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SPECIAL ISSUE:

Virtual care and occupational therapy

Guest editor:
Leslie-Ann Stewart

INSIDE

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Table of Contents

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Canadian Association of Occupational Therapists
100-34 Colonnade Road
Ottawa, Ontario K2E 7J6 Canada
Email: publications@caot.ca

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Phone: (613) 523-2268, ext. 241
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MANAGING EDITOR
Flora To-Miles, PhD, Reg. OT (BC)
Tel. (613) 523-2268 ext. 243
Email: ftomiles@caot.ca

DESIGN & LAYOUT
Angel Ketchum

COPY EDITING
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The shift towards virtual care and its impact on the practice of occupational therapy

Leslie-Ann Stewart

Occupational therapy is a profession in which the client is encouraged to learn by doing. This learning is done under close supervision, as the occupational therapist evaluates function through the lens of occupation. Assessing (or re-assessing), palpating, and grading activities after direct observation are what make the art and science of occupational therapy so unique. Occupational therapy is a profession in which the therapist and client establish a therapeutic bond. This client-centered practice also requires creativity to ensure that the client remains engaged throughout therapy. The practitioner enables learning and development through guided repetition, storytelling of the lived experience, and the implementation of the interconnection of the environment, occupation, and person working together to establish performance and engagement.

In 2020, as a result of the COVID-19 pandemic, the way that occupational therapy services were delivered needed to be evaluated to meet the needs of various domains within the field of health care. This pandemic affected the academic, community, hospital, and clinical settings. Due to the rapid switch to virtual care and support, many companies, universities, and organizations were left on their own to improvise and eliminate barriers by creating continuity plans. These plans were created with little consultation or direction from regulatory bodies. Occupational therapists with many years of practice, students on the brink of graduation, and professors who were well established as educators all faced a learning curve as they needed to continue daily tasks that were quickly being shifted into a virtual realm. Suddenly, we all had to learn to engage in telehealth.

Telehealth is defined by the World Health Organization (WHO) as "the delivery of health care services, where patients and providers are separated by distance" (2019, para. 1). Over the years, telehealth has contributed towards education, treatment, research, and evaluation (Cason, 2015; WHO, 2019), and now with the pandemic, telehealth has become a means of service delivery at an increased rate.

Occupational therapists are now implementing virtual health care across the lifespan by facilitating services amongst the pediatric, adult, and older adult populations (Cason, 2015). This shift is evident in the articles that make up this special issue. Readers will gain insights into the many different domains of care in which occupational therapy shifted towards synchronous and asynchronous delivery of services in the virtual space, to ensure that the practice of occupational therapy has continued to flourish during the COVID-19 pandemic. From these experiences, the authors of these articles have identified successful strategies for moving into a virtual care model as well as areas of development that should be considered if occupational therapy through telehealth is to become a more mainstream method of care.

Another aspect of telehealth to consider is the associated costs of providing services remotely. Funding costs have to be taken into account during the pandemic (Hoel et al., 2021), such as ensuring that the patient and their caregivers have access to technology, such as a smartphone or tablet, to engage in videoconferencing. In addition, the patient or caregiver also has to be able to navigate technology to be able to attend therapy sessions (Dahl-Popolizio et al., 2020). As the internet plays a huge role in enabling access to services (Hoel et al., 2021), ongoing conversations related to removing barriers to technology should also be considered when working with various populations, as limited internet or technology access continues to disqualify some individuals from engaging in a virtual model of care and education.

This special issue was a pleasure for me to review, and I hope that readers consider the impact of the role that telehealth plays in occupational therapy practice, and the ways this emergent method of care continues to impact all individuals (students, practitioners, professors, and clients) to link the person, their environment, and their occupation together. Moreover, other aspects to consider would be to ensure that practice alignment within the provinces are standardized (Hoel et al., 2021). Given that telehealth has been a relevant topic as a result of the pandemic, further study about the benefits of telehealth are needed to make certain that evidence-based approaches are implemented in occupational therapy practice so that these practice areas become standardized (Gustafsson, 2020).

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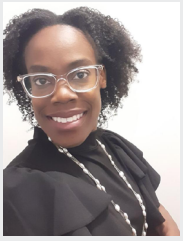

About the guest editor

Leslie-Ann Stewart, OT Reg. (Ont.), is a registered occupational therapist practicing in Ontario. She is an adjunct lecturer (status only) at the University of Toronto. She has been working in virtual care as an occupational therapist for the past six years in the field of mental health. She currently is the clinical operations manager for a telemedicine company where she manages three virtual mental health care programs nationwide. She is the Practice Management and Professional Skills topic editor for OT Now. In her spare time, Leslie enjoys going on long bike rides and capturing vivid landscapes through drone photography. She may be contacted at: leslieannstewart@yahoo.com

Learning and adapting: Using online spaces to share ideas

Anna Braunizer, Esther Dark, & Emily Polovick-Moulds

We can be physically distant while socially connected (Berger, 2020). Online spaces with social connections exist when two or more people interact via the internet or internet communication technologies, such as social media, videochat, blogs, podcasts, and websites. In March 2020, we launched *Beyond COVID* to share ideas for maintaining social connections and doing occupations during lockdown, as well as contributing towards wellbeing in our communities beyond COVID-19. In this article, we share what we learned from this experience.

Tips for knowledge sharing in online spaces

1) **Connect:** Discover and participate in online communities. We learned about the Access Health Activists (AHA) and the Coalition of Occupational Therapy Advocates for Diversity (COTAD) through social media—these are two initiatives in which people come together in online spaces to share ideas to build belonging and diversity in our profession. On Twitter, there are communities of occupational therapists who have weekly chats about practice issues using hashtags like #OTalk and #OccSciChat. During the pandemic, in a time when we missed participating in our physically local communities, it was nice to meet and connect with people from around the world in online spaces.

2) **Include:** To make your social media content accessible, use #CamelCase, alt-text, and captions, and limit use of emojis. #CamelCase allows multi-word hashtags to be read by screen reader apps as separate words. Alt-text on images is a clear, concise description of what the image includes, painting the same picture with words. There are different web tools and services out there for captioning support; alternatively, one can assign a volunteer or captioning service to type in captions as a virtual meeting occurs, for those who have the captioning feature enabled.

3) **Design flexibility:** Provide options for accessing and interacting with information, such as using audio, visual, and written content. This flexibility promotes accessibility. Having a white background with dark text can be accessible for some, while having a dark background with light text can be accessible for some others: there is not a one-size fits all approach. With web design, we used the "Accessibility and Inclusion" toolkit from the Government of British Columbia (2020), as well as discussions with team members, to inform accessible design strategies.

4) **Collaborate:** When collaborating, meet in a neutral space that feels safe and welcoming for participants (Jordan & Braunizer, 2020). When participating in *Crip Camp: The Official Virtual Experience* (Crip Camp Impact Campaign, 2020), we learned that helpful accessibility features include starting introductions with image descriptions of ourselves, naming ourselves when we talk, using captions and subtitles, having live shared documents for questions and discussions, having American Sign Language interpreters, encouraging people to contribute via chat or spoken word, and encouraging participants to turn their cameras on or off as personal preference.

5) **Compensate:** When possible, provide equitable compensation to contributors for their work and negotiate what this looks like with contributors on a one-to-one basis (Richards et al., 2018). Compensation can be financial or in the form of gift cards, food, or in-kind services. Be clear about your capacity to compensate: it is important to have everyone on the same page from the start.

6) **Reflect:** Explicitly acknowledge that, as people who share knowledge about occupations, "we are complicit in shaping the world" (Kiepek, 2020, p. 12). This is especially important in the online world, where information can be shared rapidly, and it can be easily distorted out of context.

7) **Take a break:** Take breaks from online engagement, and spend some time doing self-care and things you love. During the COVID-19 pandemic, at one time or another, most of our team experienced social media burnout and found it overwhelming to continue to use social media, even for things to which we enjoyed contributing. You can always return if and when you feel ready for it.

8) **Attend:** Expand your understanding of the world by engaging in professional development online. As mentioned above, some of our team

members participated in Crip Camp Virtual (2020). Additionally, CAOT hosted their annual conference virtually. Through Facebook groups (such as *PainOT*), some of our team participated in weekly webinars about clinical practice. We learned about Karen Whalley Hammell's lecture at McMaster University and Stephanie Bizzeth's Kelly Bang lecture at Dalhousie University, and because of COVID-19, we could attend these virtually. In these settings, we would bring knowledge from clinical and research spaces together and share ideas for moving practices forward.

As a profession that advocates for accessibility and promotes participation, we hope that you find these tips helpful when participating in online spaces.

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About the authors

Anna Braunizer, Reg. OT (BC), was the founder and co-team lead of *Beyond COVID*. She works full time with adults in community-based private practice in Victoria, BC, and graduated from Dalhousie University's School of Occupational Therapy in 2018. *Beyond COVID* can be found at doingbeyondcovid.com and @beyondCOVID on social media (Twitter, Instagram). Anna can be contacted at: anna@beyondcovid-19.com

Esther Dark, MScOT, is a PhD student in the UK. She was the *Beyond COVID* blog lead.

Emily Polovick-Moulds, OTR/L, was the co-team lead of *Beyond COVID*. She works as a pediatric occupational therapist in California.

Check out other articles on virtual care and occupational therapy that were published in previous issues of OT Now!

