CONCEPTUALIZING COMMUNITY DEVELOPMENT FROM AN OCCUPATIONAL THERAPY PERSPECTIVE: THREE CANADIAN CASE STUDIES

By

Heidi-Michelle Lauckner

A thesis submitted to the School of Rehabilitation Therapy in conformity of the requirements for the degree of Doctor of Philosophy

Queen’s University
Kingston, Ontario, Canada
March 2010

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Abstract
Despite our theoretical commitment to community development (CD) approaches in occupational therapy, current practice models focus on individual interventions, rather than identifying how occupational therapists (OTs) can contribute at a community level. Consequently, OTs attempting to work with communities may not have clear guidance on methods of community engagement or strategies for addressing community level issues. This research examined three cases of OTs working in CD in different regions of Canada in order to 1) generate in-depth interpretive case descriptions of CD practice; and 2) conceptualize CD from the perspective and practices of occupational therapy. Data collection in each case occurred over three weeks and included approximately 30 hours of observations, document reviews and 14 interviews with health professionals and program participants. Constructivist grounded theory informed data analysis. The conceptual framework generated from the cross-case analysis describes the context of CD in which the OTs bridged the health and community sectors. The OTs were in community-focused positions located within regional health authorities. The OTs strategically used both professional and personal self to enable more equitable power sharing between health services, community agencies and consumers, creating opportunities for meaningful engagement with and in communities. Four main CD strategies contributed to this power shift: 1) building consumer and community capacity, 2) nurturing community partnerships, 3) influencing the health care system, and 4) linking sectors and resources. These OTs focused on a set of core values while drawing on their professional experiences. Individual, organizational and community-level changes resulted from these CD initiatives. The conceptualizations developed in this study can inform the practice of OTs by identifying potential CD strategies for enabling occupations with communities and sensitizing OTs to historical contextual tensions and power inequities. From this, the applicability of current occupational therapy models to communities can be extended, enhancing reflexive CD practice.
Acknowledgments

I have joked that it often ‘takes a village’ to get me to the places I need to go. This dissertation is no exception. This study was about people and communities coming together to do and become more than they could in isolation. Perhaps not coincidentally, I feel like I’ve been able to do and become more with the invaluable support I’ve received along the way, for which I am very grateful.

I would like to thank the many friends who were there at the tentative start of my process, those who encouraged me through the seemingly endless confusion in the middle, and those who cheered me on when the end was in sight. In particular, I’d like to thank the following: Martin for his encouraging ‘mind mapping’ techniques; Carrie and Shelley for supportive conversations over wine and long brain-storming sessions; Cheryl for leading the way in the doctoral process and then supporting me as I approached the finish line; Nancy, who has been an invaluable new friend and mentor during the analysis, writing, and defense stages; and the many friends who listened, encouraged, and gently reminded me to have fun along the way. Thank you, Nancy, Dahlia, Jen, Sara, Mike, and many others.

I would like to thank my mom and dad, Lisa and Dick, for their patience and support through my stressful moods and at times distracted visits. My brother and his family have also been understanding with my seemingly endless ‘homework’ and I now look forward to more play breaks with Rory-Danielle, Max, and Brock, my niece and nephews.

I’m also grateful to my new colleagues at Dalhousie University. They supported me in the final stages of this process in many ways. I look forward to continuing to work together on future projects.

I am thankful for the time and support provided by my co-supervisors, Margo Paterson and Terry Krupa (Queen’s University). In particular, I appreciated Margo’s encouragement throughout my graduate studies and Terry’s analytical approach which challenged me to continue to develop and grow as a researcher. There is much more to learn! I’m also grateful to my
advisory committee members, Elaine Powers (Queen’s University) and Rachel Thibeault (University of Ottawa). I thank Elaine for her thoughtful approach, which was both encouraging and constructive. I thank Rachel for being an inspiration for the work that she does and the compassion she brings to all her interactions. It has been an honour to work with each of you.

I appreciated the financial support I’ve received during my doctoral degree from the following organizations: the Social Sciences and Humanities Research Council (SSHCR), the Ontario Graduate Scholarship (OGS), Queen’s University Inter-professional Patient-centred Education Direction (QUIPPED), and the Canadian Occupational Therapy Foundation (COTF).

Finally, I would like to sincerely thank the OTs in this study for sharing their time and thoughts with me. You have been generous and inspiring. Thank you.

For all of this, I am sincerely grateful.
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CHAPTER 1: INTRODUCTION

1.1 Situating the Research

Over the past 30 years in Canada, an emphasis on health promotion, population health and community participation has increased recognition that healthy communities result when community members actively participate to prioritize health concerns and identify strategies to address these. Community development (CD) is an approach within health promotion where the community participates in health-related decisions. Community development has been defined as “the process of organizing and/or supporting community groups in identifying their health issues, planning and acting upon their strategies for social action/social change and gaining increased self-reliance and decision-making power as a result of their activities” (City of Toronto, cited in Labonte, 1993, p. 237). Some features of CD differentiate it from more traditional approaches to health care:

- A community focus, or community segment focus, as a whole, rather than individuals;
- Community members drive its implementation, rather than experts, so that priorities are set and strategies for change are identified by actively participating community members;
- The promotion of empowered communities through capacity building, rather than an emphasis on service delivery that disregards community capacity; and
- Recognition of broad systemic health issues that challenge power inequities, rather than working within these constraints (Boutilier, Cleverly, & Labonte, 2000; Kenny, 1994; Labonte, 1993; Minkler & Wallerstein, 1997).

Occupational therapists (OTs) have joined other health professionals, such as nurses and social workers, in examining how CD can promote community health. OTs work with a wide range of people to enable health and well-being through occupation (Canadian Association of Occupational Therapists [CAOT], 2002). ‘Enabling occupation’ is the process where people are facilitated to participate in daily occupations, activities which include looking after themselves,
enjoying life and contributing to the social and economic fabric of their communities (CAOT, 2002, p. 34). In light of recent health trends encouraging CD approaches, Canadian OTs have begun to re-examine how CD can be more explicitly integrated into occupational therapy practice (Banks & Head, 2004; McColl, 1998; Scaffa & Brownson, 2005; Townsend, Cockburn, Letts, Thibeault, & Trentham, 2007; Watson & Swartz, 2004; Wilcock, 1998; Wilcock & Whiteford, 2003). Many CD principles are compatible with occupational therapy’s core beliefs, including client-centredness, empowerment, partnerships and justice (Banks & Head, 2004; Baum & Law, 1998; Restall, Ripat, & Stern, 2003; Thibeault & Hebert, 1997; Townsend, 1993), and numerous examples within national and international occupational therapy literature demonstrate the explicit inclusion of CD approaches in occupational therapy practice (Letts, 2003; McComas & Carswell, 1994; Thibeault & Forget, 1997; Thibeault, 2002; Westmorland, 1996).

1.2 Study Rationale

Despite the proposed compatibility between CD and occupational therapy, limited scholarship addresses how OTs engage in CD as part of their daily practice. Examples of OTs engaging in CD tend to be anecdotal and thus provide little research with which to critique and synthesize experiences, contributing to the lack of evidence within this area. Although recent revisions to Canadian guidelines for occupational therapy practice affirm the profession’s commitment to CD approaches (Townsend & Polatajko, 2007), the practical application of proposed theoretical constructs within CD have not been explored (LeClair, 2010; Trentham, Cockburn & Shin, 2007; Watson & Swartz, 2004). Moreover, current occupational therapy conceptual and practice models provide neither comprehensive directions on methods of community engagement, nor clear strategies for redressing power inequities that exist between health professionals and community members. Perhaps as a consequence of this, OTs have reported feeling unprepared to work in the community (Lemorie & Paul, 2001; Lysack, Stadnyk, Paterson, McLeod, & Krefting, 1995) and apply CD approaches (Lauckner, Pentland, & Paterson,
Statistics on the service areas of Canadian OTs indicate that only 0.05% of therapists work primarily in CD (CAOT, 2007), supporting the claim that CD is an underdeveloped and under-researched practice area for OTs (McColl, 1998; Watson & Schwartz, 2004).

There is a schism between the theoretical commitment of occupational therapy, which calls for increased work with communities, and the profession’s practice, which continues to focus on traditional, individually-based interventions. This study proposes to explore the application of CD in daily practice in order to explicate CD from an occupational therapy perspective. An examination of OTs’ CD practice can clarify activities, demonstrate how CD approaches are integrated with occupational therapy practice, and illustrate daily challenges. Results of this examination will strengthen the theoretical foundation of occupational therapy as applied to CD implementation in daily practice.

1.3 Research Objectives and Question

The study’s objectives were to: 1) develop three in-depth interpretive case descriptions of OTs engaging in CD in practice; and, 2) develop a theoretical framework that describes CD from the perspective and practices of occupational therapy. The main research question of this study was: How does the process of CD from an occupational therapy perspective occur in practice?

A qualitative collective case study design (Stake, 2000; Stake, 2006; Yin, 2003) was used that drew on constructivist grounded theory analysis methods (Charmaz, 2000; 2006). The case study design I used in this study enabled the collection of in-depth examples of day-to-day intricacies of OTs doing CD work. My cross-case analysis enabled the generation of a framework, transcending individual cases, to develop relevant concepts for those working in CD.

1.4 Theoretical Perspective

A constructivist paradigm informed this study. The basis of constructivism is a belief that individuals construct the meaning of their own experiences and events (Charmaz, 2006). This
research thus aimed to explore and understand various meanings of CD experiences constructed by research participants. The inclusion of multiple perspectives in the cases provided insight into the complexity of CD initiatives for participants. In anticipation of these diverse perspectives, I drew on Stake’s method of case study design that required the identification of issues, or problematic topics, that help to highlight the complexity of the cases (Stake, 2000). For example, at the onset of the research, I identified potential contentious issues among OTs working in CD practice pertaining to the generic nature of CD practice, potential inconsistency between espoused theory and practice, and anticipated tensions between medical and community-orientated approaches to health. Exploration of these potential problematic issues deepened the analysis process.

1.5 Researcher’s Stance

I came to this interest in CD through my international experiences as a rehabilitation instructor. I trained in Canada as an OT, worked in various North American clinical rehabilitation settings, and then moved overseas to work in international development in Namibia with the volunteer agency Voluntary Services Overseas (VSO).

In my role with the rehabilitation department of the Ministry of Health and Social Services in Namibia, I trained rehabilitation workers to serve as links between the community and health services. The differences in my experiences as a clinical therapist in North America made me uncertain of the expectations of an OT in this context. I found myself drawing on CD literature and strategies rather than occupational therapy literature. This unease, coupled with the need to draw on literature from other fields, made me question the ways in which, if at all, this work related to occupational therapy.

Upon returning to Canada, I enrolled in graduate studies in order to explore the experiences of OTs working in CD. Through previous research, I learned that other OTs have similarly struggled with developing their role in CD, going through a process of doing and then
reflecting on the relationship between CD and occupational therapy (Lauckner, 2005). I felt it was necessary to begin examining an occupational therapy perspective of CD in order to explicate the unique perspective OTs brought to this interdisciplinary field. I therefore explored the theoretical foundations of this perspective in a university course on occupational therapy and CD I co-taught (Lauckner, Boudreau, Donnelly, & O’Connor, 2009; Lauckner, Krupa, & Paterson, 2006).

Following this experience, I began to examine occupational therapy models and theories more critically. I also drew on approaches and skills from other disciplines to prepare occupational therapy students to work in CD. I returned to the philosophical and theoretical basis of occupational therapy to better understand how CD may be integrated into practice. When I began this study, there was only cursory mention of CD in the dominant Canadian occupational therapy text, *Enabling Occupation: An Occupational Therapy Perspective* (CAOT, 2002). Shortly after beginning my doctoral research, the CAOT launched *Enabling II: Advancing an Occupational Therapy Vision for Health, Well-being & Justice Through Occupation* (Townsend & Polatajko, 2007). This text explicitly discusses CD as an occupational therapy approach for enabling social change, and applied both new and old occupational therapy models to communities and populations (Townsend & Polatajko, 2007). However, the question remained for me: How do occupational therapists practice community development?

### 1.6 Significance

This study proposes a theoretical framework that can be used to question or inform the application of current Canadian models of occupational therapy practice to CD. The framework explicitly describes how OTs work at the community level, and describes the change processes at work in CD initiatives, as well as strategies employed by OTs to facilitate these changes. The framework also captures CD’s complexity by identifying several points of tension within initiatives, emphasizing contextual factors affecting the integration of occupational therapy and CD in practice. Consequently, this study illuminates daily challenges of CD that may contribute
to the difficulty of some OTs when expanding into CD work, and forms a basis from which to begin addressing these challenges.

Information provided by this study helps extend existing occupational therapy models, which may guide practicing therapists and students. Specifically, the case descriptions and framework developed here propose a structure for conceptualizing CD from an occupational therapy perspective. Future examination, critique and modification of the framework is likely, therefore its function at this time is to provide a preliminary basis for reflexive practice, further theory development and research.

Beyond relevance to the occupational therapy profession, results of this study add to the interdisciplinary field of CD by articulating the potential role of OTs and explicate some of the tensions that all health professionals may experience in CD practice. The framework shows how OTs can complement CD initiatives, while case descriptions demonstrate implementation in practice. Potential occupational therapy contributions enhance other health professionals’ abilities to work with OTs for the common goal of community health promotion and well-being. It is probable that some challenges for OTs described here are shared by other health professionals moving from institution-based health services into CD, thus experiences and strategies described here may be of use to others working in CD.

1.7 Outline of the thesis

This thesis contains eight chapters: Chapter 2 reviews literature related to occupational therapy and CD, with a particular emphasis on current models’ applicability to community. This literature review grounds the study in existing practical examples of OTs engaging in CD and current theoretical models, concluding that the schism between practice and theory must be addressed in order to provide guidance in how to reflexively integrate occupational therapy and CD approaches in practice, such that the experiences and uniqueness of each community is considered. Chapter 3 outlines the study’s methodology, namely a qualitative, collective case
study drawing on constructivist grounded theory. This chapter offers a rationale for the methodology and outlines the data collection and analysis processes. In Chapters 4, 5 and 6, findings of the in-depth individual case descriptions outline the case context, describe the main CD initiatives and present each case’s key CD processes. In Chapter 7, a cross-case analysis is presented to propose the emerging framework that describes the process of CD from an occupational therapy perspective as constructed from the three cases. The literature is re-examined in Chapter 8, the discussion chapter, to explore how the findings of this research confirm, refute or add to existing models and literature. The study’s implications for occupational therapy practice and education are proposed, and recommendations for future research are made.
CHAPTER 2: LITERATURE REVIEW

2.1 Chapter Overview

This chapter describes key issues in the literature pertaining to the integration of occupational therapy practice and community development (CD) approaches in Canada. CD definitions and models are used to establish compatibility with occupational therapy values and principles, and the integration process of these commonalities highlights some challenges faced by occupational therapists (OTs) working in CD. Given the lack of consistent theoretical models within these practice examples, this review addresses Canadian occupational therapy models that incorporate the concept of enabling occupation at the community level.

The Canadian Model of Occupational Performance and Engagement (CMOP-E) and the Canadian Practice Process Framework (CPPF) (Polatajko, Townsend, & Craik, 2007), are critiqued, as is a newer model, the Canadian Model of Client-Centred Enablement (CMCE) (Townsend, Polatajko, Craik, & Davis, 2007). This review demonstrates that a careful examination of how OTs engage in CD will advance our understanding of this emerging field of practice.

