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OCCUPATIONAL THERAPY NOW

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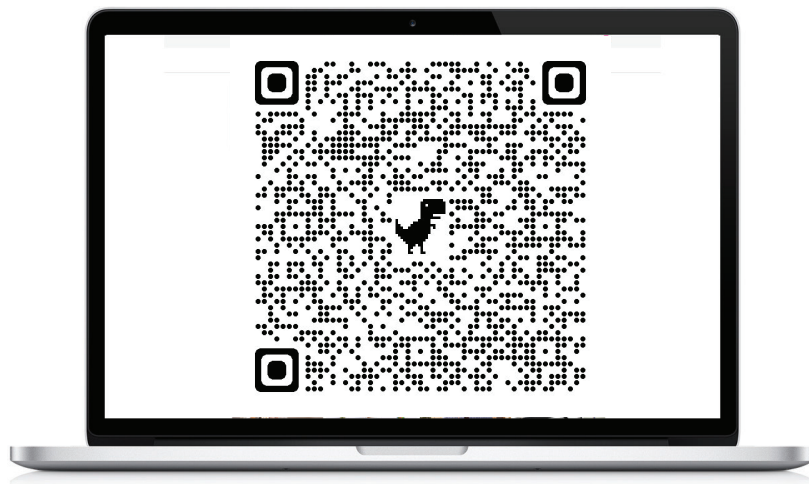
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To age in or out of place: That is the question!

Véronique Provencher

Most people want to live “at home” for as long as possible. However, for many older adults, their state of vulnerability exposes them to increased risks of falls and isolation, contributing to the precariousness of their home care. How can we find this balance between the safety, autonomy, and quality of life of older adults? How can these seemingly contradictory values be reconciled? Since risk-taking can be beneficial in supporting older adults pursue activities meaningful to them, a “harm reduction” approach could help mitigate these risks while promoting older adults’ decision-making autonomy. Indeed, through an approach focused on the older adult’s needs and preferences, it becomes possible to identify services capable of reducing these risks while ensuring that they are acceptable—i.e., in line with an older adult’s values. However, these services are not necessarily offered to older adults when and where they want, sometimes forcing them to move out of their homes and comply with worker availability.

In this issue, **Chagnon et al.** outline the benefits of using telehealth to facilitate access to occupational therapy services at home—including to prevent deconditioning exacerbated by the pandemic—while recognizing the challenges that this modality entails, such as digital literacy. On the other hand, the option of “living at home” is neither necessarily desirable nor desired by all. Two articles (**Gagnon-Coderre et al.**, **Mann et al.**) thus emphasize the importance of respecting the person’s decision-making autonomy regarding their choice of living environment. As highlighted by the pandemic, staying in your home can expose older adults to increased risks of isolation, which can be very deleterious to the realization of activities that give meaning to their lives. Indeed, as Mann et al. note, “emotional bonds are often what give a reason to get up in the morning.”

In this sense, some collective living environments can be options of interest, offering opportunities for socialization. It is also important that a given living environment respects as much as possible a person’s values, personality, and previous habits, offering opportunities to reconnect with what is familiar: that is, the person’s identity and their previous roles. For example, **Obradović et al.**’s article explores how occupational therapists could help better support

older adults who want to age in place by helping them continue to care for their pet; to overcome the growing difficulties of walking or feeding it, occupational therapists could, for example, realize the relevance of expanding the offer of home help services or promote communal residences offering spaces dedicated to animals.

Wijekoon reports on the experience of older adults with an immigrant background aging in a different society from which they grew up. To reconnect with their **cultural identity**, sharing experiential knowledge with the next generation can thus prove to be a source of valorization. More broadly, our society can draw inspiration from different cultures to diversify its vision of aging in place, in particular through the establishment of a form of intergenerational interdependence or social safety net that calls for community solidarity. To this end, **Park’s** article shares an inspiring experience where aging at home is possible thanks to a strong **resilience** drawn from inner strength and the love of those around him. As the author mentions, aging is an obligatory, universal passage for every human being—one can choose how to live it, despite limitations.

Reid and Slauenwhite’s article and highlights opportunities for occupational therapists to accompany seniors and their loved ones through a transition thought to be impossible pre-pandemic: to return home after a stay in long-term care facility. For this experience to be positive for the person and their family, it is important to help them anticipate their needs and challenges in this “new” living environment, in particular by making sure to co-construct the care plan with them.

Finally, the program review by **Bolduc, Soillis & Webster** outlines simulation workshops reflecting situations caregivers actually experience in their daily lives (www.mcgill.ca/dementia). These workshops seek to help loved ones better understand dementia and the resources available, in addition to offering them the opportunity to learn through role plays with actors with relevant lived experience, strategies to manage difficult behaviors, and ways to prevent burnout. At the same time, **Wijekoon, McGrath, Brenchley & Rotenberg** present a web portal (www.En-AGE.ca) with resources to support older adults

during transitions they experience during their aging (e.g., retirement, change of living environment). This portal is aimed at not only occupational therapists and managers, but also at older adults themselves and their loved ones. These articles also propose concrete technological solutions to inform and support older adults and loved ones to facilitate their **aging in place**.

Through this sharing of knowledge and experience, we hope that this special issue will offer occupational

therapists, older adults, and their loved ones a space to reflect on the clinical and ethical issues surrounding aging in place. In a context of resource scarcity, it becomes essential for occupational therapists to offer recommendations that go beyond formal service requests. It is thus hoped that the avenues of intervention set out in this special issue can promote the commitment and quality of life of aging people within the living environment that best suits them according to their needs and preferences.

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Simulation to support caregivers of persons living with major neurocognitive disorder

Marie-Eve Bolduc, Niki Soillis, & Claire Webster

Major neurocognitive disorder (MND), previously known as dementia, is increasingly prevalent in the Canadian population. In 2016, an estimated 564,000 people lived with MND (Population Health Expert Panel, 2016). This number is projected to surpass 930,000 by the year 2031 due to the population's aging (Population Health Expert Panel, 2016). Because of the progressive nature of most major neurocognitive disorders, persons living with MND need an increasing amount of support to live safely. Approximately 55% of persons living with MND live at home; consequently, their required support is most often provided by family members or friends who spend, on average, 26 hours per week caring for them (Canadian Institute for Health Information, 2019). Caregivers assist with a variety of daily activities. Their contributions are essential given the limited resources available in the health care system, both in terms of home care and institutionalized care. However, very few caregivers have received formal training to help them support persons living with MND (Canadian Home Care Association, 2018). Hence, the burden of caregiving can be amplified by lack of information about disease progression and available services, confusion in roles, unrealistic expectations, and lack of support (Quinn et al., 2009; Sanders, 2005).

The role of occupational therapy with persons with MND and their caregiver(s) is central in maintaining or improving quality of life for both. Interventions most often aim at adapting activities meaningful to clients, supporting positive relationships between persons living with MND and their caregivers, modifying homes to maintain a safe living environment and facilitate engagement in activities, providing resources to promote social participation, and preventing falls (Canadian Association of Occupational Therapists, n.d.).

Occupational therapy programs targeting the occupational needs of persons living with MND and their caregivers have been shown to effectively increase the client's daily function and the caregiver's sense of competency (Graff et al. 2008). However, a one-to-one care model may not be sufficient to cover the needs of our aging population and growing obligations of its caregivers. The need for capacity

building to provide adequate resources for caregivers of persons living with MND has, in fact, been at the center of Canada's first dementia strategy (Public Health Agency of Canada, 2019). The purpose of this article is to share a novel way in which occupational therapists can participate in supporting the caregivers of persons living with MND.

McGill University's Dementia Education Program was founded in 2017 by a former caregiver with lived experience, Claire Webster. Claire collaborated with the Faculty of Medicine and Health Sciences to put community workshops in place to support and educate caregivers of persons living with MND. The workshops' content was developed by the education committee, composed of a multidisciplinary team of health care professionals, including occupational therapists, and people with lived experience. The workshops aimed to develop caregivers' understanding of dementia, its progression, and the resources available within the health care system. In addition to the theoretical segment taught by health care professionals such as occupational therapists, geriatricians, and neurologists, the workshops included live scenarios and used standardized patient actors set in realistic environments.