January 2021 issue:

- Shift in practice: Enabling client-centred occupation through virtual engagements (Melissa Sztym, Carmen Lazorek, Kathy Gillis, Debra Froese, Carla Falk, Liz Mathew, Neila Nelsen, & Patricia O'Krafka)

May 2021 issue:

- Adapting to virtual fieldwork and embracing change: Developing skills as new occupational therapists during COVID-19 (Mallory Ryan, Jennifer Aird, Heather Dreise, Mara Malozewski, Bridget Marshall, Brooke Whitaker, & Andrea Hickling)
- What is a HISIE? COVID-19 inspired creativity in occupational therapy clinical education (Caroline Storr, Valerie Watters, & Karen Falcicchio)

Identifying the sustainable value of virtual care in occupational therapy

Janet M. Craik

Occupational therapists want to and need to offer quality care, but quality is not enough. We need to demonstrate that the benefits of our therapies outweigh the risks and costs (Conference Board of Canada, 2021; Horne & Manion, 2019). Mortimer et al. (2018) suggest recalculating how we identify value and consider the sustainable value of the services we offer. The Sustainability in Quality Improvement (SusQI) framework (Mortimer et al., 2018) uses a multi-dimensional approach of considering environmental, social, and financial costs, as well as client outcomes. This paper applies SusQI framework tools (Centre for Sustainable Healthcare [CSH], n.d.) to demonstrate the sustainable value proposition of virtual care by providing a case study involving an occupational therapy presurgical consult.

Case study

Meet Mr. Singh, a 69-year-old accountant who works part-time from home and is scheduled for a total hip replacement during the winter months. He lives in a bungalow 15 km from the hospital with his wife who works at a local store and is in good health. Mr. Singh has been referred to a presurgical consultation with an occupational therapist to gain knowledge about what equipment he may need, where to attain it, and how to prepare his home environment for his return after surgery.

Alex is the occupational therapist who works at the hospital's presurgical clinic one day a week. She drives 25 km to the hospital each day. The hospital is encouraging employees to engage in quality improvement activities. Alex is eager to use the SusQI framework to examine the presurgical consultation service delivery model.

The overall goal of sustainable quality improvement is to maximise sustainable value. The improved, sustainable care is intended to deliver the best possible health outcomes with "minimum financial costs and harmful environmental impacts, while adding positive social value at every opportunity" (Mortimer et al., 2018, p. 90). SusQI enables the design of services that promote ecological integrity, social equity, and economic inclusion. The SusQI framework involves the following steps: (a) setting goals, (b) studying the system, (c) designing the improvement effort, and (d) measuring impact or return on investment (CSH, n.d.).

(a) Setting goals

Alex wants to provide the appropriate education to the client, prior to the surgery, to ensure Mr. Singh feels prepared for the surgery and the post-surgical discharge at home, while avoiding cross-system waste.

(b) Studying the system

To scan the existing system, Alex maps out the stages of the presurgical consult and then identifies the environmental, social, and financial impacts (see Table 1). She highlights wastes and opportunities for improvement. For environmental impacts, she identifies both her travel and Mr. Singh's (greenhouse gases, air pollution), hospital energy use (electricity, heating to operate the clinic), medical supplies (manufacturing and procurement of personal protective equipment [PPE]), non-medical supplies (office supplies), and waste disposal of PPE. For social impacts, she considers potential social challenges (e.g., education, culture, race, employment, accessibility) of stakeholders, including the client, hospital staff, and the supply chain workers of the practice context.

She is concerned about Mr. and Mrs. Singh's time away from employment to attend the in-person visit. She is aware of the harms of attending the hospital in person because of the risk of exposure to viruses, as well as the fall risk associated with winter travel. She identifies the following social impacts: client and caregiver time, her time, and the risk of client harm. For this case, she considers Mr. Singh's housing situation (urban, internet access), as well as his education and literacy levels as enablers to online education. For financial impacts, she identifies equipment purchased and disposed (paper handouts for client, clinic furniture), travel costs (gas), staff wages (administrative and support staff), and parking fees.

(c) Designing the improvement effort

Alex decides that reducing operational resource use would be the primary driver of change for improvement. By delivering the education virtually,

Alex sees an opportunity to reduce environmental resources (the greenhouse gases), social impacts (client's time), and financial impacts (PPE, parking fees), while maintaining the same client outcomes. Alex maps out the environmental, social, and financial resources impacts (see Table 1) of both in-person and virtual care. The next stage of the framework is to measure the impacts and identify the sustainable value of the virtual care model.

(d) Measuring impact or return on investment
For the purposes of this paper, only a sampling of the potential data points will be provided to demonstrate the application of the SusQI. A number of tools are available on CSH's website for measuring environmental, social, and financial impacts. For environmental impacts, Alex can calculate the carbon footprint of in-person and virtual care using published data from carbon calculators. Alex calculates the carbon footprint for staff and client travel for the clinic visit at 17.79 kgCO2e/km, compared to 0 kgCO2e/km for the virtual visit. Alex can calculate the financial impacts in dollars. For example, Alex can show dollars saved by eliminating the client's need to pay for parking with the virtual visit.

Table 1

Scenario #1: In person		Comments on resource use	Scenario #2: Virtual		Key
Activity	Resource impacts		Activity	Resource impacts	Environmental impacts 1. Client & caregiver travel (greenhouse gases, air pollution) 2. Staff travel (greenhouse gases, air pollution) 3. Energy use (electricity, heating) 4. Medical supplies (manufacturing and procurement of PPE) 5. Non-medical supplies (office supplies) 6. Waste disposal Social impacts 1. Client and caregiver time 2. Staff time 3. Risk of client harm Financial impacts 1. Equipment purchased and disposed 2. Travel costs (gas) 3. Staff wages 4. Parking fees
Travel by car to the hospital	1, 2, 1,2,3 1,2	- Can travel be eliminated to save time for clients, caregivers, and staff, reducing the carbon footprint? - Can time be reinvested to offer more services for more positive health outcomes for more people? - Can we reduce clients' out-of-pocket expenses? - Can we reduce the need for administrative staff and volunteers? - Can the clinic space be repurposed for other hospital activity? - Can we reduce the need for PPE and office supplies? - Is there a need for face-to-face or hands-on therapy? - Is client is highly educated and computer literate? - Does attending the clinic pose any social challenges for the client?	Connect to telehealth services	3 1,2 1,3	
Park the car	3, 1,2,3 1				
Check in at reception	3,4,5 1,2,3 1,3				
Wait at reception	3,4,5,6 1, 2,3 1,3				
Engage in occupational therapy consult	3,4,5,6 1,2,3 1,3		Engage in occupational therapy consult	3 1,2 1,3	
Return to the car	3 1,2,3 1,4		Disconnect from telehealth service	1,2 1,3	
Drive home	1, 2, 3 1,2,3 1,2				

Table 1 adapted with permission from CSH (n.d.)

At this time, there are no agreed upon measures for social impacts (CSH, n.d.). Alex must reflect and use her professional reasoning to identify potential stakeholders, areas of social impact, and related outcome measures. She considers social impacts that may be avoided, such as lower levels of anxiety for Mr. Singh and his wife, as they don't need to take time off work and drive through traffic, and they aren't exposed to potential health risks involved with travel and entering a hospital environment. Alex identifies that social factors such as Mr. Singh's education levels can enable the virtual educational intervention to proceed.

Alex uses measures such as Canadian Occupational Performance Measure (Law et al, 2005) to identify Mr. Singh's outcomes. To ensure that inequalities are being addressed and that people who would benefit from the care are being reached, Alex also factors in the broader population of clients on her waitlist (e.g., how the virtual visits enable her to see more clients, reduce the length of waitlists, and enhance access to care for those living in poverty by reducing out-of-pocket expenses).

Upon examination of the environmental, social, and financial impacts, Alex can demonstrate that virtual care for the presurgical consult has a higher sustainable value than traditional methods of service delivery. The World Federation of Occupational Therapists (2018) urges occupational therapists to offer sustainable care and states that addressing sustainability in occupational therapy is necessary to facilitate our clients' wellbeing and global wellbeing. Virtual care provides occupational therapists with a method for sustainable care that can meet the needs of the clients we see today, as well as conserve resources and promote wider wellbeing for now and the future.

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About the author

Janet M. Craik, MSc, OT Reg. (Ont.), is an independent researcher and consultant. For questions about this article, she can be reached at: janetcraik@gmail.com

Top 10 tips for virtual group engagement

Sara DePottie, Laura Durling, Naomi Hatherly, Amber Paterson, Randi Vandale, Cara Brown, Lisa Diamond-Burchuk, & Pamela Wener

A key role of occupational therapists in primary care is facilitating group process within rehabilitation therapy and educational groups (Donnelly et al., 2016). Occupational therapists' understanding of group process allows them to plan and implement evidence-informed, client-centered group treatments to support self-management of physical and mental health challenges.

When COVID-19 forced the cancellation of in-person primary care services in Winnipeg, we adapted our group programs to deliver them virtually. Between five therapists, a variety of online groups were offered for managing chronic pain, developing coping skills, and dealing with COVID-19 stress. Although we had expertise in the facilitation of small group process, we had little experience with supporting group process in virtual environments.

Building cohesion or therapeutic alliances between and amongst clients and therapists is critical to running effective groups (Burlingame & Jensen, 2017; Burlingame et al., 2011; Norcross & Wampold, 2011). Emerging literature suggests that establishing cohesion in a virtual group environment underpins positive treatment outcomes (Bisseling et al., 2019; Weinberg, 2020). Combining this evidence with our experiential knowledge was the basis for our top 10 tips for supporting group process in virtual settings:

1. Support clients to remember virtual appointments

Clients seem to have more difficulty remembering virtual appointments than in-person appointments. Before the first group session, ensure clients have a strategy in place to remember their group appointments. If permitted by your privacy regulations, consider providing participants with an electronic calendar invitation or emailing clients a reminder. Consider encouraging individuals to share their reminder ideas in the first group session to build group cohesion.