2.2 Understanding Community Development

Understanding Community

Central to understanding CD is the meaning of ‘community.’ This term is often delineated by location, thus ‘community’ is used to refer to those health services offered outside a hospital. Moving beyond this elementary understanding of community, Labonte (1997) suggested that community involves the intersection of identity, geography, issue and people: “We all belong to multiple communities at any given time. The essence of being a community is that there is something that is ‘shared’. We cannot really say that a community exists until a group with a
shared identity exists” (p. 90). Geographic communities are not homogeneous and often contain sub-groups based on shared interests and identities (Jewkes & Murcott, 1996).

Due consideration must also be given to those who identify a group as a ‘community,’ particularly since professionals often incorrectly attribute communities to people that do not connect to how individuals self-identify (Jewkes & Murcott, 1996). CD approaches thus emerge from an appreciation of communities as complex entities with a range of sub-groups, all with strengths and resources that can move towards collective action.

**Key Concepts within Community Development**

CD refers to the process of working with community groups to identify their priorities and develop strategies for them to affect social change and gain increased control and decision-making power (Labonte, 1993). Internationally and within the Canadian health-care context, CD is considered a key strategy within health promotion initiatives, and primary health care (WHO, 1978; 1986). The Ottawa Charter (WHO, 1986) outlined five health promotion strategies relating to CD: (1) build healthy public policy, (2) create supportive environments, (3) strengthen community action, (4) develop personal skills, and (5) reorient health services.

Although CD has been a component of health promotion and public/population health internationally for about 20 years, perspectives regarding what constitutes CD are varied, as are perspectives on how it is best evaluated (Wall et al., 2009). Drawing on key features identified in the literature, this study defines CD as health-related initiatives that focus on a community or community segment, in which community members actively participated in addressing community-identified priorities and are empowered through the CD process (Boutilier, Cleverly, & Labonte, 2000; Kenny, 1994; Labonte, 1993; Minkler & Wallerstein, 1997). In this study, CD also involves both a recognition of and demonstrated willingness to change system inequities that influence community members’ health (Boutilier, Cleverly, & Labonte, 2000; Kenny, 1994; Labonte, 1993).
Concepts central to understanding CD include participation, empowerment, and community competence and capacity building (Minkler & Wallerstein, 1997). Zakus and Lysack (1998) define participation as “the process by which members of the community, either individually or collectively and with varying degrees of commitment: develop the capability to assume greater responsibility for assessing their health needs and problems; plan and then act to implement their solutions and create and maintain organizations in support of these efforts” (p. 2). Participation is considered to be a continuum, ranging from manipulation by those in power and passive participation of the community, to equal partnerships and ultimately collective mobilization through active participation (Arnstein, 1969; Duraiappah, Roddy, & Parry, 2005). One of the aims of CD is to enhance participation of community members and marginalized groups. It is through participation that power can begin to be shared with community members and community capacity is strengthened.

Empowerment can be understood at both the individual and community level. Individually, empowerment is described as a ‘power-from-within’ that is a means of gaining a sense of control over one’s life (Laverack, 2005). Within communities, empowerment is the process through which individuals come together to address a mutual concern through collective action (Laverack, 2005). Thus, community empowerment is simultaneously a CD process and outcome.

Community competence refers to the collaboration skills in communities that allow problem-solving, identification of priorities and the ability to work together in implementing plans (Minkler & Wallerstein, 1997). Community capacity relates to the community’s potential for addressing health concerns, and is broader in scope than empowerment (Goodman et al., 1998). Moreover, capacity “increase[es] the capacities of people to articulate and address community health issues and overcome barriers to achieve improved outcomes in quality of life” (Labonte, Woodard, Chad, & Laverack, 2002, p. 181). Like community empowerment, community capacity is strengthened through CD with the outcome of enhanced community
competence. A community’s capacities are made up of individual and organizational capacities that may be controlled by those outside the community (McKnight & Kretzman, 1997). Capacity-building recognizes these capacities, strengthens them and uses them in response to community concerns.

Within the literature, attempts have been made to differentiate CD approaches based on meaningful participation, empowerment and community capacity building from those labeled as ‘community-based’ practice. According to Labonte (1993), in community-based programs, professionals or agencies identify the problems and develop strategies to address them, with the intention that community members will eventually take over responsibility; for instance, most community health services are considered to be community-based programs. In contrast, CD strives to support community groups who have self-identified health priorities and planned strategies to address these issues (Labonte, 1993).

**CD Models and Frameworks**

Rothman and Tropman (1987) propose a popular framework, using three approaches, for understanding the variations of CD initiatives: locality development, social planning and social action. First, locality development emphasizes broad participation of the local community in identifying goals and actions. Participants are viewed as citizens while professionals act as enabler-catalysts. In contrast to this, social planning uses a top-down approach that emphasizes the technical problem-solving expertise of governments or professionals in identifying issues and determining actions to address them. Within this approach, participants are viewed as consumers of the service created, with professionals as analysts and program implementers. The third approach, social action, presumes that a segment of the population is disadvantaged and needs to advocate for greater allocation of power and resources from the broader community. Participants are viewed as victims of unjust systems, thus the professional assumes the role of activist or power broker. Rothman and Tropman’s conceptualization of CD has been criticized for its
restrictive understanding of community, which is mainly geographically defined. Additionally, the social planning approach, with its professional dominance, contradicts basic tenets of CD, while all three approaches focus on community needs and deficits, rather than strengths (Minkler & Wallerstein, 1997). In response to criticism, Rothman (1996) acknowledged that these CD approaches often overlap in practice.

Other authors depict 5 stages of CD along a continuum, recognizing that strategies shift over the life of a CD project (Jackson, Mitchell, & Wright, 1989; Labonte, 1994). The first point on this continuum, personal action and empowerment, is enhancing an individual’s sense of control and developing trust (Jackson et al.; Labonte). The second stage, small group development or mutual support, promotes change within the group by bringing individuals together and encouraging self help. These small groups move on to the third stage, where the group mobilizes to address issues collectively and links with others who share similar goals for community level change. In the fourth stage, coalition advocacy or partnerships, efforts are directed towards changing policies through committee and board memberships. The final stage, political action or social movements, emphasizes sustainable efforts and ongoing community participation in decision-making. Along this continuum, from individual to collective change, power shifts and resources are re-allocated, resulting in group empowerment (Bracht, Kinsbury, & Rissel, 1999).

Laverack (2001; 2005) integrated the CD continuum and empowerment by mapping nine domains of community empowerment onto the stages of CD described above. These empowerment domains include: 1) community participation, 2) problem assessment capacities, 3) local leadership, 4) organizational structures, 5) resource mobilization, 6) links with other organizations and people, 7) ability to ask ‘why’ questions, 8) community control over program management and 9) equitable relationship with outside agents. Laverack (2001; 2005) described the role of the practitioner at each stage, ranging from bringing people together to mobilize resources in early stages, to linking with community resources and developing critical awareness
through this weaving of the CD continuum with empowerment domains, Laverack illustrates the process through which practitioners work with communities to share power gradually.

Another conceptualization of CD describes its phases using tasks initiated by the facilitator: 1) community analysis, 2) design-initiation, 3) implementation, 4) maintenance-consolidation, and 5) dissemination-reassessment (Bracht, Kinsbury, & Rissel, 1999; Mackenzie, Neiger, & Smeltzer, 2005). Although presented as distinct phases, overlap between stages occurs and aspects of stages may need to be repeated.

The difference between Bracht’s and Laverack’s conceptualizations is that Bracht emphasizes the facilitators’ perspective without attending to potential power shifts at the community level, whereas Laverack’s empowerment approach focuses on the processes and outcomes from the community perspective. Because of the emphasis on power dynamics and the aim to empower, Laverack’s approach aligns well with Rothman and Tropman’s (1987) locality development and social action approaches to CD. Models that focus on the professional’s role and what they will be ‘doing to’ the community are more in line with social planning.

**Power and Reflexivity in Community Development**

In order to prioritize issues of power, reflexivity on the part of the professional is an important element in all CD stages (Camilletti, 1996; Ife, 1999). Reflexivity involves the deliberate and continual linking of understanding with action. According to Ife, one engages in “a constant cycle of doing, learning, and critical reflection so that each informs the other and so that the three effectively become one in what is referred to as “praxis” (Ife, 1999, p. 230). Praxis thus integrates action, understanding, learning and theory building. Reflexive praxis is particularly important in CD work where power differences may exist between professionals and the communities with whom they work. Despite intentions to engage in empowering CD practices, many health practitioners continue to practice in top-down, power-over initiatives (Laverack,
Power-over describes “social relationships in which one party is made to do what another party wishes them to, despite their resistance and even if it may not be in their best interest” (Laverack, 2005, p. 29). In CD, power-over can be seen when professional ‘expertise’ is emphasized and excludes the act of listening to the community’s identified health concerns (Laverack, 2005). With an awareness of power issues, practitioners can transform their power-over status to ‘power-with’, such that power is shared.

Based on this brief review of common conceptualizations of CD in the literature, ‘community development’ is seen to encompass a broad range of approaches that differ in emphases and span endeavours which focus on both the individual and the collective.

Challenges of Community Development in Practice

Numerous challenges can inhibit the incorporation of CD approaches into practice. First, practitioners may have oversimplified understandings of CD processes. Labonte (1997) cautions against romanticized notions of ‘community,’ which can result in downloaded responsibilities to communities without necessary supports. As well, distinctions between geographical and ideological definitions of community remain blurred. For example, there continues to be an understanding among health professionals that community refers to geography and thus anything ‘not in institutions’ is community (Levin & Herbert, 2001).

Other challenges are found in the extent to which practitioners can implement CD in practice. Professionals’ approaches are often criticized as disempowering to those they work with because they do not attend to power and control issues (Laverack, 2005); thus, deliberate effort must be taken to manage power differentials (Shuster, Ross, Bhagat, & Johnson, 2001). Often the rhetoric of governments and funding agencies do not extend to funding support (Labonte, 1993), so CD initiatives may be required to run with limited resources and few staff who have only limited training and support. This constraint can impact the sustainability of initiatives and the satisfaction of those working in CD.
2.3 Community Development and Occupational Therapy

Townsend and her colleagues claim that occupational therapy “has a long, yet relatively unknown history in community development” (Townsend, Cockburn, et al., 2007, p. 155) that dates back to occupational therapy’s beginnings in Canada. Mary Black, one of the first OTs in Canada, engaged in CD in the early 1940s. Other early Canadian OTs emphasized collective engagement in activities focused on community interdependence (Friedland, 2003), and the importance of health promotion and a holistic understanding of the broad factors that influence individuals (Friedland & Rais, 2005; Madill, Brintnell, Stewin, Fitzsimmons, & Macnab, 1986). More recently, OTs have engaged in health promotion approaches with individuals and communities (DeMars, 1992; Edwards, 1990; Finlayson & Edwards, 1995; West, 1970 cited in Wilcock, 2003); yet, occupational therapy remains relatively unknown for its contributions to enabling social change at the community level (Townsend, Cockburn, et al., 2007). The paucity of literature and research around strategies for working with communities through CD substantiates this claim (Watson & Swartz, 2004; Witman & Velda, 2001).

Renewed calls to engage with communities from an occupational therapy perspective were based on a growing appreciation of occupational engagement as central to individual and community health. The expanded definition of occupational therapy introduced in 2007 by the CAOT was consistent with this viewpoint, and indicated that occupational therapy within Canada moves well beyond individually-focused therapeutic activities to embrace the profession’s role in promoting participation through occupation at the societal level (Townsend & Polatajko, 2007). ‘Occupations’ refer to groups of life activities that are considered meaningful by individuals and society, and include activities directed at taking care of oneself, enjoying life and contributing productively to the community (CAOT, 2002).

OTs are encouraged to move beyond individual, hospital-based interventions to work in the community with new teams of non-health care professionals (Baum & Law, 1998; McColl,
but barriers to this shift to community practice remain relevant as OTs consider moving to population approaches (Wilcock, 2003). Barriers include: limited number of designated community positions, discomfort in competing for employment with colleagues in the health promotion field, and the limited scope of occupational therapy models relevant to community practice (Laukaran, 1977; Wilcock, 2003). A lack of preparation may deter OTs from working in CD (McColl, 1998).

Despite these practical barriers, practice informed by a commitment to social justice requires a community focus. The emerging framework of occupational justice acknowledges the structural factors that result in inequities. Wilcock (2006) defined occupational justice as “the promotion of just socioeconomic and political conditions to increase individual, population and political awareness, resources, and opportunity for people to participate …. [and become healthy] through engagement in occupations that meet the prerequisites of health and every person’s different natures, capacities and needs” (p. 248). An approach grounded in occupational justice emphasizes people’s occupational rights, such as: experiencing meaningful occupations, developing health and inclusion through participation in occupations, exerting autonomy through occupational choices and benefiting from fair privileges for diverse occupations (Townsend & Wilcock, 2004). Individuals, communities or populations may be unable to exercise these rights resulting in occupational injustice.

Occupational injustice manifests differently depending upon which right(s) are infringed, such as the inability to engage in meaningful occupations (Townsend & Wilcock, 2004). The denial of resources and opportunities to engage in meaningful occupations could cause occupational alienation, seen in the enslavement, confinement or forcible removal of people from their families. Whiteford (2000) suggested that occupational deprivation, or longstanding exclusion from meaningful engagement, can result when a person experiences geographic isolation, poor working conditions or incarceration. Occupational marginalization denies individuals the right to make everyday occupational choices. Overall, the link between
occupational justice and health resonates because “choice and control in what we do to participate in occupations is the basis of our empowerment as humans, and empowerment is a determinant of health for individuals and populations” (Townsend & Wilcock, 2004, p. 82).

**Commonalities between Community Development and Occupational Therapy**

CD and occupational therapy both employ process-oriented approaches that address the needs of marginalized groups. OTs work with people with disabilities, the elderly and those who are systematically excluded from engagement in occupation. In CD, community participation refers to people engaging in the planning processes; similarly, within occupational therapy, client-centered practice promotes collaborative decision-making between clients and professionals around meaningful occupation, goal setting and intervention planning (Maitra & Erway, 2006). Within occupational therapy, ‘client’ refers to recipients of occupational therapy services, who may also be referred to as ‘consumers’ or ‘consumer-survivor,’ particularly within mental health services. Although client-centered practice in occupational therapy typically addresses individual interactions, Canadian OTs recently expanded their definition of ‘client’ to include communities, organizations and populations, providing further support for OTs working within CD (Restall, Ripat, & Stern, 2003; Townsend & Polatajko, 2007).

The development of genuine, interdependent partnerships between the OT and client is a strategy shared with CD approaches (Labonte, 1997; Thibeault & Hebert, 1997; Townsend, 1993). Successful partnerships between OTs and CD practitioners recognize power influences in relationships (Laverack, 2005; Townsend & Polatajko, 2007). Both fields rely on empowerment, where individuals or communities come to gain mastery over their own lives, fundamentally shifting control from practitioners to community members (Laverack, 2005; Thibeault & Hebert, 1997). This move is commensurate with client-centred practice, which is central to occupational therapy (Townsend & Polatajko, 2007). CD and occupational therapy thus share the espoused values of community participation, empowerment, partnerships and justice.
Community Development from an Occupational Therapy Perspective

Within occupational therapy literature, definitions of CD from an occupational therapy perspective are limited. According to OTs, CD refers to community consultation that promotes individual and community-wide responsibility for health and well-being (Wilcock, 1998, p. 238). Restall and her colleagues advance this understanding of CD to emphasize relationship building based on “mutual respect, equity, inclusiveness and co-ordinated effort” and “shared leadership and power” (2003, p. 109). Although these definitions integrate the CD principles discussed thus far, they do not include the purported strength of OTs to bring a unique occupational focus (Banks & Head, 2004). A more recent definition of CD from an occupational therapy perspective includes this occupational focus: “a process that is multi-layered, community-driven, in which relationships are developed and the community’s capacity is strengthened, in order to affect social change in their community that will promote the community’s access and ability to engage in occupations” (Lauckner, Pentland, & Paterson, 2007, p. 319). In citing ‘occupation’ specifically, CD initiatives incorporate the notions of “occupation as means” and “occupation as ends” (Trentham et al., 2007, p. 63).

