WORKING TOWARDS HEALTH EQUITY IN OCCUPATIONAL THERAPY

by

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ABSTRACT

This study describes how health equity approaches are currently enacted in occupational therapy practice and documents barriers and needs to foster the integration of these approaches. Over 360 Canadian occupational therapists completed a survey based on current equity indicators in health services. Descriptive statistics and content analysis were used to analyze survey responses. Respondents reported more frequently engaging in actions to address clients' needs, while initiatives at a community and systems levels or in the evaluation of services were less frequent. Organizational constraints, systemic aspects of inequities, practical competencies and limited access to professional resources were commonly reported barriers. Supportive management and collaboration with other professionals and communities were identified as valued supports. These findings provide insights into opportunities for actions at the level of occupational therapy service delivery, and into existing barriers and facilitators that may help therapists, education programs, and organizations develop their capacity for health equity work.

LIST OF ABBREVIATIONS AND SYMBOLS USED

ACOTRO – Association of Canadian Occupational Therapy Regulatory Organizations

ACOTUP – Association of Canadian Occupational Therapy University Programs

ANOVA – One-way analysis of variance

CAOT – Canadian Association of Occupational Therapists

CIHI – Canadian Institute for Health Information

COT – College of Occupational therapists

COTF – Canadian Occupational Therapy Foundation

DF – degree of freedom

IHE – Institute of Health Equity

IQR – Interquartile range

LGBT + – acronym for sexual orientation or gender identity minority groups

M – Mean

Mdn – Median

N – Number

NCCDH – National Collaborating Centre for Determinants of Health

OT – Occupational therapy

OT ID – Occupational therapist identification number

OTPAC – Occupational Therapy Professional Alliance of Canada

P – *p* value

PHAC – Public Health Agency of Canada

R – Spearman's correlation coefficient

SD – Standard deviation

SDOH – Social determinants of health

T – t-test results

WHO – World Health Organization

WMA – World Medical Association

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CHAPTER 1: INTRODUCTION

A recent report from the Public Health Agency of Canada [PHAC] (2018) revealed significant inequalities in health outcomes and in the distribution of social determinants of health within the Canadian population. This report provided evidence of clear socioeconomic gradients in life expectancies, causes of mortality, hospitalizations due to mental illness, functional impairments, chronic health conditions, and developmental vulnerabilities in childhood (PHAC, 2018). In addition, it showed that living on a low income is strongly associated with facing adverse determinants of health, such as unmet housing needs and food insecurity, while in contrast, a higher income is almost always associated with better results in health outcomes and daily living conditions (PHAC, 2018). This report also documented inequalities faced by Canadians from structurally disadvantaged groups, including Indigenous peoples, sexual and ethnic minority groups, recent immigrants, and people experiencing disability, in terms of health outcomes, but also in terms of the social factors that shape daily lives, such as housing needs, food security, learning and working conditions, and underemployment. In particular, the report revealed that Indigenous children and adults continue to experience widespread inequalities across most health outcomes and health determinants compared with non-Indigenous Canadians (PHAC, 2018). This report also showed that adults with functional impairments face higher unemployment rates and are less likely to complete university education than adults without impairments. Adults with functional impairments are also

disproportionately represented among Canadians living in poverty, with one in five adults in the lowest income group experiencing disability (PHAC, 2018).

The social determinants of health [SDOH] provide a conceptual framework to understand that systematic health disparities, such as those documented in the Public Health Agency of Canada report, are the result of complex social processes that shape an unequal distribution of power and access to resources in our society, rather than solely the result of biological or lifestyle risk factors (World Health Organization [WHO], 2010). Put differently, a SDOH framework allows recognition that where we are situated on the web of diversity, in terms of ethnicity, gender, dis-ability, sexuality, class, age, citizenship, or geography for instance, shapes our life opportunities (Giesbrecht, Crooks, & Morgan, 2016), as well as our health and occupational opportunities. Health inequities are thought to be the "subset of health inequalities that are deemed to be unfair or unjust, that arise from the systematic and intentional or unintentional marginalization of certain groups, and that are likely to reinforce or exacerbate disadvantage and vulnerability" (PHAC, 2018, p.14). While addressing the social determinants of health requires actions from different sectors of the society, there is a recognition in Canada and internationally that the health sector plays a particular role in reducing health inequities and that "ongoing efforts are needed to further promote and incorporate health equity and social determinants of health in the design and delivery of health care services" (PHAC, 2014, p. 26; see also WHO, 2010). In other words, there is a recognition that health professionals and others working in the health sector bear some responsibility in tackling the SDOH and health equity in

their work (Allen, Allen, Hogarth & Marmot, 2013; Brassolotto, Raphael, & Baldeo, 2013; Institute of Health Equity & World Medical Association [IHE & WMA], 2016).

Concurrently, there have been repeated calls within the occupational therapy profession to pay further attention to the SDOH and health equity and to critically examine the role of occupational therapists in addressing these issues (Bass & Baker, 2017; Bruggen, 2014; Gerlach, 2015; Hocking, Townsend, Gerlach, Huot, Laliberte Rudman & van Bruggen, 2015; Pitonyak, Mroz, & Fogelberg, 2015; Restall, MacLeod Schroeder & Dubé, 2018). Official documents guiding occupational therapy practice in Canada also note the importance of addressing the SDOH in occupational therapy practice. For instance, the *Profile of Occupational Therapy Practice in Canada* (Canadian Association of Occupational Therapists [CAOT], 2012) specifies that identifying the determinants of health affecting clients and contributing to advocacy for occupational needs related to the determinants of health are part of the core competencies expected from Canadian occupational therapists. The current Canadian occupational therapy guidelines (Townsend & Polatajko, 2013) also state that occupational therapists, in partnership with their clients, can play a leadership role in addressing system-level barriers to key determinants of health such as housing, employment, transportation, or education. Despite a growing awareness of the role of occupational therapists in addressing the SDOH, the review of the literature conducted for this thesis revealed a complete absence of evidence related to how occupational therapists understand and enact this role in their clinical practice.

The purpose of this research project, conducted for my thesis in the occupational therapy post-professional Master's program at Dalhousie University, is to describe the ways Canadian occupational therapists integrate health equity approaches into their everyday clinical work and what might enhance that work. My professional experience as a community-based pediatric occupational therapist in underserved neighborhoods in Montreal acted as a starting point for this research project. It draws on my gradual awareness of how broader social factors influenced the daily lives and occupational well-being of the children and families I worked with, but also shaped my routine occupational therapy practice. My collaboration with families led me to critically reflect on how my privileged position of a white, settler-descent, temporarily-able bodied, middle-class occupational therapist had shaped my opportunities for and perspectives on occupation and health and how I was unwittingly enacting these views in my interventions. In addition, the mainstream approaches in pediatric occupational therapy provided little guidance on how to address the lived experiences of adverse SDOH with families in my daily practice. Through the courses in my Master's degree, I explored critical theories in occupational therapy and occupational science, disability studies, and social sciences. I realized that, as an occupational therapist, I have been trained to listen and be responsive to individuals' stories, but not structural ones. Moreover, critical perspectives on SDOH and health equity and theorizing about social responsibility for social justice (Young, 2011) allowed me to think more clearly and deeply about how unequal structural processes operates and how everyday actions and interactions might contribute to these unjust processes, including in healthcare settings. Furthermore, while it was clear in my search of the literature that there was a theoretical commitment to equity and social justice within the occupational therapy

profession, the review of the literature also revealed a lack of concrete guidance on the local actions that occupational therapists can actually undertake to tackle these issues in their clinical practice.

In the research presented here, an online survey design was used to answer the following research questions:

(1) What are the current actions that Canadian occupational therapists undertake to address the SDOH and health equity in their everyday practice?

(2) What are the perceived barriers, enablers, and needs to better integrate health equity approaches in occupational therapy practice?

(3) How might the actions reported by occupational therapists be related to characteristics of their practice contexts or to factors associated with respondents' perceptions of or competencies in health equity approaches?

This thesis is divided in separate chapters that explore the integration of health equity approaches in occupational therapy practice. In the next chapter, chapter 2, I will present a review of the literature on the integration of the SDOH and health equity approaches in occupational therapy and will identify current gaps in the literature. Chapter 2 also includes important definitions and conceptual frameworks that form the theoretical basis of this study. In chapter 3, I explain the methodological approach for this descriptive study which employed an online survey method. Chapter 4 presents the survey results pertaining to each research question and chapter 5 provides a discussion of these findings as well as their implications for delivery of occupational therapy services, organizational decisions about

services, and occupational therapy education programs. Finally, the conclusion of this thesis presents a summary of this study, identifies limitations, practice and policy implications, and avenues for future research.

CHAPTER 2: REVIEW OF LITERATURE

The purpose of this chapter is to synthesize what is known about the integration of the SDOH and health equity in occupational therapy practice. More specifically, it will examine how the role of occupational therapists in tackling the SDOH and health equity has been described in the occupational therapy literature as well as the reports of how therapists are currently acting on these issues in their clinical work. While the focus is on the occupational therapy literature, this review also includes publications in the public health and health literature to contextualize current occupational therapy perspectives within a broader interdisciplinary discourse on SDOH and health equity. It is important to note that this synthesis doesn't aim to evaluate the effectiveness of occupational therapy approaches, but rather to provide an understanding of current equity-oriented approaches within the profession.

Defining the SDOH, health equity, and roles of health professionals

There are several models of determinants of health that have been developed to guide understanding and actions on health inequities and these models vary with regard to the factors that are included and in the ways these factors are understood to be interrelated (Giesbrecht et al., 2016). The WHO (2010) proposed a conceptual framework for the SDOH and health equity to understand the complex social processes that result in systematic health differences for specific social groups. The WHO's model emphasizes that structural factors, such as the educational system, the labour market, social and local policies, as well as societal values, norms, and systemic forms of discrimination, support

an unequal distribution of power and access to resources in our society. In turn, these structural determinants shape an inequitable distribution of the conditions in which people live, which are the more immediate determinants of health such as housing or working conditions, access to healthy food and water, community infrastructure, social support, and stressful life events among other realities. Behavioural factors, including healthy occupations such as physical activity or balanced diet as well as occupations regarded as presenting a health risk such as smoking or excessive alcohol use, are also well-documented determinants of health. However, the relationships between these 'lifestyle' factors and health inequalities are complex and the WHO (2010) brings forward the importance of understanding individual factors within the broader social contexts which interact in shaping individual behaviours. The health system is also included as a determinant of health in the WHO model. The role of the health system is particularly apparent with regard to differences in access, utilization, and outcomes of health services among different social groups. In this model, the health system is also understood to be well positioned to influence intersectoral and policy actions on structural determinants of health and social equity. As such, one of the most significant contributions of the WHO framework on SDOH is to highlight that actions to improve health equity must not be limited to approaches that focus on the downstream determinants, such as interventions that target individuals' knowledge, skills, or behaviours, but most also tackle the upstream determinants of health inequities through intersectoral and participatory approaches (WHO, 2010).

Health equity refers to the absence of unfair and remediable disparities in health across population groups (WHO, 2010). Put simply, health equity work is understood to be both a service delivery process, associated with ensuring equitable access to care, and a social change process, focused on upstream actions such as the development and implementation of healthy public policies for all (National Collaborating Centre for Determinants of Health [NCCDH], 2018). In recent years, there have been initiatives to better integrate health equity work and actions on the SDOH across the health sector in Canada (PHAC, 2014; NCCDH, 2018) and internationally (Allen et al., 2013). Conceptual frameworks have been developed to guide healthcare organizations and healthcare professionals on how to integrate actions on SDOH and health equity in their services and programs. For instance, the Institute of Health Equity and the World Medical Association (IHE & WMA, 2016) presented a report synthesizing the evidence on how healthcare professionals and their professional associations could tackle the SDOH in their work. The framework identifies six potential areas of actions, which are:

1- integrating the SDOH and relevant competencies in the education of health professionals;

2- building evidence about health inequalities and SDOH at the local and population levels;

3- addressing the SDOH in clinical encounters and building relationships with local communities;

4- addressing inequities within the healthcare system;

5- developing partnerships outside the health sector with community organizations and other government sectors; and

6- participating in advocacy on SDOH for and with individual clients, as well as at the local, national, and international levels.

Meanwhile, Wong and colleagues (2014) advanced that current indicators to evaluate and monitor health services in Canada put a focus on access to services and adherence to clinical guidelines for treatments. They pointed out that these indicators do not reflect the complexity of the work of front-line healthcare professionals and organizations providing services to groups most affected by structural inequities. Based on a review of the literature and the findings of an ethnographic study in two primary healthcare centers in low-income communities in Canada, the authors identified four dimensions to equity-oriented health services, which are:

1-inequity-responsive care, addressing social determinants of health as legitimate and routine aspects of health care;

2-trauma and violence informed care, that is, care that consists of respectful, trusting and affirming practices informed by understanding the pervasiveness and effects of trauma and violence;

3-contextually-tailored care, meaning the tailoring of services in ways that meet the needs of specific populations within local contexts; and

4-culturally-competent and culturally safe care, meaning attending to the cultural meanings people ascribe to health and illness and seriously taking into account their experiences of racism, discrimination and marginalization (Wong et al., 2014, p. 5).

Wong and colleagues (2014) also developed a set of specific indictors to guide equity-oriented services in primary care settings. From the point of view of research, these two conceptual frameworks are interesting because they identify dimensions of health equity work through which we can operationalize the practices of health professionals, including those of occupational therapists.

The intersection of SDOH and OT theoretical models

Occupational therapists have pointed out that the concept of SDOH is well aligned with the environmental factors in occupational therapy models like the Canadian Model of Occupational Performance and Engagement or the Person-Environment-Occupation Model (Bass & Baker, 2017; Bass & Haugen, 2016; Nilsson & Townsend, 2014). In occupational therapy models, the environment is understood to include not only the immediate physical and social environments, but also the impact of broader social factors such as social and cultural norms, as well as institutional environments, public services, policies, and legislation (Townsend & Polatajko, 2013). Furthermore, key determinants of health, such as employment, education, or food security, are associated with participation in meaningful activities and roles and pertain to the occupation component of occupational therapy models.

Theoretical texts in occupational therapy suggest that the distinctive analysis of occupation as a determinant of health for individuals and communities could contribute to a more comprehensive understanding of the relationship between occupation, participation, and well-being that may not be considered in usual public health actions on SDOH (Madsen,

Kanstrup, & Josephsson, 2016; Moll, Gewurtz, Krupa, Law, Larivière, Levasseur, 2015; Rosenfeld, Kramer, Levin, Barrett, & Acevedo-Garcia, 2018). However, a systematic review on the topic of health inequities in the occupational literature revealed that, despite the fact that occupational therapy models emphasize the transactional nature of occupation, environment, and health, there remains a lack of empirical knowledge to guide application of these occupational perspectives to work towards reducing health inequities in occupational therapy practice (Madsen et al., 2016). The literature review also showed some discrepancies in the way health inequities are approached in occupational therapy research. For one thing, the concept of health inequities is often framed as a matter of occupational injustice and Madsen and colleagues (2016) problematized the tendency within the profession to rename health equity issues in occupational terms without exploring more in depth the link between occupations and health inequities. For another, the review showed that research on health and occupations often focus on factors at the individual level, such as occupational choices, occupational balance, and routine, while the impacts of broader social and structural determinants remain under-theorized.

There is a growing interest within the profession in better integrating the broader social factors that are part of occupational therapy models into occupational therapy practice. For instance, Bass and Haugen asserted that "as occupational therapy has broadened its scope of practice to address health equity, participation, and community engagement, inclusion of social factors in the evaluation process has become critical to research on occupational performance and the development of effective occupational therapy interventions." (p.400, 2016). In a vignette about pediatric occupational therapy, Pitonyak and colleagues (2015)

employed a SDOH theoretical framework to guide the occupational analysis of breastfeeding in occupational therapy evaluation and interventions. In this vignette, they illustrated that child-focused interventions can be effective to improve the occupational performance in clinical settings, but these interventions may not elicit lasting positive changes for all families because occupational therapists do not identify with their clients nor address the structural barriers to occupations that are part of their clients' everyday lives, such as family income, social support, employment conditions, or childcare conditions for instance. Pitonyak and colleagues (2015) suggested that expanding occupational therapy professional reasoning to integrate the potential impacts of social determinants on clients' occupational realities could improve the outcomes of occupational therapy processes. At the same time, they raised the fact that occupational therapists' awareness about the influence of social determinants on client occupational participation is an aspect of client-centered practice that requires further study.

Concurrently, some occupational therapists have problematized the individualistic and biomedical analysis of occupation prevalent in occupational therapy routine assessments and interventions, clinical guidelines, research, and education which tend to focus on individuals' abilities or immediate physical and social environments (Gerlach, 2015; Gerlach, Teachman, Laliberte-Rudman, Aldrich, & Huot, 2018). They raise concerns about how occupational therapy approaches that overlook broader social determinants and that fail to engage the agency of those who experience structural disadvantages may inadvertently reproduce the social structures that promote health and occupational inequities (Gerlach, 2015; Gerlach et al., 2018; Trentham, Eadie, Gerlach & Restall, 2018).

At the same time, these individualistic and biomedical perspectives contribute to framing the social determinants of health as being beyond the scope of practice of health professionals (Brassolotto et al., 2013; Metzl & Hansen, 2014).

Reports of actions on SDOH and health equity in OT

While the occupational therapy literature on health equity is still emerging (Gerlach, 2015; Madsen et al., 2016), a scan of literature shows that occupational therapists, in Canada and abroad, are already involved in a range of actions on the social determinants of health. However, it is important to note that existing approaches in occupational therapy that address the SDOH may be labelled differently within the occupational literature. In addition, while many health professionals regularly engage in interventions that could have a positive impact on the SDOH, theses interventions are rarely monitored or shared in concrete guidelines to support practices (Brassolotto et al., 2013; IHE & WMA, 2016). In turn, this makes it difficult to gain a shared understanding of what occupational therapists, and other health professionals, do or could do to act on the SDOH in their everyday practices.

A predominant perspective found in the literature is to situate the role of occupational therapists in addressing the SDOH as being part of emerging occupational therapy practices beyond interventions with individuals to approaches at the community and population levels (Bass & Baker, 2017; Bruggen, 2014; Kirsh, 2015). For instance, occupational therapists are bringing their occupational and enablement perspectives to contribute to population-based activities such as health promotion and prevention (Moll et al., 2015),

public funded initiatives such as “Housing First” or “Employment first” (Kirsh, 2015; Mazumder, Duebel, Hoselton, & Anand, 2016) and policy analysis and development in areas like inclusive education and employment (Bruggen 2014; Kirsh, 2015; Malfitano & Lopes, 2018; Mazumder et al., 2016). Occupational therapists in Canada and internationally are also contributing to community development initiatives, working with local communities to identify the health issues, occupational needs, and assets of the community, and building communities’ capacity to identify and implement sustainable solutions that will contribute to their collective well-being (Bruggen, 2014; Lauckner, Krupa, & Paterson, 2011; Leclair, 2010; Malfitano & Lopes, 2018). In addition, we know that some occupational therapists undertake participatory research with people with lived experiences of structural disadvantages to advocate for and inform policy changes (Gerlach et al., 2018; Kirsh, 2015). For example, occupational therapy researchers and injured workers collaborated on a research program to describe and address the stigma injured workers faced within the healthcare and workers’ compensation systems in Ontario and that negatively impact workers’ health recovery and return to work (Kirsh, 2015).

Drawing on a critical analysis of actions on SDOH, we can see that these examples of occupational therapists’ actions reflect an understanding of the SDOH that includes the societal structures which result in social and health inequities (Brassolotto et al. 2013). These approaches are also coherent with WHO’s recommendations to pay further attention to policy actions to reduce structural inequities as well as the importance of the active participation of communities in designing and implementing actions to improve the SDOH (WHO, 2010). However, the reports above come from research and emerging areas of

practices outside the health system. It is reasonable to assert that they give little concrete guidance to occupational therapy practitioners about how to approach these issues in clinical settings. However, the great majority (87 %) of Canadian occupational therapists are clinicians and about half work in hospital and long-term care settings (Canadian Institute for Health Information [CIHI], 2017). Therefore, building evidence on how to address these issues in everyday clinical practice is important because, although health professionals generally recognize the SDOH that impact the lived realities of their clients, many remain uncertain about how to address these issues in their routine clinical practices (Andermann, 2018; Metzl & Hansen, 2014; Tallon, Kendall, Priddis, Newall, & Young, 2017). Furthermore, lack of clarity about their mandates to address the SDOH and the limited availability of evidence to guide practice have been identified as barriers by health professionals (Naz, Rosenberg, Andersson, Labonté, & Andermann, 2016), including public health nurses (McPherson, Ndumbe-Eyoh, Betker, Oickle, & Peroff-Johnston, 2016) and public health professionals (Brassolotto et al., 2013).

The literature provides some insights on how actions on SDOH can be integrated into occupational therapy clinical work and programs. For instance, the College of Occupational therapists [COT], the organization that govern the occupational therapy profession in the United Kingdom, participated in a national report on health equity and provided a statement about actions occupational therapists could take in their clinical role. This statement emphasizes that occupational therapists address key determinants of health by providing rehabilitation services, like early childhood interventions, vocational rehabilitation in mental health, or illness and injury prevention services, by making sure

occupational therapy services are accessible for all and, therefore, ensuring that 'health inequities which might arise as the result of impairment are minimised' (p.78, COT, 2013). While the provision of rehabilitation services to individuals who need them is certainly central to the mandate of occupational therapists in the health sector, we can argue that this official statement puts forward a rather narrow and predominantly biomedical understanding of the role of occupational therapists in addressing the SDOH. Ensuring access to services is but a small piece of health equity work.

An important aspect of equity-oriented approaches in clinical settings described in the literature is for occupational therapists and other healthcare professionals to ask about and be responsive to their clients' self-identified priorities pertaining to SDOH, such as food and housing security or making ends meet every month (Gerlach, 2015; IHE & WMA, 2016). In a research project involving Indigenous families and service providers in urban settings in British Columbia, Gerlach and colleagues (Gerlach, Browne, & Suto, 2018) described how early child development programs with families who face structural disadvantages require that service providers shift away from child-focused interventions and adopt a model of service delivery that encompasses how poverty and other intersecting structural factors impact the whole family. Their study stressed the need to move towards a strengths-based approach in rehabilitation that value families' and communities' experiences and expertise, to center interventions on families' self-identified priorities, to support families' agency and the creation of social networks through group programs, to help families navigate and access a wide range of health, social, and cultural programs, and to mitigate potential discrimination within the healthcare and social services systems

(Gerlach et al, 2018b). Drawing from their work and research experiences with clients from marginalized groups in Brazil, Malfitano and Lopes (2018) similarly argued that the role of occupational therapists in addressing inequities includes building relationships with local communities, identifying clients' self-identified priorities and collective needs, and connecting clients to community resources and appropriate services within and outside the health sector.

There is an emerging body of research on how to integrate the assessment of SDOH-related needs in clinical encounters (Andermann, 2018) or as part of the admission process in healthcare settings (Williams-Roberts, Neudorf, Abonyi, Muhajarine, & Cushon, 2018). Collecting information on SDOH is described as being beneficial for healthcare professionals and administrators to understand the social needs of communities using their services, to support advocacy for funding, to evaluate health equity initiatives more accurately, and to inform service improvement (IHE & WMA, 2016; Williams-Roberts et al., 2018). While the research to recommend systematic screening for SDOH with clients remains mixed and limited, clinical tools are available to help health professionals identify with their clients the social and economic factors impacting their everyday lives and adapt the intervention plans to address the identified issues (Andermann, 2018; IHE & WMA, 2016). Similarly, occupational therapists can use a growing number of clinical tools to identify the potential impact of social factors on client occupational participation during evaluation and intervention planning (for example, see a review by Bass and Haugen, 2016; Rosenfeld et al., 2018). To date, we know little about the extent to which occupational therapists attend to the SDOH in clinical encounters. However, we know from two

integrative reviews in pediatric care (Albaek, Kinn, & Milde, 2018; Tallon et al., 2017) and from an implementation study in Canadian healthcare settings (Williams-Roberts et al., 2018) that many healthcare professionals feel uncomfortable and perceive they lack the competencies to ask about often stigmatized and sensitive psychosocial issues and to respond to these issues in a way that would be beneficial for their clients. Several studies also reported organizational constraints to addressing the SDOH in clinical settings such as the prevailing medical model, limited availability of clinical tools appropriate to their practice contexts, time pressure, workload measurement tools, funding which prioritizes the delivery of direct services, lack of buy-in by management, compassion fatigue and burn-out among healthcare workers, as well as a lack of resources and of effective partnerships with other organizations to meet clients' social needs (Albaek et al., 2018; IHE & WMA, 2016; Tallon et al., 2017; Williams-Roberts et al., 2018).

Some authors noted that the role of occupational therapists in addressing SDOH and health equity must include a critical reflection and transformation of the routine practices and processes in occupational therapy and in the healthcare system that may inadvertently perpetuate health inequities (Gerlach, 2015; Gerlach et al, 2018; Jull & Giles, 2012; Restall, et al., 2018; Trentham et al., 2018). For instance, Restall and colleagues recently reaffirmed that occupational therapists have the responsibility "to become increasingly aware of the social factors that impact peoples' health and access to (as well as the utilization of) health care and to use their skills and influence to address these factors" (p.187, 2018; parentheses are from me). These Canadian occupational therapists designed the *Equity Lens for Occupational Therapy* tool to help therapists evaluate the potential effects of occupational

therapy programs on health inequities among the local populations who access their services (Restall et al., 2018). Their tool consists of a series of reflective questions which use the SDOH as a framework to help identify tangible actions to reduce healthcare inequities related to the access, utilization, or outcomes of occupational therapy services.