2. Keep groups small

Keeping virtual groups small sets the stage for a safe and welcoming environment. Small groups also promote clients being accountable to each other. A group size of five to six clients is ideal, so that all the participants can see all the group members. For larger groups, use break-out rooms supervised by facilitators to provide all group members an opportunity to participate.

3. Plan discussion questions

We found that it was challenging to promote participation in virtual discussions because participants cannot rely on non-verbal feedback from each other. This makes participants less likely to speak up when asked a vague or poorly worded question. As a facilitator, it is difficult to determine why participants are silent, and it is difficult to read body language virtually. Prepare discussion questions in advance to ensure they are structured, open-ended questions tailored to the group participants. This careful planning will build group cohesion as participants will be more apt to participate (see Box 1).

Box 1.
Process-oriented discussion questions to ask participants

Warm-up

- What is one activity you do to relax?
- What is one way you connect with others during COVID-19?
- What is one thing you do to help with sleep?

Goal review

- In what way did you use this skill effectively last week?
  - What was your biggest challenge in meeting your goal with this skill last week?
  - What, if anything, helped you succeed with your goal?

Checking understanding

- What was the most helpful piece of information from today's session for you and why?

Goal setting

- What is a strategy you will use to help yourself meet your goal this week?
- What will you do if your goal is more difficult to meet than you thought?

4. Craft email invitations carefully

It is important to keep emails with the group session URL as short and succinct as possible. Ensure the URL in the email is obvious and easy to find. If participants have trouble understanding the email or finding the link, they may experience a resulting sense of failure, decreasing the likelihood of establishing group therapeutic alliances. Don't underestimate the importance of setting participants up for success when considering these small details. Use an email template to keep messaging clear and consistent for participants. Send it to a colleague for review in the format it will be received by clients.

5. Conduct individual technology check-ins

Provide clients with clear instructions a minimum of one week before the first session—this communication point is one of your first opportunities to develop a therapeutic alliance with your clients. A technology check-in provides everyone with an opportunity to try accessing the platform, with enough time to get help with any technology concerns. For clients who need more technological support, offer to help in becoming familiar with the technology before the first session. Consider walking the client through the steps for logging onto the platform over the phone, or asking administrative staff to help with this.

6. Discuss co-facilitator roles

Virtual group facilitation can be tricky; this is not the time to take away a second group facilitator. When facilitating groups virtually, it is critical to discuss previous experiences and group knowledge with your co-facilitator to ensure a unified approach. We learned to assign facilitator responsibilities for dealing with technological requirements and technological issues that arise. This includes who will send out URLs, monitor the waiting room, manage the group chat, answer client questions, facilitate screen sharing, and address client audio and video issues. This planning will ensure that when (not if!) technology issues arise, one group facilitator will maintain the group process while the other addresses technological issues.

7. Optimize participant engagement

Optimizing participant engagement will positively impact group cohesion by increasing trust and respect amongst group members. Participants will need guidance on both the verbal and non-verbal behaviours that will show others they are attending to the group. This guidance is particularly important in the virtual environment, where the facilitator has less control over participants' physical environment.

a) **Develop group guidelines.** Just as with in-person groups, the expectations for the group need to be clear. Clients may not understand the importance of being focused on the group and may engage in behaviours that distract themselves or others. Guidelines can help your clients understand how to get the most out of the group by treating it as an in-person session. This includes waking up with adequate time to get dressed and eat before the group, and refraining from behaviours like driving or substance use during the group.

b) **Teach clients to set up their environments.** Teach clients the importance of setting up their environment to optimize participation in the group. Some helpful tips include limiting distractions by turning off the sound and picture of the TV or radio, and setting cell phones, computers, and tablets to "do not disturb" or "silent." Take time during the first session to teach clients about setting up their workspace to help them to stay attentive and alert, such as sitting at a table instead of a couch or bed.

8. Review use of virtual platform features

Review the use of virtual platform features with clients to create a safe space for participants to engage with one another. Encourage clients to keep their video on, as it aides in paying attention and engaging in the group process. You may need to remind clients to mute themselves when not speaking, as background noise can be distracting and divert focus from the speaker. This needs to be balanced with ensuring that group members are getting enough verbal feedback to allow them to feel heard, rather than feeling like they are speaking into a vacuum. To optimize appropriate participation, review and practice how to use features like mute/unmute, and how to contribute to the discussion in the chat box with the participants.

9. Address privacy and confidentiality

Consider the differences in privacy and confidentiality for a virtual group. Talk to your clients about the importance of trying to find a quiet, private space in their home for sessions so group members can trust that their audio and video will only be heard and seen by other group members. Encourage clients to wear headphones if they are in a space where others might overhear the group discussion. Assure clients that sessions will not be recorded and that facilitators will also be following these privacy guidelines. Addressing privacy and confidentiality will contribute to creating trust within the group. It will allow clients to respect and appreciate the privilege they have of hearing and learning about one another, creating opportunities for group cohesion.

10. Share group resources and materials

Consider how and when you plan to share group resources. Some clients prefer to have their resources ahead of time to be able to take notes or follow along,

while others prefer to receive them after the group. Screen sharing during the sessions was preferred by some clients due to personal learning needs (e.g., writing notes). It is important to ensure that clients have access to physical copies of the group materials so they can engage with and review the material to get the most out of the group.

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About the authors

Sara DePottie, Laura Durling, Naomi Hatherly, Amber Paterson, and **Randi Vandale** are occupational therapists working in primary care and mental health sites in Winnipeg, Manitoba. During the COVID-19 pandemic, they have offered group therapy via online platforms, including groups focused on chronic pain management, COVID stress management, and dialectical and cognitive behavioural therapy.

Cara Brown, Lisa Diamond-Burchuk, and **Pamela Wener** are faculty in the Master of Occupational Therapy Program at the University of Manitoba. They are interested in supporting primary care occupational therapy through teaching, research, and the The Manitoba Primary Care Community of Practice. For any questions or comments about the article, please contact Sara at: sdepottie@wrha.mb.ca

AD HOC TOPIC EDITOR: MARYSE DIONNE

Providing virtual occupational therapy in Canada: Occupational therapists' experiences with multi-provincial licensing

Laura Kalef & Leslie-Ann Stewart

We (the authors) want to share our experience in providing occupational therapy services virtually across the country, prior to the start of COVID-19. Our aim is to start a conversation to enable change and improve support for occupational therapists working in virtual care nation-wide.

Virtual care is defined as the "use of advanced technologies enabling interactions and exchange of information between [health care professionals and clients] who may not have face-to-face interaction at any time" (Demeris, 2006). The internet has become a means to create accessibility by joining a client's case team together regardless of geographical location. In the realm of telecommunications, clinicians have identified videoconferencing as one method of offering virtual care. Other methods include online message boards, automatic mailing lists, and private chat rooms. In setting up and establishing virtual care communities, there has been a noticeable paradigm shift within the health care system from an institution-focused system to a client-focused system (Demeris, 2006). This is because the offering of virtual care has led to a potential expansion of a client's care team, outside institutional walls, and a bridging of geographic distance using technologies. In addition, virtual care offers alternative ways of communicating between a client and specialized clinicians. These aspects facilitate continuity of care (Demeris, 2006) and the management of varying illnesses from the comfort of a client's home.

According to Deschamps (2019), the Montreal Economic Institute (MEI) reported that around 1% of Canadians used telemedicine in 2019 to remotely address their general medical concerns. By accessing this type of service, clients can be provided with timely access to medical care without the client leaving their home. In Ontario alone, there has been an increase in telemedicine services by 30%, according to Glauser and colleagues (2015). Specific programs and services are growing rapidly, such as mental health services, including virtual doctor visits, psychology treatments, and psychiatry assessments (Marzano et al., 2014). For example, hospital programs have implemented virtual care for mental health services in Canadian regions with high Indigenous representation as well as individuals in other rural and remote areas, supporting remote access to specialists, local capacity, and client-directed interventions (Glauser et al., 2015; Hensel et al., 2019).

Thanks to the evolution of virtual care, occupational therapists can engage with clients through remote appointments for assessment and intervention (Mantovani et al., 2004). While virtual care facilitates access and reduces the relevance of a client's geographical location, there are some challenges that come with embracing technology. For practitioners, these challenges may include, but are not limited to, ensuring privacy, adapting practice to a technology-based communication, establishing a therapeutic rapport without being physically present, educating clients on this new wave of interaction for support and therapy and, last but not least, navigating the issue of multi-licensing. In light of these challenges, it is important to explore how occupational therapists can be involved in virtual care and to navigate these inherent difficulties in order to maximize the benefits of virtual care to Canadians.

As with other health care practitioners, occupational therapists have adopted a position on virtual practice. A 2014 World Federation of Occupational Therapists (WFOT) Position Statement notes the following:

> Telehealth is an appropriate delivery model for occupational therapy services when in-person services are not possible, practical, or optimal for delivering care and/or when service delivery via telehealth is mutually acceptable to the client and provider. It can also be part of a hybrid model wherein some occupational therapy services are provided in-person and some occupational therapy services are delivered at a distance (2014).

WFOT's statement supports occupational therapists across the world who incorporate virtual services as part of their delivery model of care. In Canada, the Canadian Association of Occupational Therapists (CAOT) has also demonstrated support for e-occupational therapy as an effective, efficient, and

accessible means to provide occupational therapy services and education to Canadians (CAOT, 2011).

In light of COVID-19 and the changes in the health care landscape, CAOT has more recently released practical considerations for occupational therapists working in telehealth (CAOT, 2020) and have hosted forums on this topic. While virtual care is now an increasingly common way of providing occupational therapy services, there are still gaps in streamlining provincial licenses for those who practice nationwide.

