

OCCUPATIONAL THERAPY NOW

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INSIDE

Reflections of an Interprofessional Practice Leader: The power of humility, curiosity, courageousness, and self-reflection

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Patricia Saad

SPECIAL ISSUE:

**Better Together:
Occupational Therapy and
Multiprofessional Practice**

Guest Editors:

Maria Mullaly and
Ruheena Sangrar



CAOT • ACE

COVID-19

OCCUPATIONAL THERAPISTS: ESSENTIAL TO MENTAL HEALTH



TAKE ACTION NOW!

Send a message to inform decision makers that OTs should be recognized as mental health providers and included in public and private health care plans.

Despite the unprecedented disruption that COVID-19 has wreaked on everyday lives, most Canadians cannot access occupational therapy services as occupational therapy is not covered under most public and private health care plans.



Send this letter to your employer/union/insurance company asking for OT to be included in your health plan.

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Family Disruption



Returning to Work



Social Isolation

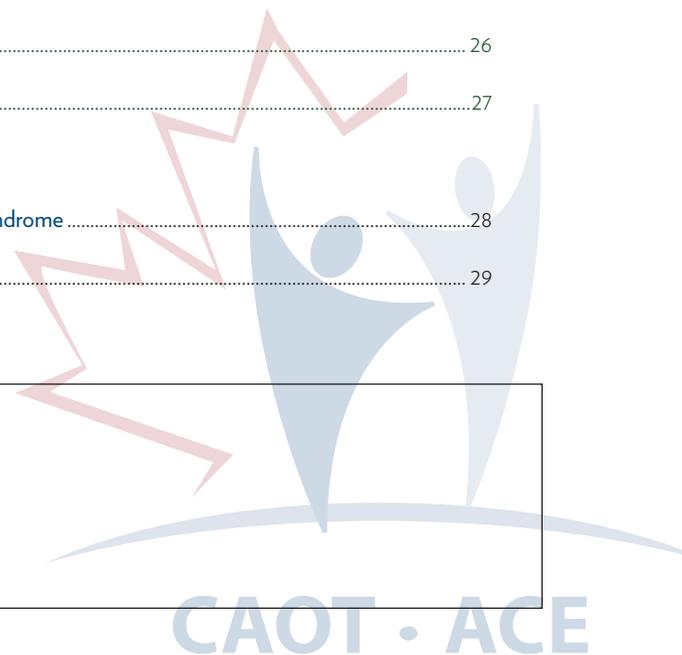
We're all in this together. Occupational therapists are essential to mental health.

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Editorial: Better together—Advancing occupational therapy practice through alliance-building and collaborative learning

Ruheena Sangrar & Maria Mullally

Welcome to the July 2020 special issue of *Occupational Therapy Now*. As the guest editors, our interest in this issue stems from our own experiences of success and growth on multi-professional teams. We consider these opportunities to be significant and meaningful to our professional identities. Between us, we have been part of interprofessional teams in clinical settings, and also are currently involved in interprofessional education and interdisciplinary research. Through our careers, we have partnered with healthcare professionals and non-traditional partners. These individuals include life-skills counsellors, people with disabilities, equipment vendors, administrators, policymakers, and driving instructors, to name a few. With each collaboration, we come to better understand the importance of optimizing our ability to work together.

We never could have anticipated the circumstances in which we would be writing this editorial; COVID-19 is currently responsible for a global pandemic and a nationwide state of emergency. Our health system is becoming strained beyond its capacity, and in some contexts, occupational therapy services have been deemed non-essential or have been transferred to virtual platforms. Our peers in health care, seniors care, and social services brave the front lines and continue to treat the most vulnerable members of our population. We have all had our daily routines disrupted; we've been re-deployed within our organizations to new practice settings, challenged to rebalance our personal and professional roles, all the while struggling to maintain a sense of stability given an uncertain future.

What do we do when we are faced with such a huge problem, such significant change, and so much uncertainty? Whalley Hammell (p. 7) and Zafran (p. 5) raise the importance of using coping strategies following experiences of occupational disruption. They urge us to consider how we can extend our clinical expertise to manage these circumstances. But how might we pool our efforts with others to support those in our society who are experiencing any form of marginalization or injustice? For them, the impact of this pandemic is amplified, leading to a greater risk of worsened health outcomes, social isolation, and economic instability. As occupational therapists, we are uniquely positioned to reduce the effect of this crisis by coping collaboratively with others.

A word on words

We use the phrase “multi-professional practice” to refer to all forms of interprofessional, interdisciplinary, and

multidisciplinary partnerships, in hopes of capturing all the ways occupational therapists work alongside colleagues in academic, practice, and research settings. In this issue, we deferred to each contributing author to define the terms they opted to use given their unique contexts and collaborators. Beyond terminology, many contributors also describe the personal meanings they attached to these partnerships and the perceived value in building alliances and learning with others.

Where occupational therapists excel

As occupational therapists, our ability to see the big picture is described by St. Aubin (p. 9) and Roberts (p. 17) through their experiences of leadership in new roles within their respective practice contexts. Our ability to extend the boundaries of our practice, to take on non-traditional roles, such as on ethics committees and as interprofessional practice leads, optimally positions us to guide our colleagues in complex situations (Shams, Batth, & Duncan, 2019). For example, de Haan (p. 11) shares her experience of a rare opportunity to lead practice process change in a new clinical team, with the tangible outcome of improving client care.

Another predominant theme in this issue is the occupational therapy role in shaping interprofessional education (IPE) for students and experienced clinicians. With a growing evidence base (Boshoff et al., 2020), IPE is an integral component of academic curricula in all Canadian occupational therapy education programs. Several authors describe structured approaches to delivering IPE in university programs as well as continuing education within clinical settings. Some introduce the Canadian Interprofessional Health Collaborative's (CIHC) National Interprofessional Competency Framework (2010) to outline key competency domains targeted by IPE. Langlois, Boyle, and Cadavid (p. 21) and Perlman and Asseraf-Pasin (p. 14) describe how competency-based IPE can be integrated across health disciplines in a university setting, with Langlois and colleagues also highlighting the important role of patient partners. Chai, Aparicio, and Wang (p. 19) provide the student perspective of innovating interprofessional learning opportunities for themselves and their peers in medicine. De Haan (p. 11) also describes a step-by-step approach to developing both a shared language and a shared understanding of clinical roles and responsibilities. As a whole, these articles showcase occupational therapists and students taking on progressive roles and advocating for relationship-building with colleagues and clients. These examples highlight not only their ability, but more importantly,

their willingness to learn “about, from, and with each other” (World Health Organization, 2010, p. 7). The CIHC (2010) has highlighted the importance of collaborative leadership and other competencies for health professionals, as well as the importance of integrating skill development in professional education programs. The writers in this issue of *Occupational Therapy Now* provide us with clear illustrations of reflective practice as they navigate barriers, challenges, and change—we hope their stories will inspire students, academics, and practitioners alike.

Charting the way forward

While acknowledging the diversity of articles in this issue, there are gaps as well. Many of our submissions are from similar geographical and practice contexts, which do not provide a pan-Canadian representation of complex regional health care and social service realities. We also challenge our readers to reflect on who else they might consider partnering with outside of the health care bubble, with the ultimate aim of improving client-centered care. For example, what stories can we tell about our relationships with administrators, experts in business, finance, and legal disciplines, as well as engineers, innovators, and designers? How can we expand on client involvement in creative ways?

The current pandemic has prompted reflection on the boundaries of our current roles and the opportunities available to refine and extend our areas of expertise into non-traditional

domains of practice. We are grateful for the contributions of all the authors and each unique perspective. We believe that these articles portray examples of how occupational therapists are well positioned to take on new roles as leaders and educators on multi-professional teams now and as we move into the uncharted territory of a future that needs collaborative leadership more than ever. Perhaps these articles will provide you with additional information and inspiration to expand your own thinking and practice, whatever the future holds.

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Occupational gifts in the time of a pandemic

Hiba Zafran

As the world adapts to shifting priorities in new ways, health care workers are described in the media as being on the frontlines of a battle, families are cut off from each other by closed airports, economic challenges are present for too many, and the marginalized are at risk of becoming even more so. In spite of creative adaptation, scientific problem solving, and the benefits of an eventual, more sustainable “new normal” in which environmentalism, economic priorities, and health care structures are reconsidered, awareness of the global phenomenon of a pandemic can generate challenges to maintaining our mental health. Occupational therapy offers its own perspective on resilient being and doing as we transitioned into restricted social and work environments—while acknowledging that the ability to choose to distance and self-isolate is a privilege.

After decades of research on resilience, a metareview of the evidence concluded that “resilience rests, fundamentally, on relationships” with self, others, and the world writ large (Luthar, 2006, p. 780). Moving past a focus on genetic studies, individual behaviours and skills, and complex systemic statistical analyses, fourth wave resiliency research highlights the relational experiences of spirituality and community building in peoples’ abilities to survive and thrive (Richardson, 2016). Rachel Thibeault is an occupational therapist whose rich career has focused on community-based rehabilitation initiatives with the World Health Organization in post-conflict zones, as well as with refugees and Indigenous communities in Canada. She received the Order of Canada in 2012. Drawing on her work with “unsung heroes,” Rachel coined the term “occupational gifts” to describe those meaningful activities that specifically foster resilience, spirituality, hope, and belonging in challenging situations (Thibeault, 2011). Here, I will introduce these five specific types of occupations and apply Rachel’s ideas to the current experience of physical distancing. Which of these types of activities are running short in your lives during this time of transition and adaptation? Do you live alone or are you now constantly sharing space with others? Which type of activities do you need the most?

Connecting occupations are those in which we experience belonging to others and to life. Sustaining connection is certainly what is at the forefront of many minds: how to remain authentically connected to loved ones when everything shifts online, beyond seeing and being seen. Some take a friend on a walk by talking on the phone with headphones. Virtual group coffee and martini hours have sprung up. Multiple activity-based communities have moved online. Members of families spread across countries already know the value of parking a phone with a video chat enabled on a surface while

both parties are engaged in a household activity, side by side. Yet, we can think of connection in broader ways, such as our interconnectedness with nature as we cuddle pets or say hello to the first signs of spring. There can be connection to our neighbours as we (safely) chat over balcony railings when the weather warms up. We are more connected globally than some may have initially thought. Whom or what are you less connected to that matters to you?

