University of Alberta

An Investigation into the Roles of Occupational Therapists Working with Children within a Community Setting

by

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Abstract

The aim of this study was to identify the roles of occupational therapists working within pediatric community settings in Edmonton, Canada, and to determine the nature of any discrepancy between the roles identified by therapists and service providers. This study is descriptive and exploratory in nature and used mixed methods. Convenience sampling was used to recruit 17 occupational therapists from the Edmonton Occupational Therapy Pediatric Interest Group, and 2 supervisors or managers from community-based organizations. Data were collected through separate surveys for each group and one therapist interview. Results indicate a consensus between therapists and service providers on the task-oriented roles; however, the results on professional roles are less clear. Some professional roles identified by therapists as being within their scope were not identified by service providers. The lack of knowledge about occupational therapy as a profession emerged as a principal factor that therapists see as limiting their role.

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List of Abbreviations

AAROT – Alberta Association of Registered Occupational Therapists

ACOT – Alberta College of Occupational Therapists

ACOTRO – Association of Canadian Occupational Therapy Regulatory Organizations

ACOTUP – Association of Canadian Occupational Therapy University Programs

AOTA – American Occupational Therapy Association

CAOT – Canadian Association of Occupational Therapists

HPA – Health Professions Act

ICF – International Classification of Functioning, Disability, and Health

IEP – Individualized Education Program

IPP – Individualized Program Planning

OTPA – Occupational Therapy Profession Act

PAC – Presidents' Advisory Committee

SAOT – Society of Alberta Occupational Therapists

Introduction

Occupational therapy is concerned with assessing and promoting function through meaningful occupation, thus enhancing a person's quality of life. Occupational therapists work with people of all ages, ranging from young children (including neonates) to seniors and the frail elderly. They also work in a variety of settings including the home and community, institutions, industry and business, and the government (Canadian Association of Occupational Therapists [CAOT], 2006). Within the larger community setting, occupational therapists may work in various subgroups of the community, including: home care, private practices, community mental health centres, clinics, halfway houses, group homes, schools, vocational programs, community action groups, and workers' compensation boards (CAOT, 2006). There is currently a shift towards community based intervention within Canada and internationally (Lysack, Stadnyk, Paterson, McLeod & Krefting, 1995; Lemorie & Paul, 2001). In 1996, 37% of occupational therapists in the health sector within Canada worked in the community (McColl, 1998). In 2005, 41.4% of the occupational therapists registered with the Canadian Association of Occupational Therapy (CAOT) who elected to participate in the membership survey reported their primary practice setting as the community (CAOT, 2005). Although a change in practice setting occurs when services are delivered in the community rather than in a medical facility, the competencies of an occupational therapist remain the same. A few of these responsibilities include things such as: conducting assessments, providing individualized intervention or treatment, consulting with the client and/or other stakeholders involved, providing injury prevention strategies, and modifying the environment so that clients can participate in occupations that they

enjoy (Alberta Association of Registered Occupational Therapists [AAROT], 2003; Society of Alberta Occupational Therapists [SAOT], 2006).

Within the school system subgroup of the community setting, children between the ages of birth to 13 years are the main recipients of occupational therapy services (Kardos & White, 2005). However, most therapists work mainly with elementary-aged children between the ages of 3 to 12 years (Fairbairn & Davidson, 1993; Rodger, Brown & Brown, 2005; Dule, Korner, Williams & Carter, 1999). In 2005, of the occupational therapists registered with the Canadian Occupational Therapy Association who elected to participate in the membership survey, 31.2% of therapists employed in Alberta and 28.6% of therapists in Canada worked primarily with school aged children (CAOT, 2005). In the same year, 16.7% of members in Alberta and 9.2% nationally listed their primary practice setting as the school system (CAOT, 2005).

According to the Oxford English Dictionary, a definition of the word "role" is: "the behaviour considered appropriate to the interaction demanded by a particular kind of work or social position" (Oxford English Dictionary, 2005). Although the roles of occupational therapists working solely within the larger community or school settings have been studied and determined, role confusion (where therapists are unclear of the roles they are expected to fulfill, or where certain occupational therapy roles are being fulfilled by other team members) has been noted as occurring within both of these settings (Coutinho & Hunter, 1988; Colman, 1988; Royeen & Marsh, 1988; Kellegrew & Allen, 1996; Agrin, 1987; Lysack et al., 1995; Lemorie & Paul, 2001; Mitchell & Unsworth, 2004; Krupa, Radloff-Gabriel, Whippey & Kirsh, 2002). However, there is a

lack of research into the roles of community-based occupational therapists working with children. While it is tempting to take what has been found about roles in the community setting in general and in the school settings specifically, and combine these to determine the roles for pediatric community therapists, this is not advisible as the roles and responsibilities of occupational therapists vary with the practice environment as well as with the client population (CAOT, 2006).

The main goal of this study was to determine the roles of occupational therapists working within a community setting in Edmonton, Canada, and determine the nature of any discrepancy between the roles identified by therapists and service providers. For the purposes of this study, 'role' is defined as the functions or purposes that the occupational therapist fulfills. A community setting is any setting located in the community including subgroups such as schools, other educational institutions, and the home setting. Pediatric occupational therapists are classified as those who work with children ranging from the age of five up to, and including, the age of twelve years.

Literature Review

Roles of occupational therapists in community settings

There has been limited research in this area as a strong shift towards community based services has only recently occurred in Canada. Roles identified in the literature for occupational therapists working within the community setting as a whole include: consultant, administrator, mentors in group settings, educator, entrepreneur, and researcher (Lysack et al., 1995; Lemorie & Paul, 2001; Mitchell & Unsworth, 2004; Krupa et al., 2002, Wittman & Velde, 2001). In a study of community-based

occupational therapists in Ontario in 1992, the principal role of a therapist is identified as a consultant/educator, with additional roles as a clinician, administrator, and manager (Lysack et al., 1995). However, a survey conducted a few years later by Lemorie and Paul (2001) of occupational therapists in Illinois found that although community-based occupational therapists most frequently fulfill the role of a consultant/ educator, the role of clinician is equally important. Additional roles that were identified in this study include: mentor, entrepreneur, business administrator and researcher. The difference in the additional roles identified between the two studies may be indicative of the cultural or societal difference between Canada and the United States, or may reflect a change towards a more business-oriented approach to the profession during the time interval between the studies.

In the community setting, the potential for blurring of job roles is significant. Not only are occupational therapists in community settings responsible for carrying out their profession-specific roles, but they also occupy a diversity of generalist roles (Krupa et al., 2002; Mitchell & Unsworth, 2004). Furthermore, the lack of role clarity renders it unclear to employers what functions an occupational therapist fulfills, and can also lead to therapists being unsure of their contribution to the profession (Lemorie & Paul, 2001). In looking through the literature, although there are articles addressing the role of occupational therapists working in the community with the adult and geriatric population, there is a lack of research addressing the pediatric population. This is an important aspect that needs to be addressed as pediatric occupational therapists are not only employed through the school system but also in a variety of agencies within the non-school subgroups (Rodger et al., 2005; Fairbairn & Davidson, 1993).

Roles of occupational therapists in a pediatric school setting

A general consensus within the literature is that the occupational therapist in a school setting has a multitude of roles and responsibilities. These can be divided into task-oriented roles and professional roles. Task-oriented roles are those that involve initiation, provision, and evaluation of intervention, whereas professional roles are those that involve non-therapeutic responsibilities such as collaboration and mentorship with other professionals and families. Task oriented roles that have been identified in the literature by Coutinho and Hunter (1988), Colman (1988), Royeen and Marsh (1988), Kellegrew and Allen (1996), and Agrin (1987) include:

- conducting assessments and evaluations
- initiating treatment planning
- providing direct intervention or supervision of intervention to address dysfunction and weakness
- providing compensatory strategies as needed
- addressing gross and fine motor delays
- inquiring into sensory processing problems
- facilitating access to equipment and services, and
- promoting the enhancement of social skill and group interaction skills

There is consensus within the literature on these task specific roles that occupational therapists generally fulfill within the school setting.

Professional roles have become increasingly important as occupational therapy programs within school settings are not viewed as a separate entity within the educational system,

but rather as a complementary component supporting the overall education plan of the child (Coutinho & Hunter, 1988; Case-Smith & Cable, 1996). This requires collaboration with many other members of the child's educational and support team. As part of a multidisciplinary or transdisciplinary team, the occupational therapist works with others: the child's teacher and teaching assistant, the child's parents, physical and speech therapists, psychologists, and behavior or counseling service providers (Kellegrew & Allen, 1996; Agrin, 1987; Royeen & Marsh, 1988; Coutinho & Hunter, 1988). Children who are receiving specialized services are required to have an individualized education program (IEP) (Alberta Education, 2006). Therefore collaboration is an essential skill for therapists to possess in order to provide intervention which supports the goals within the IEP (Coutinho & Hunter, 1988; Agrin, 1987).

Consultation is a professional role that is considered essential in school-based practice. Consultation with the teacher is especially important as therapy is becoming more integrated within the classroom setting rather than as a direct pull-out service (Weintraub & Kovshi, 2004; Kellegrew & Allen, 1996). According to a study conducted by Dule et al. (1999) of 143 occupational, physical, and speech-language therapists working in the school system in New South Wales, Australia, 73% of therapists preferred to use joint planning with the teacher and/or team to incorporate therapy into the student's educational program. In a survey conducted by Weintraub and Kovshi (2004) of 77 school-based occupational therapists in Israel, 70% of occupational therapists reported that they interact frequently with teachers. This indicates that consultation within the child's educational team is seen as a vital role of an occupational therapist employed in a school setting.

Another professional role is that of an educator to colleagues and to the parents of the child (Royeen & Marsh, 1988). In a survey conducted by Brown (1989) referred to by Schultz (1992), the role of an occupational therapist in providing parent training is seen by educators as being as important as providing intervention. This is supported by results of the study by Dule et al. (1999), in which the two roles of therapists: being a resource and support to the families, and providing reciprocal consultation with colleagues, were identified as being the third and fourth most important, after the roles of: facilitation of functional skills and activities, and developing adaptations/equipment to encourage functional participation. This shows that although there may be fewer identified professional roles than task specific roles, professional roles are viewed by therapists as being equally important to task-oriented roles.

Because of the acknowledged value of collaborative educational and therapeutic services, the roles of individual team members may become less clearly defined. The concept of blurring of roles is identified as a problem because as occupational therapists incorporate the educational model into their practice, certain aspects of the therapists' role may be carried out by other team members (Colman, 1988; Case-Smith & Cable, 1996). With the increased flexibility of roles among professionals on a child's team, there is a need to differentiate occupational therapy from other services in order to assert occupational therapy's position in the school system (Royeen & Marsh, 1988). This becomes increasingly important as school boards seek cost effective therapy services for children, while avoiding duplication of services. Apart from discussions of occupational therapists working within schools, and play therapy, the amount of information in the literature on occupational therapists working with children remains limited (Scaletti, 1999).

