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OCCUPATIONAL THERAPY NOW

Table of Contents

EDITORIAL

This house is not a home: Rebuilding an occupational therapy with and for us	5
Hiba Zafran & Naomi Hazlett	

CONTENTS

Accounting for our history: Ableism & White supremacy in occupational therapy	7
Susan Mahipaul	
Enabling equity starts from within.....	11
Amie Tsang & Zehra Haque	
Pause, reflect, reframe: Deep discussions on co-creating a decolonial approach for an antiracist framework in occupational therapy.....	14
Musharrat J. Ahmed-Landeryou, Isla Emery-Whittington, Sheela Roy Ivlev, & Rebecca Elder	
Towards reimagining and fostering a new era of accountability in occupational therapy: The narratives of building a collective.....	17
Samira Omar & Tanjot Gill	
Living social accountability praxis: A working group's narratives.....	21
Havelin Anand, Marianne Baird, Giovanna Boniface, Fizza Jafry, Leanne Leclair, Susan Mahipaul, Samira Omar, Elizabeth Pooley, H��l��ne Sabourin, Ruheena Sangrar, & Hiba Zafran	
Toward more socially-accountable service user involvement in education: Embracing Critical Disability Studies.....	24
Stephanie LeBlanc-Omstead & Susan Mahipaul	
Accounting for our words: Anti-oppressive documentation in occupational therapy practice.....	27
Janna MacLachlan & Marie-Lyne Grenier	
From shelter to home and beyond: How occupational therapists can become more accountable to women in transition to post-shelter housing.....	30
Karla Jacobsen & Vanessa Seto	
Conversations that Matter: The Podcast—A step toward social accountability.....	32
Justine Jecker & Holly Reid	



Cover photo credit: This image is a collection of our 6-word stories from humans across Canada who attended our July event on Moving Beyond Occupational Narratives. The idea of a 6-word story originated from Ernest Hemingway. The generation of these stories was inspired by Stephanie Lurch, a Black physiotherapist who co-created and facilitated a workshop on anti-Black racism at the University of Toronto. Special thank you to Athulya Pulimood, who captured our vision and brought our ideas to life.
by Samira Omar & Tanjot Gill

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CANADIAN ADDRESSES TO:

Canadian Association of Occupational Therapists
150-34 Colonnade Road
Ottawa, Ontario, Canada K2E 7J6
Email: publications@caot.ca

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ADVERTISING

Tracy Jolliffe
Phone: (613) 523-2268, ext. 241
Email: advertising@caot.ca

SUBSCRIPTIONS

Phone: (800) 434-2268, ext. 221
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MANAGING EDITOR

Naomi Hazlett, Bsc., MScOT, OT Reg. (Ont.)
Tel. (613) 523-2268 ext. 243
Email: otnoweditor@caot.ca

DESIGN & LAYOUT

JAR Creative

COPY EDITING

Claire Hurd, BA, MScOT, OT Reg. (Ont.) (English)
Alexa Gravel, M.Sc., OT Reg. (Ont.) (French)
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This house is not a home: Rebuilding an occupational therapy with and for us

Hiba Zafran & Naomi Hazlett

Yet while I am hungry for a path back for those who do harm, it is not the burden of people who have been harmed to continue to cover for, reach out, and hope for accountability from the people who have harmed them.

(Shank in Dixon & Piepzna-Samarasinha, 2020, p. 39)

The house we are in

Occupational therapy has not actively grappled with the implications of White supremacy and colonization on notions of justice (Emery-Whittington, 2021) or occupation (Lavalley and Johnson, 2020) until recently. As a straight-passing Arab immigrant student sitting in an occupational therapy class in a debrief the day after 9/11, I (Hiba) was chastised by both faculty and peers for daring to reflect out loud about the broader role of US imperialism in global events rather than wail at the imminent danger 'we' were living in. As a descendent of Syrian-Lebanese-Palestinian heritage, I knew what would come: decades of Islamophobia and the demonization of Arabs, an ongoing and legitimized danger in North America analogous to the rise of anti-Asian racism in the wake of C19.

I (Naomi) am privileged with the external appearance of the traditional occupational therapist. Yet I often wonder if I belong in occupational therapy's house and what belonging means. The damage of White supremacy extends deep roots, teaching those who 'pass' to be still and complacent to survive. 'Catastrophizing' was the term the professor used as I sat in tears across her desk explaining my need for more frequent breaks during a three-hour lecture to manage my pain. I despaired, thinking that all successful occupational therapists needed to suppress their body's needs for hours on end. I now work in and alongside communities, make my schedule my own, and live outside an eight-hour shift and other boundaries more fragile than some of us are led to assume.

The imposed coherency of the 'we' in both those classes, as opposed to an understanding that

there are different versions of 'us' facing very different dangers, remains damaging throughout the profession. When our 'we' dares to speak up, we are told that we are 'emotional and difficult', that it is 'different here', that 'we need to compartmentalize', that we are 'unprofessional' and 'not team players'. The visions of justice that *our we* brings to the profession have also been labeled too different and cornered into tokenized spaces where they are deemed 'intellectually interesting'.

This house built on White supremacy is not our home. Moving the furniture around will not make it one. Asking some of *us* to bend and tiptoe through the corridors ignores that not everyone is comfortable or welcome here. Attempting to address injustice through the usual tools and worldviews may expand the servant's quarters or the attic, but it will not make it a home (Lorde, 1984), and that is simply because without rebuilding the foundations, those of you sitting comfortably in the living room will never know the strengths and gifts we bring to the profession and particularly to those we serve who are *just like us*.

Addressing the cracks in the foundation

The upcoming joint position statement (JPS) "Towards Justice: Equity and Accountability in Occupational Therapy" identifies social accountability as its framework, acknowledging that we need tools to rebuild created by and for the peoples who seek and deserve equity. Social accountability emerged in the 1970s in the Global South and draws on multiple theories to bridge between systemic institutional design and social movements intended to liberate and empower (Lodenstein et al, 2013). It focuses on creating processes that hold individuals and groups responsible for ensuring that their decisions and actions embody the forms of justice that marginalized groups demand. This special issue on social accountability is an experimental prequel to the JPS: what could an occupational therapy that counts everyone in, counts for everyone, accounts for our foundations, that engages with leadership from the margins, questions, dismantles, and rebuilds, look like?

Of the 23 articles submitted to this special issue, we retained nine although there was room for 13. Most of the manuscripts focused on individual reflection and education, necessary in terms of personal accountability but not addressing systemic issues; or, engaged in sanctioned forms of advocacy that maintains the status quo by retaining power within professional status. In neither approach do we see an actionable shift in power dynamics to promote marginalized peoples' participation in determining and governing for their own survival. The profession can assist people into the house one at a time, or even build a ramp, but accountability is about going back to the land on which we all live, and intentionally redesigning a profession that is respectful of each of us and our surroundings.

A blueprint for editorial accountability

As editors we wanted to both demonstrate and apply social accountability in this issue's production. Hiba actively reached out and cultivated connections with marginalized occupational therapists to share their perspectives and practices. We prioritized submissions by authors from under-represented groups in the selection of the article shortlist. To formalize equity, we reviewed articles independently and came together to discuss which articles illustrated elements of social accountability, with a 100% inter-rater agreement. Given that some of the authors are not writers or academics, a bi-directional mentorship process was collectively established whereby we learnt about their ethics and work through discussions along the pages' margins, and invested in supporting the articulation of their ideas.

In the multiple rounds of revisions, we asked what kind of feedback was preferred, and made explicit that suggestions could be accepted, dismissed, or discussed. To create an inclusive space that pushes against neoliberal publication norms, deadlines were extended to minimize ableist expectations, word limits were negotiated to give space for the development of new ideas, writers were encouraged to choose their own language style and to name actors without the veil of a passive voice. Authors were encouraged not to write to a presumed *white gaze*, disrupting the assumption of a coherent 'us'. We invited authors to call us out if we veered towards *tone policing*, allowing ourselves to be uncomfortable and visible in the process, rather than a silent authoritarian influence in the background. We did not always come to consensus and maintained respect for authors' visions for their work by ensuring alternatives for publication in other *Occupational Therapy Now* topics. We thank all the authors for trusting us with their voices, engaging in dialogue, teaching us what works for them, and improving blueprints for the integration of diversity of

thought in a relationship-based editorial process.

Surveying possible plots

This issue, and the articles within it, focus on *accountability in processes*, as it is only in changing how we act and relate to each other that we can hope for different—equitable—outcomes. Possible plots and building codes for a new home are illustrated in the stories told by marginalized occupational therapists and their allies as they demonstrate ethics, principles, and directions for accountable actions. Mahipaul exposes the foundations of White supremacy and ableism in occupational therapy, Tsang and Haque shift and share power, Ahmed-Landeryou et al. talk about how to talk, and Omar and Gill brew a cup of chai to nourish leadership from the margins. Anand et al. tell the story of what living social accountability is like in a national workgroup, LeBlanc-Omstead and Mahipaul ask us to invite critical disability justice and scholars in, MacLachlan and Grenier show how to account for our words, Jacobsen and Seto co-create accountable community services, and Reid and Jecker hand over the mic. Although we don't know exactly what occupational therapy's new home looks like, the voices in this issue help us locate where and how to start.

Making a home

There is rage in this colonial house, but there is no longer a tense silence. There is despair and innovation and trauma and paradoxical hope. Dismantling means we must bear exposure when some have been protected from the elements. Rebuilding foundations is a transformative and uncertain process where we need to ask:

- Who is (re)designing these foundations?
- Who decides what can or should be changed and the codes for how to proceed?
- To which communities have we have been versus should be accountable to within and beyond the profession?
- How do we collectively recognize and heal the harms still caused by our profession?

Living with equity and justice involves a multi-level reconfiguration of governance structures and mechanisms, with attendant resource redistribution, to be a home that is inclusive of, centered on, guided by, and accountable to the voices, capacities, and rights of underserved communities. We all should have keys to the architecture of this house.

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About the authors

Hiba Zafran is a third culture kid, queer poetess, and guest editor for this special issue. She [questions, teaches, creates trouble, practices and gives care](#) on unceded Kanien'kehá:ka territory. She can be reached at: hiba.zafran@mcgill.ca

Naomi Hazlett is the interim managing editor of *Occupational Therapy Now*. She is White, queer, neurodivergent, and lives with chronic pain. They work and live in Toronto, the traditional territories of the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee, and the Wendat peoples. Naomi can be reached at: otnoweditor@caot.ca or at naomi.hazlett@gmail.com

Accounting for our history: Ableism & White supremacy in occupational therapy

Susan Mahipaul

As my fingers rest on my keyboard, I reflect on how I was never taught, as a disabled woman, about the disability rights movement, ableism, and how social practices disable people. The environment around me taught me at a young age that I was a problem, a failure, deficient, broken, and to be fixed. I identify as a white, physically disabled,¹ cisgender, female occupational therapist. Critical Disability Studies (CDS) underpins my practice. I work to understand ableism and how systemic oppression and power are enacted in disabled peoples' lives. I am rooted within the disability rights movement that reinforces that disability rights are hard-fought civil rights that create essential laws. Disability rights reinforce that those of us with disabled identities have the right to be who we are and that we deserve support to live a quality life. I am an ally to Mad Studies and the Mad Pride movement and their work to dismantle sanism—Mad and mentally ill people are not dangerous and do not need to be locked up nor controlled. Within white accountability, I ally with the disability justice movement, led by and for disabled People of Colour (POC) and queer, trans, and gender nonconforming disabled people, recognizing that we exist in a world built for and structured by whiteness and ableism (Brown, 2021; Invalid, 2019; Withers et al., 2019). Ableism reinforces messages of our struggles that occur in interlocking

systems of oppression—messages that disabled people wish to be cured, that we should undergo extensive and invasive treatment and rehabilitation to be normal, and that we suffer, are dependent, and need experts to make our lives better. Beyond the clinical context, ableism teaches us that poor individuals are lazy, incompetent, and irresponsible; that people experience racism because they are dangerous, threatening, or choose to be victimized; that women experience inequality because they exaggerate gender gaps, are weak, and are too emotional/hysterical; and, finally, that one is disabled because one hasn't, or refuses to, try harder.