There also have been calls to apply principles of cultural safety in occupational therapy to more effectively address the SDOH and healthcare inequities faced by Canadian Indigenous peoples (Jull & Giles, 2012; Trentham et al., 2018). This approach requires that occupational therapists become aware of the personal and professional assumptions and blind spots that they bring to healthcare encounters, as well as the impacts of colonization and other inequitable power relations on Indigenous peoples' access to and experiences of health services, including occupational therapy (Trentham et al., 2018). Echoing WHO's recommendations for more participatory spaces in healthcare organizations (WHO, 2010), cultural safety also stresses that the active participation of Indigenous communities in organizational decisions regarding the planning, delivery, and evaluation of occupational therapy services is key to addressing more effectively the SDOH experienced by Indigenous communities (Jull & Giles, 2012). Concurrently, in a critical perspective on client-centred practice in occupational therapy, Hammell (2016) argued that developing structural competency constitutes an important aspect of client-centred occupational therapy. Structural competency (Metzl & Hansen, 2014) is defined as the ability of healthcare providers to identify the impact of institutional and social factors – such as public policies and upstream decisions, poverty, stigma, racism, ableism, colonialism and other forms of discrimination– on clinical-level issues, as well as their commitment to

address the structural determinants of inequities and to interrupt individual and institutional practices that sustains health and healthcare inequities (Browne, 2017; Hansen & Metzl, 2019; Metzl & Hansen, 2014). However, we know very little about how these approaches are perceived by occupational therapy clinicians nor about the factors that would facilitate the integration of these equity-oriented approaches into their work.

Summary and significance

This chapter sought to examine how the role of occupational therapists in tackling the SDOH and health inequities has been described in the occupational therapy literature as well as reports regarding how therapists are currently addressing these issues in their clinical work. This synthesis shows that there is a growing consensus that occupational therapists have a role and a responsibility in addressing SDOH and health equity in their practices. However, there is a gap between this theoretical commitment and the lack of available evidence and concrete guidance on the local actions that occupational therapists can actually undertake in their clinical practice. Again, documenting the current understandings and actions taken by occupational therapy practitioners to act on the SDOH and health equity as well as the supports needed to tackle these issues in their everyday practices is an important starting point to support more equitable and socially responsive occupational therapy. Sharing these experiences could also contribute to making visible the opportunities for occupational therapists to take actions on the SDOH in their clinical work and fostering occupational therapists' individual and collective capability to act on the SDOH and health inequities.

CHAPTER 3: METHODOLOGY

Research questions

The overall aim of this research project was to describe how equity-oriented approaches are currently understood and implemented in everyday occupational therapy practice in Canada as well as what might enhance that work.

The research questions guiding this research process were:

1. What are the current actions that Canadian occupational therapists undertake to address the SDOH and health equity in their everyday practice?
2. What are the perceived barriers, enablers, and needs to better integrate health equity approaches in occupational therapy practice?
3. How might the actions reported by occupational therapists be related to characteristics of their practice contexts or to factors associated with respondents' perceptions of or competencies in health equity approaches?

Research design

Overview methodology

To explore the current state of practices of Canadian occupational therapists related to SDOH and health equity as well as the possible factors influencing their work, I conducted a descriptive study employing an online survey method. A descriptive design is a quantitative design that aims to provide a comprehensive and well-grounded representation of the characteristics of a group or situation and to explore potential relationships among

the variables under study as they naturally occur (Depoy and Gitlin, 2016). Since the integration of SDOH and health equity approaches in occupational therapy practice has been discussed in theoretical studies and position papers, but has not been addressed empirically within the profession, descriptive research was an appropriate choice for this research project, providing a basic, yet accurate, synthesis of the current practices, opportunities for actions, and challenges encountered by Canadian occupational therapists in their clinical work.

The online survey method is characterized by data collection that uses digital questionnaires and that relies on the internet at various steps of the survey process (Vehovar & Manfreda, 2017). An online survey provided the opportunity to reach occupational therapy practitioners across a wide range of practice settings and geographic regions more easily than in a more qualitative design. This increased the possibility to have a study sample representative of various practice contexts across the country. By the same token, it enabled me to explore and document if practice patterns and therapists' understanding of the issues vary across areas of practice, work settings, client groups, types of funding, or provinces for instance. From a more pragmatic perspective, online survey was also an effective research method in terms of time and resources which increased the feasibility of the study in the context of my Master's degree.

This research project was informed by a post-positivism paradigm. Like positivism, post-positivism assumes that a social phenomenon can be studied objectively, that relationships between factors can be identified, and that findings from a sample can produce a valid description of a broader social context (Ponterotto, 2005). However, a post-positivist

paradigm acknowledges that 'true reality' can only be measured imperfectly and that the researcher's bias, assumptions, and values may impact the study (Ponterotto, 2005). During this project, I was aware that my professional background as a community-based occupational therapist in low-income communities in Montreal, my middle-class socioeconomic status, my personal experience of having a brother who experiences disability, my position as a novice researcher and graduate student, and my values and perspectives on social justice, all had an influence on the research process. Nonetheless, this awareness encouraged me to aim for objectivity and transparency during the research process in an attempt to better capture the multiple perspectives of respondents and to generate findings that could have real-word applicability and relevance for occupational therapy practice.

It is also important to say that critical theoretical perspectives on health equity and structural inequities served as a theoretical anchor for this research process. This project was informed by critical theories on power relations and how they pertain to the analysis and actions on the SDOH (WHO, 2010; Raphael, 2011) and on shared responsibility and collective actions on structural inequities (Young, 2011). For Young (2011), taking responsibility for structural inequity, such as health and healthcare inequities, requires that we join with others in collective actions to changes the institutional habits and processes that produce unjust outcomes and systemic disadvantage to some and to which we contribute (often unwittingly) in our everyday actions. From an occupational therapy perspective, a critical analysis of power relations also encouraged me to look at how certain ideas and practices dominate within the profession, while others tend to be marginalized,

and how structural factors such as policy, organizational factors, and funding mechanisms shapes occupational therapy practices (Townsend & Polatajko, 2013).

Study sample and recruitment

The study sample included Canadian occupational therapists who matched the following inclusion criteria:

- were registered to their provincial professional organization;
- were currently providing direct occupational therapy services as part of their work.

For the purpose of the study, direct services were defined as services to individual clients including clinical, case management, or consultation services. The questionnaire began with two screening questions to verify if respondents matched the inclusion criteria. If not, they were sent to a thank you message and exited the survey. There were no additional exclusion criteria. Respondents could complete the survey in French or in English depending on their language preference.

Self-selection sampling, a type of convenience sampling in online surveys, was employed to recruit potential respondents. This strategy combines various recruitment channels on the internet in order to publish the survey invitation on different online platforms and reach a broad sample (Vehovar & Manfreda, 2017). Recruitment invitations were sent to Canadian occupational therapists of the different provincial occupational therapy associations in October 2019. Those who saw the study information and were interested simply needed to click the hyperlink to access the consent information and survey. The type of invitation (i.e. email and reminders, publication in the association's newsletter, publication on the association's Facebook page) varied depending on the requirements of

each provincial association. The provincial associations from Prince Edward Island and Newfoundland and Labrador didn't respond when they were contacted to publish a recruitment invitation to their members. Therefore, email invitations to current postgraduate students in occupational therapy at Dalhousie University and publications on the Facebook page of the Dalhousie School of occupational therapy were used in an attempt to reach occupational therapists from the Atlantic region. The link to the survey was also published on the research page of the Canadian Occupational Therapy Association. Lastly, the email invitations were distributed through relevant CAOT practice networks. Examples of the recruitment invitation are in Appendix A and Appendix B.

Research instrument

The study used a self-administered online questionnaire mounted on Opinio software. Since there was no available questionnaire to inquire about health equity and SDOH approaches in occupational therapy, I developed a questionnaire based on a review of the literature, existing frameworks and health equity indicators in health services, published research on the topic, insights from my clinical experience, as well as feedback from my committee and informants who tested the questionnaire draft.

For the purpose of this study, the concept of "action on the SDOH and health equity" in occupational therapy practice was operationalized into 5 domains:

1- addressing the SDOH with clients during the OT practice process;

2- adopting equity-oriented practices in the evaluation of OT services;

3- partnering with communities and other government sectors;

4- integrating SDOH and health equity in education activities;

5- advocating for the occupational needs related to the SDOH at the individual, local and system levels.

These domains and associated professional activities were adapted from the approaches identified in "Guidelines for doctors: Tackling the social determinants of health" (IHE & WMA, 2016), health equity indicators in healthcare settings developed by Wong and colleagues (2014; Browne, Varcoe, Ford-Gilboe & Wathen, 2015), and competencies related to the SDOH identified in the *Profile of Occupational Therapy Practice in Canada* (CAOT, 2012).

Barriers, enablers and needs related to the integration of equity-oriented approaches were operationalized into 4 domains of factors known for influencing the implementation of clinical practices in the literature (Cabana, Rand, Powe, Wu, Wilson, Abboud & Rubin, 1999), which are:

1- factors related to therapists' attitudes (i.e., perceived scope of practice, perceived relevance);
2- factors related to therapists' competencies (i.e., self-efficacity, knowledge, practical competencies);
3- outcome expectancy and client-related factors;
4- environmental factors (i.e., resources, organizational factors, practice settings).

A matrix was used to develop survey items that covered the different aspects of the research questions and served as an analysis plan for potential associations between variables.

The survey questionnaire consisted of three sections as well as information regarding the definitions used in the survey to ensure that respondents interpret these main concepts in a similar manner. The first section of the questionnaire included multiple-choice questions on respondents' practice context adapted from the CAOT membership profile. It also included a series of questions in which respondents were asked to report the frequency with which they provide services to clients from different structurally disadvantaged groups. The second section mainly consisted of closed-ended and scaled questions in which respondents were asked to report how frequently they used professional activities in the five identified domains and their perceptions (i.e., level of agreement, perceived barrier, level of importance, perceived needs) on aspects of their practice regarding health equity work. Positive and negative statements were included on the same issues in order to break response patterns associated with acquiescence bias. Likert-type scales were constructed to have a balanced number of response options on both sides of the scale. A separated "no answer" option was also provided so that respondents were not forced to select a response that may not have been accurate for them or as an option for those who preferred to skip the item for various reasons. To reduce possible social desirability in questions on self-reported actions, the structure of the questions normalized the range of answers and the item lists included options that most respondents were likely to give a positive answer to. Closed-ended questions were usually followed by an open-ended question which provided the opportunity for respondents to describe more closely their practice and may have reduced the risk of making the response process irritating because the response options did not reflect the respondents' experiences (Fowler, 2009). The last section included demographic data on respondents. These questions were put at the end of the survey

because they could be perceived as sensitive questions for respondents and could affect subsequent answers (Fowler, 2009). The final version of the questionnaire is in Appendix C. I translated the questionnaire in French, because it is my native language and I have an excellent command of occupational therapy terminology in French. The French version of the questionnaire is in Appendix D.

The online questionnaire was tested with 5 occupational therapists from different linguistic and practice backgrounds. Testers were asked to assess survey items in terms of how easy they were to understand, how easy they were to answer with response choices available, and indicate if the item was perceived as not relevant to their practice. They were also asked to assess the time it took to complete the survey and to report any problems with the navigation or layout of the survey on the computer, tablet, or smartphone. A few modifications to the questionnaire were done based on their feedback in order to eliminate any double-barrelled questions and create more exhaustive response categories. An open-ended question situated at the end of the survey was judged very relevant to their practice by 3 of the 5 testers but was not answered by any of them because of survey fatigue. This question was inserted in the middle of the survey in an attempt to increase its response rate. All the responses of the testers were not included in the final data set.

Data collection and analysis

The online survey was mounted on the Opinio platform and available online from October 1st, 2019 to December 1st, 2019. Opinio is a survey software that allows researchers to design, publish, collect and manage survey data online. During the collection data process,

the survey data was stored on Dalhousie servers which provide a secure storage of data and help to protect the privacy of respondents.

Collected data was coded and cleaned for initial analysis directly on the Opinio server and then transferred to the Statistical Package for the Social Sciences software to perform descriptive statistical analysis. Precoding of survey data included eliminating responses from respondents who did not meet the inclusion criteria, attributing a numerical value to scaled items and attributing a code to missing data. Precoding also included a review of open-ended responses provided by respondents when they selected the "other response" category. In several cases, these responses matched an existing category and they were re-coded as appropriate. Later, to analyze qualitative data obtained in open-ended questions, codes were developed to identify responses that supported items included in the survey and to identify new themes and ideas that emerge from answers. During the data analysis process, qualitative answers were used to enrich, illustrate, or contrast results from the statistical analysis.

In the first review of the results, it became apparent that response rate varied significantly between provinces because of the different recruitment methods used by each provincial association. Given the initial over-representation of respondents from Quebec (n=165) and the under-representation of those from British Columbia (n=6) compared to the data from the 2018 Canadian Association of Occupational Therapists membership statistics, a weight was calculated for each province. In order to improve the quality and analytic strength of the collected data, these weights were applied to all cases, except the six cases from British

Colombia, where data weighting would have exacerbated sample bias. Those six cases were excluded from subsequent quantitative analysis.

Characteristics of practice settings and demographic data were analyzed descriptively and compared to available data from the CAOT membership statistics to describe the study sample and estimate its representativeness. Univariate analysis was conducted to depict the frequency and dispersion of responses for each survey item. For instance, percent distribution, medians, and interquartile ranges were calculated to depict the extent to which survey respondents agreed or disagreed with statements describing aspects of occupational therapy practice. For each domain of actions, the Cronbach's alpha coefficient was calculated to explore the extent to which the actions within each domain were in fact related to one another, thus comprising a distinct domain of action. Correlational analyses were conducted to explore potential associations between the reported actions and factors related to respondents' attitudes, perceived competencies, client-related factors, and factors associated with their practice context. More precisely, Spearman's rho correlations were calculated to examine the relationship between two ordinal variables. In addition, to explore possible differences between respondents' practice contexts and the integration of health equity actions in their practice, independent sample T-tests were conducted to compare the means of two subgroups of respondents, and a one-way analysis of variance (ANOVA) was conducted when comparing the means of more than two subgroups. However, given that data from Likert-scale are ordinal variables and not normally distributed, it would have been more appropriate to conduct non-parametric tests to analysis differences between subgroups, more precisely the Mann-Whitney U test to

compare two groups of respondents and the Kruskal-Wallis test for three groups and more. It is also important to note that conducting multiple statistical comparisons to explore associations between items in the survey increases the chance of Type 1 error, or 'false positive' results. However, because the analysis is exploratory rather than hypothesis-testing, I did not use any statistical correction for multiple comparisons. A p value of .005 or smaller was employed for all statistical tests, since a smaller threshold has stronger evidence against the null hypothesis.

Ethical considerations

The research project received the approval from the Research Ethics Board at Dalhousie University in July 2019.

Informed consent process

The consent form appeared at the beginning of the survey and provided information on the research aims, what respondents were asked to do and an estimated time required to complete the survey, confidentiality, risks and potential benefits of the study, and contact information of the main research team and of the Dalhousie Research Ethics Office. The consent form is in Appendix E. The fact that respondents completed the survey indicated consent. Also, it was clearly indicated on the consent form that participation to the survey was voluntary, that respondents may skip any survey questions they do not wish to answer, and that they may end their participation simply by exiting the survey and closing their browser. However, the consent form specified that if respondents exited the survey before its completion, the answers that they have already provided were going to be included in

the study data in aggregate statistical form and could not be removed. At the beginning of the survey, all respondents had the opportunity to enter their email or the name and email of a non-profit organization in a cash-price draw as a gesture of my appreciation for their participation. All emails remained in the draw even if respondents decided to exit the survey before its completion.

Privacy and confidentiality

All electronic data received from respondents on Opinio were managed and maintained in a secure and confidential manner on Dalhousie University's servers accessible only to myself and my supervisor. Emails obtained for the draw were kept separate from the actual survey data set and deleted from the Opinio platform after the draw in December 2019. After the data collection process, electronic data were transferred in an aggregate format on my personal computer, which is password protected. The data set was encrypted using VeraCrypt. The study data set will be stored in an aggregate and encrypted form for a period of 7 years after the completion of this study, after which it will be destroyed. Study results are presented in an anonymous and aggregate statistical form. Quotations from open-ended questions in the survey are presented anonymously and with no identifying information. In addition, respondents had the option to refuse consent for quotes from their answers to be used in the consent form. Demographics and practice contexts were used in aggregate form to analyze their influences on the integration of health equity approaches in practice, but individual data was not presented with those demographics which could render a respondent identifiable.

Risk and benefit analysis

There was no direct benefit for participants in this research. However, it is anticipated that the study results might contribute to better understanding the current practice patterns and needs of Canadian occupational therapists related to health equity and inform further research, education, and practices to address identified gaps and priorities.

It is estimated that the risks associated with this study were no greater than those participants encounter in their everyday life. However, given that the survey asked questions about health and social inequities and about challenges that occupational therapists may encounter in their practice, there was a risk that questions may provoke emotional or moral discomfort for some respondents based on their past or current experiences. In the consent form, respondents were encouraged to engage in self-care practice and contact their professional practice leaders or peers for debriefing if needed. No study participant expressed complaints, or reported any difficulties in relation to their participation in the study.

Dissemination plan and access to study results

Because the participation in this study was anonymous and the data was analysed in an aggregate form, it was not possible to communicate the results of the study directly to the respondents. However, the study results are being published as part of my Master's thesis, results were presented in a poster at the CAOT Conference in May 2020 and, possibly in a peer-reviewed journal.

Summary

In this chapter, I have identified the main research questions and survey method that were used to describe the integration of SDOH and health equity approaches in the occupational therapy practice in a relatively large sample of Canadian occupational therapists. The next chapter will present a description the results of the survey.

CHAPTER 4: FINDINGS

The online survey was mounted on the Opinio platform and available online from October 1st, 2019 to December 1st, 2019. When the survey closed, 461 survey forms were received. Of these 461 respondents, 54 did not meet the inclusion criteria: 20 respondents were not currently registered as an occupational therapist in Canada, and 34 were not currently providing direct occupational therapy services as part of their work. In addition, 35 forms were empty after the section on practice contexts and were excluded from the analysis. As discussed in the previous chapter, given the initial over-representation of respondents from Quebec (n=165) and the under-representation of those from British Columbia (n=6) compared to the data from the 2018 Canadian Association of Occupational Therapists membership statistics, a weight was calculated for each province and applied to all cases, except the six cases from British Colombia, where data weighting would have exacerbated sample bias. Those six cases were excluded from subsequent quantitative analysis. This left a total of 366 weighted cases for quantitative analysis and 372 cases for the analysis of open-ended responses. No respondents from Prince Edward Island completed the survey.

Given the self-selecting recruitment method online, it was not possible to calculate the response rate for the survey. However, the demographics and practice characteristics of the sample were compared to available data from the recent Canadian Association of Occupational Therapists membership statistics (CIHI, 2017) to estimate sample representativeness. The observed frequencies in the sample and CAOT membership data

are similar for age, gender, level of education, years of practice, geographic areas, and sites of practice (see observed vs expected percent in Table 1 and Table 2).

Characteristics of respondents

Practice characteristics

Respondents were asked to provide general information about their practice contexts including their geographic areas, professional roles, and practice settings. Respondents were able to choose multiple options for each question. Therefore, the calculated percentage represents the portion of respondents who selected each option. Table 1 shows the summary of the practice characteristics of respondents.

Recall that one of the inclusion criteria for the study was that respondents must be currently providing direct occupational therapy services as part of their work. For the purpose of the study, direct services were defined as services to individual clients including clinical, case management, or consultation services. The vast majority of respondents indicated that they were clinicians (90,1%) which is a proportion very close to the proportion of the Canadian occupational therapy workforce overall (87,9%; CIHI, 2017). Some respondents also indicated that they were consultants (17,3%), case managers (10,9%), coordinators or administrators (9,1%), professors (3,8%), or researchers (1,8%) as part of their professional roles. Community agencies (33,0%), general hospitals (21,3%), private sectors (20,3%) and rehabilitation facilities (16,8%) were the main employers for the respondents. In addition, 81,5% of the respondents indicated working within the public health sector in their province.

Table 1: Practice characteristics of survey respondents

Characteristics	Frequency (N=366)	Weighted %	Expected % Based on the Canadian OT population (CIHI, 2017)
Province			
Alberta	48	14.0	12.1
British Columbia	6	---	13.0
Manitoba	34	4.3	3.7
New Brunswick	7	2.4	2.0
Newfoundland	4	1.4	1.2
Nova Scotia	9	3.4	3.0
Territories	4	.2	.2
Ontario	70	38.1	33.0
Quebec	183	34.0	29.5
Saskatchewan	9	2.2	1.9
Geographic Region of Practice			
Remote region	21	4.9	5.2
Rural region	64	18.5	---
Small urban center	42	12.6	---
Medium urban center	65	16.2	---
Large urban center	234	66.9	---
Urban center (total)		95.7	94.8
Professional roles			
Clinician	333	90.1	87.9
Case manager	32	10.9	7.4
Consultant	61	17.3	---
Coordinator/Administrator	33	9.1	2.3
Professor	15	3.8	1.5
Researcher	9	1.8	.9
Practice settings			
General hospital	70	21.3	43.6
Rehabilitation facilities	67	16.8	---
Mental Health facilities	33	10.5	---
Long-term care facilities	33	9.8	4.5
Community	114	33.0	41.2
Private Practice	68	20.3	---
School	27	7.3	---
Primary source of funding			
Public	302	81.5	---
Private	69	20.1	---

In terms of geographic areas, the majority of respondents indicated working in a large urban center (66,9%) and only a smaller proportion indicated working in rural (18,5%) or remote regions (4,9%). As described earlier, participation in the survey varied significantly between provinces because the channels to contact members differed for each provincial professional association. Therefore, there were proportionally more respondents from provinces where it was possible to send emails and reminders to occupational therapists through their provincial associations (i.e., Quebec, Manitoba, Alberta).

Respondents were also asked to identify how frequently they worked with service users from structurally disadvantaged groups in their current work. Six service user groups were identified: service users who live on low income, who are homeless or home insecure, who are recent immigrants or refugees, who are from Indigenous groups, who are from ethnic or cultural minority groups, and who are from sexual or gender identity minority groups. Figure 1 provides an overview of the results.

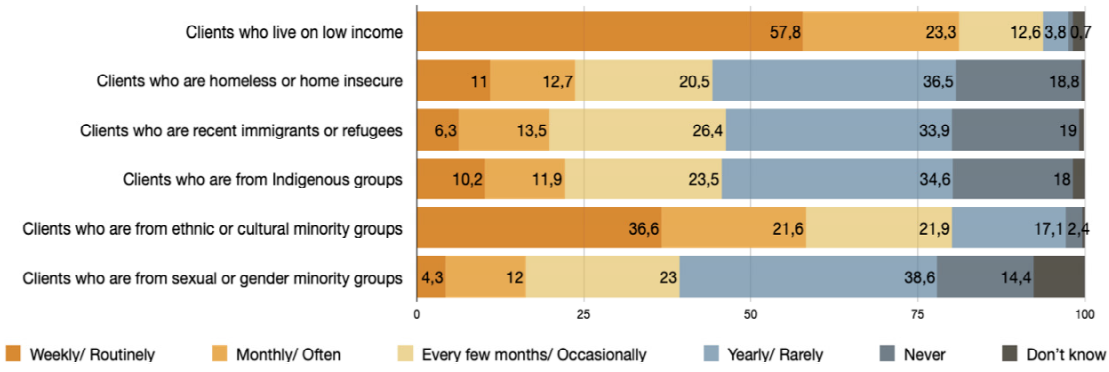

Figure 1: Frequency of work with clients from structurally disadvantaged group (percentage per response category)

Overall, respondents reported working most frequently with service users who live on low income and service users from ethnic or cultural minority groups, with 93,7% and 80,1% of respondents indicating that they were providing services to these groups at least occasionally. In contrast, less than half of the respondents reported providing OT services at least occasionally to services users who are homeless or home insecure (44.2%), who are recent immigrants or refugees (46.2%), who are from indigenous groups (45.6%), or who are from sexual or gender identity minority groups (39.3%). In open-ended responses, respondents also identified service users who are drug users, elderly people, those who experience persistent mental illness and those from linguistic minorities who are not fluent in the official languages as population groups who face disadvantage.

Demographic profile

In order to describe the sample of occupational therapists who responded to the survey, respondents were asked questions about age, education, and experience. They were also asked questions about their social and self-identity in an attempt to have some insights on the social and cultural diversity of the Canadian occupational therapists who participated to the survey. Sociodemographic data on the Canadian occupational therapy workforce documented by the CAOT is currently limited to age and gender (CIHI, 2017) so there is no national comparator. Table 2 summarizes the demographic characteristics of the respondents. The sociodemographic section was situated at the end of the survey and respondents who completed this section were fewer than in the rest of the survey (see Table 2). Most of the questions in this section were open-ended and the descriptions provided by the respondents were coded by the researcher into main categories afterwards.

Table 2 : Sociodemographic characteristics of survey respondents

Characteristics	Frequency	Weighted %	Expected % based on Canadian OT populations (CIHI, 2017)
Age (N=283)			
Average age = 38,7			40
20 to 29	70	22,3	17,8
30 to 39	94	33,0	34,3
40 to 49	70	26,0	27,4
50 to 59	39	13,5	16,1
60 and older	10	5,2	4,5
Year of practice (N=285)			
0 to 10	128	45,1	40,7
11 to 20	78	26,3	29,7
21 to 30	61	20,6	19,7
31 and more	18	8,0	9,8
Highest level of education (N=291)			
Bachelor's degree – Entry to OT practice	124	40,7	52,0
Master's degree – Entry to OT practice	140	50,1	46,5
Other Master's degree	20	7,0	---
Diploma & Graduate certificate	4	1,5	1,4
Doctorate degree	3	0,8	0,1
Gender and sexual self-identity (N=258)			
Female	241	93,0	91,2
Male	15	6,3	8,9
Heterosexual	116	95,4	---
Sexual and gender minority	7	4,6	---
Ethnic and cultural self-identity (N= 206)			
Caucasian/European descent	179	82,7	---
First Nations, Metis, Inuit	3	1,7	---
Asian descent	18	12,1	---
African descent	2	0,7	---
Other ethnic minority	4	2,8	---
Is disability part of your self-identity (N=280)			
Yes	20	9,8	---
No	260	90,2	---
Socioeconomic background during childhood (N=286)			
Upper class	9	3,9	---
Upper middle class	69	21,8	---
Middle class	137	47,1	---
Lower middle class	36	13,8	---
Working class	34	13,3	---
Poverty	1	0,2	---

The majority of respondents in the study were between 30 and 49 years of age (59,0%) and had 10 years or more of practice as an occupational therapist (58,4%). Most respondents completed an entry-to-practice master's degree in occupational therapy (50,1%), and 7,8% of respondents indicated that they had completed another master's or doctorate degree. The vast majority of occupational therapists who participated in the study self-identified as women (93,0%), from a Caucasian background (82,7%), and reported coming from a middle class or higher socioeconomic background (86,5%). Only a small number of the respondents self-identified as being part of a gender identity or sexual minority group (4,6%), as being part of an Indigenous (1,7%) or ethnic minority group (15,6%), indicated that they were raised in a lower socioeconomic background (13,5%), or indicated that disability was part of their self-identity (9,8%).