Simulation education provides unique and powerful opportunities to help caregivers learn to manage difficult situations through experiential learning. The actors receive special training to behave as a person living with MND and to act and respond in a realistic fashion. Scenarios explore themes around safety concerns, home modification, and self-care. Finally, caregivers had the opportunity to have discussions with other caregivers who have experienced similar challenges.

Having conducted more than a dozen sessions, amounting to 68 hours of community-engaged simulation workshops offered to over 200 participants, we have received overwhelmingly positive feedback on the content, organization, and delivery of the sessions. Participants have appreciated the use of a multidisciplinary team of instructors and the active involvement of a former caregiver. Most notably, participants have universally responded that they feel

more competent and prepared to face the progression of the disease after attending the workshop.

Empathy, caregiver burnout, managing difficult behavior, end-of-life decisions and assistive technologies are examples of topics that will be at the forefront of our new upcoming programs. Moving forward in the para- and post-pandemic world, there is also an unprecedented need to utilize technological innovations to assist persons living with MND in their activities of daily living and to alleviate the burden on caregivers. The power of immersive environments in raising awareness and improving management of the disease are also being considered for future workshops. Although the COVID-19 pandemic suspended in-person workshops, the Dementia Education Program introduced a comprehensive range of free online resources to support family members and informal caregivers, including a webcast series called *McGill Cares*, public education webinars available on demand, a dementia activity booklet developed by student occupational therapists, and the newly launched *Dementia: Your Companion Guide* for persons living with MND and their caregivers. Resources can be accessed at: www.mcgill.ca/dementia

The vision of the Dementia Education Program is not only to promote aging in place. Rather, it is about supporting living with grace through promoting empowerment, empathy, and resilience for persons living with MND and their caregivers. Occupational therapists are well positioned to play a central role in the development of such community-based interventions. This type of intervention may be key to reaching more persons living with MND and their caregivers in order to meet the growing needs of this population. The use of simulation within the context of group sessions has the potential to transform the way in which occupational therapists support this population.

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Sharing daily life with a pet: How can occupational therapists help support older adults who want to age with their pets?

Nataša Obradović, Émilie Lagueux, Karine Latulippe, & Véronique Provencher

About one-third of older adults living in the community report living with a pet (Toohey et al., 2018). Many of them receive services at home to allow them to stay at home as long as possible, especially in connection with the changes that accompany aging. These changes are also likely to affect how some older adults engage in activities surrounding pet care. Given the great importance older adults give to their animals and these activities, it is important to explore pets' influence on daily life from an occupational perspective—a vision that lies at the heart of occupational therapy.

Supported by a literature review, this article outlines some of the benefits and challenges associated with caring for a pet by older adults living in the community (Obradović et al., 2019). We then present the situation of an older woman who lives with her pet, based on interviews conducted with her and her occupational therapist working in home support (Obradović et al., 2021). This case study provides an opportunity to reflect on how the expertise of occupational therapists could help better support older adults who wish to age in place with their pets.

The benefits and challenges of caring for a pet

A systematic review of the literature suggests that caring for a pet positively influences older adults' psychological, physical, and social health (Gee and Mueller, 2019). Animals could improve their owner's quality of life and welfare, in addition to being a source of motivation to maintain a daily routine. This continued presence may also reduce feelings of loneliness, depressive symptoms, and anxiety, in addition to facilitating social interactions and increasing levels of physical activity (Hughes et al., 2020).

Despite these documented benefits, caring for a pet comes with responsibilities and potential challenges. First, these responsibilities may be perceived as an emotional or financial burden by some older adults. They may also experience concerns (e.g., related to health, the future, or fear of being separated from their pet) or grief (e.g., following the animal's

death; Gee and Mueller, 2019). Finally, older adults may refuse medical care or to move in part for fear of being separated from their animals (McNicholas et al., 2005). These types of decisions could have undesirable consequences on the health and well-being of the individual or their pet. Some people may be forced to age in place with limited access to certain services; for example, if they prefer to continue living at home rather than move to a living environment with more services but which does not accept pets.

Example of Violette and Jack

Occupational therapists who work with older adults with pets are likely to witness some of the above-mentioned benefits and challenges. Since these people wish to continue to care for their animals at home, it is important to ensure both their and their animals' well-being. So, we looked at the situation of Violette, a 77-year-old woman who lives with her miniature schnauzer, Jack (fictitious names). Violette travels in a motorized wheelchair and walks with prostheses due to double amputations of the lower limbs. The objectives of our study were to explore how aging with a dog influences her daily life and how this woman balances the benefits and challenges associated with caring for him.

Interviews with Violette and her occupational therapist revealed, from a common perspective, that Jack's influence on Violette's daily life is generally positive. For this woman, performing the activities surrounding her dog's needs is a significant, even central, occupation in her life. Jack ensures continuous company, helps to improve Violette's mood, and maintains her morale, allowing her to channel her anxiety. Jack offers Violette a sense of security and, without him, she reports that she would feel lonely and abandoned despite the presence of her social network. For Violette, fulfilling responsibilities related to her dog gives meaning to her life, motivates her, and structures her days, especially since she lives alone. In addition, Jack increases Violette's commitment to other occupations, such as taking care of herself, to be present for him in the future and to be able to go out into the community.

Although in Violette's situation, the benefits outweigh the challenges associated with caring for Jack, she and her occupational therapist recognized the potential presence of the latter. First, the occupational therapist recognized a fall risk that, according to her, is especially present if Violette bends down quickly to pick up Jack. According to Violette, the probability of a fall occurring because of her dog is almost zero, although she admits that predicting the future is impossible. She explains that she and Jack have adapted with her health condition's evolution: Jack often walks in front of her and now jumps on her motorized chair, while Violette avoids using the chair when she is tired. Thus, both Violette and her occupational therapist characterize the risk of falling as low. The second challenge, reported by the occupational therapist and Violette, is the financial resources required to meet Jack's needs, particularly the costs associated with veterinary care. Violette reports, however, that she finds alternative solutions to treat her dog, consults the veterinarian, and pays attention to the expenses. So, for now, costs have not been an obstacle to taking care of Jack. The occupational therapist reports that she put in place several interventions to keep Violette's motorized wheelchair in good condition to allow her to continue carrying out meaningful activities, which include walking her dog outside. In sum, Violette and her occupational therapist agree that caring for Jack is a positive experience, despite some factors that could increase the demands associated with the activity (e.g., presence of physical impairment).

The case of Violette and Jack is an example of how proper alignment between the characteristics of a person, pet, and environment can maximize benefits while minimizing challenges associated with living with an animal. The pair illustrates a situation where aging together in the community is achievable. Of course, it is not possible to generalize this example to all older adults who live with pets and to do so would be unwise. However, this example is intended

to be a starting point to initiate a reflection on the importance of considering the contribution of pets in the daily lives of older adults by occupational therapists during their functional assessments. Through their skills in analyzing their clients' activity and context, occupational therapists can examine the activities surrounding pet care and suggest possible solutions or interventions to improve well-being and prevent adverse consequences for both parties (e.g., help walk or feed the animal, support during a bereavement, the recommendation of walking areas). By supporting relationships between older adults and their pets, occupational therapists can encourage their participation in meaningful occupations in their home.

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En-AGE: A web portal to understand and support later-life occupational transitions

Sachindri Wijekoon, Colleen McGrath, Christie Brenchley, & Shlomit Rotenberg

The number of seniors aged 65 and over in Ontario is projected to almost double from 2.6 million (17.6% of the population) in 2020 to 4.5 million (22.2 %) by 2046 (Ontario Government, 2021). Given the critical and growing needs of the aging population, and its impacts on our health and social services systems, the En-AGE Advisory Council of the Ontario Society of Occupational Therapists (OSOT), composed of occupational therapy practitioners and academics experienced in older adults' care, saw a tremendous opportunity to meaningfully and impactfully contribute to older adults' health and wellbeing.

To this end, in 2018, the En-AGE Advisory Council proposed the development of a web portal, intended to be a living, evolving resource to support knowledge dissemination about occupational therapy and the many roles occupational therapists can play to support aging individuals and their families. The En-AGE Advisory Council consulted and engaged older adults, caregivers, occupational therapy practitioners, and academics over the course of three years to develop the En-AGE portal, which was launched in June 2021.

What is En-AGE?