These ideas are rooted in insidious values. They are dangerous and harm disabled people because they are underpinned by assumptions about body/minds and our lives. They raise questions such as *whose body/minds are worthy* and *whose body/minds are expendable*? They reinforce a powerful message of erasure—you don't belong here—whether in the physical environment, policies, social networks, government supports, or social services. To earn our personhood, we must repeatedly prove ourselves to deserve to be treated as human beings. These ableist principles are rooted in White supremacy, colonialism, heterosexuality, patriarchy, and capitalism. To conform

¹ I use the term *disabled people* within this paper to situate disability as sociopolitical and socially constructed. Some people—for example, institutional survivors—choose person-first language to reclaim their humanity/personhood. Others (e.g., Deaf, Blind, Autistic, Mad) prefer identity-first language to signify difference as defining and important parts of who they are. There is no one politically correct language that represents disability identity. Please ask or learn about which language(s) communities prefer.

to these standards, people are held up to whiteness, wealth and privilege, gender norms—masculinity—and ability. If you cannot prove that you are healthy, strong, sane, stable, smart, and able, then you are considered a problem (Brown, 2021). You are not considered human. You are inferior. Simply stated: *You are broken*. This paper extends the CAOT (2020) statement on White supremacy and racism in occupational therapy. I outline the inextricable links among White supremacy, ableism, and the taken-for-granted construct of disability in rehabilitation, with implications for accountability in occupational therapy. Accountability to underrepresented groups focuses on changing systems and processes so that they align with principles of equity and justice (Ackerman, 2005). To commit to social accountability within occupational therapy, we must understand current systemic oppression, so as not to reproduce normative violence (Titchkosky, 2007). *Normative violence* demands that disabled individuals overcome adversity, undergo unnecessary treatments and interventions to be normal, care for themselves, and live in isolation and poverty. Normative violence tokenizes individuals, silencing them in consultation processes and erasing disabled occupations unique to disabled people. Within occupational therapy, I learned that if I divorced myself from my disability, I would gain credibility, acceptance, and belonging (Mahipaul, 2015). Our health care systems foster the expectation that clients show motivation and compliance, as well as strive to overcome their disabilities. These expectations are entrenched in ableist perspectives, perpetuated by power differentials created by systemic, structural, and institutional oppression with deep roots in a history dominated by White supremacy and colonialism (Brown, 2021; Invalid, 2019).

Ableism as deeply intertwined with racism and other systems of power under White supremacy

“ABLEISM”

A system that places value on people’s bodies and minds based on societally constructed ideas of normality, intelligence, excellence, desirability, and productivity. These constructed ideas are deeply rooted in anti-Blackness, eugenics, misogyny, colonialism, imperialism and capitalism.

This form of systemic oppression leads to people and society determining who is valuable and worthy based on a person’s language, appearance, religion, and/or their ability to satisfactorily [re]produce, excel and “behave.”

You do not have to be disabled to experience ableism. (Lewis, 2021)

Ableism reinforces how systems such as colonialism, disablism, capitalism, and White supremacy interconnect to enact power in peoples’ lives (Withers et al., 2019). Capitalism rewards healthy, strong, whole, stable, capable, sane, functional, intelligent, and productive individuals with political and social advantages—power—over individuals considered broken, deficient, incapable, deviant, unproductive, disordered, weak, unstable, unintelligent, or subhuman (Brown, 2021). Ableism, as a value-based belief system, has firm historical roots resulting in systems of oppression designed by people in power that still underpin society and beliefs in current times.

Between 1880 and 1925, the practice of eugenics painted children and adults with intellectual disabilities as incurable “deviant social menaces” with an inherited trait that “degraded the species,” linked to poverty, criminality, and immoral behaviour (Braddock & Parish, 2001, p. 38). Eugenic beliefs supported class biases against immigrants and the poor, labeling them as unintelligent, incompetent, and irresponsible. The eugenics movement created the beginnings of public control, criminal incarceration, modern asylums, and mass institutionalization of those deemed by the dominant powers as less desirable, deviant, and unconforming. In the early 20th century, “feeble-minded,” inferior, and incapable women faced sterilization, a practice that persists today in relation to intellectual delay, deviance, criminality, and sexual promiscuity, most harshly impacting Indigenous, racialized, immigrant, and refugee communities (Brown, 2021). Physicians counsel expectant parents to consider selective abortions of birth defects, particularly with my disability—spina bifida (Church, 2017). Eugenic beliefs underpin contemporary values and decision making around core concepts such as “triaging care,” “rehabilitation potential,” “reasonable accommodation/ undue hardship,” and “competency hearings.” Compliance, motivation, and the focus on normative goals under the premise of client-centred practice all represent pervasive social practices with ableist roots (Mahipaul, 2015).

The ableist messages of White supremacy include working hard at rehabilitation (fixing oneself), not asking for help and downloading responsibility for care onto the individual/family (independence), and avoiding (erasing/hiding) disability and impairment at all costs (overcoming). Under White supremacy, ableism and racism intertwine as “roots of the same tree” (Kendi, 2021); they are rooted in systemic, structural, and institutional oppressions that hurt disabled people.

For white disabled people, White supremacy reinforces that their disabilities/impairments prevent them from being fully human. This group constantly strives to overcome and hide their disability to *pass* as

“normal.” White disabled people benefit from white privilege at the expense of disabled POC, whom White supremacy views as inferior (Invalid, 2019). Health conditions, injuries, reproductive injustice, and disabilities that result from a lack of drinkable water on reservations—or from old buildings with lead pipes or from substance abuse—represent life inequalities that disproportionately impact racialized and immigrant communities and people living under structural poverty. Disability appears at substantially higher rates in poor, racialized, and 2SLGBTQIA+ communities than in any other privileged community. Structural poverty and violence represent instances where “political inequality positions those who are poor to enact impoverished versions of health and well-being and citizenship” (Kimpson, 2015, p. 325), because their “greatest task is to try to survive” (Farmer, 2003, p. 6).

The ableist roots that underpin the field of rehabilitation

White supremacy uses ableism to allocate service delivery to different groups of individuals, deciding with precision which *kinds of people* deserve help/aid/ assistance, medical treatment, and even to breathe. Under White supremacy, white disabled people can assume a disability identity to access care, funding, and assistance, whereas disabled people with multiple intersectionalities are forced to deny their disabilities when their disability identities would allow them to access care, accommodation, and equal treatment in order to avoid double discrimination (Council of Europe, 2021). White supremacy reinforces white people to hide their disabilities to more closely approach humanness, yet judges disabled people with multiple intersectionalities as inferior, defective, threatening, and deviating from normative (white) values.

Ableism and racism intertwine to ignore people’s civil rights in health care, education, employment, and interdependent relational care settings. POC and other equity-deserving, equity-seeking, and oppressed groups experience ableism as a threat of segregation, isolation, and control due to society’s ableist obsession with building and housing disabled people (body/ minds) in institutions. These structural policies and decisions remain hidden from the public—carried out in secret and silence. Under capitalism, ableism also fuels productivity, teaching disabled people that those who cannot meet “normal” notions of productivity are disavowed. Capitalism leads to members of one group feeling that their rights come at the expense of someone else losing their rights—that accommodations do not mean equitable access to employment but instead represent disabled individuals gaining an unfair advantage. In a capitalist structure that fosters scarcity and limited resources, the strategy of maintaining one political identity separate from another (e.g., Black or

Queer or disabled) obscures ableism as a root in all forms of oppression while maintaining norms of hyper-productivity (Withers et al., 2019).

Accountability informed by a disability justice framework

Disability rights, CDS, Mad Studies, advocacy, and justice networks purposefully define *disability* broadly enough to include people born with and/or who have acquired disabilities; disabilities due to environmental disasters; people living in infrastructures that lead to inadequate housing, food, and water; people involuntarily sterilized; and people living with long-term disability due to illness (e.g., long-haul COVID-19), among others. The Americans with Disabilities Act (ADA) represented a critical achievement for disability rights in western nations. Yet the ADA continues to be perceived as a mere advantage for disabled people, where disability policy, culture, and services are still underpinned by gatekeeping over who has a right to disability rights. Moreover, it is imperative that disability rights are enforced across all race, gender, and 2SLGBTQIA+ identities and for all other oppressed groups panglobally. Disability justice creates a collective network shifting the focus away from disability rights advocacy alone to understanding how ableism lies at the roots of disability oppression.

Disability justice highlights that the achievements of the disability rights movement left us with unresolved challenges, such as focusing on single-issue identities; not accounting for intersections of race, gender, sexuality, age, immigration/refugee status, religious beliefs, culture, et cetera; and that disability rights have been built on white experiences that centre mobility impairments over other disabilities located at the margins (Invalid, 2019; Brown, 2021). As occupational therapists, we must consider whether our perspectives on disability prioritize those who can achieve status, power, and access, all reinforced within the system of White supremacy, or if we can understand the roots of ableism creating systemic oppression for every disabled individual within society (Withers et al., 2019).

Toward an accountable occupational therapy

I encourage you to deeply reflect on (and appreciate your fears of) impairment and what disability/ impairment *means* to you (e.g., tragic, broken, deficient, needs to be fixed/cured) and how you *feel* about disability/impairment (e.g., I don’t want to have it; Michalko, 2002). I have introduced you to disability justice concepts not for you to co-opt disability justice into occupational therapy, but to understand how disabled people centre ableism within White supremacy and other dominant systems. Your further reflection should include how:

- Ableism is entrenched within our scopes of practice, assessments, interventions (i.e., ask yourself if you value function/independence over community living/interdependence?), research, and perspectives on disability and rehabilitation (e.g., did you know that clients feel powerless during rehabilitation, which is incompatible with the notion of a quality of life?).
- Client-centred practice still focuses on our clients first, not on how society constructs disability in our clients' lives. How do our client-centred goals perpetuate ableism for clients (i.e., requiring change in behaviour, striving to overcome and to be "normal")?
- We seek/expect compliant and motivated clients. If a client expresses choice and control—not normal function and absolute independence—do we document their noncompliance and unwillingness to meet our notions of normative, ableist goals?

As a disabled occupational therapist, I am held accountable to the practices, policies, and procedures—our competencies—that govern our profession. These competencies were created mostly by white, able-bodied/minded, *healthy* female practitioners. I ask my able-bodied/minded colleagues to reflect on your understanding of ableism so that you can be accountable to me (a disabled occupational therapist), my disability community, and disabled colleagues. This would demonstrate a commitment to social accountability where disabled practitioners and clients can monitor, enforce, and, most importantly, sanction the profession for ableist beliefs, policies, and practices (Lodenstein et al., 2013, p. 3).

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About the author

Susan Mahipaul, PhD, OT Reg. (Ont.), can be contacted at: susan@dhnava.ca

Enabling equity starts from within

Amie Tsang & Zehra Haque

This article is a summary of and reflection on the keynote presentation at the 2020 Ontario Society of Occupational Therapists Conference, “Rising to the Challenges of Change,” which used health equity as an entry point to understand and respond to issues of inequity—an ongoing challenge for health providers. The article’s premise can be summarized by the following question ([with all due respect to internationally-renowned drag queen RuPaul](#)): “If we can’t enable equity within the profession, how are we going to enable equity for the people we serve?”

Zehra Haque and Amie Tsang collaborated to create the keynote presentation and this article. Zehra and Amie met through the Equity, Diversity, and Inclusion Committee within the University of Toronto’s occupational therapy department. For clarity, collective pronouns reflect Zehra and Amie’s collective voice and singular pronouns reflect Amie’s voice.

Our approach to putting together the keynote presentation gave us the opportunity to reflect on the nuances of our own positionality. Together, we shifted power by using a collaborative approach between clinician and student: a relationship with inherent power dynamics. We also made sure to rely on both process expertise, such as facilitation and presentation skills, and content expertise, such as using our lived experiences as part of our expertise. Though it is important to center experiential knowledge, our experiences as under-represented people in our profession have revealed that *tokenism* remains a challenge; we frequently witness unspoken expectations that conflate expertise in lived experience with expertise in educating others without adequate acknowledgement of the labour involved in using lived experience as educational content.

After observing Zehra’s facilitation skills in the classroom, I (Amie) invited Zehra to join the keynote by leading a reflective activity about social identity and positionality as an integrated part of the presentation. Conference organizers said this was “unconventional”, but they supported the idea as it modeled an example of rising to the challenges of change. Our intent was to invite learners to consider personal accountability in the context of our oppressive healthcare system as a critical component of grasping social accountability. We therefore begin with a brief overview of the recent history of understanding equity in Canada, share reflections as it relates to personal accountability, and conclude with a tool for self-reflection.

Understanding the roads to equity

Equity discourse in occupational therapy has historically emphasized increasing equity in service delivery, with much less emphasis on shifting power and enabling equity within the profession (Trentham et al., 2019). Canada has largely followed the same pattern. By establishing a timeline for understanding equity in Canada through different and related concepts (Ojo, 2019), we contextualize the equity journey for Canadian occupational therapists. The following timeline is not meant to reflect when each equity-related concept was developed; we note that anti-racist advocates have been active critics of each concept. Rather, the timeline reflects the moment of each concept’s widespread adoption.

We begin with an acknowledgement that there are deeper and more insidious roots of how Canadians understand equity with respect to colonization and Indigenous communities, and that unpacking this goes beyond the scope of this article.

Our timeline starts in more recent history, with concepts still in use within the profession. Canada formally adopted multiculturalism in the 1970s, which guided Canadians towards increasing openness to immigration and away from *colour-blindness* (Azzahrawi, 2020). As more cultures became a part of Canada’s “mosaic”, diversity & inclusion (D&I) took hold in the 1990s. Despite D&I’s social justice roots, business management co-opted the movement as a corporate litigation shield against claims of harassment based on identity (Tran, 2021). Cultural competency, and all its related terms, were developed after D&I, but became especially popular in healthcare education around the same time as D&I.

