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INSIDE

SPECIAL ISSUE:

Showcase on occupational therapy community practice in Canada

Guest Editors: Annie Carrier and Marie-Hélène Raymond

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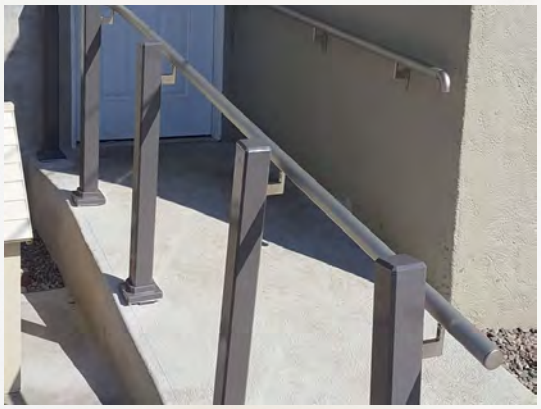

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Community occupational therapy practice in Canada: A diverse and evolving practice

Annie Carrier and Marie-Hélène Raymond

This special edition of *Occupational Therapy Now* is a showcase of community occupational therapy practice in Canada. Community practice is founded on the concept of a healthy community, namely, a community that creates environments and develops resources that enable people to "mutually support each other in performing all the functions of life and in developing to their maximum potential" (World Health Organization, 1998, p. 13). Community occupational therapy practice revolves around the social participation (social roles and meaningful activities) of the individual, group, or community. It reaches various clients in keeping with prevention, health promotion, citizen participation, and empowerment.

Despite all of its possibilities, community occupational therapy practice has not yet reached its full potential. In fact, community practice both influences and is influenced by the environmental and socio-cultural contexts in which it operates. So, like our clients who experience some difficulties in their development or well-being, our practice faces very tangible **challenges**. Some of these challenges – barriers to community practice, lack of financial or physical resources (e.g., public transit) that can lead to instability or even inability to provide services – will be addressed in the articles of this special edition. Restrictions and a lack of knowledge, both stemming from health organizations and occupational therapists, are just some of the obstacles encountered by the practice. Also among these is the emphasis on acute health problems and the biomedical model of health, in the health system. From a societal point of view, in North American culture, the praising of individualism over mutual support in communities, insidiously impedes the full development of community occupational therapy.

Yet, and perhaps even because of these challenges, community occupational therapy practice continues to develop and grow in relevance. Just like our clients progressing towards their goals, community practice persists, transforms, pushes past barriers, and explores new avenues to become what it is meant to be. Marval (p. 12-13) and Hazlett (p. 10-11) respectively, demonstrate how community occupational therapy programs successfully overcome the barriers inherent to their practice environment. Indeed, there have been many **achievements** in community occupational therapy practice for a diverse clientele. Occupational therapy expertise contributes to the empowerment of people so that they can reach their full potential: e.g., in the implementation of exercise groups for people with low vision (Teng, p. 21-22) or those with reduced mobility (Turcotte et al., p. 29), through groups for overcoming the fear of falling (Filiatrault et al., p. 30), and in the training of assistance volunteers (Lacerte et al., p. 27-28). Anchored by the conceptual models of the profession, occupational therapists play pivotal roles in the health of communities, through their preventive and health promotion interventions, by building on the strengths of individuals, and in having a broader perspective on the problems encountered in the community; for example, due to poverty (Davies, p. 14-15) or homelessness (White & O'Keefe, p. 26). Community occupational therapists' initiatives allow people with intellectual disabilities, among others, to live in their community (Yamamoto et al., p. 25); and for hairdressing students to learn how to work safely in order to prevent musculoskeletal disorders (Lecours & Therriault, p. 23-24). Similarly, the contribution made by occupational therapists in establishing a continuum of care between hospital and community services, provides a smooth return home to the post-hospitalized population (Weill, p. 20).

These successes underscore the importance of **partnership** built on the strengths of the community. These strengths can be those of community organizations and their volunteers (Filiatrault et al.; Lacerte et al.; Teng; Turcotte et al.), university programs (Lecours & Therriault; Teng; Yamamoto), Indigenous communities (Viscogliosi et al. p. 16-17), instructors of professional programs (Lecours & Therriault), or research teams (Filiatrault et al.; Lacerte et al.; Viscogliosi et al.). It turns out that successful initiatives count on the **empowerment** of populations. At the heart of each of these initiatives, the occupational therapist puts his or her expertise to the service of the community.

Nevertheless, there are still areas of expertise **to be developed**. For example, Winlaw (p. 18-19) emphasizes that occupational therapists remain relatively absent in refugee support interventions, and that it is high time that we contribute to the health and well-being of these populations in need. Moreover, according to Viscogliosi and colleagues (p. 16-17), there is a long way to go to ensure the full participation of our Indigenous peoples, all while respecting their values, a field in which knowledge still needs to be synthesized.

There are several **means** of developing community occupational therapy. The first is clinical tools, and among these is a caseload management tool, as developed by Arès et al. (p. 6-7). This tool supports community occupational therapy practice by providing concrete ways of managing challenges. Research, in partnership with community stakeholders, is another indispensable means of illustrating the relevance of developed initiatives (Filiatrault et al.; Lacerte et al.), and of identifying new avenues to be prioritized (Viscogliosi et al.). More introspectively, the self-critical analysis of professionals, and consequently that of the profession, remains an essential way of recognizing the way forward. This reflective capacity of community occupational therapy promotes the evolution of practice in new niches, wisely illustrated by Winlaw (p. 18-19). Similarly, Michetti and Dieleman (p. 8-9) demonstrate how to shift one's focus in order to transform a current practice, in this case: adopting a lens that is more oriented to occupational therapy, in case management.

Following the example of many authors of this special edition, we invite occupational therapists to think about a few questions to guide the deepening of our community practice.

- What are our achievements in relation to the people or communities we support? How do we support the connections between various partners to foster the development and participation of individuals, groups, or communities?
- What are the main constraints limiting the development of our community practice? To what extent do these barriers limit our scope?
- How can we break down or overcome barriers in order to enable our community practice to flourish? In order to better align our practice with our professional values, can we consider some elements differently?
- What opportunities could we seize, and what tools could we develop to expand or improve community practice?
- Are there new partners with whom we could collaborate, new clientele or communities to which we could contribute our expertise? Would it be possible, in our interventions and as a result of them, to target a wider community rather than isolated individuals?

This special edition of *Occupational Therapy Now* highlights various facets of community occupational therapy practice which is essential to the well-being and health of Canadians. Too often, the skills and expertise of community occupational therapists remain under-exploited. However, due to the aging population, the prevalence of chronic diseases, and the cost of the resulting health systems, experts agree on the need to invest more in frontline services for individuals and communities, as well as in prevention and health promotion interventions. According to Clark et al. (2012), Graff et al. (2008), and Zingmark, Nilsson, Fisher, & Lindholm (2016), community occupational therapy practice is able to contribute effectively and economically to this imperative. We need to recognize, and even create, opportunities to fully play this role in communities. The reflections and successes that make up this special edition are examples that we hope will inspire other innovative initiatives in Canada. By continuing to build on partnerships and the empowerment of individuals and communities, community occupational therapy practice can continue to progress, with the aim of reaching its full potential.

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About the guest editors

Annie Carrier has been an occupational therapist since 1996. She is a professor at the School of Rehabilitation at the Université de Sherbrooke. She has worked as a community clinician for about ten years. During her postdoctoral fellowship, Annie focused on the role of change agents and on strategies for influencing organizational and political decision-makers. She can be reached at: annie.carrier@usherbrooke.ca

Marie-Hélène Raymond has been an occupational therapist since 1999. She practiced in the community for twelve years while completing her doctorate at the Université de Montréal in 2016. Her thesis focused on prioritization strategies pertaining to waiting lists for home-based occupational therapy in Québec. Presently she is the Knowledge Mobilization Coordinator at the Centre for Interdisciplinary Research in Rehabilitation of Greater Montreal (CRIR). She can be reached at: marie.helene.raymond@umontreal.ca

What's new

Research Listing added to www.caot.ca

CAOT supports research activities that advance the practice of occupational therapy in Canada. Now researchers have the opportunity to post surveys and calls for recruitment on a Research Listing available at: http://www.caot.ca/site/pt/resources/reseachlisting and occupational therapists have the opportunity to participate in them. These study or survey opportunities have been vetted to ensure they are relevant to occupational therapy, supportive of occupational therapy practice and are not in conflict with CAOT values. Researchers and occupational therapists should follow this listing so that, together, we build a superior evidence base for our profession.

Registration is open! Go to: http://www.caot.ca/site/pd/CNDRC?nav=sidebar

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Paul Boase

Road Safety in Canada: Now and the Plan for the Future. Road safety expert Paul Boase will share his insights regarding road user behaviour and related research. Through his work with Transport Canada and, prior to that, with the Ontario Ministry of Transportation and Communications, Paul has participated in ground breaking projects such as graduated licensing, administrative licence suspension and photo radar.

Christine Caron

Taking Life Back! Christine Caron will share her story – surviving and overcoming a dog bite that led to septic shock and the loss of three limbs – and then re-learning how to drive with adaptive equipment and modifications. Her physical and emotional recovery was aided by many, including the Ottawa Hospital Rehabilitation Centre whose efforts allowed her to return to driving and, through that, regain her freedom.