Our experience

We are two occupational therapists who have worked in a case management role for a virtual mental health disability management program offered across Canada. This program provides early intervention mental health services for clients on short or long-term disability, with the goals of returning to daily function and to work. The role of the occupational therapist is to be a case manager and client advocate within the virtual community. The virtual care team consists of a treating psychologist, psychiatrist, primary care physician, insurance disability claims specialist, and the client. The occupational therapy lens is valuable to ensure the team is maintaining a client-centered approach and a focus on meaningful occupation. The occupational therapist completes an intake assessment and functional outcome measures throughout the program to track progress. As the client advocate in this mental health program, the occupational therapist ensures there is open communication amongst the virtual communities, enables continuity of care, and advocates for appropriate resources for the client to ensure they are progressing and achieving their goals. This program is funded by the client's insurance company.

Working within the realm of virtual care has allowed us to engage with a national client and clinician base to facilitate services in remote areas of the country. We have been able to bring experts from metropolitan areas to provide expert services to individuals living in rural communities. In addition, being part of a virtual care team from various provinces has enabled clients to learn about intervention options available across the country and increases their access to quality services. Being part of the virtual community also allows clients to engage from the comfort of their home, which many see as a safe space when initiating mental health interventions. Overall, utilizing virtual care for occupational therapy in Canada has many benefits, and these are highlighted in Box 1.

Box 1.
Benefits to virtual care in Canada

- Allows more occupational therapists to practice in smaller provinces and to provide services to clients living in remote areas
- Provides access to occupational therapy services to more Canadians
- Brings more specialized services into isolated and rural areas that may not have access
- Allows occupational therapists in private practice to expand their businesses
- Supports national health care goals in addition to provincial goals
- Provides continuity of care to clients who work or live in different provinces, travel regularly, or have moved to a new region

Challenges in providing multi-provincial virtual care

Within our role, we identified challenges when offering case management services to clients outside of an occupational therapists' traditional practice jurisdiction. To work in Canada, occupational therapists must be registered with the regulatory body of the province or territory in which they work. Working in a program that services clients across the country, multi-provincial registrations are required—despite the occupational therapist working remotely from their home province. This poses five main challenges to being part of a national virtual care program:

1) Cost

There is no denying that provincial licenses are costly. It costs approximately $400 to $900 per year for registration in each province. If you are considering registration across all provinces, the cost is approximately $6500 per year! This is a high cost for many practicing occupational therapists and presents as a barrier to providing virtual care across Canada.

2) Provincial guidelines

Each provincial body requires its own application process and license retention and renewal guidelines, with a range of requirements: PREP modules, professional development and continuing competency programs, and so on. For example, the regulatory body in Quebec—the Ordre des ergothérapeutes du Québec (OEQ)—demands that each of the four sections of a clinician's portfolio be completed within a specific timeframe (OEQ, 2020). It can be challenging to stay up to date in all provinces, as well as to understand the regulations applicable in all provinces. These could include the requirements for documentation and record-keeping, or specific guidelines related to private practice. While continuing competency programs are similar across the country, they are not presently streamlined nationally. These varying guidelines cause a lot of added self-regulation from the occupational

therapist to meet competing deadlines, requirements, and regulations.

3) Scheduling
Each provincial body has their own registration deadlines, which are not synchronized across the country. These differences can cause difficulty for occupational therapists to maintain registration schedules, stay on track with continuing competency documentation requirements, and ensure payment is received at appropriate times. This is added self-regulation put onto the occupational therapist to manage timelines and competing priorities.

4) Insurance
Insurance requirements also vary across the country. At the present time, occupational therapists need to ensure that their insurance policy provides coverage in all provinces and meets the guidelines for all provincial bodies. The Canadian Association of Occupational Therapists (CAOT) has developed a professional liability insurance offering coverage for services rendered across the country. However, this does not cover all provincial requirements as, for example, at time of writing, l'OEQ requires members to purchase a minimum level of insurance through their specific provider. Additionally, if an occupational therapist had previously been registered in only one province, that clinician may have a province-specific policy and so may require a new plan before the year ends.

5) Limited support
We have to thank the Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO) for facilitating communication between provincial bodies to ease the multi-registration process across provinces. We greatly appreciate their advocacy for developing and promoting a national strategy for consistent regulatory practices and their promotion of interprovincial mobility among occupational therapists in Canada (ACOTRO, 2016). Their efforts have provided ease of the registration process. However, once registered in more than one province, there is limited support to address any of the above-noted barriers for occupational therapists.

A reflection and call for change

With virtual care becoming more prevalent, we believe that occupational therapists working in this area will require more systemic support. An important and necessary step is for provincial associations and regulatory bodies to develop a nationwide license support program for occupational therapists.

Other professions provide an example to follow. In Canada, the Psychology Associations of Prince Edward Island, Nova Scotia, New Brunswick, and Newfoundland and Labrador have partnered together with a memorandum of understanding that registered psychologists in any one of these provinces can provide virtual care services to clients in any of the other provinces (Prince Edward Island Psychologists Registration Board et al., 2017). We believe this may be a helpful model for Canadian occupational therapists working in virtual care nationwide. For example, uniting regulatory bodies that are part of a geographic region of Canada (Atlantic Canada, Central, Pacific, etc.) would allow occupational therapists to provide their services virtually, with an agreement that the service provider's regulatory body is responsible for clients' complaints. Alternatively, providing a streamlined nationwide registration process for occupational therapists providing virtual services in Canada could help to facilitate the process and enable the future of virtual care in the occupational therapy profession.

Conclusion

Access to care has changed with the introduction of the internet, allowing practitioners to provide virtual health care services to clients. Occupational therapists and other health care professionals now can reach Canadians through virtual technologies. Nationwide processes facilitating occupational therapy multi-provincial licensing may be one means towards improving access to occupational therapy services throughout Canada. Added benefits may include increased awareness and access to the profession of occupational therapy nationally, streamlined continuing competency programs for occupational therapists, and alignment with registration calendars. Ultimately, the intent is to provide more individuals with access to occupational therapy care while simplifying the barriers for healthcare providers.

Are you an occupational therapist working virtually in multiple provinces? We want to hear from you! Let's advocate for an improved program or national registration process to support the future of occupational therapists working virtually across Canada! Feel free to reach us via email to connect.

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About the authors

Laura Kalef, OT Reg. (Ont.), is an occupational therapist passionate about mental health and wellness. She currently works as a supervisor of clinical operations at telemedicine company. She holds a status position with the Department of Occupational Science & Occupational Therapy at the University of Toronto. She enjoys yoga, drinking tea, volunteering, and spending time with her dog. She can be reached at: laurakalef@gmail.com

Leslie-Ann Stewart, OT Reg. (Ont.), is an occupational therapist who has over 10 years of experience in the field of disability management. She currently works as a clinical operations manager for a telemedicine company in their mental health programs. She is an adjunct lecturer with the Department of Occupational Science & Occupational Therapy at the University of Toronto. She enjoys working out and spending time with her family. She can be reached at: leslieannstewart@yahoo.com

TOPIC: STUDENT PERSPECTIVES | TOPIC EDITORS: KATHARINE FUCHIGAMI & ALANNA VEITCH

The virtual fieldwork student experience with CAOT

Annmarie Villanueva & Provvidenza DeArcangelis

We are occupational therapists who recently graduated from the University of Toronto's Occupational Therapy program. In May and June 2020, as student occupational therapists, we gained experience in a virtual fieldwork placement setting with the Canadian Association of Occupational Therapists (CAOT). We did not expect, in February 2020, that we would complete the placement virtually, and once informed that we could not attend or participate in the placement in person, we were at first skeptical about the competencies we would develop. Despite this uncertainty, after completing fieldwork with CAOT, we can confidently say that there are many things that we were able to both learn and achieve. Therefore, our purpose in sharing our experiences working with CAOT is to inform readers of the rewarding experience that virtual, non-clinical placements can offer, and the ways in which such placements enable the development of occupational therapy competencies. We hope that these insights will springboard discussions about the uncertainties that students may face while on virtual placements, and about the options that preceptors and educators can pursue to better address these concerns. Ultimately, we both feel that our virtual placement at CAOT was just as rewarding and beneficial as every other in-person placement we have had.

One of the main projects we undertook was the development of a comprehensive professional practice resource library. We were responsible for finding resources for 37 areas of practice and for creating recommendations on how they could be shared with CAOT members. Although challenging, the experience was rewarding, as we not only drafted recommendations for practice but went one step further by creating a prototype of a practice portal to advance CAOT's strategic priorities and better support occupational therapists in Canada. Through this project, we conducted market research, population needs analyses, and stakeholder outreach. We also developed intricate decision trees and vetting systems that will be useful for future students at CAOT and for CAOT's continued efforts to support occupational therapists across Canada. Our decision tree is a supportive tool that guides the user through several questions to assist with determining and selecting which resources are beneficial, trustworthy, and applicable to the Canadian practice context. It also aids in providing future directions, possible solutions, and outcomes, and will be useful for the progression and advancement of resource-sharing at CAOT.

In addition to the placement, we were accepted to present our research project, "Developing Observational Skills in Occupational Therapy," at the 2020 CAOT Virtual Conference. Initially, we were disappointed that we would not have the opportunity to present in person, because we believed that a virtual audience would not be engaged by our research presentation. However, our skepticism was quelled as we discovered ways to interact with the audience by using the videoconferencing platform to its fullest extent. As both presenters and facilitators, we were able to contribute to the success of the event, which showcased a variety of engaging topics, and to share our own research endeavours with occupational therapists nationwide. From this experience, we learned that adaptability and resourcefulness as a student, new grad, or clinician is important, as it allows one to embrace new methods of practice as well as expands one's body of knowledge.