As Grenier articulates, “...cultural competency should be regarded not as a response to, but rather as a logical product of, institutionalised racism that functions as a tool in the reproduction of White supremacy in healthcare systems.” (2020, p. 3) Indeed, multiculturalism, D&I, and cultural competency have all been criticized for becoming tools that focus on changing individual behaviours as opposed to changing systems, policies, or procedures that reinforce and/or maintain the current power and hierarchy within our oppressive systems (Azzahrawi, 2020; Tran, 2021). For example, when workplaces add a racial diversity statement to their job posting without putting any effort towards ensuring anti-racism policies are in place, they increase the number of racialized workers in harm’s way. Critical concepts such as anti-racism and anti-

colonialism push us forward towards systemic thinking; however, we must be careful that the concepts do not also become co-opted in the system's favour, making it about reputation and tokenization rather than justice and equity.

Health equity is a great entry point for occupational therapists to understand equity as a whole. As defined by Health Quality Ontario, "health equity allows people to reach their full health potential and receive high-quality care that is fair and appropriate to them and their needs, no matter where they live, what they have or who they are" (n.d.). This definition gives room to occupational therapists to focus on individuals—still typically the focus of their work—while keeping the system in mind.

Without implying that dictionaries are definitive authorities (a form of colonial thinking), Merriam-Webster updated the definition of racism to include prejudice **plus** social and institutional power in 2020 (Zimmer). As a profession, and as Canadians broadly, we spend a lot of time unlearning

prejudice, but not a lot of time disrupting power. This is an occupation worth engaging in.

Understanding personal accountability

When I (Amie) began teaching in 2015, I felt I was trying to sell learners on the importance of understanding equity in healthcare. During the pandemic, more people became aware about issues of health equity, even if the media was not explicitly using this term. Learners in occupational therapy programs now come to the classroom equipped with basic equity knowledge. I attribute this partially to a growing social understanding and partially due to increasing diversity within incoming student occupational therapists, who have personal connections to issues of inequity.

Despite these shifts, confusion between responsibility and accountability remains a barrier for learners. Responsibility is a duty to complete a task, while accountability is about taking ownership of the task's results. In the context of systemic equity, this means we must be accountable and address inequities through

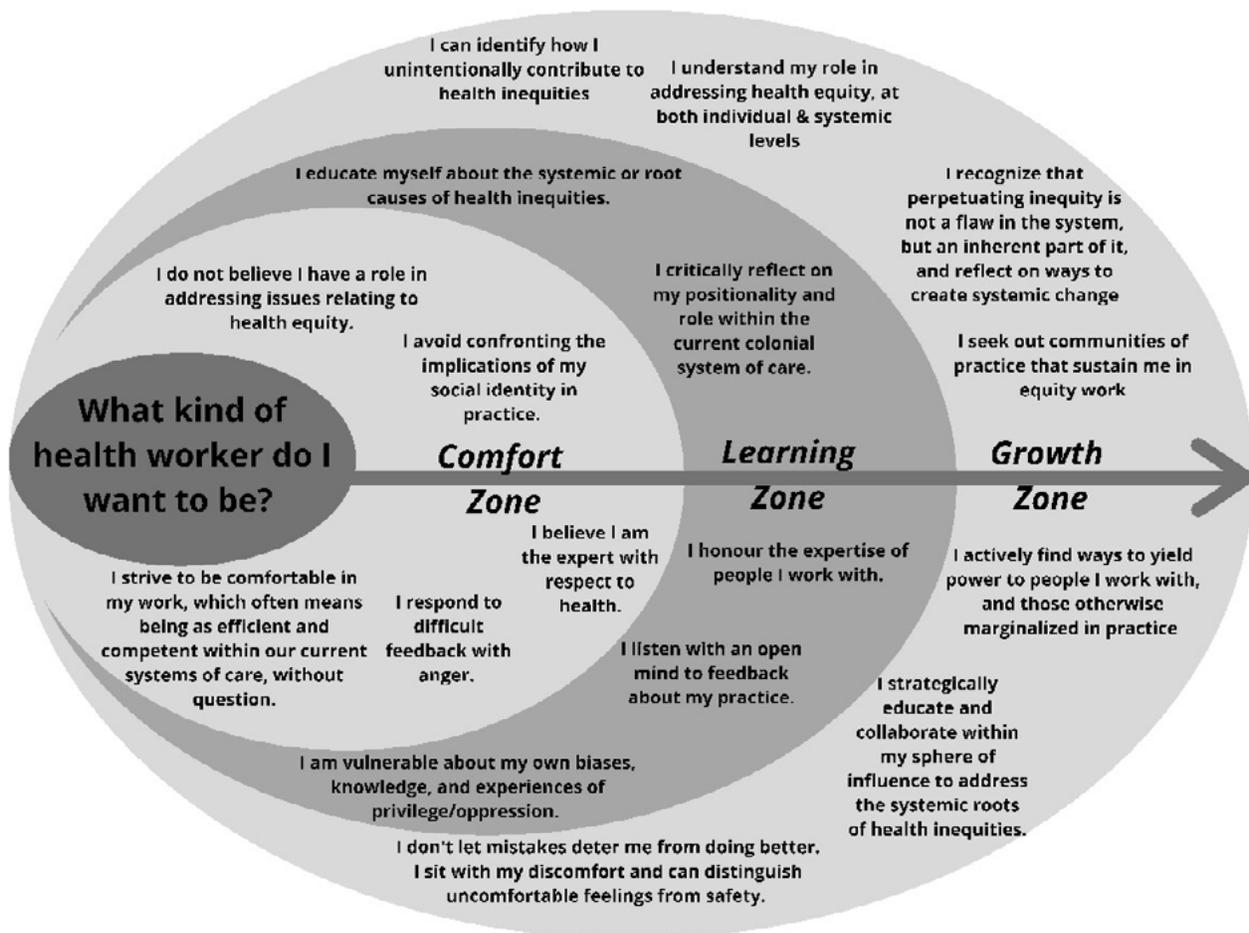


Figure 1. This chart was adapted by Amie Tsang, MScOT, OT Reg. (Ont.) from "Becoming Anti-Racist" chart by Andrew M. Ibrahim MD, MSc., who adapted work from Ibram X. Kendi (2019). Framework based on "Who Do I Want to Be During COVID-19" chart, credited to journalist Celina Canales.

action, even if we as individuals are not responsible for causing them in the first place.

I observe two main pathways stemming from this confusion. First, learners may shut down and reject concepts surrounding equity because they do not feel any personal responsibility towards the issues. Alternatively, this confusion may lead learners to hold themselves responsible for all inequities in the system. Somatic coach Garina (2021) articulates these issues as *under-* and *over-accountability*, respectively, and advocates for a more centered approach.

Personally, I began by learning equity-related concepts as a frontline occupational therapist, applying them to individuals I supported. My career is focussed on structural poverty, and I work primarily with people who are unhoused. It wasn't until I began a new job facilitating workshops about health equity, as well as experiencing personal issues related to health equity, that I grew increasingly frustrated at the divide between increasing knowledge about health equity and implementing action to enable equity. I fell into the trap of over accountability. I entered the profession believing I could make a difference and felt distressed when I faced the realities of systemic oppression. Logically, I know that I cannot solve problems like homelessness or racism, but emotionally, I desperately want to end suffering that I perpetuate but did not cause.

This is why I now pair conceptual understandings of equity with critical self-reflection and action. Personal accountability is a key component to social accountability—it is about tuning in with yourself first, to know who and what you are actually accountable to and for, and what your sphere of influence is, so that the tasks you assign yourself to be responsible for, with respect to changing systems, are realistic and centered between over and under accountability. Effort towards understanding personal accountability helps us move beyond shuffling resources around to address individual needs, and towards meaningful systemic change.

What kind of health worker do you want to be?

I developed a chart keeping in mind the aforementioned challenges of teaching about health equity. With ideas from Kendi's (2019) work, the chart is an amalgamation of two others. Through reflexive dialogue with colleagues in the community mental health sector (including peer support workers, recreational therapists, social workers, and occupational therapists) I changed the former fear zone to the comfort zone to acknowledge most health workers do not enter this work out of fear, though fear is a possible motivation to stay in the comfort zone.

The four main behaviours addressed in the chart are: enabling health equity, responding to feedback, valuing expertise, and reflecting on positionality and comfort level in practice. It's important to note that people enter from a different zone for different equity-related topics. In a colonial Canadian context, we commonly begin in the comfort zone, comfortable knowing what we know and ignorant and/or avoidant to what we do not know. We move to a learning zone where we acknowledge what we don't know and begin to challenge our biases. The growth zone is where change happens; we lean into discomfort, do the life-long work of unlearning, and begin to shift power. A key component of the *growth zone* is that it is where we move from theory to action.

The chart is not meant to be unidirectional. Certainly, it is ideal to move in a forward direction towards growth, but realistically, we often oscillate between zones, such as entering the learning zone, becoming unsure what to do with new information, and returning to complacency and comfort. The chart can be used for self or group reflection and to set goals for movement towards growth.

Our profession needs to move beyond examining individual biases through a competency-based paradigm, which is the dominant discourse in current occupational therapy education (Grenier, Zafran & Roy, 2020). Addressing prejudice will continue to be an important part of the process, but if reflexivity and individual notions of responsibility continue to be separate from accountability and the context of disrupting power, there will be no meaningful change.

Systemic change and social accountability cannot be addressed through personal accountability alone, which is why part of the growth zone includes seeking community. We consider addressing equity within our profession to be a form of professional accountability; something to be addressed as a collective of occupational therapists. Though this article focuses on personal accountability and does not address what can or should be accomplished as a collective, the root message is the same when considering institutional, professional and/or social accountability: it must begin from within, because "if we can't enable equity within the profession (or ourselves), how are we going to enable equity for the people we serve?"

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About the authors

Amie Tsang, OT Reg. (Ont.) and **Zehra Haque** live and work in Tkaronto. Amie is a Queer, Chinese Canadian woman, with past experience as an occupational therapist in community mental health and current experience as a writer and educator in the same field. Zehra is a Muslim, Pakistani, first-generation Canadian woman and recent graduate of the University of Toronto's occupational therapy program. Amie can be contacted at: amie.tsang@gmail.com

Pause, reflect, reframe: Deep discussions on co-creating a decolonial approach for an antiracist framework in occupational therapy

Musharrat J. Ahmed-Landeryou, Isla Emery-Whittington, Sheela Roy Ivlev, & Rebecca Elder

It is no longer a question of *if* the profession is racist; it is a matter of telling the truth about how, where, and when racism occurs within occupational therapy's structures. Since 2020, tackling institutional racism within this profession has occurred at pace with activist scholars and collectives taking direct action—for example, an open letter to the Royal College of Occupational Therapists from BAMEOTUK Network (2020). These acts of open protest have forced the profession to discuss racism after 104 years (Kronenberg, 2020). Liberation is about *process* and *outcome* and is perceived in the briefest of conversations and largest of rallies. If antiracism is collective liberation (North American Students of Cooperation, 2015), then liberation and the status quo of the profession are currently incompatible.

Knowing this, disrupting racism within the profession must extend to practice models, attained by—but not easily—altering the process of model development so that the *process is itself* decolonising. Antiracism and *liberation as process* centre collaboration that deeply examines the structural and environmental conditions that promote and hinder equity and justice, thus enabling impactful change. To date, racism and oppression have not been, cannot be, and will not be disrupted from the Global North segment of the profession because there is

no plan to end them. After decades of bearing witness, Global South heritage *disruptors* (fighters of all forms of discrimination and oppression) and *co-conspirators* (collective of disruptors) from the profession, such as the DisruptOT collective, gather to share reflections, to strategise, and for community and agency.

This reflective commentary is written by four occupational therapists, one of whom is also a social worker. We are cisgender women of different ethnic, sexual, and ability identities. We each bring unique experiences and perspectives and use these when storytelling to disrupt the status quo of institutional racism (Bell, 2010) in occupational therapy education and practice. In September 2021, following the first DisruptOT summit, we gathered to discuss co-creating a preliminary concept map for an antiracism occupational therapy framework. A visual was inspired by the Power and Control wheel and corresponding Equality wheel developed by the Domestic Abuse Intervention Project (1984) in Duluth, Minnesota, and the Dismantling Racism wheel created by the Women of Color Caucus and Social Justice Task Force of the Virginia Sexual and Domestic Violence Action Alliance (2014). There are many versions of these wheels used in several languages for anti-oppression and antiracism work worldwide as they are open sourced for this

purpose (Immigrant Women’s Support Service, 2021). They inspired us to consider how occupational therapy education, practice, research, and policy might benefit from antiracist frameworks. As we started imagining possible adaptations, our conversations integrated intersectionality, that is, critical race, gender, sexuality, class, geopolitics, and ability lenses to occupational therapy. Here, we outline aspects of the collaborative process of exploring the potential of and for an antiracism model of practice in occupational therapy, which demands active creation and coproduction of equalising conversations between disruptors and co-conspirators.

To me, the circle shape reflects cycles in nature and helps remind us humans that we are part of nature. Circles are engaging and seem to denote perpetual motion—dialing, rotating, revolving, always in motion. (Isla)

The pause

During our first virtual meeting, we spent time building connections to engage in a sacred process of honouring each other’s stories, ancestors, lands, drives, and trauma. However, in a response to a rush to meet a deadline, we arrived together to a kind of pause, a comfortable silence, to question our reaction to fill a predetermined gap and, consequently, the possibility that we may be recolonising a professional conversation rather than sharing our agency, energy, and humanity. Audre Lorde cautioned that change does not happen by using the “master’s tools” (1984). We needed to find the questions we wanted to answer (Cojocariu & Butnaru, 2014) to avoid recycling a colonial vision of wellbeing and healthcare.