Occupational Therapy Now call for papers for March 2018 special issue

With the compelling title "Get Prepared!" and a focus on how being prepared empowers individuals/groups and builds resilience, you will want to join guest editor Sandra Hobson in exploring this topic in our *OT Now* issue next March. We are looking for submissions regarding the roles that occupational therapists are currently playing, or could play, in the realm of preparedness. The call for papers is posted at: http://www.caot.ca/site/pd/OTNow?nav=sidebar

Deadline for submission is October 1, 2017. Questions and submissions go to **otnow@caot.ca**

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- Internationally Educated OTs
- Chronic Pain and Occupational Therapy
- Rural/Remote Practice
- Ergonomics

User guide for SAGE journals

CAOT members can search and browse more than 1,000 journals including CJOT. Sage has prepared a user guide on searching and navigating their new site and some of the tools and features available. Go to: http://journals.sagepub.com/pb-assets/PDF/SJUserGuide_Feb2017.pdf

A caseload management tool : Supporting the work of occupational therapists in home care

Isabelle Arès, Marie-Claude Comeau, Amélie Payeur, and Judith Robitaille

The occupational therapy team at our organization's home support program is committed to applying the best clinical practices, including caseload management. In the last few years, the arrival of several occupational therapists has highlighted the issue of caseload management methods. There is a great variability in how therapists manage caseload such as taking over and closing cases, and duration and frequency of visits. While respecting the differences in practice style, these methods may impact the follow up with clients, the frequency of care to clients waiting for service, as well as the occupational therapist's feeling of self-efficiency .

In an effort to ensure the quality and equity of the occupational therapy services rendered, a committee was created within our work team in the fall of 2015, in order to find a tool that could support occupational therapists in their caseload management. It has been determined that this tool must exhibit some key features: be simple and quick to fill out, allow the description of the caseload, meet the needs of the daily organization of occupational therapists, and permit a review of the daily caseload evolution over time for a specific occupational therapist (intra-individual comparison).

A brief survey of the literature was performed to identify existing tools. In light of the summary, analysis of three identified tools (Canadian Association of Occupational Therapists, Canadian Physiotherapy Association and Canadian Association of Speech-Language Pathologists and Audiologists, 2011; Ordre des travailleurs sociaux et des thérapeutes conjugaux et familiaux du Québec, 2009; Simard, 2008; Syndicat des ergothérapeutes du Québec, 2003), we concluded that none of these tools met all the aforementioned features. The Committee therefore developed a Caseload Management Tool (CLMT).

Description of the CLMT

The CLMT targets occupational therapists who practice in the context of a home support program. The occupational therapist records in a computer file all of his or her cases (surname, first name and file number), in addition to the level of complexity determined for each case. The three levels of complexity are: light, moderate, and complex. Each of the levels are described through a series of criteria (e.g., several interventions to perform in the short term, detailed writing, urgency to act). The tool may then be customized to meet the daily organization needs of each occupational therapist (e.g., follow-up, writing). The intensity and nature of the interventions remain dependent on the occupational therapist's judgement. An example of the file is presented in Figure 1.

A global complexity rating is then generated, taking into account the number of cases assigned to the occupational therapist, their complexity level, and the number of days per week worked by the occupational therapist.

The classification of each case by complexity level does not allow the subjective appreciation of the caseload felt by the occupational therapist. Therefore, the CLMT also includes a measure of self-perception of the "weight" of the caseload. The CLMT proposes a numerical scale graded from 1 to 10, where 1 = "I need more challenges" and 10 = "I feel overwhelmed".

Surname, first name of the occupational therapist:		Ergo, Rose			
Days/week worked:		5			
Date (YYYY-MM-DD):		2017-02-01			
File #	Surname	First name	Level of complexity	Main diagnostic*	Reason for intervention*
111111	Aaa	Aaa	3	Multiple sclerosis	Transfers to the wheelchair
222222	Bbb	Bbb	5	Left middle cerebral artery stroke	Functional assessment
333333	Ccc	Ccc	1	Loss of independence	Hygiene independence

* These sample columns are customized according to the needs of the occupational therapist.

Figure 1. Example – Caseload Management Tool (CLMT)

Use of the tool

After using the CLMT, our team's occupational therapists reported the following impacts. The tool:

- allowed a common language between the members of the team in discussing case complexity;
- facilitated the management of routine work;
- facilitated the transfer of information for absence or leave;
- objectified the case distribution in the workload;
- allowed the appreciation of the weight of one's caseload and of its evolution over time;
- increased the feeling of efficiency in the caseload management;
- guided the taking over of new cases;
- allowed participation in the health and well-being of the professional stakeholders (e.g., prevention of burnouts).

The CLMT was also used in the context of discussions with a clinical coordinator in order to validate, amongst other things, consistency in the occupational therapists' services. However, the CLMT does not take into consideration non-clinical tasks (e.g., administrative tasks, meetings); and the tool is neither a measure of the occupational therapists' performance nor a tool to compare performances between therapists. It only allows an intra-individual follow-up on the caseload complexity.

Impact on practice

The use of the CLMT has had a positive impact on the practice of the occupational therapists within our team. Its simplicity leads us to believe that other institutions and other professionals could easily use this tool and avail themselves of its benefits. To this end, the complete tool with user guide, is available in French. People who are interested in viewing this document are invited to contact the authors.

Acknowledgements

The authors thank all the stakeholders who contributed to the development of the CLMT as well as the managers who lead the older adults independence support program of the Memphrémagog facility.

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About the authors

Isabelle Arès, OT, has been an occupational therapist in home care for 15 years. She has held the position of clinical coordinator in the occupational therapy and physiotherapy team of the CIUSSS-Estrie-CHUS, Memphrémagog facility, for two years. She can be contacted at iares.mm@ssss.gouv.qc.ca. The co-authors have been occupational therapists on this team since September 2014.

Occupational therapists as case managers in community mental health teams: Applying the occupational therapy lens

Jennifer Michetti and Crystal Dieleman

Many community mental health teams (CMHTs) consist of professionals from various disciplines serving in a dual role of generalist case manager and profession-specific specialist (e.g., occupational therapist, nurse, social worker). Within these teams, every member is responsible for attending to every aspect of their clients' lives, involving other team members only as needed for profession-specific needs (e.g., assessment of daily living skills by an occupational therapist; Culverhouse & Bibby, 2008; Parker, 2001).

As part of my master's thesis about the role of occupational therapists on CMHTs, I interviewed several occupational therapists about how they understand their dual roles. A key finding was how occupational therapists chose to apply, or not apply, an occupational therapy (OT) lens to their case management duties. This article outlines how occupational therapists working on CMHTs can adopt a dual role by choosing to apply an OT lens.

What is the shared case manager role?

Regardless of their professional education, case managers adhere to ethical and legal requirements regarding privacy and confidentiality and have a shared set of core competencies, including: counseling, providing individualized care, using a recovery-based approach, implementing illness and suicide prevention strategies, using problem solving skills and supporting balance in their clients' lives (Ministry of Health and Long Term Care, 2005). Examples of specific duties that could be categorized within these core competencies include: dropping off medication and/or observing a client taking medication, accompanying a client to a medical appointment, completing applications for income benefits, negotiating with a client's landlord or grocery shopping with a client.

The OT lens continuum

A continuum of perspective, or of the OT lens, was uncovered when analyzing occupational therapists' comments about their work (see Figure 1). In this project, "OT lens" is defined as the extent to which occupational therapists engage in their work using an occupation-based perspective. The occupational therapists in the study all spoke of shared case manager roles and OT–specific roles, but the manner in which they viewed them differed. One end of the continuum reflects workers of different professional backgrounds fulfilling a case manager role from a shared perspective (lacking an OT lens). The other end of the continuum reflects occupational therapists engaging in OT–specific work (e.g., assessing independent living skills) using OT–specific theory and models (e.g., the Person-Environment-Occupation Model, which focuses on enabling clients to do what they need and want to do; Law et al., 1996). The middle ground of the continuum is where occupational therapists turn a shared role into an OT role by applying OT theory and models – an OT lens – to their work.

Figure 1. OT lens continuum

Some therapists felt that they fully lived out their OT roles in everything they did, "because [they] get to help the whole person...assist them with their actual day-to-day living". A cause for concern is that other therapists considered very little of their day-to-day work to be OT. They expressed a desire to "have more time just dedicated to working on OT–specific goals with clients" and a sense of losing their OT identities at times due to the lack of OT–specific work being done. They identified case manager duties as taking precedence over OT tasks. One participant described "going to the doctor, going to the lab, ensuring all [the clients'] basic needs are taken care of before we pursue some of their functional goals."

About the authors

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Reflection

In reflecting on my own work in a CMHT, I realized that I adopt an OT lens in shared roles (section B of Figure 1) by using activity analysis (breaking activities down into performance skills components) to identify and build upon clients' foundational and transferrable skills. Applying my fundamental OT skills came naturally to me, and it was not until I accompanied a non-OT co-worker on a client visit that I recognized the stark differences in our approaches. Conversely, a non–OT co-worker queried why I posed particular questions to a client. For example, when I engaged in light conversation (role modeling acceptable social behaviour) during a session and posed questions to the client (encouraging the client to take an active role in decision making) my co-worker asked me, "When will you start working on [the client's] independent living goal?" It was at that point I consciously recognized the need to explain my approach to my co-workers and demonstrate how activity analysis and foundational skill building can lead to the transfer of skills (e.g., being on time for a visit with the CMHT can translate into being on time for a job interview).

Since most CMHTs are case management–based, with professionals of various disciplines serving as case managers, Table 1 highlights the differences between a shared case manager role with the application of a shared lens versus a shared case manager role with the application of an OT lens. Table 1 uses the example of accompanying a client to a medical appointment. Included among the OT principles and practices that are evident through the application of an OT lens is a holistic approach to client care that goes beyond simply attending an appointment. Activity analysis attends to the different skills necessary for participating in a medical appointment, including preparation and planning, and an OT perspective encourages active rather than passive engagement from the client. It involves *doing with* the client and/or *enabling the client to do for herself/himself* rather than doing aspects of the activity *for* the client or on the client's behalf.