Centring occupations foster presence, awareness, and calm. Meditation walks in nature are a classic example. However, any repetitive type of activity such as knitting, folding laundry, jogging, grooming a pet, or doing gentle yoga cycles of sun salutations focused on the breath can foster calm. Some may now be living constantly with family or roommates—do you get time and space to centre and connect to yourself? Attention to the sensory or ecological dimension that allows us to be present in the moment is an additional element in centring activities. What does the activity look like? Smell like? Feel like? Sound like? One can engage in low-light cooking with gentle jazz music playing, attending to the scents and flavors, or push furniture out of the way to create more physical space to dance to favorite music in the dark. What centres each of us can be quite unique and different. Which activities help you to feel calm and receptive?

Creative occupations meet the human need to explore, play, and create without judgment. All those with children at home may have their fill of finger paint, and ...[c]hildren may have their real small-scale disasters, but adults have their very own large ones: war, catastrophe, accidents, hurricanes, riots, sickness, and death. ...The unreal worlds of play...are about how to react emotionally to the experience of living in the world and how to temporarily vivify that experience by transcending its usual limits. (Sutton-Smith, 1997, p. 162, 159)

We all could do with writing a silly sonnet, drawing an alley cat, or singing a superstar song. Maybe now is a good time to learn a new skill, like a signed language, attend to a home project that has been languishing, or make handcrafted gifts for others and send them by mail. “Pantry cooking” involves combining foods from the back of your shelves or bottom of your freezer in novel and nutritious ways. For many of us, finding new tools and ways to teach and do research remotely can be experienced as creativity. Are you taking the time to create in ways that draw on your imagination and that you enjoy?

Contemplative occupations are those that induce awe of life. Unlike centring, which grounds us in our bodies and the

present, contemplation fosters perspective taking, pulling us out of ourselves toward the (much) bigger picture of what others (now and in past and future generations) and the planet may be experiencing, as well as how all have the capacity to adapt and evolve. One might also simply contemplate a basil plant on a sunny windowsill. The art of contemplation can be challenging, as the noise of the outside quiets beyond the online world, which can leave much psychic space for anxiety and worries to arise. Journaling, praying, taking long walks in nature, doing yin yoga that favours postures in which you thank the earth for holding you up, listening to specific types of music (for me its solo cello pieces), reading beautiful literature and novels, visiting a museum online, or simply allowing yourself the time for morning stares hanging onto your coffee mug can all foster contemplation. What do you do that allows you to ponder the enormity of it all with quietude?

Contributing occupations allow us to give back within the communities that hold us up. Researchers are reaching out to partners to see how projects can be turned around to be more immediately useful, local students are checking in with their international peers, and therapists are forming online collectives to support frontline workers. This is all wonderful to see and experience. In my neighbourhood, almost every home with a child suddenly has a painting of a rainbow in the window, to signal brighter days ahead. People are reaching out to elderly neighbours down the hall and offering to drop off groceries at their front doors, spring cleaning and then sharing extra resources with others less fortunate, setting up virtual ways for grandparents to be involved in homeschooling or storytime, creating a telephone tree for emergencies, circulating an informational newsletter of resources, or

donating a skill to a community organization challenged to care for its service users. Health care and humanitarian aid workers are risking a lot for all of us. And, many groups will be made more vulnerable, more isolated. What do you do to be a valued member of a community?

These “5 Cs” of occupation help us reflect on the quality of what we do and why we do it. I would add a sixth C—culture(s), and the richness each of us can draw on in relation to the above five essential types of activities, such as cultural rituals and ceremonies, traditional arts and crafts, comforting family recipes and games, folk songs, novels and movies in your native tongue, stories of resilience, and communities to which you are connected. Beyond all the things we have to figure out how to do in different ways in curtailed environments, which values and actions will each of us choose to enact in this time of change in order to (re)engage in meaningful activities that can foster our resilience, and therefore our collective ability to sustain ourselves and those in need, in the times ahead?

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Errata

1. With reference to the following article:

Zafran, H., Barudin, J., Saunders, S., & Kasperski, J. (2019). An occupational therapy program lays a foundation for Indigenous partnerships and topics. *Occupational therapy Now*, 21(94), 28-29. [Special Issue. Time for Action: Occupational therapy responses to the Truth and Reconciliation Commission]. <https://www.caot.ca/document/6768/OT%20program%20lays%20a%20foundation%20for%20Indigenous%20partnerships.pdf>

The purpose and process in producing the evidence-informed document that is summarized in the article was to build the knowledge and capacity of McGill University's Occupational Therapy program in finding an ethical and wise path to respond to the Truth and Reconciliation Commission's Calls to Action and the United Nations Declaration on the Rights of Indigenous Peoples. In line with the ethos of collective knowledge, the complete report is now available for consultation, dialogue and referencing. It is openly accessible here: <https://escholarship.mcgill.ca/concern/papers/nc580r997?locale=en>
Contact: hiba.zafran@mcgill.ca

2. The correct website information for the photographer of the cover of May 2020's issue of *Occupational Therapy Now* is as follows: <https://katelyrachphotography.pixieset.com>

Engagement in living during the COVID-19 pandemic and ensuing occupational disruption

Karen Whalley Hammell

Measures being taken to slow the spread of the COVID-19 virus have disrupted the lives of countless millions of people around the world. For many of us, life “before” seemed seductively predictable, our diaries full of the appointments, commitments, events, and trips that constituted an envisioned future. And then everything changed.

For the many people who share with me the experience of social privilege that accompanies our class, educational, professional, cis-gendered, and “able” statuses, it has been frustrating to endure, albeit temporarily, the sort of deprivation of occupational opportunities usually reserved for disabled people and others marginalized and disempowered by poverty, racism, and the legacies of colonialism—people for whom life is consistently unpredictable and fraught with uncertainty. Now, much of the population is sharing a fear of financial uncertainty and concerns about obtaining food and other necessities. Experiences that have constituted everyday life for many of those on the margins are now shared by the majority population: the lack of opportunity to access educational and employment settings; the inability to access buildings, libraries, public spaces, as well as arts, cultural, social, recreational, and other public resources; and the loss of opportunity to move freely within our own communities or around the world. These constraints on the abilities and freedoms many formerly viewed as rights and entitlements—and fear of the virus itself—have left intense feelings of anxiety and uncertainty.

Fortunately, as occupational therapists, we already possess the knowledge required to fully engage in life despite the current, formidable challenges. We have had the opportunity to learn from the experiences of so many clients whose seemingly predictable lives—and the mundane, taken-for-granted expectations, plans, and routines that had structured those lives—have been disrupted by factors beyond their control, such as serious injury or illness, job loss, acts of violence, natural disasters, or forced migrations. From our clients and from research evidence, we know that resilience in the face of crisis is the norm rather than the exception. We know that the problem-focused coping style—“what do I need to do?”—that is the norm within many global cultures is associated with lower levels of anxiety and ill health than the ubiquitous Western, emotion-focused style of coping that centres on “how am I feeling?” (Summerfield, 2001). We know that “doing” is important.

From clients confronting the devastating life disruption of severe physical injury, we have learned that, when it is no longer possible to engage in previous occupational patterns, it

is important to focus on what we can do and not on what we can't. And we have learned to seek out alternative occupations through which we can apply our existing skills, knowledge, and strengths to contribute to others, and to maintain a positive sense of competence and self-worth.

From clients with mental health challenges, we have learned the importance of occupational engagement to provide order, routine, and structure; to alleviate stress and reallocate cognitive resources from ruminating about our problems; to distract, keep busy and manage time; to experience enjoyment and fulfilment; to build a positive sense of self-worth; and to foster hope.

From our work among refugees and other people who have experienced forced migration, we have learned that hope is an antidote to disillusionment. We also know that hope is one of the most important determinants of recovery among people with mental illnesses, and is integral to the ability to find meaning in one's life. We also know that occupations that link our present to the past and to the future are effective in engendering hope.

Our occupational therapy literature informs us that the process of rebuilding a life and fostering wellbeing following profound occupational disruption demands attention to some specific needs: to take care of ourselves and others; to experience a sense of belonging and connectedness; to foster a sense of self-worth; to experience pleasure, purpose and meaning through engagement in roles and occupations we value; to enact choices in our lives; and to experience hope and a sense of coherence and continuity within our lives (Hammell, 2020). As occupational therapists, we know that each of these contributors to wellbeing has strong occupational dimensions, and that mental health is enhanced when people experience a balance among occupations that foster belonging, connecting, and contributing; occupations that build routine; occupations that are creative or productive; occupations that are chosen or essential; and occupations concerned with the care of bodies and minds.

In addition to the opportunity to draw on what we have learned from clients about how everyday lives might be rebuilt within constraining parameters that are not of our choosing, we also have the opportunity to learn from the insights that Canadian occupational therapist Dr. Rachel Thibeault (2002, 2011) has derived from her international work among people who have endured extremes of trauma, violence, and torture. Drawing from both her own experiences and from research evidence, Thibeault has outlined five activities that play an

How Kelly got her groove back

Kelly St. Aubin

Over the last two years, I have been on a journey of learning, self-discovery, and joy seeking. I have been an acute care occupational therapist for 18 years, primarily in neurosurgery, but I have worked in general medicine, cardiac surgery, and stroke rehabilitation as well. My work life was once comfortable and routine, which worked well for me as I was sandwiched between the demands of parenting my two young children and caring for my aging parents. In time, as these demands diminished, I began to look for a new position and a new passion within my career. Five years ago, I saw a flyer about joining our hospital's Clinical Ethics Committee (CEC) and a spark was lit. This committee was made up of health professionals from all parts of the large hospital in which I worked. I was exposed to different roles, different wards, and many different disciplines, as well as the ethical dilemmas they all faced. I soon became inspired to begin a Master of Health Science (MHSc) in Bioethics at the University of Toronto. The degree program is open to any health care professional, truly illustrating and emphasizing the importance of interprofessional learning and practice. My experience working and learning with individuals who are not occupational therapists has enhanced all aspects of my work life. I will describe my experience in discovering bioethics, how the fire and passion returned to my work, and how I finally "got my groove back" with the help of my interdisciplinary colleagues.