2.4 Examples of Community Development in Occupational Therapy Practice

A literature review sought to explore peer-reviewed examples of OTs engaging in CD. The key heading ‘occupational therapy’, was combined with search terms ‘community development’, ‘community-capacity building’, ‘consumer participation’ and ‘social action’ in key databases (CIHNAL and Psycinfo). References were scanned to indicate that the article described an OT engaging in CD and ensured compliance with the following criteria: 1) description of an OT’s practices working mainly with a group or community, 2) explicit mention of CD, community organizing or capacity building approaches, and 3) project or initiative aim to effect change at the community level. Search results were narrowed to Canadian OTs working in CD. Below is a synthesis of the seven search results.
Overview of Sample Community Development Initiatives from the Literature

Noticeable diversity was evident in the programs and communities described. Two articles describe how CD approaches can be used in occupational therapy student fieldwork with community placements (Banks & Head, 2004; Klinger & Bossers, 2009). In these examples, innovative placements were secured at community agencies that did not employ OTs. Students worked with an agency to identify a community project in line with the agency's priorities. These initiatives allow students to appreciate the processes involved in working with community agencies, including building trust and being guided by community priorities (Banks & Head, 2004), while community agencies benefit through newly developed resources (Klinger & Bossers, 2009).

The remaining articles examined the work of OTs with people with disabilities. McComas and Carswell (1994) describe their work with a group of women with disabilities who felt health professionals were largely unaware of their experiences and priorities. Information from women with disabilities about their healthcare system experiences and service improvement suggestions was gathered by professionals and participants; the resulting report was shared with both groups. Participation in this process was described as empowering for all group members. The women with disabilities felt their voices were valued and provided an impetus for change, while the health professionals developed new ways of engaging with women with disabilities outside of traditional professional-client interactions (McComas & Carswell).

Westmorland (1996) worked with groups and organizations in a consortium aimed to develop employment opportunities for people with disabilities in a Canadian city. To this end, people with disabilities, government departments, employment support agencies and employers met to discuss issues; the collaboration helped establish an employment consortium of sub-group representatives. Consortium members, including an OT member-at-large, worked together to create additional employment opportunities for people with disabilities within that community.
Two other examples of OTs working with people with chronic illnesses or disabilities were described by Trentham and his colleagues (2007). One initiative involved a community action group with older adults who wanted to create a ‘senior-friendly’ neighbourhood. The group’s actions resulted in enhanced neighbourhood accessibility and the group’s inclusion on a coalition dealing with broader policy issues. The second initiative featured a steering committee comprised of consumer-survivors and facilitators who planned and co-facilitated workshops on managing daily life for community members. These initiatives provided opportunities for individuals to participate in community activities and helped build skills the individuals used to affect their environments (Trentham et al.).

Wynn and colleagues (2006) recount collaboration between a grass-roots parent network and university-based researchers to address traditional service-provision gaps that influenced the transition of youths with developmental disabilities to adulthood. To this end, the group gathered background information, held a community forum to increase awareness about existing community resources, and evaluated both the processes and outcomes of the project. Community members attending the forum, including the youths, became more aware of the community’s resources (Wynn et al.).

The final article describes two community-based rehabilitation (CBR) programs facilitated by Canadian OTs, one in northern Canada and one in West Africa (Thibeault & Forget, 1997). The northern Canada project involved the training of community workers to provide services to children with disabilities in a remote community. After receiving training from OTs, these workers implemented the trainers’ programs and regularly consulted with the trainers outside of the community. The second project involved the development and implementation of a CBR worker training program in Burkina Faso. The need for the program, which developed in response to local contexts, was locally identified by representatives of five CBR programs in the region (Thibeault & Forget).
This brief overview attests to the diversity of CD work done by OTs. Considering this diversity, what do these CD examples reveal about the implementation of such projects from an occupational therapy perspective? There is some consistency in how CD is conceptualized by OTs; however, a range of models is used to guide CD and these refer minimally to occupational therapy models. Furthermore, the examples show that OTs work with a broad range of CD partners, taking on a variety of roles and using a range of strategies to influence community-level change. Lastly, examples identify a number of challenges inherent for OTs.

Definitions of Community Development

Commonalities across the definitions of CD, as well as implicit guiding principles, were evident in the literature, although four of the seven articles did not provide a definition of CD. Each project aimed to build upon existing community resources of peoples’ skills and experiences, local services or other resources. All projects were guided by community-identified priorities pertaining to environmental, not individual, social determinants of health. Such priorities included challenging negative attitudes towards groups of people, promoting accessible neighbourhoods, and identifying advocacy strategies affecting policies and services. Individual outcomes and community level change was noted.

The projects were all community-directed, with the OTs acting in a facilitative role to minimize their involvement over time. The community-directed nature of projects was achieved with the aid of people with disabilities, their family members and other service providers.

Communities and Partners in Community Development Practice

Common to all projects was diversity amongst the OTs’ partners, who included collectives of people with disabilities and/or their families, employers and business owners, service providers, community agencies, government representatives, universities and rehabilitation workers. ‘Community’ in these examples pertained to geographic groupings, service-defined areas and those with shared interests. The projects aimed to affect individuals
within the community, most often people with disabilities, and changes at the community level affecting larger numbers of people.

**Models Guiding Community Development**

There was significant variability in the models used to guide these CD initiatives. Five of the articles explicitly described an occupational therapy perspective, such as the Canadian Model of Occupational Performance, guiding the program’s development (Banks & Head, 2004), or an approach that integrated key occupational therapy principles (Klinger & Bosser, 2009; Trentham et al., 2007; Westmorland, 1996; Wynn et al., 2006). Two articles did not reference any occupational therapy principles or models.

All examples were grounded within guiding CD frameworks. Two projects drew on McKnight and Kretzman’s (1997) asset-based CD approaches, and two projects drew on Labonte’s work on health promotion (1994) in which individual empowerment can lead to social action through small group development. Trentham et al. (2007) based their programs on the CD continuum (Jackson et al., 1989), Rothman’s taxonomy (Rothman and Tropman, 1987) and the health promotion framework outlined in the Ottawa Charter (WHO, 1986). One of the fieldwork examples employed a consultative student supervision model (Klinger & Bosser, 2009). Models related to community-based rehabilitation were used in the projects described by Thibeault & Forget (1997). Two examples also attempted to describe the phases of their projects’ development over time. It can be concluded that OTs are drawing on a range of CD models to inform their practice, with the majority of articles under review making explicit the contribution of their occupational therapy perspective. In general, occupational therapy models were not used to guide these CD projects.

**Key Strategies & Roles in Community Development**

OTs were involved in a range of strategies within the CD initiatives. Many projects began with a community needs assessment in which community strengths and priorities were explored.
Community members were actively involved in identifying these priorities at group meetings or community forums. Once priorities were set, actions included resource development, marketing, consultation, program development and education. Within these strategies, OTs took on a range of roles, including consultant, trainer, co-facilitator, evaluator, catalyst and “capacity finder and developer” (Trentham et al., 2007, p. 65).

Challenges and Gaps in Community Development

Some challenges to CD initiative implementation related to general CD implementation, while others were specific to occupational therapy. Challenges related to CD included the time required to develop trust and relationships (Klinger & Bossers, 2009; Westmorland, 1996), and the limited resources available for such work (Klinger & Bossers, 2009; Thibeault & Forget, 1997; Trentham et al., 2007). Negotiation of the many perspectives inherent in community collaborations was crucial, particularly when working across sectors that often have different cultures and priorities (Westmorland, 1996).

The realistic involvement of people with disabilities also raised ethical issues in CD. Westmorland (1996) warns that health professionals must be cognizant of the level of commitment required of people who may already be involved in various initiatives. Similarly, Trentham et al. (2007) raised the ethical question of the appropriateness of OTs decreasing their involvement in a project when program participants are reluctant to take on additional tasks.

Parallel to ethical considerations, a number of authors identified the importance of recognizing and working to rectify power imbalances between health professionals and participants (McComas & Carswell, 1994; Thibeault & Forget, 1997; Trentham et al., 2007). McComas and Carswell explained that the relationship between professionals and consumers in their CD initiative was different from typical professional-client relationships: instead of the ‘expert’ therapist, health professionals were meeting with consumers on an “equal footing” (p. 263).
The inclusion of occupational therapy models in these examples varied, suggesting a gap in the profession’s theoretical foundations in responding to CD practice. OTs experienced difficulty balancing facilitation, aimed at benefiting the group, with occupational development of individuals (Trentham et al., 2007). The articles indicate limited support and remuneration for CD strategies addressing social determinants of health, and often such strategies appear to be outside the health care role of most OTs (Trentham et al.). Only relatively recently have OTs acknowledged the need to address systemic barriers through political processes (Kronenberg & Pollard, 2005).

Within occupational therapy, priority is placed on clinical interventions; in one CD initiative, fieldwork hours pertaining to CD were excluded from required fieldwork hours, so as not to “compromise [students’] access to more traditional forms of clinical placements” (Klinger & Bossers, 2009, p. 174). Hence, even in occupational therapy training programs that value CD, this field and its associated competencies are considered to offer less value than traditional clinical occupational therapy skills.

The challenges identified in these CD examples are supported by recent research on the emerging roles of Canadian OTs in CD (Lauckner, 2005; Lauckner et al., 2007), where Canadian OTs working in CD experienced: minimal recognition and awareness of OTs’ contribution to CD; few occupational therapy-specific positions in CD and limited funding for these positions; the absence of explicit CD mandates or supports of CD in traditional occupational therapy positions and lack of preparation of OTs for this field. More recently, Restall and Ripat (2008) confirm that OTs continue to struggle with the implementation of community organizing, coalition advocacy and political action.

To date, examples of OTs working in CD describe individual initiatives. Some examples examine existing models that are applied to CD, though occasionally modifications to such models are made (e.g., McComas & Carswell, 1994). Despite this, no systematic attempt has been made to examine multiple examples of OTs working in CD to determine how CD promotes
participation in occupations. This gap pertains to how OTs conceptualize their CD practice, how CD is implemented from occupational therapy perspectives, and what theory or framework could guide the process(es) of OTs working in CD. Gaps such as these demonstrate that there is no theoretical framework generated from experiences in the field that describes CD process(es) from an occupational therapy perspective.

As McColl (1998) proposed, “the obvious need for theory development to support community practice in occupational therapy may be one reason why the past two decades have seen so little real progress in the development of community occupational therapy” (p. 16). Recent developments in Canadian occupational therapy models will thus be examined in order to determine the extent to which they integrate concepts of community and practices of CD.

2.5 Current Canadian Occupational Therapy Models: Where is Community?

Historically, occupational therapy theory has focused on individual rather than community assessment and interventions. More recently, Townsend & Polatajko (2007), under the auspice of the Canadian Association of Occupational Therapists [CAOT] and through a consultative process with OTs across Canada, compiled *Enabling II: Advancing an Occupational Therapy vision for health, well-being, & justice through occupation*. This book is a watershed in Canadian occupational therapy practice because it “advances the transformation of occupational therapy from being a profession focused on the therapeutic use of activity, to one dedicated to enabling all people to be engaged in meaningful occupation and to participate as fully as possible in society” (Townsend & Polatajko, p. 2). *Enabling II* extends OTs’ focus beyond occupational performance, or the ‘doing’ of an activity, to engagement, a broader term that involves all the experiences of being occupied or participating (Townsend & Polatajko). The book reaffirms and strengthens OTs’ involvement with clients that encompass individuals, families, groups, communities, organizations and populations. The authors also present a new Canadian Practice Process Framework (CPPF) that claims applicability to the broad range of clients with whom OTs
might work (Townsend & Polatajko). Lastly, *Enabling II* presents ‘enabling’ and ‘enablement’ as a core competency of occupational therapy, introducing the Canadian Model of Client-Centered Enablement (CMCE). The models of *Enabling II*, the CMOP-E, the CPPF and the CMCE, each have current applicability to CD practice; however, relevant literature identifies their potential gaps, which are described below.

*Canadian Model of Occupational Performance & Engagement (CMOP-E)*

The CMOP-E (Polatajko, Davis, et al., 2007) is a visual illustration of the dynamic interaction between the person, occupation and environment that portrays occupational performance and engagement. Visually, the CMOP-E is a set of overlapping shapes, with a centre triangle that depicts the person and his/her abilities (affective, cognitive, physical and spiritual), an intersecting circle of occupations, and a broader circle enclosing both to depict the environment (see Figure 1 and Appendix A for copyright permission).
Figure 1: Canadian Model of Occupational Performance and Engagement (CMOP-E)

This model stresses that OT’s domain of concern is occupation. Thus OTs are concerned with the person and the environment to the extent that they influence only occupation and “those aspects of person or environment that are not related to occupation are beyond [occupational therapy’s] scope” (Polatajko, Davis, et al., 2007, p. 24). The expansion of the original CMOP (CAOT, 2002) to the updated version that includes engagement (CMOP-E) (Polatajko, Davis, et al.) broadens OTs’ focus from how an occupation is done (i.e. performance), to dimensions such as nature, intensity, extent and the subjective sense of individuals’ satisfaction (Polatajko, Davis, et al.). Polatajko and colleagues note that by including engagement, the model broadens OTs’
scope of practice to consider “occupationally supportive environments while maintaining occupational therapy’s focus on the occupational human” (p. 27).

Within this model, ‘community’ is seen as part of the physical, institutional, cultural or social environment, and distinct from, yet related to, the individual. Community, as one component of the surrounding environment, influences occupation and the person, and conversely, the person and the person’s occupations can impact the environment; CD approaches can therefore be situated within the environment. The location of CD within the environment of this model does not, however, satisfy questions of the collective nature of community. Rather, the CMOP-E focuses on the individual, where other people with similar interests and values are distinguished from the individual within the social environment. How, then might this model help OTs understand notions of community in relation to CD? The CMOP-E does not provide concepts that might assist in translating the model from the individual to communities.

*Canadian Practice Process Framework (CPPF)*

The Canadian Practice Process Framework (CPPF) (Craik, Davis, & Polatajko, 2007; Davis, Craik, & Polatajko, 2007) is a generic process framework that describes eight action points in the occupational therapy process including assessment, intervention, and evaluation (see Figure 2).
The CPPF describes collaborative and reflective processes in which the OT and client engage as they move through the action points, with the overall CPPF goal for the client to attain his/her identified occupational goal (Craik et al., 2007). The model’s three contextual elements include the societal context, the practice context and the frame(s) of reference. The societal context comprises the cultural, institutional, physical and social environmental elements in which
the therapist and client are situated (Craik et al.). In this model, other contextual elements and action points are imbedded in the societal context. Both therapist and client engage in the societal context independently, prior to initiating a therapeutic relationship that develops within the practice setting. Examples of the societal context include: the natural and built environment, social networks, community resources, ethnicity, cultural habits and rituals, health care systems, policies and procedures of institutions (Craik et al.).