Table 1
Duties accompanying a client to a medical appointment

Section A Shared role/shared lens	Section B Shared role/occupational therapy–specific lens

Knock on client's door, lead client to bus stop, tell him/her which bus to board and ensure correct fare is paid;
Sit quietly while riding, ring bell for correct bus stop;
Sit with client in appointment, answer/pose questions based on the level of consent given by client.
	• Prior to appointment:
	  • Engage in discussion around hygiene expectations with client;
	  • Discuss concerns and write down questions to ask at apptointment;
	  • Research bus route/ schedule/travel time/ fare with client;
	• Meet client in lobby of his/her apartment building; notice if client is on time;
	• Prompt/remind client as necessary to ensure boarding correct bus/giving correct payment/getting off at correct stop;
	• Model light conversation skills while travelling on bus;
	• Advocate on behalf of client as appropriate in appointment;
	• Encourage client to pose questions.

Conclusion

A generic case manager role can be turned into an OT role through the adoption of an OT lens. This approach can enable clients to actively engage in every aspect of the activities that make up their occupational lives, build foundational transferable skills, improve self-efficacy and self-confidence, enable recovery and promote the clients' perceptions and experiences of success (Townsend & Polatajko, 2013). This simple mental shift, of occupational therapists applying an OT lens to the shared case manager role, ultimately has the potential not just to improve client care, but to reinforce positive professional identity and increase job satisfaction among occupational therapists on CMHTs.

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Kenora in ACTTion: Community practice in northern Ontario

Naomi Hazlett

October 30, 2016 (1:30 am): *I step off the Greyhound® bus into the parking lot by the bus depot. I'm alone, in the dark, thousands of kilometres away from home. I go to the gas station, suitcase in tow, to find a phone and call a cab, which arrives an hour later.*

October 31, 2016 (10:00 am): *I wake up in my student housing. Through the living room window, I see the town of Kenora, Ontario, across a sparkling lake in the morning sun..*

Kenora is located on the Trans-Canada highway, roughly 200 kilometres east of Winnipeg and north of the US border. The town has approximately 15,000 permanent residents (Statistics Canada, 2011). Higher in latitude than Toronto or Ottawa, Kenora is considered to be in northern Ontario. For the next seven weeks, I experienced Kenora as part of my fieldwork placement with an assertive community treatment team (ACTT). Part of the Canadian Mental Health Association – Kenora Branch (CMHA-K), this ACTT is one of multiple mental health programs offered by CMHA-K. This article will discuss the unique challenges and solutions found in community occupational therapy practice in remote areas of northern Ontario that I witnessed in my student placement.

The ACTT model

ACTTs assist individuals living with mental illness to achieve self-identified goals and live as independently as possible in the community. The majority of the clients of the CMHA-K ACTT have a diagnosis of schizophrenia and/or a psychotic disorder, and many have concurrent issues related to substance use. Some of these clients are of Indigenous heritage. Interventions can range from cognitive behavioural therapy (CBT) for anxiety to assistance with grocery shopping. The overall goal of occupational therapy in this ACTT is to enable clients to do what they need and want to do. This includes achievement of personal goals as well as performance of activities of daily living (ADLs). Interventions take place in clients' homes, at the ACTT office, and in the community. The therapist works individually with clients to promote personal health and well-being. This can include addressing physical factors like addiction or unhealthy behaviours, as well as mental factors like anxiety or motivation.

Occupational therapists working in community mental health are well positioned to combine in-clinic intervention with real-world practice. This practical approach is one of community practice's greatest strengths and is exemplified in Kenora. For example, while engaging in the occupation of cleaning together with clients, I discussed strategies for housecleaning, such as having a routine or creating a chore calendar. In running a weekly craft group, I facilitated clients in engaging in an occupation, expressing themselves creatively, and socializing. I also facilitated further opportunities for social interaction and participation through attending events in the community with clients.

Challenges

Long distances between communities and inadequate access to resources are unique challenges in the north. Travel can be a major barrier to accessing care. Kenora's ACTT uses a "district" ACT model (CMHA, 2017), in which clients who are not residents of Kenora can access services remotely in their neighboring communities, through the Ontario Telemedicine Network or through collaboration with a local case manager. The Kenora ACTT's clients therefore inhabit Kenora, Keewatin and beyond, including the 64 neighboring Indigenous communities. As not all medical services in Kenora use this model and thus do not offer remote services, clients living in Indigenous communities must often travel long distances to access health services. There is only one Greyhound bus to Kenora every day and one local bus running every hour within Kenora—still, having a car is simply not an option for some. One of the closer Indigenous communities, Asubpeeschoseewagong Anishinabek (Grassy Narrows), is an hour and a half drive away from Kenora on a winding logging road. A round trip from a fly-in community can be thousands of dollars on the local airline. Addressing transportation in practice means balancing enablement strategies on a situational basis. Some clients are able to walk to appointments, groups and events by themselves. Others make use of the public transportation system or other free services. In other cases, the ACTT provides rides to clients for therapeutic purposes.

Addressing diversity is another challenge in northern Ontario. In 2006, 83.3% of the population of Kenora was of European descent, 15.8% was Indigenous and 0.9% was composed of visible minorities (Statistics Canada, 2006). Stigma is not only a problem faced by those living with mental illness, but also affects Indigenous individuals living in the region. The historical context of the relationship between Indigenous and European cultures has had an ongoing impact. Rupert Ross, a retired crown attorney in the district of Kenora, described lasting effects of the trauma from cultural loss and

abuse in the residential school system: "...the traumatization of children in residential school led to traumatized behaviour once they returned, and to the modelling of that behaviour by subsequent generations" (2014, p. 127). The last such school in Kenora, Cecilia Jeffrey Residential School, closed in 1976 (Aiken, 2013). Friction between the Indigenous population and the majority European population of Kenora remains, thus greatly increasing the stigma faced by Indigenous peoples. For clients living with the dual stigma of mental illness and Indigenous status, the cards can be highly stacked. Occupational therapists must acknowledge and address potential cultural and institutional barriers to best enable Indigenous clients to achieve their goals.

Solutions

There is no easy solution to allow occupational therapists to increase cultural competency in northern Ontario, but engaging in community practice is a step in the right direction. Therapists work in the homes and territories of Indigenous clients, as well as participate in cultural events and communities, and so may understand what role they can play in promoting healthy living, healing and quality of life.

Navigating sparse or expansive transit systems to provide essential services, combating stigma in isolated communities while being visibly different from community members and developing cultural competency are challenges that occupational therapists working in ACTT are facing every day in Kenora. While I had the privilege of witnessing therapists find effective and creative solutions in the face of these challenges, there are still many gaps to fill. For example, during my placement, I was informed by a resident of Grassy Narrows that a successful suicide prevention program had recently been discontinued. This situation highlights the necessity of raising awareness regarding the needs of remote communities and advocating for programs that are currently addressing such needs. In the meantime, occupational therapists are currently addressing the above-identified gaps in a number of ways. As part of an initiative to connect Indigenous clients with culturally relevant occupations, I accompanied clients to a Powwow held on Remembrance Day. To address transportation, clients were offered rides to and from the Powwow by both the ACTT and the community centre hosting the event. When delivering a session on nutrition and healthy eating for the Challenge Club Mental Health Day Treatment program at Lake of the Woods District Hospital, my student occupational therapist partner and I discussed how to integrate traditional Indigenous foods into a balanced diet.

While resources are limited, there are ways to make the most of them. Providing successful support and intervention requires collaboration with the residents of Kenora and the neighboring communities, regardless of their levels of privilege, to determine what services are most needed and how they can effectively be delivered. It is also crucial for health care providers to not only educate themselves about the issues facing their own communities, but also to raise awareness of them and advocate for desperately needed funding, to succeed in supporting the quality of life that all community members deserve.

Conclusion

As I waited in front of the entrance to a sweat lodge in Wauzhushk Onigum, also known as Rat Portage, an elder asked me why I had come to Kenora. I told him that I wanted to understand what I could do to help, and that I wanted to do so by listening. He replied, "Many people don't know how to do that."

December 25th, 2016 (5:30 pm): *I am back home, in Toronto, opening a gift from a client. A handmade dreamcatcher emerges from the wrapping paper. It now hangs on my bedroom wall, reminding me, as an emerging therapist, to remember, listen and advocate, in order to help those in need wherever I go next.*

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Community-tailored occupational therapy in primary health care to promote individual and community health

Rebecca Marval

The term *community* describes belonging to a group by being in a geographical area or holding a "common identity" (Trentham, Cockburn, & Shin, 2007, p. 56). According to the World Health Organization (WHO), a healthy community enables people to "mutually support each other in performing all the functions of life and in developing their maximum potential" (1998, p. 13). Occupational therapists could be natural stewards of community health, yet despite our shared professional values, individual efforts and designation as "community" practitioners, I believe we fall short in supporting individuals to be healthy in their communities, let alone in supporting whole communities in achieving health. What follows is a critical reflection on limiting factors and one alternate possibility for community occupational therapy, community-tailored primary health care, based on clinical experience in one urban, Canadian context.

Limiting features of community practice

Ideally, a community-dwelling individual accesses an occupational therapist, achieves a goal (e.g., independence in community mobility) and enjoys some related benefit (e.g., increased autonomy). This person generalizes the newly acquired benefit (e.g., to access a public library), improving individual health through meaningful participation in occupations and roles. Better still, this individual's improved function generates benefit for others (e.g., development of a reading program that others can attend), contributing to the health of the community as a whole. In my experience, such a chain of events is often the only employer- or program-approved mechanism for community occupational therapists to impact the health of a community. This mechanism is tenuous given its focus on individuals and reliance on their membership in a healthy community (e.g., one that has a library), and so, to promote healthy communities, occupational therapists need to directly contribute to community health.