Working on a neurosurgical unit led me to be conflicted regarding some of the decisions that were being made on our ward. Being an occupational therapist on a surgically focused floor is challenging. Our training as occupational therapists leads us to look at the person, not the disease, and it appeared that at times others working on my floor could not see past the brain tumour or the surgery that could fix it. It sometimes felt like an uphill battle attempting to talk about function, quality of life, and the notion that neurosurgery cannot fix everything. It seemed unfair, for instance, to offer surgery to a patient but then not be able to get them onto a rehabilitation floor to address their new impairments. I couldn't find the words to influence change as much as I wanted to. Finding that flyer inviting me to join the CEC, however, brought me to like-minded individuals who had some of the same concerns about ethical decision making in health care and were looking for guidance around how to ensure decisions were right, good, or just.

My four-year term with the CEC enabled me to understand the role of the clinical ethicist and appreciate the impact one could have on a patient's life. Going to the committee's

interprofessional meetings, I felt a joy and excitement that I had not had since my early days as a young, keen occupational therapist. I was inspired by the work that was being done and the different experiences of my fellow committee members. Working with nurses from the intensive care unit, child life specialists from our children's hospital, and physicians from employee health led to fascinating discussions that challenged my thinking. I gained understanding of the ethical tensions within an eating disorders clinic and the complexity in providing care to adolescents with severe mental health challenges, situations outside my everyday experience. One of the many benefits of this interdisciplinary committee was that there was no hierarchy. We all came from different backgrounds, brought together by a common need for education, and we were learning together. During my second-last year on the CEC, I realized that I wanted to continue this learning. I wanted to know more about the theories and principles the ethicist spoke about. I had a thirst for knowledge and had finally found an area in which I could see myself working, aside from my beloved occupational therapy role. I applied to and was accepted into the MHSc program.

During the first class of my MHSc, I felt insecure, old, and above all, like an underachiever. "What have I been doing all this time?" I thought, feeling imposter syndrome creeping in. While the other individuals there were amazing, I was "just an occupational therapist." I initially felt alone in my struggle. I was intimidated by my classmates, doctors, lawyers, critical care nurses, and doctoral students, but through working with my colleagues (now friends) and learning the program material, I realized that I too had a lot to offer. Through the structure of interdisciplinary learning, I brought examples from the clinical field and introduced others to the world of occupational therapy. As a result of this knowledge translation to my peers, I was able to affirm that being "just an occupational therapist" was amazing as well. I had (and have) such an excitement for learning and a passion for occupational therapy, and this new degree program has allowed me to remember why. We, as occupational therapists, think differently from most other health care professionals. Like ethicists, we see the "big picture," not just what is happening in front of us. In occupational therapy practice, the patient/client is the centre of every interaction, as it should be when ethically analyzing a situation. What is right for one person is not necessarily the best fit for another, and several factors must be taken into consideration when determining what the best plan is for a patient. This degree has been a flawless dovetail, a perfect fit,

with my education as an occupational therapist. I find myself loving this new challenge more and more, which has enabled me to brush the cobwebs out of my mind.

When I reflect about what truly pushed me through this program, stimulated me, impressed me, and continues to inspire me, I look to my classmates. They have encouraged me to develop my speaking skills, improve my confidence, think differently, and continue to bring my knowledge to the field of bioethics. They gave me the fuel to stoke the fire in our class discussions. My newfound friends were able to open my eyes and mind to new ways of thinking about topics that I had previously closed my mind to and set firm opinions on. My classmates modelled ways to approach sensitive subjects, brought in different viewpoints, and questioned my thought processes, and as a result, my understanding of the health care system expanded. To be clear, we were not a homogenous group in professional background, culture, or gender. These differences enhanced our learning, helped to us to build a strong foundation, and enabled us to highlight the importance of all professions in the delivery of patient-/client-centred care (Barnsteiner, 2007). We learned both together and from one another, which appears to be crucial in interprofessional collaboration (Thistlethwaite, 2016). It became obvious that the diversity of our class was at the epicentre of my new insights into not only bioethics, but health care more generally. I have been working interprofessionally my entire career. I have been on teams on which I was the only occupational therapist—therefore, diversity is not a new phenomenon to me. However, this time, we were all starting on the same page. We came together to get a better understanding of bioethics, and by bringing in our own experiences, were able to learn from each other. There was no hierarchy, there was not the daily reality of a patient before us requiring a decision, and there were no bed pressures to consider.

Given my last two years of intense learning and connection, I am much more confident in my knowledge of bioethical issues and interventions, as well as my ability to bring ethics more overtly to my current role—truly bringing ethics to the bedside. In addition, I have been able to help ensure that patients' voices are heard, even if they are unable to communicate. This program has also enabled me to see where my occupational therapy and ethical analytic skills can intersect to ensure patients receive the care and treatment they want in a beneficent and just manner. I am now better prepared to support patients and families in their care experience, to participate in quality initiatives, and to assist in policy development. I am more confident when addressing ethical issues in my frontline position and happy to be the ethical sounding board my clinical team can turn to for support. My confidence in my education and my new knowledge acquisition has allowed me to develop the language I need to influence change within my floor. My preparation would not have been complete without the opportunity to learn and connect with other health care professionals who are joined with me in the goal to provide the best care possible for our patients. I think it is safe to say that my fire and passion for health care has returned, and I will be able to use my bioethical skills and knowledge for the remainder of my career, be it working with patients and families, surgeons, quality improvement initiatives, or management. Thanks to this learning experience and, most importantly, my interprofessional classmates, I got my groove back!

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Interprofessional education in a community hospital: Discovery and opportunity

Kim de Haan

Interprofessional education provides an opportunity for students and health team members to learn with, about, and from each other, with the intent to foster collaboration and enhance quality of care (Thistlethwaite, 2012). The difference between a multidisciplinary approach and an interdisciplinary approach has been explained by Choi and Pak (2006): “Multidisciplinarity draws on knowledge from different disciplines but stays within their boundaries. Interdisciplinarity analyzes, synthesizes and harmonizes links between disciplines into a coordinated and coherent whole” (p. 351). It is presumed that interdisciplinary or interprofessional teams deliver care in a more integrated manner, generating a positive impact on patient outcomes (Kilgore and Langford, 2009). Based on this premise, this article will describe an interprofessional learning opportunity that was provided to an evolving rehabilitation team, facilitated by an interprofessional education team. The author will share the learners’ expectations, the education process, and the discoveries made at the end of the experience, as well as the contributory roles of the occupational therapists on the rehabilitation and education teams.

Context

The leaders of a newly formed 10-bed geriatric rehabilitation unit in a 60-bed community hospital in rural Ontario recognized the need to optimize the theoretical and practical rehabilitation knowledge of the frontline team, which included nurses, personal support workers (PSWs), and allied health team members (an occupational therapist, a speech-language pathologist, physiotherapists, and occupational therapist assistant/physiotherapist assistants [OTA/PTAs]).

The hospital engaged an external group of health professionals (an speech-language pathologist, nurse, physiotherapist, and occupational therapist) experienced in rehabilitative care and dedicated to the facilitation of competent and collaborative rehabilitative interprofessional practice to develop and implement a training and education event tailored to the needs of the rehabilitation team.

Prior to the event, the education team dedicated a day to observation and discussion with rehabilitation team members to determine the current state of the team, opportunities for improvement, and priorities for learning and team development.

The education team learned that the rehabilitation team had been working on a unit that was established 11 months prior to the learning sessions and had physically relocated to another

area six months after opening. Not only was the team still evolving, its members were adjusting to a new environmental layout with its own set of obstacles to the rehabilitative approach. During the observation day, a rehabilitation team member offered that in addition to the newness and the challenges of the setting, there were variations in the techniques and approaches used by rehabilitation team members with patients—inconsistencies that were felt to create confusion not only for the patients in their functional recovery, but for the team as well. Despite this, they felt that the staff was “coming together as a team” with “more collaboration and communication.”

One of the education team members had previously discovered in her research that registered practical nurses (RPNs), who deliver most of the bedside care on rehabilitation units, are not provided with rehabilitation-specific competencies on the job or within their nursing education and also do not identify themselves as part of the therapy team (Snobelen, 2016). With the premise that nurses are an integral part of the therapy team, a plan to engage the whole rehabilitation team was initiated.

The education team recognized the importance for the rehabilitation team members to respect and value each other’s complementary skills and expertise while at the same time to understand where their skills overlap and where gaps in knowledge exist, in order to promote true interdisciplinary collaborative practice (Orchard et al., 2005).

Process and expectations

As a result of the site visit, the education team developed a four-module curriculum, with two four-hour sessions occurring over two consecutive days, being followed by a two-week team practice opportunity, and concluding with two more four-hour sessions. The content included theory and principles of rehabilitation; person- and family-centred care; aging and functional challenges; therapeutic techniques and interventions; a competency framework for the rehabilitative RPN, which emphasizes that the knowledge and skills of rehabilitation nurses are integral to patients’ functional recovery (Snobelen, 2016); and interprofessional teamwork. The education team conducted the sessions using a variety of approaches, such as lectures, reflective exercises, demonstration, and interactive practice. During an early discussion of local statistical data and current trends in rehabilitation, the education team discovered that this general rehabilitation unit was in fact a unit specializing in geriatric

rehabilitation, setting the stage for focused learning and an exploration of opportunities to enhance patients' experiences and outcomes.

A total of 21 staff members participated in the sessions, including 12 RPNs, two PSWs, and seven allied health staff (one occupational therapist, three physiotherapists, one speech-language pathologist, one OTA/PTA, and one PTA).

On the first day of the learning event, common wishes and expectations that the rehabilitation team members identified included to:

- “learn better strategies for implementing therapy”
- “better understand each others' roles”
- “[develop] collaboration between nursing and allied [health staff]”
- “enrich [the] team approach”

These goals reflected the need for the rehabilitation team members to improve their rehabilitation knowledge and skills, coupled with the desire to optimize interprofessional team function.

