no affordable housing options for you?"

Andrea became an active member of Health Providers Against Poverty, an organization of health-care providers committed to addressing the impact of poverty on health. What she believes will help her clients most are things she labels "resources." As she explains, clients she sees in a hospital or long-term care facility who come from affluent backgrounds have assistive devices, comfort items and one-to-one caregivers. Many of her clients in the same facilities, however, are unable to afford them. She finds these discrepancies disturbing, "Even when people no longer live out 'in the community,' the social divide and its impact on health continues."

Andrea feels strongly that students should be exposed to the reality of poverty so they can understand the circumstances of their clients' lives. She tells a story of a student who had prepared to perform a kitchen assessment for a client, however, when she arrived at the client's apartment, there was no food in the fridge. As Andrea states, "I think this was a real awakening moment for that student about social determinants of health – assuming the fridge would just be stocked."

Andrea believes that occupational therapists can be great champions in the fight against poverty. The following are some ways therapists can adopt a poverty-informed practice:

- Ask "Is my treatment plan affordable to a person living in poverty?"
- While assessing skills is important, assessing means (access and affordability) is as deserving of our attention.

- When supporting a client in their workplace, look beyond the usual accommodations: Do they have benefits? Can they take a sick day? Are they receiving a living wage?
- Find out what health benefits or programs are available in your region or municipality (income optimization, assistive device programs).
- Provide clear language, step-by-step instructions or tip sheets to educate your clients on the benefits they may be entitled to, offering navigation support.
- Connect with your national or provincial occupational therapy association regarding systems-level advocacy.
- Consider whether your workplace requires clients to travel for appointments. Are visits structured to minimize the economic burden for clients?
- Can care conferences or family meetings be booked at times that accommodate a caregiver's work schedule (to avoid unpaid leave from work)?
- Let government officials know you believe poverty is a threat to your clients' health and well-being. Write to your national, provincial and municipal representatives!
- Join Health Providers Against Poverty: <http://www.healthprovidersagainstpoverty.ca/>

Recovery and occupational engagement via an innovative housing project

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The Prevention and Early Intervention Program for Psychosis at the Douglas Mental Health University Institute in Montreal, Quebec (PEPP-Montreal) offers specialized, rapid-access services for young people aged 14-35 experiencing a first episode of psychosis and their families (Douglas Mental Health University Institute [DMHUI], 2015b). A case management approach is used, whereby outreach and community-based follow-up are among the best-practice services offered. Best practices also stipulate that long-term, stable housing, with clinical support, leads to improved functional outcomes (Ontario Ministry of Health and Long-Term Care, 2011); however, there is a lack of affordable and safe apartments in Montreal for young people with mental health difficulties and low income. In January 2014, PEPP-Montreal began an innovative project to address this. A housing-first model was adopted (implemented by the At Home Project [DMHUI, 2015a]), providing safe, affordable housing by

means of a two-year subsidy to house twenty clients. Participants' choice is emphasized, and the objective is increasing autonomy and promoting occupational engagement. Each participant continues to be followed by his or her treatment team and an occupational therapy intervention plan is implemented to enable resumption of meaningful occupations. Based on a thorough evaluation, occupational therapy interventions range from developing independent living skills (e.g., managing personal finances, meal planning, household maintenance) to returning to work or school to resuming leisure activities. Interventions can be tailored to each participant based on individual objectives and abilities and the participant's environment. The participants also receive individual placement and support intervention for vocational and educational recovery so that they have the means to keep their apartments post-subsidy. So far, ten participants have been housed, the majority of whom were homeless or on the verge of homelessness. Five clients have resumed work or school. Three people who had disengaged from follow-up were reengaged via this project. Thus, this service delivery model promotes recovery among youth in their natural environments. Occupational therapists' expertise is key on several levels, as we are well-positioned to promote resumption of meaningful occupation; advocate with and for participants for their right to adequate housing, leading to destigmatization of mental illness; and, with further research to justify the model, advocate for its adoption on a larger scale and participate in its design and implementation at a population level. This project illustrates the role of the occupational therapist as a change agent on both the micro scale, helping to foster hope and improve quality of life on an individual basis, and on the macro scale, towards shifting service delivery models to advance occupational performance and engagement.

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Social determinants of health and occupational therapy

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People with mental health issues are faced with a number of barriers that limit their access to stable income and often result in a life of poverty. Income and mental health are intricately linked, and the effects of poverty have a profound negative impact on mental health (Mental Health Commission of Canada, 2013; Wilton, 2004). Occupational therapists enable individuals to participate in meaningful occupations. When working in mental

health, occupational therapists strive to address the impacts of poverty by breaking down barriers and promoting engagement in valued occupations, so that all individuals have equitable access to healthier outcomes. As occupational therapists within the Social Determinants of Health Service at the Centre for Addiction and Mental Health, we aim to address the needs of our clients, who are at high risk for poverty, unemployment, homelessness, and social exclusion due to a variety of factors, notably inadequate access to community supports and resources. Our service strives to reduce barriers that clients face, with the goal of supporting their recovery, for example, through implementing and supporting a financial literacy program, creating and maintaining housing partnerships, organizing employment-oriented workshops and training, and coordinating non-credit basic literacy and academic upgrading programs in collaboration with community partners. These programs aim to mitigate the effects of poverty, homelessness, unemployment and social exclusion, and promote mental health and equitable occupational engagement.

Occupational engagement rarely occurs in a vacuum and can be impeded by barriers – such as poverty – that limit access to important occupational opportunities and that are known social determinants of health. Occupational therapists are educated to analyze the transactions that occur between people, their environments, and their abilities and opportunities to engage in occupations. We believe it is essential to look beyond individual abilities and the physical environment and consider the conditions in which people live and work – the social determinants of their health – when facilitating their engagement in occupations. We therefore support Hammell's and Iwama's assertion (2012): "If occupational therapists are to take seriously their espoused commitment to enabling equitable access to participation in occupation, the inequitable conditions of people's lives will need to be addressed" (p. 385).