Yet, there are a number of environmental influences that limit community occupational therapists' contribution to community health. One is the **historical positioning of occupational therapy** within the health sector (Townsend & Sandiford, 2012) and the dominant medical model that has organized occupational therapy practice by pathology and prioritized treatment over prevention. This is further complicated by the limitations inherent in the **siloing of resources** into health, justice and other sectors when it comes to working holistically with people and communities to address multifactorial issues. Another factor is a **Western cultural focus on individuality** that separates persons from their environment, an idea contrary to the established importance of social determinants on individual and community health (WHO, 1998) and to occupational therapy's holistic theoretical perspective. Finally, **hegemonic assumptions** reflected in policies that favour those who already belong to "healthy" communities limit occupational therapy's impact in other communities, due to factors such as socioeconomic status, education and more. For instance, a policy to discharge clients after missing a mailed-out appointment notice disadvantages those without a stable address or with literacy challenges and prevents access to occupational therapy for those who missed the appointment due to lack of transportation, caregiver support or even a telephone to reschedule the appointment.

Given these systemic limiting factors, the achievement of the WHO's vision of healthy communities will likely require major systemic change, which occupational therapists can help actualize through the coming years. Yet even now, there are opportunities to move community occupational therapy into better alignment with this vision. One way forward is through community-tailored primary health care practices (Health Canada, 2012) that are built to address the broad, social-determinants-of-health needs of specific communities, taking into consideration their members' common concerns and preferences, such as in the following example of current practice.

Mobile Outreach Street Health (MOSH): An example of community-tailored occupational therapy in primary health care

MOSH is a primary health care team created to improve health among persons who are street-involved, at risk of homelessness or experiencing homelessness. Working as the occupational therapist with MOSH has provided me with opportunities to put the WHO's vision for healthy communities into practice. In 2009, I was empowered and supported by the community and my employer to customize my practice with as few unnecessary limitations on service delivery as possible, to facilitate individual and community health. The following table highlights features of my practice that have been tailored to the needs, concerns and preferences of persons experiencing homelessness, as per service provider and first-person accounts, as well as per the health literature (Frankish, Hwang, & Quantz, 2005).

In my community practice, making an impact on individual and community health as an occupational therapist remains challenging, but it is tangible. A few successful examples of initiatives that have had individual and community reach include the MOSH Bike Project, which has matched over 90 street-involved persons with bicycles as affordable, active transportation, and Adsum for Women & Children's PeerWorks, a mentored

Table 1
Practice features to promote individual and community health

Community considerations	Community-tailored practice features
Reducing barriers to access to service is essential.	Accept referrals from any source, including verbal self-referrals. Offer quick access to capitalize on windows of opportunity like release from jail, opportunity for tenancy or interest in substance use change (quick access can result in a large caseload, but individual engagement fluctuates frequently, permitting adequate caseload management for a proportion of engaged individuals at any given time.) Recruit potential clients through outreach at community gatherings. Avoid restrictive policies related to "no shows," duration of time on caseload, prerequisite health or functional problems permitting eligibility for service, etc.
Relationship-based care (i.e., a relationship with a trusted provider) facilitates positive outcomes.	Be present and patient, to build trusting relationships rather than only to accomplish a goal. Work to full scope of practice—partake in transdisciplinary activities to efficiently meet individuals' needs rather than only making referrals for activities that are within occupational therapy's scope of practice. Be open minded to possible applications of occupational therapy—entertain a broad range of occupation-based goals important to individual and community health, such as maintaining tenancy through addressing hoarding behaviours or learning to prepare for bed bug treatment; apply holistic problem solving, such as to help landlords house individuals who struggle with tenancy.
Systemic issues play a very significant role in individual and community health, as lack of resources constrains individuals' power to impact outcomes.	Work with the community to identify common challenges and champion change through activism (Townsend & Sandiford, 2012), inclusion, community development (Lauckner, Krupa & Paterson, 2011) and institutional and neighborhood change, sharing resources, research and other means. Share occupational therapy knowledge and values with community members, service providers and decision makers, to contribute to the community's capacity to sustainably meet their own health and occupational needs.

work program that has engaged women with lived experience of homelessness in paid apartment management activities for a non-profit housing provider to the economic, social and occupational benefit of all involved parties. Community-tailored primary health care occupational therapy lends itself well to using occupation to meet individual and community needs while contributing to both individual and community health.

If community practice rests on the concept of healthy community, let occupational therapists recognize the conditions necessary for community health and partner with decision makers to make the systemic changes necessary to embed ourselves accessibly in communities. As practitioners, let us be intentional in applying visions of possibility to factors limiting individual and community health.

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Occupational therapy in low-income communities: Uncovering strengths, building capacity and creating sustainability

Stephanie Davies

Poverty is often defined in monetary terms. As health care providers, occupational therapists often work with populations labelled as low-income and must shift away from this ubiquitous understanding of poverty by viewing it within its wider context. The World Health Organization (2006) proposed understanding poverty through its characteristics such as lack of access to education, health care and occupation. The denial of these fundamental rights causes these communities to face occupational injustices, which are inequities in opportunities and resources to engage in meaningful occupations (Townsend, 2004). Rather than viewing occupational injustice as a problem that requires *fixing* by an outsider, we can address it by harnessing a community's assets.

When occupational therapists understand a broad definition of what an impoverished community is, they can facilitate positive re-engagement through applying a top-down approach that focuses on communities' unique strengths. On the contrary, when a bottom-up or problem-focused approach is used, particularly with a vulnerable population, it can be disempowering and perpetuate dependence. In this article, I will describe what a top-down approach looks like, viewing poverty in a wider context.

Community capacity assessments: A strengths-based approach

There is a strong argument in community development research that all communities have an inherent capacity for sustained regeneration (Kretzman & McNight, 1993). The resources to continuously resolve occupational issues inherently lie within communities. When working in vulnerable communities, health care providers must conscientiously work as collaborators rather than experts. Using a top-down approach that focuses on drawing out a community's strengths and building capacity is one way to map out and release its assets. Kretzmen and McKnight (1993) proposed three steps to community assessment that could be used to understand assets in impoverished communities:

1. Identify skills at an individual level (e.g., by creating surveys to determine priorities, talents, education);
2. Identify assets within the local community that may serve individuals (e.g., churches, libraries, schools);
3. Determine how the reciprocal capacities of the individuals and the community could build relationships (e.g., a local sports complex offering free exercise space to individuals assisting with landscaping).

It is within an occupational therapist's scope to conduct capacity assessments and help identify the skills that exist within a community rather than view the community as one that requires fixing. This strengths-based approach empowers individuals to act as agents of change by applying their skills.

The Person-Environment-Occupation (PEO) Model: A top-down approach

The PEO model supports client-centred practice by encouraging occupational therapists to understand the transactions between the dynamic roles of persons and the environments in which they work, live and play (Law et. al., 1996). During a capacity assessment, information can be collected regarding the community's PEO fit—that is, the degree to which person- environment-occupation factors are congruent with one another. For example, individuals in low-income communities wishing to engage in an exercise program but who are not in proximity to one, or able to afford to participate in such a program, would have a low congruence between this occupation and the environment in which they live. An occupational therapist might discover assets among community members (e.g., experience leading exercise groups) and within the environment (e.g., an available nearby public park). These assets can close the gap between the environment and occupation by connecting motivated and knowledgeable community members wishing to exercise to a free space.

By understanding a community's collective PEO factors, occupational therapists position themselves as collaborators and gain an understanding of potentially meaningful opportunities. Meaningful participation contributes to one's overall health, perception of stress and life purpose(White, Ma, & Whitney, 2014). The community and individual assets uncovered by capacity assessments can help create a meaningful PEO fit.

Summary

Through facilitating community capacity assessments and using the PEO model, occupational therapists uncover meaningful opportunities and empower individuals to be agents of change in their environments. Sustainable

occupational therapy interventions in low-income communities are client-centred, collaborative and empowering. Occupational therapists are well positioned to work in low-income communities using their expertise in applying a top-down, strengths-based approach.

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Supporting Indigenous Elders in their contribution to the well-being of their communities: A partnership approach

Chantal Viscogliosi, Hugo Asselin, Suzy Basile, Yves Couturier, Marie-Josée Drolet, Dominique Gagnon, Jill Torrie and Mélanie Levasseur

The challenges faced by occupational therapists in an Indigenous context

With an approach that promotes intercultural dialogue, our project aims to support the social participation of Indigenous Elders through intergenerational solidarity, to foster the well-being of Indigenous communities. Occupational therapists are currently involved in Canadian Indigenous communities with clients of all ages, in adaptation and rehabilitation, whether in physical or mental health. Yet the work of occupational therapists faces challenges in terms of cultural competence, which limits the effects of health and social services on issues faced by Indigenous peoples. In accordance with traditional Indigenous models of healing (TRC, 2015; Simard-Veillet, 2015) and community development (AFNQL & FNQLHSSC, 2007), this project is based on the World Health Organization's (2001) International Classification of Functioning, Disability and Health, and the Canadian Model of Client-Centered Enablement (Townsend, Polatajko, Craik, & Davis, 2007). Based on the reciprocal sharing of knowledge between Elders and Indigenous representatives on the one hand, and our research team and collaborators in the health and social services sector and community on the other hand, our project brings to light Indigenous approaches to wellness. Consequently, it contributes to the improvement of cultural safety (Coffin, 2007). This is based on a continuum ranging from an awareness of the individual's culture, to the development of the professional's cultural sensitivity, and eventually to his or her cultural competency, in order to ensure the individual's cultural safety (Baba, 2013). People's cultural safety, based on respect and the prevention of discrimination, is essential in optimizing their ability to express their concerns and preferences, their adherence to the treatment plan, and their seeking subsequent consultations (National Collaborating Centre for Aboriginal Health, 2013).