In addition to learning from these projects, we gained a deep appreciation for creating relationships with fellow occupational therapists. Although we physically and independently worked from home, it was important to us that we continued to foster meaningful connections with CAOT's team and network leads. Indeed, as a national association created to support occupational therapists across Canada, CAOT provides a unique opportunity to connect occupational therapists who are geographically separated. We spoke with occupational therapists across the country, from British Columbia to New Brunswick to Nunavut, about the critical gaps in the availability and provision of culturally sensitive clinical resources for their practices. The perspectives and feedback we shared with our CAOT colleagues were essential not only for our project development but also for our personal and professional growth. With these new perspectives, we felt motivated to share what we learned, including the voices and experiences of those with whom we had meaningful discussions. As a result, we launched

a podcast entitled "OT4U," which chronicles the experiences of leading occupational therapists in various practice areas and their transitions from academia to practice, from a student position to that of a new clinician.

We would not have been able to achieve all that we had without the supportive team and work environment at CAOT. We were fortunate to have been placed with a wonderful preceptor and network leads who were willing to mentor us by continuously sharing their knowledge and skills. They urged us to always question current norms and to challenge the status quo. An example of this was when we took the time to examine different practice resources and determine if they had a culturally sensitive lens, amongst other important features. Whenever we had questions about organizational processes or expressed learning needs, our preceptor would point us in the right direction and allow us to establish our own processes in completing our various responsibilities. Through this supportive process and culture, we were able to refine our reflexive and advocacy skills, build confidence and courage in taking initiative, and appreciate and understand the value of considering the bigger picture.

Whether or not you are completing an in-person or virtual placement, mentoring opportunities are available. We have learned about the importance of networking in order to find professionals who are willing to guide students, and to being open to such opportunities that will support and facilitate success in one's professional and personal endeavours.

Being an occupational therapist requires the embodiment of many competencies, such as being a professional or a change agent (see Table 1). Throughout this placement, we have realized that virtual fieldwork placements can indeed provide

Table 1.
Occupational Therapist Competencies and Student Achievements

Occupational Therapist Competency	Student Achievements
Change Agent	• Developed a professional practice portal for Canadian occupational therapists, and advocated for this portal to CAOT's Senior Leadership Team • Brought attention to ways in which CAOT can support student and new graduate members through conducting a population needs analysis and presenting a summary of key findings
Practice Manager	• Independently managed placement schedules and coordinated meetings with pertinent stakeholders • Developed effective strategies for the sustainability of the practice portal • Provided peer support and mentorship to incoming student occupational therapists to ensure a smooth transition of responsibilities
Collaborator	• Connected with Professional Practice Directors and Network Leads in the creation of practice portal recommendations • Created the podcast *OT4U* and collaborated with Network leads working across multiple settings and countries to discuss pertinent occupational therapy topics
Professional	• Demonstrated high levels of professional interaction in written, spoken, and video contexts • Developed solution-focused approaches to conflict management • Consistently and punctually met all project and task deadlines
Scholarly Practitioner	• Conducted a comprehensive search for trustworthy practice resources for 37 different areas of practice • Effectively presented research efforts at the CAOT conference and fielded questions to facilitate learning and contribute to the dissemination, application, and translation of knowledge • Independently completed online courses in a lifelong pursuit to maintain and build personal and professional expertise
Communicator	• Established strong relationships with our preceptor, the CAOT team, and stakeholders • Co-founded and co-hosted a podcast directed at student occupational therapist and new graduates, to disseminate knowledge about key practice gaps • Moderated and facilitated presentations and discussions during the CAOT Conference 2020

you with opportunities to refine and develop new competencies specific to occupational therapy. For example, we were able to direct the time we saved from not having to physically commute (including between meetings or conference rooms) towards the expansion of our learning and utilization of additional online resources relevant to our work.

Although some aspects of virtual fieldwork are different to a traditional, in-person clinical setting, a virtual placement offers an equally valuable and rewarding experience. In conjunction with the core competencies, our virtual experience allowed us to advance our technological aptitude as we completed coding courses, web design, and software management during our placement. Technological aptitude is especially relevant as we are now, more than ever, experiencing a major shift in academia and professional practice through the increased use of and reliance on technology, as COVID-19 in particular has forced us to become comfortable online and virtually accessible.

In retrospect, we feel proud of everything we were able to accomplish in only eight weeks with CAOT. We embraced the uncertainty that came with the fieldwork changes that accompanied the pandemic, and we gained a tremendous amount of experience that we can carry into practice. The placement also challenged us to become adaptable, flexible, and self-directed, which are crucial skills that practicing occupational therapists must embody. Ultimately, our virtual placement opportunity allowed us to enhance and refine the occupational therapy competencies that we have outlined in the table below. We are so grateful for this virtual fieldwork experience and feel prepared to transfer everything that we have learned to enhance our careers as occupational therapists.

About the authors

Annmarie Villanueva, OT Reg. (Ont.), and **Provvidenza DeArcangelis, OT Reg. (Ont.),** recently graduated from the Occupational Therapy program at the University of Toronto. They both completed their third fieldwork experience virtually with the Canadian Association of Occupational Therapists in May and June, 2020. The authors can be contacted at: annmarie.villanueva@mail.utoronto.ca and provvidenza.dearcangelis@mail.utoronto.ca

Shifting an in-person pain management group to a virtual group

Allison Banks

At the Stan Cassidy Centre for Rehabilitation in Fredericton, New Brunswick, we provide expertise in neurorehabilitation for the province of New Brunswick. Pain profoundly affects our patients' quality of life in physical functioning, family relationships, vocation, recreation, and mental health. A review of patients with spinal cord injury admitted to our centre found that 86% had pain prior to admission and 90% had pain at some point during their admission, yet pain education was documented as being provided to only 12% (Savoie et al., 2019). These statistics suggested that, if we were to provide more pain education as a team, patient outcomes could significantly improve.

Our team consisted of a psychologist, physiotherapist, and occupational therapist. These practitioners developed and introduced group-based pain education, focusing on evidence-based non-pharmacological pain management strategies, for both in- and outpatients in a face-to-face setting at our facility, with 8–10 people in each group. We provided information on pain neuroscience and self-management strategies, which included goal setting, sleep hygiene, stress management, emotion management, breathing techniques, acceptance, physical activity, and pacing and adapting activities (Butler & Moseley, 2003; Cai-Duarte et al., 2018).

Gentle yoga was incorporated into our out-patient group, led both by a registered yoga teacher who is also an occupational therapist and by a physiotherapist with training in therapeutic yoga. The out-patient group consisted of people with various neurological diagnoses. The group took place several times a year, and patients travelled different distances to our centre. Due to the size of New Brunswick, not all patients could access the out-patient pain group, creating a disadvantage to people with chronic pain who live in rural areas.

COVID-19 led to cancellation of a new out-patient session that was about to begin. Horizon Health Network, our health authority, quickly provided us a new virtual platform (Zoom). We received enough enthusiastic responses from the participants to put on a virtual group. All therapists and participants took part by viewing PowerPoint slides and engaging in open discussions. Brief guided chair yoga was also incorporated through this virtual platform.

There were a number of advantages to the virtual group. Patients who lived several hours away from our centre were able to participate in the pain group. Patients were able to comfortably stay at home and had less pain from not having to travel in their vehicle. The sessions were shorter, and more sessions were added to keep the group meeting to one hour, anecdotally improving attention and minimizing pain and fatigue.

Yet we also faced challenges in implementing the virtual group. Some participants did not have an email address or know how to operate Zoom. It was difficult to obtain anonymous feedback about the virtual sessions: we received only two responses. Of these responses, one person preferred in-person group for the group interaction and learning. Another person enjoyed the gentle yoga in a group setting. It was suggested by a client that the morning time was not a good time for their pain. In the future, it would be helpful to have an administrative assistant complete the feedback survey with the patients to increase the response rate and feedback. We could consider recording the sessions, which would allow participants to participate when they could. Further research is needed to assess how to optimize learning virtually versus in-person.

Overall, our clients were able to share stories and information in the virtual group; they were educated on different self management strategies; they did gentle yoga and mindfulness exercises virtually; and, they felt that they were not alone in their pain. The group in the future will likely include a hybrid model, providing an option to do the group online or in-person. Since starting the group virtually, our referrals from our physicians have tripled. COVID-19 has opened doors to allow us to increase delivery of equitable service across our province of New Brunswick.

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About the author

Allison Banks, OT Reg. (NB), is a registered occupational therapist at the Stan Cassidy Centre for Rehabilitation in Fredericton, New Brunswick, and is a registered yoga teacher. Allison has worked for 14 years with an adult neurological diagnosis population. She has keen interest in pain management. For more information, she can be contacted at: Allison.Banks@horizonnb.ca

Welcome to the Rehabilitation Advice Line – I'm an occupational therapist. How can I help you?

Justine Greene, Christine Mireault, Safieh Rajan, Magda Roberts, Sherry Dobler, Allison Burkart, Laura Coggles, & Katie Churchill

The COVID-19 pandemic resulted in an unprecedented shift to virtual practice for occupational therapists across Canada. In Alberta, the temporary closure of out-patient and community-based rehabilitation clinics resulted in Alberta Health Services (AHS) mobilizing the launch of a provincial phone-based rehabilitation service. This article highlights the experience and learnings of occupational therapists involved in the implementation and operation of a novel Rehabilitation Advice Line. The use of virtual modalities is an opportunity to increase equitable access to rehabilitation services (CAOT, 2011), and the pandemic provided an accelerant for its use in occupational therapy practice in Alberta.

The Rehabilitation Advice Line is an innovative telerehabilitation service that is part of the province-wide Health Link department within AHS. Occupational therapists and physiotherapists deliver phone-based self-management advice, resources, education, and wayfinding to callers located anywhere in Alberta who have functional concerns related to an existing condition, or who are recovering from the COVID-19 virus. In this telerehabilitation role, occupational therapists are well-positioned to help callers re-engage in the occupations that are meaningful to them through the delivery of self-management education, resources, and strategies.