Transformation to an interprofessional team

The second day of learning addressed functional and psychosocial health issues in rehabilitative care, therapeutic techniques, and treatment and recovery of disabling conditions; it was led by the occupational therapist on the education team (this author). The session focused on the whole person from a biopsychosocial perspective and included: ensuring patient readiness to participate from a cognitive, perceptual, emotional, sensory, and communicative perspective; fostering an awareness of functional challenges in activities of daily living (basic, instrumental, and advanced); employing the use of seating, positioning, and adaptive equipment to facilitate recovery and function; and encouraging and enabling patients to participate as much as possible, regardless of their limitations. A variety of coaching and cueing techniques were reviewed, to encourage each team member to pursue every opportunity with to engage patients in their daily activities, as little or as much as they are able to participate, in their journey toward being as functionally independent as possible.

The hands-on portion of the second day involved rehabilitation team members practicing coaching of the use of an adaptive dressing aid, as well as group work with transfers and mobility. In groups of three, which were to include an allied health member, an RPN, and/or a PSW, there was an opportunity to problem solve through challenging transfer scenarios with a variety of mobility aids, with each person taking turns as the “patient” receiving instructions. The objective of this part of the session was not to have the education team primarily instruct the rehabilitation team members on correct transfer skills, but rather to have the rehabilitation team teach, learn, and problem solve together; to explore how to interact before, during, and after the transfer or mobility activity; and to communicate with the patient and each other to ensure a safe and effective interaction.

Occupational therapists as facilitators

After the initial observation day, prior to the second education session, the education team occupational therapist consulted with the rehabilitation team occupational therapist to gain their perspective on the team's greatest needs in terms of rehabilitative intervention skills and team function, to help determine the areas of focus for the hands-on component of the second education day. The occupational therapists and one of the rehabilitation team's physiotherapists then met to develop typical scenarios that the team might encounter, specifically related to patient function and movement. Adaptive and mobility equipment were arranged for the session so that team members could use these items to problem solve together through a series of patient functional and mobility scenarios before the two-week interprofessional practice session on the rehabilitation unit with their patients.

Discovery and reflection

Early in the second education day, it became evident that there was a difference in the use of terminology to describe transfers and mobility equipment between the rehabilitation team members. A transfer communication sheet became a topic of discussion when rehabilitation team members noted that they did not use the terms in the same way and called pieces of equipment by differing names. This was of particular concern to the team members who had recently spent a great deal of time revising the form. After the discovery that not only had they been using different terminology, the interactive session led to further discovery that they were using different techniques to facilitate patient movement. Problem solving helped the rehabilitation team members to work together and explore common ground on terminology and techniques for each scenario. The rehabilitation team also discovered that the differences in terminology and techniques extended to the patients' charts, identifying that different terms as well as varying levels of detail were used in the descriptions of patients' activities and capabilities in the documentation.

After the second education day, the rehabilitation team members engaged in a two-week practice period, during which they were asked to take as many opportunities as possible to work with various interprofessional colleagues during their time with patients. They were encouraged to continue the dialogue around standardizing communication and intervention approaches, and to reflect on what they noticed, in order to report back after two weeks.

After the two-week interprofessional practice period with the patients on the rehabilitation unit, a discussion revealed the following reflections:

- “patient abilities change rapidly throughout the session and over a 24-hour period”
- “everyone has a different level of confidence—patients and staff members”
- “patients need the team to be building their confidence every day with every interaction”
- “as a team, we can learn from each other” and “skills can be shared with new staff”

Learning and next steps

The education team evaluated the learning event with a participant survey; a pre- and post-test assessment of rehabilitation beliefs; and the Assessment of Interprofessional Team Collaboration Scale (AITCS-II), a tool to identify strengths and opportunities in collaborative practice in the areas of partnership, cooperation and coordination (Orchard et al., 2018). The results of the AITCS-II confirmed the rehabilitation team members' respect and trust for one another and helped to identify strategies to better address patients' needs together. As the rehabilitation team continues to develop and learn together, this tool could be used to monitor collaborative progress (Orchard et al., 2012), along with other methods to determine the impact on patient outcomes.

While the four-session learning opportunity explored much more than what is discussed here, the overall learning was consistent with the reflections on the second day and the observations shared after the two-week practice period. The rehabilitation team's learning included, but was not limited to, the following discoveries: that every team member contributes skills and knowledge that benefit patients in their functional recovery and transition to the community; that together team members can facilitate and enable patients to have opportunities to engage in functional activities regardless of the level of a given patient's abilities; and, finally, that they can reach across disciplinary boundaries and pursue individual and team development opportunities, to learn about, with, and from one another. Feedback suggested learning

opportunities should extend to the orientation and training of new rehabilitation team members, including team leaders and physicians, to ensure that consistent knowledge, skills, and processes (such as regular team communication and planning) are established to support optimal patient and organizational outcomes.

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“Learning with, from, and about each other”: Preparing student occupational therapists for interprofessional collaborative practice

Cynthia Perlman & Liliane Asseraf-Pasin

Health care professions have shifted from siloed practice to collaborative practice targeting a more holistic model of patient care (Gilbert, 2013; Pardue, 2015). Interprofessional education (IPE) provides foundational building blocks for students in the health professions by allowing them to learn with, from, and about each other, with the goal of changing attitudes and behaviours to align with interprofessional practice (Centre for Advancement of Interprofessional Education, 2002; Gilbert, 2013; Pardue, 2015). IPE is now included as a curriculum standard within national academic accreditation self-study guides for health professions. The *Academic Accreditation Standards and Self-Study Guide* published by the Canadian Association of Occupational Therapists (CAOT; 2017; see Standard Outcome 2.713) has mandated that academic and fieldwork education components incorporate IPE and collaborative practice.

Coordinating students from different health professions to learn together requires considerable commitment, logistical organization, budget, and knowledge of IPE instructional design. The Office of Interprofessional Education (OIPE) within the Faculty of Medicine at McGill University in Montreal, Quebec, developed, implemented, and evaluated an IPE curriculum for over 660 health profession students. This paper will highlight the development and pedagogical construction of this curriculum and share lessons learned regarding IPE curriculum design.

Developing the IPE curriculum at McGill University

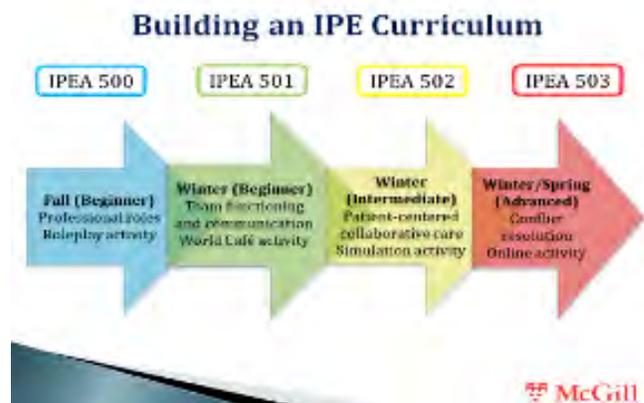
McGill established the OIPE (previously the “Joint Curriculum Committee”) in 2016, with representation from occupational therapy, physical therapy, medicine, nursing, and speech-language pathology (<https://www.mcgill.ca/ipeoffice>). The associate dean of education in the Faculty of Medicine strongly supported the governance and mandate of the OIPE since IPE was one of three educational strategic goals guiding education and scholarship. The OIPE formalized the IPE curriculum for all students in the health professions programs.

The OIPE based the IPE curriculum on evidence-based and best practices for IPE design and implementation. The curriculum integrates the IPE competencies from the Canadian Interprofessional Health Collaborative (CIHC) National Interprofessional Competency Framework (CIHC, 2010). This framework comprises a set of six competency domains: role clarification, team functioning, interprofessional communication, patient-/client-/family-/community-centered care, interprofessional conflict resolution, and collaborative leadership. The IPE curriculum uses learning theories for adult learning and instructional activities that focus on interaction, communication, and teamwork processes. These activities are supported by debriefing opportunities with trained facilitators (faculty members and practitioners from different health professions) to

promote student reflection on learning. The OIPE provides faculty development sessions for each IPE course.

Course descriptions

The curriculum includes a series of four mandatory courses: IPEA 500, Roles in Interprofessional Teams; IPEA 501, Communication in Interprofessional Teams; IPEA 502, Patient-Centred Care in Action: An Interprofessional Approach; and IPEA 503, Managing Conflict Within the Interprofessional Health Care Team. All four IPE courses are introduced at formative stages of the occupational therapy professional master’s program, beginning in the pre-master’s year when the concentration of professional content begins. These courses span four semesters during the pre-master’s year and the first year of the master’s program. See Figure 1.



Applying a framework of evidence and competence

The pedagogical approaches in the IPE curriculum are consistent with best practices by virtue of being applicable to real-life situations, being active and participatory, and addressing relevant competencies through roleplay, a “World Café” format of group rotation, and simulation of teamwork in action (Barr et al., 2005; Thistlethwaite, 2015).

Students in the occupational therapy program are prepared to gain competencies for skills and roles to enable health, wellbeing, and justice (Townsend & Polatajko, 2013) and to respond to the micro-, meso-, and macro-level changes in health care practice. Responsiveness to changing needs requires first having knowledge about one’s own professional roles and the roles of other health professionals, which leads to reflexivity about professional identity. The chosen IPE instructional activities enable student occupational therapists to reflect on their developing professional identities and

the competencies outlined in the *Profile of Practice of Occupational Therapists in Canada* (CAOT, 2012).

In IPEA 500, Roles in Interprofessional Teams, students practice teamwork to address the client's needs. Students clarify their own roles in relation to those of the other health professions students and discuss opportunities for role overlap. Each health profession student brings forth their own unique values about themselves and others into any IPE learning activity, meeting the targeted learning objectives by enacting them and practicing collaboratively (Reeves et al., 2016). The student occupational therapist explains the role of the expert in enabling occupation in relation to a complex case context involving diverse needs, and as an interprofessional team, the students address the client's personal and environmental factors. During this process, the student occupational therapist builds on prior knowledge of occupation-based models of practice, including the Person-Environment-Occupation model (Law et al., 1996), the Canadian Model of Occupational Performance and Engagement (Townsend & Polatajko, 2013), and the Model of Human Occupation (Taylor, 2017). In addition, health-promoting models including the International Classification of Function, Disability and Health (World Health Organization, 2001) are introduced to allow students to identify the facilitators and barriers to participation and engagement in chosen or meaningful occupations.