Additional research outside of these two topic areas is needed to obtain a more accurate and complete grasp of the pediatric therapists' scope of practice.

Limitations on the role of occupational therapists

As professionals, occupational therapists seek direction regarding their roles from various sources, including the regulatory body of occupational therapy, and educational policies developed by the government that affect the delivery of therapy services for children with special needs.

Within the Province of Alberta, the profession of occupational therapy is governed by the Health Professions Act (HPA) (Government of Alberta, 2006). In the HPA, the practice of occupational therapy is defined as including:

- in collaboration with their clients, develop and implement programs to meet everyday needs in self care, leisure and productivity,
- assess, analyze, modify and adapt the activities in which their clients engage to optimize health and functional independence,
- interact with individuals and groups as clinicians, consultants, researchers, educators and administrators, and
- provide restricted activities authorized by the regulations.

In the previous governance act, Occupational Therapy Profession Act (OTPA) (Government of Alberta, 1990), the practice of occupational therapy has been defined as including:

- identification and assessment of dysfunction
- application and interpretation of evaluations and assessments

- planning, administration, and evaluation of programs, and
- providing consultative, advisory, research, and other professional services.

Occupational therapists working within Alberta are directly regulated by the Alberta College of Occupational Therapists (ACOT). In their Standards of Practice published in 2003, practice guidelines for occupational therapists were outlined and occupational therapists working within the Province of Alberta are held to these standards. This document recognizes five major roles for occupational therapists: practitioner (clinician), educator, consultant, researcher, and administrator (AAROT, 2003).

The practice setting in which an occupational therapist works can also add further stipulations and constraints to the roles the therapist is expected to fulfill. While some community organizations expect a specific range of services from a therapist, other organizations are unsure of the roles a therapist can fulfill, leading to therapists acting as generalists who fulfill a variety of roles (Krupa et al., 2002). Exceptions to this are in structured organizations such as hospital facilities or school settings, where specific guidelines are present to guide and limit practice. An example of this is the Edmonton Regional Education Consulting Services- Special Education Support Team, where the role of an occupational therapist includes: consultation, program development/ implementation, inservicing, and home visitations (Edmonton Student Health Initiative Partnership, 2006). Furthermore, occupational therapists working in educational settings who are involved with Individualized Program Planning (IPP) are further expected to meet the roles outlined by Alberta Education. Roles in this area include:

- developing, planning, implementing, monitoring and evaluating the IPP

- conducting assessments and providing programming through direct services or consultation
- reporting on the child's progress to, and communicating and collaborating with team members
- providing training, direction, monitoring, and feedback to classroom staff and parents, and
- adapting or modifying activities and strategies as necessary (Alberta Education, 2006).

These guidelines provide specific expectations of occupational therapists in the school setting, and act as a framework within which occupational therapy services are delivered. For community organizations other than schools and hospitals, boundaries on the role of occupational therapists may be based on the type of services the provider offers, the type of clientele it serves, and the direct employer of the therapist. This causes some difficulties as these boundaries may not be clear or may be based on an unclear concept of the roles that occupational therapists may fulfill.

Although the constraints placed on the role of occupational therapists have not been well-explored, there is some literature on this topic within the area of nursing. According to Bryant-Lukosius, DiCenso, Browne and Pinelli (2004), factors that influence the determination of roles include the work environment, the health care system, and government policies that define roles of nursing and nursing-related professions. Perhaps because the advanced nursing practitioner profession is still quite young and there is a lack of clearly defined goals, the roles that emerge are those that are shaped by

stakeholders (including managers and the nurses themselves), resulting in a wide variety of identified roles (Bryant-Lukosius et al., 2004). A study of four nursing homes in England found that registered general nurses and care assistants looked towards the policies and procedures set out by the nursing home to determine which procedures would be assigned to each profession (Perry, Carpenter, Challis & Hope, 2003). Care assistants liked having the procedures and policies to help define their role. However, the registered general nurses felt that the amount of procedures and policies that were in place, and whether they were able to exercise judgment on issues that may or may not have gray areas, prevented them from knowing what they could or could not do within their role (Perry et al., 2003). This suggests that although policies and stakeholder expectations are useful in defining roles, they may also cause difficulties in limiting the roles that professionals are comfortable filling and may also cause some role confusion.

Research Question

The main goal of this study was to identify the roles of occupational therapists working within pediatric community settings in Edmonton, Canada, and determine the nature of any discrepancy between the roles identified by therapists and the service providers who employ them.

Design and Methods

Methodology

Surveys are useful data collection methods in that they provide a numerical description of trends from a sample of the population in which the researcher is interested (Creswell, 2003). According to Johnson and Turner in Tashakkori and Teddlie (2003), the strengths

of using a survey are that: they are inexpensive, there is quick turnaround, it is relatively easy to conduct data analysis for closed-ended items, and they have moderately high measurement validity if the survey has been well tested. Weaknesses identified include: they need to be validated, must be short in length, there is a possibility of missing data, open-ended items may provide vague information, and data analysis can be time consuming for open-ended items (Johnson & Turner, in Tashakkori & Teddlie, 2003). A survey was an appropriate method of data collection for this study because it could provide demographic and general information on what therapist roles are currently being fulfilled. This background information was needed to provide a current picture of the roles and opinions of therapists, which will then help guide a focus group in exploring in more depth the ideas that result from the survey.

Focus groups are beneficial in that while the discussion is focused on specific topics, participants have the opportunity to add to ideas that grow out of the discussions, and can lead to new ideas being generated (Ulin, Robinson & Tolley, 2005). This may also provide information and insight to the researchers on topics that were not previously determined. Furthermore, focus groups allow for interactions between participants to be observed and for the collection of data from several participants in a relatively short period of time (Ulin et al., 2005; Asbury, 1995). A focus group was appropriate for this study as it explored a new area of research, and provided an arena for both individual and group ideas to be discussed and explored (Asbury, 1995). Furthermore, focus groups help to interpret and better support information obtained earlier from other data collection methods (Johnson & Turner, in Tashakkori & Teddlie, 2003).

Study Design

This is an exploratory study that used mixed methods to gain an understanding of the roles of pediatric occupational therapists working in the community, from both the perspectives of the therapists and of the community service providers who employed them. According to Creswell (2003), mixed methods is a procedure that requires the collection of data using more than one method within a single study. The strength in using mixed methods is that it not only allows for numerical data and statistical information to be obtained and trends to be determined, but also allows for additional information or issues to be addressed or discovered. Qualitative methods may furthermore be used to supplement data obtained from the quantitative methods. Mixed methods also provide an opportunity for presenting and exploring a greater range of ideas (Tashakkori & Teddlie, 2003). Mixed methods were important for this study because the data obtained using quantitative methods provided trends or central ideas for the researcher to further explore using qualitative methods with participants in the second part of the study.

The Sequential Explanatory Strategy was the model used to explore the research question (Creswell, 2003). This strategy involves collecting and analyzing data first using quantitative methods, followed by the collection and analysis of data using qualitative methods (Creswell, 2003). The primary objective of this design was to use qualitative results to help explain and interpret information that was obtained in the quantitative stage (Creswell, Plano Clark, Gutmann & Hanson, in Tashakkori & Teddlie, 2003). The strengths of this strategy are that it has a straightforward design and makes information easy to describe; the weakness is that data are collected in two stages (Creswell, 2003).

This is time consuming as the quantitative and qualitative data are collected separately and sequentially (Creswell, 2003). This is an appropriate model for this study because of its explorative nature. Numerical and background information were obtained first to provide some direction to the research question, as well as informing the qualitative aspect of the study which was to further explore and expand the knowledge obtained from the quantitative section.

Sampling

Recruitment to the Survey: Occupational Therapists

Participants were recruited through the Edmonton Occupational Therapy Pediatric Interest Group. The Edmonton Occupational Therapy Pediatric Interest Group is comprised mainly of occupational therapists working with the pediatric population in Edmonton, but is also open to other rehabilitation professionals such as physical therapists. The group meets about once every three months to discuss pertinent issues in pediatrics, or to increase their educational knowledge through presentations by guest speakers. As of January 12, 2007, there were 79 therapists on their e-mail list. Since the population of pediatric occupational therapists working in the community setting is small, convenience sampling was used to identify participants for the study. Snowball sampling was also used to recruit additional pediatric occupational therapists identified by members of the Edmonton Occupational Therapy Interest Group. Snowball sampling consists of participants in a study identifying or recruiting additional members into the study (Domholdt, 2005). Information about this study and recruitment for a web-based survey was sent out via e-mail to all therapists on the Edmonton Pediatric Interest Group e-mail list. All members of the e-mail list who volunteered were recruited into the study.

Consent was obtained through a statement at the beginning of the web-survey form stating that by filling out the survey, consent to participate in the survey part of the study was considered to be obtained. Please see Appendix A for a sample of the recruitment aid.

Inclusion criteria:

1. Occupational therapist registered with the Alberta College of Occupational Therapists
2. Provides services to children ages 5-12 years
3. Works a minimum of 0.5 FTE for a community service provider, in a community setting within the city of Edmonton and/or surrounding area
4. Minimum one 1 year experience as a pediatric occupational therapist

Exclusion criteria:

1. Therapists working solely in private practice

Recruitment to the Survey: Service Providers

For the purposes of this study, community service providers were defined as any facility located in the community including institutions such as schools or other educational institutions. Community service providers were identified from data collected from the therapist survey.

Community service providers identified were contacted by telephone to determine who at the organization would be able to give permission for the service provider to participate in this study. The immediate supervisor of the occupational therapist was identified as the person who would ideally be the key informant to fill out the facility survey. An

alternate informant could be either a supervisor or manager with a health-related background who is familiar with the role of occupational therapists in the organization and/or works with occupational therapists. If there was more than one key informant in an organization, the informant who was most familiar with the roles of occupational therapists was recruited.

Inclusion criteria:

1. Community service providers that provide services to children ages 5-12 years in the Edmonton region and/or surrounding area
2. Employs at least one pediatric occupational therapist working at least a 0.5 FTE

Recruitment to the Focus Group: Occupational Therapists

Therapists who participated in the survey stage had an opportunity to further participate in a focus group, by including their name and contact details on the survey. According to Ulin, Robinson and Tolley (2005), eight to ten participants in a focus group is adequate to stimulate discussion and encourage participation from all members, while ensuring that the group remains efficient and effective. However, according to Krueger (1995), the most effective focus groups are composed of between six to eight participants. For this study, recruitment of a maximum of six therapists was planned as this number of participants allows for a manageable amount of discussion and data collection. If attrition occurred before the focus group, the withdrawing members would be replaced. Participants were separated into groups based on the type of service provider they work for (schools vs. non-school subgroups), with three participants from each group chosen through simple random selection. This type of sampling gives an equal chance for each participant to be selected for the focus group; however, only one therapist from each

specific service provider was recruited into the focus group. This was to ensure that participants in the focus group had a variety of practice experience, and were a diverse group (in that they did not all work for the same service provider). It was anticipated that there would be enough participants to run at least one focus group. However, the number of focus groups run depended on how many therapists volunteered for this part of the study, and the variety in the sample e.g., volunteering therapists do not all work for the same service provider.