The En-AGE web portal (www.En-AGE.ca) is a dynamic, publicly accessible web-based knowledge mobilization venue catering to three audiences: older adults and their caregivers, occupational therapists, and health policy decision makers (e.g., hospital administrators, government officials, etc.). Occupational therapists have unique skills that can support older adults to adapt to the changes that may be imposed by older age; the profession's focus on enablement and reablement is reflected in the site's name of En-AGE: *enabling aging, growth, and engagement*.

The web portal currently features ten modules, each focused on a key occupational transition commonly experienced in older age and how occupational therapy services can support older adults, and those who care for them, to navigate these:

1. Thinking About Retirement
2. New Challenges as an Older Worker
3. Driving and Getting Around in Later Life
4. To Move or Not to Move: Deciding Where to Live and Who We Grow Older With
5. Growing into Senior Citizenship
6. When Caregiving Becomes an Identity
7. Staying Socially Connected
8. Religion and Spirituality
9. Managing Changing Abilities
10. Reaching the End of Life

The modules are founded in best evidence and were developed by leading researchers and occupational therapists working in the care of older adults. The modules are further grounded in the lived experiences of older adults, caregivers, and occupational therapists through the integration of stories. The goal is to maintain the site as a dynamic, evolving body of evidence and resources.

For many older adults, later life is a time of great adjustment. Some changes are expected and may be easier to cope with, while others may be unforeseen and often unwanted, requiring older adults to adjust to a new role or identity. Either way, occupational transitions are at the heart of human experience (Settersten & Thogmartin, 2018); as occupational therapists, we can play a vital role in preparing, planning, and supporting older adults to grow through these life changes.

Five ways occupational therapists can use the En-AGE website include:

1. **Share the En-AGE web portal** as an information hub for clients and caregivers.
2. **Use the En-AGE web portal as an advocacy tool** to celebrate and demonstrate the distinct value of occupational therapy in older adults' care and to support efforts to promote new programs, access to services, and more.
3. **Promote occupational therapy as a vital support to older adults and their families.** Post about it on your social media platforms, promote it to community centres and services for older adults, include links to it in your communications and websites, and share it widely.
4. **Enrich your practice knowledge and approach to enabling older adults' health and wellbeing.** En-AGE informs and inspires by highlighting innovative practices, by providing insights into the life journeys and challenges of older clients, and by sharing links to evolving evidence and resources to support occupational therapy practice with older adults.
5. **Contribute to ongoing enhancement of the site.** The En-AGE web portal is intended to be a dynamic and evolving resource. To ensure that diverse lived experiences are represented, and that the modules are relevant and meaningful, OSOT and the En-AGE Advisory Council invite you to share your experiences, resources, and feedback with: osot@osot.on.ca

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Aging in place—but at the cost of loneliness?

Jim Mann, Flora To-Miles, & Lillian Hung

Canada’s aging population is expanding rapidly in number. In 2019, 17.5% of the Canadian population was 65 years of age and older, and an increase to 22.7% is projected by 2031 (Statistics Canada, 2019). To meet the needs of older adults, Canada (along with many other countries) promotes the idea of *aging in place*, which is having access to “the health and social supports and services you need to live safely and independently in your home or your community for as long as you wish and are able” (Federal/Provincial/Territorial Ministers Responsible for Seniors, 2016).

There are many benefits of aging in place, including sustaining quality of life and physical health as well as reducing financial health care costs (Marek et al., 2012). Another benefit is maintaining one’s social connections in one’s familiar environment (Tümer et al., 2021). While there are many advantages to aging in place, living at home can be a lonely situation if social supports are not in place, especially for those declining in health (Mayo et al., 2021). When an individual no longer has optimal social connections and ties, is aging in place the best option?

This article discusses how aging in place can have implications for social isolation and loneliness, with reflections from Jim Mann, an individual living with Alzheimer’s disease and has had experience in caring for his mother (who also had Alzheimer’s disease) both at home and then in a care setting. We then conclude with some suggestions for policy makers and occupational therapists to consider when pursuing the goal of ensuring that older adults are socially engaged while aging in place.

Aging in place and social isolation: Insights from Jim Mann

The image that comes to mind when “aging in place” is mentioned is one with friendly neighbours or family close by, always ready to lend a hand, and with home care available and reliable as clockwork, if and when it is needed. However, people may not have such supports in their lives. They may also not want or be able to leave their home to engage in the community, to socialize, or to see or meet other people. The focus of aging in place is solely on that—to age in your home.

Aging in place involves more than adapting a home in which to live safely every day by adding grab bars in the shower. Governments and even societies that promote the idea of “better-at-home” by saying everybody wants to live at home as long as possible illustrate to me just how easy it is to say those words. The reality of aging in place is complex when ensuring a good quality of life for an individual with dementia living alone, or for an older couple dealing with a spouse with dementia. As Stephen M. Golant, a University of Florida professor of gerontology, has expressed: the current aging-in-place movement is too “simplistic” (Kunkle, 2015).

Carol Bradley Bursack, a caregiver for a family member with Alzheimer’s disease, wrote that even though she visited her mother-in-law daily in her condominium and “bought her groceries and fixed her meals, she steadily went downhill, especially cognitively” (Bursack, 2015). But when she moved into a long-term care home, her mother-in-law was so “rejuvenated by the social atmosphere” and the feeling of safety and caring that she was “utterly transformed” (Bursack, 2015).

Bursack’s personal account reminds us that beyond the hope or desire to live at home, issues of social isolation and loneliness experienced by older people, especially those with dementia, need to be top of mind. Loneliness is a risk factor for many mental health issues, including depression and suicide (Donovan et al., 2017). This stark reality is even more pertinent during the COVID-19 pandemic, during which people have been advised to stay home and avoid contact with others as much as possible.

As my point of reference in this discussion about aging in place, I look to my wife’s and my godchildren—two boys (now grown up) whose proud parents live in our area but rely on technology to keep in touch with their children, who live in other countries. Through virtual means, they in turn can keep in touch with their parents and provide some social and emotional support. But what about older adults who do not have children? They may also not have any living brothers or sisters or other relatives.

Older adults not only need social support; they may also rely on other people to provide some practical supports in their activities of daily living (ADLs). Individuals who are aging in place may have restricted mobility and/or physical limitations; they may be able to function in their home but require assistance with some ADLs like meal preparation or bathing. Time allocated for each visit by a home care provider is limited, which, in my opinion, is likely to provoke responsive behaviours from clients. Health reporter and columnist André Picard wrote that home care in Canada is a “complete disaster” (2021, p. 79). Workers may show up late, if at all, and he observed that “care aides didn’t seem to have any specialized training for dealing with patients with dementia” (Picard, 2021, p. 80). Therefore, we cannot rely on home care to provide the social, emotional, and practical supports that older adults require.

Dementia and social withdrawal

As the age of the Canadian population increases over time, so too will the prevalence of aging-related conditions. One such condition is dementia. Research shows that 62% of people who live alone with dementia experience loneliness, compared to 38% of all people with dementia (Alzheimer’s Society, 2014). A contributing factor to this loneliness, I suggest, is the tendency for people with dementia to withdraw from socializing, which is why I emphasize the need for every person to have a purpose. How vital that purpose is for people with dementia—a reason to get out of bed in the morning. Without social supports in the home, that purpose may be hard to find. Finally, living with dementia can be overwhelming and challenging, and those challenges can make one feel even more lonely and isolated.

Social withdrawal—avoiding friends, family, and activities—is a consequence of age for many older adults. Yes, programs can be developed at the local community centre or library, for example, which are great, but they rely on individuals to be motivated and able to travel to the activity centre, which is a challenge for some—especially, I would suggest, for those living with Alzheimer’s disease.

A man I’ll call Charles, from my support group, lived with his wife in a basement suite while his daughter, son-in-law, and their two children lived upstairs. A year after Charles’ wife passed away, he realized that with his daughter and son-in-law at work and the children at school, his days were spent watching television with no other human contact. His solution was to move to an independent living apartment, where he was able to make friends and join others for activities and meals.

My mother, who also had dementia, lived alone in her condominium after my father’s passing and was lucky enough to have a neighbour who offered to grocery shop for her. As she didn’t drive, she was very thankful. My mother was mobile, yet she liked to keep to herself. Her world had shrunk, and she became socially isolated. Was she lonely? She said no, but in reality, who knows?

I believe she benefited from her move into independent living, where meals were offered to all residents in the complex’s dining room. While she may have returned to her suite between meals, she engaged with others over a meal. She also made friends with one of the other women and, together, they would go to select evening events, activities that would not even be a consideration to my mom when she lived in her condominium.