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Facilitating interdisciplinary ethical decision making: Occupational therapists as leaders in the emerging practice of professionally assisted dying

Chelsea Gordon, Marie-Josée Drolet and Kevin Reel

Health-care providers in Canada, including occupational therapists, are direct stakeholders in the Supreme Court of Canada's recent decision to decriminalize physician-assisted suicide and euthanasia in *Carter v. Canada* (2015). Occupational therapists may find their professional or personal ethics challenged by the prospective complexities of enabling a client's decision to seek a professionally assisted death. By engaging in a methodical ethical analysis, occupational therapists and their interdisciplinary teams can be assisted in finding professional and personal clarity and will develop a foundation for decision making. Sound ethical decision making regarding client care empowers occupational therapists to be effective change agents.

The purpose of this article is to demonstrate that occupational therapists can be leaders and change agents within and outside of their profession in an important emerging practice context — professionally assisted dying. To accomplish this goal, the article will introduce a 10-step occupational therapy-driven framework for ethical decision making (Drolet, 2014).

QET: The four windows of ethical analysis

An ethical analysis that is well conducted should appeal to relevant ethical theories as well as to the values of the people involved (Drolet, 2014). As such, the 10-step ethical decision-making framework incorporates the Quadripartite Ethical Tool (QET) created by Drolet and Hudon (2015), which suggests four windows to guide an ethical analysis.

1. Utilitarian ethics: Focuses on the consequences of each option considered with the goal of doing the most “good” for the most individuals.
 - Strengths: Offers flexible consideration of particular circumstances.
 - Challenges: It can be complex to calculate the most “good,” or even to decide what constitutes “good” in unique situations.
2. Deontological ethics: Starts from the premise that there can be a few overarching rules to guide how we make ethical decisions. True deontological “rules” are few, but one example might be “the golden rule” of doing to others what you would want done to you.
 - Strengths: Can offer very specific parameters to guide decisions.

- Challenges: The “rules” can be inflexible in the face of particular circumstances.
3. Virtue ethics: Seeks excellence in human interactions. Assumes that if we instill admirable virtues in children and citizens, they will be innately prepared to respond to complex ethical situations — referred to as the ethics of character.
 - Strengths: Offers flexibility by looking to the value of good character. Virtues are typically seen as a balanced position on a continuum.
 - Challenges: There is no definitive list of agreed-upon virtues, and real life application is potentially difficult and variable. What if virtues are not instilled in childhood?
 4. Professional values: The values of professional practice domains that are considered most important to the work done by those in the field.
 - Strengths: When chosen well, professional values offer a touchstone for setting aspirations and evaluating behaviour in practice.
 - Challenges: The terminology of professional values is variable. They can be stated as values, principles or codes of ethics to describe “do” and “do not” behaviours.

Case example: A potential future scenario

In palliative care rounds, the occupational therapist informs the health-care team that a client with late-stage cancer wishes to have a professionally assisted death. Acknowledging the client is within his rights, the team agrees to explore this option with the client. However, the client has requested that his wish be kept from his partner, who has until now been involved in nearly all aspects of his care. Agreeing that his partner's continued involvement would likely benefit the client and ease the ethical stress of his care providers, the team is unsure of how to proceed. The occupational therapist recommends engaging in an ethical analysis to guide the team in deciding how to provide the best care to this client (see Table 1).

Steps one through eight prepare the team to make a decision. Before acting, a decision should be tested against the four ethical windows of the QET (step nine). Once those involved have decided and taken action, the tenth step is to carry out an extensive evaluation (described in detail in Drolet, 2014). The evaluation equips the team with useful information

Table 1. Steps 1 through 8 of ethical reflection for occupational therapy practice (Drolet, 2014)

Step 1	Identify the ethical problem Is it more important/ethical to respect the client's wishes for secrecy (being client-centred) or to encourage the involvement of his partner (truth-telling and being family-focused)?	
Step 2	Recognize and criticize spontaneous moral reactions	
	Spontaneous Reaction "I cannot imagine not involving my partner if it were me." "It would feel like we are lying to his partner."	Critical Reflection "We do not know his partner like he does. He could have good reasons that we do not understand to withhold this information." "He has a right to confidentiality."
Step 3	List and verify the main hypotheses There are many reasons this client could want to withhold his wishes from his family. Some hypotheses to consider and discuss with the client are: 1. The client does not know about the many ways the health-care team can support and involve his family. 2. The client does not realize that the health-care team cannot guarantee 100% secrecy, as his death must be documented and someone in the hospital could accidentally say something. 3. He is afraid of having conversations about death with his spouse and children (due to fear of upsetting them, fear of judgment, etc.). In this case, verifying these hypotheses is best done through respectful discussions between the client and a trusted member (or members) of his health-care team.	
Step 4	Identify and analyze the main ethical issues (QET analysis)	
	Utilitarianism: • Undermining trust — if client wishes are not respected; if family members feel shut out unfairly or disrespected • Trauma for family members when they likely learn the truth • Isolation of client without family support	Deontology: • Must be sure not to "use" the client's situation to feel good about the team's work • Act in a manner the team can agree should always happen in similar circumstances
	Virtues: • Team must bring respect, trustworthiness and honesty in balance • "Phronesis," or practical wisdom — given the team has experienced many lives ending and the client may have not	Professional values: • Team might discuss their common professional values, such as empathy, client-centred care, family-focused care, client autonomy, respect, trust, excellence and compassion
Step 5	Define the main options and their consequences on all actors in the situation	
	1. Provide some encouragement to the client to involve his partner. Possible outcomes: a. The client is fully informed about his options, including how and when he can involve his partner and the available support. b. The client tells the partner of his wishes resulting in supportive or distressing reactions. c. Ethical stress is diminished for involved health-care professionals. d. The client feels pressured to make a decision with which he is not comfortable and may feel his wishes are not being respected. 2. Inform the client of the option to involve family, but do not actively encourage it. It is possible that: a. The client feels his wishes are being heard and respected. b. His partner finds out anyway, and trust/confidence is diminished among the partner, client, health-care team and institution. c. Ethical stress of involved health-care professionals increases. d. The client and family miss opportunities for meaningful final experiences together.	
Step 6,7,8	Identify (step 6) and clarify (step 7) all relevant terms, phenomena, procedures, standards and values, and prioritize (step 8) the most important four items These steps are combined and items are not clarified for brevity and because terms will inherently differ depending on context/policies/laws. 1. Laws and legislation regarding process for professionally assisted dying 2. Continuous free and informed consent 3. Client-centred care (includes confidentiality, autonomy and enablement) 4. Family-focused care	