To me a circle speaks of the whole of life. (Rebecca)

Reflect: What are occupation and occupational therapy?

These questions arose early, perhaps as a search for common ground and to ensure that we actively resist assumptions about having a shared understanding of these concepts. Almost immediately, we came to the well-trodden track that occupation is defined and understood so differently and expansively and that, in fact, this was not common ground for us. We agreed that much of the profession’s infrastructure is dominated by the ideological parameters and philosophies of the English language, potentially limiting collegial sharing of global theorizing, education, and practice of occupational therapies (Guajardo et al., 2015).

We fostered our accountability by sharing personal and collective intentions and exploring what lenses we bring to this work. The collective nature of this process was critical, and so the space created was affirming and equalising. Deep acknowledgement is part of the re-humanising energy and conscious healing that people can bring to each other. We all noted that this kind of

process is rare within the profession’s mainstream spaces and shared our frustrations with the over-representation of colonising ideologies and practices. The decolonisation energy of reverently perceiving each other as contributing, dedicated, and whole humans guided our exploration of possibilities rather than crystallising concrete answers, tick boxes, and checklists.

During our second meeting, where we considered the next draft, it became even clearer that we could not treat this as a production line for a well-defined end product-as-outcome. The connections that are so important to enabling potential co-creation of an antiracism wheel(s) for occupational therapy require time and global collective voices. In this meeting, we shared our individual experiences of confronting racism in professional settings and the resulting exhaustion. This unfolding led to conversations about who bears the responsibility for doing “the work” of disruption and liberation. Evidently, engagement in self-reflection and cultural humility have not unburdened the load. We considered the social change process of domestic violence and how, initially, the burden for change was placed upon “victims” or “survivors” of the violence, often women, rather than perpetrators who were generally, though not always, men. Similarly, and in spite of privilege and opportunity, our collected experiences highlight that the Global North is yet to meaningfully share in the heavy lifting of disruption and liberation.

Reflect: Why do we still think that models of practice will be universally culturally relevant?

Global North theories and models are steeped in the values and ideologies of colonialism and dominate the profession (Hunter & Pride, 2021) despite negligence and even harm to racialised communities (Gordon-Burns & Walker, 2015). The epistemology of ignorance (Sullivan, 2007) is a useful lens to critique the profession’s slippery relationship with knowledge. That is, amongst calls to develop frameworks, fill knowledge gaps, and unlearn racialised ways of knowing on a backdrop of institutional racism, one thing remains a constant: power remains where it is. Further, such solipsistic meanderings have yet to evidence either equity, an end to racism, or justice, occupational or otherwise (Emery-Whittington, 2021).

Occupational therapy was conceived under the myth that *by* white people is *for* everyone (e.g., Anderson & Reed, 2017; Wilcock, 2002). Occupational therapy has countless models and frames of reference to abstract and explain in order to plan how to meet the person’s needs, but they are not explicitly representative of cultural relevance beyond Eurocentrism. This circles back to our original intention of creating an antiracist and liberation (Love, 2013) model that is fully conscious of power and intersectionality. Tapping into and making space for creative moments sparked imagery of circles, spirals, life

cycles, and wheels, intersected to support and convey the energy of the spoken word to paper. We shared a number of philosophies and models, including elements of the Transcultural Model (Drabble et al., 2012) used within social work programs, which was created with attention to respectful partnership; positionality and self-reflexivity; awareness of power, privilege, and oppression; and cultural knowledges.

We recognised that constant vigilance during model development is necessary to prevent slipping into the colonising habit of promoting deficit-based approaches. Instead, we privileged actions and goals that promote justice-based approaches, meet needs, and honour rights of all communities. In other words, people don't have to fit models; rather, models need algorithms of antiracism and liberation designed into them to honour all people.

I associate it with the Wheel of Life, which represents the Karmic cycle of birth, life, death, rebirth, and everything associated with being. (Sheela)

Reflect: How might an antiracism frame contribute to socially accountable occupational therapies?

There already exist an infinite number of possible solutions and concepts for socially accountable occupational therapies, such as occupational consciousness (Ramugondo 2015). As our global equalising collaborative processes have shown, antiracist model development is not only possible but absolutely necessary wherever institutional and structural racism are experienced. When people connect with their therapist, they hope to be seen for who they are and all the social and occupational possibilities that exist for them and theirs. It is possible that antiracism occupational therapy frameworks might at a minimum provide a medium with which to check practices and organisations. Consequently, such levels of integrity and social accountability are supported by making the focus to be socially responsible first, especially as accountability alone is not enough (Davis, 2016). That is, to be socially responsible and accountable, we must be cognisant of the hegemony that is dominant in our current practices through the everyday and disrupt it (Ramugondo 2015).

It's just continuous, never ending, and that's what the work for antiracism is; you have to keep checking you are fit for antiracist purposes as individuals, services, and organisations. (Musharrat)

Conclusion

We disrupted a "usual" process of initiating model development through the gentle acknowledgment of professional experiences of racism and oppression and our disinvestment in reproducing such processes. Using the imagery of circles/wheels, we contributed to a wider

plan of socially accountable occupational therapies that might inform liberatory processes. What we learned is that the process and content of model development requires deliberate collaborations of global disruptors and co-conspirators, constant vigilance, and refusal to engage in colonising processes and habits, in order to foster social accountability enacting occupational consciousness. So, readers, where to now?

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About the authors

Musharrat Ahmed-Landeryou (she/her/hers), SFHEA, MSc Clin. Neuro Sci., CLTHE, Lic. TCM Ac., BSc Hons Occ. Ther., BSc Hons Phys. with Med. Applic., is a senior lecturer at London South Bank University, and two days a week she is a student success and antiracist education practitioner. She is a co-founder of the BAMEOTUK Network, a campaign and pressure group of Black, Asian, and Minoritised Ethnicities (B.A.M.E.) students, staff and educators, to promote equity and justice from the occupational therapy profession body and in education and the profession in the United Kingdom. She has been on local and international events discussing why we need to decolonise occupational therapy and science. She is currently doing her PhD on the topic of service improvement and occupational therapy. She can be reached at: ahmedlmj@lsbu.ac.uk

Isla Emery-Whittington (she/her/ia) is a Māori wahine from Aotearoa NZ and affiliates to Rereahu and Ngāti Kahungunu ki Wairarapa tribes. A PhD candidate with the SHORE Whariki Research Centre, Massey University, Isla conducts research examining everyday occupations as sites of transmitting and disrupting colonialism. Isla can be reached at: isla@whittington.nz

Sheela Ivlev (she/her) is an occupational therapist specializing in mental health and wellness, currently in private practice. As a South Asian woman born and raised in San Francisco, the unceded ancestral homeland of the Ramaytush Ohlone, she understands health and wellness from diverse perspectives and values the connection of culture and healing. She is committed to removing the barriers to care that keep people from accessing health and wellness services. She can be reached at: sheela@otbayarea.com

Rebecca Elder, MS OTR/L, MSW, LCSW, (she/her) has practiced occupational therapy for years in a multitude of mental health settings. She is also a Social Worker currently practicing in mental health in Humboldt County California.. She lives and works in Northern California in the ancestral homeland of the Yurok, Wiyot, Hupa, Karuk, and Tolowa Tribes and the Whilkut and Tolowa Nations. She specializes in sensory modulation and trauma-focused, strengths-based care using the Transcultural and Wellness and Recovery models. She is caucasian and differently-abled and continues to learn how to do anti-oppression work and how to be aware of her own racism, classism, and privilege. She can be reached at: practiceswot@gmail.com

Towards reimagining and fostering a new era of accountability in occupational therapy: The narratives of building a collective

Samira Omar & Tanjot Gill

Moving beyond narratives of hope, equity, and justice: The catalyst

Embracing leadership does not look or feel the same when students of Colour take the lead. The same dynamics and systemic barriers that society has attuned to in the last year are obstacles for racialized students in leadership roles. Occupational therapists must be both responsible and socially accountable for addressing the needs of communities they serve and research. But what does this look like and who decides it? Social accountability involves leadership by and with those who are deeply impacted by an unjust system and are underrepresented in it. We reflect on a cocreated event that centred on the voices of BIPOC occupational therapists to highlight our experiences with taking leadership.

We are two students in rehabilitation science, occupational science, and occupational therapy

from the University of Toronto who, along with four other peers, co-led and co-created a two-day virtual event in July 2021. The event aimed to bring together BIPOC students and allies across occupational therapy and occupational science programs in Canada to build community, share narratives, raise critical consciousness, and foster a new era of social accountability. We think of moving beyond narratives of hope, equity, and justice as a point of departure to mainstream conversations and intentions around diversity and inclusion and desires for a better tomorrow. This was an opportunity to reflect, challenge, and move towards structural understanding, collective reimagining, and praxis. Our pedagogy is rooted in an anti-racist lens that acknowledges the importance of sharing and understanding as a means towards transformative change, not an end in and of itself.

The event was our call to action. Over the last years, we have advocated and held space for dialogues about White supremacy, equity, justice, anti-Black racism, anti-Indigenous racism, racialization, intersectionality, and so much more. We organized together, bonded over our differences and similarities, and shared amazing moments that will last a lifetime. We created this event out of shared frustration, genuine curiosity, and the belief that occupational therapy has the potential to solve some of life's most pressing issues. We asked: how do we be, do, participate, and belong in an unjust society? We wondered where that left us as racialized students committed to breaking barriers to enabling everyday doing and living.

Have you ever felt the feeling of missing something you didn't even know you needed? This event was just that. In promoting the event, we tweeted, "if you didn't register and show up, then what are you doing?". The conversations were profound, deep, provocative, and stimulating. Here, we recount and reflect on our process and experiences during this event, and provide guidance for other under-represented student-leaders (see Table 1).

Aromatic spices: The chronicles of building a collective

Recognizing situations that impact ethical behaviour starts with the relationships we have with ourselves and those around us. We have our own beliefs and values, but during the event, we shared a common vision and hope for a better tomorrow where occupational therapy would serve as a tool to overcome some of life's most pressing concerns. bell hooks (2003) named *trust* as the foundation to humanize all relations, relations which form in mutuality in the face of immense difference and separation. The occupation of being a racialized student is a tenuous and fraught one in colonial and White-dominant institutions, which means that we must heal ourselves and our families alongside the people we will be working with. Engaging in an occupation for the sake of survival and healing requires a different form of relationship building, one that embodies a genuine commitment to trust, honesty, and fostering a sense of belonging for the long run. When you do find your people, and you can be you, share ideas, and bring out the best version of yourself, then you nurture these connections with care.

Ramugondo and Kronenberg (2013) refer to collective occupations as everyday doing and being with the sole purpose of coming together in solidarity and connectedness towards a common good. What we did not consciously process was that in those moments of

Table 1. A cardamom recipe for fostering belonging.

Cardamom Recipe for Fostering Belonging
<i>Select a focus:</i> What do you want to organize about and why?
<i>Create a plan and outline:</i> Map out your ideas
<i>Create roles and delegate tasks:</i> Who is going to do what and what will that look like?
<i>Seek funding support:</i> Are there funds in your institution or professional associations?
<i>Share ideas and collect feedback:</i> How would you do this in a way that is collaborative rather than competitive and leaves space for all voices?
<i>Negotiate speakers and secure spots:</i> Who do you want to invite and why?
<i>Create day of event themes and questions:</i> How can you work together as a team to brainstorm and produce this?
<i>Connect with speakers ahead of the event:</i> To become familiar with one another and provide a space to ask any questions in preparation for the event.
<i>Create a social media presence on Twitter, Instagram, and/or other platforms:</i> As a method of disseminating knowledge, engage others, encourage students to sign up, and learn from one another.
<i>For example:</i> We used Mighty Networks as a platform to begin to build a community and get to know one another days leading up to the event.
<i>Co-create a script for moderators and hosts and rehearse</i> to deliberately choose words and intentionally create a welcoming safe for all.
<i>Nights of the event:</i> Bring all the sweets and spices together, have fun, and enjoy!
<i>Debrief</i> with team, celebrate, and back to the drawing board!

organizing together, sharing experiences, healing, and learning from and with one another, we were building the basis of a collective through collective occupation. This was our fire to cook our chai.

Whipping up a warm chai: Setting the aim

Setting the aim was like putting together a warm chai on a cold winter day—to slow down and think things through. It was meticulous and satisfying. We co-created the foundations of a community that fosters critical hope via collective reimagining and social change. *Critical hope* is not the same as traditional or mainstream forms of hope. It entails seeing the world in a dual reality: one that works in the struggle and the painful realities of our intersections but also sees the light and the possibilities for a world where change is achievable. Engagement with critical hope involves a

push away from its enemies “fear, apathy, isolation, and despair” (Bishundat, Phillip & Gore, 2018, p. 94). Critical hope is praxis through reflection and action.