A partnership approach to health promotion

Our research team, including researchers from Indigenous nations, is currently conducting a *Knowledge Synthesis* (Viscogliosi et al., 2017) in partnership with Elders and representatives of Indigenous communities, as well as an advisory committee. The committee is comprised of experts in social participation and Indigenous ethics, representatives from the First Nations of Quebec and Labrador Health and Social Services Commissions, health and social service providers, as well as stakeholders from community organizations and Indigenous Friendship Centres. Scientific grey literature, written sources, and video or audio produced by Indigenous communities or organizations working with them, contribute to the richness of this synthesis, as well as to the reciprocal sharing of knowledge (Asselin & Basile, 2012). The Advisory Committee referred us to sources such as the Council of Elders, Indigenous documentation centres, and the websites of Indigenous Friendship Centres and communities. We currently gather with Indigenous communities for coffee-meetings where we share experiences of the contributions made by Elders to the well-being of communities. Furthermore, we meet individually with Indigenous Elders who agree to share their knowledge, explain the issues they face as well as the conditions that facilitate their contributions, and who offer suggestions for participatory research aimed at optimizing their contributions to the well-being of their community. In order to maximize the involvement of Elders in different areas of knowledge, values, and cultural identity, a toolkit – presentation of the key elements of the Elder contribution initiatives will be shared with the communities at the end of the project. Our *Knowledge Synthesis* will foster exchanges with Elders, community representatives, and knowledge users on solutions that encourage the use of individual and collective strengths. In its respectful approach to values and culture, this synthesis will contribute to promote cultural safety, which is fundamental to greater health equity. Lastly, it will support Elders so that they can use traditional knowledge to improve the well-being of their communities.

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Making the connection: Why refugees and asylum seekers need occupational therapy services

Kara Winlaw

Canada has recently experienced a mass influx of asylum seekers and refugees. The daily challenges faced by members of these groups are numerous and complex, with high prevalence rates of anxiety, depression and post-traumatic stress disorder (PTSD) being commonly reported among them (Fazel, Wheeler, & Danesh, 2005). Post-migration factors such as social isolation, discrimination and unemployment serve to prolong and exacerbate these mental health issues (Carswell, Blackburn, & Barker, 2011).

Many professions and organizations within Canada are dedicated to addressing the challenges faced by refugees and asylum seekers. However, by and large, occupational therapists appear to be missing from this landscape. For example, within British Columbia, only 15 occupational therapists are listed among thousands of health care providers on the provider list of the Interim Federal Health Program (IFHP), a program providing limited, temporary health care benefits to this population. When I previously practiced in a trauma service designed for asylum seekers and refugees in Scotland, I saw firsthand the tremendous benefits occupational therapy can offer. The literature also suggests that occupational therapy has a crucial role to play in making a meaningful difference to members of this population (Smith, Stephenson, & Gibson-Satterthwaitec, 2013; Trimboli & Taylor, 2016; Whiteford, 2005). In this article, my goal is to share how occupational therapists, particularly those in the community, can make a unique contribution to empowering asylum seekers and refugees through skill development, meaningful occupational engagement and community integration. With true appreciation of what our profession can offer, I hope we can work together to overcome potential barriers to service provision.

Resettlement in a new country can initially be a relief for those fleeing war and persecution. However, relief can quickly be replaced by confusion and fear as refugees and asylum seekers attempt to navigate a new society with different rules and systems. Finding oneself in an unfamiliar culture, potentially separated from family and dealing with the effects of trauma, can make the process of resettlement an extremely challenging endeavor. An important factor in successful transitions for refugees and asylum seekers is the acquisition of **new skills for everyday living** (Suleman & Whiteford, 2013). Using a variety of assessments, community occupational therapists can assess current life skills and occupational performance, determining areas in self-care, productivity and leisure that are lacking and in need of support. They can then collaborate with refugees and asylum seekers to create tailored interventions incorporating life skills education. Teachable skills can include everything from safely cooking within the home, to taking public transportation, to job searching, to managing money, to accessing community services, to learning new coping mechanisms. Not only are skills like these practical, but they can also lead to increased confidence and fulfillment and promote community engagement, acting as precursors to occupational engagement and well-being (Suleman & Whiteford, 2013).

Many reputable organizations within Canada offer skill development programs for refugees and asylum seekers; however, eligibility requirements vary, workshops are often sporadic and rely on volunteer participation, and one-to-one support is limited. Moreover, for individuals with mental health issues such as PTSD, leaving the safety of the home and joining workshops with unfamiliar people can pose too great of an obstacle, particularly in the initial stages of resettlement. With in-depth training in mental health interventions and activity analysis, as well as knowledge of how to positively impact learning and motivation, occupational therapists are ideal candidates to offer this type of support. Unfortunately, opportunities are few and far between. The IFHP is one possible avenue to service provision. However, this service delivery model is not ideal, as it only covers individuals ineligible for provincial health insurance, a physician's referral is mandatory and team collaboration is minimal. To provide services that better meet the needs of the entire population, community occupational therapists should ideally work in partnership with non-profit refugee organizations and the government. This would encourage information sharing as well as the creation of an environment of learning and the use of an integrated approach, with each profession offering its own unique skill set. To potentially initiate such partnerships, occupational therapists could try to take on consulting roles in program development with these organizations.

Reduced participation in meaningful occupations and isolation are major problem areas for refugees and asylum seekers (Carswell et al., 2011). As experts in occupational engagement, occupational therapists have the skills to

adapt occupations to each circumstance, taking into account considerations such as culture and previous trauma. This approach ensures refugees and asylum seekers are encouraged to engage in occupations that hold significance for them. Community therapists use this approach and their extensive knowledge of community resources to further support **meaningful engagement** when educating individuals about what is available and when acting as advocates for better services and greater access to them. In one example, an occupational therapist in the United States used her knowledge of local community resources to empower a group of Karen refugee women from Burma to return to their traditional occupation of weaving (Smith et al., 2013). As a result, these women were able to maintain their cultural identity, enhance their social networks, feel a sense of pride and belonging and pass on an important skill to their children (Smith et al., 2013). In Scotland, occupational therapist Sharon Rae worked in partnership with Forestry Commission Scotland to implement an outdoor program called "Branching Out." This program allowed refugees and asylum seekers to learn new skills, become familiar with the local environment, experience the benefits of nature therapy and make social connections with others. In these instances, in which occupational participation is meaningful and community integration is involved, the rewards for participants are numerous and include increased confidence and self-esteem, reduced social isolation, improved mental well-being and a renewed sense of purpose.

Occupational deprivation is a state of exclusion from necessary and meaningful occupations due to external restrictions (Whiteford, 2005). It is a common challenge for refugees and asylum seekers who often spend time in refugee camps before their arrival to a foreign country where everything is new and unfamiliar. Daily routines offer an important opportunity to instill a sense of normalcy and re-establish previous roles that have been lost. Community occupational therapists can work with this population to gradually build these routines by using daily planners and progressive goal planning programs. Focus on daily occupation can provide much-needed respite from everyday problems and symptoms (Whiteford, 2005). For refugees and asylum seekers facing ongoing struggles such as unemployment and family separation, involvement in an intervention focused on the positive is crucial. An occupational perspective of enablement and participation can mitigate challenging circumstances and lead to positive outcomes, such as enhanced well-being and social connectedness (Suleman & Whiteford, 2013).

Occupational therapy is based upon the central tenet that occupation and health are intrinsically linked. Research within the field increasingly shows that occupation is a life necessity and that meaningful occupational engagement improves quality of life (Whiteford & Townsend, 2011). Encompassing this understanding, the World Federation of Occupational Therapists published a position statement on human rights (2006), stating that all people have the right to participate in occupations that promote fulfillment and satisfaction congruent with their cultures and beliefs, allowing them to flourish. This right is not subject to conditions and applies to all people regardless of status. Our lack of professional input with refugees and asylum seekers is not simply a missed opportunity; it fundamentally represents a failure to uphold our professional values. Occupational therapy services have the potential to create positive change for this population by addressing mental health issues and minimizing social isolation, discrimination and unemployment. Now, more than ever, is the time to show support for refugees and asylum seekers by ensuring they have access to the same health care services as the rest of the Canadian population. By devoting our time to this cause, we would be confronting one of the biggest challenges in the global community while honouring our historical commitment to social justice (Trimboli & Taylor, 2016).

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Transitioning home

Alanna Weill

Over the past decade, health care in Ontario has undergone some dramatic changes, with a focus on getting patients the right care at the right time in the right place (Ontario Ministry of Health and Long Term Care, 2012). This emphasis on patient-centered care, to be offered in the most efficient way possible while making good use of available resources, has challenged occupational therapists to critically examine their practices. It has also fostered creative thinking about new ways of offering service to bridge gaps. One example of an identified gap is in the transitions of medically complex, frail seniors being discharged from inpatient units of a geriatric hospital in Toronto. Due to tightened timelines from admission to discharge, concerns about patient safety at home, and the burden of care on caregivers, a new and innovative stream of the hospital's existing community outreach team was created: Transition Home.