Phone-based health delivery has existed for decades (Picot, 1998). The innovation of the Rehabilitation Advice Line comes in its application to the rehabilitation context. The goal is to help individuals self-manage their conditions and be able to participate in their daily activities. The Rehabilitation Advice Line offers Albertans increased access to rehabilitation services by eliminating geographical, social, and economic barriers; improving navigation to existing services; and offering individualized rehabilitation advice over the phone.

The service was launched in May 2020, and there have been a wide variety of clinical calls to date. The largest groups of callers have been those with musculoskeletal conditions—new injuries or chronic conditions—and those awaiting or recovering from hip or knee arthroplasty surgeries. Other calls have been focused on the management of chronic neurological conditions, such as multiple sclerosis, Parkinson's disease, and stroke. There is a rapidly increasing number of calls from Albertans requiring rehabilitation support as they recover from the COVID-19 virus and experience the newly emerging sequelae of symptoms associated with it. Occupational therapists are uniquely positioned to provide a holistic approach to self-management and focus on the enablement of participation in meaningful occupations regardless of diagnosis or clinical condition.

Occupational therapists at the Rehabilitation Advice Line work in a contact centre environment. The practitioners receive extensive training on the technology required for calls and are trained on virtual platforms that manage the phone processes in addition to an electronic medical record (EMR) for clinical documentation.

Telerehabilitation requires a thorough consent and screening process, as the assessment and treatment are completed without the ability to visually or physically assess the caller. The occupational therapists use a standardized approach to screen out medical emergencies, but use their own clinical reasoning and assessment skills to both navigate calls and provide appropriate self-management advice and recommendations. As well, the provincial scope of the service has resulted in the practitioners needing to have a province-wide knowledge base of available clinical services and to use evidence-based resources such as education handouts, videos, and self-management instructions that they can share via email.

The Rehabilitation Advice Line brings together practitioners with broad and varied experiences. The clinical diversity on the team provides the occupational therapists with an opportunity to leverage the expertise within the team and to provide real-time best practice recommendations and immediate consultation.

The COVID-19 pandemic has been a driver for many health systems to switch to virtual services, and was the catalyst in launching the Rehabilitation

Advice Line. Occupational therapists are well-positioned to adopt virtual practice and apply a client-centered approach to calls. The Rehabilitation Advice Line, staffed with occupational therapists and physiotherapists, is an innovative telerehabilitation service that provides increased access and eliminates barriers to facilitate callers' re-engagement in meaningful occupations during the COVID-19 pandemic and beyond.

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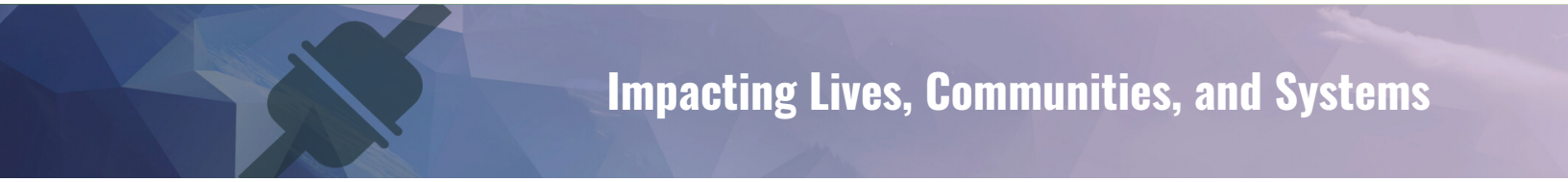
About the authors

The contributing authors of this report are all occupational therapists who have been part of the development, implementation, and operation of the Rehabilitation Advice Line. This provincial service brings together occupational therapists from diverse backgrounds to provide the service to anyone located in Alberta. The service is based out of Calgary. For any questions or comments about this article, please contact Katie Churchill at: katie.churchill@ahs.ca



Connection beyond the screen: Enabling clients in their mental health recovery through virtual group therapy

Wendy Fox Harker & Patricia Jocelyn

The BRIDGE mental health day treatment program has been supporting clients of Markham Stouffville Hospital (MSH) in their personal mental health recoveries for over 25 years. Former clients titled the program BRIDGE, as they felt that this embodied its true essence: Building, Recovering, Initiating, Developing, Growing, and Empowering. This daily 12-week group-based psychoeducational program supports clients aged 18+ who are coping with various mental health diagnoses including major depression, anxiety, bipolar disorder, adjustment disorder, substance use disorder, schizophrenia, and borderline personality disorder. The program focuses on life skills across themes such life balance, self-compassion, coping with illness, communication, stress management, self-esteem, healthy relationships, strategies for change, and cultivating hope. Clients participate in daily groups that include small group discussion, role plays, yoga therapy, and daily meditation and relaxation. Using a client-centered and recovery-oriented framework, members of the interdisciplinary team coordinate care by addressing clients' personal recovery goals, referring them to community resources, and optimizing their support systems. At the end of the program, clients often express positive feelings about their growth. As described by one, "Having BRIDGE to wake up for and fill the hours of my day gave me hope. I am not my symptoms."

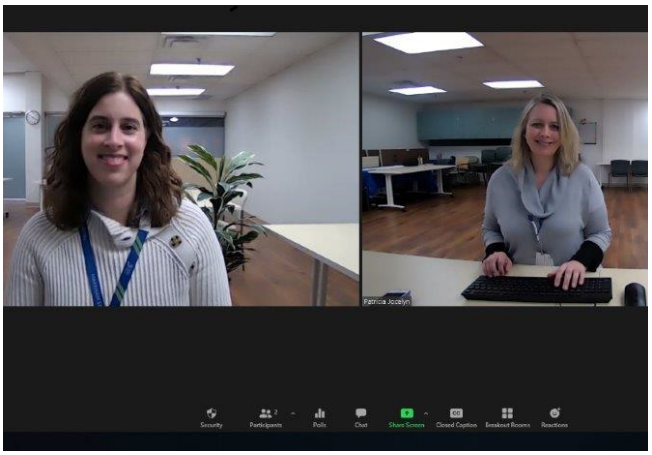
When the World Health Organization (WHO) declared the coronavirus pandemic in March 2020, this crisis necessitated the cancellation of in-person gatherings. As a result, BRIDGE groups were indefinitely suspended, and staff initially moved to a model of delivering individual telephone support for existing clients. Our clients were reporting isolation, loneliness, heightened anxiety, and a need for increased and accessible support. Nationally, an online survey of

1803 Canadian adults conducted by Mental Health Research Canada found that, compared to their experiences pre-pandemic, rates of self-reported high to extremely high anxiety quadrupled (from 5% to 20%), and rates of self-reported depression more than doubled (from 4% to 10%) (Dozois, 2020). Ekperigin (2020) highlighted that the urgency to address these needs was evident to health professionals across the province: "From the loneliness and isolation of prolonged social distancing, to the angst, sadness and despair expressed by the marginalized, I see groups of people needing to engage in therapeutic dialogue and mental healing" (para. 1).

To our knowledge, virtual care had been generally used to provide psychiatric care to patients in remote areas, and primarily on a one-to-one basis. The therapeutic relationship in e-therapy (email, video conferencing, virtual reality technology, or chat technology) had been found to be at least equivalent to the therapeutic relationship in face-to-face therapy (Sucala, 2012). Once the pandemic started, hospital-based outpatient mental health services began to move online, as psychotherapists and psychiatrists shifted practices using Zoom, telemedicine video-chat platforms, or telephone calls (Yousif, 2020). In May 2020, Prime Minister Justin Trudeau announced $240.5 million in funding for virtual care and mental health tools to support Canadians, and provinces added billing codes for psychiatrists offering virtual care visits (Yousif, 2020). More than 3,000 Ontarians registered for internet-based cognitive behavioural therapy (iCBT) in five weeks (Ekperigin, 2020).

Development of the virtual program

Our team recognized the need to augment care and began to explore opportunities to deliver group programming virtually. By early April, we sought on-site training using the Ontario Telemedicine Network (OTN) platform for delivering group sessions and began developing a five-week virtual program focused on coping with the challenges of COVID-19. The first two pilot virtual groups commenced on April 20, 2020. Adapted from the full BRIDGE program content, the program focused on themes relating to self-care, productivity, and leisure. The program evolved away from COVID-19 themed topics and expanded to a six-week program, with two-hour groups meeting five days per week. Based on client feedback, a weekly transition group was added upon completion of BRIDGE, in which clients focused on weekly goals and linkages to community supports. In addition, a dedicated 65+ seniors' virtual group was developed in response to the increase in referrals received for this population and their unique challenges. In the first 11 months, a total number of 173 clients were admitted across 20 cohorts of groups.



Group facilitators Wendy and Patricia awaiting clients on the Zoom platform.

Challenges

We encountered some hurdles along the way in launching this virtual group therapy program. New protocols for provision of consent and agreements to maintain confidentiality in the online setting were developed in collaboration with hospital administration. Adapting the OTN format for one-to-one virtual visits with a group of eight to ten clients also had its limitations. Key challenges included having a limit of nine participants (including the host) that could be seen on the screen, the inability to maintain view of participants on the screen when sharing written material, and a significant lag between visual and audio output when showing videos. Additionally, some referred clients did not have access to required technology, such as a smartphone, tablet, laptop, or desktop computer with a webcam. To increase virtual accessibility, BRIDGE staff reached out to Frontline Connect Canada, a physician-led grassroots initiative, which provided donated tablets to clients for the duration of the program (Frontline Connect, n.d.). These tablets were instrumental in breaking down barriers faced by several of our clients, enabling them to access the virtual care in a timely manner. BRIDGE staff also provided telephone support for clients to learn the technology as needed. Lastly, unanticipated events such as family members coming into rooms in which clients were situated, clients attending group not fully clothed, smoking cigarettes or cannabis on camera, or logging on to group while driving (evidenced by overhearing them ordering at the drive thru!) required prompt responses by facilitators, telephone follow-up, and an update to group norms and expectations.