You know that gut feeling you get when you pull off something remarkable, that meant so much to so many different people? We pushed the boundaries of reimagining and put hope in action. BIPOC students expressed their excitement and contentment for the space we created and the stories we shared. For some, this was the first time that they could have honest conversations about the struggles they face as humans, caught up in what Crenshaw (1989) describes as the *matrix of domination*, referring to the organization of power in society. For others, the need to stand outside the predetermined molds of diversity, equity, and inclusion was dire to unmasking the erased narratives of BIPOC peoples. Our version of equity, justice, and inclusion is one where we all belong, are heard, and seen. To this extent, that means a shift in paradigm away from dominant discourses where the unspoken narrative is that we should be grateful for our existence in these institutional spaces and the assumption is that it is welcoming, equitable, and inclusive. As student leaders, we fostered a new sense of possibility in occupational therapy where we elevated and maintained the voices of BIPOC students—our human survival depends on it.

Key ingredients: Cardamom for fostering belonging

We were critical and intentional at every step, from our design, to generating interest and engagement in the event, who we invited, and what we asked of others. Early in the planning process, members of the collective shared the ideas of our event at the annual anti-oppression learner-led symposium at the University of Toronto. Later, we hosted a Conversation That Matters session at the CAOT Virtual 2021. We checked in with one another frequently, some of us daily. Key to our cooking was maintaining the presence of all our voices from our agenda to our scripts. We created a social media presence and a Mighty Networks platform to start the dialogue prior to the event. Potential participants were invited to respond to reflective questions on social media and got to know each other on the platform. Each step was iterative and complex like a fresh cardamom that is fruity, minty, spicy, and citrusy. This was our recipe for fostering belonging among racialized students in occupational therapy and science. A recipe for catastrophic hope and happiness.

Over the two days of the virtual event, we engaged in dialogue in a series of panel discussions with BIPOC scholars, educators, and clinicians working across different settings including academia and the care

continuum. Dr. Khalilah Johnson engaged with us in a thought-provoking, radical reimagining of justice, equity, and inclusiveness in occupational therapy. Her keynote was followed by a panel of interdisciplinary occupational therapists sharing counter narratives and raising critical consciousness. At the end of the first night, students engaged in a silent reflection. On the second night, we engaged in dialogue about critical hope, restoring balance, reimagining, and fostering a new era of accountability reflecting on where we go from here. We had a graphic recorder assist us in visually and vitally capturing the participants’ narratives. Since we were asking and answering questions often left out of the academic space, we sought a way to present these co-created learnings through a means aligned with the beginnings. Please visit Athulya Pulimood’s Instagram highlights or Facebook photo albums for images from the ‘occupational narratives’ event.

Mindful sharing: Reflective narratives and lessons learned

Our collective reflects on our experiences and hopes for the profession of occupational therapy following the event.

I often wonder: if human occupation is the root of our existence, are occupational therapists equipped with the right tools to address some of life’s most pressing questions and concerns? What does it mean to be experts in enabling occupation? What does that mean for people who are Black and experiencing disability? Can OT actually be about change that considers the unique needs of different communities of people and not one whose interests converge with the status quo? When we talk about diversity, why does it have to be masked within the context of BIPOC? Diversity for whom? Can OT as a profession break unique barriers to participation for people who are Black? - Samira Omar

I long for feeling a sense of comfort and confidence with existing in this space of occupational therapy. - Tanjot Gill

An occupational perspective has the ability to create connection and transformation in the context of doing, not only amongst people, but between communities and generations. However, we must be eager to turn that lens onto our profession; to inwardly examine being and doing as we do for those in our care. We must be encouraged to care for the parts of us that are told they exist in contradiction of what it has historically meant to “become” an OT, or an occupational scientist. What parts of us are asked to shrink in this journey of becoming? When we are celebrated for showing up as our full selves, we can hold each other accountable to these values and

thrive as clinicians, students and communities. - Amanda Mah

What would allyship look like if it challenged the notions of “perfectionism” and “right to comfort” that are inherent in White supremacy culture? -Madeline Maio

Does the OT lens truly allow us to appreciate the complexities of human life and connection? How can we continue shifting this lens to foster more acceptance and harmony? - Anoli Shah

I wonder how revolutionary OT could be within the larger healthcare system. What if we from marginalized backgrounds did not exist in pockets of resistance? What if we were not invited to the table for change as little tokens and tools of White supremacy that ultimately maintain the status quo. I do not want to engage in change-making with a scarcity mindset, one that makes us believe there isn't room for all of us non-white folks to exist in the same sphere of leadership - Zehra Haque

Next steps and food for thought

Occupational therapists do not exist in isolation but in relation to one another and the surrounding society they inhabit. Raising critical consciousness entails ongoing reflexivity and intentional awareness of how power, privilege, and inequities show up in our everyday relations and are maintained by interdependent institutions and systems. We believe it is important to continue nurturing the cardamom of critical hope and curating more opportunities to craft warm cups of chai as a collective occupation with and among those of us who are racialized in the profession. We wish to share the exciting news

that we plan to continue the dialogue through the forthcoming launch of our podcast *Occupational Therapy Futures* and a speaker series on *Conversations that Matter*, so stay tuned for more updates in the future and follow us on Twitter and Instagram (@OcNarrativesHEJ).

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About the authors

Samira Omar is a PhD Candidate at the Rehabilitation Sciences Institute, University of Toronto. Her doctoral research focuses on the Black experience in traumatic brain injury rehabilitation and the ways in which racism shapes occupational life trajectories: samira.omar@mail.utoronto.ca

Tanjot Gill is a recent graduate of the MScOT program at the University of Toronto. She is currently practicing as a community-based occupational therapist in Vancouver, BC: tanjot.gill@mail.utoronto.ca

Living social accountability praxis: A working group's narratives

Havelin Anand, Marianne Baird, Giovanna Boniface, Fizza Jafry, Leanne Leclair, Susan Mahipaul, Samira Omar, Elizabeth Pooley, H el ene Sabourin, Ruheena Sangrar, & Hiba Zafran

In June 2020, the Canadian Association of Occupational Therapists (CAOT) released a statement taking a stance against racism and White supremacy. One of the actions that quickly followed was the decision to “retire” the 2014 *Joint Position Statement on Diversity* and, in partnership with Occupational Therapy Canada (OTC), craft a joint position statement (JPS) on equity and justice. For OTC, this initiative was a strong fit with its ongoing discussions about equity and belonging in occupational therapy. What was initially anticipated to be a three-to-six-month task turned into a two-year, multi-level, iterative, and ongoing process. Within a global context of openly reckoning with colonial genocide, systemic racism, and failures of neoliberal capitalism during a pandemic, OTC selected social accountability as a framework to help define the JPS’s principles and shape its development.

The United Nations Development Programme (UNDP) introduced social accountability (SA) in the late 1970s with the core belief that a people’s participation is essential for survival (UNDP, 1993). Integration of SA in both the health and development sectors soon followed, with a focus on the rights and priorities of under-represented citizens, as identified jointly by and with citizens in respectful partnerships (Boelen & Heck, 1996; Aslam et al., 2015). In health care, social accountability is described as “the capacity to respond to society’s priority health needs and health system challenges to meet such needs” (Boelen, 2016, p. 101). SA initiatives in the development sector seek to transform institutions and foreground accountability, transparency, and participation as key to advancing objectives (Aslam et al., 2015; Halloran, 2015). After selecting SA as a framework, a member of this working group completed a comprehensive review of published and grey literature to inform the development of principles that would guide the JPS. The aim of this article is to share three principles supporting SA, describe how we applied these principles to our own group processes, and illustrate some of the challenges and lessons we learned.

Respectful partnerships engaged in inclusive decision making

When CAOT first reached out to me to ask for two reps on the working group, I didn’t want just two people to have to represent all diversities. I reached out within the Occupational Therapy and Indigenous Health Network and the Justice, Equity, Diversity and

Inclusion Practice Network, and then I wrote back and explained that it was important to have five diverse members to widen the identities and professional experiences represented, and to be in equal number to OTC reps...and that those who are part-time or students should receive honoraria. —Hiba

Social accountability involves amplifying voices and collaborative methods (as well as confrontational ones) of citizens and communities, with the goal of participation, engagement, and empowerment (Aslam et al., 2015). CAOT, in consultation with the other organizations, decided to balance the composition of the working group so that members with experiential knowledge were equal in number to those with formal OTC positions. Later, to promote inclusion with attention to power dynamics, we agreed that the first reviewers of the JPS would be occupational therapy groups that identify as equity deserving, completing their reviews of the draft JPS prior to the OTC.

With our own group processes, we avoided relying on a consultation model of opinion gathering, instead actively seeking feedback through multiple avenues (e.g., individual chats, emails, and asynchronous writing in joint online documents). This amplified opportunities for all voices to be heard, challenged Western norms of quick processing and immediate responses, and provided ways of opinion gathering outside of the power dynamics of meetings. In addition, leadership from staff within OTC’s institutions who identify as part of an equity-deserving group helped legitimize the decentering of knowledge from formal leadership to those with experiential knowledge. These efforts support synergistic participation, which includes taking time for dialogue, clarification, and anti-oppressive consensus to improve the effectiveness of action (Boelen, 2000). Such efforts allow partnerships to move “beyond tokenism to sharing power and decision making more equitably” (Ocloo & Matthews, 2016, p. 630).

Responsive governance, reflexive leadership

Before we focus on including diversity, we have to clean up our own house first. We can’t intentionally bring people into spaces of harm. —Susan

Equity is possible when people design formal governance structures to support participation, accountability, and transparency while advancing goals the organization and communities share

(Halloran, 2015). OTC member organizations showed responsive governance when they decided that commitment statements would accompany the position statement, agreeing to lead by example. This decision offers an example of reflexive leadership that fosters “curiosity, openness and a willingness to rethink one’s position” (Alvesson et al., 2016, p. 15), leading to action.

While reflexivity can be uncomfortable, the ability to name and engage with the impacts of systemic power is core to accountable leadership, as “it is only when we make ourselves uncomfortable that we break the status quo and begin to learn other ways to relate to the people, the systems, and the world around us” (S. Mahipaul, email, 2021). Some of us revealed an internalized acceptance of the traditional steps involved in creating a position statement—that the CAOT Board would have to first approve the initial draft before soliciting broader feedback. Collectively exploring the way position statements are “usually” produced led to conversations about who would be involved, when, and how. This led to a questioning of our process and the explicit shared desire to ensure that the process of creating the JPS itself would be an accountable one. Group members representing OTC organizations were critically reflective and able to question social and organizational realities, which created opportunities to co-create collaborative inclusive processes in writing the JPS (see Cunliffe, 2009).

A further turning point took place during the writing of this article after some members wrote of a perceived differentiation between a “lobby group” of diversity representatives and OTC “governance” members. One of the co-chairs made time to discuss our functioning and processes, and we re-established the goal of co-creation and named power dynamics. One year into the process of foregrounding trust and learning from each other’s theoretical and experiential knowledge—with a focus on co-creating an anti-oppressive process rather than an expedient outcome—allowed us to engage in this vulnerable dialogue where the self-identified “lobby” group members were able to express their concerns and “governance” members were able to clarify their intentions and commitments. This led to the group taking a collective stance on prioritizing under-represented groups in the JPS consultation process and maintaining the final responsibility for the JPS within our intentional group. Reflexive leaders and decision makers who are ready to “account for their actions and for citizens to be able to sanction them if they are not responsive to citizen demands” advance SA (Ayliffe et al., 2017, p. 20).

Organizations and people embracing complexity and nuance

I thought this was such a unique opportunity and at the same time a huge responsibility to be the only voice that looks like me, so initially I felt like I had to push to be heard, being an outsider. —Samira

People working toward equity and accountability embrace the complexities of creating productive relationships (Boelen, 2000). They use nuanced and politically informed approaches that attend to contextual power dynamics (Halloran, 2015). We recognized the complexity of the task ahead, with one representative of the occupational therapy organizations saying, “We need paradigm shifts in attitudes, actions, and behaviour” (H. Anand, minutes, 2020). Later, when we produced the [draft of the interim JPS statement](#), we paid attention to intersectionality and experiences of oppression as we created its inclusive wording. Consideration of intersectionality—the simultaneous experience of multiple forms of oppression and privilege that cannot be separated (Crenshaw, 1989)—supports a nuanced view of people. The organizational representatives recognized this complexity, participated in dialogue, and supported this process instead of pressing for a version to meet the initial externally imposed deadline.

Supporting complexity often involves new learning. The language in the interim statement can be considered complex, and one organization felt it was too academic for frontline occupational therapists. One member pointed out that occupational therapists are continually learning complex medical model concepts, advocating for their capacity to learn social concepts as well (Zafran, 2021). The group discussed the challenge of working toward clarity without “sanitizing” the message (H. Anand, minutes, 2021). Some of the group’s ideas to address knowledge translation and new learning included a plain language summary, an interactive version of the JPS with links to support self-directed learning, interweaving narrative with theory, providing examples of integrating social concepts into practice environments, creating a podcast series, and employing a skilled editor. The complexity within this project, similar to other SA initiatives, involved “contextualized strategies, analytical capacities, organizational learning, and flexibility and adaptation” (Halloran, 2015, p. 13).