In the foreword for the book, *Life at Home for People with a Dementia*, I wrote: “Am I completely sold on the idea of staying at home as long as possible? The jury is still out” (Bartlett & Brannelly, 2018, p. xi).

It has been four years since I wrote that foreword, and for me, the jury is still out.

Gerontologists refer to aging in place as a process, subject to ongoing negotiation (Wiles et al., 2012). The meaning of place may change as the care needs of an older adult change; further, a place can be material, physical, social, and symbolic. In a study that interviewed 121 older adults in Canada and New Zealand, aging in place was viewed as a sense of attachment, security, and familiarity (Wiles et al., 2012). As Jim has suggested in his above reflection, some people may find that an independent/assisted living facility or a long-term care home offers social relationships and a sense of safety and security. The meanings of aging in place for older people and their relationships to loneliness and isolation have important implications for occupational therapy research and practice. Occupational therapists can explore what makes a living environment good for aging, what constitutes a sense of attachment, and what can be done to best support a sense of familiarity and security, as well as social relationships, for their older adult clients.

Community occupational therapists should assess whether their older adult clients have social supports, and if they do not, work together with them to access them. Accessible transportation is essential so that older adults can attend community centres, libraries, and other places to meet their social needs (Council of Canadian Academies, 2018); occupational therapists need to assess whether their clients can safely access their communities easily. In addition, occupational

therapists can educate the community regarding the challenges encountered by older adults and provide strategies on how to best support them (e.g., working with bus drivers to ensure safe and accessible transportation for older adults). Overall, aging in place is and should be a personal choice. It has the potential to maintain quality of life, but we need to ensure that appropriate supports are in place so that older adults are socially connected and flourishing (not just aging) at home.

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An immigrant family's journey through stroke over three decades

Elly Park

"It is not joy that makes us grateful. It is gratitude that makes us joyful." —Anonymous

I write this piece primarily as a daughter—although as an occupational therapist in Canada I have become more attuned to how my family's experience with stroke may resonate with others—to provide a unique perspective about the deep intersections among aging, culture, family, and home.

In 1994, my father, Jong, had a cerebrovascular accident (CVA) affecting the left side of his brain and right side of his body. He was 45 years old. At the time, my dad was an active member of his church and president of the local Korean society. My dad's sense of identity and self-esteem transformed overnight. The stroke ended up causing right hemiparesis and severe aphasia. My mom became his full-time caregiver. She faced distress, obligation, and a multitude of roles she was not prepared to take on.

My parents immigrated to Canada in 1975. They worked in factories and small businesses until they were able to purchase a restaurant in 1982. Their resourcefulness and tenacity turned it into a thriving business, still in operation today. My parents were eventually able to sponsor their parents and siblings to join them in Canada from Korea. My mom and dad had five daughters; their youngest was only twelve years old when my dad had his stroke. I have contemplated how living in Canada profoundly impacted my parents' health care experiences, particularly in terms of access to services and financial aid that we received, which would not have been available in Korea.

My mom had to shift her priorities after the stroke. Instead of working full time at the restaurant, she started boarding students from abroad so she could be at home to attend to my father. My paternal grandparents lived with us and were able to help with household chores and provide some assistance with caring for their son and five grandchildren. My grandparents taught my siblings and me about the Korean language and culture, which we still cherish today.

My dad was not able to return to the family business. Although he remained at home, he independently

carried out his daily occupations within the first few months. He relearned how to drive, and he could help take the boarding students to and from school. In later years, he oversaw pickups and dropoffs for the grandkids! He could navigate using the computer to pay bills through online banking. He was dedicated to attending church and has remained on the church board as an elder. He was still able to sing despite his aphasia, and he continues to participate in the church choir even today.

Over the past 28 years our lives have progressed—my sisters and I went on to pursue our passions and start our own families, and we have collectively given my parents 11 grandchildren! As part of a close-knit family, my sisters and I are often called upon to help my mom and dad navigate various social systems and institutions, including health care. I have realized that due to having many daughters, my parents are able to get support from each of us in different ways, and we can share the responsibilities.

My father recently expressed to me that he feels gratitude rather than regret for what has happened. It took many years for him to get to this point, but he said that having a stroke was the best thing that happened to him. Those words have perplexed me as I think about what seemed to me like a tremendous loss for him. As my sisters and I have reminisced, my dad was "larger than life" to us as a leader in the community, successful businessman, and father of five. He intimidated and impressed those around him. We knew him as ambitious, charismatic, and wise. It is his wisdom that now shines through; he sees not what he has lost, but how rewarding and fulfilling his life has been. He has felt true joy.

After he had his stroke, I noticed how many of my dad's friends moved on, leaving my dad behind. Those closest to him stayed by his side, and their dedication was a testament to their loyalty. One friend came to our house every night and provided massage therapy and stretches to help with circulation and strength for months. Others would come and play the Korean game Go with my dad, which I believe helped him maintain cognitive acuity. My mother also turned to close friends for companionship and support. My father's younger brother and his wife managed the restaurant for several years—a tremendous service

to my mother. My sisters and I all worked at the restaurant along with cousins, aunts, and uncles. It is through this community that my dad has been able to age with dignity. Perhaps the pure love felt within this group is what my dad feels, and that is why he is grateful for what has happened and the life he lives today.

Lived experience session

In November 2021, I presented at a health care conference on the shared perspectives of our experience through stories compiled in collaboration with my parents and sisters. Using family photographs and stock photos, as well as a few videos taken of my father, I created three digital stories. These videos can be accessed through the YouTube links below. During the session, health care providers and caregivers shared some of their experiences in working with clients and loved ones who are at varying stages of stroke rehabilitation and other chronic conditions. We discussed the challenges of being supportive when there is a sense of hopelessness, anger, and frustration. Often clients are emotional, and as therapists, we are not sure how to best serve them. Storytelling has been recognized as a powerful tool and may be used for therapeutic reflection, education, and knowledge dissemination (Park et al., 2021). Perhaps sharing or creating digital stories is one way to share lived experiences as part of the rehabilitation process.

Opening new paths

As my sisters and I get older, we are determined to provide respite for my mom financially, emotionally, and physically. We realize how fortunate we are to live in a country where we have assistance and resources available to us, giving my dad opportunities he would not have had otherwise. My siblings and

I are close, but I wonder if we would have been as close as we are today were we not connected by our love and concern for my dad and mom. The reverence we have for our mom permeates our own lives, and I am motivated and inspired by her strength, resourcefulness, perseverance, and grit. My mother has made their home into a place where my father can be comfortable and feel safe.

Going through this process of reflection has been insightful and gratifying. When I see my parents today, my eyes fill with tears, but my heart is full. My mom and dad have been able to stay in their home, but as a family, we are interdependent and need each other to truly thrive. We rely on one another, and in doing so, our lives have been enriched. What I have come to realize is that aging is not something that passively happens to us. We all age, but we can feel remorse and pain as we endure it, we can reject it and deny it is happening, or we can embrace it with grace and humility.

Digital story links

Video 1 – Journey to Canada
<https://youtu.be/UC0ideZXhU4>

Video 2 – Experiences of having a stroke
<https://youtu.be/7wGSigNtDsU>

Video 3 – Family reflections on the past and present
https://youtu.be/HULNgNn_Wd8

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Aging in place is not a universal solution: Lessons for occupational therapy

Sachindri Wijekoon

Aging in place refers to continuing to live in the same or a familiar place or community for as long as possible (Bigonnesse & Chaudhury, 2020). It aims to enable older people to maintain their social relationships and daily routines in a familiar environment, which also facilitates independence and a sense of control over their lives (Iecovich, 2014). Consequently, *place* has gained considerable attention from both policy and gerontological perspectives in addressing the needs of aging populations.

However, much of what we know comes from research studies conducted with samples from middle- and upper-income populations with adequate housing and key resources to support aging in place (e.g., Graham et al., 2014; Paganini-Hill, 2013). Instead, housing concerns of older adults who are Indigenous, immigrants, and/or rural dwellers have been largely overlooked in the literature (Weeks & LeBlanc, 2010). In Canada, Indigenous Peoples are the most poorly housed social group, affected by numerous health challenges due to inadequate housing (O'Donnell & Tait, 2004). In rural settings, social isolation and fragmented service delivery, affected by factors such as practitioner shortages, can pose challenges with maintaining long-term independence (Quinlan et al., 2020). Finally, the concept of aging in place may not capture the experiences of those who have crossed international borders in their older age.