In IPEA 501, Communication in Interprofessional Teams, students hone their communication and relational skills to examine a client safety issue. A World Café format, comprising group rotations, enables new peer group interactions and opportunities for team communication and role clarification. Three rounds of discussion and shared decision making enable students to identify safety issues and contributing factors to adverse events. Student occupational therapists can better articulate their roles through each successive team encounter and to recognize opportunities for role overlap. Student occupational therapists are also encouraged to build on prior knowledge of cultural sensitivity (both personal and institutional) and concepts of health promotion when faced with client safety issues. At the end of this course, student reflection on learning is encouraged through a one-minute reflective paper.

The second set of IPE activities, in the first year of the master's program (IPEA 502 and future IPEA 503), expands on students' knowledge on collaborative leadership, patient-/client-/family-/community-centered care, and interprofessional conflict resolution, during which advocacy for client and family needs is emphasized. Student occupational therapists integrate their clinical and teamwork experience in IPEA 502, Patient-Centred Care in Action: An Interprofessional Approach, and in IPEA 503, Managing Conflict Within the Interprofessional Health Care Team. These courses build on the complexity of client-centred practice and enable the student occupational therapists to reflect on their own roles of professional, change agent, and practice manager, fostering leadership. Shared decision making is encouraged; however, the interprofessional student team must engage in perspective taking, build on goodwill, and negotiate priorities within the team to contribute to collaborative client-centered care (Bainbridge & Regehr, 2015).

Transformative learning is significantly valued in occupational therapy curricula, to align with professional competencies of collaboration, leadership, and professionalism. Student occupational therapists can experience transformative learning when they

reflexively question their professional perspectives (philosophies, theoretical frameworks, ethical practices) by engaging in personal reflection, dialogue with others through teamwork, and deliberate debriefing with faculty members and clinical facilitators (Clark, 2009; Pardue, 2015).

To meet its strategic goals, the OIPE implements a process for program evaluation that ensures ongoing review and revision of the IPE courses. The ongoing evaluations of these courses with students and faculty facilitators alike demonstrate a high degree of satisfaction with the content areas covered and with the relevance of the learning activities in addressing the CIHC's competencies (2010). The OIPE and the clinical community associated with McGill University have shared observable behavioural changes in student occupational therapists and other health professions students, including increased interest in other healthcare roles and responsibilities, appreciation for role overlap, professional accountability, and respectful communication both in the classroom and in clinical settings.

The OIPE has articulated the following lessons learned while designing an IPE curriculum. Note that students' course evaluations and program evaluations to date have informed these findings:

Pedagogical issues

Integration of the CIHC's IPE competencies allows the OIPE to scaffold the students' learning into the defined competencies in a logical and efficient manner, going from simple cases to those that are more complex. The curriculum begins with building on the knowledge of one's own profession (IPEA 500); proceeds to supporting understanding of others' professional roles, the impact of role overlap, and patient safety (IPEA 501); and ends with integrating multiple perspectives to solve care issues emerging in patient-/client-/family-/community-centred practice (IPEA 502). The OIPE plans to integrate all IPE competencies, including conflict resolution and collaborative leadership, into a fourth course to complete the curriculum.

The OIPE integrates the IPE competencies of role exploration and clarification within each successive IPE course. The instructional activities enable students to maintain and build on their knowledge and sharing of these competencies. The OIPE recognizes that having different levels of learners with varying experiences is advantageous for team and leadership development, as it mirrors the reality of interprofessional teams in clinical practice. Student testimonials on role clarification and role overlap include:

- "Through discussions of a case, my own role becomes clearer to me." (student occupational therapist)
- "Listening to what other colleagues have to say is crucial to one's own practice, since most medical fields overlap." (student nurse, IPEA 501 World Café, 2018)
- "It is important to communicate concerns and acknowledge the advantage of role clarification and of overlap" (student occupational therapist, IPEA 501 World Café, 2018)
- "As a first-year medical student, I could not contribute as much as others (like [occupational therapists and physical therapists]), but I learned a lot from them; for example, I did not know [occupational therapists] could deal with swallowing." (medical student, IPEA 502, 2019)

Challenges arise when using patient-/client-/family-centered cases because the instincts of the facilitators (faculty members and practitioners from different health professions) and students are to focus on the content expertise of each profession rather than on interaction and teamwork processes. Therefore, the OIPE implements ongoing faculty development training sessions with trained experts that focus on debriefing techniques to assess team dynamics and promote reflection on learning. In addition, the OIPE recognizes that providing authentic interprofessional teamwork opportunities will influence the learning of skills for interprofessional and collaborative practice; therefore, future plans to develop an evidence-based clinical interprofessional curriculum with McGill University's clinical partners is in progress.

Physical issues

The practical challenges encountered in creating an IPE curriculum for six different professional programs (with a total of 650 to 700 students) were twofold. The first challenge concerned scheduling the IPE activities at times that aligned with the schedule of all students within the Faculty of Medicine. Negotiating with each curriculum chair to find the best possible days and times was crucial to maintain interprofessional representation within each of the small groups. In fact, each course needed to be scheduled on several days (between two and six days, depending on the course) to accommodate all students. The solution was for all programs to reserve certain days in an academic term to dedicate to IPE. The second challenge was reserving rooms large enough for a plenary session as well as 35 to 40 rooms for small-group discussions on each day of implementation. Scheduling needs to be confirmed at least one year in advance to secure room availability.

Preparing student occupational therapists to participate optimally within interprofessional teams that value perspective taking, shared decision making, and goodwill begins with a well designed IPE curriculum. Opportunities for student occupational therapists to learn collaboratively with other health professions students build on their knowledge of their own competency roles (CAOT, 2012) and allow for effective participation in the IPE courses and in occupational therapy clinical practice. IPE must address the substantive changes occurring in health care and have increased emphasis on the ability of health care providers to engage in teamwork, effective communication, and collaborative client-centred care.

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Reflections of an Interprofessional Practice Leader: The power of humility, curiosity, courageousness, and self-reflection

Niki Roberts

I am an occupational therapist who is an Interprofessional Practice Leader. I work in a community hospital in the Interprofessional Practice and Education Department. A large part of my role is to help build healthy interprofessional practice teams. I work with multiple professions to engage relevant stakeholders, explore best practices, make recommendations to improve practice, create plans to implement best practices, and coordinate and deliver education on those best practices. I see evidence every day that interprofessional practice is better when all team members collaborate. I wanted to share this reflection in an effort to inspire others and offer suggestions that might help ease the journey towards interprofessional practice.

My journey into interprofessional practice leadership

I have always held great stock in the importance of clearly defined processes and procedures, a well-functioning team, continuous quality improvement, and measurable outcomes that can refine practice. At the point in my clinical practice in which all of these things seemed to be in place, I wondered if there might be opportunities for me to promote these ideals in other areas of the hospital. I identified and reached out to mentors within the hospital to learn more about the path into their roles. For the positions that sparked my interest, I explored what skills I needed to develop and identified opportunities—and a subsequent plan—that might help to broaden my experience in those areas. When a position on the Interprofessional Practice and Education team opened up, I applied and was thrilled to be the successful candidate.

Interprofessional practice through an occupational therapy lens

I strongly feel that my occupational therapy frame of reference has helped me to be successful in this position. I'm always looking at the holistic big picture and trying to determine any possible contributing factors to a particular incident. I analyze problems using a modified Person-Environment-Occupation model (Law et al., 1996): I look at the people involved in a situation and identify their strengths and opportunities for improvement. I consider the environment and explore possible modifications to correct barriers. I break down the problem ("occupation") into its component parts and identify gaps and possible opportunities. I consider the relationships between all three domains and outline a plan that attempts to mitigate obstacles and improve performance. However, without the foundational competencies in communication and

collaboration which are built into occupational therapy practice (Canadian Association of Occupational Therapists, 2012), I could not be effective in this role. These skills are essential, and in turn are the basis for effective conflict resolution, which, as I later elucidate, no highly effective team can function without.

The interprofessional practice team: Successes and lessons learned

My fabulous team is made up of registered nurses, a registered practical nurse, a respiratory therapist, a physiotherapist, a dietitian, an ethicist, a librarian, two administrative assistants, and me. We aim to support best practice in all areas to provide optimal patient care. We work daily to improve patient outcomes through identifying and reducing errors, as well as increasing patient safety, health care quality, and patient satisfaction. We live interprofessional teamwork every minute of every day; that is to say, we value each other's expertise, respect each other's opinions, collaborate in decision-making, and share leadership. To do all of this, we also practice effective conflict resolution skills every day!

In my three and a half years in this role, I have had victories and failures, all of which have been invaluable opportunities for growth and learning. The greatest successes have arisen when I am modelling and fostering optimal interprofessional teamwork. The update of my organization's falls prevention program in 2017-18 is one example. I brought together an interprofessional working group including senior leadership, managers from in- and outpatient areas, frontline clinicians from nursing and allied health disciplines, and non-clinical participants including porters and volunteers. This diverse group helped ensure that many different opinions and ideas were shared, discussed, and incorporated into the final project. Because we had input and buy-in from all areas, we ensured that everyone's needs were met. The success of the project highlighted that all opinions and ideas are relevant and important to consider when working together. Within two years, we had updated our inpatient falls program, created a new outpatient program, begun generating more relevant data for improved evaluation of the program, re-educated all staff to the new policy, and successfully met our Accreditation Canada Required Organizational Practice standards for falls.

Throughout my transition from frontline clinician to interprofessional practice leader, there have also been challenges. It is daunting to support disciplines and areas of practice in which I do not have any expertise. It is challenging to constantly consider my role and the voices of each group

that I support during each project, to ensure no areas or professions are missing an opportunity to contribute. It is stressful to be mindful of implicit or explicit hierarchies and of the best methods to collaborate with new interprofessional colleagues. However, each of these challenges is also exciting. On reflection, these challenges are not that different than working on the front line. My teams are now my clients, project meetings replace family meetings, and interactions with new colleagues take the place of interactions with new clients or families. The skills that are needed for success are all the same.