that can be used to guide similar future circumstances with efficiency. In every case, this ethical framework invites occupational therapists to make decisions that are based on relevant facts and values.

Occupational therapists as interdisciplinary change-agents

Occupational therapists can be leaders and change agents in the emerging practice context of professionally assisted dying. They can empower their teams to engage in sound,

methodical decision-making by using an explicit, occupational therapy-driven ethical framework that supports consistent, transparent and accountable practice in an area of health care typically characterized by “grey areas.” This type of accountability in decision making can provide the client and other stakeholders, such as family, support staff or quality assurance teams, with confidence in the decision-making processes of these health-care teams.

To learn more, readers are invited to consult the full French publication of the 10-step ethical framework (Drolet, 2014). An English translation is expected in 2016.

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Snapshots of occupational therapists as change agents: End-of-life care

Creating change: Integrating end-of-life care into everyday practice.

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The thing that I remember most clearly is Lesley's amazing smile. Until her last breath, she taught me – her occupational therapist – about what truly brings meaning to a person as they live through their dying experience. "I want to be in my home, climb my stairs and water my beautiful garden ... most of all, I want to be there at my daughter's wedding..." Lesley's goals about what could be possible at the end of her life inspire us to see "visions of possibilities" (Townsend et al., 2013) for occupational therapy in Canada to fully integrate end-of-life care into everyday practice.

Research studies demonstrate that end-of-life has a significant impact on engagement in meaningful daily activities (also known as occupations) both for the person who is dying (Park Lala & Kinsella, 2011) and for their loved ones (Hoppes & Segal, 2010). A core occupational therapy model, the Canadian Model of Occupational Performance and Engagement (CMOP-E; Polatajko, Townsend, & Craik, 2007), provides occupational therapists with a useful model to conceptualize the individualized meaning that end-of-life has for each individual and family. The CMOP-E prompts therapists to examine the dynamic interaction between the person, their environmental context and the occupations that the person wants to, needs to or is expected to engage in or perform. Of note, the CMOP-E places spirituality at the core of the person, denoting that each individual ascribes and expresses unique meaning to the things they do, including dying. The *Occupational Therapy and End-of-Life Care* position statement by the Canadian Association of Occupational Therapists (CAOT, 2011) states that "all people of all ages in Canada have the right to quality end-of-life care that allows them to die with dignity, free of pain, surrounded by their loved

ones, in a setting of their choice" (para. 1).

While the CMOP-E and the CAOT position statement situate occupational therapists as vital health-care professionals with tools to help people who are dying and their loved ones to meaningfully engage in the dying experience, there is a gap between current practice and what could be. Canadian palliative care remains focused on symptom management; the impact is seen in a recent Ontario-based palliative oncology survey of occupational therapists who reported that their top interventions include equipment prescription for mobility and activities of daily living, seating recommendations and positioning (Spreeuw, Taylor, Dirks, DeSouza, & Heck, 2015).

The goal of the Quality End-of-Life Care Coalition of Canada (QELCCC) and the Canadian Hospice Palliative Care Association (CHPCA) is to bridge the gap between what health-care professionals are doing and what they could do in Canadian hospice palliative care. CAOT has representation on the QELCCC and supports the adoption of *The Way Forward National Framework* recommendations (CHPCA, 2015) for an integrated palliative approach to care across all practice settings. These recommendations encourage all health-care professionals working in any area of care to incorporate a holistic care approach into their current and ongoing work with any person presenting with frailty or chronic illness. This means addressing physical, emotional, psychosocial and spiritual needs, and reinforcing the person's right to actively participate in care and exercise a sense of control.

Because of advances in technology and treatments, "when" someone will die is less predictable and most people never receive the palliative care services that could enhance life even in the face of chronic illness (CHPCA, 2015). Therefore, *The Way Forward National Framework* (CHPCA, 2015) endorses use of the "surprise" question to help determine when an integrated palliative approach is needed, i.e., "Would it be a surprise if this person were to die?" This question puts the emphasis on what could happen and also helps health-care providers think more holistically about the person's needs throughout the illness trajectory, not just at the end of life. Every occupational therapist can expect to work with a client for whom they would not be surprised if the person were to die. Every Canadian occupational therapist therefore needs to be prepared to integrate a palliative approach into everyday practice.

The dying experience is a part of people's living. Canadian occupational therapists have a core role as change agents (CAOT, 2012) to enable the most meaningful occupations for people who are dying. We now invite you into an ongoing dialogue, considering two questions: What is possible when occupational

therapists routinely integrate a palliative approach into their client-centred care? And, what needs to happen to include and support occupational therapists as vital team members in achieving the aligned visions of CAOT, QELCC and CHPCA for the betterment of those living through the dying experience?