Aging in place is also a Western concept that emphasizes ideas of continuity, place attachment, maximization of independence, and fit between person and environment (Cristoforetti et al., 2011; Wiles et al., 2012). While this Western conceptualization is intuitively understood by most occupational therapists, many of whom are white, middle-class women, because it aligns with their own understandings and experiences, it may not resonate or reflect minoritized aging perspectives. As an example, for some older adults, aging in place may not be a preferred, feasible, and/or realistic option. For instance, multigenerational households are among the fastest growing types of living arrangements in Canada due to cultural norms brought by immigrants, economic necessity in an

era of surging housing prices, and shifting values (Bruemmer, 2018).

In the absence of lived experience and a shared understanding of minoritized aging experiences, occupational therapists may not be well equipped to assist older adults for whom aging in place is not an option. So, occupational therapists must advance collaborative roles with minoritized older people including those from diverse socioeconomic statuses, cohorts, and racial/ethnic/cultural backgrounds, as well as familiarize themselves with minoritized aging experiences through conversations with clients and colleagues with diverse lived experiences. Below I describe one minoritized aging experience—the experience of late-life immigrants aging *out of place*.

Late-life immigration: An example of “aging out of place”

In an age of globalization, the experience of aging in a foreign land is part of the late-life experience of many older adults (Sadarangani & Jun, 2015). Increases in life expectancy and refugee admissions (Montayre et al., 2017), as well as elderly parents following their adult children to their new countries after emigration because of economic considerations and cultural norms regarding caring for elderly parents and relatives (Zhou, 2012, 2017), have contributed to the rising global phenomenon of late-life immigration.

For these older adults, the concept of aging in place may not resonate with their physical and emotional experiences. Following immigration, these older adults typically face great difficulty integrating into the host country, resulting in feelings of dislocation and alienation. Late-life immigrants experience a demoted status in the host society and within the intergenerational family with whom they often reside. Social and linguistic isolation and transportation barriers negatively impact the wellbeing of late-life immigrants (Wijekoon et al., 2021). In fact, late-life immigrants experience higher levels of acculturative stress, depression (Wrobel et al., 2009), and loneliness (Guo et al., 2019; Wu & Penning, 2015) compared with non-immigrants.

Although late-life immigration is a stressful life transition that can transform an older adult's aging trajectory, late-life immigrants engage in a process of making home by drawing on occupations to negotiate place in the process of migration and subsequent integration. Late-life immigrants actively and continually create a sense of home in the host country through occupations that connect their past and present experiences of home. For instance, embeddedness in familiar occupational spaces, such as religious spaces and ethnic hubs, allow late-life immigrants to engage in familiar cultural practices and create biographical continuity between their old and new lives. Moreover, engagement in culturally prescribed occupations, such as religious practices, transmission of cultural knowledge to younger generations, and noneconomic contributions to the intergenerational household, restores purpose and meaning and eases the experience of aging out of place (Wijekoon et al., 2021). So, meaningful occupational engagement is crucial for transforming the sense of disorientation and alienation experienced in the host country into a sense of home.

Implications for occupational therapy

Occupational therapists should broaden their understanding of aging in place because it is not a one-size-fits-all concept and may not be realistic, feasible, or beneficial for all older adults. Occupational therapists can support late-life immigrants to establish a sense of home by fostering security, familiarity, and control. Occupational therapists can:

- Enable participation in meaningful occupations through skill development (e.g., providing public transit training, supporting self-efficacy skills, re-establishing previous occupational roles, developing routines, etc.) and community integration (e.g., educating about community resources and fostering social occupations, spaces, and networks; Huot et al., 2021).
- Incorporate religion, culture, and belonging to an ethnic group, which can buffer against the stresses of late-life immigration, into intervention plans.
- Advocate for culturally relevant and responsive services and opportunities that acknowledge the social, cultural, linguistic, and structural barriers to occupational engagement, to support late-life immigrants to establish a sense of home in the host community and country.
- Reflect on personal beliefs and values and how they compare to the beliefs, values, and experiences of clients.

By supporting the development of strong emotional bonds to the host country through meaningful occupation, occupational therapists can assist late-life immigrants not to age in place, but to age in a place that meets their diverse circumstances and needs.

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Suicide and OT Practice Network – new resources available

Occupational therapists have been called to address suicide in their practice, as stated in the CAOT role paper: Suicide Prevention in Occupational Therapy. The Suicide and OT Practice Network responded to the request by CAOT members for resources, education and support to address the issue of suicide prevention. There are now three documents added to this practice network's page <https://www.caot.ca/site/pd/otn/sot?nav=sidebar> that provide guidance in using resources for suicide prevention, intervention and postvention. Prevention topics include risk factors/warning signs, assessing risk management procedures

in the workplace, introducing the conversation and using screening assessments to determine an individual's level of risk for suicide. Intervention topics address lethal means restriction, coping strategies, safety planning – content and process, and phone applications. Postvention topics address support for those affected by suicide. The documents include case scenarios to aid in the illustration of putting resources into practice. We encourage you to view these resources and welcome your feedback on benefits and/or gaps in information. Contact information for network members is available on the webpage.

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Connected occupational therapists to promote health and healthy aging!

Mathilde Chagnon, Marie-Hélène Lévesque, Patrick Boissy, & Mélanie Levasseur

The population's aging and current pandemic are leading to significant changes in occupational therapists' practice. To comply with access restrictions, public health considerations, and growing needs that were previously less frequent in their practice (infection prevention, fragility, social isolation; Donnelly et al., 2021), occupational therapists have turned to telehealth (Hoel et al., 2021)—that is, a mode of health care delivery using telecommunications tools such as telephone and smart devices (Sarsak, 2020). Even if telehealth is versatile, it is mainly in a consultative and *coaching* mode that it is most used and effective (Dahl-Popolizio et al., 2020; Hoel et al., 2021). Since chronic disease prevention and health promotion activities rely heavily on these activities (Pentland et al., 2016), telehealth remains an important option to explore to promote aging in place and health (MSSS, 2021). To do this, it is important to adapt certain prioritized interventions to telehealth, including the prevention of deconditioning, and to support the adoption of a critical view by occupational therapists on issues related to this modality. This article provides an overview of the benefits and challenges of using telehealth as well as the PROMOSANTÉ initiative (**P**rogramme **m**ultimodal de télésanté axé sur l'**a**utogestion de la **s**anté [multi-model telehealth program focused on self-management of health]; Boissy et al., 2021), an example of innovative and inspiring practice for occupational therapists.

For older adults (Wakasa et al., 2020), including those in rural areas (Kringler et al., 2020) or with chronic diseases (Hansen et al., 2020), telehealth contributes to improving service access. Since telehealth makes it possible to cope with difficulties related to transportation, energy conservation, symptom management, and the interruption of daily routine, this modality deserves to be integrated in a sustainable way into occupational therapy services. Furthermore, while nearly half (49.0%) of occupational therapists turned to telehealth during the pandemic (Hoel et al., 2021), the digital shift was being embraced by older adults a few years earlier (e.g., increased internet connections and increased use of technology;

Krendl & Perry, 2021; Statistics Canada, 2021), which allowed them to maintain their access to occupational therapy services (Ng & Park, 2021). In some conditions and for some people, however, telehealth involves challenges such as restricted access to the internet, low levels of digital literacy, or the lack of caregivers to support the usability of devices. An adequate analysis of the environment and the user's capacities is thus recommended. Although there are solutions (e.g. involvement and training of relatives), some problems (those structural in nature, such as limited access and speed of connectivity in rural areas) may remain unresolved (Sarsak, 2020), so telehealth should not be considered as the sole mode of care delivery. However, given its benefits, telehealth could contribute to more accessible, inclusive, and ongoing care.