Transition Home is a collaborative, time-limited, community-based occupational therapy service aimed at optimizing the discharge home for both patient and family. The Transition Home therapist works together with the inpatient team to help meet length of stay targets, provide immediate continuity of care and enable occupational engagement, as well as improve patients' function, maximize their safety and enhance their quality of life.

Transition Home offers pre- and/or post-discharge home visits for patients of inpatient rehabilitation units who reside in a specific geographical catchment area. A referral for the type(s) of visit (i.e., pre- and/or post-discharge) is determined by the inpatient therapists, based on their clinical reasoning and knowledge of the patient's unique situation. A patient is often referred to Transition Home if he or she has experienced a significant change from baseline level of functioning. These patients frequently have multiple comorbidities and the inpatient team is concerned about their safe returns home and management of care needs post discharge. These patients may also have outstanding issues that have not been fully addressed while on the unit, yet their hospital stays are unable to be extended.

The Transition Home pre- and/or post-discharge home visit(s) is/are scheduled following case review with the patient's inpatient therapists. If a pre-discharge home visit is recommended, it is timed appropriately in order to be able to positively impact the remainder of the patient's hospital stay and to be of benefit in assisting the inpatient team with appropriate discharge plans. The Transition Home occupational therapist assesses the patient's overall status and current functional abilities/limitations within the context of the home environment, making recommendations with regard to home safety, functional mobility and caregiver education. Consent to take photographs or videos is obtained. Pre-discharge visit assessment findings, photographs, videos and recommendations are discussed in detail with inpatient therapists one or two days following the visit. Post-discharge visits are intended to follow through on safety and mobility recommendations initiated by the inpatient team and/or as determined at a pre-discharge Transition Home visit. These post-discharge visits are ideally scheduled on day of discharge. The Transition Home occupational therapist also assists the patient and family in navigating the health care system by creating needed connections with community partners (e.g., the Community Care Access Centre) for longer-term support.

Early feedback from involved inpatient teams, patients and families has been extremely positive—for example:

"The pre-discharge photographs and/or videos and assessment reports act as our eyes and ears into the patient's home. The visits provide timely identification of potential discharge issues, which are confronted as realities when the patient is in their home."—an inpatient occupational therapist

"These Transition Home visits give me more confidence in making final discharge recommendations, especially for high-risk patients with challenging environments."
—an inpatient physiotherapist

"These visits were not only practical and helpful from the equipment and safety aspect, but also helped decrease patients' and their families' anxiety and stress about returning home."
—an inpatient social worker

"The recommendations provided during the Transition Home visit were practical and essential in allowing my mother to safely return home." —a patient's daughter

To ensure program efficiency and effectiveness, an evaluation of patient-centered outcomes and other objective indicators is required. This could include subjective patient/family satisfaction reports (e.g., immediate and six months after discharge) and data regarding hospital readmission rates and long-term care admission needs.

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Aqua Vision: Addressing the needs of individuals with visual impairments through community-built aquatic programming

Minnie Teng

Participating in aquatic group exercises yields benefits beyond physical fitness—it also improves mental health (Ourania, Georgia, Ioannis, & Marina, 2011) and social inclusion (Dolan, 2016). Occupational therapists work with clients to promote health and overcome physical, social and emotional barriers to maximize clients' quality of life (Mitchell & Unsworth, 2004). This article illustrates an example of a student occupational therapist engaging in community practice by identifying barriers to participation through community immersion and forming partnerships with relevant organizations to develop a program that addresses these barriers (Doll, 2010).

Identifying a need through community immersion

As a person with intermittent strabismus, a visual disorder, I volunteered for a support group for older adults experiencing vision loss. One of the topics that repeatedly came up during meetings was the limited number of physical and social activities these older adults have access to. Many of the participants mentioned a desire to engage in exercise, as most used to be physically and socially active. Being an aquafit instructor, I suggested aquafit, also known as water aerobics. One man expressed interest in returning to aquafit classes, but due to his limited vision he was not able to see the instructor. Another woman shared her experience of accidentally hitting another person when she tried aquafit. Many participants expressed interest in aquafit, especially as this activity can mitigate symptoms of other health conditions present in this population, such as arthritis. Thus, I contacted British Columbia (BC) Blind Sports, a charity dedicated to providing sports and recreation opportunities for people with visual impairments, to inquire about aquafit programs adapted for the visually impaired, but found that there was no such programming. Through my volunteer and community immersion experience, barriers to participation in aquafit and a need for accessible aquafit for the visually impaired were identified.

Partnering up with community organizations

BC Blind Sports and the Canadian National Institute of the Blind (CNIB) are leading organizations in BC that provide services for people with visual impairments. These two organizations employ staff members who are visually impaired and are experts in providing advice on how to improve accessibility for the visually impaired. When I approached the staff of BC Blind Sports, they were very excited about the idea of accessible aquafit and agreed to provide partial funding for the pilot project in Vancouver. Personnel from CNIB also helped to spread the word. Partnering with community organizations shows acknowledgment that the knowledge and experience of community members are as valued as the knowledge and experience of occupational therapists (Doll, 2010). As a student occupational therapist, I led the pilot project, applied for various community grants to help fund it, and hosted fundraisers. The pilot project eventually received a grant from the University of British Columbia.

Aqua Vision

Several meetings involving myself, stakeholders (such as BC Blind Sports) and interested participants took place to discuss how aquafit could be adapted to enhance accessibility. Throughout the planning and implementation process, staff members of BC Blind Sports who are visually impaired as well as individuals from the visually impaired community were involved. They contributed suggestions, such as to decrease the volume of music during aquafit sessions to better enable participants to hear instructions, to avoid the use of words such as "this" and "that" (as these terms are visual references) and to have the instructor wear a bright headband or cap for visual contrast. One challenge persisted—how could clients ensure they are at a safe distance from others? An idea came to me one evening when I stepped into the shower—we could try using non-slip mats as landmarks! Each participant is given a mat that sticks to the bottom of the pool, to use as a tactile landmark to gauge how far she or he can freely and safely move her or his arms and legs (see below picture).

Over a year passed between the inception of the idea of adapted aquafit and the actual implementation of Aqua Vision. In the winter of 2016, the first accessible aquatic exercise program in BC for the visually impaired was piloted—and it turned out to be a great success!

Participants using non-slip mats during an Aqua Vision session

Occupational therapists as social innovators

Following the success of Aqua Vision, other community groups in British Columbia reached out and inquired about providing accessible aquatic services for specific populations. This community practice experience thus led to my founding of the Aquafit for All Association, a non-profit organization providing accessible aquatic opportunities for people of all abilities. Occupational therapists possess unique knowledge and skills related to identifying personal and environmental factors that impact people's engagement in important and meaningful occupations. Using our understanding of the impact occupations have on health and well-being, occupational therapists have a role to play as social innovators—to identify unmet needs in the community, problem solve, collaborate with community groups and then to develop programs that make a difference.

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Cover photo credit: Vickie Teng
Photo submitted by: Minnie Teng

Minnie says: *"The image depicts an Aqua Vision session where adults with visual impairments participate in aquafit (water aerobics). This project is the first of its kind, and means a lot to these individuals as for some participants, this is the only exercise they are able to participate in due to their vision challenges."*

"Taking an active role in my health and safety at work": An illustration of community occupational therapy practice in the promotion of workplace health

Alexandra Lecours and Pierre-Yves Therriault

Occupational therapists play a leading role in workplace health. Scientific literature suggests that occupational therapy interventions in this area of practice are primarily in the rehabilitation of injured workers (Kollee et al., 2013). However, the Canadian Association of Occupational Therapists encourages its members to become more involved in primary prevention and workplace health promotion (CAOT, 2015). With the aim of taking a proactive approach against occupational hazards, the purpose of this article is to illustrate how occupational therapists can intervene with the promotion of workplace health. For this purpose, this article presents a project carried out by occupational therapists using a population-based approach with clientele emerging from the community: students learning a trade.

Project

The *"Taking an active role in my health and safety at work"* project is part of a broader study focused on the health of apprenticeship students in vocational training programs. This project arose from a need reported by teachers of a hairdressing program, during interviews being conducted on students' workplace health. Teachers expressed the desire for resources that were better adapted to the reality of their profession in order to improve the teachings they offer to students regarding workplace health. In order to meet this need, a collaboration between the training setting and a team of occupational therapy researchers was formed. The challenge was daunting. It was imperative that they combine the occupational therapist's expertise in analyzing the activity - adapting to the environment and empowering people in prevention strategies - and the competencies of the teacher, gained through experiential learning.

Approach

Based on the premises of an occupational therapy model for promoting health (Moll et al., 2015), the theoretical principles of designing learning activities (Paillé, 2007) and the steps of a worker training process (Kirkpatrick & Kirkpatrick, 2007), the team developed three 60-minute training workshops. These

Table 1
Description of training workshops

Competencies	Contents specific to the trade	Learning modalities
Workshop 1		
Understanding how my body works and recognizing the symptoms of health problems	• Health and safety statistics specific to the hairdressing profession • Knowledge of anatomy/physiology • Concepts of ergonomics • Symptoms of health problems	• Lecture-based training • Working in sub-groups • Self-assessment questionnaire/individual reflection • Case history • Discussion and exchange as a large group
Workshop 2		
Detecting and preventing risks to health or safety at work	• Risks to health or safety specific to the hairdressing profession • Analysis of a work situation • Strategies to reduce risk (e.g., modifying work technique, adapting to the environment)	• Individual risk analysis of a work situation • Workshop simulation • Team observation • Using photos and videos • Presentation of before/after work situations • Testing strategies to reduce risk
Workshop 3		
Maintaining my health at work	• Importance of reporting identified risks to health or safety in a work situation and advocating for change • Occupational balance, time use, life schedule • Stress management • Prevention of risks to health or safety in out-of-work activities	• Lecture-based training • Integration of workshop learning through exercises • Testimony on the consequences of work-related injuries or illnesses • Presentation of prevention tools (e.g.,warm-up exercises related to the trade)

workshops promoted the empowerment of students, based on the principles of prevention and promotion of workplace health. They focused on analyzing the risks of a work situation, integrating strategies to reduce occupational risks, stress management, and occupational balance related to life at work. The presentation of case histories, group discussions, self-assessment exercises and workshop simulations were among the various pedagogical modalities used. Table 1 provides a brief description of the characteristics of each of the training workshops. The competencies, content, and learning modalities of the workshops were approved by a committee comprised of an occupational therapist, a teacher, a representative of the health and safety committee of the institution, and a pedagogical counsellor. The training workshops were facilitated by an occupational therapist and a teacher.