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Agents of choice: Occupational therapy can improve assisted dying across Canada

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As occupational therapists, we appreciate that we should not take a one-size-fits-all approach to intervention planning. Being client-centred, appreciating each client as an individual and respecting each client's specific goals are principles that guide our practice. We believe these are essential to enabling participation in daily life activities and when exploring end-of-life options that we may consider lamentable.

End-of-life care is an important and essential component of the health-care system. Palliative care is a viable option for many. It is not an ideal option for everyone, however, as has been made apparent by various personal stories recently profiled in the media,

such as those in the CBC's *Last Right* series (<http://www.cbc.ca/thenational/indepthanalysis/lastright/index.html>).

It can be difficult to truly understand an experience of suffering that leads someone to want to end their life in order to be relieved of it. As client-centred practitioners, we feel we have the responsibility to try to understand and help where we can – as practitioners, as innovators and as advocates.

The recent Supreme Court of Canada decision on assisted dying (*Carter v. Canada*, 2015) enables individuals to regain some level of control over their lives and offers some minimal choice in how it ends. Without such an option, control is greatly diminished for those who would choose it.

We believe that a good experience of assisted dying will inevitably rely on an interdisciplinary approach. Our client-centred approach in occupational therapy enables us to explore a client's wish to die, their understanding and appreciation of such a request and their continuing possibilities for purposeful engagement. We can also offer unique and profoundly valuable insights into what a "good death" may look like from an occupational perspective of "the end of life." This includes finding constructive ways an individual's roles and relationships of many years and decades may be brought to their conclusion. We feel we can help with creating both a more meaningful death experience for clients and a more positive death legacy for those around them (family, friends and health professionals) who then carry that legacy themselves until their own deaths.

Our interest in this topic led us to undertake a Canada-wide survey of occupational therapists on their perspectives of assisted dying and potential occupational therapy roles. We are currently analyzing the results, and the interim data suggests most therapists share similar views on the need to enable client choice at the end of life, and that our profession can make a range of contributions. We will seek every forum and medium possible to share final results with policy-makers and with occupational therapists across Canada and beyond.

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Occupational therapy leadership in military, Veteran and family health

Megan Edgelow and Heidi Cramm

Military personnel, Veterans and their families may have unique health needs and challenges in their daily lives. Military personnel may face issues related to their service and deployments, such as performing job duties while under exceptional stress and personal risk, or re-integrating into daily life post-tour. While recovering from physical or operational stress injuries (OSIs) sustained during service, Veterans may have challenges relating to friends and family members, securing and maintaining meaningful work, driving and making the transition to civilian life (Cogan, 2014; Radomski & Brininger, 2014).

In addition to providing direct service to the Department of National Defence and Veterans Affairs Canada, occupational therapists engage with this population and their family members in contexts like acute care, outpatient clinics and school-based services. Occupational therapists can provide leadership as change agents in health-care delivery by recognizing the unique health requirements and vulnerabilities of this population, being sensitive to these potentially stigmatizing issues and using a family-centred approach that addresses the full needs of the military member or Veteran (Norris, Cramm, Eichler, Tam-Seto, & Smith-Evans, 2015).

Unique methods of service delivery should also be explored. For example, student occupational therapists at Queen's University recently completed community development fieldwork with the Kingston Military Family Resource Centre. Students became sensitized to the needs of military families, showcased occupational therapy's potential to develop system capacity and improved coordination with local community services.

In this special issue, several best practices and service delivery models are shared. Guidelines for trauma-informed care, useful with this population, but also with other groups who have experienced trauma, serve to sensitize therapists to the need for physical and emotional safety as a cornerstone of a therapeutic relationship (Kitchen & Hosegood, p. 24). The role of service providers within Veterans Affairs Canada, and the focus of occupational therapists, is detailed by Card (p. 25). The specific

work of occupational therapists with military personnel and Veterans at an OSI clinic, including intervention models, is shared by Beauchesne and Jacques (p. 26). Finally, the unique role of occupational therapists within the Canadian Armed Forces in a rehabilitation program shows the opportunities for holistic work with military personnel (Brown & Marceau-Turgeon, p. 25). These four articles offer concrete examples of occupational therapists as change agents for military personnel and Veterans.

The Canadian Association of Occupational Therapists (CAOT) leads the occupational therapy profession within the Military and Veterans Affairs Canada Network (MAVAN), which advocates on behalf of occupational therapists and their clients to government, policy-makers and third-party payers so that they understand how essential occupational therapy services are when they are making significant decisions that affect our profession. CAOT is acutely aware of the need to develop professional resources that can equip occupational therapists with the knowledge and skills to recognize and address personal challenges experienced by military personnel, Veterans, and their families. To ensure these resources are rigorously developed and evaluated, CAOT is eager to support initiatives from the Canadian Institute for Military and Veteran Health Research (CIMVHR), a pan-Canadian network of almost 40 universities dedicated to advancing the health and well-being of military personnel, Veterans and their families through health research.

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Snapshots of occupational therapists as change agents: Military and Veterans

Joining forces: Occupational therapists as change agents with military personnel and Veterans using trauma-informed care

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Occupational therapists often work with individuals who have experienced trauma, including active military personnel and Veterans. As of July 2011, over 30 000 Canadian Armed Forces personnel had been deployed to Afghanistan. At that time, three quarters of Veterans taking part in the Veterans Affairs Canada rehabilitation programs, following their release from active service for medical reasons, were receiving treatment for mental illness (Paré, 2011). Emerging data from the Department of National Defense (Brewster, 2015) suggests that Canadian soldiers report higher incidences of adverse and traumatic childhood experiences, including abuse, corporal punishment and witnessing domestic violence, and that these experiences correlate with higher rates of depression and suicide. To provide client-centred care to clients who have experienced trauma, occupational therapists are challenged to offer services through a trauma-informed lens.