Inclusion criteria:

1. Participated in the survey stage of this study
2. Available to attend focus group

Recruitment to the Focus Group: Service Providers

Participants were recruited for a focus group in the same way for service providers. Six participants per group were aimed for, with service providers lost to attrition being replaced before the focus group took place. The key informant or the designated person who completed the survey was the one recruited to participate in the focus group. As the focus group aimed to expand on the information obtained from the survey, recruiting the key informant or designated person from the survey phase would be ideal as they would already have an understanding of the aim of this study, would be familiar with the survey, and could reflect on or expand on the answers they had provided in the survey. It was planned that at least one focus group would be held, with the possibility of additional focus groups depending on the number of service providers willing to participate. Service providers would be separated into two groups (schools, non-school subgroups) to ensure that there was some variety in the service providers participating in the focus

group. Three participants from each of the two groups would be chosen to participate through simple random selection. All the participants for the "school group" would be placed into a box, and three names will be drawn to participate in the focus group. Then the same procedure would be done with the "other community subgroups group" to select three other participants. These six participants would form one focus group, and if there were enough participants to conduct additional focus groups, the same procedure would be done to select participants. This was to ensure that each service provider had an equal chance of being selected for the focus group, and that each group was comprised of a diverse set of participants. This strategy would provide a wider and more representative range of information from the community organizations.

Inclusion criteria:

1. Participated in the survey stage of this study
2. Key informant available to attend focus group

Procedures

Survey

The survey consists of three parts: the first part requests demographic information, the second part determines the current roles of occupational therapists (therapist survey) or queries how the roles of therapists are determined and service providers' knowledge of occupational therapy roles (service provider survey), and the third part consists of an open-ended question designed to elicit additional information from the participant. Both of the surveys were web-based. Web-based surveys are beneficial in that: they provide anonymity to the respondents, provide an initial analysis of the data, encourage the survey to be filled out properly by limiting where and the amount of answers that can be

given, and is cost-effective while potentially decreasing the turnaround time for the survey (Dillman, 2000; Klein, 2002). Klein (2002) found that the majority of researchers state that web-based surveys have a comparable response rate to surveys that are mailed out. A web-based survey was appropriate for this study in that most members of the study population had access to a computer and the internet as they are already members of an e-mail mailing list. They were more likely to fill out a web-based survey because it is less time consuming and could be filled out immediately and returned with minimal effort. Furthermore, for therapists who work in multiple settings and with various service providers, the use of a web survey decreased the likelihood of the survey being misplaced by service providers, or not reaching the recipient.

Two surveys were created based on items adapted from the survey used by Dule et al. (1999), which was adapted from a questionnaire created by Giangreco (1990). In their study, Dule et al. were interested in examining how therapists perceived their roles, how they prioritized their therapy services, and their use of best practices. The survey section of the study by Dule et al., regarding the perception of the role of therapists, was adapted and expanded for this study. In Dule et al.'s study, this section was constructed using a five-point Likert scale in which respondents were asked to determine their level of agreement with ten role statements. These role statements were used in this study together with other roles identified in the literature to achieve a more complete list of therapists' roles.

In the demographics section of the surveys, choices are provided and respondents are asked to check off the response that best applies to them. For the therapists' survey, the

demographic section includes one question which asks therapists to indicate the type of organization for which they work. There is also an option for the therapists to list an alternative type of organization if none of the choices apply to them. This helped provide a profile of the types of service providers the respondents worked in.

For the service provider survey, participants were asked to select their type of organization, with the option to list an alternative type of organization in addition to the choices provided. Participants were also asked to provide their job title. These helped provide a profile of the types of service providers and of the job roles of participants who participated in the survey.

The second section addresses roles and is composed of 6 closed items in a checklist format, and one ranking item. Both the therapist and service provider surveys contain the same seven questions, with the wording changed from occupational therapist to service provider in the items, depending on the survey. A checklist format is useful in that it helps determine the range and frequency of responses for each item, while the ranking question provides information on how important therapists view the roles that are available to them.

The third section of the survey is an open question which asks what information is needed to help better define the role of pediatric occupational therapists working in the community setting. This open question was important as it provided an opportunity for respondents to list ideas or opinions that were not addressed in the other parts of the survey. It also provided information for the researcher on areas that may need to be explored further or addressed in the focus groups.

The last section of the survey is optional and asks therapists and service providers interested in participating in the focus group to provide their contact information. As well, therapists also had the option of indicating the name of the organization for which they work, so that the organization could be contacted to participate in the service provider survey. A statement is included on the therapist survey indicating that no identifying information of the therapists would be divulged to the service provider.

One pilot of the questionnaire was conducted in order to determine and critique whether it provided information that will inform this study, whether it was user friendly and if the clarity and language of the survey was appropriate, and the amount of time it took to complete the survey. Since the population for this study is small, occupational therapists working with children under the age of five and over the age of twelve, or in other settings, were accessed to pilot the questionnaire. Comments made by therapists in the pilot were reviewed by the researcher, with changes being made to the survey as necessary. The therapist surveys and those of the service providers were not matched in order to maintain confidentiality and anonymity for the participants in both the data collection and data analysis phases. However, it was made clear in the therapists survey that the information they provided, specifically the answer to the item requesting information regarding the service provider for which they work, would be used by the researchers to select and recruit service providers. Please see Appendix B for a sample of the therapist survey, and Appendix C for a sample of the service provider survey. Anonymity was assured through the web-based survey program.

Focus Group

Data collection for this study was planned in two stages, with the survey component administered first followed by focus groups. Although focus groups were not possible due to an insufficient number of participants, an interview was conducted with one individual following the same format as had been planned for the focus groups. Both the therapist and service provider survey contained similar questions with the wording changed so that the questions applied specifically to each group. The survey was administered to the therapists first, followed by the service providers which they identified in the demographic section. Once both groups completed the survey, the data were analyzed. Following this, the therapist focus group was to take place followed by the service provider focus group. Data from the focus group were to be transcribed and analyzed. Please see Appendix D for a sample of the focus group script. The five questions planned for the focus group were designed to verify the information obtained in the survey. Thus therapists and service providers would have had a chance to address these questions in an open-ended way, and have the opportunity to elaborate on the answers they provided in the survey. As well, this would have provided a chance to determine whether the results obtained from the survey could be supported by the information that came out of the focus groups.

Two sessions of focus groups were to be held at the University of Alberta at a date and time that was convenient to the participants and researcher. The first session of focus groups would have consisted of occupational therapists; the second session would have consisted of the key informants from the service providers. The focus groups would have begun with ground rules explaining the purpose of the study, and participants were to be

requested not to share information discussed within the group in order to maintain the confidentiality of disclosed information. The participants were to be told that if at any time they felt uncomfortable with the topics being discussed, they could refuse to participate in the discussion, excuse themselves from the room, or withdraw from further participation in the study without repercussion. The researcher (VN) would have acted as the facilitator for the focus groups, and would have used guiding topics or questions to introduce the topic and guide the discussion. Please see Appendix D for a sample of the focus group script. The focus group would have lasted up to an hour, and the discussions would have been audio taped and later transcribed by the facilitator. During the discussions, field notes would have been taken by the recorder (GC) on the interactions between participants and other observations to supplement the information obtained through the audio taped discussion. Field notes are useful in facilitating the checking of the accuracy of the transcripts against the audio recording (Kidd & Parshall, 2000). For both focus groups, participants would have been reimbursed for the parking fee only.

Data Analysis

Quantitative Data

Results obtained from closed questions on the survey were analyzed using descriptive statistics. Frequency tables were constructed for the closed questions in order to determine the roles which therapists most frequently fulfill, from both the therapists and service providers point of view. This provided information on which roles are the most often filled by pediatric therapists in the community setting. For the ranking question, the top five ranked items for therapists and for service providers were determined with

differences being looked at descriptively. This provided an indication of which roles each group viewed as being the most important.

Qualitative Data

The information from the audio tape of the focus group interview was transcribed and analyzed manually by the researcher. An inductive analysis was conducted, with information being coded to generate themes and sub-themes (Creswell, 2003). The researcher also reviewed the analysis to ensure that logical associations between the themes were present. The qualitative data were then used to further supplement the findings of the quantitative data, and to expand on the quantitative findings or help explain discrepancies (Creswell, Plano Clark, Gutmann & Hanson, in Tashakkori & Teddlie, 2003).

Trustworthiness

The validity and reliability of the survey data depended on whether the survey provided useful information, and if it provided results that were consistent with those obtained in the qualitative data. A field journal, kept by the researcher throughout the course of the study, helped in the verification of the qualitative data. The purpose of a field journal is to allow the researcher to record and be aware of her biases, motives and interests, and determine what influence these may have on the way data were collected or how the content analysis was conducted (Krefting, 1991; Domholdt, 2005). This helped the researcher to reflect on whether her biases and motives of the researcher impacted the results of the study. The researcher is currently a pediatric occupational therapist working in a community setting and as such, had expectations regarding the findings. In

having the journal, the researcher became more aware of what her expectations were and how her experience affected the way the data were interpreted.

The main bias noted by the researcher through the field journal was regarding role confusion, as this was something the researcher had struggled with within her clinical experience and which had led to the exploration of the current research question. Another bias which also originated from the researcher's clinical experience is the limited knowledge service providers have of the roles that occupational therapists are trained for and can fulfill. The field journal was useful and beneficial as it allowed the researcher to become more aware of her biases, and to be able to step back from the data in order to analyze and interpret it in a more objective manner. As a result, the researcher was able to challenge the interpretations critically to see whether the same conclusions would be reached if the analysis was looked at from different points of view. This was also helped by the fact that although the results came to similar conclusions as the main biases in the field journal, most of the data that was obtained was quantitative which allowed for less interpretation and coloring by the researcher. With the interview, the set list of questions used by the researcher helped decrease the amount of bias that might be present in the results, in comparison to a less-structured interview where there would be a greater chance for the researcher to introduce her biases into the results. Decreasing biases in the focus groups would have required more vigilance from the researcher, for example, in the way clarifying questions are worded in order to not purposefully lead participants into making statements which supported the researcher's biases.

Ethical Considerations

This research proposal received approval from the Health Research Ethics Board at the University of Alberta in March 2007.

Participants interested in volunteering for this study were given a letter detailing the study along with the researchers' contact information (Appendix E). Consent to participate in the survey was implied through the completion of the survey by participants. Written consent was to be obtained by the researcher from each participant in the focus group immediately before the start of each focus group (Appendix F). Participants could withdraw from the study at any time without repercussion. In order to facilitate anonymity of the participants, each participant was assigned a pseudonym used in transcriptions of the interview as well as any other documentation produced in this study. The survey was conducted through a web-based survey program to ensure respondent anonymity. Access to the data was available only to the researcher team. The survey data, audio-recordings, field notes, and transcripts are stored in a secure location in Corbett Hall at the University of Alberta.