In the context of a pandemic, ensuring the safety of users and professionals, while respecting health restrictions, is a key issue to which telehealth makes it possible to respond (Monaghesh & Hajizadeh, 2020; Sarsak, 2020). By limiting the number of physical contacts and trips to healthcare settings, telehealth reduces the risk of contamination and promotes optimization of individual (e.g. energy conservation for older adults) and organizational resources (e.g., cost-effectiveness of interventions; Jennett et al., 2003). To ensure the quality and ethics of telehealth services, however, safety must be considered more generally. As a result, the informational aspects (e.g. confidentiality of the electronic platforms used), financial aspects (e.g. reimbursement of services), and respect for the individual's preservation of dignity (e.g. avoiding exposure to the camera during intimate interventions such as observing hygiene care) should all be considered. Occupational therapists must also have the necessary computer skills and be informed about existing guidelines for remote care, including those of the Canadian Association of Occupational Therapists (2011) and of the World Federation of Occupational Therapists (2014).

To reap the benefits of telehealth and better meet the challenges of the pandemic and an aging

population, occupational therapists need to rethink their practice by integrating more preventive and virtual interventions. Developed from evidence and shown to be effective in improving older adults' functioning and quality of life, the Lifestyle Redesign® program (Clark et al., 2021) is a promising preventive occupational therapy intervention to promote aging in place. Designed to be offered in person, this program is currently adapted to a hybrid service (online and in person) and will also be integrated into the PROMOSANTÉ initiative (Boissy et al., 2021): a multimodal telehealth program co-created by a multidisciplinary research team and aimed at preventing the deconditioning of older adults. Focused on self-management of older adults' health and social participation, PROMOSANTÉ also includes physical activity and psychology interventions offered in person and online.

While allowing for aging in place, this combination of interventions from occupational therapy, kinesiology, and psychology will help reduce the strain on health services. More specifically, PROMOSANTÉ's interventions will be accessible through a web platform and will include synchronous meetings and asynchronous activities. For example, some group sessions of the Lifestyle Redesign program will be offered virtually and synchronously, promoting collaborative learning and real-time exchanges. At the same time, asynchronous activities (e.g. video clips) support older adults' empowerment through relevant content they can explore at their own pace and apply in meaningful contexts. Ultimately, PROMOSANTÉ could contribute to an offer of services that are accessible, safe, and adapted to older adults' needs.

In conclusion, telehealth occupational therapy interventions have several advantages and are increasingly used in practice. With older adults more connected and health measures that promote technology use, the context is favorable for the implementation of digital interventions. To make it a permanent option, and to address the associated challenges, however, the use of telehealth must be guided by clear guidelines as to the most convincing interventions, how to transfer them to telehealth, and the identification of the clientele and contexts most favourable to its application. To do this, it is important to document the use of telehealth through projects such as PROMOSANTÉ which, by using innovative technologies and multidisciplinary expertise, will expand the scope and impacts of occupational therapy interventions, particularly in terms of preventing older adults' deconditioning. Ultimately, an adequate telehealth service offering could not only help occupational therapists move beyond conventional solutions for fairer and more accessible care, but also support them in adopting new visions for the future

where they can stay active longer and age better at home.

Want to know more? Get the Lifestyle Redesign program manual at <https://www.caot.ca/client/product2/1077/item.html> or consult the PROMOSANTÉ project sheet at <https://bit.ly/3sru9gF>.

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Aging in place: The importance of choices in situations of vulnerability

Véronique Gagnon-Coderre & Mélanie Levasseur

Aging in place means that a person can live in their home and community safely, independently, and comfortably, regardless of age, income, or level of ability (Centers for Disease Control and Prevention, 2022). The physical and social environment of the neighborhood thus represents *home*. According to some authors, home should not only be limited to conventional homes but should also include other types of residences (e.g., private residences for older adults). Therefore, to promote aging at home, it is important to favor a heterogeneity of life situations (Weil & Smith, 2016) and to accentuate home as a place that generates feelings of belonging and security. For many older adults, being able to age in their home is synonymous with autonomy, independence, control (Bercaw, 2020; Simard et al., 2015), and freedom (Stones & Gullifer, 2016). However, aging in place is associated with a positive image of aging, often promoted by healthy older adults, stigmatizing those with disabilities or vulnerable living situations who are more likely to either stay in an environment that is not adapted to their needs or leave their homes.

Aging in place is not only a goal for older adults; many health professionals want older adult clients to stay at home as long as possible. However, not all of them want to live their last years at home. Due to a decline in their abilities, some older adults fear becoming prisoners in their homes and, in order to regain a certain level of independence, wish to move to continue to carry out most their activities in a more suitable home (Finlay, 2021). With increasing life expectancy and limited home support resources, it may no longer be as realistic to expect a person to stay at home for the rest of their lives while their health declines and their need for support grows. Health and social services professionals and, particularly occupational therapists, must therefore support older adults in identifying answers to a few questions.

First, does the older adult want to age in place?

Every older adult is unique. Their needs, values, and desires may vary from one individual to another. It is therefore important to consult older adults to know their preferences while promoting reflections on the

choice of staying in their home. Taking ownership of this reflection involves knowing the available options for living environments and listing their advantages and disadvantages, while also considering the services required and the older adult's objectives.

Second, is the older adult in a vulnerable situation?

Regardless of what the older adult wants, we must recognize situations of vulnerability and their effects on aging and objectives related to aging in place. A *situation of vulnerability* is defined as a set of circumstances in which one or more people experience biological, psychological, socio-economic, social, or environmental complications (Levasseur et al., 2022). These complications increase their risk of being injured, harmed, or having difficulties adapting leading to consequences on their lives.

When an older adult wants to age at home, but the complexity of their situation means that this home no longer meets their needs, it is important that they be aware of the potential consequences, and that solutions be considered proactively.

Third, how can situations of vulnerability or their consequences be reduced?

To reduce these situations and their consequences, it is necessary to assess what complications the older adult is experiencing and to identify how to intervene, whether at the individual, family, community, societal, or political level.

A loss of choice in the face of situations of vulnerability

Lack of choice represents a kind of loss of independence, autonomy, and control in one's life. Failure to respect a person's speech, wishes, or desires is a common phenomenon during aging; this represents infantilization (Laublin, 2008). During advancing age and in the presence of biological, psychological, and social complications, a person is more likely to be infantilized by those around them and, thus, be devalued. Since not being heard can increase the risk of situations of vulnerability, losing this freedom of choice fosters the creation of a vicious cycle.

Countering situations of vulnerability to promote aging in place

Women, people from ethnic or linguistic minorities, people with low incomes (Hames et al., 2017; McDermott-Levy et al., 2019), or marginalized people (e.g., sexual diversity, substance abuse) are more at risk of experiencing situations of vulnerability (National Gay and Lesbian Task Force, 2010). These characteristics can also occur throughout life and in old age, and thus create more vulnerable situations related to aging at home. By identifying these people, particularly among older adults, it becomes possible to better intervene to include them in the identification of facilitators and barriers to their home support, to value them, and to develop interventions or policies relevant to their reality. Facilitating their integration into the community and creating resources more economically or culturally accessible to them would promote these older adults' participation and thus independence (United Nations Economic Commission for Europe, 2009).

Occupational therapists should help identify complications related to situations of vulnerability and assess how they interact to develop their recommendations. For example, in the presence of reduced mobility, it is possible that an older adult may require accommodations, technical aids, or services to ensure safe and comfortable aging at home. Low income, distrust of strangers (Brim, Fromhold & Blaney, 2021), fear of being placed in a residence, and lack of awareness of available services can prevent necessary home modifications and maintenance. Informing older adults of available services (Brim et al. 2021), encouraging peer-to-peer communication (Bercaw, 2020), and providing maintenance services through recognized resources could reduce the burden of renovations. It is important for older adults who wish to obtain financial assistance or support from government services, but who have difficulty completing these requests, to guide them to resources that can support them in these efforts. Finally, when the discussion focuses on changes to be made in the home, it seems relevant to advocate for a positive approach, highlighting how the home could be improved, instead of focusing on how the home is not adequate (Bercaw, 2020).

The community may also act as a source of vulnerability or as a facilitator of aging in place. The occupational therapist must consider what a community offers and means to the older adult, and then assess the risks, such as social isolation. In this regard, the occupational therapist must be interested in the social environment, often in collaboration with a social worker or community organizer. Aging well in one's community is often represented by a

continuation of one's social role, supports, as well as closeness to family and friends. Transportation and services provided by the community must also be adequate, accessible, and affordable to meet older adults' needs, regardless of their abilities. In short, it is important to consider what is valued by the older adult, and then introduce the resources that will be useful to them in achieving their objectives.