Trauma is multidimensional and can range from a single incident to a complex repetitive event. A traumatic event is defined as “a single experience, or enduring repeated or multiple experiences, that completely overwhelm the individual’s ability to cope or integrate the ideas and emotions involved in that experience” (Klinik Community Health Centre, 2013, p. 9). Trauma within military and Veteran populations can present itself as an operational stress injury (OSI), which results from performing an operational duty that causes ongoing psychological trauma. Post-traumatic stress disorder is the most commonly reported OSI and involves the re-experiencing of the traumatic event over a long period of time, affecting daily functioning (Canadian Mental Health Association, 2015).

Trauma-informed care represents an understanding of trauma in all aspects of service delivery, placing physical and emotional safety as the cornerstone of the therapeutic relationship. Consider these practice tips for becoming a trauma-informed practitioner, gathered from our own personal practices as well as evidence-based resources developed by the Klinik Community Health Centre (2013) and the British Columbia Provincial Mental Health and Substance Use Planning Council (2013):

- *Learn more about trauma and its effects on daily life.* The

experience of trauma can have lasting effects. Ongoing symptoms of a trauma response may include panic attacks, poor sleep and the use of substances. These, as well as many other symptoms, can impede how a person functions at home, at work and in the community.

- *Practice asking about trauma.* When asking about trauma, provide rationale for the questions. For example, a practitioner might say, “Things we have experienced in our lives may impact our health, even if these experiences happened a long time ago. Are there experiences from your past that still bother you?” Regardless of whether a client chooses to disclose, reinforce the client’s strength and choice.
- *Increase your own comfort in responding to disclosures of trauma.* Try practicing this with a peer and seek feedback.
- *Provide education about the effects of and responses to trauma.* Reframe the symptoms of trauma as a client’s adaptations to the event and ongoing trauma-response. Providing a sense of universality – that others who have experienced a traumatic event may have a similar response – can be very healing for a client.
- *Reinforce a client’s resilience and strengths.* Clients who have experienced trauma have developed unique arrays of strengths and coping skills to continue to function after a traumatic experience. Even though these coping skills may present as maladaptive, they are the ways that clients have discovered to adapt to an ongoing trauma response. Identifying these strengths and coping skills can help clients to recognize that they have the attributes needed to heal and recover.

As occupational therapists, we pride ourselves on our ability to provide client-centred care. Understanding a client’s experience of trauma, as well as how the experience affects daily life, can help occupational therapists act as change agents to join with clients to reframe experiences of trauma into journeys of strength, resilience, and healing.

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Canadian Armed Forces occupational therapy

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Canadian occupational therapists have strong historical connections with the Canadian Armed Forces (CAF). “History shows occupational therapists were heavily involved and highly valued with respect to rehabilitation of returning injured military members of World War I and World War II. By the 1950s, however, the number of occupational therapists . . . had dwindled” (Brown & Hollis, 2013, p. 1244). Recently, occupational therapy services are being re-established within the Canadian Forces (CF) Physical Rehabilitation Program (Besemann, 2011). The CF rehabilitation program has a mission to provide expertise and coaching to assist CAF personnel in the re-integration of meaningful activities (National Defence, 2013).

CF occupational therapists believe that the CAF member is at the centre of care and that rehabilitation outcomes are strongly linked to motivation, effort and support. Further, CF therapists value members’ family, peers and chain of command as strong sources of motivation and recognize them as essential members of the rehabilitation team. The CF therapist sees the ill and/or injured member as a recovering athlete (Godsell, Besemann, Heber, & Hazledine, 2013) who needs to be challenged and provided an environment that fosters discipline and focus (National Defence, 2013).

The CF rehabilitation program clearly recognizes the “interdependencies and indivisibility of physical and mental health” (National Defence, n.d., p. iii). As in civilian populations, a referral to an occupational therapist can be made for a member who has sustained a physical injury and has a concurrent mental health diagnosis, such as depression, anxiety or post-traumatic stress disorder (PTSD). In all referrals, the focus for the CF occupational therapists is to reduce barriers and encourage participation in valued roles and routines to enhance health and well-being. Within the military context, valued roles and routines are considered to be what military members want to do and are expected to do. The overarching goals of CF occupational therapy are return to duty (RTD) and sustained RTD. For those military members who are unable to RTD, CF therapists work with CAF health services and Veterans Affairs Canada (VAC) to ensure a smooth transition to VAC services and supports. The current position of CF occupational therapy continues to emerge and incorporate new approaches to improve participation in CAF military members’ valued roles and routines.

Mireille Marceau-Turgeon, a CF occupational therapist describes her work:

The job of an occupational therapist in the CF presents many challenges. At the Valcartier military base, the clientele is diverse and the needs are varied. Although our mandate is to provide soldiers with physical rehabilitation, the overall view of occupational therapy brings us to treat our clients in all aspects of their being, including the psychological aspect. With problems such as chronic pain or traumatic brain injury, it is impossible to distinguish between symptoms brought on by PTSD and those stemming from a physical diagnosis. But is it necessary to do so? As an occupational therapist, I take a holistic approach and my desire is to overcome their difficulties, no matter where they come from. This is how my work environment allows me to celebrate beautiful victories; I am convinced that adopting an approach that takes the emotional and physical histories of my clients into consideration helps me give them a chance to progress even further.