Lessons learned

As equity committees and workgroups proliferate across institutions and programs, we recommend drawing on principles of social accountability to highlight the need for systemic problems to be addressed with systemic commitments and solutions.

We offer takeaway points and reflexive questions for equity workgroups:

Deliberately approach co-creation so as not to recreate inequities within the process. Be clear if either one or more organizations or leaders is/are leading an initiative with others participating, or the process is a true collaboration that is acknowledged as such.

Be transparent so participants know how their contributions will be used and who will make decisions and/or approve both the process and the final product.

Responsive leadership may lead to discussions within the organization(s) or group as representatives are “calling people in, and not calling people out” (S. Mahipaul, minutes, 2021), inviting people to re-envision their culture and context from the inside out (S. Mahipaul, email, 2021).

Consensus building takes strong relationships, multiple avenues for safer participation, time, and patience with efforts to decentre whose knowledge is both compensated and prioritized.

Complex problems can invoke a clash between pressures for individualism, organizational efficiency, and anti-oppressive equity work. Strong and respectful group processes help navigate such pressures.

Reflexive questions

Reflection to promote an anti-oppressive environment and support equity processes:

What are the explicit versus implicit ethical priorities of your organization?

What does your resource and fiscal allocation reveal about your organization’s stated versus actual priorities?

Do your expectations of time and performance conform to oppressive and ableist or empowering and trauma-informed strategies?

How do you share power with equity-deserving groups in your organization?

How can your organization’s mechanisms be more responsive, adaptable, and flexible?

What mechanisms could be established for under-represented individuals and groups to participate in safe, reciprocal, compensated, and valued ways?

Do you appraise the environmental justice impacts of your actions?

Reflective questions to support in-group processes toward equity:

Do you take an intersectional approach to equity work?

Does your group consider systemic initiatives and potential partnerships with diverse others in your organization?

How can you create space for uncomfortable conversations and celebrate those who are brave enough to engage in “good trouble”?

In what ways do you communicate progress and barriers for equity initiatives with stakeholders and community members?

Do your evaluation processes include outcomes and indicators identified by equity-deserving minority groups?

Conclusion

I don’t know what to dream of yet. —Hiba

The equity and justice JPS working group defined principles that support SA and used them as a guiding framework both in writing the JPS and in its own evolving processes. When such principles are centred in equity initiatives, we change the way things have “usually” been done within our colonial structures to resist White supremacy. This opens possibilities for co-creating that haven’t existed before. The JPS working group will continue to develop a collective praxis for SA, and we hope that sharing our processes offers one example for others working to advance equity and justice in occupational therapy.

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About the authors

The authors who contributed to this article are members of the CAOT joint position statement working group. **Havelin Anand** is the director of government affairs and policy with CAOT. **Marianne Baird, MBA, BScOT, OT Reg. (AB)**, is a registrar with the Alberta College of Occupational Therapists. **Giovanna Boniface, MRSC, BScOT, Reg. OT (BC)**, is the president of CAOT. **Fizza Jafry, MSc, OT Reg. (QC)**, is a faculty lecturer at McGill University. **Leanne Leclair, PhD**, is an associate professor at the University of Manitoba. **Susan Mahipaul, PhD, OT Reg. (Ont.)**, is a Critical Disability scholar and disability advocate. **Samira Omar** is a PhD student at the Rehabilitation Sciences Institute at the University of Toronto. **Elizabeth Pooley, MSc, BSc(OT), OT Reg. (Ont.)**, is an independent scholar. **Hélène Sabourin, BScN, MHA**, is the chief executive officer of CAOT. **Ruheena Sangrar, PhD, OT Reg. (Ont.)**, is an assistant professor (teaching stream) at the University of Toronto. **Hiba Zafran, PhD**, is an assistant professor (professional) at McGill University. For inquiries about this article, please contact: hiba.zafran@mcgill.ca

Toward more socially-accountable service user involvement in education: Embracing Critical Disability Studies

Stephanie LeBlanc-Omstead & Susan Mahipaul

Involving people with lived experiences of using healthcare services—*service user involvement* (SUI) hereafter—is recognized as an important facet of health professional education. SUI is founded on the premise that service users ought to be involved in shaping the systems and services they experience, with a rich source of experiential knowledge to offer the health professions. For us, this work requires a constant striving toward social accountability to groups and communities of Mad, mentally ill, neurodivergent, and disabled (MMIND) people, especially those affiliated with justice-oriented movements and activism. If to be socially-accountable is to address the priority concerns of underrepresented communities then SUI's potential to promote social accountability in occupational therapy education is clear, with its basis in inclusion, co-production, and partnership,

SUI offers an actioned response to the well-known rallying cry of MMIND communities: “nothing about us, without us.” However, as a practice, SUI often falls short of this aim. Service user educators continue to contend with issues of tokenism, inadequate remuneration, and expectations that they serve

as *spokespersons* for MMIND communities rather than as subject matter experts. While each of these warrants its own in-depth discussion, this paper focuses on just one issue standing in the way of a more socially-accountable SUI: *discursive confinement* (Voronka & Grant, 2021). This article builds on years of reflexive writing and dialogue between us about our experiences as Mad and disabled occupational therapists involved in occupational therapy education, and is informed by our individual and partnered teaching efforts grounded in our experiential knowledge as users and survivors of healthcare systems and services. *Experiential knowledge* involves more than just lived experience, but importantly, a critical/political understanding of that lived experience. We offer insights drawn from this experiential knowledge, our research, and both Critical Disability Studies (CDS) and Mad Studies literature.

Discursive confinement: Limiting the power of experiential knowledge

We use the term *discursive confinement* here to refer to the way service users' experiential knowledge,

and even service users themselves, are ‘confined’ to the constructions and interpretations of occupational therapy audiences according to dominant narratives and available theoretical frames or language (Voronka & Grant, 2021). Occupational therapy student/faculty audiences often interpret service users’ experiential knowledge through the lenses they already possess—e.g., biopsychosocial models, or neoliberal understandings of “recovery” and “care”—irrespective of what service users intend to communicate. Consider my (Susan’s) experience in the role of patient interviewee for first-year occupational therapist students:

I spoke to students about my chronic pain; about finding/receiving appropriate care; stigmatization; and at-times inhumane treatment by pain specialists. I recalled being forced to stand up out of my power wheelchair without any supports and falling to the ground in front of my partner, mother, specialist and residents; then being chastised for crying and the specialist screaming at my mother “don’t help her!”. So, for me, pain was intertwined with an abusive health care *system*. Yet students laser in on *me* and the decisions and choices *I* made and whether I was communicating appropriately with my healthcare providers. While they followed program instructions, I was left feeling naked, stripped bare, panicking in silence, and questioning whether I was “good” at caring for myself. I used to brush off the regularly asked normative questions: *Did you experience any bullying? When did you first know that you were different? Did you ever struggle with low self-esteem? Does it bother you that you cannot do certain things?* Now I have started to pay closer attention to how students relate and respond to my narrative and how their individualizing questions impose a medical gaze that sets me up as the “other”, someone who is deficient, broken, dependent, and in need of intervention and help. I now always point this out to students, and call attention to what the students don’t understand—and have not been taught to understand—in my stories: that there is a shadow of systemic oppression and trauma cast onto me, and that always follows me. I reiterate this in every class I teach. I challenge students to understand that much of the discrimination, barriers, and ableism I experience in my life are not because of my disability—my body—but because of what doctors, nurses, teachers, and therapists do/did to me *because* of my disability. Sharing this makes the classroom vulnerable and uncomfortable but allows us to co-narrate and hold the profession socially accountable to the disability community I belong to.

Resisting discursive confinement: Laying the epistemic groundwork

Harrison et al. (2021) recently pointed out that the occupational therapy profession has still yet to adequately engage with the vast body of CDS/Mad Studies-produced knowledge (Guenther-Mahipaul, 2015). While SUI holds promise for addressing the occupational therapy profession’s lack of engagement with CDS/Mad Studies we must also be concurrently facilitating students’ *unlearning* of certain narratives and languages. To truly forefront social accountability and avoid the trap of discursive confinement, these narratives/languages should be replaced with the language used within CDS/Mad Studies. This means moving beyond soft language like *stigma*, and including the systemic oppressions known as sanism and ableism in our conversations around equity, diversity, anti-bias, and anti-oppression (Brown et al., 2019; LeBlanc-Omstead & Kinsella, 2018).

Not unlike Susan, the experiential knowledge I (Stephanie) have shared with students related to systemic sanist oppression, microaggression, and discrimination has often seemingly solidified—rather than destabilized—pathologizing and paternalistic views of mental distress and diversity. This is evident in questions and comments related to, for example, whether I have received “approval” from health professionals around my occupational choices (e.g., engaging in something as ‘strenuous’ as university). Several years ago, I developed and instructed an elective mental health-focused occupational therapy course. Its development was informed largely by our collective experiences, and those described to me by service user educators during my doctoral research. The following reflection details my first attempts at laying the epistemic groundwork for a cohort of occupational therapy students (LeBlanc-Omstead, in press):

I introduced students to Mad Studies and other MMIND-informed perspectives through assigned readings/media and through SUI. However, mindful of Voronka and Grant’s (2021) caution that, “systemic criticism is often literarily unheard” (p. 7), I dedicated part of each class to introducing and unpacking sensitizing concepts (e.g., sanism, Mad Studies/Pride, intersectionality/confluence, anti-oppression, etc.) in an effort to help students understand these perspectives as knowledge belonging to a collective, rather than as individual recovery narratives. Put simply, I was trying to add to the language, concepts, and theories available to students to make sense of what service user educators might share with them throughout the course. I also centered experiential knowledge to support students’ ‘unlearning’ in the way that

Snyder et al. (2019) describe it: as “questioning what we think we already know, and making room for multiple ways of knowing” and in particular as “troubling the dominant understandings of madness that abound in higher education” (p. 2). With the epistemic tools needed to understand service users’ systemic critiques and concerns, students now also had adequate/appropriate language for describing their own experiences (e.g., during practicum). For instance, one student identified and named her preceptor’s derogatory comments about a client as constituting a sanist microaggression or even hate speech; rather than as simply disturbing or uncomfortable to witness—or worse, viewing this as commonplace or acceptable language and behaviour for occupational therapists.

Conclusion

As Mad and disabled scholars, we understand that as educators, we “are immersed within an atmosphere where it is expected that we step outside of our disability experiences... [and to be] able to write, research, and educate about a *normal life*” (Mahipaul, 2015, p. 231). However, after years of striving to fit this mould, our teaching no longer centers around normative embodiment(s), “recovery”, or “overcoming.” Instead, we find ourselves increasingly committed to social accountability to the MMIND communities in which we belong, focused on alignment with the priorities, values, and knowledge developed by and within these stakeholder groups. To

this end, we use—and ensure our students have—the epistemic tools (e.g., concepts, language, theories) required to truly understand these priorities as they are articulated. Without closer engagement and a more critical understanding of CDS/Mad Studies concepts, theories, language and principles, a socially accountable SUI will remain an unattainable goal.

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About the authors

Stephanie LeBlanc-Omstead, PhD, OT Reg. (Ont.) is an occupational therapist and Mad studies scholar committed to the issue of epistemic justice for service user educators and making space for anti-sanist praxis and Mad-positive discourse in occupational therapy education, research, and practice. She can be reached at: slebla8@uwo.ca.

Susan Mahipaul, PhD, OT Reg. (Ont.), identifies as a disabled occupational therapist and Critical Disability Studies scholar who consults and practices in the areas of systems navigation, academic ableism, equity & justice, and disability positive & anti-oppressive services. Susan can be reached at: susan@dhnv.ca.

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Accounting for our words: Anti-oppressive documentation in occupational therapy practice

Janna MacLachlan & Marie-Lyne Grenier

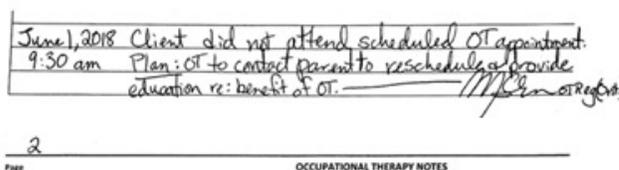
Documentation is an inherently political act, as the words we write as occupational therapists hold great power to construct people as service users and, in turn, influence their occupational choices and opportunities. Mattingly (1998) warned us of the power of *chart talk* to reify “normative conceptions of clinical rationality” (p. 273), conceptions frequently grounded in biomedical discourses in occupational therapy practice. Ramugondo’s concept of *occupational consciousness* further helps us to understand that “[...] dominant practices are sustained through what people do every day, with implications for personal and collective health” (2015, p. 488). Documentation practices can either sustain or resist dynamics of power and hegemony, yet such practices have long been viewed in occupational therapy practice as apolitical *everyday doings*, shrouded by what Seybolt (1996) calls the *myth of neutrality*.