Actions currently undertaken in OT practice

The aim of this section is to present the results to answer the first question of this research project: "What are the current actions that Canadian occupational therapists undertake to address the SDOH and health equity in their everyday practices?". My aim is not to provide a detailed description or evaluation of each of these approaches, but rather to provide an overview of the range of actions that are currently undertaken by Canadian occupational therapists and to make visible current contributions, gaps, and opportunities for occupational therapists to take actions on the SDOH and health equity in their clinical practice.

As described in the previous chapter, to identify the current actions undertaken by Canadian OTs in their practice, respondents were asked to rate how frequently they used each of the identified activities in five domain of actions: addressing the SDOH with clients during the OT process; adopting equity-oriented practices in the evaluation of OT services; partnering with communities and other government sectors; integrating SDOH and health equity in education activities; and advocating for the occupational needs related to the SDOH at the individual, local and system levels. Respondents were also asked in open-ended questions to share an action that they felt most positive about to work towards health equity in their practice and to comment on the integration of SDOH in the assessment process in occupational therapy.

The frequency of use for each response category, median [Mdn], and interquartile range [IQR] for each item will be presented to describe current actions undertaken by respondents in their practice. The Cronbach's alpha coefficient for each domain of actions will be provided to explore the extent to which the actions within each domain are in fact related to one another, thus comprising a distinct domain of action. In addition, the main themes that emerged from open-ended responses will be presented to enrich or contest the quantitative findings.

Identifying and addressing SDOH with clients during the OT process

Inequity-responsive care is a component of health equity work in healthcare and is defined as addressing the client's needs and priorities related to their lived experiences of SDOH as a legitimate and routine aspect of the clinical process (Wong et al., 2014).

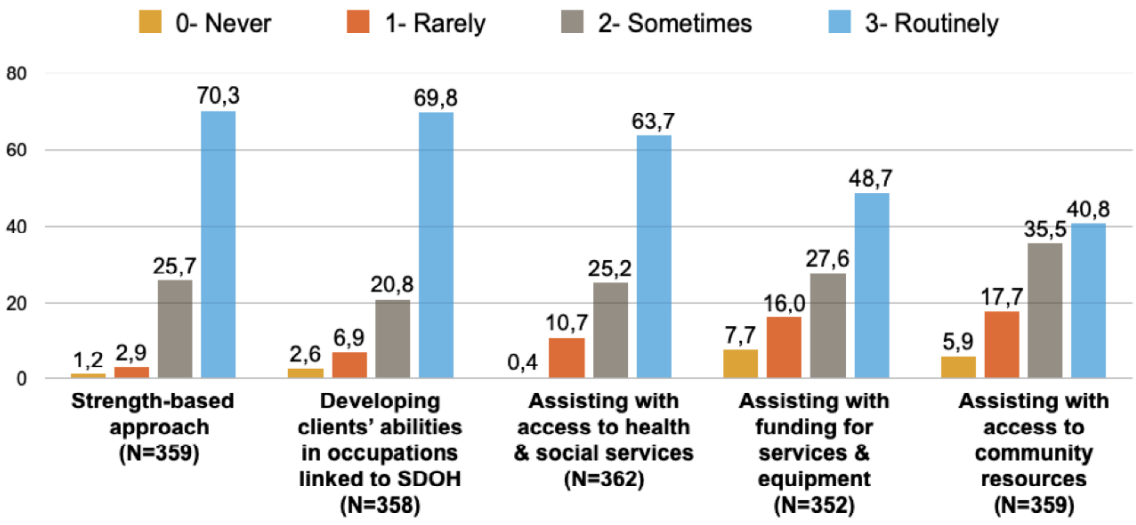

Figure 2: Frequency of use of actions related to addressing SDOH with clients during the OT process (percentage per response category)

As shown in Figure 2, overall, respondents indicated being frequently involved in actions associated with addressing clients' SDOH related needs as part of their OT clinical process. The majority of respondents reported using routinely the following approaches: adopting a strength-based approach (70.3%; Mdn = 3, IQR=1), providing interventions intended to develop client's abilities in occupations related to key determinants of health such as child development, education, or employment (69,8%; Mdn = 3, IQR=1), and helping clients to access the health and social services they need (63,7%; Mdn = 3, IQR=1). In addition, less than 3% of respondents reported never engaging in these three actions which suggest a widespread integration in the everyday practice of respondents. It is important to note that the actions above are key elements of the occupational therapy practice process and are not specific to health equity work. Several occupational therapists also reported routinely assisting clients to access financial support for needed services or equipment (48,7 %; Mdn=2, IQR=1) as well as routinely referring clients to community services for non-

clinical issues related to clients' health and occupational well-being (40,8%; Mdn=2, IQR=1). The Cronbach's alpha coefficient for these five survey items is 0.708, suggesting that these items have an adequate internal consistency and that these five actions are correlated together within this domain of actions.

When asked to share an action that they felt most positive about to work towards health equity in their practice (N=197), the largest part of qualitative responses (N=81; 41,1%) described actions that address clients' needs linked to SDOH as part of the OT practice process, which reflects the predominance of individual level actions in respondents' practices. For instance, several respondents (N=28) described linking clients to existing community resources that could meet their clients' needs associated with SDOH, such as transportation services, early education centers, housing programs, or employment and financial support services. Other actions often shared by respondents were associated with helping clients to navigate healthcare systems to access needed clinical and social services (N=26) and assisting clients to get the financial support for needed services and equipment (N=18). Advocacy on behalf of individual clients emerged as a recurrent theme among these comments.

In subsequent survey items, respondents were asked if they identified client SDOH related factors that might be impacting everyday lives and occupations as part of OT assessments. As shown in Figure 3, some SDOH related factors such as social support network and meso-level environmental factors (e.g., access to transportation, educational or work environments, financial support programs) are more likely to be a routine part of OT

assessments for respondents. Other factors, such as inquiring about clients' priorities in occupations linked to SDOH or screening for adverse material conditions or psychosocial risks, are less frequently included in their OT assessment process. Interestingly, results from correlation analyses suggest that respondents who asked about their clients' knowledge and experiences of community resources, material needs (i.e. income, food and home security) or psychosocial risks during OT assessments were more likely to refer their clients to non-clinical services and community resources ($r=.485$, $p < .001$; $r=.462$, $p<.001$; $r=.349$, $p < .001$).

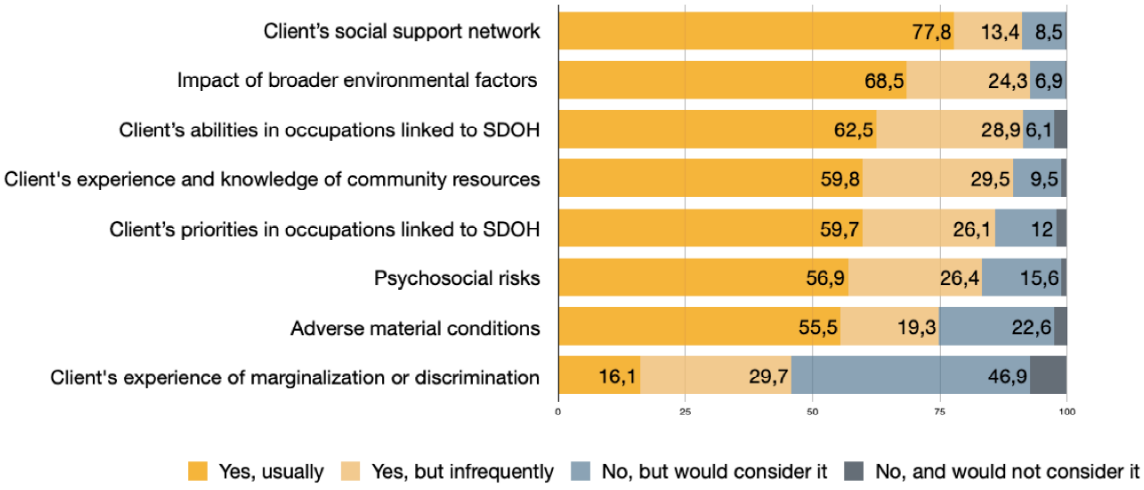

Figure 3: Integration of SDOH-related factors as a part of OT assessments (percentage per response category, N=311)

When asked to comment about routine occupational therapy assessment and SDOH, some respondents pointed out that the *Canadian Model of Occupational Performance and Engagement* addresses the institutional and psychosocial environments and their impacts on occupational engagement. Others indicated that the *Canadian Occupational Performance Measure* has the potential to identify with clients how SDOH related factors may influence their occupational engagement. Some respondents indicated that SDOH was

an important part of their initial assessment and recognized that needs such as housing, income, and food security were central to their clients' well-being and often took priority over "traditional OT goals" (OT ID 8334361). A small number of respondents also highlighted the importance of being aware of how their personal or professional biases may impact the assessment process. One respondent wrote that professional biases make standard assessments inappropriate for many clients:

> I do little standardized assessments– as many have many built in middle-class assumptions around budgeting, meal prep, money management, etc. I follow more a Maslow's hierarchy of needs (…) "Where do you live. Is it ok?" and "Do you have enough money to make ends meet?" are very simple, and effective ways to start the conversation in practice. (OT ID 8332416)

In addition, some respondents pointed out the importance of framing interviews on sensitive topics (e.g., experiences of discrimination, housing and food insecurity, financial issues) within a trauma-informed approach and that these conversations should always be client-lead and respectful of clients' choices about disclosure.

While a great majority of respondents thought that addressing the SDOH and social needs during the OT practice process was key to improving the occupational outcomes of their clients (83,0%; Mdn=4, IQR=1) and that asking about SDOH during the clinical process was within the scope of practice of occupational therapists (78,9%; Mdn= 4, IQR=1), 73,6% (Mdn=4, IQR=2) of the respondents reported that assessing clients' needs and priorities related to SDOH was done by other professionals in their practice setting.

Similarly, when asked to add comments about routine occupational therapy assessment and SDOH, a significant portion of the comments (25%) indicated the importance of interprofessional collaboration to be responsive to clients' needs and priorities related to SDOH. Several respondents added that assessing and addressing these issues was mostly the mandate of social workers or case managers in their workplace. For some respondents, this interprofessional collaboration allowed them to better consider these issues in their OT interventions. For other respondents, the inclusion of SDOH related factors in the OT assessment was not a routine part of their practice. The reported reasons for this differed. Some perceived that these aspects were not relevant or "appropriate" to their specific mandate in their practice context or to the needs of their clients. Others expressed concerns about confidentiality and the relevance of disclosing this information in their documentation to third party payers. Finally, some respondents felt that, while they recognize the impacts of SDOH on the occupational engagement, health, and well-being of their clients, it was better not to address these issues during clinical encounters because they felt they could not "do something with the clients to help address them" (OT ID 8322707), because of time constraints, or because of the lack of services and resources in the community to meet their clients' needs. The barriers encountered by respondents when integrating SDOH and health equity approaches in their practice will be detailed further in another section.

Adopting equity-oriented practices in the evaluation of OT services

Equity-oriented evaluation of occupational therapy and other health services includes the documentation, analysis, and reduction of healthcare inequities within an existing program or organization (Restall et al., 2018).

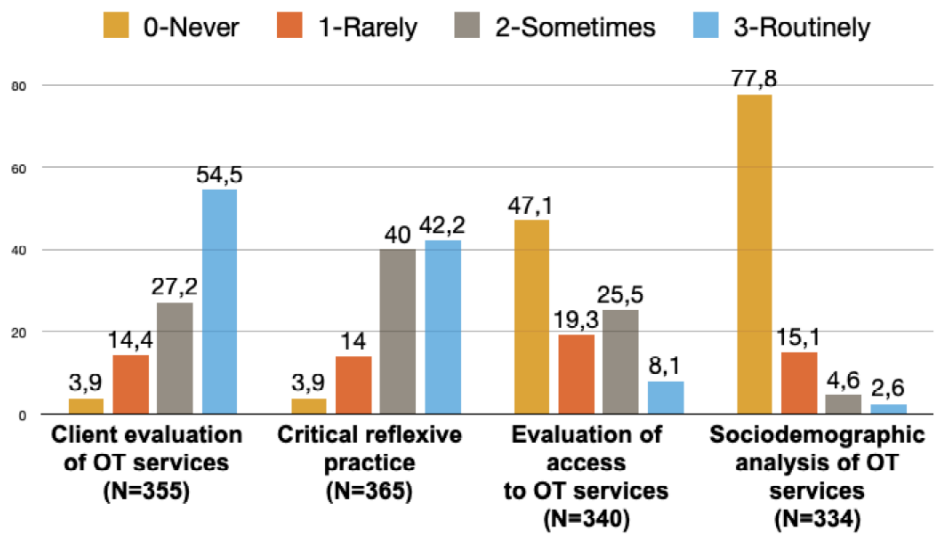

Figure 4: Frequency of use of actions related to equity-oriented practices in the evaluation and improvement of OT services (percentage per response category)

As Figure 4 demonstrates, differences emerged in the frequency of use for the four activities related to the integration of equity-oriented approaches in the evaluation and improvement of OT services. A majority of respondents reported engaging sometimes or routinely in reflective practice by questioning how their own and professional and social positioning may impact their practice and relationship with their clients (82,2%, Mdn=2, IQR=1). Similarly, the majority of respondents (81,7%, Mdn=3, IQR=1) reported assessing sometimes or routinely whether clients report that their needs have been met as a results of OT services. These two activities are components of equity-oriented practice in healthcare settings (Wong et al., 2014), but they are also key professional competencies expected from occupational therapists in the *Profile of Occupational Therapy Practice in Canada* (CAOT, 2012). In contrast, only a third of the respondents (33,5%, Mdn=1, IQR=2) reported examining sometimes or routinely how aspects of OT service delivery, such as location,

hours, or referral processes, may impact the access and utilization of their services for different service user groups. Moreover, the great majority of respondents (77,8%, Mdn=0, IQR=0) reported never collecting or using sociodemographic data to understand the needs of their services users. Overall, this last approach was the least frequently used compared to all the other actions included in the survey. The Cronbach's alpha coefficient for these four items is 0.469, which indicates that these items have a low internal consistency, reflecting considerable heterogeneity in the ways OTs reported using these four actions. This is not unexpected, since the survey items here were measuring a range of ways to evaluate services, from the most obvious and simple, to the more complex and difficult. They show the variance anticipated.

When asked to share an action that they felt most positive about to work towards health equity in their practice (N=197), some respondents (N=17) described ways they adapted the delivery of OT services so that they are more easily accessible to, or responsive to the needs of services users. Some of the modifications included adapting service hours and providing services in community settings or at home to account for their clients' work schedule or lack of transportation and community mobility, adopting more flexible cancellation policies, and using telehealth in remote geographic areas. Others provided examples of findings ways to adapt their routine interventions to make them more responsive to the socioeconomic, cultural, or religious backgrounds of their clients, such as making recommendations that are affordable and searching for low-cost alternatives for equipment for service users who live on low income. Only a few respondents spontaneously described the importance of integrating critical reflexivity and of addressing

routine practices in healthcare settings that could be discriminatory or disempowering for service users. This comment illustrates how one respondent enacts these actions in everyday practice:

> I find that the majority of health care providers within the team, myself included, come from background of privilege and have to make a concerted effort to understand the experiences of our patients who are marginalized and live with health inequity and injustices. (…) Colonial and oppressive practices are not far from the surface within hospital setting and I find that I encounter passive and systemic oppression around every corner. I've been trying to model and practice culturally-sensitive and trauma-informed care, including the language I use when reporting, rounding, and charting. In practice, I try to address dialogue around me that is discriminatory or inappropriate, such as stereotypes, slang, and assumptions. I feel the soft skills, such as active listening and validation are an important part of how I integrate health inequality into my documentation and clinical process.
>
> (OT ID 8333816)

In addition, a substantial portion of the qualitative responses (N=35, 17,8%) described actions intended to drive organizational changes in the ways services are provided within healthcare organizations and health system. These actions tend to focus on increasing access to services, such as the prioritization and management of waitlists for OT services or contributions to the development of more coordinated approaches to deliver services across different programs. Some respondents also described contributing to other organizational changes to address routine practices or processes in healthcare organizations

that may be barriers to the utilization of services such as reducing architectural barriers in healthcare facilities, requesting language services, promoting trauma-informed care, and creating drop-in clinics, or equipment loan services for underserved groups, among other initiatives.

Partnering with communities and other government sectors

Partnering with local communities and other government sectors outside the health sector is a component of health equity work and involves collaborative actions in areas such as early child development, education, employment, or housing (IHE & WMA, 2016; Wong et al., 2014).

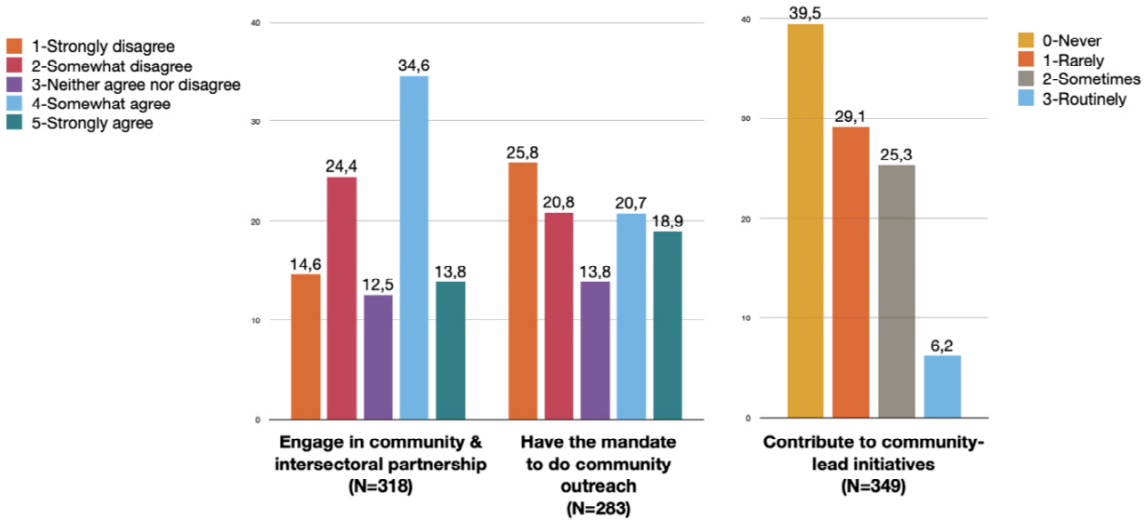

Figure 5: Integration of actions linked to partnering with communities and other government sectors (percentage per response category)

Overall, community level and intersectoral actions to improve SDOH and health equity remains relatively infrequent in the everyday work of respondents. Nearly half of the respondents (48,4%, Mdn=3, IQR=2) reported that they consult and partner with community services and other government agencies so that OT services better meet the

need of local communities. On the other hand, fewer respondents (39.6%, Mdn=2, IQR=3) reported that community outreach was part of their current workplace mandate or reported that they were at least sometimes involved in community-lead initiatives to tackle local priorities related to SDOH (31,5%, Mdn=1, IQR=2). The three survey items related to community level approaches have a Cronbach's alpha coefficient of .691, suggesting that these items have a moderate internal consistency, and are correlated as part of the same underlying domain of actions.

When asked to share an action that they felt most positive about to work towards health equity in their practice, respondents' contributions to community or intersectoral actions represented 12,2% (N=24) of the responses. Some respondents shared examples of contributions to projects tackling the SDOH and related occupational needs at the community level, including contribution to housing programs, financial literacy programs, school food programs, affordable sport activity programs, projects to increase physical accessibility in the community (e.g., affordable housing, school, public spaces), or affordable transportation alternatives, among other initiatives. In addition, some respondents reported that they do work in partnership with community resources to increase the proximity of their services for marginalized or 'hard-to-reach' service users and to facilitate references to support services in the community. For other respondents, their engagement with community-based projects was done outside of their paid work, on a volunteer or personal basis, as exemplified in the following comment:

> I currently work within a team that values advocacy and support working in the community with clients to meet basic determinants of health. In the past, when

working with a local community group on developing housing for individuals with mental health issues, I was forced to stop by a director who was very negative about housing. My favorite work in this area is as a volunteer where I get to organize my contribution to community development and do not need to worry about the employers' political agenda.

(OT ID 8323291)

Including SDOH and health equity in education activities

Increasing awareness and training on SDOH and health equity is a component of equity-oriented approaches in healthcare settings (IHE & WMA, 2016; Browne et al., 2015).

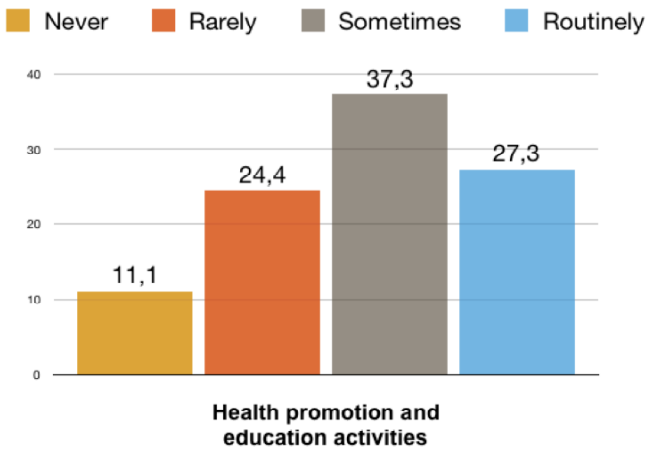

Figure 6: Frequency of use of actions linked to health promotion and education (percentage per response category, N=359)

As shown in Figure 6, health promotion and education activities are relatively frequent with 64,6% of respondents reporting that this type of actions is performed at least sometimes in their current practice (Mdn= 2, IQR= 2). Interestingly, the addition of this survey item to the three items related to community level activities (discussed in the

previous section) increases the Cronbach's alpha coefficient to .777, which suggests that this item is correlated with the three survey items on community level activities.

Furthermore, 15% (N=27) of the open-ended responses on equity-oriented action provided examples of education and health promotion activities, including activities such as:

- capacity-building initiatives for clients and families on topics such as health management, financial literacy, or home safety;
- training in various community settings to build community partners' capacity to better understand and act on health issues such as early child development, impacts of trauma and stigma, promotion of mental health in the workplace, etc.;
- providing training to support professional development of healthcare providers;
- including SDOH and critically reflexive practice in the training of future occupational therapists.

For many respondents in this study, providing education or training activities was a way to build service users', community partners' or other healthcare providers' capacity to understand and act in an area where respondents themselves had an expertise or specialized knowledge. For instance, one respondent working in a large urban center described that she felt she was contributing to reduce healthcare inequities through providing training to occupational therapists working in Indigenous communities, because this way, most clients would not be required to travel long distances to receive this specialized service in a city center. For other respondents, promoting health equity in their practice was pursued by encouraging critical reflexivity in occupation therapy students during internships or in

occupational therapy university programs and by providing opportunities to enhance future occupational therapists' attitudes to work across social differences. One respondent wrote:

> I hope that the students learn that our experiences in life are not universal and that it is worthwhile to examine our biases that can be so embedded that we do not even realize that they are there. More importantly, what OTs can do to readjust their practice to reduce the biases to ensure that people have access to healthcare services, and to demonstrate respect to our clients. (OT ID 8322655)

Advocating for the occupational needs related to SDOH

Contributing to advocacy for occupational needs related to the determinants of health is stated as one of the key competencies expected from Canadian occupational therapists in the *Profile of Occupational Therapy Practice in Canada* (CAOT, 2012).

As mentioned in a previous section, respondents often described advocating on the behalf of individual clients (N=32) to facilitate access to funding for needed services and equipment or to facilitate access and utilization of health and social services with the healthcare system. Several respondents provided examples of advocating for individual clients "when declined from major funding sources" (OT ID 8323721) and for those who do not meet the eligibility criteria of funding programs for needed equipment or assistance services because of diagnosis, income level, age, or immigration status, among other reasons. Respondents also described advocating for individual clients within the healthcare system and using their insider knowledge of the healthcare system to help clients access needed services and navigate the system more easily.