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Occupational therapists working with Veterans Affairs Canada

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Occupational therapists have had the privilege of working with Canadian Veterans since the First World War. Veterans Affairs Canada (VAC) continues to be committed to including occupational therapists through various programs, including but not limited to the Veterans Independence Program, Operational Stress Injury clinics and the New Veteran’s Charter (Canadian Association of Occupational Therapists [CAOT], 2009).

Occupational therapy interventions with Veterans are commonly associated with home assessments and recommendations for adaptive equipment to maintain safety and independence. While these remain key functions, occupational therapy has a broader role, using a holistic approach to physical and mental health issues. With the onset of the New Veteran’s Charter, dedicated

to enabling the health and independence of Veterans and their families (VAC, 2014), occupational therapy has an important role in promoting wellness and helping members transition back to civilian life and civilian work (CAOT, 2012). Cognitive rehabilitation and remediation strategies have emerged as a treatment of choice for modern-day Veterans who may present with traumatic brain injury, post-concussive syndrome, as well as various mental health issues, including post-traumatic stress disorder. Individual activity reactivation programs and standardized cognitive behavioural and activity programs are used to reduce disability and increase function.

Occupational therapy assessment, consultation and intervention are based on evidence from research, best practice and experiential knowledge. Meaningful occupations (e.g., looking after one's self independently, enjoying sport or creative leisure activities, socializing, caring for a home, participating in family life, being gainfully employed, volunteering) are important to achieving the goals of rehabilitation and ultimately re-establishment into the civilian world. Exciting opportunities exist for expansion of VAC occupational therapy services and partnering with CAF to meet the needs of Veterans and ensure smooth transitions from military life to civilian life.

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From combat to compassion: Enabling change in Veterans

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As occupational therapists, we work for the Residential Treatment Clinic for Operational Stress Injuries (RTCOSI). It is a tertiary care inpatient facility serving Veterans, Canadian Forces members and Royal Canadian Mounted Police members experiencing operational stress injuries (OSI). These men and women who serve our country are often diagnosed with depression, anxiety, post-traumatic stress disorder (PTSD) and co-morbid substance abuse linked to their work in the line of duty. They are referred to us by their local service provider and are admitted at the earliest available time for a period of approximately 12 weeks. Typical occupational therapy interventions include:

- clarifying personal values and priorities
- identifying valued roles and occupations
- assisting clients in identifying and implementing a satisfying and healthy routine

- supporting transition processes (i.e., military to civilian life, hospital to home environment)

Enabling clients to participate in significant activities remains the primary focus of most interventions. Our work is influenced by the Model of Human Occupation (Kielhofner, 2008) as well as other approaches and resources, such as Acceptance and Commitment Therapy (ACT; Walser, Westrup, & Hayes, 2007), Action Over Inertia (Krupa et al., 2010), mindfulness meditation (Moore Jackman, 2014) and motivational interviewing (Miller & Rollnick, 2012). We find the use of therapeutic strategies from these different approaches to be effective in empowering clients to take charge of their lives. For many, we find this process is more than welcomed, often following months or even years of a chaotic, unfulfilling life, overrun by the person's struggle with OSI symptoms.

ACT, with its mindfulness component, and Action Over Inertia play an important role in promoting engagement in valued activities as the way to move toward a meaningful life despite the challenges posed by OSIs. Mindfulness practice, taught on a regular basis and reinforced throughout the client's stay at the clinic, offers the opportunity to experience occupation in the present moment, with acceptance, positive intention and compassion (Moore Jackman, 2014). An increase in self-compassion is thought to "potentially buffer feelings of grief, shame and guilt which are pervasive in chronic PTSD" (Kearney et al., 2014, p. S36). We feel that as clients learn to develop self-compassion, acceptance of the pain brought on by trauma is facilitated, allowing them to redirect their energy and efforts on building a fulfilling life.

We have also observed that time-management interventions are effective in enabling clients to implement and maintain a healthy and satisfying routine that is compatible with their abilities and consistent with their values. Setting realistic occupational goals is essential to achieving a more satisfying level of engagement, which we find leads to increased feelings of empowerment and hope.

In order to ensure that clients have the proper support to maintain an optimal level of occupational engagement post-discharge, we communicate our observations and recommendations to the referral source before clients depart. We feel privileged to witness our clients' journeys toward recovery throughout their stay at RTCOSI.

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Innovative occupational therapy practices improve access to services for children and families

Cheryl Missiuna, Debra Stewart and Leah Dix

The health-care system in Canada is facing increasing challenges associated with rising costs, lengthy wait times, the need for evidence-based best practices and a desire for “value added” services (Deans & Wade, 2011) that meet the needs of the health-care recipient. This is particularly true for children with disabilities. Families are advocating for more timely health services and are asking that services address their children’s needs for participation and inclusion at home, at school and in the community (Anaby & Law, 2013).

Occupational therapists bring a unique lens to the access and design of pediatric services. They understand the dynamic interplay between the child with a developmental or health condition, their environment and the activities that are important to him or her. The family-centred nature of occupational therapy practice means that attention is given to the individual and changing needs of each child and family, and also to the environmental influences facilitating or hindering the child’s health and participation.

When occupational therapists examine the needs of a child requiring service, they do so with the knowledge and skills required to recommend changes and adaptations to activities and environments that support the child’s participation in meaningful activities (e.g., socializing with peers, riding a bicycle, becoming independent in toileting, playing at the park). This understanding has led occupational therapists to implement innovative approaches that support not only the child, but also the adults who surround the child and who directly influence the child’s daily activities (Missiuna et al., 2012b). Occupational therapists are increasingly focusing not only on children whose needs have been identified, but also on health promotion and prevention of secondary health consequences that can arise as a result of environmental influences, such as living in communities with high rates of poverty (Regehr, 2013) or not receiving service in a timely manner (Missiuna et al., 2012b).