In using an online survey, a risk is that the participants could be linked to their survey responses. This was addressed by using a web-based survey program through which the survey could be accessed, which provided anonymity to the participants. Since service providers asked to participate in the study were included based on the demographic data offered by a therapist completing the survey, there was a possibility that this information might indicate the service provider they worked for. This was minimized by the use of pseudonyms for interview data, and by ensuring that the quantitative data are presented in

a way which does not link the therapist to their service provider. An issue with focus groups is that the information divulged by participants may end up outside of the session. This issue was to be minimized by asking participants to keep information from the focus groups to themselves. The participant was reminded at the beginning of the interview that he/she did not have to answer any questions or participate in discussions with which he/she was uncomfortable. Economic consequences were minimized by choosing a date and time for the interview that was both convenient to the participant, and which interfered minimally with the participant's work schedule.

Risks and Benefits

We did not anticipate any risks or benefits to the participants in the study. Benefits should ultimately be to the future practice of occupational therapy in schools and other community settings.

Results

79 therapists were contacted via the e-mail list and 17 participated in the survey. Three of the therapists indicated an interest in attending the focus group; ultimately only one participated in an individual interview. Three service providers were contacted, 2 participated in the survey and none volunteered to attend the focus group. As not all of the participants responded to every survey question and some questions allowed for more than one answer, the number of respondents and responses varies throughout the survey items. Although the number of participants in this study was small, it is believed that the results are valid and reliable as some of the quantitative data was confirmed by the qualitative data (Ulin, Robinson & Tolley, 2005; Creswell, Plano Clark, Gutmann &

Hanson, in Tashakkori & Teddlie, 2003). Trustworthiness of the study was strengthened by a process of constant reflection by the researcher on the findings and her expectations and comments documented in the field journal throughout the data collection period.

Characteristics of Respondents

Table 1: Respondent Profile

	Occupational Therapists (N=17)	Service Providers (N=2)
Schools/School Board	7	1
Community Agencies	4	1
Public Health Clinic	3	0
Local Health Authority	2	0
Home Care	1	0

Figure 1: Respondent Profile of Occupational Therapists (N=17)

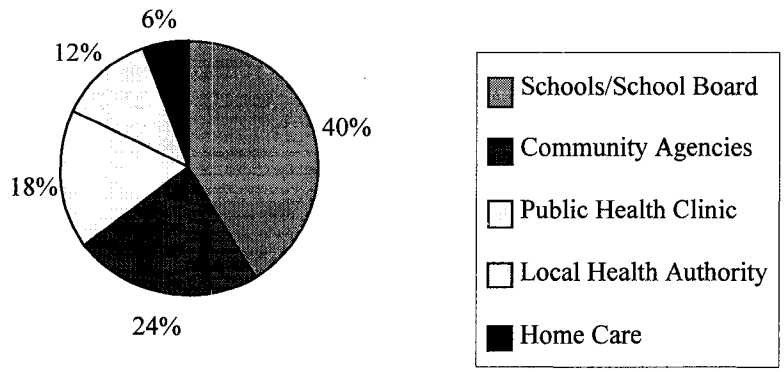

Table 1 provides an overview of the types of subgroups in the larger community the respondents were employed by. Figure 1 provides a percentage breakdown of the subgroups therapists participants are employed by. Although pediatric occupational therapists in the community are employed by a variety of service providers, the school system employs the greatest number of respondents (7), followed by community agencies (4) and public health clinics (2). Out of the two service providers that participated in the survey, one was from the school system, the other was from a community agency.

Principal Professional and Task-Oriented Roles

Table 2: Principal Professional Roles

	Current Roles		Additional Roles	
	Occupational Therapists (N=15*)	Service Providers (N=2)	Occupational Therapists (N=13*)	Service Providers (N=2)
Mentor	10	1	2	1
Educator	8	1	3	1
Manager	3	1	2	0
Administrator	2	0	0	0
Advocate	1	0	8	1
Researcher	1	0	5	0
Entrepreneur	0	0	1	0
Other	4	1	0	1

* Not all respondents answered every question

Table 2 provides a summary of which professional roles are being fulfilled, or if not, additional roles that should be fulfilled by community-based pediatric occupational therapists, from the perspectives of the therapists and of the service providers. The three most common professional roles from the view of therapists are: mentor, educator, and manager. Other current roles that were identified by therapists include: being a collaborator and a program developer. Being a mentor, an educator, and a manager were also identified by the service providers as roles that are being filled by occupational therapists, along with an additional role of being a consultant. In terms of additional roles, being a mentor, educator, and manager were identified by both the therapist and service provider groups as roles that should be filled by therapists. One interesting result was that 8 therapists believed that the role of an advocate should be filled by therapists; this was also identified by one service provider. Other additional roles identified by therapists included: researcher and entrepreneur, neither of which was indicated by the service provider group. The role of a consultant was again identified by the service provider group as an additional role which therapists should fill.

Table 3: Principal Task-Oriented Roles

	Current Roles		Additional Roles	
	Occupational Therapists (N=16*)	Service Providers (N=2)	Occupational Therapists (N=12*)	Service Providers (N=2)
Conducting Assessments and Evaluations	15	2	1	0
Treatment Planning	14	1	0	1
Providing Direct Intervention	11	1	1	1
Supervision of Intervention	13	1	1	1
Providing Compensatory and Alternative Strategies as Needed	15	2	0	0
Addressing Gross Motor Delays	10	2	0	0
Addressing Fine Motor Delays	15	2	0	0
Addressing Sensory Processing Deficits	15	2	0	0
Facilitating Access to Equipment and Services	14	2	1	0
Removing and/or Modifying Barriers to Participation	13	2	1	0
Developing Equipment and/or Adapting Current Equipment	10	2	0	0
Addressing Social Skills and/or Group Interaction Skills	10	2	2	0
Being a Resource to Families	15	2	1	0
Being a Resource to Schools	12	2	2	0
Being a Liaison Between the Medical Community and/or School Team and/or Family	12	2	4	0
Other	1	1	0	0

* Not all respondents answered every question

Table 3 summarizes the results from both the therapist and service provider groups on the task-oriented roles that are being fulfilled, or if not, additional roles that should be fulfilled by therapists. All of the task-oriented roles listed are roles that were filled by at least 10 out of the16 therapists that participated in this survey item. Five task-oriented roles were identified by 15 out of 16 therapists, these are: conducting assessments and evaluations, providing compensatory and alternative strategies as needed, addressing fine motor delays, addressing sensory processing deficits, and being a resource to families. Fourteen out of 16 therapists also identified: treatment planning and facilitating access to equipment and services. One therapist identified the role of liaison between different parties, e.g., between consultants, the school, and the family in addition to the other 15 roles. The service provider group identified the same 15 task-oriented roles as the occupational therapists, with the exceptions of treatment planning, providing direct intervention, and supervision of intervention, which were identified by only one of the two service providers. One service provider indicated that another role therapists are fulfilling is that of assisting with student IPPs. In terms of additional task-oriented roles for therapists, providing direct supervision and supervision of intervention were listed by both the therapist and service provider groups.

Table 4: Most Important Task-Oriented Roles

Rank	Occupational Therapists (N=15)	Service Providers (N=2)
1	Conducting Assessments and Evaluations/Treatment Planning	Conducting Assessments and Evaluations/Treatment Planning
2	Providing Direct Intervention	-
3	Supervision of Intervention	-
4	Addressing Fine Motor Delays	-
5	Addressing Sensory Processing Deficits	-

Table 4 lists which task-oriented roles the therapist group identified as being the 5 most-important. For the service provider group, only the most important task-oriented role could be identified due to the small number of respondents and a large variance in the ranking. This may be due to different service provision and mandate of the two service providers. Both the therapist group and service provider group listed "Conducting Assessments and Evaluations/Treatment Planning" as the most important task-oriented role. The next four roles identified by the therapists in order of importance are: providing direct intervention, supervision of intervention, addressing fine motor delays, and addressing sensory processing deficits.

Role Definition and Limiting Factors

Table 5: How the Role of Occupational Therapist is Defined

	Occupational Therapists (N=15)	Service Providers (N=2)
Self-defined by Occupational Therapist	8	0
Occupational Therapy Manager	2	0
Non-Occupational Therapy Manager	2	1
Governance Board	1	0
Government Policy	0	1
Human Resources	0	0
Other Team Members e.g., Physicians	0	0
Other	2	0

* Not all respondents answered every question

Table 5 provides an overview of the main individuals or influences that define the role of pediatric occupational therapists working in the community setting. Eight out of 15 therapists identified that their role was self-defined; 4 stated that their role was defined by a manager: 2 by an occupational therapy manager, 2 by a non-occupational therapy manager. The occupational therapy regulatory board was indicated by one therapist as the main influence defining the therapist's role. Two therapists stated that the definition

of their role was a collaborative process, with the occupational therapy team defining their role as a whole, or with the therapist determining their role with the guidance and support of an occupational therapy manager. For the service provider group, one respondent indicated that the role of therapists is defined by a non-occupational therapy manager, while the other stated that government policy was the main determinant of therapist roles.

Table 6: Factors Seen as Negatively Limiting the Roles of Occupational Therapists

	Occupational Therapists (N=15)	Service Providers (N=2)
Service Expectations from the Facility	11	1
Service Expectations from the Team	10	0
Limited Knowledge by the Facility about the Skills of Occupational Therapists and the Roles they can Fulfill	10	1
Service Expectations from the Family	7	1
Facility Organization*	6	0
Therapist Unfamiliar/Uncomfortable with Certain Roles	5	0
Board Governance of the Facility**	2	1
None	0	0
Other	4	0

* e.g., specific therapists mandated to focus on specific aspects of service delivery only
** e.g., rules and regulations

Table 6 summarizes which factors are seen by the therapist and service provider groups as negatively limiting the ability of therapists to use all the roles they believe they should be fulfilling. From the therapists view, the three main factors negatively limiting therapists are: service expectations from the facility, service expectations from the team, and limited knowledge by the facility about the skills of occupational therapists and the

roles they can fulfill. Four therapists indicated other negative factors, including: recommendations from the government multi-disciplinary panel; having a "manager figure" who determines role-responsibilities and limits opportunities for joint case-management; funding limitations; and time limitations. Negative factors which service providers view as limiting the role of therapists include: service expectations from the facility, limited knowledge by the facility about the skills of occupational therapists and the roles they can fulfill, service expectations from the family, and board governance of the organization.