Recent developments to the program include MSH adopting the Zoom for Healthcare platform for virtual care as of January 2021. This platform allowed for larger group sizes and reduced our wait times for new referrals. In addition, the group experience has been

enhanced by features such as gallery view—so that all participants can be seen on the screen—breakout group rooms for small group discussion, and the ability to share online videos. A virtual orientation session prior to group commencement was added as an opportunity for group members to trial the technology and to review the group norms and expectations of this new virtual world.

Highlights: Daily routine and peer support

The virtual program enabled some clients to participate who otherwise would not have been able to due to symptoms, location, lack of transportation, or caregiving demands. Although clients expressed meeting virtually was "not the same" as attending in person, feedback about the benefits of the program was overwhelmingly positive. As summarized by one participant, "It was an excellent beginning to my re-discovery road … It brought a lot of tools to my toolbox." Upon conclusion of the program, clients have the option to complete an anonymous online satisfaction survey. Of the respondents at time of writing, 84% indicated they were satisfied or highly satisfied with the content of the virtual program, and 71% indicated that most or all of their needs were met (n = 75). The therapeutic benefits rated most highly by clients were daily routine, social interaction, and reflection on personal and shared mental health experiences through group discussions. This powerful peer support was observed in the form of non-verbal encouraging gestures between group members, open sharing at unstructured break times, and plans made by some group members to maintain contact as support communities for each other following the completion of the program. In the summer of 2020, when restrictions were partially lifted, some reported they had independently arranged to meet for physically distanced in-person gatherings.

Conclusion

Overall, while some challenges were experienced initially, the majority of virtual group members reported receiving significant positive benefits from participation in this program. Due to the ongoing isolation and expected continued elevation rates of mental health issues, occupational therapy–led psychoeducational support and social-recreation group programs using virtual technologies can offer instrumental support in optimizing clients' mental health recovery. With online care likely here to stay, virtual group therapy can provide meaningful connections beyond the screen, for both client and therapist.

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About the authors

Wendy Fox Harker, OT Reg. (Ont.), and **Patricia Jocelyn, OT Reg. (Ont.),** are occupational therapists working in the BRIDGE Day Treatment Program at Markham Stouffville Hospital (MSH). They each have 20 years of mental health experience working in outpatient, inpatient, and community settings. For more information, they can be reached at: wfoxharker@msh.on.ca and pjocelyn@msh.on.ca

How COVID-19 changed my practice: Lessons learned

Lauren Hershfield

While the current pandemic has been devastating on many levels and has led to significant challenges for many patients and families accessing medical services, we believe that the necessary transition within our program to a virtual care model has enabled us to discover some hidden benefits and efficiencies.

Our clinic at BC Children's Hospital serves patients from across British Columbia and the Yukon who are referred for a feeding and swallowing assessment. Prior to the pandemic, an assessment would be completed over the course of one day. Our occupational therapist and dietician would review each patient's medical history, complete an oral motor and nutrition assessment, observe feeding, and perform a videofluoroscopic feeding study. This service model was not without its issues. Due to the large geographic region we service, many families travelled great distances to our centre. On many occasions following our initial feeding observation, we would not feel a videofluoroscopy feeding study was warranted; however, given the time invested and expectations, the study was done for completeness. Our specialized program also had significant wait times—often in the three- to six-month range. On occasion, by the time patients were able to come to our clinic (often from afar), their symptoms had resolved or been managed sufficiently by a community practitioner.

When the COVID-19 pandemic began to take hold, we were told we had to stop seeing patients in person. Our program was determined to quickly pivot so that we could continue to serve our patients in some capacity. We began to trial virtual feeding assessments, and quickly set up virtual appointments with families. These virtual visits were structured around the completion of a medical history and a feeding observation. With the information that we gleaned from this initial appointment, we would triage patients based on their need for a videofluorosocopy feeding study and the level of urgency. By creating a triage system, we could see our patients in person based on priority of need, ensuring that those who were most urgently in need of further investigations would be looked after first.

Shifting our service delivery model has significantly changed our clinic. We have learned that seeing a child in their own feeding environment, in their own homes, allows us to get a clearer view of family dynamics, typical mealtime behaviours, and mealtime structures. We observe the environment and the seating systems and techniques used. Real-time observations allow us to ask relevant questions during the observation and give us the ability to manipulate specific elements of the feeding interaction for assessment or treatment purposes. While as occupational therapists, we know the value of seeing a child in their own home, work in a tertiary care setting often does not lend itself to this. Virtual care has now granted us with this opportunity. Additionally, completing a feeding assessment in real time provides a more comprehensive assessment and allows the practitioner to provide instant feedback to the family. We have also seen an overall reduction in the amount of unnecessary videofluoroscopy feeding studies being done.

We have also learned that we are able to see families who otherwise would not be able to get to our clinic, especially from remote communities. These families have reported to us that they are grateful that they can be seen in their own home and relieved that we can provide care to their children who otherwise would be waiting a long time to access services.

Research in the area of virtual health and dysphagia show similar strengths to what we have experienced. There is evidence of opportunities for increased services and of reduced travel and costs to families; there also is excellent agreement between face to-face and remote assessments, and intra-rater agreement on dysphagia severity (Clark et al., 2019; Figueiredo, 2019).

At time of writing, we are moving through the second wave of COVID-19. As the pandemic continues, and after the virus is controlled, we hope to continue with our virtual care and explore how these changes impact our care. We are hoping to gain further insight into how feeding assessments over virtual health can best be performed. We plan to look at the impacts of virtual feeding-based care on the family, as well

as their level of compliance with recommendations and their overall family satisfaction. We believe the changes we have made will have a lasting effect on our clinical program and shift service delivery to greater efficiencies and improved care for our patients and families.

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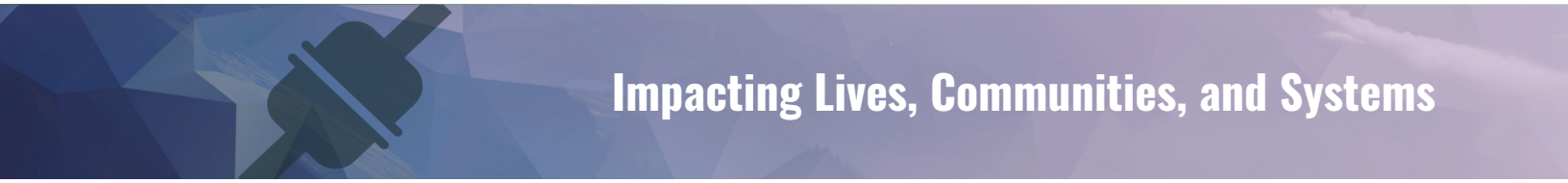
About the author

Lauren Hershfield, Reg. OT (BC), completed her occupational therapy degree at the University of Toronto and has been practicing for 15 years. She currently works at BC Children's Hospital in the Department of Occupational Therapy as well as in private practice, and can be contacted at: lauren.hershfield@cw.bc.ca



"Just eight minutes": The experience of occupational therapy educators designing and teaching virtual occupation-based groups for psychosocial issues

Hiba Zafran, Melissa, Park, Suzanne Rouleau, Raphael Lenchuca, Sandra Everitt, & Marc-André Clément

Occupation-based group therapies address psychosocial issues that impede occupational engagement or place it at risk. We offer a graduate course within McGill University's Occupational Therapy program that focuses on intentionally integrating narrative and procedural reasoning (Mattingly, 1998) in designing groups. That is, for groups experiencing psychosocial issues and occupational disruptions, student occupational therapists learn to first identify meaningful person-centred goals, and then select the best-fit frame of reference to address the psychosocial issues of concern when designing and implementing an occupation-based group seminar. These experiential seminars take place over an eight-week period in a closed-group format of 10–12 students, facilitated by one instructor. When shifting our teaching to a remote format for Fall 2020, we had to redesign these learning experiences for the virtual context with no available evidence. The first two authors adapted the essential elements of a group session to the virtual context, and all authors (a teaching team) practiced it with each other and then with the students. This article reflects on how we approached this challenge, and provides lessons learnt for occupational therapists who teach about or offer activity-based group therapies.

Illustrating the process

1) Identify your population and narratives of their experiences

We are a group of occupational therapy educators at various stages in our careers who—in addition to adapting to remote teaching during the COVID-19

pandemic—have experienced occupation disruptions in research, retirement, clinical, community, and family life. Deidentified composite narratives from our colleagues during that time period highlight urgency:

> I don't even have time to think; it's just putting out fires all the time. I was in the middle of class, sitting in my basement—it is the only quiet place with the kids at home—with the laundry piles shoved to the side, when suddenly my youngest decides I should catch him as he throws himself towards me from the top of the staircase, and I suddenly disappear from the screen in the middle of class to catch him. I pop back onto the screen … and … we just keep going with class. Some days I'm the perfect parent and other days, the five of us are on the floor crying. The noise of the world has entered my home and it is scary. It's like being haunted, constantly moving in order to avoid getting this virus, respond to each urgent next thing—while knowing that I am one of the privileged. I'm doing more student support too, especially with our racialized students.

2) Apply narrative reasoning to understand how what matters can be meaningfully enacted in an activity
In the midst of a pandemic and global political unrest, what mattered to occupational therapy educators was the desire to slow down, attend to the world and people around us, and have a space for ourselves to make sense of the changing world and to re-situate our place, rhythms, and relations in it.