As with the CMOP-E, which shares this understanding of environment, ‘community’ can be located in the CPPF within the societal context. Community assets may be identified in the environment’s social, cultural or institutional elements. This model acknowledges that client-therapist interactions occur within a broader societal context and may include communities to which each belongs. This model implicitly hints that the client and therapist are “distinct individuals” (Craik et al., 2007, p. 236), suggesting that prior to engaging therapeutically, they do not share commonalities and likely would not identify as belonging to similar communities.

Considering the complexity of communities and the ability of people to move between them (Zakus & Lysack, 1998), OTs using this model may benefit from reflecting on various communities to which they do and do not belong and relationships between these. Because professionals often incorrectly attribute members to particular communities (Jewkes & Murcott, 1996), it may also be valuable for OTs to gain emic understandings and self-definitions of various communities.

According to the CPPF, the client-therapist relationship begins once the therapist receives a referral or request (Craik et al., 2007), again suggesting a pre-existing disconnect between the therapist and client. Where the therapist and client meet to begin the therapeutic relationship is identified as ‘the practice context’, in which the therapist and client are influenced by broader environmental factors as well as their respective personal qualities (Craik et al.). For example, the therapist brings personal attributes like resources, knowledge, abilities and attitudes (Craik et al.). When the client is a community or population, the model proposes the client’s personal factors
might include the “collective personality of the community, or the educational level of a population” (Craik et al., p. 237). Although it is commendable that explicit examples of community factors are included, these factors are minimally explained, making it difficult for a therapist to identify the type of community information to be gathered and strategies for doing so. For example, a therapist’s consideration of the community capacities identified by McKnight and Kretzmann (1997) might further assist in identifying the personal factors of the community.

The final contextual factor of the CPPF is the frame(s) of reference the therapist brings to the therapeutic interactions. Frame(s) of reference encompass the professions’ beliefs and values, theories that guide the addressing of issues, and models of service delivery (Craik et al., 2007). Therapists might draw upon theories pertaining to the physical, psycho-emotion, neuro-integrative, socio-cultural and environmental determinants of occupation (McColl, Law, Doubt, Pollock, & Stewart, 2002). Although the model does not specifically depict the client’s frame(s) of reference, one author provides a reflective memo within the text that raises questions about the influence of the client’s perspective on the process and understandings of his/her role in therapy (cited in Craik et al., 2007, p. 243). The memo addresses a potential omission of the CPPF, where client values or conceptualizations, comparable to the shared and diverse beliefs, values and conceptualizations of community, are negated. Community or not, the client’s frame(s) of reference require as much, if not more, consideration than the therapist’s. It is therefore essential to clarify community members’ understanding of common concepts such as participation and justice, which may have different meanings for different groups.

The CPPF does not discuss the client’s frame(s) of reference, suggesting the perpetuation of professional dominance that is one of the main criticisms of ineffective CD initiatives. Thus, a key principle of CD – the community as leader – is not included in this model; instead, the model emphasizes the clinical expertise brought by the therapist without explicit recognition of the strength inherent in the community.
Moving on from the model’s contextual factors, the CPPF outlines eight practice processes: enter/initiate, set the stage, assess/evaluate, agree on objectives and plan, implement the plan, monitor and modify, evaluate the outcome, and conclude/exit (Davis et al., 2007). Three of these actions are additional to the process’s original set of actions – enter/initiate, set the stage and conclude/exit – and have been included in the CPPF in order to “recognize the importance of building client-centred relationships, mediating power relations, and decision-making mechanisms” (Davis et al., p. 205). These points help to determine client participation and define expectations within the client-therapist relationship (Davis et al.).

Each action point is clearly described in relation to an individual client, but the application to communities is limited. For example, at the enter/initiate point, the CPPF speaks mainly of a referral or contract, formalizing the initial entry into a therapeutic relationship. Any informal relationship building occurring during the initial phases of CD is not mentioned.

During the next action point, set the stage, the therapist and client determine how they will work together (Davis et al., 2007). This includes “rapport building, establishing ground rules, fostering client readiness to proceed, and expressing mutual expectations” (Davis et al., p. 254). At this stage, if one is working with communities, the model suggests relevant occupational history would be shared, acquired through discussions with the client about previous occupational challenges and how these have been handled (Davis et al.). Inclusion of discussions about the complexity of community, its heterogeneity and issues of representation from CD literature would be a helpful addition at this point. Because interactions with communities may take the form of a partnership rather than a client-professional relationship, issues of informed consent and ethical obligations warrant further examination.

During the assess/evaluate point, therapists “draw on their frame(s) of reference, past experience, expertise and research knowledge to ascertain plausible explanations for the clients’ occupational challenges” (Davis et al., 2007, p. 256). Although suggestions are made about potential assessment approaches with communities (such as focus groups, surveys, participant
observation) (Davis et al.), the model emphasizes the therapist’s expertise in assessment, administration and analysis, thereby disregarding CD principles. Similarly, “occupational therapy expertise” is required during the action point of agreeing on objectives and plan (Davis et al., p. 258).

During the actions of monitor and modify, and evaluate outcomes, the OT again features in the ongoing formative evaluation of the client’s progress and the outcome evaluation of goals (Davis et al., 2007). The CPPF provides general suggestions with no explanation of implementation: “With community, organization and population clients, outcomes will be evaluated according to the plan, using methods appropriate to the situation” (Davis et al., p. 262). In the final action, conclude/exit, the practice relationship is ended, usually because the client has achieved his/her goals (Davis et al.), and a client discharge summary/community report summarizing recommendations is completed.

Although community is included in the contextual elements of the CPPF model, examples of how the model applies to communities are “almost absent” (E. Townsend, personal communication, September 29, 2009), and CD principles are superseded by the therapist’s lead in the process. When considering the CPPF in light of the different CD models discussed previously, the emphasis on professional expertise and leadership suggests the CPPF is in line with Tropman and Rothman’s social planning approach (1987).

*The Canadian Model of Client-Centered Enablement (CMCE)*

The final occupational therapy model for review, the Canadian Model of Client-Centered Enablement (CMCE) (Townsend, Polatajko, et al., 2007), explores enablement, “the core competency of occupational therapy, drawing on an interwoven spectrum of key and related enablement skills which are value-based, collaborative, attentive to power inequities and diversity, and charged with visions of possibility for individual and/or social change” (Townsend, Polatajko, et al., p. 111).
The CMCE is a conceptual model that depicts two asymmetrical, intersecting curved lines that illustrate the collaborative client-professional relationship that begins with the enter/initiate action in the CPPF and ends with the conclude/exit step. The purpose of this relationship is to enable “individual and social change, through occupation, in occupational engagement and the social structures that influence engagement in everyday life” (Townsend, Beagan, et al., 2007, p. 109).

This model is based on six enablement foundations that shape the enabling process: choice, risk, responsibility; client participation; vision of possibility; change; justice; and, power-sharing (Townsend, Beagan, et al., 2007). The CMCE’s applicability to and compatibility with CD was implicitly intended by the authors (E. Townsend, personal communication, September 29, 2009). For example, in support of choice, risk and responsibility, OTs are encouraged to work collaboratively with clients throughout the process and to encourage client decision-making. This foundation resonates with an emphasis on community-guided processes within CD literature.

Client participation is also emphasized as a foundation of enablement, clearly linked to discussions of participation in CD literature. The notion of occupational citizenship is introduced, which is “optimal engagement as a fully integrated citizen in a just and inclusive society with entitlement to participate and to promote health and well-being for all” (Townsend, Beagan, et al., 2007, p. 101). This notion of citizenship characterizes the individual as an active agent within society and is compatible with CD approaches.

Another foundation to enablement, visions of possibility, encourages clients to participate as citizens in a manner they may not have originally thought possible (Townsend, Beagan, et al., 2007), and speaks to CD’s social action element.

The fourth enablement foundation, change, speaks to the potentially transformative nature of enabling occupation (Townsend, Beagan, et al., 2007). At the community level, collective issues may create the impetus for either negligible or radical change (Townsend, Beagan, et al.). Radical change can impact the societal level (Townsend, Beagan, et al.) and thus
satisfies one of CD’s intended outcomes: to create community-wide change. Furthermore, this model recognizes that clients and therapists may transform their perspectives based on the changes that have occurred.

Justice and power sharing are the final enablement foundations. A justice perspective encourages therapists to reflect on diversity and equity, recognizing broader structural factors that impact the therapist, individual clients and communities (Townsend, Beagan, et al., 2007). A justice perspective is necessarily a critical perspective.

Similarly power-sharing, as the final enabling foundation, requires therapists to examine the traditionally hierarchical nature of their profession critically in order to strive for more collaborative client partnerships (Townsend, Beagan, et al., 2007). The struggle inherent in this mission is captured when occupational therapy is recognized as operating “at a crossroads where contradictory power structures meet – at a point where the hierarchical structure of professions and health services confronts the horizontal, collaborative, power-sharing ideal associated with enabling client participation through occupation” (Townsend, Beagan, et al., p. 108). This reported tension within occupational therapy parallels discussions on the contradictory nature of CD work within health services. As well, Townsend and her colleagues’ call for critical reflection on the potentially transformative influence of OTs’ power also echoes Laverack’s discussions of power (2005).

Building upon its enablement foundations, CMCE presents 10 enabling skills: adapt, advocate, coach, collaborate, consult, coordinate, design/build, educate, engage and specialize (Townsend, Beagan, et al., 2007), which enable social change through CD initiatives (Townsend, Cockburn, et al., 2007). For example, various enabling skills can be seen when therapists are working with communities as the therapist comes to respect local knowledge, listens to clients in the first step of power sharing, and includes voices of non-dominant groups (Townsend, Cockburn, et al.). Thus, of the three models reviewed here, the CMCE most explicitly integrates CD principles.
2.6 Chapter Summary

This review spanned the general field of CD to clarify definitions of ‘community development’ and to outline key models used within that field. The historic and current compatibility between CD and occupational therapy was discussed, followed by an exploration of examples of Canadian OTs working in CD. Occupational therapy models were inconsistently applied in the examples reviewed, exposing gaps between the espoused compatibility of occupational therapy and CD in theory and their integrated application in practice. The conclusion reviewed three major Canadian occupational therapy models, whose critiques show that working with communities is not fully integrated with professional practice. Yet some OTs are engaging in CD and the professional association is promoting CD practice, despite the disconnect in theoretical foundations. This study explores the ways in which practitioners are engaging in CD from an occupational therapy perspective.
CHAPTER 3: METHODOLOGY

In this study, I used a collective case study design (Stake, 2000; Yin, 2003) informed by constructivist grounded theory data analysis methods (Charmaz, 2006) to develop a framework proposing theoretical generalizations. Following a description of the research design, I describe its theoretical frameworks, my researcher stance, the case study protocol, and case recruitment and data generation methods. Lastly, I present my approach to data analysis, and the strategies employed for enhancing the trustworthiness of this study.

3.1 Research Purpose and Research Questions

This study sought to 1) develop in-depth interpretive case descriptions of three exemplars of occupational therapists (OTs) engaging in community development (CD); and, 2) based on a cross-case analysis of these descriptions, develop a theoretical framework that describes process(es) of CD from an occupational therapy perspective. The phrase ‘from an occupational therapy perspective’ refers to those stances taken by OTs that are informed by their professional training or experiences. This study answered the following research question: How does the process of community development from an occupational therapy perspective occur in practice?

The following sub-questions helped guide the research process:

a. What are the central strategies and activities of the CD process in practice?

b. What are the intended and actual outcomes of this process?

c. How do OTs facilitate this process?

d. How are key concepts, values and approaches of occupational therapy integrated into CD practice?

e. How do contextual factors enable the CD process?
f. What are key points of tension encountered by OTs in daily practice and how are these managed?

3.2 Research Design

Case Study Design

Case study design is appropriate when examining a “contemporary phenomenon within its real-life context, especially when the boundaries between the phenomenon and context are not clearly evident” (Yin, 2003, p. 13). CD involves blurred distinctions between phenomenon and context, since contexts are different across and within communities. Case studies are also useful in analyzing processes that examine “how” and “why” questions in situations when there are a range of factors (Merriam, 1998), such as those found in communities.

A case is “a specific … complex, functioning thing” (Stake, 2000, p. 2), such as an individual, a program or an event, like the CD initiatives and consequent processes discussed here. As can often occur in qualitative case studies, my understanding of the case boundaries changed over time. I responded to participants’ understanding of CD which at times included other ‘non-CD’ activities; this responsiveness illustrates my conscious effort as a researcher to be open to unanticipated perspectives arising during data collection.

This case study is embedded (see Yin, 2003) and involves analysis of sub-units within the case. Data were gathered at the program level (e.g., program goals), as well as from individuals within the initiative who acted as the case sub-units, including the OT, participants and colleagues. The research focus remained with OTs, who had the most intimate understanding of the phenomenon under investigation, while program participants and colleagues who offered perspectives and experiences, acted as secondary units of analysis.

A multiple case study involves the in-depth analysis of a number of individual cases, followed by a cross-case analysis that allows for the examination of similar or different relationships across case elements. Two prominent case study researchers, Robert Yin and Robert
Stake, suggest different rationales for examining multiple cases. Yin (2003) explains that within multiple case studies, analysis across cases may illustrate similar results (literal replication) or contrasting results for predictable reasons (theoretical replication), and recommends the identification of variables across cases to illustrate predictable differences. In contrast, Stake seeks variety across cases to ensure richness and depth in order to understand the shared phenomenon of interest (Anaf, Drummond, & Sheppard, 2007; Stake, 2000). Stake’s rationale recognizes the possibility of oversimplifying the complex interactions across cases that may not necessarily be predictable. Yet Yin and Stake agree that multiple case study allows the opportunity for development and elaboration of findings among many cases (Yin, 2000; Stake, 2006). Multiple case study risks reducing complex cases to a few comparable variables, resulting in the loss of the idiosyncrasies of individual cases (Stoecker, 1991). To mitigate this risk, Creswell (1998) suggests that no more than four cases be examined to allow individual cases to be adequately explored. This study examines three initiatives where Canadian OTs worked in CD amidst different contexts and community groups, offering a range of CD initiatives and providing the opportunity to identify common and distinct processes. Only CD initiatives within Canada were selected to ensure the relevance of findings to Canadian occupational therapy training and models.

This study demonstrates the characteristics of an instrumental case study (Stake, 1995; 2000) that explores larger phenomena. The broad phenomenon examined in this study is the CD process in practice from an occupational therapy perspective, requiring a multiple case study design that is analytic in nature in order to develop a framework featuring key aspects of the phenomenon. An analytic case study includes descriptive data “used to develop conceptual categories or to illustrate, support or challenge theoretical assumptions held prior to data gathering” (Merriam, 1998, p. 38) rather than simply describe each case’s events.
Research Paradigm

Placed within the constructivist paradigm, this research was approached using qualitative methods, which are particularly useful when exploring a topic, such as CD from an occupational therapy perspective, which is not easily defined and does not have a strong theoretical base (Creswell, 1998; Patton, 2002). Constructivism assumes that the meaning of experiences and events are constructed by individuals, and therefore people construct the realities in which they participate (Charmaz, 2006). From this stance, research aims to elicit and understand how research participants construct their individual and shared meanings around the phenomenon of interest. Also particular to constructivism is a similar construction of meaning by researchers that “their interpretation of the studied phenomenon is itself a construction” (Charmaz, p. 187); this shared pattern permits the co-construction of meaning by participant and researcher. In allowing for indeterminacy and prioritizing patterns within and across CD initiatives, my resulting interpretation is characterized as ‘interpretive theory’ (Charmaz, pp. 126-127).