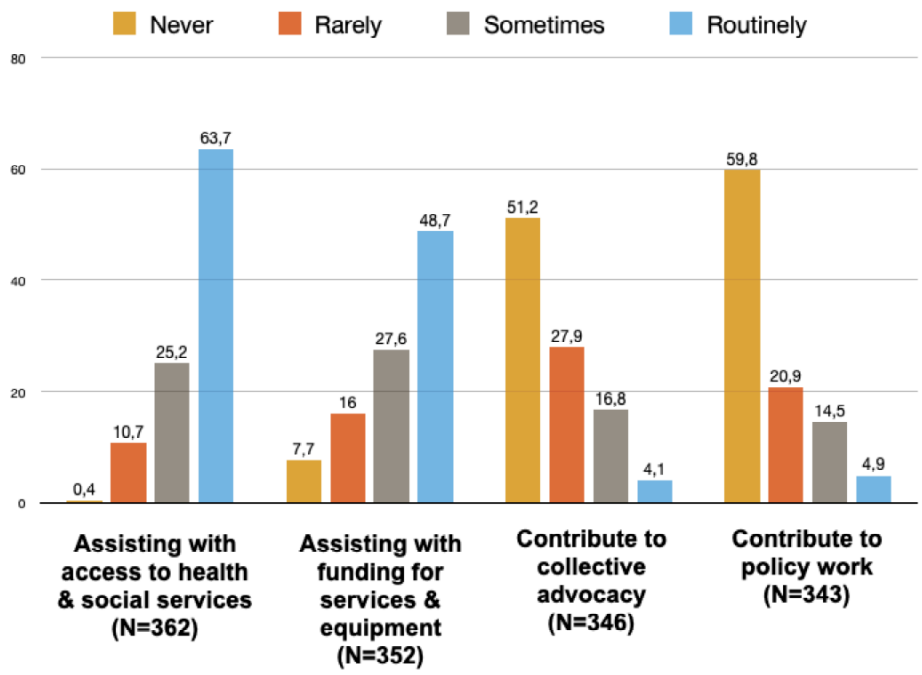

Figure 7: Frequency of use of actions related to advocacy (percentage per response category)

This respondent explained how they enact their advocacy role in their practice context:

> Working towards health equity in my day-to-day practice means advocating for people with disabilities in university settings to enable full participation on student life. It also means helping them to secure funding (government and other type) in order to access the health supports they need. (OT ID 8354291)

Some other specific examples of advocacy on the behalf of individuals included: writing letters for safe and affordable housing conditions, offering navigation support to new immigrant families to access health and inclusive education services, or having a mediating role within the healthcare system for service users with complex clinical needs (e.g., individuals with physical impairments and chronic mental health issues). Importantly,

respondents recognized that providing this kind of support to clients was often a time-consuming process.

As Figure 7 shows, more than half of the respondents reported never participating in collective advocacy initiatives (51,2%, Mdn=0, IQR=1) or in policy work (59,85%, Mdn=0, IQR=1) to tackle key social determinants of health and occupational well-being. Overall, these two activities were among the least frequently used in respondents' practice compared to the other actions included in the survey. Moreover, only a small number of respondents (N=17) provided examples where they were directly involved in system-level advocacy and policy work. These activities often focused on improving healthcare services or advocating for a more equitable model for equipment provision for specific groups in the population (e.g., Indigenous people living on reserves, people living with low income, recent immigrants, LGBTQ+ groups). These activities often included contribution to research activities (N=8) such as documenting disparities in access to healthcare services or in access to funding programs for specific population groups, mapping out available resources in local communities, or evaluating interventions and programs designed to address the SDOH. These research projects were often participatory research and included service user groups or local communities. Other respondents indicated that advocacy and system level activities were not part of their mandate as clinicians and that advocacy on behalf of individual clients was how they could undertake an advocacy role in their practice. Yet, respondents were also cognizant that advocating for individual clients was only a small part of health equity work, "a one-step-at-a-time thing in practice" (OT ID

8333816) and that health and social inequities experienced by some of their clients required changes at a broader level.

Quantitative and qualitative findings show that respondents are engaging more frequently in activities associated to advocacy at the individual level compared to advocacy at the local or system level. However, the Cronbach's alpha coefficient for these four survey items is .661, which suggests that a moderate internal consistency in the way respondents have answered to the four items related to advocacy activities and that these items are correlated together as part of a of domain of actions.

Perceived barriers, enablers and needs to support the integration of health equity approaches

The aim of this section is to present the results associated with the second question of this research project: "What are the perceived barriers, enablers, and needs to better integrate equity-oriented approaches in occupational therapy?" As described in the previous chapter, to identify perceived barriers, enablers, and needs experienced by Canadian OTs in their practice, survey items were created based on factors known in the literature for influencing the implementation of clinical practices among healthcare providers, including practice environment factors as well as factors related to therapists' attitudes and abilities (i.e., perceived scope of practice, perceived relevance, practical competencies) (Cabana et al., 1999). Respondents were also asked in open-ended questions to identify the factors that they felt had the greatest impact on their capacity to integrate equity-oriented actions in their everyday practice and to name resources that would best support their practice.

Descriptive statistics as well as the main factors that emerged from open-ended responses will be presented to depict the current barriers, enablers and needs identified by respondents in this study. When relevant to the analysis, Spearman's rho correlations [r] are presented to examine the relationship between two ordinal variables. The three main types of barriers, as discussed below, are those concerning organizations, systems, and therapist's attitudes, knowledge and competencies. The main enablers are concerning interprofessional collaboration, organizational support, community partnership, training and individual competencies, and aspects of the occupational therapy profession.

Perceived barriers

Organizational constraints were the most frequently reported barrier to the integration of equity-oriented approaches, both in quantitative and qualitative responses. While only 31,2% (Mdn=3, IQR=2) of respondents perceived that health equity was a low priority in their current work settings, a great majority of respondents (77,9%) perceived that organizational factors, such as cost-control mechanisms, workload measurements and/or scarcity of resources in their workplace, had a powerful impact limiting the integration of health equity actions in their everyday practice. The distribution of responses for this item (Mdn=4, IQR=1) suggests widespread agreement among respondents, with 44,7% of respondents strongly agreeing with this statement. In addition, 67,1% (Mdn=4, IQR=1) of respondents reported difficulty accessing resources to address SDOH related needs in ways that would be beneficial for their clients, and 60% (Mdn=4, IQR=1) of respondents reported that time constraints prevent them from addressing these issues with their clients during the OT process.

When asked which factors had the greatest impact on their capacity to integrate equity-oriented approaches in their everyday practice (N=188), over half of the qualitative responses (N=108) were related to their organizational context of practice. Comments often described insufficient resources, including time constraints, shortage of occupational therapists and other healthcare providers, lack of funding, as well as associated factors in their practice environments such as high caseloads, very long waiting lists for publicly funded OT services, discharge pressure, and the limited scope of OT services covered by third party payers. Several respondents wrote that they felt that their organizational context restricted significantly their scope of practice as an occupational therapist. This concern is reflected in the comment below:

> Cost-control mechanisms through my company have a big impact on what I can do. We are paid per home visit, which includes an assumed amount of indirect paperwork/calls, etc., but does not cover the reality of how much communication, advocacy, networking, and liaising is required to provide more holistic care (including health equity actions). In order to feel like more than a mere equipment provider, I must contribute unpaid hours. (OT ID 8324489)

Other respondents provided examples of how their current program mandate was limited to addressing short-term functional or clinical outcomes and how this hinders their capacity to tailor their interventions to meet other needs and priorities of their clients, including the social and material factors they knew impact the functional outcomes and health of some clients after discharge. In addition, respondents often described a lack of alignment

between equity-oriented approaches and the current organizational culture and priorities at the management level which often focus on efficiency and cost reduction of services. The following comment illustrates this perceived gap:

> In the organizational structure, there is no place for innovative practices or for discussion on the role of front-line practitioners in the community. All the attention is directed towards the percentage of completion of the OCCI[1] and on performance targets based on the numbers of individual clients seen. The quality of professional acts and the development of partnerships with the community are not topics that are discussed in the CLSC[2]. (OT ID 8337372, translated from French)

Several respondents reported that management priorities and performance targets based on direct contact services had an impact on their capacity to carry out non-mandatory professional activities such as building partnerships with local communities and taking actions on a community or regional level to improve health equity and SDOH. Other reported barriers included a lack of means to support front-line practitioners' engagement in organizational changes, including limited opportunities for front-line clinicians to contribute to organizational decision-making and lack of dedicated structures such as working groups or steering committees to support changes on health equity issues within healthcare organizations.

[1] The OCCI (outil de cheminement clinique informatisé) is a computerized clinical assessment tool used in Quebec healthcare settings.

[2] CLSC are community-based health and social services centers in Quebec.

System-level barriers

Respondents' open-ended responses about the factors that most impact their capacity to integrate health equity actions in their everyday practice revealed that many occupational therapists have a structural understanding of the health and social inequities that they encounter in their daily practice. In fact, more than a quarter of the comments (N=51, 27,1%) described some structural process, constraints or social relations at play in respondents' day-to-day practices.

Within this category of responses, the majority of comments (N=39) described structural processes within the health system itself that contribute to health and healthcare inequities. Some respondents mentioned budget cuts in their provincial health system and resulting organizational constraints in their practice. Several respondents indicated that the limited access to publicly funded health and social services, including OT services, the "long waitlists and restrictive eligibility" for publicly funded programs, were also contributing factors to inequities in healthcare. In addition, some respondents working in private practice recognized that the nature of private OT services made them accessible only to those who have insurance coverage or those who can pay out-of-pocket. Others expressed concerns that measures put in place to increase efficiency in service delivery and reduce waitlists for occupational therapy services, such as strict absence policies or mandated shorter intervention blocks, contributed to reducing the 'fit' of their programs and interventions for service users with complex needs or for those from structurally disadvantaged groups. Some respondents also spontaneously described the difficulty navigating the social and healthcare systems in their province or were cognizant of the

resources (e.g., transportation, money, time, and work flexibility) and knowledge (e.g., health literacy, knowledge of the services and programs, fluency in official languages) required for individual service users to access these services.

Respondents' comments also revealed issues of fragmented government policies and programs to fund equipment and assistance services in the community for those who experience disability. Respondents shared that the structure of the funding programs for equipment was a systemic barrier that they frequently encountered in practice as something that puts additional financial constraints on those experiencing disability who have low income. This respondent shared a practice example:

> It can be very challenging working with low-income clients to get them the services and equipment they require. There are funding options and some services through the (provincial fund), but often clients will not qualify for funding or only get partial funding, and they cannot afford to cover the cost of the equipment or service they need to stay safely living in their home. Many private home care services that are not covered through the (provincial fund) are not affordable to many low-income or fixed-income clients. (OT ID 8366127)

Some respondents also shared that federal and provincial laws also complicated access to OT services and equipment for Indigenous people living on reserves.

Several occupational therapists in the study spontaneously described adverse SDOH impacting the daily lives of their clients such as food insecurity, housing needs, income insecurity, lack of adequate educational opportunities, as well as a lack of resources in

communities to meet these needs. Less frequently, respondents situated the problem in broader social relations such as the racism and colonialism that impact the lives of their clients and the relationships between therapists and clients. Some spontaneously shared their thoughts on how occupational therapy and healthcare culture in general was sometimes a barrier, in itself, to health equity. For instance, some indicated that the biomedical view in healthcare settings continued to frame health problems as separate from social inequities. Others mentioned that discrimination and indifference within the healthcare system as well as the lack of awareness among healthcare providers of their own biases was a barrier to equity in healthcare settings, yet these were not easily addressed in practice. As one respondent wrote: "It's a huge barrier because it's uncomfortable enough to acknowledge my own biases, but it is a greater challenge to have constructive conversations within the workplace about biases that colleagues may have" (OT ID 8334633).

Factors related to therapists' attitudes, knowledge, and competencies

Overall, respondents perceived the importance of equity-oriented approaches in occupational therapy and therapists' attitudes did not emerge as major barriers, in the quantitative or qualitative data. There was an overall consensus among respondents about the importance of understanding the influence of upstream determinants (i.e., sociocultural, economic, political factors) on clients' occupations, health and well-being in occupational therapy, with 90,4% of respondents agreeing with this statement (Mdn=5, IQR=1). As described previously, a great majority of respondents thought that addressing the SDOH and social needs during the OT process was key to improving the occupational outcomes

of their clients (83,0%; Mdn=4, IQR=1) and that asking about SDOH during the clinical process was within the scope of practice of occupational therapists (78,9%, Mdn=4, IQR=1). Similarly, only 14,2% (Mdn=1, IQR=1) reported that SDOH were not relevant to the issues for which their clients seek their services. Over two thirds of respondents (69,9%, Mdn=4, IQR=1) also perceived that engaging in policy work to address occupational needs related to SDOH was within the scope of practice of occupational therapists.

Although the importance of equity-oriented approaches appears to be a common ground among respondents, a majority of respondents (74,1%, Mdn=4, IQR=1) reported that they often felt at a loss about how to address the social inequities that impact their clients' health and well-being in their work. Some respondents described a tension between recognizing the structural issues experienced by their clients and their capacity to address them within their mandate. This tension is reflected in the comment below:

> I feel there is little that I can do from an inpatient clinician position to make system level changes to barriers my clients face, especially around receiving adequate supports after discharge. I do my best to advocate for each individual case, but I am often at a loss for how to get more needed services for clients who face a double stigma – mental health and old age. I believe I would need to move to a different position as a policy consultant or project manager, not a front-line clinician, to be able to even make small changes to the system. (OT ID 8338237)

Other respondents in this study reported a lack of channels for practicing occupational therapists to participate to system level actions, collective advocacy initiatives, or policy work. As one respondent wrote:

> There is no mechanism for committee work or group-initiated advocacy work as part of my position. (…) I would be going alone, outside work commitments and without organizational support. Advocacy that does happen is on an individual patient basis, not a community or organizational level. (OT ID 8366005)

The majority of respondents also perceived that they lacked easy access to professional resources to support the integration of equity work in their practice. A majority of respondents (69,4%, Mdn=2, IQR=2) reported that they had no appropriate tools to evaluate if their services were equity-oriented and inequity-responsive. Similarly, over half of the respondents (53,7%, Mdn=4, IQR=1) reported that there was limited access to evidence to support interventions on the SDOH in occupational therapy. When asked to rate on a ten-level scale how well their entry-to-practice education in occupational therapy had prepared them to understand and address SDOH and health equity in their work, respondents indicated that their education had somewhat prepared them regarding these issues, with a median of 6 out of 10 (IQR=3). Respondents who graduated more recently from an OT program were more likely to indicate that their educational experience had prepared them well on these issues (Mdn=7, IQR=3); years since graduation was moderately correlated to respondents' perceived level of preparedness ($r = -.379$; $p < .001$). However, across all respondents, self-perception of preparedness through their occupational therapy education was not statistically related to the extent to which

respondents felt at a loss regarding how to address SDOH and health equity in their current practice (r =.049; p <.001). In other words, feeling well-prepared through education did not reduce that sense of being at a loss in practice.

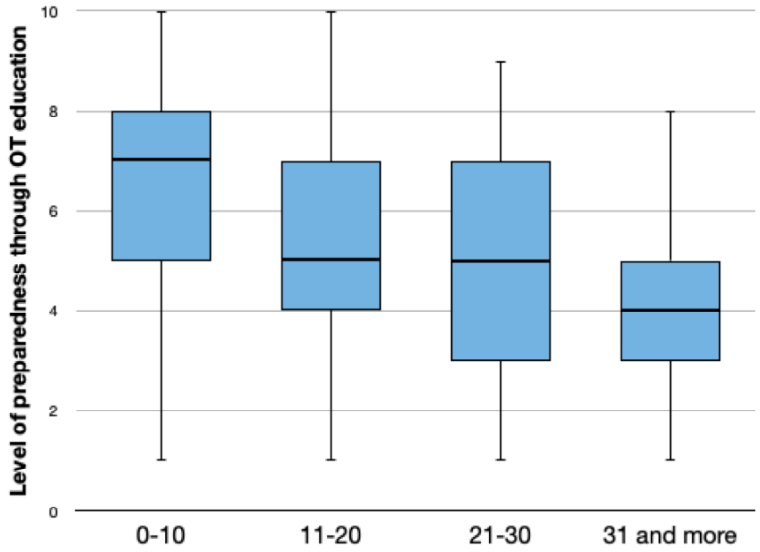

Figure 8: Perceived level of preparedness through OT education by years of practice

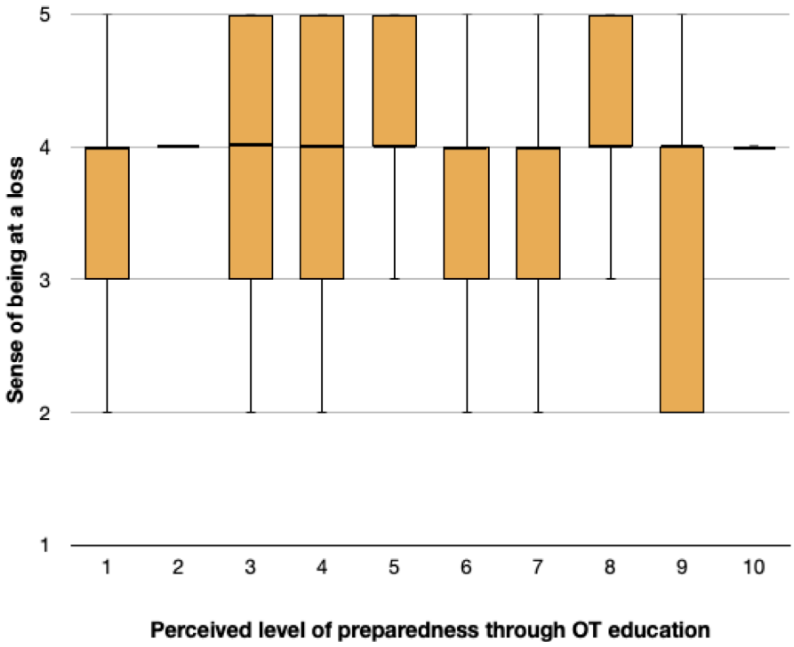

Figure 9: Level of agreement with the statement: "I often feel at a loss about how to address the social inequities that affect my clients' health and occupational well-being" by perceived level of preparedness through OT education

Regarding respondents' perception of their practical competencies in equity-oriented approaches, 44,4% of respondents reported that they lack the training and competencies to engage in advocacy for and with clients whose occupational lives were impacted by adverse SDOH (Mdn=3, IQR=2) and 37,3% of respondents reported that they did not know how to consult and build partnerships with community and other governmental agencies (Mdn=3, IQR=2). In addition, 46,1% of respondents perceived that they didn't have the training or competencies to deal with the emotional impact of working with clients who experience trauma, interpersonal and structural violence, and other forms of inequity (Mdn=3, IQR=2) and nearly a third of respondents (34.8%, Mdn=3, IQR=2) reported that they lack confidence in their abilities to address SDOH related needs in ways that would be beneficial for their clients. When asked which factors had the greatest impact on their capacity to integrate equity-oriented approaches in their everyday practice (N=188), 15,7% (N=17) of comments reported lack of training or competencies as a barrier. However, the great majority of these responses also reported the presence of organizational factors, suggesting that therapists' individual competencies alone may not be the most significant barrier encountered by respondents in their day-to-day practice.

Perceived enablers

When asked which factors had the greatest impact on their capacity to integrate equity-oriented approaches in their everyday practice (N=188), over a third of open-ended responses (N=68, 36.2%) were related to enablers in respondents' everyday practice. A main theme that emerged from these open-ended responses was the importance of interprofessional collaboration to promote equity-oriented and inequity-responsive care in

clinical practice (N=22). Several respondents highlighted that collaboration with other professionals helped better understand and address clients' complex health and social needs. This included emotional support within their team to deal with issues that may arise. There was also a recognition that SDOH and health equity were interdisciplinary issues; these needed to be valued and addressed by all professions within a program and were not specific to one profession. Some respondents also reported that increased representation of diverse social groups (e.g., ethnicity, LGBT+, socioeconomic realities, etc.) among healthcare professionals promoted different perspectives within their interdisciplinary team, as one respondent noted:

> Being part of a team that includes individuals who reside in the First Nation communities where I provide service is very helpful in identifying local barriers and enablers. (OT ID 8350516)

The importance of developing community partnerships was another important theme that emerged from the open-ended responses (N=17). For several, having a good knowledge of the needs and resources in communities where they work and "learning what is out there" (OT ID 8322657) was an important enabler to provide services more responsive to client realities and to help clients build their social support networks. Maps or up-to-date lists of community resources, including their mandate, reference processes, and admissibility criteria, were useful resources often mentioned in comments. One respondent provided a concrete example of how collaboration with a community group took place within the scope of their clinical practice:

> Health equity, to me, means being aware of the social determinants and larger forces at play, and tailoring assessments and interventions with that in mind. Not necessarily changing those determinants, because of many things I've already mentioned (time, scope, how can one person change them?). For example, I have asked for help with the local Indigenous support group when the hospital team was struggling with the care of a patient who was Indigenous. I didn't change the societal discrimination or history at play but it helped us come together to identify shared goals – getting the patient home safely and working together. (OT ID 8335356).

In addition, quantitative data revealed that the great majority of respondents (86.7%) thought that it was very important (i.e.,8 on of a 10-point scale) to have the organizational support to work to the full scope of occupational therapy practice in order to address clients' occupational, social and clinical needs (Mdn= 10, IQR=2) . This was the case for respondents across all sectors of practice. Several open-ended responses (N=19) also indicated that administrative support was an important enabler in their everyday practice. A few respondents identified that their workplaces had explicitly adopted health equity frameworks and offered critical thinking workshops, diversity training, and/or working committees for front-line practitioners. Others indicated that their programs had integrated sociodemographic information in prioritization criteria or need assessments which allowed them to take SDOH-related needs into account when making decisions about service delivery. Most frequently, respondents discussed the importance of having managers who foster a culture of equity and who provide support to initiatives around health equity. Examples of buy-in at the management level included according to practitioners the

mandate, level of practice autonomy, time, or workload to work with communities or to undertake education and advocacy activities.

Several respondents indicated that their individual competencies, knowledge, and experience (N=16) facilitated the integration of equity-oriented approaches in their practice. Competencies to promote health equity in occupational therapy included: knowledge of the healthcare system and of government programs available to clients, negotiation and advocacy skills, organizational development, community engagement, trauma-informed care, and culturally safe practices. Some respondents described that their experience of working with clients from structurally disadvantaged groups have raised their awareness of health inequities and led to adapting their clinical practice. As one respondent wrote: "I only began to recognize the importance of this through experience and by learning the hard way that I was not meeting clients' needs through mainstream practice" (OT ID 8332471). Others indicated that they developed competencies in health equity work when pursuing education in disciplines outside occupational therapy, such as organization management, disability studies, or sociology.

Another theme that emerged from open-ended responses was how some attribute of the occupational therapy profession supported the integration of equity-oriented practice (N=12). Client-centered and family-centered practice were frequently identified as facilitating clinical practices that are empowering and responsive to clients' lived experiences. In addition, some respondents perceived that occupational therapists were well positioned to understand and address SDOH-related needs given that occupational

therapy models, such as the *Canadian Model of Occupational Performance and Engagement*, promote a holistic and occupational perspective on health and well-being, and include the impacts of broader environmental factors on health and social participation.

Perceived needs

Respondents were also asked to identify resources that might help with the integration of equity-oriented approaches in their everyday work. As shown in Figure 10, the majority of respondents (83,7%) identified the need for training to develop practical competencies in approaches related to health equity, such as community development, advocacy, trauma-informed care, and culturally safe practice.

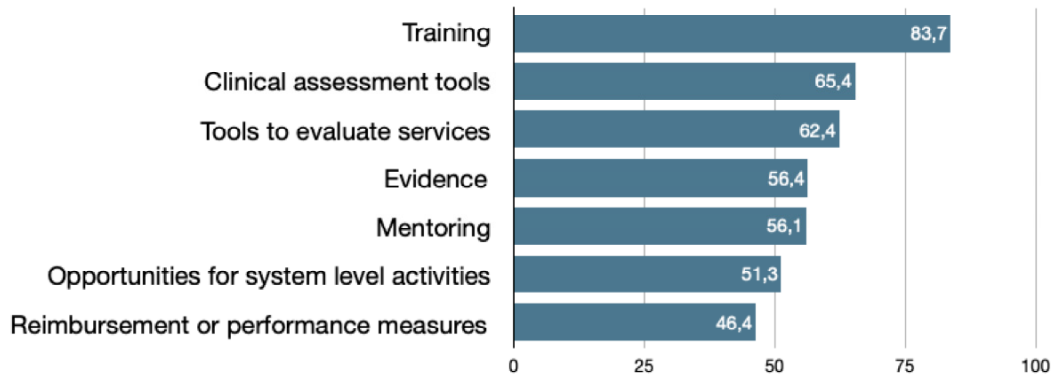

Figure 10: Resources identified by respondents to support the integration of health equity actions in their practice (percentage per response category, N=295)

In open-ended responses, respondents suggested that there is a need to better integrate SDOH and health equity in occupational therapy education programs. Some specific suggestions included encouraging critically reflexive practice and integrating critical theories in the curriculum, exposing students to case studies that reflect the realities of clients who face health inequities and adverse SDOH and more closely resemble the

challenges and barriers in everyday practice, and supporting fieldwork placements in role emerging settings. Respondents also identified the need for professional development for practicing OTs including: documentation and webinars available on occupational therapy association websites, professional development in specific approaches such as community approaches, policy work, culturally safe practice, or trauma-informed care, as well as professional practice networks and mentorship to encourage knowledge exchange and support innovative approaches in occupational therapy. In addition, Figure 10 shows that the majority of respondents also identified the need for tools to integrate equity-oriented approaches in their clinical practice, including clinical assessment tools and equity-oriented tools for evaluation and planning of OT services.

While the majority of quantitative and qualitative responses focused on competency development for individual occupational therapists, some respondents also reported the need for changes within the occupational therapy profession and across healthcare organizations. In general, respondents identified the need to discuss health equity more broadly within the profession and for better guidance on how to tackle these issues in occupational therapy practice. As one respondent wrote, “educating and empowering the occupational therapy players in leadership roles at college, university and association levels on the matters and mobilization strategies for all our communities” is an important element to better promote health equity practices within the profession (OT ID 8337260). Other specific suggestions included that occupational therapy associations and professional bodies should make more explicit the effect of SDOH on accessing occupations as well as the assumptions and biases within the profession more explicit, should advocate and

promote the role of occupational therapists in community and primary care settings, and should examine the admission process in occupational therapy university programs to ensure access to the profession for students from underrepresented groups. Finally, other respondents pointed to the need to better integrate health equity priorities across healthcare organizations, noting that management and healthcare administrations should be supportive and dedicate resources (i.e. time, money, mandate) to equity-oriented approaches in their programs and services.