Most children with disabilities who are identified when they are young are able to access needed health care services in hospitals and treatment centres across Canada. However, many children who need support to facilitate their development or health do not meet criteria for services provided through those venues. Further, many children are not identified as needing health services until they enter school; these children may be referred to occupational therapists for support after they have begun to struggle and

experience frustration. A Tri-Ministerial Review conducted in Ontario by Deloitte (2010) reported lengthy waitlists and wait times for school-aged children with special needs who had been referred for pediatric rehabilitation services. Waiting for services places a child at increased risk for future developmental, physical and mental health issues (Missiuna et al., 2012b).

Partnering for Change

Occupational therapists worked as agents of change in the development of an innovative service delivery model to address the needs and improve the lives of many of these “at risk” school-aged children. Partnering for Change was developed in Ontario with health-care leaders working in partnership with researchers at the *CanChild* Centre for Childhood Disability Research to create a model in which occupational therapists focus on building the capacity of educators within the school system to support children with special needs (Missiuna et al., 2012b). Instead of intervening with one child at a time, the school becomes the “client.” This model introduces a crucial change in who is able to access services; previously, school aged children with “mild” disabilities were often overlooked or left on lengthy waitlists because they were not considered to be as needy as other children. The irony is that the milder needs of these children can be met immediately when occupational therapists embed principles of universal design for learning into elementary schools, changing physical and social environments and facilitating learning (Missiuna et al., 2012a; 2015a).

In Partnering for Change, occupational therapists work collaboratively with educators in the natural context of the classroom to identify children with special needs as soon as possible and then design solutions and implement strategies that support their active participation at school. For specific intervention examples, refer to Missiuna et al. (2015b) or the webinar by Missiuna and Campbell (2015). Family involvement is encouraged, both to ensure understanding of a child’s health condition and to build capacity for family members to advocate for the child at home and in the community. Instead of the health-care system managing the waitlists and paperwork associated with a referral for occupational therapy services, the referral process is reversed — the occupational therapist, educator and family identify the child and, whenever possible, intervene right away. The success of this model was shown in a demonstration project

(Missiuna et al., 2012a; Campbell, Missiuna, Rivard, & Pollock, 2012). A two-year study funded by the Ontario Ministry of Health and Long-Term Care and Ministry of Education is now confirming that Partnering for Change is a collaborative, evidence-informed occupational therapy service that eliminates wait times while promoting integrated, needs-based care for children with special needs in Ontario (Missiuna et al., 2015a).

Partnering for Change uses a tiered approach so that all children with special needs have equitable access to occupational therapy services, while children with higher needs can have more frequent sessions allotted for addressing individual accommodations and sharing strategies with their educators and families. This shift in approach is similar to the change that was introduced in the Saskatchewan education system during the transition from a medical model to a needs-based model. There, a three-tiered approach supports the participation of all students through responsive instruction, classroom-based and school-wide interventions, targeted or group screening, and individualized strategies and suggestions. Occupational therapists provide flexible and context-based supports to students with special needs through different levels of intervention and timely provision of services that promote inclusion and participation (Saskatchewan Ministry of Education, 2011).

Further examples of change agency

In this special issue, we see numerous other examples of change being created by occupational therapists across the country to ensure that children with special needs receive the right service at the right time and in the right place (see pp. 29-30). Among such changes is a new program for young children with autism spectrum disorder that aims to extend the reach of the occupational therapist in order to support parents to facilitate their child's development and inclusion (Beaudoin & Couture). In three urban child care settings, LeClair and Restall were able to improve the developmental skills of at-risk children who had not been referred for service. They also worked collaboratively with early childhood educators in order to extend the suggestions that were made to other children in those settings. School-aged children with disabilities are benefitting and waitlists are diminishing due to the unique summer service offered in rural Ontario by the Closing the Gap occupational therapists. Consultation with families over the summer ensures that goals are achieved and that reports and recommendations are communicated on the first day of school, facilitating immediate access to the equipment, programming and support that each child needs for full participation in school.

Occupational therapists across Canada have taken up the challenge of improving access to pediatric services for children

with disabilities in many groundbreaking ways. The novel approaches described in this issue involve models that could be used to improve access to, and the design of, services delivered by occupational therapists across the country; they may also provide inspiration for other health professionals who are working to improve the lives of Canadian children and families.

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Snapshots of occupational therapists as change agents: Access to pediatric services

Providing early identification and group intervention for at-risk preschoolers: Building capacity among early childhood educators

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Occupational therapists have a role in the primary health care of children at risk for developmental concerns. As many as one in five children are at risk for developmental delay, but less than 50% of children with these types of concerns are identified prior to school entry (Centers for Disease Control and Prevention, 2015). Earlier identification and intervention around many developmental issues can be provided by early childhood educators (ECEs) if they receive training and health professional support. Recognizing this problem, an occupational therapy project was developed to build educator capacity to identify preschool children at risk for developmental delays in child care settings and to offer an occupational therapy designed group intervention.

Children from three child care settings in an urban community were screened using the Ages and Stages Questionnaire (ASQ) (Bricker & Squires, 1999), which parents or the ECE completed. An occupational therapist assessed children who screened “at risk” on the ASQ to determine their suitability for a group intervention that included a variety of fine, visual and gross motor activities. Twenty-two children who were identified as at risk across the three settings (14 boys and eight girls, mean age= 3.93 years) participated in the groups. In each setting, the occupational therapist worked collaboratively with an ECE once a week for two hours over 12 weeks to train and support the ECE in delivering the group intervention. The ECEs developed the knowledge and skills to incorporate many of the group activities into programming with other children, both at that time and in the future, and shared the ideas with other educators.