Ramugondo (2015) argues that everyday doings can also be “[...] a potentially liberating response to oppressive social structures” (p. 488). We propose that taking an anti-oppressive and structural competency approach to documentation can help mitigate or prevent some of the harms perpetuated through documentation practices, and even transform documentation into a force for good. Anti-oppression approaches aim to mitigate effects of oppressive social forces (e.g., racism, sexism, ableism, colonialism, etc.; The Anti-Oppression Network, n.d.), while *structural competency* supports practitioners in recognizing how historical, political, institutional, and social conditions (e.g., poverty, neoliberalism, etc.) impact service users and practitioners and shape clinical interactions (Metzl & Hansen, 2014). These approaches support social accountability by prompting us to document in ways that more accurately capture service users’ complex realities and effectively help shape our responses to the oppressive social forces that limit their occupational choices and opportunities.

In this article, we demonstrate how occupational therapy’s documentation practices can lead to tangible oppressive harms, particularly for marginalized communities, by unpacking a sample note. We will also demonstrate how documentation practices can be used as a tool for resistance against these oppressive harms by outlining concrete actions we can take as a community.

Thinking critically about documentation

Figure 1 depicts a documentation note for a fictional service user—a young boy being followed in a pediatric outpatient clinic in an urban rehabilitation center. He was referred for service related to a diagnosis of developmental delay. What implicit messages lurk between the lines of this seemingly benign note? How might others interpret it? Our critical analysis through anti-oppressive and structural competency lenses reveals important and potentially harmful discourses.



June 1, 2018 Client did not attend scheduled OT appointment
9:30 am Plan: OT to contact parent to reschedule & provide
education re: benefit of OT. *[Signature]*

Page 2

OCCUPATIONAL THERAPY NOTES

Figure 1. Fictional sample note.

The *myth of meritocracy*, a common discourse in our society, assumes that everyone has an equal opportunity to succeed if they simply work hard enough. This note may imply that the child’s parent is not working hard enough and, as a result, may be preventing the child from experiencing success. The note could convey to readers that the child’s parent is not invested in the therapy process, does not prioritize their child’s well-being, and is unwilling to “comply” with therapeutic recommendations. The licensed healthcare professional’s signature conveys authority and an air of objectivity, while the service user’s name, voice, and context are absent. The occupational therapist does not explicitly unpack the reasons why the child missed the appointment but rather implies that it might be because they do not know the importance of occupational therapy.

Does the note’s author set middle-class expectations that are more difficult for parents experiencing poverty to achieve? Does the author, for example, imply an assumption that the service user can organize, access, or pay for transportation and can afford to take time off from work for an appointment? Have they accounted for parents who have difficulty getting to an appointment during work hours? Does their perception of the intervention’s urgency match that of the family? If a family is worried about putting food on the table (survival occupations), for example, occupational therapy appointments may not be a priority.

Readers are left to draw their own conclusions. What if the parent chose not to attend because the Western worldview underpinning many of our occupational therapy practices (Hammell, 2018) does not match their own? As Turcotte & Holmes (2021) note, “Exposing oppressive forces in our discipline means confronting the esthetic regime imposed by discursive authorities doggedly defending occupational therapy’s intrinsic goodness” (p. 14). That the note is written in English is also a political act. Service users may be unable to read (and correct) the way they are constructed following a biomedical rationality (Mattingly, 1998). Are our clients made aware of their right to access and request changes to that which is written about them? Is access offered? Documenting from a Western perspective without explicit acknowledgment of that perspective’s limits inscribes its logic as the norm or standard, maintains power, and sets up a framework by which service users are judged against this presumed norm and standard. The family’s point of view is not included in the note, nor is space created for it to be explored.

Let us suppose that the parent in the note is Indigenous or Black. Black and Indigenous families in Canada are more closely surveilled by child protective services, police, and worker’s compensation agencies, and their children are apprehended at worryingly disproportionate rates within this colonial state (Adjei et al., 2018). The note above could be read as casting blame on the family and could draw the attention of child protection workers. Reinforcing the “benefit of occupational therapy” to the parent could be perceived as judgemental and even threatening, especially if they are concerned that such services may become involved. Similar notes may be weaponized against service users seeking worker’s compensation benefits or disability benefits, among others.

As occupational therapists, we likely do not intend to imply the kinds of judgements described above in charting notes. In *chart talk*, the service user’s context is often omitted, as is the therapist’s relationship to the service user (Mattingly, 1998). Reasons for not including relevant context in a note might include time pressures or neoliberal workplace norms. Leaving context and narratives out of documentation leaves room for readers to interpret and read between the lines, too often with implicit biases.

Let us now consider the following note documenting the same scenario but whose author is adopting anti-oppressive and structural competency approaches.

In this fictional note, the therapist provides the reader with more contextual information and is explicit about their critical reasoning. This may decrease the number of times the reader tries to read between the

June 1, 2018 Joe's parents, Brenda + Sam, agreed by phone last week 9:30am to come to an appointment today, but did not arrive. They said they had not implemented suggestions I made at the last appointment. I did not ask if their son my recommendations aligned with their priorities + needs.

Analysis: Recognizing that my age, class + racial background are not shared with Joe's parents, + that the structured systems + norms of my workplace are not welcoming + inclusive for all people, it is possible my recommendations + how they were delivered did not align with Brenda + Sam's needs + expectations. I may have underestimated power dynamics at play.

Plan: Call Brenda + Sam Acknowledge their agency + expertise regarding their son's care. Reinforce their right to refuse OT services + disagree with my suggestions. Plan follow up if parents request, exploring alternate means of engaging if appropriate.

Jessie McIvor, OT

Figure 2. Documentation as a tool for resistance

lines. The therapist moves away from chart talk to a narrative where the service users’ and therapist’s motives and actions are contextually situated. The therapist acknowledges their role and responsibilities vis-a-vis the power dynamic at play and opens space for the service user to share their motives and actions and have them validated. The occupational therapist is not a neutral, objective, and infallible authority figure; rather, they are a person in a relationship with the service users. Everyone is identified by name in this note—they are all humans with complex lives and imperfect trajectories.

This note allows for the possibility that the issue lies with the therapist or the system, not the service user. By including narratives (or in this case, stating the absence of a narrative regarding the family’s needs) and context, the occupational therapist is cued to critically reflect on why the appointment was missed, which they can further explore in the note’s analysis and plan sections. Critical reasoning is supported by storytelling (Mattingly, 1998); the content and form of the note and the process for writing it are all changed. The analysis section prompts the therapist to locate their responsibility in the therapeutic process, to seek to understand the service user, consider actions that might be more meaningful and helpful to the family, and respect the service users’ right to refuse care without prejudice. The note and therapist demonstrate humility, empathy, and vulnerability. What differences might there be in how our healthcare colleagues perceive the family in reading this note compared to the first? We encourage readers to complete similar exercises with their own documentation. We next offer some reflective questions and practice tips that may help with this work.

Reflective questions**

1. Whose agenda is my documentation accountable to? Does it conflict with the best interests of the service user(s)?
2. Whose knowledge and values are represented as the norm in my documentation?
3. Does my documentation support Indigenous/Black/Queer/etc. self-determination?
4. Does my documentation open space for collaboration and partnership? How is the therapeutic relationship represented?
5. Does my documentation convey what I do and do not know of the service-user(s)' beliefs, values, and context?
6. What occupational opportunities are made available or constrained by my documentation?
7. What assumptions does my documentation make? Do assumptions reinforce any systems of privilege or oppression?
8. How might my documentation shape the impression readers make of the service-user(s)? What potential harms could result?
9. How would the service-user(s) react if they read my documentation?
10. Have I conveyed humility and compassion in my documentation?

** Above questions inspired by Byrne et al. (2020), MacLachlan, Phenix and Valavaara (2019), and Nixon et al. (2017).

Practice tips

1. Ask a colleague to read your note and describe their impressions of the service-user(s). What have you conveyed in your note? Is it accurate, complete, or fair?
2. Collaborate with marginalized communities and persons to identify areas where oppressive harms might be done through documentation in your practice context.
3. Practice relational accountability. Write as though the service-user(s) is going to read the note. Where possible, offer them the opportunity to have a copy of your notes, or even to review and correct them.
4. Document injustices. Name human rights violations, systemic barriers to occupational rights, barriers to Indigenous and Black self-determination, etc.
5. Be strengths oriented. Report on more than problems and traumas. Avoid pessimistic or victimizing language (e.g., "struggles with").

6. Be humble. What if the problem lies with you or the system?
7. Be clear about whose impressions are being recorded. Present impressions as impressions, not as facts. Acknowledge the normative limitations of "objective" assessments. Place emphasis on qualitative findings.
8. Be transparent about the nature of your relationship with the service-user(s) and to what extent therapeutic plans were co-created.
9. Write about people in the way they want to be described. Use names, not client. Use correct pronouns. Use accurate population names (e.g., Cree, Inuit, etc.)
10. Ensure the occupational analysis you perform involves integrating the social, historical, economical, structural, or institutional factors that contribute to the service user's current status, diagnosis, and occupational barriers. Include this information as essential context in your documentation.

Conclusion

Social accountability requires that service users be able to audit and sanction the words written about them. As a political process, documentation can either be a site of oppression or of accountability. We encourage readers to question Western ideals of objectivity and neutrality we are cultured into with our documentation practices. As occupational therapists, we can individually and collectively reflect on and discuss how we can bring increased accountability into our daily practices. We are hopeful that readers will find the anti-oppression and structural competency-informed approaches to documentation discussed in this article helpful in this endeavour. We have an opportunity to be leaders in our interdisciplinary teams by setting an example for more respectful, helpful, and equitable healthcare.

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About the authors

Janna MacLachlan (she/her), PhD (candidate), OT Reg. (Ont.), is a White, cisgender woman of settler descent currently living in Nunavut. Janna can be reached at janna.maclachlan@mail.utoronto.ca

Marie-Lyne Grenier (she/they), MScOT, DOT, PhD (candidate), erg., is a White, non-binary and Queer-identified occupational therapist of settler descent currently living in Tiohtià:ke. Marie-Lyne can be reached at marie-lyne.grenier@mcgill.ca

From shelter to home and beyond: How occupational therapists can become more accountable to women in transition to post-shelter housing

Karla Jacobsen & Vanessa Seto

In Canada, women make up approximately 30% of those experiencing precarious housing situations (Gaetz et al., 2016). For women who have experienced interpersonal and systemic violence, meeting their needs for safety and secure relationships is essential to maintaining permanent and stable housing (McAll, 2018; Phipps et al., 2019). The field of women’s homelessness provides a unique set of challenges and opportunities for occupational therapists, including ensuring that the occupational therapy curriculum includes relevant practical training to prepare future practitioners to work alongside underserved populations in a socially accountable way (Clithero et al., 2017).

Here, we will share how we, as occupational therapists and women, partnered for accountability while working in the field of women’s homelessness to move past a charity-model mentality of “having a roof over their heads and food in the fridge is good enough.” Vanessa works part time as a frontline occupational therapist in the community at Logifem, a Montreal-based homeless shelter for women and their children. She is advocating to expand programs for women in residence and in post-shelter services, which has contributed to a collaboration with other occupational therapists, including Karla, who is involved in research at McGill University’s School of Physical and Occupational Therapy (SPOT) at the graduate level. We are both involved in conducting community-based participatory research, supervising student occupational therapists, pursuing doctorate

level education, and teaching at the graduate level. We illustrate how the university–community partnership evolved from meeting occupational needs to becoming socially accountable within the domain of women’s homelessness.

Partnering for occupational needs

Student occupational therapists from SPOT contribute to addressing Logifem residents’ needs that fall outside of community workers’ and social workers’ domains of expertise through ongoing role-emerging placements. This contributed to the creation of a part-time generalist occupational therapy position at Logifem, which Vanessa currently holds. Together with her team at Logifem, Vanessa identified further needs for post-shelter services and expanded the shelter’s occupational therapy program. She assists in enhancing the agency and autonomy of the women confronted with individual and systemic obstacles on their paths to stable housing. They are often caught in repeated cycles of homelessness due to a transition to independent living without adequate support or resources to ensure their stability. Obstacles that led them to homelessness (e.g., structural poverty, social marginalization, conjugal violence upheld by patriarchal systems, lack of affordable housing in safe neighborhoods) often remained unchanged despite them having found shelter, structure, and stability while supported by Logifem.

Post-shelter services, in the form of the expansion of the occupational therapy role in homecare and of follow-up post departure from the shelter, have become an integral offering at Logifem in tandem with role-emerging fieldwork. At Logifem, the team emphasizes the importance of occupation, leisure, self-care, and social connection to aid clients to cope with trauma and to create or maintain support networks. This kind of support differs from homecare services in the community at large, in that many of those having transitioned to permanent housing after a shelter stay have forgotten how to practice or have never practiced activities of daily living (ADLs) or instrumental ADLs. In this context, productive activities become a representation of function and societal integration, inspiring hope and becoming a significant goal to look forward to after other functional difficulties with stability are resolved. Collaboration and referrals with community partners have also become part of Vanessa's central role, as post-shelter services currently only last a year after a resident has moved out.