Conflict resolution is hard. Everyone has a different level of skill and comfort in practicing it. Every conflict is slightly different, and having a good experience once does not mean you will have a good experience the next time. There are days when I want to run away from all conflict and days when I want to address every conflict head on. There are also days where I need someone to help remind me that I am in conflict and to gently push me towards resolution and away from complaint. It takes courage and a good deal of patience and compassion to address conflict. Conflict resolution also requires a culture of safety and openness. These are qualities that my organization is working towards building amongst all of our teams and staff.

I actively participate in this process through addressing conflicts that arise in my role, building the conflict resolution skills of my team members, and, as needed, assisting with managing conflict amongst team members. These skills include being open to others' perspectives, being able to take responsibility for your own part in a conflict, and being willing to work together to identify a solution. My organization offers conflict management courses, which all staff are encouraged to attend. We often discuss concepts related to conflict resolution in weekly team huddles. Team leaders, including practice leaders, not only model conflict management skills, but also are available to consult one-on-one to help staff identify action plans to address challenging issues.

Skills for success and next steps forward

Beyond communication and collaboration, I have found some additional characteristics to be crucial in my work. Humility drives me to seek help when I do not know or understand something; it has enabled me to garner respect from my

colleagues and teams, who know I can be trusted to practice within my own scope. A spirit of curiosity allows me to be excited at the learning opportunities that lack of knowledge provide. I also require courageousness to step towards conflicts and problems instead of avoiding them. For me, courageousness comes from giving myself permission to make mistakes. I have found that offering myself compassion when I fail helps me to move beyond my disappointment and fosters courage to attempt again. Finally, I believe self-reflection to be a very powerful attribute. I use it both as a tool for performance improvement as well as a strategy to help me to process difficult situations. In reflecting on a difficult conversation, my day, or my week, I can remind myself of successes or positives in the interaction. I can describe what did not go well. And, I can identify what is within my control to change. In self-reflecting, I hope to improve the outcome of future, similar incidents. Self-reflection thus gives me power over a challenging situation and builds my courageousness to attempt it again.

As I engage in this reflective writing, I wonder what grounds I have to offer others advice on improving their interprofessional practice and interprofessional partnerships. I do not feel that I am an expert, although I do have lived experience. I am passionate about the values and characteristics required for best interprofessional practice. Perhaps most important is simply that I am feeling courageous at this moment, and wonder if somewhere, somehow, this shared reflection might be enlightening to someone.

I encourage all of you to take a moment to reflect on your current practice, to identify challenges, and then to approach them with a sense of humility and curiosity. I encourage you to practice courageousness, and to ask yourself: What is one thing I can do to improve interprofessional practice?

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Learning side by side: Innovating interprofessional education by developing Faces of Healthcare

Emily Tsing-yee Chai, Samantha Aparicio, and Sijia Wang

Interprofessional collaboration is crucial in developing best practices in health care systems. At the University of Toronto, interprofessional education (IPE) is a course requirement for various health disciplines, including occupational therapy and medicine. The opening of a new occupational therapy Masters satellite program at the Mississauga (UTM) campus—as an extension to the program at the University of Toronto’s downtown St. George campus—provided an opportunity to bring IPE to students at UTM. As student representatives from the Interprofessional Healthcare Students Association (IPHSA), we—Samantha, Sijia, and Emily—created two student-led IPE sessions at the UTM campus, with feedback and administrative support from faculty members. We drew cases from *Faces of Healthcare*, a website that documents real-life patient experiences, often revealing systemic and attitudinal challenges in the health care system. We titled our IPE session *Faces of Healthcare*, and students discussed and reflected on patient cases that focused on interprofessional care.

Faces of Healthcare IPE session: the co-creation and evaluation

The first challenge of this project was to co-create relevant material to MD and MScOT students that would encourage interprofessional collaboration. Furthermore, access to practitioners was limited due to the volunteer-based nature and timing of sessions, so the IPE sessions needed to be student-led. Faculty members supported us in using Zones of Proximal Development (ZPD) to underlie the construction of the IPE session (Goos et al., 2002). We therefore used ZPD theory to structure the IPE sessions, integrating peer group learning, scaffolded questions, and learning partnerships. We assigned students to facilitator, note-taker, and timekeeper roles to ensure active participation. We developed separate packages of instructions for each student role, with one of us acting as a coordinator during the session. The questions centered around competency development, role blurring, and professional scopes of both occupational therapy and medicine.

To evaluate the session, we used an adapted Kirkpatrick’s four-level model of education survey, which included evaluating participants’ reactions, learning, and behaviour, as well as the overall impact of the learning (Smidt et al., 2009). We administered a pre-test survey and the Interprofessional Attitudes Scale (IPAS) (Norris et al., 2015), which assesses attitudes towards core competencies of interprofessionalism, as well as a post-

test of the IPAS. In using these assessments, we hoped to find that ours was a sustainable program, and that a student-led IPE session would be beneficial in inspiring students to participate more actively in IPE.

The MD student perspective: Sijia

Sijia: In my second year of medical school at the Mississauga Academy of Medicine (MAM) campus at UTM, we were notified that student occupational therapists would be joining our campus. In our preclinical years, most interactions with other allied health professionals were through a few mandatory downtown IPE courses. However, MAM MD students now would have the chance to learn alongside and from our new colleagues.

In developing the program, I realized my peers and I had a vague understanding of the responsibilities and skills of occupational therapists. Early in our planning, we made a chart depicting our roles and responsibilities in a specific patient’s care, and to my surprise, there were several overlapping points of care. The overlap emphasized the core of IPE: health professionals negotiate the provision of patient care from different angles through collaborative communication. Realizing this, a major focus for our IPE session was communication skills: when to consult, what information is needed, and how to present the information efficiently.

Having allied health care workers involved in optimizing a patient’s health fills in gaps in their care. For example, a physician may identify a child with autism and recommend that the parents help the child to develop coping and behavioural skills. A referral to an interprofessional team may involve a pediatric occupational therapist who will assess and guide development in language, behaviour, emotional expression, and motor skills. The medical, psychological, social, and behavioural aspects are all addressed by the combined efforts of an interdisciplinary team. As an MD student, understanding what services our occupational therapy colleagues can provide will enable us to properly recognize and refer all eligible patients for enhanced support and care.

With the *Faces of Healthcare* IPE sessions, MD students had an opportunity to reflect on the experiences of patients and recognize gaps in care that need to be fulfilled by an interprofessional team. The group activities further enhanced our communication skills, respect, and desire to learn from each other, which are crucial to interprofessional collaboration. MD students benefited greatly from the knowledge and skills gained from these IPE sessions, as the sessions facilitated our critical thinking to

coordinate cohesive patient care as we enter our clinical training and beyond into our medical practice.

The occupational therapist student perspective: Emily and Samantha

Emily: Although my cohort was initially excited by interprofessional education, our excitement waned over our program's two years, as we increasingly thought of each IPE session as a requirement to graduate rather than an essential competency to refine. Faculty members therefore sought more creative ways to garner student interest and increase attendance in interprofessional education. While creating this student-led session, we all recognized the need for IPE sessions to create community and to help students develop an understanding of how collaboration is fostered between various disciplines.

Using real-life cases, we were able to highlight the importance of understanding each others' roles in a more accessible format, without the need for practitioners to provide personal experiences. Throughout the development and feedback of the sessions, students revealed misconceptions about each other's roles and responsibilities. Most MD students are given a very general overview of when to refer to occupational therapy, largely for hospital settings, even though the scope of occupational therapy is so much broader! It also became apparent that the best way to enhance interprofessional collaboration was to focus on the patient experience: putting students in the shoes of the individuals receiving care further highlighted specific issues that could be addressed by both doctors and occupational therapists.

Samantha: I had the opportunity to first attend and then facilitate the *Faces of Healthcare* IPE session. Not only was this my first year of occupational therapy studies, but I also was part of the first cohort attending the UTM satellite campus, so it was very exciting to be part of this innovative IPE session. I felt that I did not have a firm grasp on what it meant to be an occupational therapist yet. However, because this session was a student-led IPE session, it provided us with a chance to critically think about how to apply our knowledge to a patient case, without a faculty member or practitioner guiding us.

When I became a facilitator, students commonly expressed increased comfort with interprofessional discussions, as opposed to during practitioner-led discussions, in which they reported reluctance to sharing thoughts and experiences. Being a facilitator also helped build supportive guidance communication, as I encouraged and prompted the group for responses rather than providing them with answers. Supportive guidance communication is a valuable skill, as occupational therapists

often use this approach with clients. Additionally, this session helped MScOT and MD students get to know one another, learn from each other's unique perspectives, and practice team facilitation skills. In practice, it is important to understand what the interprofessional team members offer, but it is also crucial to develop rapport, trust, and even friendships with the professionals that we work with—which these student-led activities allow.

Outcomes and future directions

This MScOT and MD student collaboration is now into its third cohort, with two sessions planned by IPHSA. Future student IPE representatives now have a template on which to build their student-led case-based sessions. The feedback from the participants indicated a high level of engagement: the Interprofessional Attitudes Scale scores averaged 4.3 out of 5 for achieving learning objectives, application to future practice, overall learning benefits, and understanding interprofessionalism—indicating a positive attitude towards interprofessionalism. Future research could examine which specific factors of student-led and peer group learning impact attitudes towards interprofessionalism. The *Faces of Healthcare* IPE sessions will continue to evolve and change as new IPE representatives refine and challenge first-year MScOTs and MDs, helping support a foundation for interprofessional practice in the future.

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Embracing Interprofessional Practice: Clients Partnering with Students

Sylvia Langlois, Jennifer Boyle, & Elizabeth Cadavid

While occupational therapists have a deeply rooted tradition of a client-centred approach to assessment and provision of services, other health and social service professions are also adopting and developing similar approaches. Concurrently, many hospitals have been moving towards advancing team-based or collaborative care of clients over the past decade. The development of team-based models typically involves health professionals exploring topics such as an understanding of each other's roles, communication practices, and collaborative quality and safety efforts, yet the focus of enhanced interprofessional practice is the client and their family or caregivers. While the client's wishes are often considered, they are not always included as members of the health care team. As clients express a desire for greater engagement in the health care process, the topic of inclusiveness on the team has become one of interest in practice, and consequently, in the educational preparation of future occupational therapists. One effective strategy to enable this shift in approach is the inclusion of client partners in the educational preparation of student occupational therapists and students of other health professions.