A statistical exploration of factors influencing the integration of health equity actions in OT practice

The aim of this section is to present the results that address to the third question of this research project: "Are the actions reported by occupational therapists related to characteristics of their practice contexts or to their perceptions of equity-oriented approaches in occupational therapy?" To explore possible relationships between respondents' practice contexts and the integration of health equity actions in their practice, respondents' main professional roles, practice settings, and geographic areas were analyzed to identify any significant differences in the frequency of use of each of the 13 equity-oriented actions. T-tests were conducted when comparing the means of two subgroups of respondents, and a one-way analysis of variance was conducted when comparing the means of more than two subgroups. In addition, the frequency of use of each action was compared to the frequency of work with diverse population groups to identify any significant correlations between these variables. To explore possible relations between respondents' perceptions and competencies and the integration of equity-oriented actions in practice,

correlations with respondents' experience, education, perceptions of the importance of these approaches, level of preparedness, and competencies were also examined.

Factors associated with practice settings

Respondents were categorized into two groups based on their geographic region of practice (i.e. remote/rural regions vs urban regions). All 13 equity-oriented actions were tested, and t-test results indicated no significant difference between rural-urban practice and use of equity-oriented approaches. While healthcare systems vary among provinces and might impact the integration of health equity approaches in OT practices, actions were not compared based on respondents' provinces of residence because of the lack of representativeness of all the provinces in the sample.

To explore if there was a possible relationship between respondents' professional roles and the frequency with which they engaged in equity-oriented actions, respondents were categorized in two groups; those who reported working only as clinicians (N=246), and those who reported working in a clinical role and/or other professional roles (i.e. case manager, consultant, coordinator/administrator, professor, researcher; N=120). When comparing the two subgroups of respondents, clinicians were less likely to report engaging in 6 of the 13 equity-oriented actions, 5 of which are actions at a community or system level. These were all statistically significant differences. Table 3 and Figure 11 show the differences in integration of actions by professional roles.

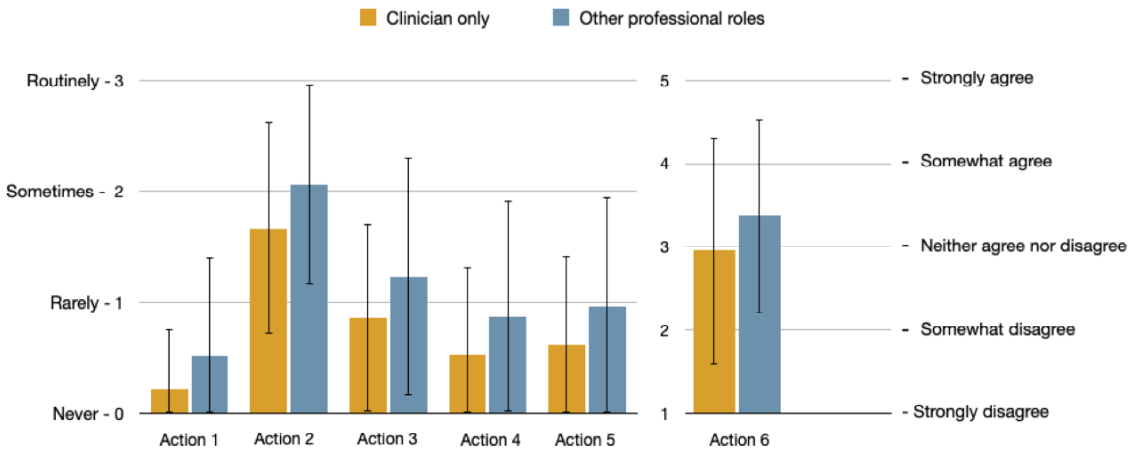

Figure 11: Differences in use of health equity actions by professional roles

Table 3: Results of independent sample t-test comparing the use of health equity actions by professional roles

Equity-oriented practice	Clinician		Other roles		t-test results	
	M	SD	M	SD	t(df)	p
Action 1: Collect & analyze sociodemographic data	0,22	0,54	0,52	0,88	-3,25(141,426)	.001
Action 2: Health promotion and education	1,67	0,96	2,06	0,90	-3,89(241,576)	.000
Action 3: Contributions to community-lead initiatives	0,86	0,85	1,23	1,07	-3,59(180,938)	.000
Action 4: Contributions to policy work	0,53	0,79	0,87	1,05	-3,83(170,198)	.000
Action 5. Contributions to collective advocacy	0,62	0,80	0,97	0,98	-3,55(344)	.000
Action 6. Partnership with community and other government sectors* (measure based on level of agreement	2,95	1,36	3,37	1,16	-2,97 (316)	.003

To explore if there was a possible relationship between respondents' practice settings and the frequency with which they undertake equity-oriented actions in their practice, a one-way analysis of variance (ANOVA) was conducted. When comparing the frequency of actions between practice settings, there were statistically significant differences between

groups in 5 of the 13 equity-oriented actions, 4 of which are actions at an individual or clinical level.

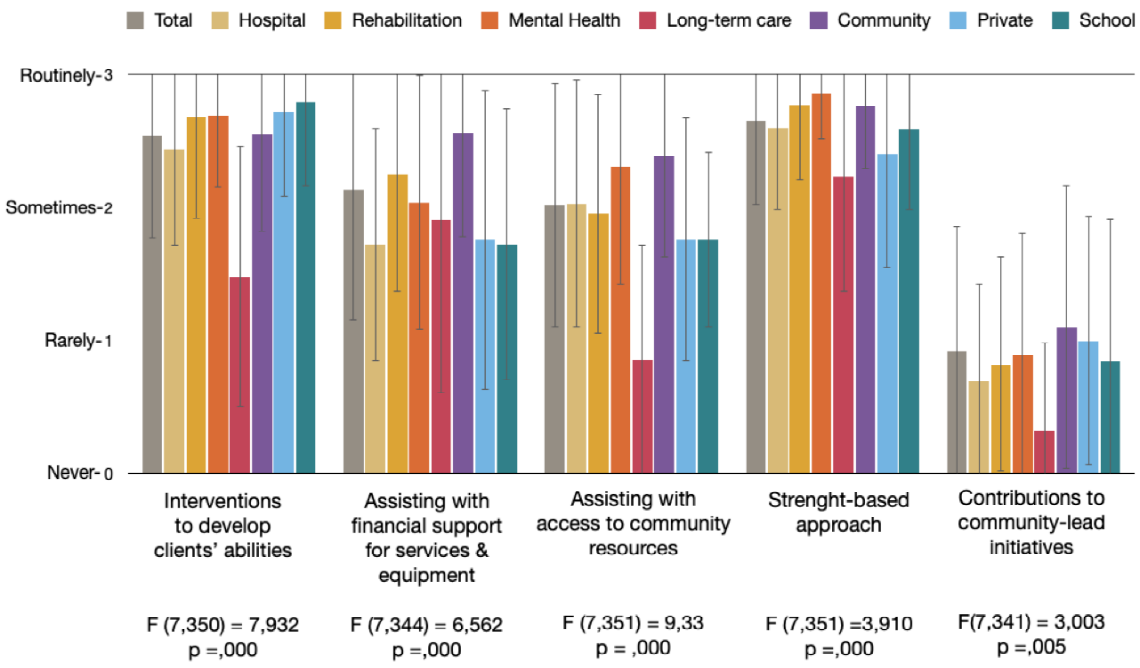

Figure 12: Results of one-way ANOVA comparing use of health equity actions by practice settings

Figure 12 shows the differences in the frequency of use of these actions between practice settings as well as the corresponding results of the one-way ANOVA. As seen in Figure 12, respondents working in community settings were more likely to report assisting clients to get financial support for services and equipment (M= 2,56, SD= 0,79), referring clients to community resources (M=2,39, SD= 0,77) and contributing to community-lead initiatives (M=1,10, SD=1,07). In contrast, those working in long-term care settings were less likely to carry out interventions to develop clients' abilities linked to SDOH (M= 1,48, SD= 0,98), to assist with access to community resources (M=0,85, SD= 0,88), to adopt a

strength-based approach with clients and families (M=2,23, SD=0,87), and to contribute to community-lead initiatives (M=0,32, SD = 0,67).

Workplace mandates also affected frequency of equity-oriented actions. Respondents who reported that community outreach was part of their current mandate were also more likely to refer clients to community resources during the OT process ($r = .333$, $p < .001$); to undertake health promotion and education activities ($r = .391$, $p < .001$); to contribute to community-lead initiatives on SDOH issues ($r = .364$, $p < .001$); to contribute to collective advocacy initiatives ($r = .348$, $p < .001$); and to engage in community and intersectoral partnership to tailor OT services to the needs of local communities ($r = .362$, $p < .001$).

No associations were found between the extent to which respondents reported the presence of organizational constraints in their practice context and the frequency of use of equity-oriented actions in their work. Statistically, this lack of difference could be explained by the fact that a great majority of respondents perceived that organizational factors had an impact on their capacity to integrate equity-oriented approaches, and therefore differences in practice would have to be quite marked to show significant variance.

Another characteristic of practice context is the diversity of population groups with whom occupational therapists routinely work. Spearman's rho correlation analyses were conducted to determine if respondents who worked more frequently with service users from structurally disadvantaged groups differed from those who worked less frequently with those population groups with respect to their use of equity-oriented approaches.

Survey results suggest that respondents who worked more frequently with clients who live on low income or with clients who are home insecure were more likely to refer clients to community resources ($r = .300$, $p < .001$; and $r = .346$, $p < .001$, respectively). In addition, respondents who worked more frequently with clients who are home insecure, who are from Indigenous groups, or who are from sexual and gender minority groups were more likely to consult and partner with community services and government agencies so that OT services better meet the needs of the local communities ($r = .320$, $p < .001$; $r = .362$, $p < .001$; and $r = 0.326$, $p < .001$, respectively). No statistically significant associations were found for other actions and other population groups. In contrast, respondents who reported that SDOH were not relevant to the issues for which clients seek their services were less likely to refer clients to community resources ($r = .318$, $p < .001$).

Factors associated with respondents' perceptions and competencies

To explore if there was a possible relationship between respondents' perceptions of equity-oriented approaches and the frequency with which they undertake actions in their practice, Spearman's rho correlation analyses were conducted for all 13 actions and the 6 items intended to measure respondents' perceptions of these approaches (i.e., perceived scope of practice, perceived importance). Only one statistically significant relationship was found: the extent to which respondents agreed that understanding the influence of upstream determinants (i.e., sociocultural, economic, political factors) on clients' occupations, health, and well-being was key to heath equity approaches showed a positive association with engaging in critically reflexive practice ($r = .361$, $p < .001$). No other statement measuring respondents' perceptions was correlated with the frequency of actions in

practice. Again, this lack of statistical association could be explained by the fact that a great majority of respondents recognized the importance of health equity approaches in occupational therapy or indicated that these approaches were within the professional scope of occupational therapists, so these items showed little variance. Thus, differences in practice would have to be quite marked to show correlations. At the same time, these results suggest that there may be discrepancies between respondents' understanding of the importance of equity-oriented approaches and their capacity to enact those in their practice.

To explore if there was a possible relationship between respondents' education, experience, or practical competence in equity-oriented approaches and the frequency with which they undertake actions in their practice, Spearman's rho correlation analyses were conducted for all 13 actions. Surprisingly, respondents' perception of their preparedness to understand and address SDOH and health equity through their occupational therapy education was not statistically related to any of the actions in the survey (all $r < .100$; $p < .001$). Neither was the years of practice of respondents nor their level of education completed (all $r < .170$; $p < .001$). However, the extent to which respondents judged that they had the knowledge and skills to engage in advocacy activities as well as the knowledge and skills to build community and intersectoral partnerships were both statistically correlated with the frequency of undertaking activities at the community or systems level; which are health promotion and education activities (advocacy skills $r = .342$, $p < .001$; partnership skills $r = .421$, $p < .001$), contributions to community-lead initiatives (advocacy skills not correlated; partnership skills $r = .389$, $p < .001$), contributions to policy work ($r = .301$, $p < .001$; $r = .418$, $p < .001$, respectively), contributions to collective advocacy initiatives

(r=.360, p <.001; r =.437, p <.001), and engaging in intersectoral partnership to tailor OT services to the needs of local communities (r =0.360, p <.001; r=.740, p <.001). Put differently, those who undertook these actions in their practice were more likely to perceive that they have the practical competencies to engage in advocacy and outreach approaches. Alternatively, those who perceived that they have advocacy and partnership skills and knowledge were more likely to contribute to health promotion, community-led initiatives, policy work, advocacy and intersectoral partnerships. It is worth noting that self-perceived partnership skills were consistently more strongly correlated with these actions than advocacy skills.

Summary

This chapter presented the survey results as well as a description of the characteristics of the occupational therapists who participated in this study. It described which SDOH and health equity approaches were used in respondents' practice and revealed those that were less frequently undertaken in practice. It identified the current barriers, facilitators, and needs experienced by respondents in their everyday practice. It also explored possible relationships between actions reported by occupational therapists and characteristics of their practice contexts and factors associated to respondents' perceptions of, or competencies in health equity approaches. In the next chapter, these findings will be discussed in more depth and compared to current literature on health equity.

CHAPTER 5: DISCUSSION

There is a growing recognition of the importance of promoting and incorporating health equity and the social determinants of health in the design and delivery of health services (Allen et al., 2013; Browne et al., 2015; PHAC, 2018; PHAC, 2014), including in occupational therapy practice (Bass & Baker, 2017; Bruggen, 2014; CAOT, 2012; Gerlach; 2015; Jull & Giles, 2012; Pitonyak et al., 2015; Restall et al., 2018). Yet, as mentioned in the review of the literature, there is a complete absence of evidence related to how occupational therapy providers are currently attempting to address these issues in their work. The study findings provide a starting point to identify opportunities to integrate SDOH and health equity initiatives in the delivery of occupational therapy services and identify the factors that support the implementation of these approaches in everyday practice. Results that may have implications for practice and delivery of occupational therapy services, organizational decisions about services, and education programs are highlighted and discussed in this chapter.

Opportunities for action in OT practice

Recall that equity-oriented approaches were operationalized into five domains of action: addressing the SDOH with clients during the OT process; adopting equity-oriented practices in the evaluation of OT services; partnering with communities and other government sectors; integrating SDOH and health equity in education activities; and advocating for the occupational needs related to the SDOH at the individual, local and system levels. The survey results provide evidence that some aspects of Canadian

occupational therapy practice contribute to promoting SDOH and health equity and that a range of actions are currently employed in practice at the level of clinical encounters, in the evaluation and monitoring of occupational therapy services, and at community and population levels. Interestingly, while Canadian occupational therapists in the study were already practising core elements of equity work, several respondents noted that they were not necessarily calling it by that name. As we saw in the previous chapter, some domains of activities were more often undertaken in respondents' practices than others. Therefore, survey results also reveal areas of practice that could be explored further to enhance the integration of equity-oriented approaches in occupational therapy.

Building inequity-responsive practices

Inequity-responsive practice is part of how health equity work can be integrated in health services and is defined as addressing the client's needs and priorities related to their lived experiences of adverse SDOH as a legitimate and routine aspect of the clinical process (Wong et al., 2014). There are still significant gaps in knowledge about how to make healthcare services, including occupational therapy, more responsive to the needs of structurally disadvantaged groups and how to address the lived realities of adverse SDOH in clinical practice (Browne et al., 2015). The results of this study provided emerging evidence of initiatives that occupational therapists have built into their routine practice to better take into account their clients' needs and priorities related to SDOH within their practice processes.

An examination of the frequency of use of actions included in the survey shows that the majority of respondents engaged, at least occasionally, in actions to address clients' needs related to SDOH during the practice process. Overall, this component of health equity work appears to be the most commonly integrated into everyday occupational therapy practice. For instance, using a strengths-based approach (such as the recovery models in mental health), building clients' abilities in occupations associated with key determinants of health (e.g., work, education, early development, etc.), and referring clients to needed health and social services are strategies that appear to be widely integrated into respondents' practices. These actions are elements of effective enablement and are not specific to health equity approaches as such. However, given that these interventions were the most frequently employed among respondents, they could provide a common ground in ongoing discussions about how occupational therapists might contribute, minimally, to tackle SDOH and health equity within the scope of their practice.

Interestingly, most respondents reported expanding the scope of their routine assessment beyond their clients' functional abilities to identify client concerns and priorities about basic determinants of health (e.g., income, food, and housing security), their social support networks, or the meso-level environmental factors (e.g., transportation services, education or working conditions, financial support programs, service organization, etc.) impacting client occupational engagement and well-being. Similar to the conclusion from a multimethod study in Canadian healthcare settings (Naz et al., 2016), the results of the correlation analysis conducted in this study revealed that respondents who integrate SDOH related factors in occupational therapy assessment were more likely to also connect their

clients to community-based services. These findings draw attention to the importance of identifying with clients their needs and priorities related to SDOH during OT encounters as a starting point to be responsive to clients' non-clinical occupational needs within the practice process. Put differently, to be able to do something to positively impact the social and economic factors that detrimentally affect clients' occupations and everyday lives, occupational therapists must first ask their clients about these factors. While this study remains an exploratory survey and does not provide evidence that these factors are integrated broadly during the assessment process in occupational therapy, it seems to suggest that practitioners do attend, to some extent, to SDOH and related social factors during clinical encounters and do not necessarily reduce occupational issues only to individual-level factors, such as abilities or personal choices, for instance. Coherent with the literature on equity and diversity in occupational therapy (Beagan, 2015; Gerlach, 2015; Hammell, 2019), some respondents also reinforced the importance of using standardized assessment tools with caution, recognizing that built in sociocultural assumptions and middle-class views about 'normal' occupational performance made those assessments inadequate for some clients.

In addition, several practitioners indicated that principles of trauma-informed care framed the ways they understand and address clients' experiences of adverse SDOH in clinical encounters. Some respondents recognized the need to mitigate the potential triggering effects of routine interventions, such as standardized assessments or screening protocols for instance, as well as the importance of mitigating potential experiences of dismissal and discrimination within healthcare settings. In general terms, trauma-informed and violence-

informed care aims at recognizing and modifying routine practices in health and social services that have potential traumatizing effects and creating safe and trusting clinical contexts (Browne et al. 2015; Wong et al., 2014). Trauma- and violence-informed care involves recognizing that people impacted by social and health inequities are often at greater risk of experiencing interpersonal and structural forms of violence and that they often face more barriers to access support and services to improve their emotional and physical safety (Browne et al., 2015).

From a critical health perspective, trauma is not limited to its interpersonal and psychological factors, but intersects with social determinants of health such as immigration-related factors, socioeconomic inequities, gender inequities, systemic racism, disability and ableism, stigma, historical injustices, and other forms of discrimination (Birnbaum, 2019). For instance, Link, Phelan, and their colleagues (Hatzenbuehler, Phelan, & Link, 2013; Phelan, Link, & Tehranifar, 2010; Phelan & Link, 2015) documented how socioeconomic inequities, racism, and stigma, are rooted in inequitable social relations that increase the risks of being exposed to traumatic events, and to pervasive stress due to adversity, discrimination, and social marginalization. In turn, these social structures create inequities in access to the resources (i.e., money, knowledge, social connections, power and prestige) necessary for improving health, well-being, and security and influencing the utilization of health and support services (Hatzenbuehler et al., 2013; Phelan et al., 2010; Phelan & Link, 2015). Increasingly, culturally safe and trauma-informed approaches are adopted in different healthcare settings as essential components to understand and address health and social inequities in clinical practice (Browne et al, 2015; PHAC, 2018). While

there is a growing attention to the principles of cultural safety in occupational therapy in Canada (Association of Canadian Occupational Therapy Regulatory Organizations [ACOTRO], Association of Canadian Occupational Therapy University Programs [ACOTUP], CAOT, Canadian Occupational Therapy Foundation [COTF], & Occupational Therapy Professional Alliance of Canada [OTPAC], 2014; Jull & Giles, 2012; Gerlach, 2012; Trentham et al., 2018), especially regarding more equitable services for Indigenous peoples, trauma- and violence-informed practices have received less attention within the profession. Integrating trauma- and violence-informed care to occupational therapy practice has the potential to improve occupational therapy services for those who experience persistent adverse SDOH and to create safer occupational therapy encounters both at the client-therapist level and at an organizational level.

Connecting clients to community services, assisting with accessing programs and funding for needed equipment and income support, and assisting clients with navigating the healthcare system to access needed services were found to be an important part of how occupational therapists adjusted their practice and integrated advocacy for clients' SDOH related needs in their everyday practice. Respondents recognized that the healthcare system, funding programs for equipment and assistance services for those who experience disability, and other government agencies were often complex to navigate. They were also cognizant of the resources (e.g., transportation, money, time, and work flexibility) and knowledge (e.g., health literacy, knowledge of the services and programs, fluency in official languages) required for individual service users to access these services, including occupational therapy services. Albeit less frequently, occupational therapists in this study

also consulted with communities to better tailor occupational therapy programs to the priorities and needs of local communities and to create pathways to access services, plus contributed to build community capacity by sharing their specialized knowledge and skills with families and community-based workers, for instance. These results are coherent with emerging approaches in the occupational therapy literature (Gerlach et al., 2018a; Malfitano & Lopes, 2018) which suggest that connecting clients to community resources, tailoring occupational therapy services to each community and building partnerships with community organizations are practice-level interventions that could support more socially responsive occupational therapy services. Making explicit the professional activities that address clients' SDOH related needs and recognizing those as being a legitimate aspect of routine occupational therapy practice is important because, as respondents in this study emphasised, these professional activities are often made invisible, or unfeasible, in the accountability data through which the healthcare system focuses on indicators such as direct contact time, length of stay, and other caseload measures. A subsequent section of the discussion will examine further the impact of organizational constraints on the integration of equity-oriented approaches in occupational therapy practice. But first some attention to how survey respondents integrated an equity lens into program evaluation.

Integrating a health equity lens in evaluation and improvement of OT services

The survey results show heterogeneity in the way the different equity-oriented approaches to the evaluation of occupational therapy services are integrated in practice. This study provides evidence that critical reflexivity and client evaluation of services, which are both identified as key competencies in documents guiding Canadian occupational therapy

practice (CAOT, 2012; Townsend & Polatajko, 2013), are actually being employed in occupational therapy practice. In contrast, results indicate that the integration of approaches specifically aimed at collecting and analyzing data, and reducing inequities in access, utilization, and outcomes of occupational therapy services remain marginal.

Within the last decade, critical reflexivity is an approach towards diversity that has received growing attention within the profession and has been officially adopted by the profession in Canada as one of the main approaches to work across social and cultural differences (ACOTRO, ACOTUP, CAOT, COTF & PAC, 2014). Critical reflexivity goes beyond the recognition of therapists' individual-level biases or taken-for-granted professional assumptions and requires the examination of everyday professional practices and client-therapist encounters in relation to social contexts, social structures and power relations (Beagan, 2015). For practitioners, critically questioning their own practice is less contingent upon organizational context and workplace mandate than other forms of program evaluation, which may explain in part why a majority of occupational therapists in this study seem to have integrated this approach in their professional practice. Interestingly, results from the correlation analysis suggested that respondents who engaged in critical reflexivity were also more likely to recognize the importance of structural factors on health and occupational well-being. Yet, a majority of respondents thought they had little guidance on what they could actually do to tackle structural inequities in their clinical practice. As some critical occupational therapists have suggested (Gerlach et al., 2018; Hammell, 2016), the insights gained from this study point to the possibility of integrating

structural competency in occupational therapy education and professional reasoning to better implement critically reflexive analysis into routine clinical practice.

Structural competency is an approach based on interdisciplinary understandings of diversity and health equity that is emerging in medicine and medical education in the United States. The approach aims at developing a set of competencies in clinicians to understand how social structures affect client health and to rearticulate clinical symptoms (e.g., depression, trauma, substance use) or cultural differences in structural terms; to understand how structures affect clinical encounters, routine practices, and institutional behaviours in healthcare; and to generate strategies to address stigma and inequities in and beyond clinical practice, including anti-racist practices, community engagement, peer support training, and policy analysis and advocacy, among other interventions (Hansel & Metz, 2019; Metzl & Hansen, 2014). This approach also highlights the need for clinicians to develop structural humility (Metzl & Hansen, 2014) which is defined as "respecting and deferring to the knowledge of patients and communities, rather than only or primarily considering the knowledge of the health 'expert'" and it "encourages clinicians to follow the lead of patients and communities in developing appropriate, sustainable interventions to address harmful social structures" (Neff et al., 2019, p.58)

Survey results also revealed that there is a need to better integrate a health equity lens in the evaluation and monitoring of occupational therapy services. What stood out in the literature on health equity in the health sector is that the collection and analysis of sociodemographic data is needed to inform decisions about development, evaluation, and

funding of services and programs and for policy advocacy about SDOH at a community or population level (Giesbrecht et al, 2016; IHE & WMA, 2016; PHAC, 2014; PHAC, 2018; Williams-Roberts et al., 2018) For instance, in its recent report on health inequities in Canada, the Public Health Agency of Canada (2018) called for the collection and analysis of disaggregated data to document disparities in experiences of health and healthcare services for different population groups. Disaggregating data, for instance by age, gender, sexual orientation, income, income source, rural/urban location, race, ethnic background, disability and citizenship status could help expose hidden trends about access, utilization, and outcomes of occupational therapy services. For example, the sample in this study seems to have a low proportion of occupational therapists working routinely with individuals who are recent immigrants or refugees, who are from Indigenous groups, or from sexual and gender minority groups, which raises questions about access to occupational therapy services for these groups in the Canadian population.

Equity-oriented impact assessments have been recommended to identify both known and unanticipated consequences of programs design and delivery in healthcare services (PHAC, 2018). Restall and colleagues (2018) recently proposed a framework to integrate SDOH and equity principles into the existing program evaluation and development process. However, the survey results suggest that these principles have not yet been taken up in practice. As respondents in the study indicated, there are few opportunities for front-line practitioners to take part in decisions at an organizational level within the health system. Moreover, while clients' evaluation of OT services seems to be integrated in the practice process of respondents, the study provided only a few examples in which OT

service evaluation and improvement processes have been done in collaboration with communities or service user groups. Although the occupational therapy profession values client-centred practice, there is a need to better integrate practices which move beyond the participation of individual service users and facilitate the active participation of community and service user groups in decisions about OT services.