The acknowledged co-construction of the researcher’s interpretation in constructivist research demanded that I conduct research in a reflective and transparent process (Mills, Bonner, & Francis, 2006). Reflection entails “thinking about the conditions for what one is doing [and] investigating the way in which the theoretical, cultural and political context of individual and intellectual involvement affects interaction with whatever is being researched” (Alvesson & Skoeldberg, 2000, p. 245). Articulating my assumptions and experiences through reflective and analytical memos, written prior to and during data gathering and analysis, helped me achieve this transparency (Mills, Bonner, & Francis, 2006).

My experiences in international development, research and teaching provided me with a number of professional lenses for approaching this research. Specifically, I brought a) a general understanding of clinical occupational therapy in outpatient and community settings, b) a critical perspective about the relevance of clinical experiences to various contexts, c) an appreciation of
other OTs who define their role in CD within Canadian contexts, and, d) a desire to clarify the contribution of OTs to CD in order to better prepare students for such work.

Theoretical Framework of the Cases

In addition to identifying the macro-level constructivist paradigm in which this research is situated, both Yin (2003) and Stake (1995; 2000) emphasize the importance of establishing a specific theoretical framework that structures a case study. Yin supports the development of theoretical propositions at the onset of research but recognizes that exploratory research may not offer such propositions (2003). The exploratory nature of this case study prompted me to follow Stake’s suggestion in outlining main “issues” that focus on the concerns that highlight the complexity and contextuality of the phenomenon under investigation: “issues are not simple and clean, but intricately wired to political, social, historical, and especially personal contexts. Issues draw us toward observing, even teasing out, the problems of the case, the conflictual outpourings, the complex backgrounds of human concern” (1995, p. 17). Within a multiple case study, Stake’s issues raise individual case research questions, distinct from the overall study (Stake, 2006).

At the beginning of this research, potential issues for exploration were extrapolated from my experience, previous research with OTs working in CD (see Lauckner, 2005) and related literature, in particular recently revised occupational therapy models (Townsend & Polatajko, 2007). These issues are summarized in Table 1.
Table 1: Initial Issues Guiding Research

<table>
<thead>
<tr>
<th>Issue 1</th>
<th>To what extent and in what ways do OTs bring a unique occupational perspective that is explicit in their CD work?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue 2</td>
<td>To what extent is there congruency/incongruency between the espoused theories of occupational therapy in general or those of these specific OTs and how they practice CD?</td>
</tr>
<tr>
<td>Issue 3</td>
<td>Considering the uncertain applicability of occupational therapy models to communities, what guides OTs in the integration of their occupational therapy knowledge and skills into their daily CD work?</td>
</tr>
<tr>
<td>Issue 4</td>
<td>How do OTs negotiate the anticipated tensions between the medical model which tends to dominate health services and a more community-oriented approach that would be required in CD?</td>
</tr>
</tbody>
</table>

Stake explains that as the researcher gains a greater understanding of the cases, initial research-identified issues evolve and are influenced by emic issues raised by the study’s participants (1995). In this study, particular issues were explored in each case and shared issues directed the cross-case analysis.

Case Recruitment and Selection

Prior to recruitment, ethical approval was obtained from the Queen’s University Research Ethics Board in May 2007 (see Appendix B). Maximum variation purposive sampling (Patton, 2002) to strengthen the richness and depth of the data collected was used to identify cases that depict a variety of practice contexts in different regions in Canada.

The study’s inclusion criteria were:

- Participants were registered OTs in Canada working in CD, as indicated by self-report and their program’s explicit mandate of CD activities,
- At least half of each OT’s time was spent on CD initiatives,
• The OT was central to the development and implementation of at least one CD initiative that was ongoing at the time of data collection, and

• The OT was identified by another colleague as making a valuable contribution to CD.

Recruitment materials were not translated into French and I would be unable to conduct the research in French because of limited proficiency in that language. Consequently, Francophone OTs were not included. Initial requests for potential research participants made to 13 key informants with strong ties to CD yielded only a few potential cases. Consequently, additional recruitment strategies were developed and submitted for ethical approval.

Supplemental recruitment strategies included searching the Canadian Association of Occupational Therapists’ national occupational therapy registry and recruiting through a CD network group (see Appendix C). Overall, 65 OTs potentially working in CD were emailed an invitation to participate and requested to pass on the invitation to colleagues. Of the 18 OTs who initially responded, two did not respond to follow-up, nine did not meet inclusion criteria, and three self-excluded citing time conflicts. Of the remaining participants, three were selected from different regions of Canada (west, central and east) that depicted diverse practice settings working with different populations. Each case took place in mid- to large-sized Canadian cities which were regional centres.

The three cases examined in this study were:

1. Case 1, in which an OT in a rehabilitation centre worked with a community agency to develop a pilot peer mentoring project for stroke survivors;

2. Case 2, in which an OT in a community mental health program worked with people with a history of mental health illness to raise awareness about recovery approaches to mental illness; and,
3. Case 3, in which an OT in a seniors’ health team worked with seniors to develop community-run programs and linked senior volunteers to these programs.

Site Entry

The OT in each case was contacted and informed about the research process. Ethics requirements for each case setting (all located in health authorities in their respective provinces) were completed and approved, after which a letter of information and consent form (see Appendix D) was sent to each OT, who acted as the site’s contact person, liaised with her manager, and, crucially, oriented me to the site (Creswell, 1998). The OT and I negotiated a convenient timeframe for onsite data collection.

Participant Recruitment at Each Site

In each case, the OT and I identified potential research participants with varying perspectives on CD initiatives. Participants at each site included: at least one manager, health colleagues, community members or agencies (separate from the health authority) and program participants. The OT approached potential research participants on my behalf to request an interview and letters of information and consent forms were provided to each interviewee. A similarly collaborative process was used to identify key events or activities I should observe, in addition to informal observations. In conducting formal observation sessions with people who were not also interviewed, my general role as a researcher learning about CD was explained.

Data Generation

For each case, information gathered was guided by a data collection protocol consisting of questions regarding the type of information to be collected and possible sources (Yin, 2003). Although a protocol was developed at the onset of the research in order to plan data collection, the protocol was applied in a flexible manner. I aimed to gather a similar variety of information about each case to answer the topical questions of the protocol, but allowed myself to follow potential lines of inquiry that arose, which were unique to each case. The case study protocol for
approaching individual cases in this study is described in Appendix E. The questions asked of research participants are outlined in interview guides located in Appendix F.

I sought to integrate Yin’s case study protocol and Stake’s issues in this study by distinguishing between the protocol’s initial questions, which were informational in nature and similar to Stake’s topical questions, and the issues identified at the onset of the research, which were more problematic in nature and served to assist me in better understanding individual cases. Emerging case-specific issues, which evolved over time (Stake, 2005), acted as analytic tools, rather than research questions, in that they helped to focus my attention on potentially informative events or dynamics and consequently deepened my understanding of each case.

As is consistent with case study design (Yin, 2003; Stake, 1995), data collection methods in this study included in-depth semi-structured interviews, document review, direct observation and participant observation. Information was gathered from the inception of the initiative to the present time in order to capture process changes. Data collection occurred between September 2007 and February 2008, where 12 to 14 days of onsite data collection occurred per case, with approximately two months between each case to allow for preliminary analysis and compilation of documents. Table 2 below summarizes each case’s amount and type of data collection. A more detailed summary of the data gathered at each case, including the people interviewed, events observed and documents reviewed and the key information gathered, is found in Appendix G.

Development of Interview and Observation Guides

Interview guides were developed based on the information gathered from the case study protocol. The occupational therapist interview guides were piloted with two local OTs working in CD initiatives. This sensitized me to the complexity of CD, resulting in modified interview questions allowing OTs to speak to their complex role but then narrow down to one main CD initiative. When conducting interviews from a constructivist stance, my intention was to be reflexive and flexible in my interview approach to share my stance and ideas, be mindful of Mills
et al.’s (2006) explanation that an interview is considered a means of knowledge construction between the researcher and the interviewee. Participant interviews took the form of informal conversations at convenient times between activities and meetings, in which I minimized potential hierarchies by locating myself as a graduate student seeking to better understand a phenomenon that had perplexed me from my own experience. In order to foster a sense of reciprocity with participants, I shared general research findings to date if an interest was expressed. Occasionally I presented research participants with some emerging theoretical ideas to gather their feedback.

Table 2: Brief Summary of Data Collected from the Three Cases

<table>
<thead>
<tr>
<th></th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Peer mentoring</td>
<td>Mental Health awareness raising</td>
<td>Seniors volunteering</td>
</tr>
<tr>
<td>Days on site</td>
<td>13.5 days</td>
<td>14 days</td>
<td>12 days</td>
</tr>
<tr>
<td>Number of Participants</td>
<td>14 people</td>
<td>14 people</td>
<td>14 people</td>
</tr>
<tr>
<td>Number of Interviews</td>
<td>24 interviews in total</td>
<td>17 interviews in total</td>
<td>28 interviews in total</td>
</tr>
<tr>
<td>Observations</td>
<td>29 hours of documented observations</td>
<td>33 hours of documented observations</td>
<td>33 hours documented observations</td>
</tr>
<tr>
<td>Documents Reviewed</td>
<td>39</td>
<td>34</td>
<td>37</td>
</tr>
</tbody>
</table>

A general field note observation guide was developed (see Appendix H) that recorded and attended to various events and details. Interviews and observations were the primary sources of data, with documents gathered to provide background information and fill in details of events.
Data Management

NVivo software (QSR International Pty Ltd, 2006) was used for data management. All interviews were audio-taped, transcribed verbatim by a transcriptionist, reviewed for accuracy and entered into NVivo 7, as were field notes from observations, and on-site memos. Electronic copies of program documents were also stored in NVivo 7.

3.3 Data Analysis

Merriam (1998) proposes that case study methodology can be used with a variety of methods of data analysis, including the constant comparative method of grounded theory. Grounded theory is a research approach which develops concepts and theories that are grounded in or developed from data rather than deducing hypotheses from existing theories which are then applied to the data. I used constructivist grounded theory approaches (Charmaz, 2000; 2006) to analyze data because these approaches develop theoretical constructs from the data, rather than externally imposed ideas from extant theories.

Charmaz’s work (2000; 2006) on constructivist grounded theory that premises the social construction of reality informed my approach. Within research, participants’ meanings of events are seen as social constructions in which the researcher is a co-creator. In constructivist grounded theory, the researcher seeks tacit meaning about values and beliefs revealed through immersion in the data (Charmaz).

Just as case study methodology can employ a range of analysis methods, Charmaz (2000; 2006) similarly states that researchers can use grounded theory techniques with varied forms of data collection and within different qualitative traditions. Thus, this study employed a case study design to guide data collection, and constructivist grounded theory analysis methods (Charmaz, 2006) informed data analysis. Case study design promoted the collection of rich data from multiple sources and constructivist grounded theory approaches enabled the insightful and methodical questioning of data during analysis in order to develop substantive theory.
Data analysis occurred in two stages: Stage 1 involved the independent, in-depth analysis of each case; and, Stage 2 involved a cross-case analysis of the three cases. Preliminary data analysis occurred simultaneously during data collection, in which preliminary case summaries and reflections on the research questions were developed and discussed with my advisory committee (see Appendix I for excerpts). As is consistent with qualitative case study methodology (Stake, 1995; 2000; 2006), issues were identified that guided the individual case examination. During data collection, preliminary data analysis built upon such issues, which then informed further data collection.

**Stage 1: Individual Case Descriptions**

In this collective case study, each case was analyzed and written up separately, providing a contextual description and interpretation. The following four strategies of constructivist grounded theory analysis (Charmaz, 2006) informed the analysis of data gathered from each case:

1. **Line-by-line open coding**

   For each case, one key interview from the OT, her main community colleague, her manager and a participant was reviewed using line-by-line coding to ensure I was exposed to multiple perspectives early on in the coding process. At this initial stage of coding, Charmaz (2006) suggests looking for tacit assumptions, explicating actions and meanings, comparing data with data and identifying gaps in the data (p. 50). It was at this stage that two interviews from two cases were also reviewed by one of my thesis supervisors in order to discuss potential emerging concepts and processes that informed the subsequent analysis stage. As is consistent with a constructivist approach, this informal analyst triangulation fostered further reflexivity and deeper questioning of the data as this ‘new set of eyes’ asked for further clarification and shared impressions of the data.

2. **Focused coding**
In this phase, the most significant and/or frequent earlier codes were used to sift through remaining data. Some focused codes were topical in nature, helping to organize the various activities engaged in by the OT, and others were conceptual, such as the identification of potential processes or tensions emerging. Example topical codes included groupings such as ‘health care context’, ‘community context’, ‘describing the position’, ‘OT roles’, and ‘CD activities’. These codes were further divided into major topics or sub-codes that captured activity and movement, using the gerund form for labeling. For example, under ‘OT role’, which was broken up into roles pertaining to CD activities and non-CD activities, action codes included ‘bringing people together’, ‘negotiating disagreements’, and ‘being diplomatic’. Each case had approximately 20 main codes used to deconstruct data into smaller units.

3. **Memo-writing**

Memos were written during data collection and data analysis stages. During data collection, onsite memos were written following interviews to summarize key ideas and potential questions for follow-up, as well as emerging issues that required further exploration.

The consideration of Charmaz’s early and advanced memo questions (2006, p. 80-81) with each emerging category prompted the reconstruction of data in new ways, making connections between categories and sub-categories. During this stage of analysis, all data and memos relating to a category were gathered and examined through the posing of questions (Browne, 2007), such as: In what ways is this category the same as, or different from, other categories? What is the connection between this category and other categories? A comparison of concepts within and between key categories explored potential relationships between context, actions and consequences within cases.

4. **Diagramming and memo sorting**

Following the examination, through memoing, of each category’s text, concepts that linked together were identified in and illustrated by basic diagrams. Contextual factors, strategies
or actions, and resulting outcomes that influenced the processes were identified and diagramming within and across categories assisted in distilling main processes and events. The memos and summary diagrams were examined and compared to each other, allowing further grouping of similar processes through a process of sorting that aided the analysis process.

5. Development of core categories

In anticipation of cross-case analysis, main processes pertained very loosely to common elements across cases, including how the OT worked with consumers, community partners, and other health professionals. Although each case was analyzed separately, concepts from previous cases inevitably influenced subsequent data analysis by raising additional questions. Analysis continued during the writing and revisions of the three case descriptions. During this writing process, I critically examined and clarified concepts in response to my ongoing analytic questioning and that of my supervisors and colleagues.

Stage 2: Cross-Case Analysis

In Part 2, each case’s main categories were compared to explore how different contexts and processes varied across the cases. Key issues identified for each case were re-examined to distill common issues. As I proceeded to the stage of cross-case analysis, I examined case-specific issues to identify those that affected all cases. In total, five cross-case issues were created through a process of comparing and merging salient case-specific issues.

Five cross-case issues found to be relevant to all cases were developed, helping to structure individual case descriptions that facilitated cross-case comparison. A list of these emerging issues is located in Appendix J. Charmaz’s stages of final analysis - diagramming and memo-sorting and identification of core categories - were re-visited to examine and question data combined from the three cases. Memos from key categories and individual case diagrams were examined across cases to determine shared and variant processes. Commonalities and unique
features across the cases were identified and raw data were re-examined to describe shared strategies and processes, as well as to propose potential contextual features that explain the variations across the cases. Further refinement of concepts and relationships occurred during the writing process and the development of the conceptual diagram. These cross-case processes developed an integrated theoretical framework applicable to all cases that was then examined in light of extant theory.