Informing the Process of Role Definition

The last item on both the therapist and service provider surveys asked what information service providers needed, if any, to better inform the process of defining the roles of pediatric occupational therapists working in the community setting. There were 11 therapist respondents to this question, and 1 service provider respondent. An interview was also conducted with one respondent from the therapist group, which provided a platform for further discussion on similar questions to those asked in the surveys. The main idea that emerged from both surveys and the interview is that service providers need to have a greater understanding about the breadth and scope of practice of occupational therapy, including areas such as, models of practice, training and skills that occupational therapists possess. From the point of view of one service provider respondent, service providers need to be able to clarify to other members of a team what the role of the occupational therapist is, so that those working with the therapists are able to know what services they can expect from the therapists. Overall, therapists indicate that the lack of knowledge about the breadth of practice of occupational therapy, not only in the school

system but also in the general public, is one of the largest barriers which prevent therapists from fulfilling their roles to greater potential. Another issue which works in conjunction with increasing the understanding of the role of occupational therapists is the lack of knowledge on how therapists work as part of an interdisciplinary team within different settings; for example, that occupational therapists possess the skills to act as case managers for a child's team. The fact that occupational therapists are a valuable resource to schools, families, and other professionals also appears to be unknown.

Discussion

The results should be interpreted with caution due to the small number of respondents in the study, and because the conclusions made in this discussion could not be confirmed by results from the focus groups.

Principal Roles of Community-based Pediatric Occupational Therapists

From the survey, the two professional roles which therapists emphasized that they were fulfilling were that of being a mentor and an educator. The role of an educator has been previously identified in the literature as one of the principal roles that community-based occupational therapists fulfill; however, the role of being a mentor is not one which has strongly emerged as a principal role in previous studies (Lysack et al., 1995, Lemorie & Paul, 2001). One reason that the role of a mentor may have emerged so strongly as a principal role in this study is that a large portion of the therapist respondents worked in the school setting, where they may provide mentorship to therapists who have just begun working within the school setting. Respondents who work within the non-school based community subgroups, where organizations may only employ one occupational therapist,

may also value the role of a mentor: they may be able to serve as a resource to and help other therapists establish their role and navigate the flexible nature of working within the community setting. The additional role which emerged as being the most important for occupational therapists to fill is that of an advocate, which supports findings from previous research; however, it is a role that only one therapist identified as he/she is currently fulfilling (Lysack et al., 1995, Lemorie & Paul, 2001). While advocacy is seen as an invaluable role in the community setting, the fact that most of the respondents in this study work within a school setting may limit the amount of advocacy therapists are able to do. Although therapists working within the school setting seek to be child-centered in their service approach, they may be limited in the amount of advocacy they are able to do as they need to work within the expectations and needs of the school system and of other school-based professionals (such as principals and teachers). For example, a child's family may request for the therapist to address a certain area or skill; however, the teacher may not see that skill as being a priority and may ask that other concerns be addressed instead. Furthermore, as governments are generally more inclined to provide funding to children and as there are frequently many services for children, from therapies to specialized equipment, the occupational therapist may be more involved in helping a child access services rather than acting as an advocate for a child. That is not to say that there is no need for advocacy, as a child's access to therapeutic services may be contingent on the ability of the therapist in providing sound therapeutic judgment regarding the child's need for occupational therapy.

The role of researcher was also highlighted by occupational therapists as one that they should be more involved in, which supports the findings by McColl (1997). In contrast

to the previous findings by Lemorie and Paul (2001), therapists in the current study appear to identify with the relevancy and importance of adopting the role of a researcher. As evidence-based practice is now considered the main basis for practice in occupational therapy, therapists may see the need to conduct research in the clinical setting on treatment modalities that may not have yet been tested or validated in a rigorous study (CAOT, Association of Canadian Occupational Therapy University Programs [ACOTUP], the Association of Canadian Occupational Therapy Regulatory Organizations [ACOTRO] & the Presidents' Advisory Committee [PAC], 1999). Neither of the service providers indicated "researcher" as a role which therapists are or should be fulfilling. This may be because service providers are more familiar with seeing occupational therapists in a direct clinical role, rather than as a researcher in the community setting. As well, depending on the type of community subgroup, service providers may either be unaware that therapists can function as researchers and/or prefer having their therapists focus more on delivering services to their clients. A similar situation may apply for service providers with regards to seeing therapists in the role of an administrator. Although two therapists responded that they are active in the role of administrator (such as being in charge of the occupational therapy department), neither service providers indicated that this was an additional role that therapists can occupy. A professional role that was indicated by a service provider but not by therapists is that of a consultant. As this role was identified in the literature as being essential in school-based practice, the fact that this role was not identified by therapists might indicate that although therapist within the school system are functioning in this capacity, they are more

familiar with and are able to fulfill a more direct clinician role even within a consultative model of service delivery.

As the different categories of professional roles were not defined in the survey, it is unclear whether all respondents had a similar definition or comprehension of the different roles. Although it is believed that having defined the different roles may not have changed the results, it would have allowed for the respondents to reference a uniform set of definitions of the roles, and may have enabled respondents to more accurately identify the roles they believe occupational therapists fulfill or should be fulfilling. A suggested list of roles can be found in appendix J.

In terms of task-oriented roles, all of the 15 roles on the survey were identified by more than half of the therapists as roles they fulfill, which indicates that therapists are generally fulfilling similar roles regardless of the type of community subgroup they are employed by. This similarity of roles was also indicated by the service providers as all the roles were filled at both organizations except for 3. From the five task-oriented roles which 15 out of 16 participating therapists identified that they are fulfilling (conducting assessments and evaluations, providing compensatory and alternative strategies as needed, addressing fine motor delays, addressing sensory processing deficits, and being a resource to families), all except one are related to addressing the impairments of a client. According to the World Health Organization's International Classification of Functioning, Disability, and Health (ICF) (2002), impairment interventions have a medical or rehabilitative focus and may work to decrease or prevent limitations, increase capacity levels, and increase the performance of a task. This result suggests that pediatric

occupational therapists and their managers see providing direct services to children which focus on impairments as their main role. This finding is echoed by the results from the ranking question, in which the five most important task-oriented roles identified by therapists relate directly to service provision in the form of providing intervention and addressing functional deficits. Both the therapist and service provider groups were in agreement that the most important task-oriented role is that of conducting assessments and evaluations/treatment planning. This may be because an integral part of occupational therapy is the determination of what areas of intervention is required followed by the formulation of a treatment plan. This finding supports research by Coutinho and Hunter (1988) who indicated that an important role for therapists is conducting an evaluation, as this is the initial step for determining a child's eligibility for services in a school setting. Furthermore, there is an inherent requirement within the profession for therapists to be able to demonstrate sound clinical judgment in not only identifying functional impairments and providing appropriate treatment, but also in explicating a child's need for occupational therapy services. Although the survey used in this study was based on that used by Dule et al. (1999), the roles which were identified as being the most important differed between the two studies. The reason for this difference may be because of the change in the way the roles were worded, the addition of other roles not found in the previous study, and the difference in study population: pediatric community-based therapists (current study); school-based therapists (study by Dule et al. [1999]).

Identification of how Roles are Defined and Limiting Factors

In regards to how the role of pediatric occupational therapists working in the community is defined, the majority of therapist respondents indicated that their role is self-defined.

While this provides some flexibility in roles that the therapist can fulfill while assuring that the roles chosen are appropriate for an occupational therapist, this flexibility may be difficult for new therapists working the community who are more accustomed to having their roles defined for them. Although not all of the therapist respondents have the opportunity to self-define their role, most therapists appear to have some input into how their role is determined, whether by a manager who is familiar with occupational therapists or as part of a collaborative process with other occupational therapists and the manager. This collaboration is advantageous as the therapist not only has the opportunity to ensure that the roles they are being asked to fulfill are appropriate, but they are also able to educate the manager on the roles and scope of practice of the profession. This sentiment is echoed in the study Lysack et al. (1995) who identified that although most of the therapists in their study reported to a non-occupational therapy manager, this arrangement provided an opportunity for therapists to promote the benefits to clients of pediatric occupational therapists.

Although occupational therapists bring a broad range of skills to their practice, the main barrier that therapists in this study identified as limiting their scope of practice is the general lack of knowledge about the breadth and depth of the practice of pediatric occupational therapists. There is an indication from therapists this lack of knowledge limits their roles, as one therapist indicated that occupational therapists can address "more than motor and sensory issues." Another therapist stated that "marketing about occupational therapy in generally is poor", and that in helping people understand what occupational therapy does, "they would know to ask for our services." This limitation was also identified by one of the service providers, which indicates that community

facilities may not necessarily understand everything that occupational therapists can do, and as such may not make the best use of them within their organizations. These statements suggest that there is a lack of knowledge within the general public about the profession of occupational therapy, and that this lack of recognition plays a part in limiting the ability of therapists to fulfill the roles that they see as being important to their clients.

Service expectations from both the facility and the team were also identified as limiting factors by both therapists and service providers, specifically the roles of occupational therapists within the school setting. While therapists in this setting may have the opportunity to function as part of an interdisciplinary team, therapists indicate that oftentimes their role is limited by teachers who are viewed as the lead person on a team. As one therapist put it, "these are long held attitudes held by the political bodies, that teachers do all in classrooms. Other professionals are thought of as health care providers only." This view proved to be a source of frustration, as therapists indicated that decisions may not be made as a team and opportunities to rotate or share case manager duties for the children become limited. This resistance by team members towards working within a collaborative model has also been noted in the literature (Dule et al., 1999; Scaletti, 1999). A reason for this may be due to a lack of understanding of roles, the difference in how certain roles are defined, and the difference in the philosophy and views between therapists and teachers. Occupational therapists are interested in how students relate to an activity, whereas teachers are more focused on the outcome and the quality of performance (Fairbairn & Davidson, 1993; Coutinho & Hunter, 1988). As well, members of an interdisciplinary team may not realize the scope of occupational

therapy as the role of the therapist is generally self-defined, and may not be made clear to other team members. However, as teachers and members of a child's interdisciplinary team gain a greater understanding about occupational therapy from working with therapists, they appear to be able to better utilize this resource within their classrooms (Fairbairn & Davidson, 1993). As one therapist stated, "I find the more time I spend with school teams, the stronger the rapport and they see and trust what I can offer...".

In addition to having occupational therapists working with school personnel as a way of increasing understanding of the potential contribution of the profession, one therapist suggested that another way of addressing this problem is by having education students learn about the profession through lectures by occupational therapists. In that way, after these students graduate and begin working, they will be better prepared and knowledgeable about the different health professions within the educational system, and will be able to utilize and collaborate with these different professionals more effectively. As suggestions have been made in the literature for occupational therapists to educate teachers about the profession, this may be an effective strategy as newly graduated teachers would have some knowledge and understanding of the roles and scope of practice of therapists in the school setting (Royeen & Marsh, 1988; Coutinho & Hunter, 1988).