Beyond occupational needs: Partnering for accountability

In addition to role emerging fieldwork, the long-term partnership between Logifem and SPOT has included sequential professional master's degree research projects that have centred the experiences of cis and transwomen who are service users at Logifem. These projects have highlighted the women's own intersectional priorities and the need for universal accessibility, safe spaces for the 2SLGBTQIA+ community, and activity adaptations developed as part of institutional and occupational therapy services. The Logifem team also realized that providing permanent housing was insufficient to address the women's priorities when they left sheltered living. Rather than going along with the status quo of the system's shortcomings (e.g., lack of housing or post-shelter case management services), the team opted to try to begin processes enacting systems-level change. The shelter team increased its collaboration with SPOT to co-create a post-shelter housing support program for women, and so Project Lotus was born. One of the first steps taken toward accountability in Project Lotus was the creation of a cross-sectoral Community Advisory Board (CAB) to oversee the project. This CAB consists of 11 women, including women with lived experience of homelessness, community-level managers, frontline service providers, and Karla, Vanessa, and their PhD supervisor. The CAB chose the name "Project Lotus – Hope together" for this initiative because the lotus flower represents the capacity to adapt and flourish, as it grows and thrives without being rooted, in water that is constantly shifting. "Hope together" symbolizes the importance of representation and equality of all voices through collaboration.

Project Lotus: Occupation-based accountability

Project Lotus highlights the intentional inclusion of the voices of diverse women who have transitioned from shelter to home, revealing gaps in the system and providing opportunities for solution-based discussions driven by those to whom we should be accountable. An occupation-based approach that takes power dynamics into account, including PhotoVoice and World Café collective activities, has aimed to intentionally ensure the inclusion and representation of women with lived experience to inform changes. Project Lotus is an example of intersectoral action addressing health and social inequities through the examination and reconfiguration of practices, structures, and beliefs. For example, our project has found the need for increasing practical supports (e.g., moving assistance, food security, etc.) and the implementation of individualized case management, peer support, and therapeutic group activities for women in post-shelter services. We are working with students toward building sustainable and reciprocal relationships supported by organizational infrastructure commitments (post-shelter services) between community (women and children with lived experiences of homelessness), organizational (Logifem), and institutional (university) players.

The formalization of an ethical and reciprocal long-term partnership between Logifem and SPOT has increased capacity to meet occupational needs in the community and established a systemic process by which the CAB can oversee actions and practices—a core principle of social accountability (Grandvoinet et al., 2015). As more student occupational therapists work with marginalized women, becoming aware of local community rights and needs, the necessity for a shift toward socially accountable approaches in occupational therapy education is highlighted insofar as preparing new practitioners for the field. Next steps are to determine, examine, and continually monitor the alignment between

the priorities of women made vulnerable by systemic factors and occupational therapy competencies.

Key takeaways

- Developing intentional partnerships with community stakeholders, organizations and institutions helps to increase knowledge of existing resources and gaps, as well as allow for better engagement in community-led, person-centered change.
- Formalizing a community advisory board (CAB) as part of the structure and process ensures that all stakeholders have an equal voice in decision making.
- Using collective activities such as PhotoVoice and World Cafés can elicit lived experience narratives that guide socially accountable practices.
- We hope inspiration can be found in the amplification of occupational therapy on the ground via intentional

partnerships that support the development of sustainable social accountable structures and practices.

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About the authors

Karla Jacobsen (she/her), MScOT is an occupational therapist in mental health, a PhD candidate and course lecturer in psychosocial rehabilitation at the School of Physical and Occupational Therapy at McGill University. She can be reached at: karla.jacobsen@mail.mcgill.ca

Vanessa Seto (she/her), MscOT, is an occupational therapist at Logifem, a shelter for women and children in difficulty, and is pursuing her PhD at McGill University. She can be reached at: vanessa.seto@mail.mcgill.ca

Conversations that Matter: The Podcast—A step toward social accountability

Justine Jecker & Holly Reid

Conversations that Matter: The Podcast first aired in late spring of 2021 and has since released monthly episodes directed at addressing a variety of topics connected to the fabric of social accountability. In this podcast, social accountability refers to how occupational therapists perceive and experience responsibility to individual clients, families, communities, and the larger health care system. Social accountability is relations-based, meaning it influences, and is influenced by, connections that occupational therapists have in their personal and professional lives (World Health Organization, 2000). Advocacy, allyship, and use of power and privilege to push for change are some ways that occupational therapists can be socially accountable.

Some of the podcast's important discussions include acknowledging and addressing racism, sexism, ableism, and power differentials, while also examining the experiences of occupational therapists who may not feel that their voices are heard or represented

elsewhere. The podcast's concept and name stemmed from the Conversations that Matter series beginning at the CAOT Virtual 2021 conference; there, practice networks hosted conversations on challenging, relevant, and timely topics on equity and justice not often addressed at previous conferences. For a description of these discussions, please see the *Occupational Therapy Now* September/October 2021 Conference issue.

This podcast is intended for therapists working in every area of practice, including clinical, non-clinical, management, and leadership positions. A unique feature of the podcast is that we are seeking under-represented occupational therapists at home and abroad who may not be well known or published, but who undoubtedly have valuable stories, experiences, teachings, and perspectives to share with others. This practice of social inclusion leads to accountability, going beyond relying on empathy-generating testimonials of lived experience to be inclusive of

Examples of podcast topics are:

<p><i>Ableism</i>—this topic explores everyday language, practice processes, and Western ideologies that perpetuate the assumption that having a disability is negative and inferior. It is important for occupational therapists to truly consider: are they a part of the problem or the solution?</p>
<p><i>Advocacy</i>—this topic discusses how advocacy is a key skill for occupational therapy and that we are all responsible for engaging in systems-level care. Advocacy is a powerful tool, so what happens when occupational therapists use their own voices with good intentions but miss the mark? Let’s talk about how, and when, to pass the mic.</p>
<p><i>Beyond the Gender Binary</i>—this topic discusses ways in which we are representing persons who do not identify as either a man or a woman. How can we celebrate and acknowledge a diverse range of genders, and what is the role of an occupational therapist in disrupting the gender binary?</p>
<p><i>Fatphobia</i>—this topic questions why society is preoccupied with policing bodies and operating on the assumption that people who are fat are less healthy and care less about their health. How are occupational therapists engaging in this discussion and applying learning to their practices?</p>
<p><i>Intersectionality</i>—this topic engages in conversations on double discrimination related to queerness and race, as well as discusses how the historical context of occupational therapy has been either a support or barrier to accessing health care services.</p>
<p><i>2SLGBTQIA+ and Allyship</i>—how can occupational therapists have the language and knowledge to know how to support and advocate for 2SLGBTQIA+ clients when institutions do not readily teach this to students? Reflections and stories from occupational therapists and students will be the focus.</p>
<p><i>Racism</i>—this topic considers racism experiences specific to occupational therapists who do not see themselves represented among their peers, clients, and educators. How are we supporting occupational therapists who identify or are identified as a marginalized and/or racialized individual?</p>
<p><i>Research and Evidence</i>—this topic engages in a conversation about what occupational therapists bring to the table when doing research—particularly when involving patients and clients as partners—and what message they have for non-academic occupational therapists who want to engage in research but do not have the time or resources to enroll in a four-year or longer PhD program.</p>
<p><i>Self-Care and Trauma</i>—this topic acknowledges that self-care has changed globally and dramatically since 2021. At the forefront of our thinking are mental health services and the notion of addressing political-historical trauma together with the ensuing intergenerational and childhood trauma. If we do not become knowledgeable companions in healing politically generated/caused trauma, then how do we help others engage in meaningful occupation?</p>
<p><i>Social Accountability and Activism</i>—this topic examines how the occupational therapy profession is socially accountable: How are we acting in the best interests of the environment and society as a whole? What role does activism play in our profession? Are we pressing the boundaries and challenging the status quo? Who is and should be leading these endeavors?</p>
<p><i>Truth and Reconciliation</i>—this topic acknowledges that to engage in the decolonization process, truth-finding and the action of reconciliation are paramount to healing for Indigenous and non-Indigenous people. How are occupational therapists engaging in decolonization practices?</p>

concepts, voices, and perspectives that are often overlooked or excluded due to systems of racism, white supremacy, patriarchy, and ableism. In essence, the purpose of the podcast is to welcome guests to share their experiential knowledge as an occupational therapist in relation to other components of their identity.

For a taste of learning about social accountability, see our podcast reflections below from episodes two and four. Additionally, episode six specifically focuses on social accountability and activism, with follow-up conversations in the works for episodes seven and eight.

Podcast reflections

Episode 2: Pride month and occupational therapy allyship

As a member of the 2SLGBTQIA+ community, I know how valuable it can be to hear about shared experiences and feel that you are not alone. I hope that listeners can digest this conversation in a way that feels safe and accessible through the podcast medium. I am an auditory processor, and speaking words holds a lot of power for me, so being invited into this space and sharing a candid and meaningful conversation felt affirming. Having the opportunity to verbalize experiences provided me with an opportunity to consolidate my thoughts and reflect on my experiences, and I walked away from this recording

with a lot to reflect on, learn about, and grow through. It sparks hope for me that clinicians are seeking out these conversations, and I am grateful to have been called in as a contributor. **Caleigh Jenkins, MOT, occupational therapist**

Episode 4: Intersecting identities and compounding forms of discrimination

I very much enjoyed sharing in conversation with Justine and Holly about how occupational therapists should reflect upon and respond to issues regarding intersecting identities and marginalization. The cohosts are both such thoughtful individuals who created a safe environment for me to discuss how power, privilege, and intersecting forms of oppression affect both clients and clinicians. As a Queer and Métis individual, I have personally faced compounded discrimination when accessing health and social services. I have also experienced and witnessed both queerphobia and anti-Indigenous sentiments from clients with whom I am working as their occupational therapist, which has been uncomfortable and required me to develop skills in self-advocacy and resilience. At the same time, I have had success leveraging my power as a cis-man and respected health care professional to advocate for clients who were facing marginalization when trying to receive the care they needed. I hope listeners of our conversation can reflect on their own experiences of power and marginalization, with a goal of determining ways they can enact social change starting in their places of work. **Justin Turner, MOT, Occupational Therapist**

Each episode features one or both hosts in either the role of host or conversationalist with at least one other occupational therapist. Those who are interested in being on the podcast can contact practice@caot.ca with a description of their area of practice, issues or topic relating to justice and social accountability, and anticipated take-home messages for listening occupational therapists. The episodes are intended to be 30 minutes in length and can be appreciated during a lunch break or during a period of downtime. Delivery of information via a podcast may be a better fit for those who do not have the time, interest, or means to read academic or non-academic literature, thereby increasing accessibility to listeners.

We welcome you to join us as we begin a journey of listening, sharing, and exploring topics relevant to occupational therapy. We will focus on the reality of being an occupational therapist in the 21st century and how to navigate the complexities of the world in which we live, work, and play. We will listen to feedback and work hard to create and maintain a safe place for occupational therapists and listeners to come and share the joys, struggles, and everything in between. Please see our webpage for more information: <https://www.caot.ca/site/pt/podcast?nav=sidebar>

References

World Health Organization. (2000.) *Towards unity for health: Challenges and opportunities for partnership in health development*. https://www.who.int/hrh/documents/en/TUFH_challenges.pdf

About the authors

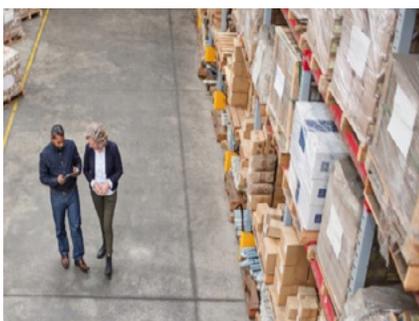
Justine Jecker, PhD, OT Reg. (Ont.), the director of professional practice at CAOT, identifies as a white, cisgender, French-Canadian occupational therapist with a background in forensic mental health, community health, and working with First Nations communities in northwestern Ontario. In her role at CAOT, she supports practice networks, networking, and practice resource development.

Holly Reid (they/them), MOT, BSc Kin, the interim professional practice lead at CAOT, is a trans non-binary western educated occupational therapist and PhD student who has worked in mental health, community settings, and in public, private practice, and non-clinical settings. They are Métis on their mother's side and a settler of Scottish origin on their father's side.

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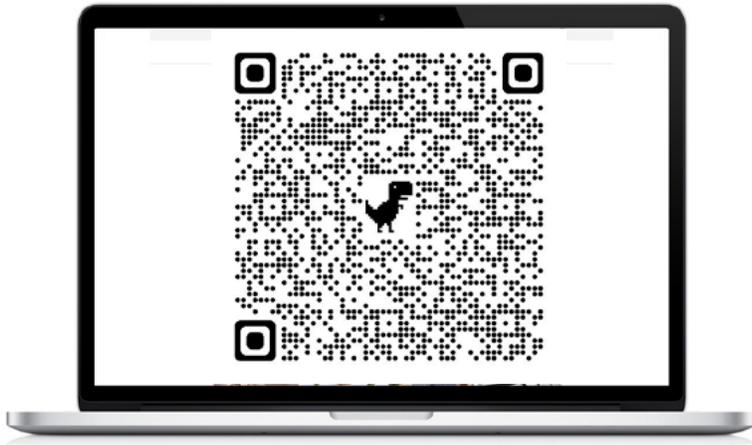
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