3.4 Trustworthiness of Data

Qualitative research needs to demonstrate credibility (i.e., the complexity of the interpretation and the trustworthiness of the data collected) and rigour (i.e., the researcher has included rival explanations and accounted for irregularities in the data) (Patton, 2002). Trustworthiness, or a study’s soundness, is based on: the extent to which the findings accurately describe/capture the phenomenon studied (i.e., credibility), the ability of the study to account for variability over time (i.e., dependability), the extent to which the process of collecting data and coming to conclusions is clear and can be followed by another (i.e., confirmability), and the likelihood that the findings have meaning in other similar situations (i.e. transferability) (Krefting, 1991; Streubert & Carpenter, 1999).

Specific strategies to enhance this study’s trustworthiness include:

1. *Prolonged engagement in the field* – I was onsite for data collection for each case for 12-14 days over 3 weeks, during which time extensive data were collected from multiple sources.

2. *Multiple sources and methods* – A variety of data collection methods was used at each site (interviews, observations, document review) obtained from a range of sources (the OT, staff and participants). By giving voice to multiple perspectives
within the study the credibility, dependability and confirmability of the study was further strengthened.

3. **Analyst Triangulation** – Excerpts of two transcripts from two cases were reviewed and coded by myself and one of my thesis supervisors in order to deepen first level coding. This afforded me the opportunity to discuss emerging issues with an experienced qualitative researcher who encouraged sophisticated abstraction by raising additional questions for consideration.

4. **Member checking** – The preliminary case descriptions were forwarded to the OT from each case for review and comment. Although all three were interested in reviewing their case description, only two were able to provide comments within the allotted time. Within a constructivist paradigm, rather than aiming to determine if the research’s interpretation was ‘correct’ - which would be difficult because the interpretation integrates multiple perspectives - member checking provides an opportunity to further explore the tensions and complexities of the proposed interpretation (Charmaz, 2006).

5. **Case study protocol** – The use of a case study protocol, a data storage system and ongoing methods and analytical memos enabled the development of an audit trail, which contributed to the confirmability of the research.

6. **Inclusion of thick description** – In the individual case descriptions, a detailed description of the setting and interactions aimed to provide readers with adequate information for them to feel that they have vicariously “experienced” the case, allowing for naturalistic generalizations (Stake, 1995). Such thick description contributed to the transferability of the study.
7. Reflexivity of the Researcher – As described previously, I maintained a field journal during data collection and memoed my reactions and emerging interpretations throughout data analysis. Peer examination by my advisory committee and colleagues further promoted my own reflexivity and thus the credibility of the study.

3.5 Chapter Summary

In this chapter, I described the study’s design as a qualitative, embedded case study design situated within a constructivist paradigm. I reviewed the case study protocol that outlined the questions and sources for data collection, and showed it provided a general structure for the topical information to be gathered, whereas emerging contentious issues that arose during data collection deepened my analysis by directing subsequent observations or lines of further inquiry.

Processes around case recruitment and data generation methods were reviewed, including an overview of the amount of data gathered from several resources. Interviews, observations and document reviews were conducted at each site, resulting in a total of 69 interviews with 42 participants conducted, along with almost 100 hours of formal observation and the review of 110 documents across the three cases. I then described how constructivist grounded theory informed my data analysis process through the use of the constant comparison method, along with memo writing, diagramming and memo sorting to deepen the analysis process while maintaining the data’s contextual situation and participants’ voices. Lastly, I presented the general strategies I used in this study to strengthen its trustworthiness.
4.1 Overview of Findings Section

This study consisted of three cases of OTs engaged in CD. The findings of this research underwent two stages of analysis: Stage One (Chapters 4-6), which resulted in individual case interpretations for each case, and Stage Two (Chapter 7), which resulted in a cross-case analysis of shared processes among the cases. In Stage One, each case description begins with a brief overview followed by an in-depth description of the case’s context. For each, this involved describing the physical setting, the historical context of the program and the OT’s position, and the background of the key sectors involved. These key sectors included the health care setting from which the initiatives arose, community services with whom the OTs partnered, and service users who participated in and implemented the initiatives. This is followed by an overview of the OT’s main activities and a description of CD as understood within that case. An interpretation of the key processes of CD from an occupational therapy perspective is then presented. Processes refer to an evolving sequence of unfolding interactions over time in response to a situation or context that result in change (Strauss & Corbin, 1998; Charmaz, 2006). Participants’ own voices are used to illustrate these processes. Note that pseudonyms are used throughout, identifying information has been removed and quotations have been edited for clarity. Finally, each case is summarized by highlighting its salient features.

Table 3 provides an overview of the main case elements that are described in ensuing chapters.
Table 3: Overview of the Three Cases

<table>
<thead>
<tr>
<th>Elements</th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary CD initiative</strong></td>
<td>Peer mentoring project for stroke survivors</td>
<td>Recovery education and programming with consumer-survivors</td>
<td>Linking seniors to community volunteer opportunities</td>
</tr>
<tr>
<td><strong>Program’s name and/or position name</strong></td>
<td>Community Liaison Coordinator position within the Acquired Brain Injury Program</td>
<td>OT position within the Community Links program</td>
<td>Senior facilitator within the Seniors’ Health Team</td>
</tr>
<tr>
<td><strong>Position funding source</strong></td>
<td>Health authority</td>
<td>Health authority</td>
<td>Health authority</td>
</tr>
<tr>
<td><strong>Primary setting/location</strong></td>
<td>Rehabilitation Hospital in a large Canadian city</td>
<td>House rented with a community agency in the downtown of a small Canadian city</td>
<td>Seniors’ community centre, in a mid-sized Canadian city</td>
</tr>
<tr>
<td><strong>OT's pseudonym</strong></td>
<td>Karen</td>
<td>Carla</td>
<td>Evelyn</td>
</tr>
<tr>
<td><strong>Occupational therapy experience prior to CD position</strong></td>
<td>Approximately 10 years at the rehabilitation centre</td>
<td>Approximately 10 years within mental health services</td>
<td>Approximately 10 years in hospital settings</td>
</tr>
<tr>
<td><strong>Length of time in CD position</strong></td>
<td>1.5 years</td>
<td>5 months</td>
<td>8 years</td>
</tr>
<tr>
<td><strong>Participants</strong></td>
<td>Stroke survivors within the rehabilitation hospital’s catchment area</td>
<td>Consumer-survivors of the mental health system</td>
<td>Older adults within a geographic region of the city</td>
</tr>
</tbody>
</table>
4.2 Introduction to Case 1

Karen was working for one-and-a-half years as the community liaison coordinator in the brain injury program of a well-established rehabilitation hospital in a large Canadian city. The purpose of this non-clinical, liaison position was to strengthen the links between the rehabilitation hospital and the community agencies that provide ongoing support to discharged clients. Part of the OT’s role was working with hospital clinicians to facilitate their in-house processes, such as managing waitlists and improving discharge planning, in order to enhance clinical services. The other component of the position involved partnering with a community agency to develop a pilot peer mentor project for stroke survivors.

4.3 Context: An Institution Working to Build Community

Position Location and History

The community liaison position and the majority of its activities were situated within a brain injury program at the rehabilitation hospital. The aim of the position was to enhance community reintegration through a variety of means, including the development of community partnerships and community initiatives. The OT’s manager specified that the position “isn’t just about developing new [programs], it’s about linking to current [community initiatives].” Responsibilities listed in the job description included: “Facilitates community reintegration of discharged clients by linking clients with available services/resources . . . contributes to the development of community resources . . . enhances inter-agency/community communications/relationships” (Job description, Case 1 [C1]). This focus on developing community resources was in response to feedback from former clients and community services claiming that community support for discharged people was lacking. One of Karen’s colleagues described this feedback:

We were getting feedback from the community saying that we’re sending people home totally unprepared, that clients were unprepared,[and] the service providers were
unprepared. They were unprepared to deal with being in the community and living in the community . . . both felt abandoned by [the rehabilitation centre]. (OT Colleague, C1)

The hospital, supported by the health authority, focused on developing community resources to address this identified gap. The manager explained how addressing this gap was also a “business decision” that was in the best interest of the hospital because it would reduce the number of re-admissions that result from inadequate community support:

What happens with people with brain injury, more than any other diagnosis, is if you don’t support them in the community they come back into acute care . . . they’re going to be re-admitted. So it’s a business decision in that if you’re going to shorten length of stay [in hospital] and you don’t provide something out in the community, they’re bouncing back and they’re going to cost you more money . . . and then they’re probably going to come back in at a lower functional level, so they’re going to go back out at a higher needs level, and they’re forever going to cost you more money. (Manager, C1)

In addition to this, the rehabilitation centre was responding to current trends in health care. With a growing emphasis on chronic disease management amid recent discussions about a regional stroke strategy, stroke had become a “sexy topic” that could receive funding.

Although there was a push from the institution’s side to develop services in the community, there was also a reported undercurrent working against this endeavour that was based on the long-standing belief that the rehabilitation hospital’s services were superior. The manager described the philosophy of many of their clients as: “If I need something, it’s going to happen at [the rehabilitation hospital] and all the brains are [here], and anyone who could heal me is at [the rehabilitation hospital].” The hospital management wanted to dispel that perception by strengthening community initiatives and building community capacity to meet clients’ needs outside the hospital through the peer mentoring project.

**Peer Mentoring Project Background**

The need for a peer mentoring project was identified when a hospital committee gathered information about the needs of their clients. A committee member explained that one of the issues identified by discharged clients was that they were missing “a sense of purpose in their life, a sense of belonging . . . [there was a need for] peer support and recognition or feeling valued.”
The funding for the hospital’s first attempt at developing a peer mentoring project was not secured and the original committee disbanded as a result. A year later, when the liaison position was filled by Karen, the OT, the peer mentoring project was revisited. The need for peer support remained an identified priority for professionals and survivors alike.

**Survivor Experiences: “Walk in My Shoes”**

The value of peer interactions provided a backdrop in this case. An informal peer support group for younger survivors of stroke had been initiated in the community to fill an identified gap in supports for this survivor group. A number of participants in the peer mentoring project came from this group. The importance of peer support was underscored by some of the experiences of the stroke survivors. One person describes her early hospital rehabilitation experiences:

As a patient, all you do is wait for somebody to throw you a bone. Because it's like you're just riddled with negativity from the staff. [All you hear is], “No one ever recovers. . . . You won’t walk, you won’t talk.”. . . It was really negative. So for a patient to maintain a sense of hope, it’s really difficult. I would be amazed at the number of patients that I would meet in the hospital that had been told the same thing. (Stroke survivor 1, C1)

This survivor noted that in this negative context, hope provided by other survivors was central:

[Hope] was so key. This one woman I met in the hospital. . . . was the same age as me when she had her stroke. . . . And she just said, “They are going to tell you that you will never walk but I’ll tell you: you might. And you just have to keep the faith. You might, you might, you might.” So I took that away, so for months I would say to myself, you might, you might. And then I stood up. (Stroke survivor 1, C1)

This participant’s experience suggested a divergence in perceived perspectives between survivors and professionals. Survivors, inspired by the experiences of their peers, hoped for improvements. In contrast, the professionals emphasized what they perceived to be realistic expectations. One survivor described how she perceived the difference between professional knowledge and the knowledge of survivors, which was grounded in the lived experience of daily challenges:

I know that everybody here [at the rehabilitation center], you’ve all been to school and everything, but you haven’t actually experienced [it]. You’ve done the school part but
you haven’t actually experienced it. You’re not in a wheelchair, you’re not one-handed. (Stroke survivor 2, C1)

This distinction between the “school” knowledge of professionals and the experiential knowledge of survivors alluded to a perceived divide between some survivors and professionals. One survivor described the divide she perceived during her rehabilitation at another hospital:

[There was] that very strict line between “we’re the therapists, we may be very informal and we may be wearing just ordinary clothes, and we may be on first name terms with everybody, but we have the information and we don’t give you that information.” . . . I found that demeaning, I felt demeaned by it. (Catherine, Stroke survivor and peer coordinator, C1)

The ‘information’ referred to was the patient’s hospital file, which came to represent the control professionals had over the survivor. This survivor noted that though the professionals probably felt they were doing their best to provide appropriate services, there remained a sense that

[The professionals are] the people who help, [and] we’re the people receiving help. . . . I found that so hard . . . to go from being one of the people who helps . . . to being one of the people who are being helped. . . . I felt a loss of status. I wanted to say “But I’m a professional too!” (Catherine, Stroke survivor and peer coordinator, C1).

Although there was a range of experiences among survivors, recognition of this potential tension between survivor and professional helps to situate the peer mentoring project within a historical context of survivors’ previous experiences with rehabilitation professionals. Many of the stroke survivors in the peer mentoring project had interactions with rehabilitation professionals while in hospital and thus they had experience with in-patient and out-patient rehabilitation. Their positive and negative experiences from that time form a basis for interactions with professionals and peers that influenced and were influenced by the peer mentoring project.

Building upon the importance of experiential knowledge, stroke survivors spoke of wanting to be able to give back to other survivors in a meaningful way. One stroke survivor recalled his time in rehabilitation at the hospital:

I remember sitting in the cafeteria, especially at lunchtime, and seeing people that are really unhappy and . . . they’re just new “kids on the block” . . . not a month ago that they had their stroke. It might be very much of a comfort for them . . . to be able to talk to
somebody that’s been through it. That’s the same old [adage]: “walk in my shoes.”
(Stroke survivor 3, C1)

This desire to contribute further supported the impetus for the peer mentor project.

**Community Sector**

The key partner in the peer mentoring project was an agency from the community sector. This agency provided informal support groups for stroke survivors in different communities around the region but had limited financial and human resources. With only two paid positions, it was mainly volunteer-run. The agency coordinator explained that it “was basically running on a shoestring of staff, funds . . . just to stay afloat.” The contrast between the stability of the health sector compared with the constant change in the community sector affected partnerships between the rehabilitation centre and the community. The manager from the hospital described the challenges of working with the non-profit, community sector:

> I think that the biggest challenge for us [the rehabilitation hospital] is in the non-profit world where we tend to partner. There’s a constant change of staff, and [with] new staff in non-profits you get very different skill sets and very different visions. And the Executive Directors don’t tend to last terribly long. (Manager, C1)

The agency that became involved with the peer mentoring project wanted to refute its reputation as a “mom and pop” organization that simply runs social groups once a week (Community agency, C1). With a new executive director, this agency was focusing on enhancing consistency across its branches and building relationships with other organizations. Partnering with others was seen as one way to strengthen the agency’s credibility. As the agency coordinator explained, “When you have [the rehabilitation centre] as your partner, it adds more value to the project, [and] to the program. . . people then will take you seriously.”

> It is within the context of three overlapping spheres – a rehabilitation centre that wanted to develop community services to combat the belief that they need to occur within the hospital, survivors that valued peer supports and had had varying experiences with professionals, and a community agency that sought strategic networks – that the peer mentoring project was situated.
4.4 Main Activities: Peer Mentoring and In-House Activities

Understanding of Community Development

Although the work-related tasks in CD involved mainly coordination or administration, many of the small, seemingly unrelated projects had “ripple effects” that the OT built upon in order to share information or initiate other projects. The aim of such initiatives was to impact services. Karen explained that within this process, she “look[ed] at the whole person . . . the environmental influences, and the social influences”, and the person is kept central to discussions with community partners and service providers so that changes to the system ultimately result in benefits for the person. From an institutional perspective, the manager explained that CD specifically aimed to strengthen services within the community to better meet the needs of people who have been discharged from the hospital. It was reported that it is common for initiatives to be guided by “people from above” and the availability of funding.

Peer Mentoring Project Overview

Karen’s primary CD initiative was the peer mentoring project. This pilot project aimed to train 10 mentors and match them with newly discharged stroke survivors. The program mandate was: “building community capacity for stroke survivors and [ensuring] they have a heard voice and are able to advocate for themselves” (Karen, OT, C1). The intent was to do this by building participants’ self-esteem, developing interpersonal skills, deepening participants’ understanding of stroke, and developing leadership and self-advocacy skills (Project Outline Document). Thus, the project aimed to develop the stroke survivor community.