In contrast to pediatric occupational therapists working within the school system, the narrowing of roles of therapists working elsewhere within the community may be due to the therapists themselves. As there are service providers with the community who may be limited in financial resources and may only be able to employ one occupational

therapist, therapists may limit the scope of their role as a way of managing their caseload. This becomes important for therapists working within settings where they may be one of the only health professionals at the facility, leading to the possibility of a high client caseload. Coupled with the fact that community-based therapists may also need to fulfill a diversity of generalist roles as indicated by Krupa et al. (2002) and Mitchell and Unsworth (2004), it becomes apparent that although limiting one's therapeutic role may not be ideal, it nevertheless becomes essential in order to provide quality occupational therapy services to as many clients as possible, and where it is most beneficial.

Similar to other occupational therapists working in the community setting but with a different population, the lack of role clarity for pediatric occupational therapists based in the community was also identified. The blurring of roles is also present within the pediatric community setting, as indicated in previous studies by Colman (1988) and Case-Smith and Cable (1996) regarding occupational therapists within the school setting, and by Lemorie and Paul (2001) within the community setting. As children accessing services within the community may be receiving many different services, the overlap of occupational therapy roles with those of other professionals becomes significant. One respondent indicated that examples of overlapping roles include: "feeding with speech-language pathologists, social skills with teaching staff, anxiety/relaxation with speech-language pathologists, gross motor with physical therapists, and sensory integration with behavioral consultants."

Although there are guidelines within the school system and the occupational therapy profession, there appears to be a need for a clearer indication from service providers and

from the profession on which roles occupational therapists are entitled or ethically-bound to address versus other disciplines. However, this may prove difficult due to the flexible and changing nature of working within the community setting, and working in collaboration with different health professionals and services as part of a child's team.

Implications of Findings for Practice

Time plays an important part in the shift towards community based intervention, which brings more therapists into the community setting who then begin to have a greater understanding of the challenges of working within this environment. Since the progress of time allowed for additional roles to be identified in the literature, these were added to the survey used in this study to more accurately reflect the roles which therapists are currently fulfilling. It is believed that the findings of this study reflect the changing roles over time of pediatric occupational therapists working within the community setting.

The outcomes of this study suggest:

- that there are many roles that community-based pediatric occupational therapists fulfill
- that roles are defined by the type of community subgroup in which therapists are employed
- factors that influence roles include: service expectations, a general lack of knowledge about the breadth and scope of practice of occupational therapy, and the therapist themselves
- that there is a lack of role clarity for pediatric occupational therapists based in the community.

Translation of the Findings into Practice

Based on these findings, suggestions for ways in which therapists could help educate others about the roles and scope of practice of the profession include:

- delivering a presentation to the staff at the therapists' place of employment on what occupation therapy is, and the scope and breadth of the profession
- delivering a session on occupational therapy to post-secondary students enrolled in programs that have a greater likelihood of working with therapists (e.g., students in the faculties of education, medicine, and psychology)
- increasing the understanding of roles within a therapeutic team by ensuring that all members are using the same definition for the different types of roles. Appendix J lists suggested definitions for professional roles
- educating clients and their families about the profession of occupational therapy, and the services that occupational therapist are able to provide via child and parent friendly pamphlets
- educating students enrolled in occupational therapy programs about the different roles that they can fulfill, so that they may be more aware of and better negotiate their roles when they begin their practice
- collaborating closely with children and their families in the development of intervention programs, specifically goal setting and evaluation of results.

Limitations

Since the study population for occupational therapists was obtained from one e-mail list in Edmonton, not all therapists in the area who meet the inclusion criteria will have had the opportunity to participate in the study and it is not known how this might have

affected the findings and their generalizability. Since information of service providers was obtained from therapists who completed the survey, some eligible pediatric community service providers in Edmonton were excluded. Also, since few therapists provided information regarding service providers, it became necessary for the researcher to identify and contact additional service providers that fit the inclusion criteria for this study. The number of service providers that were contacted was small, and there were even fewer who agreed to participate in this study, which does not provide for a complete view on the roles of therapists from service providers.

Recruiting to and arranging the timing of the focus groups was problematic. Although most occupational therapists and service provider managers work a consistent shift from early morning to late afternoon, there are also those who work from the afternoons into the evening. As well, there are also those who work their primary employment position during the day but then perform consultation work during the evenings and weekends. It was difficult to accommodate these varying needs for the focus group. A more flexible study design to allow for individual interviews or more focus groups per study group would have been beneficial.

As convenience sampling was used and as the overall participation numbers were small, it is not known if those who participated in the study and in the interview did so because of a particular interest in the topic or because they held strong views, which may not accurately reflect the views of the population studied.

Since the number of participants was small, specifically in regards to the service providers, the number of conclusions and comparisons that could be made between the

therapist and service provider groups were limited. The small number of respondents also affected participation in the focus groups, thus limiting the discussion and expansion of information that could be obtained from the surveys. This limitation could be addressed in future studies by increasing the sample population to include therapists and service providers working with children aged 18 and younger; however, this would introduce other issues, such as the difference in roles of therapists working with children in early education settings compared to those working with the adolescent population. Expanding the study to locations in addition to Edmonton would also increase the number of therapists and service providers that could be accessed; however, issues such as the geographical location (urban vs. rural) and differences in service delivery models would need to be accounted for.

Conclusion

Although some research has been conducted into the roles that occupational therapists perform in the community and within the school setting, there has been limited research into the roles of occupational therapists in a pediatric community setting. As an increasing amount of therapeutic intervention is occurring in the community, it is important to determine essential professional roles in order to provide practice guidelines to therapists, as well as clarifying existing roles when working in conjunction with other health professionals or team members.

From this study, it appears that there is a general consensus between therapists and service providers on the principal professional and task-oriented roles that community-based pediatric occupational therapists fulfill, although there remain some roles identified

by therapists as being within their scope of practice which were not identified by service providers. This suggests that although service providers are familiar with occupational therapy as a profession, there is a difference in roles that therapists see as being important and may be currently fulfilling, and those which service providers may not be as familiar with or not view as being a part of a therapist's practice. Although service expectations from community facilities and interdisciplinary teams are seen as negatively limiting the roles of occupational therapists, this study also found that the lack of knowledge about occupational therapy as a profession and the breadth of skills that therapists possess is one of the principal contributing factors therapists see as limiting their role. Further studies expanding upon this pilot study while utilizing a larger study population may be beneficial in providing a wider and more complete and conclusive look at the roles of pediatric occupational therapists working in the community setting, and the challenges they face in defining their roles.

It is hoped that the findings of this study and implementation of the suggestions provided for educating occupational therapists, team members, and clients/families will provide current and future pediatric occupational therapists and their managers with a clearer idea of their roles as well as assisting in generating role guidelines for this area of occupational therapy practice.

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Roles of Pediatric Occupational Therapists in the Community

- Are you an occupational therapist with more than 1 year experience working with children 5-12 years old?
- Do you work in the community including school settings?

Are you interested in participating in a study exploring the roles of community pediatric occupational therapists and the constraints they experience in their day-to-day work?

If you are interested: You will be asked to complete a web-based survey.
There will be the possibility of participating in a focus group.

If you would like to be involved in this study, please contact:

- Vivian Ng at (780) 488-6600 ext.246 / vng@ualberta.ca, or
- Dr. Gill Chard at (780) 492-8854 / gill.chard@ualberta.ca

Appendix B: Therapist Survey

An Investigation into the Roles of Occupational Therapists Working with Children Within a Community Setting

Principal Investigator: Gill Chard, PhD, Associate Professor
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Cindy Tom, MSc.(OT), Pediatric Occupational Therapist
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Megan Hodge, PhD, Professor
(780) 492-5898, megan.hodge@ualberta.ca

Introduction

We are interested in obtaining the views of pediatric occupational therapists with at least one year of experience, who work with children aged 5-12 years in the greater Edmonton region, and who are employed by at least one community-based service provider (not including private practice).

The main goal of this study is to establish the roles of pediatric occupational therapists working in a community setting within Edmonton and the surrounding area. We are also interested in determining the nature of any discrepancy between the roles identified by the therapists and those identified by the service providers. We are interested in this because the amount of research in this area is quite small, and because we would like to see what factors, if any, may contribute to such discrepancies.
To obtain the views of occupational therapists and service providers, a separate survey has been developed for each group and will be administered independently of each other. The survey will take approximately 15 minutes to complete.

To follow up on information obtained from these surveys, we will also be running separate focus groups for therapists and service providers. If you are interested in participating in the therapists' focus group, please ensure that you complete Section 4 of this survey.

In completing this survey, you are consenting to participate in the survey part of this study. Participation in the study is entirely voluntary and you may withdraw from the study at any time without repercussion. There are no direct benefits or risks involved with completing the survey. Your name will not be attached to any documentation produced from these data. Access to the data will only be available to the research team named at the beginning of the Information Letter, and will be stored in a secure location in Corbett Hall at the University of Alberta for a minimum of seven years. Any report resulting from this study will only contain aggregate information so that you or your service cannot be identified.

If you have any questions or concerns about this study or would like more information, you may reach the main researchers at the phone numbers and e-mail addresses listed above. If you have any questions or concerns regarding your rights as a participant, you may contact the Health Research Ethics Board at (780) 492-0302.

We hope that the information from this study will provide some insight into the roles of pediatric occupational therapists in the community and the constraints which may limit the roles they fulfill.

Section 1.

N.B. If you are employed by more than one community-based service provider, please answer the questions in this survey in relation to the employer for whom you work for the greater amount of time (FTE -full time equivalent). For example, if you are employed at "A" at a 0.7 FTE, and at "B" at a 0.3 FTE, you would use your practice and experience working for "A" to answer the questions in this survey.

Type of service provider you are employed by:

- ☐ home care
- ☐ public health clinic
- ☐ community agency
- ☐ group home
- ☐ school
- ☐ Other _____

Section 2.