The importance that it is really a choice

Every older adult should have the right to choose to age in place without prejudice, stigma, and—most importantly—without fear of success or failure (Weil & Smith, 2016). Considering the heterogeneity of older adults and their needs, equity can only occur if various housing options are available (Building with Mission, 2022). Finally, occupational therapists must be involved in identifying environments that can better meet older adults' preferences. If necessary, the occupational therapist should be responsible for assessing the individual's abilities and vulnerable situations, identifying resources that allow the older adult to adapt and, subsequently, documenting their impact on their quality of life. In short, we must recognize the importance of choices, celebrate the diversity (Finlay et al., 2021) that exists regarding the desire to age at home, and find innovative solutions, so that each older adult can age according to their own perception of home.

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The COVID catalyst: The increased need for occupational therapists to assist with discharge from long-term care to home

Holly Reid & Jill Slauenwhite

Occupational therapists work in dynamic settings, with an ever-changing need for adaptation of our roles and scope of practice. Some scenarios are simpler, while others are more complicated, such as discharge planning from a facility. Planning for discharge from acute care to home is a key role for occupational therapists working in hospitals, requiring in-depth collaboration with the interdisciplinary team to get an understanding of a client's current function and care needs, as well as the level of functioning required to safely return home. Working in conjunction with community occupational therapists provides valuable information about the client's home environment, identifying barriers to safety and function and potential solutions to mitigate these barriers. Whenever possible, clients and family members are involved in these conversations, as decisions are most effective when the plan is co-created in a client- and family-centered manner. The purpose of this article is to identify the challenges community occupational therapists are facing related to client care during the COVID-19 pandemic and to provide solutions to assist in addressing these gaps in practice.

The challenge

As of January 5, 2021, long-term care (LTC) and retirement homes have accounted for 11% of COVID-19 cases and a total of 73% of total deaths in Canada (Norris, 2020). Many care facilities have limited or prohibited visitors, inclusive of family members, as a response to COVID-19. Group activities and access to outdoor spaces are also severely limited. Influenced by the ongoing restrictions resulting from COVID-19, we are seeing an increasing number of families discharging their loved ones from facilities to bring them home. Highlighted by British Columbia's Seniors Advocate, Isobel MacKenzie, the extremes of loneliness and isolation of loved ones in facility care have been difficult for both clients and their families to bear (Griffin, 2021). Initially, clients remained isolated from their family members who previously visited weekly, if not daily, and provided both emotional and practical support. Later, guidelines were changed to allow one designated visitor on a

limited basis, but this did not meet the needs of all clients and families. Although clients have been taken home by family from all levels of congregate care, it is clients with more complex needs coming from LTC who present more significant challenges to community occupational therapists. LTC was once considered a destination where one can live out all remaining years in a supported environment, to maximize quality of life. It is only now, in light of a global pandemic, that clients are leaving facilities to return to the community.

The challenge illuminated during the COVID-19 pandemic is a lack of established channels of communication, protocols, and processes to guide this transition, since it was previously uncommon for a client to leave LTC. This is a stark contrast to the standardized protocols and processes in place within acute care settings, as a primary goal within these settings is discharging clients from the institution to the community. Those living in LTC may not have community housing anymore, because the goal was not to return home. This means a new discharge destination must be identified, collaborating and consulting with family living either locally or outside of the region. It takes a group effort to make this happen, and even when the client has a destination, the transition can be challenging. As occupational therapists, we must identify potential and real challenges in a given context and offer solutions that enable both clients and families.

Within this context, there are many concerning gaps in meeting clients' functional and occupational needs that are being observed by community occupational therapists. Family members are willing to bring a client home to provide care, but they may not be informed of and understand the risks and responsibilities involved. As human beings, we only know what we know—in other words, if family members do not know the care needs of their loved one, how can they be adequately prepared for the task of being a caregiver? This is where the opportunity arises for community occupational therapists.

Proposed solutions

Client and family advocacy: Advocate for the family to receive the care plan from the facility in advance, so family members can begin to determine if they can collectively meet the care needs with available resources. Having access to a detailed care plan from the facility would enable a family to begin to formulate an understanding of what may be required for a safe transition home and reduce the likelihood of hospitalization or preventable functional decline. Occupational therapists can facilitate collaboration among all stakeholders, who may include equipment providers, facility staff, colleagues from other professions, the family, and the client, among others.

Assessment of environment: Equipment needs to be arranged in advance so the client can come home to an environment that enables them to navigate it without unnecessary risks. This involves a home visit to assess the environment, to promote the desired level of independence as well as a safe care setting for both the client and the family caregivers. The assessment will lead to recommendations for equipment and home adaptations that create an environment that will best meet the client's needs.

Educating families: We have expertise in enabling occupation and share this expertise through educating others, which can include conversations, the sharing of reliable and trustworthy resources, and demonstrations. We can educate and coach the family on safe body mechanics when assisting with transfers, proper use of equipment, and injury prevention, as well as discuss caregiver burn out. We can also provide information on behavioural needs for clients with dementia, which can be exceptionally challenging for caregivers.

Collaboration and team-based approach: Being truly family centered requires coming to a shared understanding of what the family's strengths are and where the limitations may be. Throughout discussions a more accurate picture can be painted—each question representing a stroke of the paintbrush, filling in a gap. Involving our interdisciplinary team members early on to support families in the provision of all

aspects of care can aid in smoothing the transition and build the confidence of both client and family.

There are currently no established and consistent regional protocols, communication channels between community and facility, or discharge processes for the scenario of discharge from LTC. Each client and family have unique needs that must be evaluated through information sharing and transparency into the complex needs of the client prior to their return home. By becoming involved before a client is discharged home, we can work with the family to create a realistic plan.

If there is anything occupational therapists are up for, it is new challenges and coming up with solutions. Working with stakeholders to find a means of providing families with a care plan and checklist for all necessary steps prior to bringing their loved one home would assist with transition home from LTC. A proactive approach is beneficial only when all those involved are aware of the steps and are included in the decision making along the way. We are in a time of discovery, and community occupational therapists are working toward finding solutions that address these gaps, and—most importantly—enable the engagement of both the family and the client, in whatever ways are meaningful to them.

Since the writing of this article, there may have been new developments and changes to the management of COVID-19 for those living in LTC facilities and their families.

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About the authors

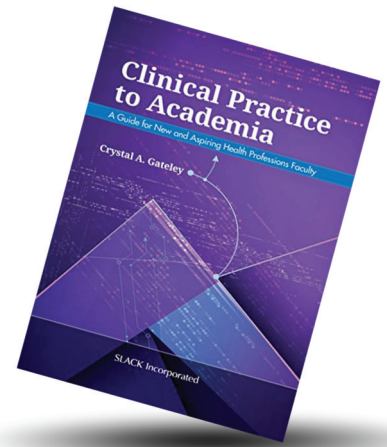
Holly Reid, Reg. OT (BC), is a recent graduate of the University of British Columbia's occupational therapy program, an occupational therapist, and the professional practice lead at CAOT at the time of writing this article. They live and work on the traditional territories of the W̱SÁNEĆ and SENĆOŦEN-speaking peoples and can be reached at: hollyreid@live.ca or on Twitter at: @curious_OT

Jill Slauenwhite, Reg. OT (BC), has been practicing occupational therapy for 18 years and works as a community occupational therapist on the Saanich Peninsula, the unceded traditional territory of the W̱SÁNEĆ peoples.



Book

REVIEW



Gateley, C. (2021). *Clinical practice to academia: A guide for new and aspiring health professions faculty*. SLACK. 211 pp. ISBN 9781630914363

With rising competition for academic positions, occupational therapists considering a career change that will include academic involvement or those embarking on an academic career often seek guidance. The book *Clinical practice to academia: A guide for new and aspiring health professions faculty*, written by Dr. Crystal A. Gateley, PhD, OTR/L, proposes to assist health professionals in preparing for and starting in teaching and/or research faculty roles. As new assistant professors in two different Canadian occupational therapy university departments, we both jumped at the chance to review a book written with this purpose (in other words: please give us guidance to make this transition easier!).

The book is written in a unique style, characterized by the author as informal or conversational, resulting in an easy read. However, this style also increases the length of the book and decreases focus on the key relevant points; at 211 pages, the book is quite long for its likely very busy intended audience.