Introduction to the University of Toronto Interprofessional Education Program: Integrating the client perspective

At the University of Toronto, the Interprofessional Education (IPE) curriculum includes students from eleven health profession programs: dentistry, kinesiology, medical radiation sciences, medicine, nursing, occupational therapy, pharmacy, physical therapy, physician assistant, social work, and speech-language pathology. The IPE curriculum aims to develop collaborative competencies identified in the Canadian Interprofessional Health Collaborative Competency Framework (CIHC, 2010); it provides learning opportunities for students from the professional programs to learn "about, from and with each other" to improve collaboration and optimize health outcomes (World Health Organization, 2010).

The University of Toronto IPE curriculum provides several illustrations for students of the engagement of client partners that enhance the health care team. At the foundation of the curriculum is the Patient/Client Advisory Committee, with strong client partner representation, which reviews IPE learning activities to determine where to elevate the client voice, ensuring the relevance of materials. Client partners participate as active members of all working groups responsible for the development of IPE learning activities. Examples of IPE learning activities that demonstrate client collaborations are:

1. *Understanding Client Partnerships in a Team Context:* Approximately 600 first-year student health professionals learn strategies to enhance team partnerships with clients and their family members. They interact with the client partners and participate in a reader's theatre, using a script prepared by a faculty member and student team that highlights client and practitioner perspectives on the issue of partnership in practice settings (Langlois, et al., 2017). Trained client partners facilitate small groups to enhance and focus learning.
2. *Health Mentor Program:* Students meet with client partners to learn more about the impact of a chronic health challenge and the client's experiences in the health care system, as well as collaborative team-based care, professional ethics, and quality and safety.
3. *Empowering Clients in an HIV Context:* Client partners collaborate with faculty members to develop and deliver curriculum aimed at exploring approaches to fostering empowerment with HIV-positive individuals in the health care team context.
4. *Autism: Partnering with Family to Provide Optimal Support in the Community:* Parents of children on the autism spectrum share their experiences and support students as they work through scenarios, with the goal of enabling the role of parents on teams.

Client collaborations: The evidence

Several studies conducted at the University of Toronto demonstrate that students do indeed learn important lessons through these experiences. One study reporting student learning resulting from participation in the Health Mentor Program identified the following themes: seeing client autonomy as a crucial consideration in the provision of optimal client care, enabling the improvement of future practice through client perspectives on clinical error, embracing interprofessional communication and collaboration, and identifying qualities of remarkable clinicians to inform personal ideals for future practice (Langlois, 2016; Langlois & Lymer, 2016). In another study, key themes that emerged from a qualitative analysis of reflective assignments included student development of fresh insights offered through the client perspective, student desire to promote partnerships with clients, recognition of attitudes that promote therapeutic relationships, and a need for advocacy for the client to be a team member (Langlois, 2020).

The following student comment from the latter study reflects the value of learning from clients in an interprofessional context:

My favourite part of this activity was meeting the client and hearing about his experience. The take-away messages for me were 1) making sure the patient is a main participant in the discussion about their health, [and] 2) collaboration amongst professionals is necessary for the treatment and wellbeing of the patient.

Clearly, the IPE learning activities engaging the input of client partners in an interprofessional context have contributed to fostering development of collaborative client-centred competencies for students in an academic environment. However, learning is not limited to students. When faculty members co-develop learning activities for students with client partners, these faculty members also experience a shift in thinking, as the following comment illustrates:

Utilizing the patient's perspective was instrumental in guiding the agenda of the IPE session... I found myself amazed at the patient's ability to engage the students in thinking about interprofessional collaboration. Students commented how appreciative they were in involving the patient in the IPE session, and how it enabled them to view the patient's perspective.

Through IPE, learners start to recognize the reality that health care outcomes are impacted not only by clinical care interventions but also by client experiences. They can reflect on how client experience can be improved—what worked and what did not work. Clients should be valued and active team members, recognizing the tenet “nothing about me, without me.” The comment below reflects how a client felt when she was included as part of her health care team:

When I know that my health care provider sees me as part of the team, I feel trusted and encouraged. I also feel reassured when one of my providers understands the care and challenges I am experiencing when seeing another provider, as this usually translates into synergistic solution. For example, my PT suggested I get special AFO [ankle-foot] orthotics. These are very costly, but my OT filled out the forms for a partial grant, and my specialist doctor filled out the prescription to qualify for the balance through my insurance.

Client collaborations during fieldwork

The continuity of education between university and practice settings is essential to the education of student occupational therapists. Preceptors are in a unique position to develop and reinforce these concepts with learners during clinical placements. Some examples of potential approaches unique to practice settings might include the following:

- Encourage students to discuss how much clients would like to be engaged as team members, what that engagement might look like, and how to consider readiness as well as implications of timing
- In hospital settings, support students to connect with patient advisory boards to help them consider potential approaches to the client and family member role on the team
- In a community setting, foster student connections with client organizations to consider the challenges of team roles when the team is not co-located
- Invite clients to participate and potentially develop interprofessional learning activities in which the client perspective is highlighted and integrated
- Encourage students to foster inclusion of the client as a team member and to consider where client input can support rethinking of practice-based approaches

Embracing interprofessional practice, including client partnerships in a team context, should move from a concept reflecting the ideal state to one that is normative. Occupational therapy preceptors are in a unique position to reinforce learning when students are in practice settings. This expansion of the notion of interprofessional practice, in which clients are valued as team members, serves to empower them to participate in their own care plans. Additionally, student appreciation of team partnership prepares them to advocate for change within existing practice models. Occupational therapy's strong foundation of client-centredness can thus be explicitly extended to one of advocacy for client partnership with the interprofessional team.

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From the Canadian occupational therapy community: In memoriam Ann A. Wilcock



Ann Allart Wilcock, PhD, Fellow of the College of Occupational Therapy, Graduate Diploma in Public Health, BAppScOT, DipCOT; honorary doctor of the University of Derby; fellow of Brunel University; professor of occupational science and therapy, Deakin University; retired associate professor of occupational therapy, University of South Australia.

Canadian occupational scientists and occupational therapists join our international colleagues in mourning the loss of Dr. Ann Allart Wilcock on October 16, 2019, in Adelaide, South Australia. Dr. Wilcock's scholarship, teaching, and service have contributed internationally to occupational therapy and occupational science. As examples, Dr. Wilcock initiated the *Journal of Occupational Science* in the early 1990s and was co-founder of the International Society of Occupational Science. Within Australia, Dr. Wilcock contributed significantly to the development, delivery, and leadership of occupation-focused education programs in occupational therapy at the South Australia Institute of Technology (now the University of South Australia; UniSA) and at Deakin University. As beautifully summarized by Dr. Mandy Stanley:

Her contribution to occupational therapy and occupational science has been immense. Whilst she may no longer be with us in person she leaves an incredible legacy through her teaching, her writing, her research supervision and mentoring, and her passion for the role of occupation in health, well-being and occupational justice. Her mark on occupational therapy has been indelible. (posted online on behalf of all who have studied and worked at South Australia Institute of Technology/UniSA Occupational Therapy Program).

Within this memorial to Ann, we wish to further acknowledge her contributions to occupational therapy and occupational science in the Canadian context. Ann was well known to Canadian occupational therapists, particularly through her multiple publications and her keynote presentations. Canadians can be proud to have hosted her landmark keynote address at the 1998 World Federation of Occupational Therapists Congress in Montreal, where she introduced "Reflections on Doing, Being, and Becoming" (Wilcock, 1998b), to which she later added the important concept of "belonging" (Wilcock, 2006). Occupational therapists embraced this phrase enthusiastically for framing the profession around the world (Hitch et al., 2014a, 2014b). We again welcomed Ann to Canada when she delivered her keynote address at the 2004 Canadian Association of Occupational Therapists Conference: here she drew upon various aspects of her work, including scholarship related to occupational justice and injustice, to mark out key directions for expanding research and practice addressing occupation and health (Wilcock, 2005). As well, Canada's *Enabling Occupation* guidelines were influenced greatly by many of her publications, notably her celebrated texts on an Occupational Perspective of Health (Wilcock, 1998a, 2006). Occupational science in Canada was also influenced by her foundational work. In particular, Ann's scholarship, including her monologues (e.g., *Occupation for Health*, volumes 1 and 2; 2001, 2002), demonstrated the importance of attending to history, population health, and socio-cultural-political determinants of occupational injustices. Her challenge and legacy to us is to continually evolve what "occupation for health" means and to build a knowledge base that demonstrates the centrality of occupation to human health, wellbeing, and justice and informs ways forward in enabling occupation from individual to societal levels.

Ann was a wonderful colleague of the four of us writing this memorial. We were all fortunate to publish in the *Journal of Occupational Science* with her keen support. She spent time at Western University where Helene, Debbie, and Lynn were instrumental in building on Ann's work to develop graduate studies in occupational science. Liz and Helene were inspired by Ann to start the Canadian Society for Occupational Scientists with the 2002 Dalhousie University Symposium

Contributed by Debbie Laliberte Rudman (Ontario), Lynn Shaw (Nova Scotia), and Liz Townsend (Prince Edward Island & Nova Scotia)

at which Ann was an inaugural keynote speaker. Liz and Ann are known for introducing the concept of occupational justice when they began to collaborate 20 years ago. There are so many ways in which Ann touched the lives of many occupational therapists. Our own experiences with Ann were that she was a person who loved to laugh and challenge the taken-for-granted. The idea of an “occupationally just world” that she championed certainly challenges taken-for-granted ways of living in Canada and beyond! Ann, may you rest in “occupational peace,” to coin a phrase that would have made you smile.