From a slightly different perspective, the current Canadian occupational therapy guidelines, *Enabling Occupation II*, indicate that occupation-based enablement is not well captured in biomedical accountability system in healthcare services and suggest that the profession needs "to develop program evaluation and quality assurance with accountability data on occupation-based enablement" (Townsend et al., 2013, p. 309). The growing importance of building robust evidence about SDOH and health equity in public health and healthcare settings could be an opportunity for the profession to build alliances with other professions, service user groups, and health administrators and to develop new forms of accountability that could make both health equity and enabling occupation more explicit.

Opportunities for actions at community and systems levels

Over a decade ago, the WHO report on the SDOH (2010) contended that approaches to tackle SDOH require intersectoral policy actions to reduce inequities stemming from public policy decisions in areas such as employment, public provision of education and health services, housing, and social security, and other policies that have a significant impact on life opportunities and living conditions in our society. The report emphasised that these actions need to reach beyond the health sector and need to be undertaken collaboratively

with communities, including groups in the society that are disproportionally affected by adverse SDOH (WHO, 2010). However, survey results showed that contributions to community-led initiatives, collective advocacy, and policy work to improve key determinants of health and occupational well-being were among the approaches least frequently integrated in respondents' practices. Despite the occupation therapy literature increasingly supporting the role of occupational therapists in occupation-based approaches at the community, organizational, and population levels beyond their roles in the health sector (Bass & Baker, 2017; Bruggen, 2014; Kirsh, 2015; Malfitano & Lopes, 2018; Lauckner et al., 2011; Leclair, 2010; Townsend et al., 2013) the study evidence suggests that these approaches are currently undertaken only by a small percentage of Canadian occupational therapists. Moreover, given the self-recruitment method used in the study, we can assume that respondents who completed the survey were already interested in issues pertaining to SDOH and health equity. The non-response bias, the fact that non-responders may hold different views or behave differently than those who participated in the study, is therefore likely to have over-estimated the extent to which occupational therapists currently undertake such approaches in their work.

The limited use of broader level approaches to tackle SDOH in occupational therapy practice highlighted in this study is concerning because it seems to narrow the roles of occupational therapists in addressing the SDOH to approaches at the level of individuals. Authors in public health argue that limiting SDOH-focused and health equity approaches to intervention programs directed towards specific individuals or groups to promote the development of skills and 'healthy lifestyle choices' (e.g., health or financial literacy,

counseling, parenting workshops, physical activity, health promotion activities, etc.) need to be applied with caution and are insufficient because they tend to leave untouched the public policy decisions and other broader societal factors that lead to inequitable distribution of adverse SDOH (Brassoloto et al., 2013; PHAC, 2018; Raphael, 2011). These concerns are relevant to occupational therapy practices. Indeed, critical occupational therapists have raised concerns about how predominant occupational therapy approaches that focus on changing individuals' behaviors or skills linked to occupational performance reinforce an individualist and neoliberal perspective in which individuals are held responsible for their health and occupational engagement and unintentionally contribute to maintaining the status quo (Gerlach et al, 2018; Hammell, 2016; Hammell, 2019).

Nonetheless, some respondents provided examples of contributions to a range of community-based initiatives to tackle occupational issues linked to SDOH and of contributions to collective advocacy and research activities in alliance with specific groups in the population to advocate for more equitable access to health services and equipment provision. However, recall that these were sometimes undertaken on a voluntary or personal basis, outside respondents' paid positions as occupational therapists. The possible explanations for the limited use of broader level approaches to tackle SDOH in everyday occupational therapy practice are multifold. As some respondents reported, it may be that some occupational therapists do not think that these approaches are relevant to their clinical practice and do not seek opportunities to be involved in these types of initiatives. On the other hand, it could also be that, despite a willingness to integrate broader level approaches in occupational therapy practice, these professional activities may not be supported by

occupational therapists' workplace mandates and local managers or that there may be few opportunities for front-line OT practitioners to engage in collective actions in their work. For instance, we saw that respondents who worked only in a clinical role were less likely to get involved in these approaches than respondents who also had other professional roles. This is not a surprising result since occupational therapists in a clinical role would be more likely to be accountable for direct therapy with individual service users. With a very high proportion of the Canadian OT workforce in clinical roles (87,9% according to CAOT membership statistics; CIHI, 2017), there is a need for professional organizations to promote the contributions of occupational therapists in community-based and population approaches, not only within the profession, but more broadly to employers and government agencies. Furthermore, the study results exposed the need to build occupational therapists' collective ability and to put in place mechanisms that support contributions to intersectoral actions on health equity and SDOH rather than putting the responsibility for undertaking such initiatives only on individual therapists.

Factors influencing the integration of health equity approaches

This study aimed to identify factors associated with practice contexts and with knowledge, skills, and perceptions of occupational therapists that may influence the integration of health equity approaches in occupational therapy practice. Of course, the integration of health equity approaches in day-to-day occupational therapy practice is complex and multifaceted. However, the survey results provide descriptive evidence of the main factors that were identified as barriers and enablers by occupational therapists in their practice. To paraphrase the critical social theorist Young (2011), constraints and opportunities for

actions on structural inequities are often framed as something unchangeable and identifying these processes as well as our connection to them contributes to opening up possibilities for change.

Incongruence between values and capacity for actions

As discussed previously, a great majority of respondents reported that organizational constraints, such as cost-control mechanisms, workload measurements, lack of management buy-in, scarcity of resources, time constraints, and staff shortages in their workplace, had a profound restrictive impact on their capacity to implement health equity approaches in their daily work. Organizational barriers to SDOH and health equity actions have repeatedly been identified by healthcare providers in other studies conducted in Canadian contexts (Brassolotto et al., 2013; McPherson et al., 2016; PHAC, 2014). Similar barriers have also been identified in occupational therapy studies showing that occupational therapists' intentions to integrate enabling and client-centred practices beyond services to individual clients were often restricted by organizational and institutional processes in the health system (i.e., job descriptions, documentation, accountability measures, program policies and guidelines, etc.) that do not support these kinds of approaches (Durocher, Kinsella, Mccorquodale, & Phelan, 2016; Restall, 2008; Townsend, 1998).

Furthermore, results in this study revealed a possible misalignment between respondents' perceptions of the importance of health equity approaches and their actual capacity to enact those approaches in their practice settings. We saw that while a majority of respondents perceived that SDOH and health equity approaches were important and that these

approaches were within the scope of practice of occupational therapists, these perceptions were not correlated with the frequency of use of health equity approaches in practice. Something else seems to stand in the way of integrating health equity work in their day-to-day practice. Survey results also indicate that a majority of respondents experienced a feeling of being at a loss about how to address the structural inequities they encountered in their practice and that feeling well prepared on SDOH and health equity issues through OT education did not reduce that sense of being at a loss in their practice.

The tensions between the perceived importance of health equity approaches and the organizational constraints experienced in practice can have significant negative consequences for both services users and occupational therapists. Importantly, occupational therapists in this study expressed concerns about the ways that long wait times for OT services in the public health system, general budgetary pressures, and restricted or fragmented access to needed services and programs, might have an impact on the accessibility, outcomes, and responsiveness of their services, especially for service users with complex clinical needs or for those from structurally disadvantaged groups. These insights also denote the precarity of health equity approaches in the context of austerity measures in the health system in many jurisdictions in Canada, especially since health equity work is not a mandatory outcome of health services (PHAC, 2014). Furthermore, we know from studies examining work-related stress among healthcare providers that a lack of congruence between clinicians' values and intentions and their ability to provide responsive care in the context of resource-constrained, labour-intensive healthcare is a significant risk factor for burnout and compassion fatigue (Sinclair, Raffin-Bouchal,

Mijovic-Kondejewski, & Smith-Macdonald, 2017). In addition, a restricted scope of practice, a diminished feeling of effectiveness, and high workload are all risk factors for burnout among healthcare providers (Sinclair et al., 2017). These constraints need to be explicitly addressed when integrating a health equity lens in occupational therapy practice and education. As discussed further in the following sections, although it is an important component, it is not sufficient to sensitize occupational therapy students and practitioners to SODH, health and social equity issues. As Browne and colleagues contended in their analysis of equity-oriented practices (2015), it is questionable whether awareness of these issues alone would lead to the integration of health equity approaches without supportive professional and organizational milieus that dedicate resources and review their policies and processes to support changes.

Enabling environments

The survey results also provide descriptive data concerning the factors that support the integration of equity-oriented and SDOH-focused approaches in day-to-day occupational therapy practice. Perhaps unsurprisingly, the most common facilitators that emerged from survey responses pertain to organizational factors, such as local management support, workplace mandate, dedicated resources (i.e., time, funding, staff) for equity-oriented initiatives, and interprofessional collaboration. Occupational therapists in this survey provided specific examples of elements in their organizations that contributed to their capacity to integrate equity-oriented approaches into clinical practice, such as the adoption of a health equity framework within the organization, access to critical thinking workshops, diversity and anti-discriminatory practice training, working committees for front-line

practitioners, integration of socio-demographic information into prioritization criteria or need assessments, and direct and senior managers who foster a culture of equity and who provide concrete support and resources to initiatives around health equity. These findings are similar to factors identified in other studies on health equity approaches in the Canadian health sector that also highlighted the importance of enabling organizational environments for the implementation of these approaches (Browne et al., 2015; McPherson et al., 2016; PHAC, 2014; Williams-Roberts et al., 2018).

Furthermore, there was a consensus among respondents on the importance of having the organizational support to work to the full scope of occupational therapy practice in order to be better meet clients' occupational, social and clinical needs. Results of the statistical analysis also support the idea that workplace mandate and having a local organizational context that makes it possible for occupational therapists to work at the full scope of their practice can have a positive impact on capacity to integrate equity-oriented approaches. Correlation analysis showed that having the mandate to engage in community outreach was positively correlated with engaging more frequently in community and systems level activities. Practice settings also seemed to have a significant influence on the integration of health equity approaches. Recall that respondents working in community and mental health settings were found to be more likely to employ some of the approaches, especially actions with individual clients during the practice process, while those working in long-term care settings were systematically less likely to do so. Of course, the models of service delivery and workplace mandates of occupational therapists can vary significantly depending on their specific area of practice across the continuum of health services. For

instance, it is likely that occupational therapists working in long-term care settings have fewer opportunities to undertake interventions such as connecting clients to community resources and building partnerships with community organizations. That being said, it would be problematic to understand health equity work as the responsibility of only some occupational therapists, such as those working in community-based settings or working frequently with clients from structurally disadvantaged groups. The SDOH affect us all across our life span and equitable opportunities for health and healthcare require occupational therapists, as well as other healthcare providers and managers, to consider how health equity considerations can be integrated into their routine work regardless of healthcare setting. The differences between practice settings observed in this study suggest, however, that research and knowledge exchange among occupational therapists are needed to better identify how to adapt equity-oriented approaches to the specificity and challenges of different settings and areas of occupational therapy practice.

In her theory of social justice, Young (2011) alleged that responding to structural inequities was not part of most people's assigned responsibilities and this excuse was often used by individuals and institutions to distance themselves from their responsibility to take specific actions to address the social processes that produce inequities. She put forward the model of *shared responsibility* in relation to structural injustice as a "model that involves joining with others to organize actions to reform the structures" (Young, 2011, p.112). While some survey respondents perceived that addressing SDOH-related needs was more the mandate of other professionals (i.e., social workers, counsellors, case managers), there was also a recognition that providing socially responsive and equity-oriented services was a shared

responsibility within a team. Addressing the SDOH and health equity is complex and cannot be achieved by a single program or profession. Interprofessional collaboration and engagement with communities have been identified as key facilitators in health equity work in health services (Wong et al., 2014). Similarly, several occupational therapists in this survey reported that working in collaboration with other professionals within their program and with different resources in the community enhanced their capacity to meet their clients' needs and priorities related to SDOH. In addition, exploratory analysis of the survey results suggests that self-perceived competency in building community and intersectoral partnerships was positively correlated with frequency of actions at community and systems levels. These findings seem to support the importance of building partnerships with communities and with interdisciplinary colleagues within and outside the health sector to support equity-oriented approaches in occupational therapy.

Building occupational therapists' capacity for health equity work

The Institute of Health Equity & World Medical Association (2016) recommended that the education of health professionals should go beyond a theoretical understanding of SDOH and should include practical competencies to tackle the SDOH and health equity, such as taking social histories, communication skills in advocacy roles, partnership skills, and integrating health equity considerations in the provision and evaluation of health services. The findings of this study seem to support the idea that integrating health equity and SDOH content into existing occupational therapy curriculum and professional development resources should put an emphasis on the development of practical competencies linked to health equity approaches. While a client-centred practice, an occupational perspective on

health, and the inclusion of broader environmental factors in occupational therapy theoretical models were attributes of the profession that were perceived as supportive to the integration of SDOH and health equity approaches, occupational therapists in this study identified the need to discuss health equity issues more broadly within the profession and for better guidance on how to tackle these issues in clinical practice. When asked about what resources would best support the integration of health equity approaches in their work, a great majority of respondents identified the need for training on specific approaches associated to equity-oriented practices, such as cultural safety, trauma- and violence-informed practice, policy work, or community partnership. In correlation analysis, recall that perceived partnership and advocacy skills were correlated with an increased integration of equity-oriented approaches at a community and systems levels; partnership skills were more strongly correlated with the integration of health equity approaches. Partnership skills are considered core occupational therapy competencies, yet the skills included in the *Profile of Occupational Therapy Practice in Canada* (CAOT, 2012) are limited mainly to collaboration with service users and interprofessional collaboration. Building an understanding of intersectoral practices and developing partnership skills to work with communities is a facet of professional development that is particularly interesting to explore further in order to support the role of occupational therapists in tackling SDOH and health equity.

Importantly, correlation analysis showed that the perceived level of preparedness related to SDOH and health equity through entry-to-practice OT education was not correlated with integration of health equity approaches in practice. In addition, despite the fact that

occupational therapists who graduated more recently were more likely to judge that their education prepared them well on these issues, years of practice did not seem to have an impact on the overall use of health equity approaches in practice. While occupational therapy programs in Canada seem to have integrated more health equity and SDOH content in their curricula in recent years, it may be important to examine further *how* student occupational therapists are prepared to integrate and enact health equity approaches in practice contexts. Again, structural competency could be a framework warranting further examination in order to integrate practical competencies related to health equity and SDOH in occupational therapy curriculum and professional development. This framework can help occupational therapists develop a structural analysis of clinical situations and healthcare practices, and can help guide educators on how to integrate content on equity, diversity, structural violence, bias assessment, and privilege into their pedagogical approaches (Hansen & Metz, 2019).

While survey findings indicate the need for more opportunities for occupational therapy students and practitioners to develop their knowledge and competencies, building occupational therapists' capacity for health equity work also requires changes at the level of the profession. Over the past decade, occupational therapists have repeatedly voiced concerns that employing theories, assessments, and outcome measures that are culturally-specific to privileged groups in the Minority World could be inadequate, disempowering, or oppressive when employed in context that are culturally, economically or socially different (Beagan, 2015; Gerlach, 2015; Hammell, 2013; Hammell, 2019; Hocking, 2012). Recently, Hammell (2019) argued that increasing the diversity and plurality of perspectives

within the profession could lead to more inclusive, socially responsive, and culturally-safe occupational therapy practices. It is time to reconsider the social, political and cultural biases built into the very foundations of the profession, into theories, models of practice, assessments, and structures of practice.

Furthermore, a CAOT panel (2015) discussed the need to increase the diversity within the Canadian occupational therapy workforce and to facilitate the integration of professionals from diverse backgrounds in occupational therapy programs and workplace. Despite a lack of statistics on the Canadian occupational therapy workforce, the sociodemographic information gathered in this survey support the idea that Canadian occupational therapists are predominantly female, Caucasian or European descent, heterosexual, temporarily abled-bodied, and from socioeconomically privileged backgrounds. Results also showed that people experiencing disability, members of Indigenous groups, members of racialized and ethnic minority groups, members of sexual and gender minority groups, and people from working-class backgrounds are represented in disproportionately small numbers within the profession. There is an important body of evidence showing that diversity among health professionals can help reduce healthcare inequities by improving the quality of care for underserved communities, increasing the relevance and inclusiveness of clinical practices, and broadening the research agenda to address clinical and health services issues which disproportionately and negatively affect minority groups (Institute of Medicine of the National Academies, 2004). Ensuring more equitable access to the profession will require a critical review of the recruitment and admission processes in occupational therapy education programs to better support the entry and completion of occupational therapy

programs by students from under-represented groups (IHE & WMA, 2016). Furthermore, there is a need to increase retention efforts for minority occupational therapy students and professionals, since minority health professionals may be more likely to experience systemic barriers and marginalization in their education and work settings (Beagan, Carswell, Merritt, & Trentham, 2012; CAOT, 2015; Davis, 2020). Finally, increasing the collection and analysis of sociodemographic information on the Canadian occupational therapy workforce through CAOT and CIHI would help document and monitor efforts to enhance the diversity within the profession (CAOT, 2015).

Summary

This chapter discussed the survey results and their implications for occupational therapy practice. We saw that some aspects of occupational therapy practice contribute to promoting SDOH and health equity and that a range of actions were currently employed by respondents in their practice. Approaches at the level of the clinical encounter to provide inequity-responsive practice appeared to be more frequently embedded in everyday work, while equity-oriented evaluation of occupational therapy services or approaches at community and population levels are areas of practice that could be explored further to enhance the integration of health equity approaches in occupational therapy.

This discussion also raised important questions about factors that influence the capacity of occupational therapists to integrate health equity approaches in their work. It appears questionable whether awareness of these issues alone leads to the integration of health equity approaches in occupational therapy without supportive professional and

organizational milieus that dedicate resources, along with a review of policies and processes to support changes. It also appears that occupational therapy education and professional development should put an emphasis on the development of practical competencies linked to health equity approaches, including violence-informed and trauma-informed care and community partnerships. Structural competency may be a promising approach to help occupational therapists integrate structural analysis and critical reflexivity into their routine clinical practice and to incorporate practical competencies and content on SDOH and health equity into existing occupational therapy education programs. Finally, sociodemographic data gathered in this study, even if not completely representative of the Canadian occupational therapy workforce, suggest that enhancing diversity within the occupational therapy profession is a potential and important area for future actions. The final chapter of this thesis will focus on the implications of these findings for healthcare organizations, occupational therapy practice, education, and future research.

CHAPTER 6: CONCLUSION

This thesis research presented the results of an online survey conducted with over 360 Canadian occupational therapists, describing how they integrated equity-oriented approaches in everyday OT practice. It gave voice to occupational therapists regarding the barriers and facilitators they experience in their practice contexts. The statistical analysis of survey results also allowed exploration of whether actions undertaken by occupational therapists could be related to characteristics of their practice contexts or to factors associated with respondents' perceptions of or competences in health equity approaches. As anticipated at the outset, many therapists are actively working to address adverse SDOH in smaller and larger ways. Still, the study findings provide valuable insights into opportunities for actions to tackle SDOH and health inequities in occupational therapy practice, and into factors and resources that may help occupational therapists, education programs, and healthcare organizations develop their capacity for health equity work.

Strengths and limitations

This was an exploratory study on the integration of health equity approaches in occupational therapy that was conducted in the context of my Master's degree and its design has some limitations that need to be taken into consideration. First, and most significantly, these findings are obtained from a voluntary sample, which is known to overrepresent respondents who have a strong interest in the issue under study while underrepresenting those who are less interested in the topic. This sampling bias needs to be taken into consideration when drawing inferences on the integration of health equity

approaches within the profession in Canada. Indeed, it is likely that these results have over-estimated the extent to which occupational therapists support and currently undertake such approaches in their clinical work and have under-estimated those who have not embedded these approaches in their practice, as well as those who have a neutral or negative opinion of the relevance of these approaches to occupational therapy practice. Furthermore, some provinces, like Quebec and Manitoba, were overrepresented in the sample, while others, like British-Colombia and Prince Edward Island, were underrepresented or absent. This was likely due to the different methods of recruitment used through the provincial associations to promote the survey to their members. Data weighting helped reduce this sampling bias so the sample could reflect more accurately the distribution of occupational therapists across the country. Nonetheless, the perspectives of some groups of therapists are missing and may have been very different. The ability to check the demographics of the sample against CAOT statistics was also beneficial and allowed me to show that the survey sample and CAOT membership data were similar for age, gender, level of education, years of practice, geographic areas, and sites of practice. However, a probability sampling method which would have balanced the sample by province during the sampling process would have reduced these sampling biases.

In retrospect, limiting participation to the survey to occupational therapists who were currently working as frontline clinicians or direct service providers was also a non-trivial limitation to the study. This inclusion criterion has surely excluded occupational therapists in non-clinical roles whose perspectives and inputs on health equity work may have been very different. For instance, the exclusion of occupational therapists acting in managerial

roles within the health system has restricted my understanding of the organizational barriers and facilitators to the integration of health equity approaches in the delivery of occupational therapy services.

Another challenge in this study was how best to design the survey questionnaire. To date, there is no established tool to examine occupational therapy practice related to health equity. Thus, a non-standardized, author-created tool with unknown psychometric properties was the only possible approach. Basing the design of the questionnaire on existing frameworks on health equity and SDOH in health services minimized the risk of designing an unreliable and invalid measurement tool. The study design was also strengthened by developing the questionnaire structure based on current evidence in survey research (see Fowler, 2009; Saris & Gallhofer, 2007) and through pilot testing. Cronbach's alpha coefficients were calculated for each domain of actions and showed that actions within each domain were moderately related to one another, supporting, to some extent, the validity of the structure used in the measurement tool. However, it was notable that the response rate decreased halfway through the survey which increases missing data for the items later in the questionnaire. This suggests that respondents experienced survey fatigue; the questionnaire was probably too long. Furthermore, some complex concepts, such as behaviours and attitudes about social determinants of health and health equity, are difficult to operationalize and measure with survey questions (Fowler 2009; NCCDH, 2010). While closed-ended questions are more efficient to answer and analyze, the good response rate for open-ended questions and the interesting insights provided in these responses suggest that a qualitative approach would have been relevant for this topic. For instance, focus

group discussions may have provided a more in-depth understanding of the experiences, understanding, and attitudes of occupational therapists on integrating health equity approaches in their work. Focus groups would also be an appropriate method to get the perceptions of occupational therapists on the findings from this survey, especially on the factors that most significantly influence their capacity to integrate health equity actions in their practice.

However, this survey was the first empirical study to explore the integration of health equity approaches in occupational therapy which is an important strength. To date, the role of occupational therapists in tackling SDOH and health equity have been discussed in theoretical research, and this survey provided a basic, yet accurate, synthesis of the current practices, opportunities for action, and challenges encountered by Canadian occupational therapists in their clinical work. Based on other pan-Canadian surveys in therapy (e.g. Restall & Ripat, 2008; Thomas & Law, 2014), it was estimated that approximately 250 respondents might participate in the study. The relatively high volume of responses suggests that Canadian occupational therapists have an interest in addressing SDOH and health equity in their practice and indicates the importance of knowledge transfer efforts and networking for practicing occupational therapists on these issues.

Implications

The results of this study have practice and policy implications for healthcare organizations, occupational therapy practice, educational programs, and future research.

Implications for health organizations

First, it will be important to provide organizational support, resources, and manager buy-in within the health sector to support SDOH and health equity actions in occupational therapy, and more broadly, in the delivery of health services. The great majority of respondents indicated that organizational constraints were significant barriers to the integration of health equity and SDOH approaches in their practice. Organizational and policy changes within health systems are required to identify and address the practices and processes that contribute to health and healthcare inequities, across the continuum of health services. For instance, the adoption of a health equity framework and the integration of health equity indicators in the quality improvement process in health services would allow documentation of equity issues, making health organizations more accountable for the provision of equitable health services. Accountability systems in healthcare organizations should also reflect the scope of professional activities undertaken by occupational therapists to address SDOH-related needs of their clients and to reinforce community partnerships in their work. It is critical to push back against accountability structures that emphasize caseloads and discharge times, relegating equity-oriented practice to the margins. The findings also highlighted that health equity approaches would require efforts from healthcare organizations to mitigate work-related stress experienced by occupational therapists, and other healthcare workers, in the context of their work. Furthermore, there is a critical need in Canada for the collection and analysis of standardized demographic data, in an appropriate and sensitive manner, about clients using health services, including occupational therapy. This would help identify and address any gaps in access to services and differences in outcomes experienced by clients because of their ability, race and

ethnicity, sexual orientation, socioeconomic status, gender identity, or age, among other social factors.

Implications for practice

The findings indicate that more efforts are needed within the profession to support Canadian occupational therapists in integrating health equity approaches in their practice. While equity, alongside justice and diversity, is identified as a part of the enablement foundations in the Canadian Model of Client-Centred Enablement (Townsend & Polatajko, 2013), professional associations should provide concrete guidance to occupational therapists on how to integrate and apply health equity approaches in the scope of their clinical role. Developing clinical tools and best practices on SDOH and health equity approaches in occupation therapy, creating professional networks for sharing existing knowledge, initiatives and good practices, and providing access to resources, e-learning materials, and professional development opportunities to organize learning and capacity around health equity, cultural safety, violence-informed and trauma-informed care, anti-racism practice, equity-oriented impact assessments, policy work, and community partnership, among other approaches, would be beneficial. As discussed in the literature, some respondents also spoke of the importance of explicitly addressing the biases embedded into occupational therapy theories, models of practice, assessments, and methods of service delivery which may result, inadvertently, in inaccessible, unacceptable or dismissive services for diverse service user and population groups.