Impact

The collaboration between occupational therapists and the community was a positive experience for all participants. On one hand, occupational therapists developed new expertise in workplace health promotion, as an emerging practice. On the other hand, teachers felt better equipped to approach workplace health with students; and the latter reported that they were more conscious of this facet of their future jobs. The project was so well received by the training community that the workshops developed under this initiative are now part of the regular curriculum! In addition, similar projects are underway in other vocational training programs in the country. In conclusion, this initiative demonstrated that occupational therapists have the skills required to promote the health of the working population, and that they can help to positively transform their community by working with local partners. Indeed, the collaboration between the occupational therapist and the vocational training environment has enabled apprenticeship students to take active roles in their health and safety at work!

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GROW: Enhancing independence through participation in community life

Cindy Yamamoto, Lauren Coates, Sandra Sheegl and Pamela Wener

Gaining Resources Our Way (GROW) is a community-based life skills program for young adults with social and intellectual disabilities. An independent registered not-for-profit organization, the program offers year-round support to individuals pursuing independent community living.

GROW was originally developed as a summer life skills program in collaboration with the Department of Occupational Therapy at the University of Manitoba. Involvement of an occupational therapy faculty member in this partnership was important during program development. Incorporating the Canadian Occupational Performance Measure (Law et al., 2005), she helped to establish a program that is individualized, goal-oriented, occupation-focused and imbued with opportunities for learning through participation. A detailed description of the program's inception is reported elsewhere (Wener, Snow, & Altman, 2008); this article will outline three recent program developments.

Building on the success of the original program, the **GROW in Winnipeg** day program was established in 2009. Under the direction of a board of community stakeholders, the program employs two occupational therapists as program coordinators. Occupational therapists at GROW are responsible for assessment, intervention, outcome measurement, day-to-day planning, one-to-one and group work, education and supervision of staff and students, module development and program research and evaluation.

The program operates out of two neighbouring bungalow-style homes, each equipped with a full kitchen, laundry and bathroom facilities. Groupings at each house reflect different stages of readiness for vocational placement and community living. While participants do not require one-to-one support, facilitator-to-participant ratios are high (1:4) to enhance the provision of individualized services.

The schedule is structured to create a platform for learning through experiences of participation in activities of daily life. Each week, participants develop meal plans and create grocery lists. Walking or taking the bus to the grocery store, they have the opportunity to practice shopping and community mobility skills. Participants use local recreational facilities and have opportunities to access other diverse community spaces through participation in outings. As part of the daily schedule, participants cook, share meals, rehearse cleaning and other home management activities, discuss current events and engage in socialization.

Learning approaches include group work, one-to-one intervention and a flexible and responsive approach involving careful attention to naturally occurring teachable moments and opportunities for individual and peer learning. Program modules include home management, money management, healthy mind and body, vocation, leisure, and social skills development. Although the general focus is on enhancing preparedness for community living and promoting inclusion, individualized plans are based on self-identified goals; thus, participant schedules are diverse and unique to each individual.

GROW Supported Independent Living (SIL) focuses on providing support hours to participants living semi-independently (i.e., with moderate supports) in the community. The aim of SIL is to encourage safe and successful community living by providing assistance and teaching in the living space. SIL sessions have purposeful learning objectives aimed at meeting participants' personal goals and maximizing independence over time.

Depending on the goals, strengths and needs of the individual, facilitators may provide graded assistance and/or training in a variety of skill domains. Learning modules include memory, orientation and time management in the living space, home management, health and safety, accessing community spaces, leisure planning and managing social connections, technology at home and money management.

GROW Outreach is a program focused on building social and leisure skills that meets two Saturdays per month in various community spaces, allowing participants to engage in shared recreational activities. Outreach is intended to create opportunities for developing and managing social relationships, strengthening social networks and enhancing leisure skills. Planners incorporate diverse experiences to assist participants in exploring and identifying potential leisure interests. Past activities have included going to hockey games, restaurants, and community classroom events.

GROW is an example of a community organization in which occupational therapists and other service providers are supported and encouraged in their efforts to provide individualized client-centred services. As GROW continues to expand, occupational therapy will continue to play a role in shaping the practice environment and in advancing the program's vision of participants having equal opportunities for engagement in community life.

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Community-based occupational therapy: Supporting a "WISH" for a better future

Catherine White and Carmel O'Keefe

Homelessness remains at crisis proportions in Canada, with at least 235,000 people experiencing homelessness within a recent one-year period, 27.3% of whom were women (Gaetz, Dej, Richter, & Redman, 2016). Many such women are fleeing abusive relationships, have recently been released from incarceration or are living in poverty; they generally have few resources and supports, thus impacting their health and well-being (and, in many cases, the health and well-being of their children). Mental health challenges in particular are highly correlated with homelessness (Thomas, Gray, & McGinty, 2011).

Given that occupational therapists work from a holistic perspective, understand the impact of the environment and "acknowledge the importance of occupation and its relationship with health and well-being to … improve the lives of persons experiencing homelessness," (Marshall & Rosenberg, 2014, p. 331), we have much to offer this underserved population. Elusive to many, assistance with securing appropriate housing has been described as the single most important service required by people with a mental illness in order for them to live independently in the community (O'Malley & Croucher, 2005). However, securing housing is only a starting point for community integration. Participation in meaningful community-based occupations can bridge the gap between secure housing and community integration.

In Halifax, Nova Scotia, the Women in Supported Housing (WISH) program of YWCA has embraced the "housing first" approach to homelessness for people with mental illness (Goering et al., 2014). Using this approach, over 24 previously homeless women are being supported with rent-subsidized housing and support services (such as life skill development, eviction prevention, goal setting and service navigation), enabling them to move forward with recovery and community integration.

In what started out as role-emerging fieldwork, almost 30 student occupational therapists have now gained invaluable fieldwork experiences with the WISH team. Students provide program participants with in-home occupational therapy assessments, structure to help them set and achieve personal goals, and overall support toward recovery. The Canadian Occupational Performance Measure (COPM; Law et al., 2005) has been a particularly useful occupational therapy tool to support these efforts. Through identifying and prioritizing their own occupational goals, clients participating in community-based occupational therapy have been supported to:

- Access reduced-cost memberships to recreational facilities;
- Work on budgeting and access low-cost food and clothing sources;
- Plan and prepare meals to support healthy eating;
- Increase attention to personal hygiene;
- Learn about low-cost community-based events, such as art classes and library-based activities;
- Explore opportunities for joining the workforce, in some cases taking into account the barrier of a criminal record.

Until recently, access to occupational therapy has been dependent upon supervised student involvement during fieldwork blocks that span only six months of the year, with off-site preceptorship. Recent success with a grant application will allow year-round access to occupational therapy (more intense when students are available for fieldwork) for clients affiliated with the WISH program.

For women with mental health and addictions issues who have been formerly homeless (or near homeless), supported housing can fulfill a "WISH" for a better future. Securing housing can be a turning point in their lives and facilitate a sense of power and control, recovery of mental health, the development of new skills, improved relationships, movement toward productive goals and more active involvement in the community. By connecting with clients and supporting them to re-envision a future that involves engaging in meaningful occupations, occupational therapists play a valued role in the pursuit of these outcomes.

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Increasing the social participation of seniors in partnership with the community - Implementing a personalized citizen assistance

Julie Lacerte, Mélanie Levasseur, and Véronique Provencher

Social participation, i.e., a person's involvement in activities that provide interaction with others in the community (Levasseur, Richard, Gauvin, & Raymond, 2010), represents one of the key factors for active aging. In addition to being associated with the quality of life (Levasseur, Desrosiers, & St-Cyr-Tribble, 2008), social participation contributes to the prevention of functional decline in seniors (Avlund et al., 2004). Yet, the social participation needs of seniors with disabilities often remain unmet, and the related interventions are poorly adapted (Levasseur et al., 2012). Moreover, even though significant activities represent a key component of their practice (Townsend & Polatajko, 2013), occupational therapists seldom act on their clients' social participation, in particular because of time constraints (Turcotte, Carrier, Desrosiers, & Levasseur, 2015).

This article presents, through an action-research project, a novel way for occupational therapists to act on the social participation of seniors in partnership with the community. Our research team, including three occupational therapists, currently works in conjunction with a community organization and the health network to implement an initiative aiming to meet the social participation needs of seniors with disabilities. This initiative, called Personalized Citizen Assistance for Social Participation (*Accompagnement-citoyen personnalisé d'intégration communautaire* – APIC), matches seniors with citizens trained and mentored by professionals to act as attendants. These attendants support seniors in the performance of social and recreational activities linked to their interests and life projects during weekly meetings spanning a period of six to twelve months. The project pursued by a senior through the APIC could be, for instance, to participate in a bowling group. The attendant supports the senior in the realization of his or her project, in particular by helping them identify their interests, overcome obstacles to the realization of the project (e.g., by guiding them through their first uses of paratransit), and develop sustainable links with the community.