1. Professional roles are those that involve non-therapeutic responsibilities such as collaboration and mentorship. In your current practice, which are the main professional roles that you currently fulfill? (if yes, please select as many as apply)

- ☐ Administrator
- ☐ Manager
- ☐ Mentor
- ☐ Entrepreneur
- ☐ Researcher
- ☐ Advocate
- ☐ Educator
- ☐ Other _____

2. In your current practice, are there any additional professional roles which you believe should be fulfilled by yourself or another pediatric occupational therapist? (please select as many as apply)

- ☐ Administrator
- ☐ Manager
- ☐ Mentor
- ☐ Entrepreneur
- ☐ Researcher
- ☐ Advocate
- ☐ Educator
- ☐ Other _____
- ☐ N/A

3. Task-oriented roles are therapeutic roles that involve initiation, provision, and evaluation of intervention. In your current practice, which are the main task-oriented roles that you currently fulfill? (please select as many as apply)

- ☐ Conducting assessments and evaluations
- ☐ Treatment planning
- ☐ Providing direct intervention
- ☐ Supervision of intervention
- ☐ Providing compensatory and alternative strategies as needed
- ☐ Addressing gross motor delays
- ☐ Addressing fine motor delays
- ☐ Addressing sensory processing deficits
- ☐ Facilitating access to equipment and services
- ☐ Removing and/or modifying barriers to participation
- ☐ Developing equipment and/or adapting current equipment
- ☐ Addressing social skills and/or group interaction skills
- ☐ Being a resource to families
- ☐ Being a resource to schools
- ☐ Being a liaison between the medical community and/or school team and/or family
- ☐ Other _____

4. In your current practice, of the task-oriented roles which you do not currently fulfill, which additional roles do you think an occupational therapist in your position should fulfill? (please select as many as apply)

- ☐ Conducting assessments and evaluations
- ☐ Treatment planning
- ☐ Providing direct intervention
- ☐ Supervision of intervention
- ☐ Providing compensatory and alternative strategies as needed
- ☐ Addressing gross motor delays
- ☐ Addressing fine motor delays
- ☐ Addressing sensory processing deficits
- ☐ Facilitating access to equipment and services
- ☐ Removing and/or modifying barriers to participation
- ☐ Developing equipment and/or adapting current equipment
- ☐ Addressing social skills and/or group interaction skills
- ☐ Being a resource to families
- ☐ Being a resource to schools
- ☐ Being a liaison between the medical community and/or school team and/or family
- ☐ Other _____
- ☐ N/A

5. From a professional standpoint, which of the following task-oriented roles do you see as being the most important for a pediatric occupational therapist to fulfill? Please rate and prioritize ALL of the following task-oriented roles from 1 to 15, with 1 being the most important and 15 being the least important.

- ☐ Conducting assessments and evaluations
- ☐ Treatment planning
- ☐ Providing direct intervention
- ☐ Supervision of intervention
- ☐ Providing compensatory and alternative strategies as needed
- ☐ Addressing gross motor delays
- ☐ Addressing fine motor delays
- ☐ Addressing sensory processing deficits
- ☐ Facilitating access to equipment and services
- ☐ Removing and/or modifying barriers to participation
- ☐ Developing equipment and/or adapting current equipment
- ☐ Addressing social skills and/or group interaction skills
- ☐ Being a resource to families
- ☐ Being a resource to schools
- ☐ Being a liaison between the medical community and/or school team and/or family

6. In your practice setting, who primarily defines the role of the occupational therapist? (please select only ONE)

- ☐ Human Resources
- ☐ Occupational therapy manager
- ☐ Non-occupational therapy manager: please specify _____
- ☐ Government policy
- ☐ Governance board
- ☐ Other team members e.g., physicians
- ☐ Self-defined by occupational therapist
- ☐ Other _____

7. Some factors help therapists to positively define their roles; however, the same factors may also be seen as limiting a therapist's role (e.g., collaborating with teachers in intervention planning, but teachers may expect fine motor programming only and resist intervention in regards to a child's independence in the classroom). Which of the following factors, if any, negatively limit the ability of therapists to use all the roles they believe they should be fulfilling?

- ☐ None
- ☐ Facility organization e.g., specific therapists mandated to focus on specific aspects of service delivery only
- ☐ Board governance of the facility e.g., rules and regulations
- ☐ Service expectations from the facility
- ☐ Service expectations from the family
- ☐ Service expectations from the team
- ☐ Limited knowledge by the facility about the skills of occupational therapists and the roles they can fulfill
- ☐ Therapist unfamiliar/uncomfortable with certain roles
- ☐ Other _____

Section 3.

8. What information do you think service providers need, if any, to better inform the process of defining roles of pediatric occupational therapists working in the community setting?

_____
_____
_____
_____
_____
_____
_____

Section 4. (Optional) A link will direct the participant to a separate web page to input the following information.

Would you be willing to attend a focus group to discuss these survey issues further? If so, please complete the following:

Name: _____
Phone number: _____
E-mail address: _____

Preferred method of contact: ☐ via phone ☐ via e-mail

A part of this study includes having service providers fill out a similar survey to obtain their views on this topic. May we approach your service provider to complete the Service Provider survey?

- ☐ No
- ☐ Yes, name of service provider: _____

Please note that your name or any identifying information will not be divulged to any service provider or any other third party.

Thank you for completing this survey!

Appendix C: Service Provider Survey

An Investigation into the Roles of Occupational Therapists Working with Children Within a Community Setting

Principal Investigator: Gill Chard, PhD, Associate Professor
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Cindy Tom, MSc.(OT), Pediatric Occupational Therapist
cindy.tom@ualberta.net

Megan Hodge, PhD, Professor
(780) 492-5898, megan.hodge@ualberta.ca

Introduction

We are interested in obtaining the views of service providers in the greater Edmonton region who employ pediatric occupational therapists and provide services to children aged 6-12 years.

The main goal of this study is to establish the roles of pediatric occupational therapists working in a community setting within Edmonton and the surrounding area. We are also interested in determining the nature of any discrepancy between the roles identified by therapists and those identified by service providers. We are interested in this because the amount of research in this area is quite small, and because we would like to see what factors, if any, may contribute to such discrepancies.

To obtain the views of occupational therapists and service providers, a separate survey has been developed for each group and will be administered independently of each other. The survey will take approximately 15 minutes to complete.

To follow up on information obtained from these surveys, we will also be running separate focus groups for therapists and service providers. If you are interested in participating in the service provider's focus group, please ensure that you complete Section 4 of this survey.

In completing this survey, you are consenting to participate in the survey part of this study. Participation in the study is entirely voluntary and you may withdraw from the study at any time without repercussion. There are no direct benefits or risks involved with completing the survey. Your name will not be attached to any documentation produced from these data. Access to the data will only be available to the research team named at the beginning of the Information Letter, and will be stored in a secure location in Corbett Hall at the University of Alberta for a minimum of seven years. Any report resulting from this study will only contain aggregate information so that you or your service cannot be identified.

If you have any questions or concerns about this study or would like more information, you may reach the main researchers at the phone numbers and e-mail addresses listed above. If you have any questions or concerns regarding your rights as a participant, you may contact the Health Research Ethics Board at (780) 492-0302.

We hope that the information from this study will provide some insight into the roles of pediatric occupational therapists in the community and the constraints which may limit the roles they fulfill.

Section 1.

Type of service provider (please select as many as apply)

- ☐ home care
- ☐ private practice
- ☐ public health clinic
- ☐ community agency
- ☐ group home
- ☐ school
- ☐ other_____

Job title of person completing this survey _____

Section 2.

1. Professional roles are those that involve non-therapeutic responsibilities such as collaboration and mentorship. Within your organization, which are the main professional roles that occupational therapists currently fulfill? (please select as many as apply)

- ☐ Administrator
- ☐ Manager
- ☐ Mentor
- ☐ Entrepreneur
- ☐ Researcher
- ☐ Advocate
- ☐ Educator
- ☐ Other _____

2. Within your organization, are there any additional professional roles which you believe should be fulfilled by a pediatric occupational therapist? (please select as many as apply)

- ☐ Administrator
- ☐ Manager
- ☐ Mentor
- ☐ Entrepreneur
- ☐ Researcher
- ☐ Advocate
- ☐ Educator
- ☐ Other _____
- ☐ N/A

3. Task-oriented roles are therapeutic roles that involve initiation, provision, and evaluation of intervention. Within your organization, which are the main task-oriented roles that pediatric occupational therapists currently fulfill? (please select as many as apply)

- ☐ Conducting assessments and evaluations
- ☐ Treatment planning
- ☐ Providing direct intervention
- ☐ Supervision of intervention
- ☐ Providing compensatory and alternative strategies as needed
- ☐ Addressing gross motor delays
- ☐ Addressing fine motor delays
- ☐ Addressing sensory processing deficits
- ☐ Facilitating access to equipment and services
- ☐ Removing and/or modifying barriers to participation
- ☐ Developing equipment and/or adapting current equipment
- ☐ Addressing social skills and/or group interaction skills
- ☐ Being a resource to families
- ☐ Being a resource to schools
- ☐ Being a liaison between the medical community and/or school team and/or family
- ☐ Other _____

4. Of the task-oriented roles which pediatric occupational therapists do NOT currently fulfill within your organization, which additional roles do you think a pediatric occupational therapist should fulfill? (please select as many as apply)

- ☐ Conducting assessments and evaluations
- ☐ Treatment planning
- ☐ Providing direct intervention
- ☐ Supervision of intervention
- ☐ Providing compensatory and alternative strategies as needed
- ☐ Addressing gross motor delays
- ☐ Addressing fine motor delays
- ☐ Addressing sensory processing deficits
- ☐ Facilitating access to equipment and services
- ☐ Removing and/or modifying barriers to participation
- ☐ Developing equipment and/or adapting current equipment
- ☐ Addressing social skills and/or group interaction skills
- ☐ Being a resource to families
- ☐ Being a resource to schools
- ☐ Being a liaison between the medical community and/or school team and/or family
- ☐ Other _____
- ☐ N/A

5. From an organizational standpoint, which of the following task-oriented roles do you see as being the most important for a pediatric occupational therapist to fulfill? Please rate and prioritize ALL of the following task-oriented roles from 1 to 15, with 1 being the most important and 15 being the least important.

- ☐ Conducting assessments and evaluations
- ☐ Treatment planning
- ☐ Providing direct intervention
- ☐ Supervision of intervention
- ☐ Providing compensatory and alternative strategies as needed
- ☐ Addressing gross motor delays
- ☐ Addressing fine motor delays
- ☐ Addressing sensory processing deficits
- ☐ Facilitating access to equipment and services
- ☐ Removing and/or modifying barriers to participation
- ☐ Developing equipment and/or adapting current equipment
- ☐ Addressing social skills and/or group interaction skills
- ☐ Being a resource to families
- ☐ Being a resource to schools
- ☐ Being a liaison between the medical community and/or school team and/or family

6. In your organization, who primarily defines the role of the occupational therapist? (please select only ONE)

- ☐ Human Resources
- ☐ Occupational therapy manager
- ☐ Non-occupational therapy manager: please specify _____
- ☐ Government policy
- ☐ Governance board
- ☐ By other team members e.g., physicians
- ☐ Self-defined by occupational therapist
- ☐ Other _____

7. Some factors help therapists to positively define their roles; however, the same factors may also be seen as limiting a therapist's role (e.g., collaborating with teachers in intervention planning, but teachers may expect fine motor programming only and resist intervention in regards to a child's independence in the classroom). Which of the following factors, if any, negatively limit the ability of therapists to use all the roles they believe they should be fulfilling?

- ☐ None
- ☐ Facility organization e.g., specific therapists focus on specific aspects of service delivery
- ☐ Board governance of the facility e.g., rules and regulations
- ☐ Service expectations from the facility
- ☐ Service expectations from the family
- ☐ Service expectations from the team
- ☐ Limited knowledge by the facility about the skills of occupational therapists and the roles they can fulfill
- ☐ Therapist unfamiliar/uncomfortable with certain roles
- ☐ Other _____

Section 3.

8. What information do you think service providers need, if any, to better inform the process of defining roles of pediatric occupational therapists working in the community setting?