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July 2020 Update for the COTF

COVID-19

During this most difficult time, as the nation and world deals with COVID-19, COTF wants to assure its supporters and stakeholders that, now and always, we at COTF are thinking about all of you. COTF extends its utmost gratitude to all of the healthcare workers, which include OTs; all of the service suppliers; and all employees in a variety of areas who are at the front lines, serving the day-to-day needs of all Canadians. COTF wishes that everyone remains safe and healthy. Please follow the recommendations of the Public Health Agency of Canada: canada.ca/en/public-health

2020 CAOT Conference Cancelled

CAOT made the difficult but necessary decision to cancel CAOT Conference 2020. Consequently, COTF did not have the opportunity to meet with occupational therapists, to showcase COTF's award recipients, and to encourage the support of the work of COTF that benefits all Canadians. COTF encourages you to continue to support of our work by making a donation, which you can do by calling 613-319-6890 ext. 102, visiting cotfcanada.org, or mailing a cheque to COTF/FCE, 64-2420 Bank Street, Ottawa, ON, K1V 8S1. Donations support the COTF awards program, which is for occupational therapists in Canada and benefits all Canadians.

2020 COTF Research Grant Results

Congratulations to the recipients of the competitions!

- Broda Excellence in Seating Research Project \$15,000 – Karen Hall
- COTF Innovation Grant \$10,000 – Megan Edgelow
- COTF Innovation Grant \$5,000 – Janna MacLachlan
- McMaster Legacy Grant to Honour Sue Baptiste \$2,000 – Monique Lizon

Thank you to COTF's Research and Scholarship Review Committee for its work!

COTF's Recipients Database

COTF is pleased to announce its enormous and exclusive database of award-winning research in the field of occupational therapy. This database is a collection of over 35 years of dedicated research by the OT community of students and researchers. To consult the database, please visit cotfcanada.org/awards-program/results

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Remember that COTF is **YOUR** foundation! COTF supports research and scholarship exclusively for occupational therapists! To donate, please visit: www.cotfcanada.org

Wheel with Confidence: A peer training project by Maude Beaudoin



Maude Beaudoin is an occupational therapist and the recipient of a 2018 scholarship from the Canadian Occupational Therapy Foundation (COTF): the COTF/Invacare Master's Scholarship. Maude's project aimed to assess the effects of training in the use of manual wheelchairs by a peer (i.e., a person also using a manual wheelchair in their everyday life), with the goal of creating a training program that is more accessible to manual wheelchair users than what may otherwise be available.

The results of this project have suggested that peer training in the community is possible and beneficial for manual wheelchair users. The increased confidence of participating wheelchair users; the

"We don't have a lot of clinicians in research; it's always interesting when they get involved. It's really the right thing to just get started and, from there, create beautiful collaborations!"

wheelchair program the and skills of results their social wheelchair peer training

have also shown positive effects on participation. In addition, these users reported an appreciation for

and suggested including more outings in the community, such as at shopping malls and grocery stores. For occupational therapists, evidence gained from this program showcases an innovative alternative for providing effective training; having it delivered by peer wheelchair users lends credibility, as the peers also live with the reality of using a wheelchair on a daily basis. Maude has reported that there is still a lot of work to be done in this area, given that her research was done in the context of a master's project with a small sample size.

Maude concluded our interview with these words about her research experience: "It's important to just dive in. Don't hesitate to contact researchers. If you read an article in your field [...] do not hesitate to write to [the authors]. That's how I started! [...] We don't have a lot of clinicians in research; it's always interesting when they get involved. It's really the right thing to just get started and, from there, create beautiful collaborations!"

About the author

Patricia Saad is a student in the Master of Health Sciences Occupational Therapy program at the University of Ottawa. She can be contacted at: psaad047@uottawa.ca

Book Review



Jones, E. A., & Feeley, K. M. (2019). *Off to a good start: A behaviorally based model for teaching children with Down Syndrome*. Woodbine House.

Book 1: Foundations for living. 186 pp. ISBN 9781606132623

Book 2: Teaching programs. 244 pp. ISBN 9781606132883

Book one of this two-part manual recommends teaching children with Down syndrome using research-based Applied Behaviour Analysis (ABA) strategies. The authors describe the Down syndrome behavioural phenotype—that is, the observable behaviours seen—which include strengths in visual processing, social interest, and receptive language, together with challenges in auditory processing, speech, and expressive language, and specific weaknesses in cognitive and motor development. The book discusses how these characteristics can be harnessed to optimize instruction and provides research that supports this application. Practical details, such as use of reinforcers and documentation sheets for progress tracking, are provided for an ABA-based program at home.

Book two provides the curriculum for teaching infants through kindergartners. It details teaching programs to both manage behaviours that interfere with learning and facilitate the development of motor, social-communication, cognitive, and self-care skills. The authors provide specifics on how to include their instructional strategies within regular daily routines—naturalistic instruction, embedded within an activity or discrete trial training. Detailed charts for progress tracking are provided, with permission to copy for use. Book two also clearly explains concepts such as differential reinforcement, Functional Behavioural Assessment, and the function of a behaviour (e.g., self-stimulation, or to gain escape, attention, or access to an object or activity).

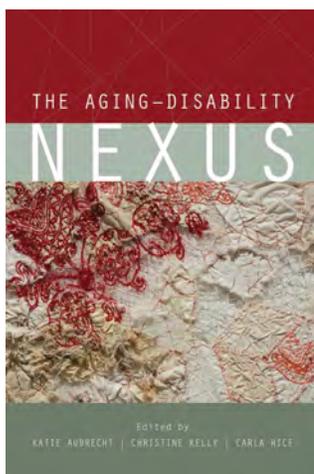
The books are directed to parents working with their child at home, using the help of extended family members and community support. Parents new to this model of instruction could probably use the support of a professional ABA team to initiate and sustain the program. The authors occasionally instruct readers to consult their therapists (occupational, physical, and speech) for suggestions.

However, ongoing team collaboration is not highlighted in this resource. This collaboration becomes critical when a child may have issues beyond a general delay that is associated with the diagnosis of Down. From the occupational therapy perspective, for example, a child with severe sensory issues, significant hypermobility of joints, or motor planning challenges will need therapeutic intervention before or in conjunction with behavioural interventions for meaningful results.

Occupational therapists will find the information in both books useful to get an overview of a behaviourally based model of instruction. Practitioners will benefit from the clear explanations and succinct definitions given here, which will facilitate collaborative work with providers of ABA interventions. Occupational therapists will learn to apply behavioural principles when appropriate to manage interfering behaviours during therapy. Understanding this frame of reference will also help practitioners to advocate the use of discipline-specific occupational therapy interventions when needed.

Review by Asha Asher, MA, OTR/L, FAOTA

Book Review



Aubrecht, K., Kelly, C., & Rice, C. (2020). *The Aging–Disability Nexus*. Publisher: University of British Columbia Press. 256 pp. ISBN 9780774863674

The overarching idea behind this original book is that while disability scholars and aging scholars have historically worked in relative isolation, there is immense potential for cross-fertilization that allows for experiences of aging and disability to be understood in a nuanced and contextually sensitive way that conflates neither aging and disability nor aging with disability and aging into disability.

This book includes 14 chapters and a closing dialogue, which are centred on three primary themes: conceptualizing the aging–disability nexus, “the politics of care,” and “timescapes and landscapes.”

There are 22 contributors to this volume, including renowned Canadian and international scholars, activists, and people with lived experience from a wide variety of disciplines including disability studies, English literature, gender studies, gerontology, health, law, occupational therapy, political science, sociology, philosophy, social work, and rehabilitation. Initially, the chapters have a Canadian focus, but

later chapters provide a more global perspective. Although there may be concerns that this book could

be overly academic, I found it was written in an extremely accessible manner. I really appreciated the breadth of topics, including experiences of dance among people with Parkinson’s; an arts-based initiative called Re•Vision, which seeks to disrupt normative narratives of aging and disability; and the stories of two women aging with and aging into cognitive disability. Furthermore, with few exceptions, most theoretical discussions are illustrated with compelling real world examples.

The book engages with a variety of thought-provoking questions that are extremely relevant to occupational therapy practice. How do normative understandings of the life course marginalize those who are aging with and aging into disability? How may people with cognitive disabilities be excluded by conventional disability theories? In contrast to disability activists’ demands for independent living, why does institutional care seem to be an unquestioned necessity for many older adults? How can we reconcile disability activists’ concerns about the detrimental effects of care, which emphasizes notions of burden and tends to downplay power imbalances in a way that devalues the care recipient, with more critical gerontological calls to recognize how we are all interdependent? How can we understand how other forms of discrimination (e.g., racism, colonialism, sexism, heterosexism) affect people’s experiences of aging and disability? Given the nature of this book, as a collection of chapters on related topics, the text does not provide either definitive or integrated answers to these questions, but it does offer some potential solutions and both encourages self-reflection and emphasizes the need for better professional advocacy.

Review written by W. Ben Mortenson, PhD, MSc, BScOT, associate professor in the Department of Occupational Science and Occupational Therapy at the University of British Columbia in Vancouver, BC

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- Houston, TX**
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- Jacksonville, FL**
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- New York, NY**
August 14-16, 2020
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August 28-30, 2020
- Denver Area (Aurora, CO)**
September 18-20, 2020
- Spokane, WA**
September 25-27, 2020
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April 23-26 (½ days), 2020
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Women's Health (Prerequisites: MFR I, Fascial-Pelvis, Unwinding)

- Wilmington, DE**
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- Sedona, AZ**
February 6-9, 2020

Advanced Unwinding

- Sedona, AZ**
June 25-28 (½ days), 2020
- Wilmington, DE**
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Myofascial Release II (Prerequisite: MFR I)

- Sedona, AZ**
March 26-29 (½ days), 2020
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August 21-23, 2020
- San Francisco, CA**
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- Nashville, TN**
November 20-22, 2020

Myofascial Mobilization

- Madison, WI**
March 21 & 22, 2020
- Erie, PA**
April 4 & 5, 2020
- North Shore, MA
(Peabody/Salem Area)**
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June 6 & 7, 2020
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August 22 & 23, 2020
- Towson, MD**
August 29 & 30, 2020

Myofascial Healing

- Cincinnati, OH**
April 3-5, 2020
- Sedona, AZ**
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Fascial-Pelvis

- Fort Worth, TX**
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- Orlando, FL**
April 17-19, 2020
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