3) Identify the psychosocial issues getting in the way of what matters
Shared psychosocial issues included anxiety, sadness, anger, risk of burnout, and 'cabin fever,' coupled with continuously shifting directives from the university and province.

4) Apply procedural reasoning to select a theoretical framework
By early summer 2020, it was clear that we would require long-term adaptation. Therefore, resiliency theory was chosen to frame the session objectives and discussion. The first author designed a virtual session for the teaching team that aimed to engage the group in contemplative activities (Thibeault, 2011).

5) Establish an agenda for the group session

a. Welcome everyone and state the purpose of the session as creating time and space for us to slow down

b. Break the ice with each person providing their personal definition of contemplation and associated activities

c. Engage in a contemplative activity of your choice in a location of your choice for ten minutes off screen

d. Hold a discussion focused on processing the experience and linking to everyday lives, and on considering how integrating a contemplative activity into the everyday can be a protective factor

6) Adapt to the virtual context
In person, the occupational therapist would have facilitated a specific meditative activity. In the virtual space, each person was invited to define and engage in an activity of their choice. Jazz music was played through the ten minutes, with the ending of the music being the signal to return.

7) Implement then analyse the group process and content
The experience of this session surprised us. We were initially apprehensive about how a two-dimensional medium would allow us to create a significant experience through activity, and foster connection for a therapeutic group process. The icebreaker began in a structured manner, with moments of connection when realizing that we shared the view that contemplation and movement are tied together. Engagement in the off-screen activity lasted less than 10 minutes, and yet created a significant shift from our formal teacher selves, to authentic dialogue and vulnerability. In 'just eight minutes'—swinging in a patio hammock, standing barefoot in the garden, listening to jazz on the terrace, doing some yoga stretches, or using the sensory equipment at the clinic—we were able to slow down, re-enter our bodies, and hear ourselves and each other.

Practical lessons learnt

Following this practice session, we conducted our student-led group sessions for eight weeks in a remote format. The students described the seminars as a significant experience for them to share and explore personal challenges, and we collectively engaged in problem-solving to scaffold the process of group development (Cole, 2018):

- **Session preparation:** Emails were sent prior to each group session with instructions, to ensure that participants were prepared for the planned activities and to foster a sense of safety.

- **Confidentiality:** In addition to maintaining confidentiality within each group, we did not allow pictures or recordings of the sessions, and required that headphones be used by participants in shared living spaces.

- **Group norms:** All pop-up screens and other technology were off during the sessions. Nonverbal gestures were encouraged for turn taking. For some activities, we had participants verbally 'tag' the next speaker, to ensure that everyone had a chance to share and participate. Use of the chat function was removed to foster attention to one another. Students asked that we all keep our audio on, so that we could all feel as if we were a part of each others' environments, and that everyone is included whether verbally contributing or not.

- **Group type:** In order to develop group cohesion, closed groups—with the same students and instructor for the eight weeks—were necessary, given the unfamiliarity of the virtual environment.

- **Length of sessions:** While initially planned as a 60-minute session to minimize cognitive fatigue, the inclusion of activities off/online and discussions were engaging, and students stayed on easily for 90-minute student-led sessions. Time for instructor-led debrief and closure was found to be beneficial after a break.

- **Scene:** Our experience in our own session of leaving our desks to various other parts of our homes highlighted the increased importance of the scene (Park, 2008) within a virtual space. Students decorated their space to match their activities when co-leading a group (e.g., draping a grandmother's handmade quilt over an armchair for a quilting activity). Some students encouraged comfortable clothing and locations (e.g., on the floor, in a bed, on a couch), and having at hand blankets, cozy items, and a cup of tea or coffee. Others asked their peers to dress up for a dance party. Students also shifted the scene by bringing the outside into the group, by asking group members to bring in pictures of things they've seen or done during lockdown.

- **Group development:** We scaffolded the process of activity-based group development from individual offline activities (meditation walk), to parallel activities online (making brunch, dancing to a streaming video with a shared screen, guided origami), to pairs and trios in small break-out rooms (creating pieces for a paper quilt or a dance routine), to collective online and co-operative tasks (online shared scrapbooking, creating a vision board, trivia games).

- **Roles:** Pairs of students took turns having their screens off for one session, to observe and provide feedback. In addition to facilitating debrief sessions after each student co-led seminar, instructors met with students regularly to guide their reasoning by integrating the struggles of daily life with course-related questions and content.

Our unexpectedly meaningful occupation-based virtual session in August 2020 allowed us to learn through doing, adapt the group protocol to the virtual context, and to use the session as a model for the students. The significant experience we had also provided us with hope for meaningful connections with each other and with students within the virtual sphere.

Acknowledgements
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About the authors

The authors are part of a teaching team at the School of Physical and Occupational Therapy, McGill University, located on unceded Kanien'kehà:ka (Mohawk) territory. For any comments or questions about this article, please contact: hiba.zafran@mcgill.ca

Dear COTF & CAOT Community,

With the first half of 2021 behind us, it has been an exciting time for the team at COTF as we continue to focus on strengthening the foundation and its community. With an improved focus on creating long-term, mutually beneficial relationships with the occupational therapy community, we have partnered on several projects and grants that are beginning to grow in 2021. These include, CIHR IMHA funding proposals, OTC Working Group: A Joint Position Statement on Equity & Justice, as well as joining the CAOT TRC Task Force.

As we head into the latter half of 2021, some of the shock, change, and trauma of 2020 is now behind us, with perhaps more uncertainty and significant challenges remaining for everyone. As the board of directors sets goals for our continued growth, the more things look different, and the more we are committing to new habits that reflect our ongoing support of occupational therapists. These new habits and actions will speak to the professional and personal elements of COTF as an organization and are more interconnected and interdependent than ever.

As we all look toward the end of 2021, let us all consider the habits we want to build, continue, or stop, throughout the elements of our personal or professional lives and work at building positive habits together.

Cale Wadden, President, on behalf of the COTF Executive Committee

COTF's Presence at the 2021 CAOT Virtual Conference

COTF thanks CAOT for the opportunity to participate at the 2021 CAOT Virtual Conference. A big thank you to our new successful "Tea with A Scholar" event speakers Skye Barbic, PhD, Reg. OT (BC) and Marie-Josée Drolet, Professeure titulaire, (UQTR). We would also like to thank our COTF sponsored session speaker, Lori Letts, on OT research during the COVID-19 pandemic: Lessons in resilience. For more information on these sessions, please contact amcdonald@cotfcanada.org

When you are renewing your membership to CAOT, please consider making a donation to your Foundation!

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March 2022 Special Issue
Socially Accountable Occupational Therapy

Call for submissions: Drawing on the Charter of Human Rights, the World Health Organization defines social accountability as "the obligation to orient education, research, and service activities towards priority health concerns of the local communities, the region and/or nation[s] one has a mandate to serve…identified jointly by governments, healthcare organizations, health professionals and the public" (Beolen & Heck, 1995, p. 3, emphasis added). To be socially accountable is to to address inequities in critically inclusive and impactful ways that are responsive to the rights and needs of stakeholders and people from equity-deserving groups. Equity-deserving groups are populations that experience structural, social, cultural, and environmental barriers based on social characteristics such as age, social class, economic status, gender, nationality, race, skin colour, sexual orientation, and disability.

We are calling for submissions for articles that illustrate the ways in which occupational therapists, occupational scientists, occupational therapist assistants, students, and those they work with, grapple with, commit to, engage in, or experience efforts to achieve social accountability.

Submissions may range from 750–1500 words (including references). Topics that address the below within specific contexts are invited:

- Illustrations of theories, models, or frameworks applied in equity- and justice-focused occupational therapy
- Participatory practices and processes in governance and decision-making in the design and delivery of rehabilitation services or curricula
- Productive, provocative, and anti-oppressive challenges to conventional, taken-for-granted words, concepts, and practices in occupational therapy
- Challenges from minority groups/communities when working with taken-for-granted oppressive languages, concepts, and practices in occupational therapy
- Successful and sustainable approaches to address racism, sexism, ableism, etc., in the profession, as identified by people from equity-deserving groups
- The role of collective occupation in relationship- and coalition-building to implement inclusive approaches to health equity and social justice

Deadline for submissions: **October 1, 2021**
Submissions should be sent to otnoweditor@caot.ca with a clear indication that the paper is for the special issue.

To review *Occupational Therapy Now* guidelines, go to:
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*Note that *Occupational Therapy Now* does not publish original research; however, we promote knowledge translation and implementation efforts to enhance occupational therapy practice across Canada.

Reference:

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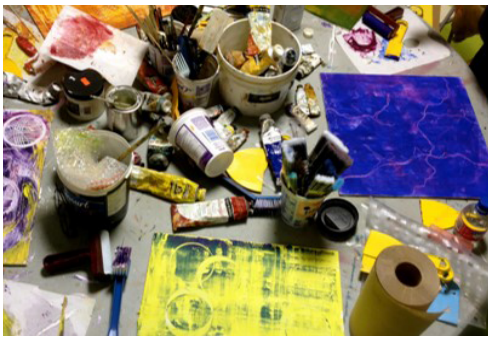

This online course equips you with the knowledge and skills to start using and to tailor an arts-based program with clients in your occupational therapy practice. The stages of building an arts-based program will be explored, from finding your champions, engaging a diverse group of stakeholders, grant writing and budgeting, creating the studio environment, and incorporating research.

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Online delivery – October 7 & 8, 2021; March 24 & 25, 2022

This workshop will introduce you to the principles of acceptance and commitment therapy and how to apply them to occupational therapy practice.

Register for this workshop

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