Despite the occupation therapy literature increasingly supporting the role of occupational therapists in occupation-based approaches at the community, organizational, and

population levels beyond their roles in the health sector (Bass & Baker, 2017; Bruggen, 2014; Kirsh, 2015; Lauckner et al., 2011; Leclair, 2010; Malfitano & Lopes, 2018; Townsend et al., 2013) the results of this study suggests that these approaches are currently undertaken only by a small percentage of Canadian occupational therapists in the scope of their professional practice. There is a need to promote the contributions of occupational therapists in community-based and population approaches on key social determinants of health such as child development, education, employment, or housing, not only within the profession, but more broadly to employers and government agencies. These findings also raise questions about the roles and responsibilities that professional associations might have to join with other social actors on advocacy initiatives for evidence-based objectives related to SDOH and heath equity. Many advocacy initiatives around SDOH and health equity in Canada are organized through intersectoral coalitions to increase political weight and share resources (NCCDH, 2105). Furthermore, as respondents in this study emphasized, building interdisciplinary and community partnerships was a significant enabling factor in their practice. Increasing the scope of Canadian occupational therapy associations' advocacy initiatives at regional, provincial, and national levels (beyond advocacy for increasing access to occupational therapy services) could allow occupational therapists, who may individually be restricted by their mandates or work contexts, to participate in intersectoral and upstream actions on SDOH and health equity issues within their professional role.

Working towards health equity in occupational therapy also comes about through equitable access to the occupational therapy profession. Evidence in the literature shows that

diversity among health professionals can help reduce healthcare inequities by improving the quality of care for underserved communities and minority groups. However, sociodemographic data gathered in the survey suggests that occupational therapists from minority groups in terms of race and ethnicity, socioeconomic backgrounds, gender and sexual identity, or disability, remain underrepresented within the Canadian workforce. Too often in occupational therapy, diversity has been discussed primarily as something that affects clients, yet it must also be addressed within the profession itself. There is a need for a comprehensive action plan to improve access to the occupational therapy profession, including access to occupational therapy education programs and employment, as well as key positions of influence within the profession. This strategic plan should include more inclusive admission and selection processes to occupational therapy programs, efforts for the retention of students from minority groups and the completion of occupational therapy studies, as well as increasing the collection and analysis of sociodemographic data in university programs and, through CAOT and the CIHI, on the Canadian occupational therapy workforce to document and monitor efforts to enhance the diversity within the profession. Professional organizations should develop concrete plans for improving the representation of therapists from marginalized groups within their ranks.

Implications for education

The survey results provided interesting and novel insights on how to better incorporate SDOH and health equity into the education of occupational therapists. Respondents who graduated more recently were more likely to report that their occupational therapy studies had prepared them relatively well on SDOH and health equity issues, which suggests that occupational therapy programs in Canada are gradually incorporating more elements on

SDOH and health equity into their curricula. However, level of preparedness through OT education did not predict the integration of health equity approaches in practice. Occupational therapy education and professional development should go beyond a theoretical understanding of SDOH and health equity to focus on the development of attitudes and practical competencies linked to health equity approaches, such as taking social histories, advocacy skills, critical reflexivity and bias assessment, equity-oriented evaluation of OT services, and community and intersectoral partnership skills, among other skills. Structural competency, an approach to equity and diversity advanced in medical training, appears to be a valuable approach to embed structural analysis and critical reflexivity into routine clinical practice and is an interesting avenue for occupational therapy education and research. In sum, scholars and educators involved in the education of Canadian occupational therapists should examine how core professional competencies pertaining to SDOH and health equity approaches should be included into courses, occupational therapy curricula, practicum placements, and more broadly into accreditation standards for OT education programs.

Implications for future research

Within the profession, there has been very little research attention to SDOH, health equity, and their implications for occupational therapy practice. This exploratory study provides an interesting starting point for more in-depth research on the experiences and understandings of occupational therapists on these issues and the applicability of health equity approaches in occupational therapy practice. There is a need to evaluate the effectiveness of different health equity and SDOH-focused approaches in occupational therapy, as well as their applicability and transferability in various areas of occupational

therapy practice. The online survey method was useful to identify the scope of actions undertaken by practitioners as well as the main gaps, challenges, and enabling factors in current practices. However, more participatory research methods involving researchers, occupational therapy practitioners, and service users would help generate findings that have more applicability for occupational therapy practice, service users, and communities.

More broadly, the growing field of research on occupational engagement and occupation-based enablement could benefit from using the interdisciplinary language related to SDOH and health equity. During my thesis research, I often wondered if the concept of occupational justice, predominant in current occupational therapy and occupational science literature, was not creating a conceptual and communication barrier with other disciplines and stakeholders regarding the issues of SDOH and health equity. While this terminology puts forward the importance of occupations in health and well-being for individuals and communities, it also runs the risk of isolating occupational therapists from interdisciplinary research, valuable approaches advanced in other fields, and intersectoral alliances on SDOH and health equity.

Finally, as suggested by other Canadian occupational therapists (Hocking et al., 2015), researchers and authors in occupational therapy should be required to consider the policy implications of their findings when publishing in a Canadian journal or presenting in professional conferences. This would help develop a structural understanding of problematics that are often framed only in clinical terms and foster occupational therapists'

individual and collective capacity to engage in policy work to address the structural barriers to health and occupations.

Final remark

During this research process, it was moving and inspiring to read the multiple accounts of occupational therapists for whom the provision of equitable and socially responsive services was important, who critically examined and adapted their practices to better meet the needs and priorities of individuals and communities, but who also felt they were restricted in their capacity to generate the needed changes at a broader level to address the inequities they encounter in their everyday work. This brought forward the need to build our collective capacity to act on SDOH and health equity, to increase the awareness of existing initiatives and opportunities for actions in occupational therapy, and to join with others on collective actions on SDOH and health equity. In honour of the work those therapists are already doing, and the limitations they identify through ongoing critical analysis, I will conclude with a quote from Iris Marion Young on the need for collective action to animate social justice:

> Thousands or even millions of agents contribute by our actions in particular institutional contexts to the processes that produce unjust outcomes. Our forward-looking responsibility consists in changing institutions and processes so that their outcomes will be less unjust. No one of us can do this on our own. (Young, 2011, p. 111)

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APPENDIX A: RECRUITMENT EMAIL

DALHOUSIE UNIVERSITY

Dear OT colleagues,

You are invited to participate in a study conducted at Dalhousie University to identify the ways Canadian occupational therapists integrate health equity approaches into their professional practice and what might enhance that work. This study, which has received approval from the Research Ethics Board at Dalhousie University (REB #2019-4859), aims at understanding current practices, opportunities for actions, and challenges encountered by occupational therapists in their day-to-day work with regards to equity.

We would appreciate if you could contribute to our online survey. Must people complete the survey in 20 minutes. As a thank you, you (or a nonprofit organization of your choice) may enter into a draw for a $250 Visa gift card.

To complete the survey, click here.

If you have any question or require additional information about the study, please contact Charlène Rochefort-Allie, reg. OT (QC, NB) and lead researcher, at Charlene.rochefort@dal.ca

Thank you for your attention.

DALHOUSIE UNIVERSITY

Cher/chère collègue,

Vous êtes invité(e) à participer à un projet de recherche réalisé à l'université Dalhousie portant sur portant sur l'intégration des approches axées vers l'équité en santé en ergothérapie au Canada. Cette étude permettra de dresser un portrait des pratiques actuelles en matière d'équité et de documenter les besoins et priorités des ergothérapeutes pour mieux soutenir leur pratique.

Dans le cadre de cette étude, nous sollicitons votre participation pour remplir un questionnaire en ligne portant sur les approches axées vers l'équité dans votre réalité professionnelle. La plupart des répondants remplissent le questionnaire en 20 minutes. Votre participation est volontaire et strictement confidentielle.

Pour vous remercier, vous ou un organisme à but non lucratif de votre choix pourrez participer à un tirage d'une carte-cadeau Visa de 250$.

Lien vers le sondage.

Pour toutes questions ou informations relatives à ce projet de recherche, n'hésitez pas à contacter la chercheure principale à charlene.rochefort@dal.ca

En vous remerciant à l'avance pour votre précieuse collaboration.

APPENDIX B: ONLINE RECRUITMENT

Contribute to our study on health equity in occupational therapy.

A research team at Dalhousie University is currently recruiting occupational therapists across Canada to participate in a 20-minute survey which aims at identifying the ways practitioners integrate health equity approaches into their everyday practice and what may enhance that work. This is an opportunity to make visible the contributions of occupational therapists in tackling the social determinants of health and to make recommendations to further integrate equity-oriented approaches based on the realities of front-line practitioners.

By taking the survey, you or a non-profit organization of your choice could win a 250$ Visa gift card.

To complete the survey, click here.

If you have any question or require additional information about the study, please contact Charlène Rochefort-Allie, reg. OT (QC, NB) and lead researcher, at Charlene.rochefort@dal.ca

APPENDIX C: ENGLISH QUESTIONNAIRE

Welcome to the survey "Working Towards Health Equity in Occupational Therapy"

Before we begin the survey, we would like to determine whether respondents are eligible to take part in the study.

Are you currently registered as an occupational therapist in Canada?

☐Yes ☐ No

Are you currently providing direct occupational therapy services as part of your work (i.e. services to individual clients including clinical, case management, or consultation services)?

☐Yes ☐ No

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Practice Contexts

This first section asks questions about the contexts in which you work.

Which best describes your current occupational therapy position(s)? Please check all that apply.

☐ Direct service provider/ Clinician
☐ Case manager
☐ Consultant
☐ Manager/ Coordinator/ Administrator
☐ Professor/ Educator
☐ Researcher
☐ Other, please specify: ---*Text box*---

In which province or territory do you work?

☐ Alberta ☐ British Columbia ☐Manitoba

☐ New Brunswick ☐ Newfoundland/Labrador ☐ Northwest Territories

☐ Nova Scotia ☐ Nunavut ☐ Ontario

☐ Prince Edward Island ☐ Quebec ☐ Saskatchewan

☐ Yukon

Which best describes the area where you work?

☐ Northern & Remote regions

☐ Rural areas (population smaller than 1,000)

☐ Small population centres (population between 1,000 and 29,999)

☐ Medium population centres (population between 30,000 and 99,999)

☐ Large urban centres (population of 100,000 and over)

Which best describes the primary source of funding for your practice?

☐ Private ☐ Public ☐Other, please specify: ---*Text box*---

Which best describes the type of organizations where you work? Please, check all that apply.

☐ General hospital ☐ Rehabilitation facility

☐ Mental health facility ☐ Long-term care facility

☐ Community ☐ Private practice

☐ School or school board ☐ Government or para-governmental

☐ University ☐ Other, please specify: ---*Text box*---

Which best describes your area of practice?

☐ General physical health
☐ Physical Rehabilitation
☐ Mental health
☐ Vocational & Return to work rehabilitation
☐ Home care
☐ Pediatrics
☐ Geriatrics
☐ Palliative care
☐ Technical aids and equipment
☐ Health promotion & wellness
☐ Other, please specify: ---*Text box*---

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While many if not all of your clients likely face disability, we would like to know how often you work with clients or service users from other socially disadvantaged groups.

How often do you work with clients who live on low income?

☐ Never
☐ Rarely or Yearly
☐ Occasionally or Every few months
☐ Often or Monthly
☐ Routinely or Weekly
☐ Don't know

How often do you work with clients who are homeless or home insecure?

☐ Never
☐ Rarely or Yearly
☐ Occasionally or Every few months
☐ Often or Monthly
☐ Routinely or Weekly
☐ Don't know

How often do you work with clients who are recent immigrants or refugees?

☐ Never
☐ Rarely or Yearly
☐ Occasionally or Every few months
☐ Often or Monthly
☐ Routinely or Weekly
☐ Don't know

How often do you work with clients who are from Indigenous groups?

☐ Never
☐ Rarely or Yearly
☐ Occasionally or Every few months
☐ Often or Monthly
☐ Routinely or Weekly
☐ Don't know

How often do you work with clients who are from ethnic or cultural minority groups?

☐ Never
☐ Rarely or Yearly
☐ Occasionally or Every few months
☐ Often or Monthly
☐ Routinely or Weekly
☐ Don't know

How often do you work with clients who are from sexual or gender identity minority groups?

☐ Never
☐ Rarely or Yearly
☐ Occasionally or Every few months
☐ Often or Monthly
☐ Routinely or Weekly
☐ Don't know

Other population group, please specify: ---*Text box*---

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Equity-Oriented Approaches in Occupational Therapy

This section asks a series of questions about ways to address social determinants of health and health equity in everyday occupational therapy practice.

The social determinants of health refer to the broad range of social, economic, and political factors that influence the distribution of resources and social advantages/disadvantages, and that, in turn, shape the conditions in which people are born, develop, live, work, and age.

In Canada, the social determinants of health include:

- income &socioeconomic status
- education &learning conditions
- employment &working conditions
- housing
- food security
- early childhood development
- social support networks
- health services
- gender &gender identity
- ethnic &cultural background and racism
- geographic location
- functional health &disability
- indigeneity &colonization.

Health equity refers to the absence of unfair and remediable disparities in health across population groups. It also includes the absence of remediable disparities in the access to and utilization of health services.

Health equity work is understood to be both:

- a service delivery process, associated with ensuring equitable access to high-quality health services that meet the needs of the local populations;
- and a social change process, associated with upstream actions such as the development and implementation of healthy public policies for all.

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We would like to know more about the types of actions that Canadian occupational therapists might undertake to address the social determinants of health and health equity in their everyday practice.

Please indicate the frequency of the following professional activities in your current practice.

I carry out interventions intended to develop clients' abilities in occupations related to key determinants of health. E.g. child development, education, employment, community mobility, health literacy and self-management, etc.

☐ Never ☐ Rarely ☐ Sometimes ☐ Routinely ☐ N/A

I assist clients to access and use the health and social services they need.

☐ Never ☐ Rarely ☐ Sometimes ☐ Routinely ☐ N/A

I assist clients to get financial support for accessing services and equipment they need.

☐ Never ☐ Rarely ☐ Sometimes ☐ Routinely ☐ N/A

I refer clients to non-clinical support services and community resources for issues that affect their health and occupational well-being. E.g. housing services, child care services, disability organizations, peer support groups, etc.

☐ Never ☐ Rarely ☐ Sometimes ☐ Routinely ☐ N/A

I work with clients starting from their strengths as individuals and the strengths of their families and communities.

☐ Never ☐ Rarely ☐ Sometimes ☐ Routinely ☐ N/A

I evaluate whether clients judge that their occupational and clinical needs have been met as a result of receiving OT services.

☐ Never ☐ Rarely ☐ Sometimes ☐ Routinely ☐ N/A

I collect and analyze sociodemographic data on who is (and who is not) using OT services.

☐ Never ☐ Rarely ☐ Sometimes ☐ Routinely ☐ N/A

I examine how service details, such as location, hours, or referral processes, make OT services accessible (or not) for diverse groups.

☐ Never ☐ Rarely ☐ Sometimes ☐ Routinely ☐ N/A

I question how my professional and social positions - such as my age, gender, sexual orientation, socioeconomic background, ability, ethnicity, religion, etc. - may impact my practice and relationship with clients.

☐ Never ☐ Rarely ☐ Sometimes ☐ Routinely ☐ N/A

I contribute to health promotion and education activities on issues related to occupations, social determinants of health, and well-being.

☐ Never ☐ Rarely ☐ Sometimes ☐ Routinely ☐ N/A

I contribute to community-lead actions on community priorities to improve key determinants of health and occupational well-being.

☐ Never ☐ Rarely ☐ Sometimes ☐ Routinely ☐ N/A

I contribute to policy analysis and development to address system-level barriers to key determinants of health and occupational well-being.

☐ Never ☐ Rarely ☐ Sometimes ☐ Routinely ☐ N/A

I contribute to collective advocacy initiatives (e.g. led by professional associations or community advocates) for policies and system-level changes to improve key determinants of health and occupational well-being.

☐ Never ☐ Rarely ☐ Sometimes ☐ Routinely ☐ N/A

Other professional activities, please specify: *---Text box---*

Tell us about something you have done and that you felt especially positive about addressing the social determinants of health and health equity in your day-to-day practice. *---Text box---*

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Below is a series of statements describing different aspects of health equity work in day-to-day occupational therapy practice.

Please indicate to what extent you agree or disagree with the following statements.

Community outreach is part of my current workplace mandate as an OT.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree

☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

Understanding the influences of upstream determinants (i.e. sociocultural, economic, political factors) on clients' occupations, health, and well-being is key to health equity approaches in occupational therapy.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree

☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

I often feel at a loss about how to address the social inequities that affect my clients' health and well-being.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree

☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

I lack the training or skills to engage in advocacy for and with clients whose occupational lives are negatively affected by social determinants of health.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree

☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

Engaging in policy development and policy changes to address occupational needs related to social determinants of health is within my scope of practice as an OT.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree

☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

Organizational factors, such as cost-control mechanisms, workload measurements, and/or scarcity of resources in my workplace, have a powerful impact on the integration of health equity actions in my day-to-day practice.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree

☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

I know how to consult and partner with community services and other governmental agencies so that OT services better meet the needs of the local communities.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree

☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

I do consult and partner with community services and other governmental agencies so that OT services better meet the needs of the local communities.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree

☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

I have training and skills to deal with the emotional impact of working with clients who experience trauma, interpersonal and structural violence, and other forms of inequity.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree

☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

I have the organizational support to deal with the emotional impact of working with clients who experience trauma, interpersonal and structural violence, and other forms of inequity.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree

☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

Equity-oriented approaches are a low priority in the organization where I work.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree

☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

Addressing social determinants of health and social needs during the OT process is key to improving the occupational outcomes for my clients.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree

☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

I have effective ways to evaluate if OT services provided are equity-oriented and inequity-responsive.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree

☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

I am often uncomfortable with the authority and influence that comes with the title of occupational therapist and with the power differences that it creates between occupational therapist and clients.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree

☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

Tell us about the factors (barriers or enablers) that have the greatest impact on the integration of health equity actions in your day-to-day practice. ---*Text box*---

---Page break---

They are many factors that may be part of assessments in occupational therapy.

Please indicate if the following factors are a routine part of OT assessments with your clients.

Do you assess with clients their priorities in occupations related to key determinants of health? E.g., child development, education, employment, community mobility, health literacy, etc.

☐ No, and would not consider it ☐ No, but would consider it
☐ Yes, but infrequently ☐ Yes, usually

Do you assess clients' abilities in occupations related to key determinants of health? E.g., child development, education, employment, community mobility, health literacy, etc.

☐ No, and would not consider it ☐ No, but would consider it
☐ Yes, but infrequently ☐ Yes, usually

Do you assess the potential impact of broader environmental factors on occupational engagement and wellbeing? E.g., transportation, educational or work situation, financial support program, service organization, etc.

☐ No, and would not consider it ☐ No, but would consider it
☐ Yes, but infrequently ☐ Yes, usually

Do you inquire about clients' experience and knowledge of community resources?

☐ No, and would not consider it ☐ No, but would consider it
☐ Yes, but infrequently ☐ Yes, usually

Do you inquire about clients' social support networks?

☐ No, and would not consider it ☐ No, but would consider it
☐ Yes, but infrequently ☐ Yes, usually

Do you screen for adverse material conditions? E.g., income and food insecurity, unmet housing needs, etc.

☐ No, and would not consider it ☐ No, but would consider it
☐ Yes, but infrequently ☐ Yes, usually

Do you screen for psychosocial risks? E.g., childhood adverse events, domestic violence, social isolation, etc.

☐ No, and would not consider it ☐ No, but would consider it
☐ Yes, but infrequently ☐ Yes, usually

Do you inquire about clients' experience of marginalization or discrimination and possible impact on occupational engagement and well-being?

☐ No, and would not consider it ☐ No, but would consider it
☐ Yes, but infrequently ☐ Yes, usually

Are there any comments you would like to add about routine occupational therapy assessment and social determinants of health? ---*Text box*---

---Page break---

We would like to know more about the barriers or deterrents that occupational therapists might face in addressing the social determinants of health with their clients during the OT process.

Please indicate to what extent you agree or disagree with the following statements.

Social determinants of health are often not relevant to the issues for which clients seek my services.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree
☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

Asking about social determinants of health exceeds my scope of practice as an OT.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree
☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

Clients would feel uncomfortable if I asked about these issues.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree
☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

I would feel uncomfortable asking about these issues.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree
☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

Standardized practice in my workplace limits the scope of my practice.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree
☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

It is difficult to access evidence to support effective interventions for social determinants of health in occupational therapy.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree
☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

It is difficult to access resources to address identified needs in ways that would be beneficial for my clients.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree
☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

I lack confidence in my abilities to address identified needs in ways that would be beneficial for my clients.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree
☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

There are other professionals in my organization who address these issues.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree
☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

Time constraints prevent me from addressing these issues.

☐ Strongly agree ☐ Somewhat agree ☐ Neither agree nor disagree

☐ Somewhat disagree ☐ Strongly disagree ☐ N/A

Other barrier, please specify: *---Text box---*

---Page break---

Here is a list of practices associated with health equity work. Please indicate how important you feel they are to occupational therapy professional practice, 1 being "Not important at all" and 10 being "Extremely important".

Addressing with clients the potential impacts of social determinants of health on their occupational engagement and well-being during the OT process.

☐ 1 (Not important at all) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extremely important)

Finding ways to improve access to occupational therapy services.

☐ 1 (Not important at all) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extremely important)

Understanding how social determinants of health and health inequities may impact the communities and client groups accessing OT services.

☐ 1 (Not important at all) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extremely important)

Engaging in regular questioning of how personal and professional assumptions as well as broader societal contexts shape one's practice.

☐ 1 (Not important at all) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extremely important)

Demonstrating respect and positive regard for clients from various cultural and social backgrounds.

☐ 1 (Not important at all) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extremely important)

Being a skilled advocate for the occupational, social, and clinical needs of individual clients.

☐ 1 (Not important at all) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extremely important)

Contributing to policy and institutional changes to address collective occupational issues faced by clients.

☐ 1 (Not important at all) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extremely important)

Recognizing and responding to routine behaviors and procedures that (often unintentionally) may be discriminatory or disempowering to diverse client groups.

☐ 1 (Not important at all) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extremely important)

Finding ways to include service users in program evaluation and quality improvement of OT services.

☐ 1 (Not important at all) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extremely important)

Having the skills and organizational support to work with clients affected by trauma, interpersonal and structural violence, and other forms of inequity.

☐ 1 (Not important at all) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extremely important)

Engaging and coordinating with other government, non-governmental, and community organizations in planning and providing OT services for clients.

☐ 1 (Not important at all) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extremely important)

Having the organizational support to work to the full scope of occupational therapy practice in order to address clients' occupational, social, and clinical needs.

☐ 1 (Not important at all) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extremely important)

Are there other elements that you think are important to provide equity-oriented and inequity-responsive occupational therapy? ---*Text box*---

---Page break---

We would like to know more about what might better support occupational therapists in integrating equity-oriented approaches in their work.

How well has your entry-level education in occupational therapy prepared you for understanding and addressing the social determinants of health and health equity in your work?

☐ 1 (Not at all) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extremely well)

From the list below, identify the resources which would be of greatest assistance to strengthen equity-oriented approaches in your everyday practice. Check all that apply.

☐ Assessment tools for inquiring about social determinants of health during OT evaluations

☐ Access to evidence to support the integration of social determinants of health and health equity in clinical practice

☐ Training to develop practical competencies related to equity-oriented approaches (e.g. community development, advocacy, policy analysis, trauma-informed care, etc.)

☐ Tools to integrate health equity considerations in the evaluation and planning of OT services

☐ Effective reimbursement and/or performance measures for professional activities beyond direct clinical interventions

☐ Opportunities to exercise policy development and advocacy roles at a population level.

☐ Mentoring by experienced peers

Other support or ressource, please specify: ---*Text box*---

---Page break---

Do you have additional comments or experiences on integrating the social determinants of health and health equity in your OT practice that you would like to share?

Suggestions:

- What does “working towards health equity” mean in your day-to-day practice?
- Sharing a strategy or tool you use to integrate social determinants of health and health equity in your day-to-day practice.

Please enter additional thoughts and comments in the text box below. ---*Text box*---

Demographics

These final few questions will help us better understand the profile of survey respondents. Feel free to skip any question you do not want to answer.

Age: ---*Text box*---

Highest level of education:

☐ Bachelor's Degree – Entry to OT practice

☐ Master's Degree – Entry to OT practice

☐ Graduate diploma or certificate

☐ Other Master's Degree

☐ Doctoral Degree

If needed, provide additional comments on your level of education: ---*Text box*---

Total years of practice: ---*Text box*---

Self-identified ethnic groups: ---*Text box*---

Self-identified gender: ---*Text box*---

Self-identified sexual orientation or sexual identity: ---*Text box*---

Is disability part of your self-identity? ☐Yes ☐ No

Thinking about socioeconomic status during childhood, would you say you were raised mostly:

☐ Upper class ☐ Upper middle class ☐ Middle class

☐ Lower middle class ☐ Working class ☐Poverty

We really appreciate that you took the time to complete our survey.

Feel free to contact us to ask for study results or details of any publications at charlene.rochefort@dal.ca

APPENDIX D: FRENCH QUESTIONNAIRE

Bienvenue au sondage “Promouvoir l’équité en santé en ergothérapie”

Avant de débuter le sondage, nous voudrions savoir si les participants répondent à certains critères pour prendre part à l'étude.

Avez-vous actuellement un permis pour exercer à titre d’ergothérapeute au Canada?

☐Oui ☐ Non

Offrez-vous des services d’ergothérapie à des individus dans le cadre de votre travail (incluant les services cliniques, la gestion de cas ou la consultation)?

☐Oui ☐ Non

---Saut de page---

Information sur votre milieu de pratique

Cette première section comprend des questions pour décrire votre milieu de pratique.

Quelles catégories décrivent le mieux vos fonctions actuelles comme ergothérapeute?

Veuillez cocher toutes les options appropriées.

☐ Clinicien ☐ Gestionnaire de cas

☐ Consultant ☐ Gestionnaire/Coordonnateur

☐ Professeur/Enseignant ☐ Chercheur

☐ Autre fonction (précisez): ---*Boite texte*---

Dans quel province ou territoire pratiquez-vous ?

☐ Alberta ☐ Colombie-Britannique ☐Manitoba

☐ Nouveau Brunswick ☐ Terre-Neuve et Labrador

☐ Territoires du Nord-Ouest ☐ Nouvelle-Écosse ☐ Nunavut

☐ Ontario ☐ Île-du-Prince-Édouard ☐ Québec

☐ Saskatchewan ☐ Yukon

Laquelle des options suivantes décrit le mieux la région où vous travaillez?