Results of the groups were very positive with children showing significant improvements in developmental areas across all three sites. Interviews with ECEs and child care centre directors suggested that the group was a welcome additional resource for children in their centres and provided access to service for an at-risk population who would not otherwise have been reached. This project provided important preliminary evidence for an occupational therapy group intervention, delivered collaboratively in the child’s natural setting, to influence developmental outcomes of at-risk preschoolers and to build capacity among ECEs.

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Occupational therapists facilitate earlier access to intervention through coaching and collaboration with parents of young children with suspected autism spectrum disorder

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Even if occupational therapy is one of the most widely used health services with children with autism spectrum disorders (ASD) in Canada, the role of the occupational therapist with this population is currently often limited to motor evaluation and sensory integration (Carbone, Farley, & Davis, 2010). Knowing that occupational therapy seeks to facilitate social participation of the person in his or her different occupations, the role of the occupational therapist would benefit from being expanded in order to improve the social participation of children with ASD. Among the specific contributions of an occupational therapist working with young children with ASD, there is: 1. development of prerequisites for social interactions, 2. physical and emotional support for the family and 3. interventions based on a vision that is holistic and occupation-centred.

Considering this increased demand for occupational therapy, interventions need to be delivered in a way that optimizes the use of existing resources. Coaching is a promising innovative strategy that allows knowledge, abilities and skills to be transmitted to collaborators (e.g., parents or caregivers) in order for them to foster the child’s development and participation through meaningful activities and interactions with family members in a variety of settings (Rush, Shelden, & Hanft, 2003).

In order to examine whether the reach of occupational therapy can extend further using this approach, research is underway to evaluate the effects of an occupational therapist-led parental support program for young children suspected of having ASD. The preliminary data from this research shows that it is possible to

decrease the need for direct service through provision of a parental support program for 12 weeks. In addition to appreciating the advice of the occupational therapist, the parents noted the importance of their presence, active listening and support in this stressful period. This service model offers very early intervention that is both low intensity and tailored to the family, and aims to find, in collaboration with the parents, intervention strategies that can be implemented within the family's daily activities. Research is continuing to evaluate the effect of the intervention on the development of the young child and parental well-being during this very stressful period.

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Innovative summer service model to increase access to occupational therapy service for pediatric clients

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A change agent may be described as “someone who knows and understands the dynamics that facilitate or hinder change” (Impact Greensboro, 2011, para. 1). Occupational therapists, by nature, are solution-focused in their effort to facilitate a client's journey to engage in occupation (meaningful daily activities). By extension, they are natural agents of change as they research, plan, build support and partner with others to create change on a broader level. This brief report shares an innovative program that is one example of how occupational therapists may be viewed as agents of change.

The Muskoka region is a rural area of Ontario that spans a large geographic space. Currently, pediatric occupational therapy school health services are arranged and coordinated through the North Simcoe Muskoka Community Care Access Centre (NSM CCAC). Occupational therapists from Closing the Gap Healthcare Group (CTG) and NSM CCAC partnered as agents of change to develop an innovative summer service model designed to improve access for pediatric clients who did not receive service during the school year.

Children were selected for this program from the waitlist through selection criteria determined collaboratively with NSM CCAC and CTG occupational therapists. Occupational therapy assessments were conducted and families were provided with treatment recommendations and consultation or teaching sessions based on client goals with the intent being to achieve these goals prior to starting school in September. Assessment reports and recommendations were provided to the schools on the first day of classes in September for incorporation into the classroom where appropriate. This facilitated immediate access to equipment and programming that could support each child as needed for the school year. The children then received two follow-up visits at school to ensure that all recommendations were reviewed and in place, with the final intervention being completed by the end of October.

This model has been in practice for the past three summers, and, as a result, close to 60 additional children have received occupational therapy service to help them more successfully participate in school. Both school staff and parents report great satisfaction with the program. Schools, in particular, reported that receiving the occupational therapy recommendations on the first day of school greatly facilitated school programming and access to any equipment that children might have required. The collaboration between CTG occupational therapists and the NSM CCAC has resulted in an innovative and successful program that increases service access.

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Update from the Canadian Occupational Therapy Foundation

Scholarship competition deadline

The deadline for the 2015 COTF scholarship competition is October 1, 2015. COTF will be offering the following awards:

1. Barb Worth Emergent Leader Scholarship
2. COTF Doctoral Scholarship
3. COTF Master's Scholarship
4. COTF / Invacare Master's Scholarship
5. Goldwin Howland Scholarship
6. Thelma Cardwell Scholarship
7. Janice Hines Memorial Award
8. Marita Dyrbye Mental Health Award

For more information and to apply online, please visit: www.cotfcanada.org Technical questions can be directed to: amcdonald@cotfcanada.org All other questions can be directed to: skamble@cotfcanada.org

2016-2018 COTF Research and Scholarship Review Committee

Did you know that COTF's awards program has a peer-reviewed virtual committee? Have you ever thought about how you could volunteer for COTF? Joining this committee is a great means to do just that. You can have a significant impact by being part of this committee, which meets twice per year by teleconference to review the applicants in COTF's research grant competition (deadline February 28) and the scholarship competition (deadline October 1). You would have the chance to work with other CAOT members across the country who represent different regions and both official languages. COTF is currently recruiting members for the 2016-2018 committee. The committee would meet six times over this period to review three research grant competitions

and three scholarship competitions. The committee meetings are normally held in April and November of each year.

If you are interested in being a member of the committee, COTF is currently looking for members from the following areas:

- Alberta or Saskatchewan
- Manitoba
- New Brunswick or Nova Scotia or Prince Edward Island
- Québec

COTF also needs at least one more bilingual member. If you are interested in being part of the committee, please contact Sangita Kamblé, COTF's executive director, at: skamble@cotfcanada.org

Canadian Occupational Therapy Foundation

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