In terms of relevance, the content is strongly oriented toward the American context and does not translate well to the current Canadian context. For example, the initial necessary steps toward a full-time faculty position in Canada are obtaining a PhD and developing a strong scholarly record, but the book is written from the author's own American-based experience of gaining a teaching position and later doing a doctoral degree. However, some of the content provides aspiring academics with good direction. For example, Chapter 5 is useful for understanding academic search committees and academic interviews, and Chapter 7 highlights ways for a new faculty member to get acquainted with the organization in which they work and organizational culture.

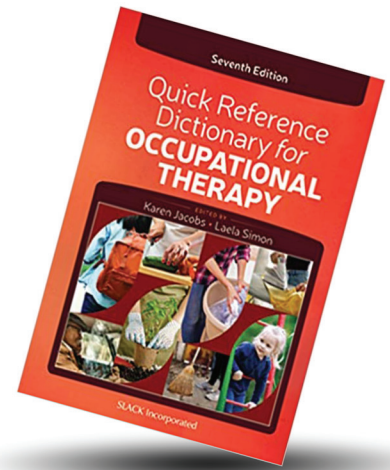
As the author's experience does not include a research academic role, this book does not provide a good understanding of the research roles that are a major part of most new faculty positions, especially tenure-track positions, but also some teaching-stream positions. Research-related activities, and the challenges of balancing them with teaching and service activities, are not well addressed in this book. Unfortunately, this is not reflected in the book's title or back cover.

To conclude, although some interesting insights on getting acquainted with the academic organization and good ideas for teaching methods can be extricated from this book and might be of interest to some occupational therapists who want to explore adding a teaching role in a professional health care program, it is not a compelling resource for an occupational therapist who is aspiring to start or is starting an academic career, especially one that will include a research role.

Reviewed by Lisa Engel, PhD, OT Reg. (MB), & Shlomit Rotenberg, PhD, BOT



Book REVIEW



Jacobs, K., & Simon, L. (2020). *Quick reference dictionary for occupational therapy*. Slack Incorporated.

This dictionary provides short definitions of terms useful to occupational therapists. In keeping with the purpose of a dictionary, the authors of this book do not offer new ideas, but instead provide essential information for understanding basic terms in a simple but precise language. The covered areas range from diagnoses, the basics of occupational therapy, evaluations, and interventions.

Furthermore, several appendices illustrate specific concepts in one or two pages, such as functional restrictions associated with hip replacement, range of motion, or stages of development of Alzheimer's disease. Figures and tables make these appendices more dynamic.

Without any fluff and clearly organized, this is a book to consult for a specific need, not to read from cover to cover. Used as a reference volume, it could be useful for students, novice occupational therapists, or those who have a diverse practice and who work with patients with varied profiles.

Reading the book reveals that the content covered is mostly related to physical health occupational therapy practice; there is less mental health-specific information. The volume also offers generic content; occupational therapists with specialized and subspecialized practices may remain unsatisfied. Finally, elements more specific to the reality of occupational therapists in the United States, such as statements from the American Association of Occupational Therapists or the basics of language to communicate in Spanish, will be less relevant to Canadian occupational therapists.

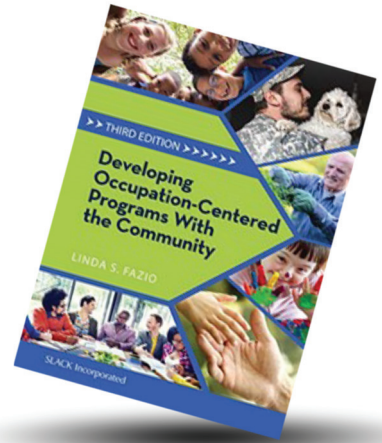
The seventh edition of *Quick Reference Dictionary for Occupational Therapy* is a practical resource for accessing basic definitions useful for occupational therapists. In these times of great accessibility to information—or even misinformation—using a dictionary specialized in occupational therapy can be an ingenious idea to ensure a practice based on reliable content!

Review by Alexandra Lecours, erg, PhD



Book

REVIEW



Fazio, L. S. (2017). *Developing occupation-centered programs with the community* (3rd ed). SLACK. 445 pp. ISBN 9781630912598

This book provides a detailed guide for designing, implementing, and evaluating occupation-based community programs. It emphasizes ensuring program sustainability and is a step-by-step guide for any occupational therapist interested in expanding their role into community- and occupation-based program development. The author targets readers who have at least an entry-level occupational therapy education. Fazio recognizes that occupational therapists can go beyond conventional roles in the community to using and developing their expertise as facilitators, asset finders, and capacity builders.

The book is organized into six parts. It is written in a workbook style, whereby each chapter offers reflective questions and exercises. Part One explores how to describe and define community and what preparation is needed for the reader to engage in community practice. The author weaves program examples throughout the text to highlight where ideas might arise when building a program, emphasizing that an idea is usually in response to a community need. There is also a helpful discussion regarding the skills needed to be an effective program planner. Logic models are introduced as a helpful overall structure to guide the reader through the various phases of program development.

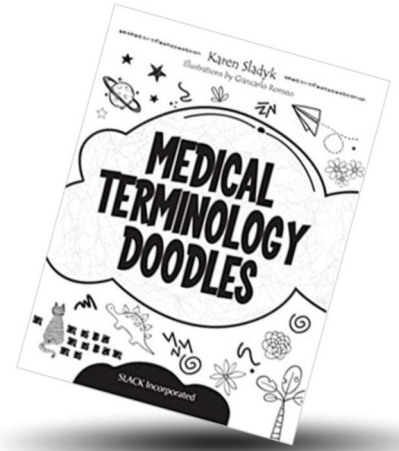
Part Two provides a detailed guide to the design and planning phase of program development. The author guides the reader through stages of completing a community needs assessment, with great attention given to strategies to ensure program sustainability. The author highlights a reflective and methodical process of shifting the focus from community needs to identifying and incorporating internal community assets. Helpful discussion is provided on how to write measurable program objectives that accompany the program goal. Occupational therapy-based theories and models of practice help the planner to ground their program in a theoretical frame of reference.

Part Three focuses on the preparation and implementation phase of program development. The content explores details around resources to support your program that include staffing/personnel, space, equipment, furnishings, funding, marketing, and supplies. Part Four discusses various program evaluation methods, ranging from community focus groups to evaluation instruments. Parts Five and Six review and provide examples of community programs and trending/emerging issues.

Overall, this book equips and empowers occupational therapists with the skills and knowledge necessary for program design.

Reviewed by Candace Crawford, OT Reg. (Ont.)

★ Book REVIEW



Sladyk, K., & Romeo, G. (2020). Medical terminology doodles. SLACK. 286 pp. ISBN: 9781630914806

This highly visual and engaging text provides students with a multisensory approach to learning and memorizing complex terminology. The author and illustrator have created a learning resource that is rich in visual, auditory, and kinesthetic discovery.

The book starts with helpful study and memorization hints as well as a brief background on the roots, prefixes, and suffixes of medical terminology. These resources are advantageous, as the author identifies the need to understand the foundations of terminology, stating that “before you can begin to understand complicated medical words, it is useful to understand how the words are put together.”

Each page begins with a word root and its definition, followed by ample space to doodle an image that correlates with the term. To finish, the reader will find a “you may already know” section highlighting an insightful array of medical terms pertaining to the original word root.

The reader can customize this book with their own drawings to create a meaningful connection for each term. Establishing an understanding of medical terminology that each individual can relate to and easily recall is made accessible through the multisensory approach incorporated in this book.

It is a useful resource for both occupational therapists and occupational therapist assistants to use with clients to connect fine motor activities with knowledge retention as “drawing doodles reminds you of the meaning of the word root and helps you learn the word root kinesthetically.”

A comprehensive medical terminology list found on pages 279 through 286 is an accommodating addition to support the reader’s understanding. Exercises are provided as review for terms, suffixes, word roots, and more, but may need to be completed on a separate sheet of paper as there is limited space. This terminology list can be used by the reader to test their knowledge. While this book is an excellent resource for studying many common terms and definitions, further research is required to gain a saturated comprehension of all medical terminology.

This book skillfully caters to the apparent demand for a new and modern study strategy by providing a style that will appeal to the unique visual, tactile, and kinesthetic needs of each reader, whether a student, occupational therapist, or occupational therapist assistant.

Reviewed by Michelle Chant, occupational therapist assistant/physiotherapist assistant

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