History of APIC

Initially developed for people with head trauma (Lefebvre et al., 2013), then adapted for seniors with disabilities, APIC enables an increase in the mobility and social participation of seniors, as well as their physical and psychological well-being (Levasseur et al., 2016). As for the attendants, they report feeling useful and empowered, while having the opportunity to improve themselves and grow (Therriault & Samuelson, 2015). In past research projects on APIC, attendants were paid for the assistance they offered. In this project, the research team accompanied a Volunteer Centre in implementing APIC by adapting it to its context, by documenting the implementation, and by identifying the enablers and barriers to this implementation.

Adaptation of APIC and training of volunteer attendants

So far, APIC has been adapted to the Volunteer Centre, in particular by adjusting it to its clientele and by reorganizing the training of attendants in accordance with the realities of volunteer work. The adaptation process involved the research team, the Volunteer Centre's officers in charge of implementation as well as the representatives of the health care network and of the seniors groups. In order to facilitate recruitment of volunteers, the training which initially spread over two days has been condensed into a single day. The contents of the training has thus been synthesized to be centered on the APIC principles, which are the establishment of an egalitarian relationship between the attendant and the attended, the customization of the assistance, the empowerment of the attended as well as the progression in the realization of a life project. The themes addressed during this training included: the role of the attendant, the assistance relationship, the factors impacting social participation, the strategies fostering empowerment, as well as the involvement in a life project and the tools to follow-up on the assistance. The training was given by the community worker of the Volunteer Centre and by a social worker from the health care network. Methods fostering interaction between participants and learning from tangible examples were preferred. Monthly support meetings then started, allowing sharing between attendants and the follow-up performed jointly by the stakeholders from the Volunteer Centre, the health care network and the research team, as well as the provision of continuous training adapted to the challenges met during the assistance experience.

APIC Participants

In accordance with the mandate of the community worker of the Volunteer Centre, people targeted by APIC are 50 years

old and over, live in the community (including residences for independent and semi-independent seniors) and face isolation. These people must exhibit sufficient cognitive and communication skills to be able to fully participate in APIC, i.e., they must be able to engage in conversations, to understand simple instructions, to be able to tell the time of day and recognize familiar places and people in the community, and to express their opinions verbally. In an effort to respect the limitations of the volunteer attendants, and in relation to the training received, the participants must be able to maintain socially acceptable behaviour, to make decisions by themselves and to participate in a social activity for approximately three hours without requiring care. As for the volunteer attendants, they are selected based on their motivation, their availability and the demonstration of soft skills which are compatible with the APIC's principles during an interview with the community worker.

Evolution of the project

At the time of writing, two of the initial groups, totalling one male and seven female attendants aged 37 to 71 years old (median age: 59 years old), have been formed. The first volunteer attendants started the matching process in January 2017. The first four participants, including one man, are aged 84 to 92 years old (median age: 85.5 years old), live alone, exhibit disabilities linked with their mobility and, for two of them, to their mental functions. Before being matched, these seniors were met jointly by the community worker and the first author, an occupational therapist. The first eight dyads will be monitored by the research team for three months.

Given the central place of meaningful activities in their practice, occupational therapists are well positioned to foster the maintenance of the capacities and quality of life of seniors through the improvement of their social participation. During the implementation of APIC, the involvement of occupational therapists, especially in the training of volunteer attendants, helped underscore the importance of social participation and the need to consider personal and environmental factors. In the follow-up of the intervention, the support of occupational therapists may facilitate the realization of the projects of the seniors attended to, most notably by advising the attendants and the community worker on the adaptation of the activities and the identification of situations requiring a professional intervention. The results of this study can help equip occupational therapists in their work, in partnership with community organizations: a promising way to foster the social participation of seniors while contributing to the development of the community.

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Revisiting our role in home support: The potential of groups to stimulate social participation

Pier-Luc Turcotte, Annie Carrier, Marie-Josée Filion, Claudine Lafrenière, Marilyn Savard and Mélanie Levasseur

Community occupational therapy practice in Québec emerged in Local Community Services Centres (Centres locaux de services communautaires – CLSC), which have a health promotion and prevention mission. This mission is namely articulated in home support, where occupational therapists play a critical role. Given the increased demand linked with the aging population and chronic illnesses, one can observe significant waiting lists for occupational therapy in home support. Thus, occupational therapists' practice has been particularly restricted regarding health promotion and prevention, which include enabling social participation (Hébert, Maheux, & Potvin, 2002). Yet community occupational therapists are well positioned to enable people's social participation; to get involved in activities that provide social interactions. To highlight their potential contribution, this article will explore promising examples of group practices, and will propose strategies to implement such initiatives elsewhere in Canada.

Building groups to foster social participation

To reflect upon the opportunities of fostering social participation, participatory research was performed with different key players in the field of home support. Group sessions were identified as an avenue to be explored, given that these encourage social interactions and complement existing resources. To foster health and social participation, group interventions are more effective than individual interventions (Clark, Jackson, Carlson, Chou, Cherry et al., 2012), although the latter make up the common practice of occupational therapists in home support (Hébert et al., 2002). By combining group and individual interventions, physical and mental well-being would be improved more than with individual interventions alone (Clark et al., 2012). Moreover, peer support foster the motivation to try new activities. Since groups reach several people simultaneously, they are also more cost-effective (Clark et al., 2012) and have the potential of reducing wait times for occupational therapy.

Promising examples

Two groups have been created by occupational therapists of a home support team in Montréal (authors MJF, CL, and MS) to better meet the needs of the community. Located on the outskirts of public transit services, this community exacerbates the isolation of people with disabilities, of which there are many in the sector. To face these challenges, weekly groups for adapted fitness and therapeutic chair dance were developed with community organizations and facilitated by occupational therapists. Two types of groups exist. First, closed groups are made up of approximately ten people who share common characteristics related to the type of disability or chronic illness. In these groups, each participant undergoes an initial assessment by an occupational therapist during which personalized goals are defined, such as to improve mobility or reduce anxiety. Second, open groups – with no initial assessment – comprise around twenty people with multiple sclerosis to minimize isolation, encourage physical activity, and maintain residual abilities.

Over the years, participants reported different benefits to the occupational therapists, including reduced anxiety, improved quality of life, increased sense of belonging, reduced use of emergency services, and better continuity of service. Based on the partnership with community organizations, group costs are capped by sharing of resources (space and personnel) and by the involvement of volunteers. Even though the specific impacts of these groups have to be formally assessed and considering the cost-effectiveness of such occupational therapy interventions (Clark et al., 2012), some organizational decision-makers expressed their interest in developing group-based initiatives in other sectors and with other populations.

Leveraging our expertise in social participation

In light of the therapists' experience and the evidence gathered, different strategies are suggested to ensure the success of these groups. Consistent with our profession's values, groups must be implemented using a personalized, local approach, taking individual and community needs into consideration. Thus, it is necessary to forge partnerships with the community organizations. To do so, it is recommended to become familiar with these organizations' internal processes by getting actively involved.

In order to convince decision-makers of group interventions' benefits, occupational therapists may act as change agents by effectively communicating evidence or by showing the gap between existing resources and the unmet needs of the population. Finally, group interventions are an opportunity to leverage our expertise in social participation and to ensure excellence within community occupational therapy practice .

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Vivre en Équilibre (Living in Balance) - A new group program targeting fear of falling and its consequences on older adults' social participation, health and quality of life

Johanne Filiatrault, Manon Parisien, Johanne Desrosiers, Agathe Lorthios-Guilledroit, Lise Gauvin and Lucie Richard

Occupational therapists can play a vital role in health prevention and promotion, notably in the context of home care practice among community-dwelling older adults. In this regard, these health professionals must consider fear of falling in their interventions with older adults, since this fear can lead to negative consequences on their social participation, health and quality of life (Delbaere et al., 2004).

Even though several fall prevention programs are available, most of them focus on factors related to older adults' physical condition or on environmental factors and fail to consider psychological factors. In response to this observation, a Quebec team developed *Vivre en Équilibre* (Living in Balance). Adapted from an American intervention with proven effectiveness (Tennstedt et al., 1998), this group program rests on the principles of the cognitive behavioral approach (Bandura, 1986). However, the particularity of the Quebec program is that it can be offered by duly trained peers. This approach offers several benefits. It promotes receptivity to health promotion messages and provides health benefits not only to participants, but to peers as well (Woodall et al., 2012).

Vivre en Équilibre aims to develop older adults' confidence in their ability to prevent falls and keep an active lifestyle. It includes eight bi-weekly sessions addressing various themes. The program was developed through a systematic approach involving validation by experts, pre-testing, followed by a pilot study (Filiatrault et al., submitted). The results of the pilot study conducted among 86 older adults point to the feasible nature of the program implementation and to the benefits of this program in terms of participants' confidence in their capacity to prevent falls and the diversity of physical and social activities they performed in their community. An effectiveness study of the program is currently conducted to examine its impact when it is implemented under real world conditions.

Vivre en Équilibre is an innovative and relevant health promotion initiative for older adults. Considering their role in health prevention and promotion, occupational therapists could target fear of falling and its consequences by offering Vivre en Équilibre directly to their clients. However, given the state of limited resources in health care and waiting lists for occupational therapy services (Raymond et al., 2016), another promising avenue should be considered. In the context of a partnership with community organizations, occupational therapists could train and supervise volunteer peers who could, in turn, deliver the program. This would then enable a large number of older adults to become better equipped to prevent falls and remain active.

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