☐ Région éloignée

☐ Région rurale (population de moins de 1 000 habitants)

☐ Petite ville (entre 1 000 et 29 999 habitants)

☐ Ville moyenne (entre 30 000 et 99 999 habitants)

☐ Centre urbain (population de plus de 100 000 habitants)

Laquelle des options suivantes décrit le mieux votre secteur d'emploi et la source de financement pour votre pratique ?

☐ Secteur privé ☐ Secteur public ☐Autre, précisez :-*Boîte texte*-

Quelles options décrivent le mieux le type d'organisation où vous travaillez?

Veuillez cocher toutes les options appropriées.

☐ Hôpital général ☐ Centre de réadaptation physique

☐ Services de santé mentale ☐ Centre d'hébergement

☐ Centre de santé communautaire ☐ Clinique privée

☐ Établissement scolaire ☐ Organisme ou programme gouvernemental

☐ Université et/ou centre de recherche

☐ Autres, veuillez préciser: ---*Boîte texte*---

Quelles options décrivent le mieux votre secteur d'activités?

Veuillez cocher toutes les options appropriées.

☐ Santé physique générale
☐ Santé mental
☐ Soutien à domicile
☐ Gériatrie
☐ Aides techniques et équipements
☐ Réadaptation physique
☐ Réadaptation professionnelle retour au travail
☐ Pédiatrie
☐ Soins palliatifs
☐ Bien-être et promotion de la santé
☐ Autre secteur d'activité, veuillez préciser: ---*Boîte texte*---

---Saut de page---

Alors qu'une majorité de vos clients ont probablement vécu ou vivront des situations de handicap, nous aimerions savoir à quelle fréquence vous travaillez avec des clients ou utilisateurs de services issus d'autres groupes marginalisés.

À quelle fréquence travaillez-vous avec des clients ayant un faible revenu ?

☐ Jamais
☐ Rarement ou annuellement
☐ Occasionnellement ou À tous les quelques mois
☐ Souvent ou À tous les mois
☐ Régulièrement ou À toutes les semaines
☐ Ne sais pas

À quelle fréquence travaillez-vous avec des clients sans domicile fixe ou qui ont un logement précaire ?

☐ Jamais

☐ Rarement ou annuellement

☐ Occasionnellement ou À tous les quelques mois

☐ Souvent ou À tous les mois

☐ Régulièrement ou À toutes les semaines

☐ Ne sais pas

À quelle fréquence travaillez-vous avec des clients qui sont immigrants récents ou réfugiés?

☐ Jamais

☐ Rarement ou annuellement

☐ Occasionnellement ou À tous les quelques mois

☐ Souvent ou À tous les mois

☐ Régulièrement ou À toutes les semaines

☐ Ne sais pas

À quelle fréquence travaillez-vous avec des clients issus d'un peuple ou communauté autochtone?

☐ Jamais

☐ Rarement ou annuellement

☐ Occasionnellement ou À tous les quelques mois

☐ Souvent ou À tous les mois

☐ Régulièrement ou À toutes les semaines

☐ Ne sais pas

À quelle fréquence travaillez-vous avec des clients issus d'un groupe ethnique ou culturel minoritaire?

☐ Jamais

☐ Rarement ou annuellement

☐ Occasionnellement ou À tous les quelques mois

☐ Souvent ou À tous les mois

☐ Régulièrement ou À toutes les semaines

☐ Ne sais pas

À quelle fréquence travaillez-vous avec des clients qui ont une identité sexuelle ou une identité de genre

minoritaire?

☐ Jamais

☐ Rarement ou annuellement

☐ Occasionnellement ou À tous les quelques mois

☐ Souvent ou À tous les mois

☐ Régulièrement ou À toutes les semaines

☐ Ne sais pas

Autre groupe dans la population, veuillez préciser: *---Boîte texte---*

---Saut de page---

Les approches axées vers l'équité en santé en ergothérapie

Cette section inclut une série de questions portant sur les approches axées sur les déterminants sociaux de la santé et l'équité en santé ainsi que sur leur intégration dans la pratique clinique des ergothérapeutes.

Les **déterminants sociaux de la santé** comprennent un large éventail de facteurs sociaux, économiques et politiques qui confère un accès différent au pouvoir, aux possibilités et aux ressources, et qui, à leur tour, façonnent les conditions matérielles et sociales dans lesquelles les individus naissent, grandissent, vivent, travaillent et vieillissent.

Au Canada, les principaux déterminants sociaux de la santé incluent:

- Le revenu et le statut socioéconomique
- l'éducation et les conditions d'apprentissage
- l'emploi et les conditions de travail
- le logement
- la sécurité alimentaire
- le développement de la petite enfance
- le soutien social
- les services de santé
- le genre et l'identité de genre
- l'origine ethnique & culturelle et le racisme
- les régions géographiques
- le handicap
- l'identité autochtone et la colonisation

L'**équité en santé** désigne l'absence de différences injustes et modifiables dans l'état de santé de groupes dans la population. Cela inclut l'absence de disparités dans l'accès et l'utilisation des services de santé.

Les approches orientées vers l'équité en santé sont considérées comme étant à la fois:

- un processus de prestation de services pour assurer un accès équitable à des soins de qualité répondant aux besoins des divers groupes dans la population;
- et un processus de changements sociaux incluant des actions intersectorielles pour mettre en place des politiques publiques favorisant la santé pour tous.

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Nous aimerions en savoir davantage sur les différentes actions que les ergothérapeutes peuvent prendre pour agir sur les déterminants sociaux de la santé et l'équité en santé dans leur pratique.

Veuillez indiquer la fréquence des activités professionnelles suivantes dans votre pratique actuelle.

Je mets en œuvre des interventions visant à développer les habiletés fonctionnelles des clients dans les occupations et habitudes de vie liés aux déterminants sociaux de la santé.

Ex. développement de l'enfant, éducation, emploi, littératie en matière de santé, mobilité dans la communauté, etc.

☐ Jamais ☐ Rarement ☐ Parfois ☐ Régulièrement ☐ N/A

J'assiste activement les clients pour qu'ils aient accès et qu'ils utilisent les services de santé et services sociaux dont ils ont besoin.

☐ Jamais ☐ Rarement ☐ Parfois ☐ Régulièrement ☐ N/A

J'assiste activement les clients pour qu'ils aient le support financier nécessaire pour accéder aux services et équipements dont ils ont besoin.

☐ Jamais ☐ Rarement ☐ Parfois ☐ Régulièrement ☐ N/A

Je réfère les clients à des services de soutien et des ressources dans la communauté en lien avec les enjeux qui affectent leur santé et leur bien-être occupationnel. Ex. services de logement, service de garde, organismes pour personnes handicapées, groupes de soutien entre pairs, etc.

☐ Jamais ☐ Rarement ☐ Parfois ☐ Régulièrement ☐ N/A

Je travaille avec les clients en partant de leurs forces et des forces de leurs familles et de leurs communautés.

☐ Jamais ☐ Rarement ☐ Parfois ☐ Régulièrement ☐ N/A

J'évalue si les clients jugent que leurs besoins cliniques et occupationnels ont été répondus suite aux services rendus en ergothérapie.

☐ Jamais ☐ Rarement ☐ Parfois ☐ Régulièrement ☐ N/A

Je collecte et analyse des données sociodémographiques concernant qui utilise (et qui n'utilise pas) les services d'ergothérapie dans mon milieu.

☐ Jamais ☐ Rarement ☐ Parfois ☐ Régulièrement ☐ N/A

J'évalue comment certains éléments des services offerts en ergothérapie (ex. horaire, accueil, critères de priorité, etc.) influencent l'accessibilité des services pour différents groupes dans la population.

☐ Jamais ☐ Rarement ☐ Parfois ☐ Régulièrement ☐ N/A

Je réfléchis aux impacts de mon statut social – incluant mon âge, mon identité de genre, mon identité ethnique, mon milieu socioéconomique, le handicap, etc. – sur ma pratique et les relations d'aide avec les clients.

☐ Jamais ☐ Rarement ☐ Parfois ☐ Régulièrement ☐ N/A

Je collabore à des actions communautaires ciblant les priorités des communautés sur des enjeux liés aux occupations et aux déterminants sociaux de la santé.

☐ Jamais ☐ Rarement ☐ Parfois ☐ Régulièrement ☐ N/A

Je collabore à l'élaboration et l'évaluation de politiques publiques qui ont une incidence sur les occupations et les déterminants sociaux de la santé.

☐ Jamais ☐ Rarement ☐ Parfois ☐ Régulièrement ☐ N/A

Je collabore à l'élaboration et l'évaluation de politiques publiques qui ont une incidence sur les occupations et les déterminants sociaux de la santé.

☐ Jamais ☐ Rarement ☐ Parfois ☐ Régulièrement ☐ N/A

Je collabore à des activités d'advocacy (menées, par exemple, par des associations professionnelles ou des représentants des communautés) pour favoriser des changements systémiques et améliorer les déterminants sociaux de la santé et du bien-être occupationnel au niveau populationnel.

☐ Jamais ☐ Rarement ☐ Parfois ☐ Régulièrement ☐ N/A

Autre activité professionnelle, veuillez préciser: *---Boîte texte---*

Pouvez-vous nous partagez une action que vous avez posée dans votre pratique professionnelle qui a eu un impact positif sur les déterminants sociaux de la santé et l'équité en santé. *---Boîte texte---*

Voici une série d'énoncés au sujet des approches axées sur l'équité en santé et la pratique clinique en ergothérapie.

À quel point êtes-vous en accord ou en désaccord avec chacun des énoncés suivants?

Contribuer à des actions communautaires fait présentement partie de mon mandat de travail comme ergothérapeute.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Comprendre l'impact des facteurs structurels (ex. : contextes socioculturels, économiques et politiques) sur les occupations, la santé et le bien-être des clients est un principe clé des actions visant l'équité en santé en ergothérapie.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Je me sens souvent impuissant(e) quant à ce que je devrais faire face aux inégalités sociales qui affectent la santé et le bien-être de mes clients.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Je manque de formation et/ou de compétences pour participer à des activités d'advocacy pour et avec les clients dont les occupations et habitudes de vie sont a ectées négativement par les déterminants sociaux de la santé.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Le champ d'exercice de l'ergothérapie inclut collaborer à l'élaboration et l'évaluation de politiques publiques qui ont une incidence sur les occupations et les déterminants sociaux de la santé.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Les facteurs organisationnels tels les mécanismes de contrôle des coûts, les mesures de rendement ou la pénurie de ressources dans mon milieu de travail, ont un impact significatif sur l'intégration d'actions visant l'équité en santé dans ma pratique.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Je sais comment consulter et développer des partenariats avec les communautés et agencies gouvernementales pour que l'offre de services en ergothérapie réponde aux besoins des communautés locales.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Je consulte et développe des partenariats avec les communautés et agences gouvernementales pour que l'offre de services en ergothérapie répondent aux besoins des communautés locales.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

J'ai la formation et les compétences nécessaires pour faire face aux effets psychologiques liés au travail quotidien auprès de clients qui ont vécu des traumatismes, de la violence interpersonnelle ou structurelle et autres formes d'iniquité.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

J'ai le soutien organisationnel nécessaire pour faire face aux effets psychologiques liés au travail quotidien auprès de clients qui ont vécu des traumatismes, de la violence interpersonnelle ou structurelle et autres formes d'iniquité.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Les approches axées vers l'équité en santé sont une priorité bien secondaire pour l'organisation où je travaille.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Intervenir sur les déterminants sociaux de la santé et les besoins sociaux des clients au cours du processus d'intervention en ergothérapie est un facteur clé à l'atteinte des objectifs liés aux habitudes de vie de mes clients.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

J'ai des moyens efficaces pour évaluer si les services offerts en ergothérapie sont orientés vers l'équité en santé.

☐ Fortement d’accord

☐ Plutôt d’accord

☐ Ni d’accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Je me sens souvent mal à l’aise par rapport à l’autorité et l’influence associés au statut professionnel des ergothérapeutes et par rapport aux différences de pouvoir que cela engendre entre les ergothérapeutes et leurs clients.

☐ Fortement d’accord

☐ Plutôt d’accord

☐ Ni d’accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Quels sont les facteurs (obstacles ou facilitateurs) qui ont le plus d'impact sur l'intégration d'approches axées vers l'équité en santé dans votre pratique professionnelle? *---Boîte texte---*

---Saut de page---

Il y a plusieurs facteurs qui peuvent être pertinents à l'évaluation des besoins des clients en ergothérapie.

Veuillez indiquer si les facteurs suivants font habituellement partie de votre processus d'évaluation avec vos clients.

Identifiez-vous les priorités des clients concernant leurs occupations et habitudes de vie liés aux déterminants sociaux de la santé?

Ex. développement de la petite enfance, éducation, emploi, littératie en matière de santé, mobilité dans la communauté, etc.

☐ Non et ne le considère pas
☐ Non, mais le considère
☐ Oui, mais peu fréquemment
☐ Oui, régulièrement

Identifiez-vous les habiletés fonctionnelles des clients dans les occupations et habitudes de vie liés aux déterminants sociaux de la santé?

Ex. développement de la petite enfance, éducation, emploi, littératie en matière de santé, mobilité dans la communauté, etc.

☐ Non et ne le considère pas
☐ Non, mais le considère
☐ Oui, mais peu fréquemment
☐ Oui, régulièrement

Évaluez-vous l'influence des facteurs environnementaux ou facteurs sociaux sur les occupations et habitudes de vie des clients?

Ex. services dans la communauté, transports, situation d'emploi, situation scolaire, organisation des services, etc.

☐ Non et ne le considère pas
☐ Non, mais le considère
☐ Oui, mais peu fréquemment
☐ Oui, régulièrement

Vous renseignez-vous sur les expériences et les connaissances des clients au sujet des ressources dans la communauté?

☐ Non et ne le considère pas
☐ Non, mais le considère
☐ Oui, mais peu fréquemment
☐ Oui, régulièrement

Identifiez-vous avec les clients leurs réseaux de soutien social?

☐ Non et ne le considère pas
☐ Non, mais le considère
☐ Oui, mais peu fréquemment
☐ Oui, régulièrement

Dépistez-vous les conditions de vie précaires?
Ex. insécurité du revenu, insécurité alimentaire, logement précaire, etc.

☐ Non et ne le considère pas
☐ Non, mais le considère
☐ Oui, mais peu fréquemment
☐ Oui, régulièrement

Dépistez-vous les risques psychosociaux?
Ex. violence familiale, isolement social, adversité pendant l'enfance, etc.

☐ Non et ne le considère pas
☐ Non, mais le considère
☐ Oui, mais peu fréquemment
☐ Oui, régulièrement

Vous renseignez-vous sur les expériences de marginalisation ou de discrimination des clients et leurs influences sur leurs habitudes de vie et leur bien-être?

☐ Non et ne le considère pas
☐ Non, mais le considère
☐ Oui, mais peu fréquemment
☐ Oui, régulièrement

Souhaitez-vous ajouter d'autres commentaires au sujet de l'évaluation des besoins des clients en ergothérapie et les déterminants sociaux de la santé? *---Boîte texte---*

---Saut de page---

Nous aimerions en savoir plus sur les obstacles que les ergothérapeutes peuvent rencontrer s'ils ou elles abordent les déterminants sociaux de la santé avec leurs clients au cours du processus d'intervention en ergothérapie.

14. À quel point êtes-vous en accord ou en désaccord avec chacun des énoncés suivants?

Les déterminants sociaux de la santé ne sont pas pertinents aux problématiques des clients qui utilisent mes services.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Aborder les déterminants sociaux de la santé avec mes clients dépasse les limites de mon champ d'exercice en ergothérapie.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Les clients seraient mal à l'aise si j'abordais ces problématiques en thérapie.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Je serais mal à l'aise si j'abordais ces problématiques en thérapie.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Des procédures et directives cliniques standardisées dans mon milieu de travail limitent mes interventions en ergothérapie.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Il est difficile d'avoir accès aux données probantes au sujet des interventions ciblant les déterminants sociaux de la santé en ergothérapie.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Il est difficile d'avoir accès aux ressources nécessaires pour intervenir sur les déterminants sociaux de la santé de manière bénéfique pour mes clients.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Je manque de confiance en mes compétences pour intervenir sur les déterminants sociaux de la santé de manière bénéfique pour mes clients.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Il y a d'autres professionnels dans mon milieu de travail qui abordent ces problématiques avec les clients.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Je n'ai pas le temps d'aborder ces problématiques avec les clients.

☐ Fortement d'accord

☐ Plutôt d'accord

☐ Ni d'accord ni en désaccord

☐ Plutôt en désaccord

☐ Fortement en désaccord

☐ N/A

Autre obstacle, veuillez préciser: *---Boîte texte---*

---Saut de page---

Voici une liste de pratiques associées aux approches visant l'équité en santé. Veuillez nous indiquer à quel point ces aspects sont importants pour la pratique professionnelle de l'ergothérapie, 1 étant "Pas du tout important" et 10 étant "Extrêmement important".

Aborder avec les clients l'influence des déterminants sociaux de la santé sur leurs habitudes de vie et leur bien-être au cours du processus d'intervention en ergothérapie.

☐ 1 (Pas du tout important) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extrêmement important)

Trouver des occasions pour améliorer l'accès aux services d'ergothérapie.

☐ 1 (Pas du tout important) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extrêmement important)

Comprendre comment les déterminants sociaux de la santé et les inégalités en santé peuvent toucher les communautés et les clientèles utilisant les services d'ergothérapie.

☐ 1 (Pas du tout important) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extrêmement important)

Avoir une réflexion critique concernant l'impact de nos biais personnels et professionnels ainsi que l'impact des contextes sociétaux sur notre pratique professionnelle.

☐ 1 (Pas du tout important) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extrêmement important)

Faire preuve de respect et de considération positive pour les clients issus de divers contextes culturels et sociaux.

☐ 1 (Pas du tout important) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extrêmement important)

Être en mesure de plaider en faveur des besoins cliniques, occupationnels et sociaux des clients utilisant nos services.

☐ 1 (Pas du tout important) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extrêmement important)

Contribuer aux changements dans les politiques publiques et les pratiques institutionnelles pour agir sur les enjeux occupationnels qui touchent collectivement les clients.

☐ 1 (Pas du tout important) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extrêmement important)

Identifier et adresser les comportements et procédures qui peuvent (souvent involontairement) être discriminatoires ou marginalisants pour divers groupes de clients.

☐ 1 (Pas du tout important) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extrêmement important)

Trouver des moyens pour inclure les clients dans les processus d'évaluation et d'amélioration des services d'ergothérapie.

☐ 1 (Pas du tout important) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extrêmement important)

Avoir les compétences et le soutien organisationnel nécessaires pour travailler avec les clients touchés par les traumatismes, la violence interpersonnelle ou structurelle et autres formes d'iniquité.

☐ 1 (Pas du tout important) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extrêmement important)

Consulter et développer des partenariats avec les communautés et agences gouvernementales pour que l'offre de services en ergothérapie répondent aux besoins des communautés locales.

☐ 1 (Pas du tout important) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extrêmement important)

Avoir le soutien organisationnel pour intervenir dans tout le champ d'exercice de sa profession afin de répondre aux besoins cliniques, occupationnels et sociaux des clients.

☐ 1 (Pas du tout important) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extrêmement important)

Selon vous, y a-t-il d'autres éléments qui sont importants pour promouvoir l'équité en santé dans la pratique en ergothérapie? ---*Boîte texte*---

---Saut de page---

Nous aimerions en savoir plus sur les moyens pour mieux soutenir les ergothérapeutes dans l'intégration d'approches axées vers l'équité en santé dans leur pratique professionnelle.

Dans quelle mesure votre formation universitaire en ergothérapie vous a-t-elle préparé(e) pour comprendre et aborder les déterminants sociaux de la santé et l'équité en santé dans votre pratique professionnelle?

☐ 1 (Pas du tout) ☐ 2 ☐3 ☐4 ☐5

☐6 ☐7 ☐8 ☐9 ☐10 (Extrêmement bien)

Choisissez, à partir de la liste ci-dessous, les ressources qui vous seraient le plus utiles pour promouvoir l'équité en santé dans votre pratique professionnelle.
Cochez toutes les options qui s'appliquent.

☐ Des instruments d'évaluation examinant les déterminants sociaux de la santé d'une perspective ergothérapeutique.

☐ L'accès à des données probantes au sujet de l'intégration d'approches axées sur les déterminants sociaux de la santé et l'équité en santé dans la pratique clinique.

☐ De la formation continue pour développer des compétences et savoir-faire en lien avec les approaches axées sur l'équité en santé (ex. développement communautaire, défense des droits, analyse des politiques, approches tenant compte des traumatismes, etc.)

☐ Des outils pour intégrer des indicateurs d'équité en santé dans l'évaluation des services offerts en ergothérapie.

☐ Des méthodes de remboursement et/ou des mesures de rendement qui inclus davantage les activités professionnelles autres que les interventions directes avec les clients.

☐ Des opportunités pour exercer mes rôles d'ergothérapeute au niveau populationnel.

☐ Du mentorat par des pairs ayant plus d'expérience dans ces approches.

Autres ressources ou besoins de soutien, veuillez préciser: *---Boîte texte---*

Souhaitez-vous ajouter d'autres commentaires au sujet de l'intégration des approches axées vers l'équité en santé et la pratique professionnelle de l'ergothérapie ?

Suggestions:

- Qu'est-ce que « promouvoir l'équité en santé » signifie dans votre pratique courante.
- Partager une stratégie ou un outil que vous utilisez pour intégrer les déterminants sociaux et l'équité en santé dans votre pratique courante.

Veuillez inscrire vos réflexions et commentaires dans l'encadré ci-dessous. *--Boîte texte--*

---Saut de page---

Renseignements démographiques

Ces quelques questions nous permettrons de mieux comprendre le profil démographique des répondants de notre enquête. Vous pouvez sauter toutes questions auxquelles vous ne souhaitez pas répondre.

Âge: *---Boîte texte---*

Quel est le niveau le plus élevé de scolarité que vous avez terminé?

☐ Baccalauréat– permettant d'exercer la profession

☐ Maîtrise – permettant d'exercer la profession

☐ Certificat d'études graduées

☐ Autre programme de maîtrise

☐ Doctorat

Au besoin, veuillez nous donner des précisions sur votre scolarité: *---Boîte texte---*

Nombre d'années d'exercice en ergothérapie: *---Boîte texte---*

Groupes ethniques auxquels vous vous identifiez : *---Boîte texte---*

Identité de genre : *---Boîte texte---*

Identité sexuelle ou orientation sexuelle auxquelles vous vous identifiez : *---Boîte texte---*

Est-ce que le handicap fait partie de votre identité? ☐Oui ☐ Non

Laquelle des options suivantes décrit le mieux, selon vous, votre situation socioéconomique durant votre enfance :

☐ Classe supérieure ☐ Classe moyenne supérieure ☐ Classe moyenne

☐ Classe moyenne inférieur ☐ Classe ouvrière ☐ Pauvreté

Nous sommes sincèrement reconnaissants du temps que vous avez consacré pour répondre au sondage.

N'hésitez pas à nous contacter pour obtenir des détails concernant les résultats de l'étude à charlene.rochefort@dal.ca

APPENDIX E: CONSENT FORM

You are invited to participate in the survey "Working Towards Health Equity in Occupational Therapy" conducted as part of the lead researcher's Post-Professional Master's degree at Dalhousie University.

Researchers: Charlène Rochefort-Allie, BScOT, OT Reg. (QC, NB), Post-professional Masters student, School of Occupational Therapy, Dalhousie University. charlene.rochefort@dal.ca Supervisory Committee: Brenda Beagan & Brenda Merritt, School of Occupational Therapy, DalhousieUniversity. Brenda.beagan@dal.ca

Purpose: Despite a growing awareness of the role of OTs in addressing the broader social factorsthat impact people's health, occupational well-being, and access to health services, there is no evidence on how occupational therapists perceive and enact this role in practice. The purpose of this study is to describe how health equity approaches are currently understood and implemented in day-to-day occupational therapy practice in Canada as well as what might enhance that work.

Participation: You may participate in this study if you are an occupational therapist, registered to practice in Canada, and currently providing direct occupational therapy services as part of your work (services to individual clients including clinical, case management, or consultation services). Participation is entirely your choice.
Participants will be asked to complete an online survey (about 20 minutes) asking about health equity approaches in OT, practice context, and demographics. Skip any questions you do not want to answer. You may end your participation at any time by closing your browser. If you exit the survey before completion, the answers already provided will be retained and included in analyses.

Privacy & Confidentiality: The survey is anonymous; we will not collect your identity or your IP address. All responses will be stored on a secure Dalhousie server accessible only to the researchers. After December 2019 the anonymous and aggregate data will be encrypted and stored on the lead researcher's password-protected computer for 7 years then destroyed. Study results will be contained in a Master's thesis, and possibly in a journal article and/or conference presentation. Responses will be presented anonymously, with any identifiable information removed.

If you prefer we do not use quotes from your survey, please click:

☐ You do not have my permission to use the words from my responses in academic and professional publications nor in conference presentations.

Benefits &Risks: There will be no direct benefit to you from participating in this research, though we hope study results will help us understand current practice and needs of Canadian occupational therapists related to health equity. Results may inform further research, education, and practice to address identified gaps and priorities.

Given that the survey asks questions about inequities and about challenges OTs may encounter regarding health inequities, some people may experience emotional discomfort; you are encouraged to engage in self-care and contact your professional practice leaders or peers for debriefing if needed.

Contact: If you have any questions or require additional information about this study, you may contact Charlène Rochefort-Allie, lead researcher, at charlene.rochefort@dal.ca. If you have any concerns about your participation in this research (REB file # 2019-4859), please contact Research Ethics, Dalhousie University at (902) 494-1462, or email ethics@dal.ca. Since participation is anonymous, we will not be able to provide you directly with the study results. Feel free to contact the lead researcher to ask for study results or details of any publications.

Proceeding with the survey implies consent.

If you agree to participate in this survey, please click next.