The planning of the peer mentoring training program began with a gathering of literature and a review of documents and resources from the previous proposal. One of Karen’s colleagues explained that on the peer mentoring planning committee, “Karen did most of the research [about other peer mentor programs]. And then she'd bring it back to us and then we’d discuss it.”
People from the rehabilitation center and Catherine, a stroke survivor, were invited to form the planning committee. The community partner was identified and planning of the project began. The committee met monthly for a year to discuss the training format, session content, budgeting, and funding. Key events in the planning of the training sessions included developing the training manual, screening potential mentors, arranging for the mentors to complete a chronic disease self-management program prior to the mentoring training, acquiring funding, hiring the peer coordinator, recruiting presenters and beginning the training. The training program consisted of 5 sessions, one morning per week, in which 10 peer mentors were introduced to topics such as understanding the brain, communication, cultural issues and coping strategies. Clinicians from the rehabilitation centre conducted the majority of the sessions which were held in the rehabilitation hospital’s out-patient area (Field notes, peer mentoring training, day 1, 2 and 3, October 2007).

In-House Activities

The community liaison coordinator position also led in-house activities to enhance hospital services. The OT worked with two groups: the outpatient team and the discharge committee. The outpatient team had difficulty managing their wait list and with recent changes in staffing, “clients were literally slipping through the cracks because [clinicians] forgot they were on their caseload” (Manager, C1). Karen worked with the team to enhance efficiency:

We needed to implement a new system [for managing wait lists] and I needed someone in there to basically tell me if it’s happening or not, was it working, [and to] make sure that all the bugs were cleared before we walked away. (Manager, C1)

The second group, the discharge committee, prepared clients for leaving the hospital ensuring that they were made aware of available community resources. The OT led a small group of clinicians in enhancing the discharge process, including developing a uniform discharge form and planning weekly information sessions in which community agencies came to the hospital to introduce their services to in-patients. Awareness of community resources was increased by 1) a shared office space set up in the hospital’s foyer that showcased key community agencies, 2) the
development of a resource room where information on relevant community services was collected for patient and family use (Field notes, September 27 2007), and 3) the compilation of a collection of community brain injury services for patients, family members, and clinicians (Document – Revised community resource list). Although seemingly distinct from the peer mentoring project, the processes described below begin to show the relationships between the various CD processes that occur in this case.

4.5 Community Development Processes

This section will explore five key processes of CD revealed in this case, conceptualized as follows: 1) Bridging Hospital and Community: Gathering “Buy-in” and Mobilizing Hospital Resources, 2) Negotiating Community Partnerships: Repairing Power Inequities, 3) Building upon Capacities to Mentor: Legitimizing Experiential Knowledge, 4) Mending Rifts: Stepping Back, so Others can Step Up, and 5) Uncovering Uniqueness in a Generic Position: An Implicit Occupational Therapy Perspective.

1. Bridging Hospital and Community: Gathering “Buy-in” and Mobilizing Hospital Resources

This first process elucidates the relationship between the in-house activities and the peer mentoring project. These two aspects of the community liaison position initially appeared discrete and unrelated, as indicated by the manager referring to the OT’s involvement with the outpatient team as “the elephant in the room because it doesn’t fit [with her other community-focused activities].” However, a member of the outpatient team disagreed, saying that the liaison was helping to develop the team’s in-house community (Field notes, October 2 2007). The development of this “in-house” community of clinicians came about by the OT responding to clinical priorities and informing of community initiatives.
Responding to Clinical Priorities – Gathering Clinician “Buy-in”

This process involved the OT being responsive to clinician priorities in order to gather their support for new initiatives. Because this OT had clinical experience, she was perceived to understand the constant pressures of daily clinical practice. As her manager explained, “People know [Karen] as a clinician, they know she has the skills and know that she understands their world in terms of pressures . . . which I think helps a lot.” Previous clinical experience enabled the OT to consider clinician time constraints in order to cultivate “buy-in” for the introduction of new programs. Examples of this included the development of handouts for the presenting clinicians in order to simplify their work with the peer mentors and the consideration of clinicians’ time constraints when planning weekly community information sessions. Karen described her approach to the clinicians:

We presented [our ideas] to staff first to make sure that there was buy-in, to say . . . this is how we want to get buy-in from the clients: [by] making it a mandatory part of their schedule. . . . You can’t schedule therapy during this time . . . it gives you guys an hour to do other stuff once a week. Does anybody see a problem with that? (Karen, OT, C1)

A similar process was used in relation to the outpatient team clinicians’ priorities and concerns. Time was spent gathering individual team members’ perspectives to get a sense of their concerns. Her manager explained:

[Karen] spent a long time sitting back, learning about what their issues were, making sure they were comfortable talking about whatever they wanted to talk about with her in the room. . . . [They] knew that she wasn’t just going to react and [say] oh, this is the problem, and here, you fix it, and walk away. (Manager, C1)

Consequently, clinicians who were initially sceptical of, and perhaps threatened by, the liaison’s role with the outpatient team, came to greatly value this contribution:

They [the team members] right away wanted to know what her role was on their team, what the parameters were in terms of could she mandate something to be used, does she have to listen to us? They were a little sceptical of why . . . she [was] here . . . but I think every single one of them now basically says, “wow, what a world of difference” and I have other teams asking for her now. (Manager, C1)

Learning about and responding to clinicians’ concerns led to trusting relationships.
In conjunction with clinical occupational therapy experience, the flexibility of the community liaison position, the broad job description, and managerial support allowed the liaison to respond to in-house needs as they arose.

[Karen’s] job description is huge, which is a good thing. So we make the job description very, very mouldable to whatever’s going on. . . . I would say it’s a very dynamic position so that the objectives of that role can be whatever you want them to be, quite honestly. And [the objectives] have been, over time, completely different. . . . Part of that is definitely just times change so quickly that we need [the position] to be very, very flexible. (Manager, C1)

The manager explained the position was deliberately created to be flexible in order to be responsive to community and institutional concerns. However, this also placed the CD aspect of the position at risk of being redirected to institutional issues that were considered more important. For example, the manager explained how the community aspect of the position had been “very marginal” for about a year because they needed a person to work on accreditation issues. The manager went on to say that it is managers’ appreciation of such non-clinical positions that help to retain such positions because “it’s very, very hard to protect those jobs because, as resources get short, the first one you’re going to be mandated to cut is a non-clinical job.” This reinforced the notion that non-clinical positions were vulnerable in a hospital setting. The ability to respond to the in-house community and address broader community issues was a way to mediate this vulnerability. Consequently, there was tension and a balancing act between the hospital’s clinical priorities and the position’s focus on CD. Through this, clinical priorities were met in order that community initiatives could be further advanced.

Informing of Community Initiatives – Mobilizing Hospital Resources

The liaison created the opportunity to inform clinicians about community services and mobilized hospital resources by supplying project updates and advertising community events during team meetings. Karen explained that the liaison role with clinicians was that of an educator, recognizing that it is “a matter of bringing [community] opportunit[ies] to [hospital
A colleague explained how Karen acted as a link, gathering information that clinicians did not have time to gather themselves:

She’s available for [the] sharing of community resources, which is hugely challenging [for us] because it changes all the time and it’s hard for clinicians to often keep up with all of the changing community resources. She acts as a link for those. (Outpatient team colleague, C1)

In this way, the liaison acted as a “bridge” between the hospital clinicians and the community. As clinicians learned of new community resources, it was anticipated that more appropriate referrals would be made, making the community programs more sustainable, as the manager explained:

Part of community development from a health care perspective is [that] if we don’t actually refer our clients to the existing resources, everything that’s developed in our community will wither away. . . . And so I would see the discharge planning part of [Karen’s] job as actually facilitating current community partners [by] getting appropriate referrals and clientele for their resources. . . . And I think if you don’t do that well . . . I think you really hurt your partners because you can develop amazing things and nobody comes . . . [because] nobody even knew they were there. (Manager, C1)

Through her position, Karen had access to various hospital resources, both financial and human. Resources for the peer mentoring project were mobilized as a result of this relationship. For example, arrangements were made for the use of hospital space for the training sessions, for the printing of materials and the recruiting of presenters and potential mentors. The liaison was therefore seen to be connected in the hospital and beyond it, using “internal” and “external” networks as required (Colleague, C1).

The OT’s role went beyond getting the clinicians to agree to participate in the peer mentor training to supporting them as they prepared. Karen reportedly coached one clinician and ensured that his presentation was appropriately targeted to the stroke survivor’s needs:

I did have to give [the colleague] quite a bit of feedback because . . . you’re talking to survivors and you want to give them really practical strategies to do things . . . and so he’d [say] okay, let me think about this again, and he’d give me something back, and I’d [say] okay, now it’s much better, but you still need to give more strategies. . . . It was a neat kind of process, and he was very open to the feedback every time. (Karen, OT, C1)
Within these in-house processes, the CD liaison became a mediator between the hospital and the community with respect to their priorities and resources; actively responding to hospital needs while simultaneously opening the hospital to community information. This enabled hospital resources to be mobilized for the CD initiative. Thus, this process of developing the in-house community can be considered a foundational process of the CD initiative.

2. **Negotiating Community Partnerships: Repairing Power Inequities**

An important requirement for the peer mentoring project was the identification of a partner to co-lead the project. Because of the hospital’s mandate to build community capacity, a “community face” for the project was needed (Manager, C1). One of the liaison’s roles was to work with the planning committee to identify an appropriate partner. This process involved the phases of *uncovering power inequities*, and *formally addressing power inequities* and ensured that risks and responsibilities were shared.

*Uncovering Power Inequities – “We Didn’t Want . . . Everything to be Dumped on Our Lap”*

Potential partners for the peer mentoring project were considered based on their fit with the project aims, the appropriateness of the clients they served and their capacity to take on such a project. The community stroke agency, which had an interest in peer support, was one of these organizations. The stroke agency had recently shifted its priorities to focus on networking and increasing its profile within the community. Thus, there was interest when the executive director of the stroke association was approached about partnering in the peer mentoring project. The resulting partnership was not formalized in an agreement at first. Instead, roles and responsibilities were discussed in the committee as the project was planned. Karen described having engaged in a transparent and “inclusive process all along”, where budgets and timelines were discussed in the committee that then moved forward with consensus.

In contrast, the community agency viewed this as a phase of tentative partnering, in which they were “testing out” the motives of the rehabilitation center. The coordinator explained:
Especially if there’s not been a relationship previously [between partners], you’re both trying to feel each other out. . . . What do they want from us? Sometimes it’s a little bit of suspicion as well, like, why have they come to us? What is it that they can’t get from somebody else? Are they here just for the funding or they really do value what we do? (Community Partner, C1)

The community agency was also hesitant to take on a leadership role, as requested by the rehabilitation centre, because they had limited resources. The agency representative explained:

> For us [our hesitancy to partner] was more because we didn’t have the funds, and also we didn’t have the staffing to be able to do it. . . . The rehab centre for their reasons also wanted to hand it over to us primarily because this pilot project is seen as a community project, and we are the community partner so it would make sense for us to lead it. (Community partner, C1)

The agency’s concerns were not raised right away. The coordinator attributed his delay in voicing agency concerns to his “lack of skills, or not understanding certain concepts”. It was only later that he brought budget information, showing the agency would be responsible for managing the funds, to his executive director, who was also apprehensive about the plans. The community agency perceived that the rehabilitation hospital was dominating the process, creating an imbalance of control and an unequal partnership. They feared they would not have the resources to sustain the peer mentoring project, and the rehabilitation centre’s push for them to take the lead was seen as being “dumped” on:

> What we didn’t want [was] . . . for it to start and then everything to be dumped on our lap, and then them to come at the end of the year and [say] “Okay, let’s look at the evaluation process. [I would question,] where were you when we . . . needed you?” (Community Partner, C1)

With these two very divergent interpretations of the same event (one feeling the planning process was inclusive, and the other feeling vulnerable in a process they felt they had little control over), the proposed partnership came close to collapse.

*Formally Addressing Power Inequities – Becoming a “50-50 Partnership”*

This pending partnership breakdown was a key event that required discussions between Karen’s manager and the community agency’s executive director. During these discussions the
community agency’s concerns were voiced, and an official memo of understanding was

negotiated to address each concern. The community agency coordinator explained this process:

[The memo of understanding] went back and forth a couple of times before it was

finalized, and once we signed off on that, it made it much clearer as to who was going to
do what. And should things not go according to plan, then there’s an option B and there’s

an option C. So there was no need to worry if things didn’t turn out . . . because we had
other options. (Community partner, C1)

The memo of understanding enabled the community agency to move forward in a “real

partnership” with shared responsibilities based on strengths:

So there was no misunderstanding or assumptions made after that. We needed to do it
together, these are the things we’re working on together . . . and so after that it really was
then a 50/50 partnership. I was doing what I needed to do from the [community agency],
[Karen] was doing [what she needed to do] from the rehab centre side. (Community
Partner, C1)

This memo of understanding ensured a working relationship at multiple levels, including

front line workers and managers, thus the project would continue even if key people left their

positions. Consequently, the rehabilitation centre and the community agency jointly carried out
tasks they were both invested in, such as the interview for the peer coordinator and screening
peers. Rather than one organization taking the lead, they agreed to shift leadership depending on
the task. For example, the rehabilitation hospital took on developing a back-up financial plan and
the community agency took the lead on liability issues by having the mentors as their volunteers.
With funding secured from different sources, the rehabilitation centre covered the evaluation and
refreshments, and the community agency covered the peer coordinator position.

In this way, the initial relationship that sought a “community face” and was perceived as
unequal was mutually negotiated to ensure that responsibilities and risks were shared equitably
between the partners, based on their different resources and strengths. Karen came to appreciate
the importance of the unique situation of the community agency, recognizing that she took for
granted the many resources she had at the rehabilitation hospital. She explained her realization:
Once you get involved in [a] partnership, it’s sometimes a business. The non-profits certainly don’t have the money to back up some of this stuff the way that you would think [because of] how small their association actually was. . . . So some of the things that you’re proposing or that you take for granted working in an organization [aren’t feasible.] (Karen, OT, C1)

As a result of this formalized partnership, each partner gained what they had initially sought in a manner that was seen as mutually beneficial: the rehabilitation centre fulfilled its mandate to work with the community to develop services, and the community agency was able to raise its profile by offering a much-needed program in partnerships with a well-known institutional partner. Through this joint effort, both were satisfied that the peer mentoring project would serve their shared client base. Because neither partner could implement the peer mentoring project in isolation, the successful negotiation of this partnership allowed the project to run. Thus, this partnership was fundamental to the subsequent processes.

3. Building upon Capacities to Mentor: Legitimizing Experiential Knowledge

The peer mentoring project aimed to build upon the notion that sharing experiences among peers is beneficial for survivors. Survivors valued interactions between peers because of the perceived credibility of someone who has lived through the experience of having a stroke. Hearing about the challenges and success of other survivors had instilled hope in the mentors, and they wanted to share their experiences with others.

The peer mentoring project aimed to build skills among the stroke community. The liaison facilitated this capacity-building process by assisting with developing individual and collective capacities throughout the planning and implementation of the peer mentoring project, and by supporting the legitimacy of the survivors’ experiences. The intended outcomes of this capacity-building process are described.