_____
_____
_____
_____
_____
_____
_____

Section 4. (Optional)- A link will direct the participant to a separate web page to input this contact information.

Would you or another member of your facility staff who is familiar with the role of the pediatric occupational therapist be willing to attend a focus group to discuss these survey issues further? If so, please complete the following:

Name of service provider: _____
Name of staff member: _____
Job title of staff member:_____
Phone number: _____
E-mail address: _____

Preferred method of contact: ☐ via phone ☐ via e-mail

Thank you for completing this survey!

Appendix D: Focus Group Schedule

An Investigation into the Roles of Occupational Therapist Working with Children Within a Community Setting

Welcome and Topic of the Focus Group

Thank you for taking the time to attend today's focus group, and for choosing to participate in our study. My name is Vivian Ng and I am an occupational therapist and also a thesis-based master's candidate enrolled at the University of Alberta. I will be facilitating today's focus group. Dr. Gill Chard is also attending the focus group as the recorder. She will be making a few notes and observations about our discussions, which will help me later on when I transcribe and analyze the information that will come out of this focus group.

Ground Rules

To begin, I would like to explain what a focus group is. A focus group is a discussion surrounding a specific topic which allows for detailed information to be obtained. For my study, I am interested in finding out more about the roles that community-based pediatric occupational therapists fulfill, and possible constraints on your roles. The discussion will be audio taped so I would ask that each person takes turns speaking rather than everyone speaking at the same time. I would also ask that you keep the information discussed today to yourself, so that your and everyone else's privacy can be maintained.

Freedom to Withdraw/Unanswered Questions

If at any time you feel uncomfortable with any of the topics being discussed, you do not have to answer any question you do not want to and you are free to withdraw from the focus group at any time.

Are there any questions?

Introductions

To begin, I would like everyone to introduce themselves, state where you practice, and how long you have worked with pediatrics in the community.

Guiding Questions:

1. On a day to day basis, what therapeutic and non-therapeutic roles do you fulfill?
    a. Does your role vary from day to day or does it remain static?
    b. Do you feel that these roles are appropriate for an occupational therapist?
2. What constraints do you feel limit your roles?
3. Do you feel that facilities have enough knowledge to define your roles

4. What information do you think will help facilities better define your roles?
5. Is there any additional information that anyone would like to share or discuss in regards to this topic?

N.B. These questions may be modified following analysis of questionnaire data

Closing

I would like to thank everyone for their participation in the focus group. The information from today's focus group will be transcribed, and analyzed. I would like to assure you that your name will not be attached to your comments in the focus group, and that pseudonyms will be used on all documentation produced for this study. It is expected that this study will be concluded by the end of August, 2007. As well, if you have any additional questions about today's focus group or the study in general, please feel free to contact me at the phone number or e-mail address listed on the information letter.

Appendix E: Information Letter for Participants

Title of Study: An Investigation into the Roles of Occupational Therapists Working with Children in the Community Setting

Principal Investigator: Gill Chard, PhD, Associate Professor
Department of Occupational Therapy
2-10, Corbett Hall, University of Alberta
(780) 492-8854, gill.chard@ualberta.ca

Co-Investigators: Vivian Ng, BSc.(OT), MSc.(OT) thesis-based candidate
(780) 488-6645, ext. 246

Annette Rivard, MSc.(OT), Assistant Professor
(780) 492-2342

Cindy Tom, MSc.(OT), Pediatric Occupational Therapist
cindy.tom@ualberta.net

Megan Hodge, PhD, Professor
(780) 492-5898, megan.hodge@ualberta.ca

The main goal of this study is to establish the roles of pediatric occupational therapists working in a community setting within Edmonton and the surrounding area. We are also interested in determining the nature of any discrepancy between the roles identified by therapists and those identified by service providers. We are interested in this because the amount of research in this area is quite small, and because we would like to see what factors, if any, may contribute to such discrepancies.

The Study

This study consists of two parts: a web-based survey and a focus group. Both occupational therapists and service providers will be asked to participate in separate surveys and focus groups. The information obtained will be analyzed separately and later compared.

Part II of the study is separate focus groups for occupational therapists and service provider representatives, and we will further discuss the ideas obtained from the survey. The focus group will take place at Corbett Hall at the University of Alberta and will last for no longer than one hour. The focus group session will be audiotaped and later transcribed by the investigators.

Consent

Before participating in the study, you will be asked to sign a consent form. We want to be sure that you have read and understood the information letter, are aware of what the study consists of, and are willing to participate in the study. Participation in the study is entirely voluntary and you may withdraw from the study at any time without repercussion. You do not have to answer any questions in the focus group if you do not wish to.

Confidentiality

Your name will not be used in any report or publication arising from this study. Each participant will be given a pseudonym which will be used in the transcription of the focus group discussion, as well as on any other documentation produced in this study. Access to the data will only be available to the research team named at the beginning of this letter, and all audio tapes, field notes, and transcripts will be stored in a secure location in Corbett Hall at the University of Alberta for a minimum of seven years.

Benefits and Risks

Although there are no direct benefits to you for participating in this study, you will have an opportunity to discuss the roles occupational therapists fulfill. In the focus group, you will also have the opportunity to meet other colleagues who work with a similar clientele in the community setting.

There are unlikely to be any risks involved with participating in this study. You may find that there are aspects of your practice that you do not want to share, and may choose not to participate in answering certain questions or discussions. Although efforts will be taken to ensure that the information shared in the focus group remains confidential, such as members being asked not to share the information outside of the group and personal information not being linked to the transcript, there is a risk that shared information may end up outside of the focus group.

Additional Questions or Concerns

If you have any questions or concerns about this study or would like more information, you may reach the principle investigator and co-investigators at the phone numbers and e-mail addresses listed at the beginning of this letter.

If you have any questions or concerns regarding your rights as a participant, you may contact the Health Research Ethics Board at (780) 492-0302.

Appendix F: Focus Group Consent Form

Part 1: Research Information

Title of Project: An Investigation into the Roles of Occupational Therapists Working with Children in a Community Setting

Principal Investigator:
Gill Chard, PhD, Associate Professor, Department of Occupational Therapy, 2-10 Corbett Hall, Faculty of Rehabilitation Medicine, University of Alberta
Phone Number: (780) 492-8854 Fax: (780) 492-4628 E-mail address: gill.chard@ualberta.ca

Co-Investigators:
Vivian Ng, BSc.(OT), MSc.(OT) thesis-based candidate, Department of Occupational Therapy
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Annette Rivard, MSc.(OT), Assistant Professor, Department of Occupational Therapy
Phone Number: (780) 492-2342

Cindy Tom, MSc.(OT) E-mail address: cindy.tom@ualberta.net

Megan Hodge, PhD, Professor, Department of Speech Pathology and Audiology
Phone Number: (780) 492-5898

Part 2: Consent Information

	Yes	No
Do you understand that you have been asked to participate in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to withdraw from the study at any time, without having to give a reason, and without affecting your relationship with the investigators?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to the research data?	☐	☐

Who explained this study to you?_____

I agree to take part in the focus group: YES ☐ NO ☐

Signature of Participant: _____

Printed name of Participant: _____ Date:_____

Witness: _____ Date: _____

THE INFORMATION SHEET MUST BE ATTACHED TO THIS CONSENT FORM AND A COPY GIVEN TO THE RESEARCH SUBJECT

Appendix G: Budget

Equipment	**Expenses**
Digital voice recorder (new)	$100
Web-survey program (Surveymonkey- available on the Internet)	$0

Materials and supplies	**Expenses**
Photocopying and printing	$50
Batteries, blank CDs and tapes, journal, pens, paper	$50

Other	**Expenses**
Phone calls	$80
Parking reimbursement (24 participants x $10)	$240
Cost of transcription of focus group (done by investigator)	$0
Refreshments for the focus groups	$40

Total Expenses	**$560**

Appendix H: Therapists Recruitment E-mail

Research participation opportunity!

We are looking for participants for a study looking at the roles of pediatric occupational therapists working within a community setting. We are currently recruiting for the survey stage of the study.

Interested participants should be pediatric occupational therapists with at least one year of experience, who work with children aged 5-12 years in the greater Edmonton region, and who are employed by at least one community-based service provider (not including private practice).

The survey is web-based and will take approximately 15 minutes to complete.

To complete the survey or to obtain more detailed information of this study, please visit: (link to the therapist survey information letter/ therapist survey).

Thank you for your interest and participation!

Appendix I: Service Provider Recruitment Script

Introduction

My name is Vivian Ng and I am an Occupational Therapy Masters student from the University of Alberta. I am currently conducting a study looking at the roles of pediatric occupational therapists who work in a community setting within Edmonton and the surrounding area, and whether there are any discrepancies between the roles identified by therapists and those by service providers. The reason I am calling is because your organization provides services to children between the ages of 5 and 12, and employ pediatric occupational therapists. I was wondering whether your organization would be interested in participating in this study.

General Study Information

This study consists of a web-based survey, as well as a future possibility of participation in a focus group. I am currently recruiting service providers for the survey part of the study. Ideally, the person who would fill out the survey would be the immediate supervisor of the occupational therapist. An alternate informant will be either a supervisor or manager with a health-related background who is familiar with the role of occupational therapists in the organization and/or works with occupational therapists. If there is more than one key informant in an organization, the informant who is the most familiar with the roles of occupational therapists will be recruited.

Recruitment Information

1. Do you have any questions? Provide contact information for any future questions.
2. Would you be interested in having your facility participate in this study?
    a. If yes, provide link to the service provider survey
    b. If maybe, ask if they would like the link to the service provider survey which includes the information letter prefacing the survey

Thank you for your time!

Appendix J: Definitions of Professional Roles

Administrator
"Manages department, program, services, or agency providing occupational therapy services" (American Occupational Therapy Association [AOTA]. Occupational Therapy Roles Task Force, 1993, p. 1093).

Advocate
Works with other team members to increase the client and family's awareness of their rights, ensures that they have enough information to make an informed decision, promotes legislation and social awareness on behalf of the client, and may use advocacy to promote the best interest of the client to other professionals (Swinth, 2001; Sachs & Linn, 1997).

Consultant
"Provides occupational therapy consultation to individuals, groups, or organizations" (AOTA. Occupational Therapy Roles Task Force, 1993, p. 1093).

Educator
"Develops and provides educational offerings or training related to occupational therapy to consumer, peer, and community individuals or groups" (AOTA. Occupational Therapy Roles Task Force, 1993, p. 1090).

Entrepreneur
"Entrepreneurs are partially or fully self-employed individuals who provide occupational therapy services" (AOTA. Occupational Therapy Roles Task Force, 1993, p.1097).

Mentor
An experienced and knowledgeable person who facilitates professional development in one who is less experienced through guidance and support (Milner & Bossers, 2004).

Researcher
Contributes to the occupational therapy body of knowledge by way of theory development, outcome studies, validation of practice and/or work on the efficacy of specific treatment modalities (Gilkeson, 1997).