Developing Individual and Collective Capacities

The CD liaison role included supporting the coordinator of the peer mentoring project through the provision of practical suggestions and encouragement. For example, Karen provided
feedback to Catherine, the peer coordinator, as she developed her peer mentoring presentation and then followed up after her first presentation (Field notes, October 4 2007, C1). One of the most valuable things that Karen offered Catherine was an affirmation of her abilities:

> I think, probably more than anything else, what [Karen has] done is given me the confidence . . . [in believing that] the experiences that I’ve had, the things I’ve done to date give me a good background to be doing that job. (Catherine, Stroke survivor and peer coordinator, C1)

The liaison became the peer coordinator’s main contact at the rehabilitation centre. Although the committee team members were welcoming to the peer coordinator, the health professionals as a group were experienced as “daunting” at first. The supportive relationship with the liaison made this experience easier, as Catherine explained:

> I felt from the beginning that [Karen] was somebody I could go to and ask questions. I could call up and she wouldn’t mind. She made herself available and gave me a phone number and an email address, and . . . it made me feel that I could speak to her. [With] anybody else on the committee that was different. . . . I don’t feel that I do have that [relationship] with the others. (Catherine, Stroke survivor and peer coordinator, C1)

The mentors also benefited from this project. The information shared in the training sessions was personally relevant, helping them grow in confidence, and providing them with strategies, such as communication skills, for sharing this information with their peers. One participant acknowledged these benefits following a training session on empowerment:

> Last week [’s training session] was very informa[tive] . . . I took away a lot personally from that. . . . I should really think more like that [in my own life] versus just having that as information to pass on to somebody else. So [the speakers] were very helpful and I felt . . . that I would feel more confident in discussing with the person going home for the first time. (Stroke survivor 1, C1)

It was anticipated that the mentors would gain confidence through the training, as well as gain perspective on their own recovery process. Catherine explained that she developed a broader understanding of her own experience within the context of the larger shared experiences of stroke survivors. She anticipated the mentors would similarly experience this:

> This [project] is educating the person so they’re understanding more about stroke, [and] they’re learning more about how other people are coping with it. So it’ll bring them on
[in their own recovery process] I think, I hope. (Catherine, Stroke survivor and peer coordinator, C1)

The role of the community liaison evolved once the mentor training began. At that point the liaison’s involvement was peripheral, through interactions with the peer coordinator and the community agency running the training. As such, the liaison was seen to directly support the development of the capacities of the peer coordinator, who in turn worked with others to develop the skills and capacities of the mentors. By facilitating the planning committee and working with the peer coordinator, the liaison contributed indirectly to building upon the mentors’ experiences so they could share these with others. This capacity-building process was seen to go beyond simply benefiting individuals to developing collective resources among a small subset of the stroke community that had the potential to benefit others.

Supporting the Legitimacy of Survivors’ Experiences

In addition to building up the capacities of stroke survivors, this formalized, health-authority supported program served to acknowledge and legitimize the value of survivor experiences within the hospital’s system. Although there was a survivor-led stroke support group in the community, it was informal with no funding and thus was considered “something, but nothing” by its founder. In contrast, the peer mentor project was a recognized and funded project.

Survivors’ contributions were recognized by health professionals, both informally and formally. During training sessions, presenters (who were mainly health professionals from the rehabilitation centre) acknowledged the value of survivor experiences by thanking the mentors for the valuable contribution they were making by volunteering in the mentoring program (Field notes, October 3, October 10 and October 17 2007). The mentors also received a small stipend for their involvement in the program. More formally, the value of a stroke survivor’s experience was validated through the creation of a paid peer coordinator position.
Payment for the peer coordinator was a contentious issue, influenced by the divergent views of the community agency and the rehabilitation centre. The community agency was mainly volunteer-based and did not have resources to pay the coordinator:

For us to put funding towards a program that is important means that funds [have] to come from somewhere else within our organization. So do we now not expand our branches because we’re now using some of that funding to pay for a peer mentoring program? So initially for us, definitely we always wanted it to be volunteer-based.

(Community partner, C1)

In contrast, the liaison and other committee members viewed payment as recognition of the value of the work being done. To develop an argument that supported a paid position, perspectives from clinicians and examples of paid peer support positions were gathered.

Examples of the comments the liaison gathered from her colleagues included: “Financial remuneration (i.e. money) reflects the value placed on the work done, [it] recogniz[es] the specific skill set required, and provides accountability” (Document - Colleague, email, May 2007), and

The person [in the coordinator position] should be paid to give value to the work that will be done. I believe that it will be a large amount of work, above and beyond the role of a volunteer and expectations in terms of time commitment.

(Document - Colleague, email, May 2007)

Based on a compilation of these rationales and following clarification on who would be responsible for paying the peer coordinator, the community agency agreed to a paid position. The liaison thus emphasized the value of stroke survivors’ experiential knowledge while advocating for formal recognition and remuneration of the peer coordinator’s contribution.

The paid status of this position and the circumstance around the hiring process influenced Catherine’s relationship with the various members on the committee. For the peer coordinator, committee involvement resulted in the blurring of the “strict line” between survivor and professional that was originally experienced as “demeaning”, as the survivor perspective became validated. Catherine explained that this made her feel “almost professional.” She qualified this with ‘almost’ because prior to being offered the peer coordinator position, she was the only
committee member who was not in a paid position. This sense of being ‘professional’ pertained to having realistic expectations placed on her as an equal committee member, having responsibilities and having opinions that were valued by the group. Yet, she did not feel her experience and expertise were fully validated until she was offered a paid position.

The job competition made the candidate feel like an outsider who had to prove her worth to the committee. This compounded her lack of confidence. Again the liaison played a pivotal role by encouraging Catherine to apply for the peer coordinator position. In Catherine’s words:

She [Karen] kept saying, “You’re really well qualified for it.” . . . because several times I was saying, “Should I be doing this?” And she’d say, “Yes, apply for it,” which was encouraging language. She really wanted me to apply. (Catherine, Stroke survivor and peer coordinator, C1)

For Catherine, being offered the position was an experience of validation that alleviated her self-doubts. She explained the position’s significance: “[It was] the first time I’ve had a job since my stroke” and “It’s recognized, it’s an official organization, and I’ve got a job with them” (Catherine, Stroke survivor and peer coordinator, C1).

Capacity building in this case occurred at different levels: with the coordinator and with the mentors. There were many outcomes or anticipated changes that resulted from these capacity-building processes. For the mentees, it was anticipated that hope would be instilled, as many of the mentors themselves had similarly experienced when they had the opportunity to speak with peers during their hospitalization. As one mentor described:

I think that . . . a very, very big part of what we’re going to be able to pass onto the people that we’re going to work with is that there are some people out there that have survived. There are people out there that have gone through this thing and they’re not doing too badly. So I think that’s very valuable to them. (Stroke Survivor 3, C1)

The mentors gained knowledge, learned skills, and developed confidence. They spoke of desiring to do something meaningful, to contribute, which is what the peer mentoring project was preparing them to do. As one participant commented, “I think what I’m going to get out of it is a feeling of accomplishment and putting something back into society” (Stroke survivor 3, C1).
Mentors began to experience a shift in perspective, seeing themselves as contributors. One mentor anticipated meeting with her first peer partner, “I’m not going to be that person receiving. I’m going to be more active or proactive” (Stroke Survivor 1, C1). The peer coordinator described a similar appreciation for being able to offer her experiences to others:

It was nice to . . . feel a bit more professional again. . . . I had seen myself in my [previous] job . . . in a helping role, and it had some status to it . . . and then after the stroke I thought that I had none. And so on the personal level being invited to be on the committee was a nice feeling of doing something that was recognized by other people as being worthwhile, and it was doing something that really was going to be helping other people. (Catherine, Stroke survivor and peer coordinator, C1)

It was anticipated that the mentoring experience would provide a “stepping stone” toward other productive endeavours such as school or work. Beyond the benefits for the individual survivors, there was a sense that having a survivor in a paid position was significant beyond the project. The paid position was made possible because the partnership between the rehabilitation center and the community agency enabled the agency to secure elusive funding. The recognition afforded to the paid peer coordinator position further affirmed for other survivors that their experiences were recognized and valued by others. Catherine noted, “I’m sort of a role model for the mentors. . . . But I suppose in a sense they respect me more [because] I’ve had a stroke too and so I’m not talking from just theory, I’m talking from experience” (Catherine, Stroke survivor and peer coordinator, C1).

This recognition for stroke survivors was important and in stark contrast with Catherine’s early rehabilitation experiences. She described these two experiences as “very different”:

And the big difference being that it’s not just white coats [in the peer mentoring project]. I know that most of the clinicians have taken off the white coats, but . . . they’re still the people who’ve got the files on you . . . and they’re all the people whose brains aren’t damaged and we’re all the people whose brains are damaged. But I think the nice thing about this [peer mentoring] is that people here are people who’ve had strokes, whose brains are damaged. [They are] being given responsibility. (Catherine, Stroke survivor and peer coordinator, C1)
Catherine anticipated that this shift in roles would be “transmitted to the person who’s being mentored [who] will see that here’s a person who has had a stroke who is actually doing something that’s respected and valuable” (Catherine, Stroke survivor and peer coordinator, C1).

Contextually, all of these capacity-building processes occurred within the rehabilitation hospital, with the support of clinicians, a community agency and stroke survivors. The availability of resources mobilized through the liaison’s in-house activities and the funding received through the partnership created conditions ripe for these capacity building processes.

4. **Mending rifts: Stepping Back, so Others can Step Up**

In contrast to the relationships forged between the liaison, the clinicians and the community agency, a component of the OT’s role pertained to linking others and the creation of links by stepping back so others could step forward.

*Linking Others - “It’s Been a Bit of a Mending Process Along the Way”*

In earlier years Catherine had created her own independent support group after encountering negative attitudes from one of the community agency’s volunteers. This history between Catherine and the agency only surfaced following discussions related to the interview process for the peer coordinator position. The objective hiring process served to minimize the influence of this history on the hiring process. Karen explained her role in repairing this relationship:

> It’s been a bit of a mending process along the way of their relationship, so as a result we . . . had to make sure we had a very objective way of determining this position. So we had to look at a posting, we had to look at where it was going to be posted, who was going to do the interviews, setting up rated interviews format, and then just being really objective and fair. (Karen, OT, C1)

Once the position was filled, the liaison worked with the community agency and the peer coordinator to ensure mutual support and reliance, which then allowed the OT to step back. Despite the tenuous start to the relationship between the peer coordinator and the community
agency, they grew to accept each other as partners in running the peer mentoring program. The community agency representative explained how they planned to work together:

[Catherine]’s going to be more hands on in every aspect of this program. I am going to be more kind of the administration, the financial guidance . . . but I will certainly be working with Catherine. . . . It’s been almost a year [that we’ve been working together on this] and if anybody knows [this project] well, it’s us. (Community partner, C1)

A more general mending of the rifts between survivors and health professionals occurred through the peer mentoring project. Catherine did not feel like an outsider: “The people here who I’ve met through the committee have not differentiated between me and themselves as a group of professionals. I haven’t felt outside in any way. They haven’t treated me as if I’m one of their clients” (Catherine, Stroke survivor and peer coordinator, C1). This process of the coordinator becoming comfortable with the committee was achieved through positive interactions with professionals over time. Catherine described how her participation in the committee changed as she came to believe that she had something to contribute that was valuable and valued:

At that [later] point I was really feeling comfortable to make a contribution and feel that it was valued and nobody would sort of pat me on the head and say, “Yes, dear.” [Initially] I was feeling a little bit in awe of everybody and not quite sure whether I could sort of put an idea forward. . . . [Eventually my suggestions] turned out to be quite a big chunk of the training. (Catherine, Stroke survivor and peer coordinator, C1)

The mentoring project provided survivors and professionals with opportunities to interact outside of the typical patient-therapist dynamic. As an example, survivors, as mentors, were given health professionals’ contact details so they could call on them if they had questions. Catherine described the informal networking she was afforded through her involvement with the project:

[I’ve been] networking on a less obvious level, just that I hear more about things that are going on. . . . The networking is something that you’re not even conscious of. . . . And you start to hear more if you’re mixing. . . . Through my being on the committee [I hear more]. (Catherine, Stroke survivor and peer coordinator, C1)

Mentors experienced being admitted into the professional world from which previously they had felt deliberately excluded.
Stepping Back - “Passing On the Torch.”

Underlying the mending of relationships, and building upon the partnerships and capacity-building processes, was a process of transitioning responsibility. The OT worked to build and strengthen connections and relationships, to establish structures and processes for the project and then shared responsibilities with others who gradually took over. For example, the OT met with the peer coordinator and the community agency individually to review various responsibilities. Additionally, the peer coordinator was encouraged to meet with presenters prior to their training sessions and provide them with background on the mentors and the project (Field notes, briefing meeting, October 2007). Consequently, the coordinator became the presenters’ main contact person for the peer mentor project and was then positioned to build a rapport with the different presenters.

Structurally, the OT ensured that the committee would continue to be available to guide the peer mentoring project once the training was complete and the peer matching began. This provided ongoing support as they took on the day-to-day management of the project. The OT completed the process of “passing on the torch” by adding this item to a committee meeting agenda. It was arranged that the peer coordinator and the community agency would, as a team, co-chair the committee meetings since they would have updates for the group as the training and matching progressed. In response to this, Catherine commented that she felt like a “five-year-old on a bike and [Karen] has been helping out and now she's letting go” (Field notes, final peer mentoring committee, October 2007). Despite these feelings of apprehension, the peer coordinator and the community agency admitted that their year of working together with the committee made them feel more confident in their ability to share the coordination of the project:

I was quite worried about sort of not having [Karen] there, and I feel less worried now, now we’ve got started with the training and I’m getting to know more people at the rehab centre. To me that’s the most important thing: I need to know more people. . . . But I mean the rest of the committee are remaining so I feel confident that they’ll support [the project]. (Catherine, Stroke survivor and peer coordinator, C1)
This stepping back process runs parallel to capacity building. It can be considered a method of building capacity by doing less so others can do more; stepping back, so others can step up to the challenge. Karen admitted that in this process, she was required to give up control as others took over. The location and context of the peer mentoring project supported this ‘stepping back’ since structures and resources had been put in place to support the mentoring project. The memo of understanding, the ongoing committee that would support the coordinators, and the development of resources that could be used again were all structures that helped to ensure sustainability of this project. Through this process in which others were linked and empowered, the OT effectively became another committee member, available for support as required.

5. Uncovering Uniqueness in a Generic Position: An Implicit Occupational Therapy Perspective

This research aimed to explicate processes of CD from an occupational perspective. However, in this case a number of factors were seen to be obscuring the occupational perspective, while others contributed to uncovering the implicit occupational therapy perspective.

Obscuring the Occupational Perspective: “She’s Not Really an OT in That Role - She’s Considered a Generalist”

The occupational therapy perspective was obscured in this case because of three main factors. First, the nature and location of the position limited the extent to which an occupational therapy perspective was obvious. The position was advertised as non-discipline specific; in the past, in addition to OTs, the position had been held by a social worker and a physiotherapist. In theory, other professionals should also be able to complete any of the community liaison’s tasks. Some colleagues commented on the generalist nature of the position, concluding that Karen’s professional training did not impact her work. One colleague explained:

If I didn't know she was an OT, then no big deal. . . . I mean the qualit[y]of an OT for me is [being] very organized and that's probably the key for that role. That's why . . . it's a
very generalist role. She's not really an OT in that role. She's considered a generalist. But she just happens to be an OT. Anyone could apply to the position. (Recreation therapist colleague, C1)

Instead, a number of Karen’s colleagues felt that personal qualities were the more important factor in this position:

When it comes to who is the right person to do these [CD] positions . . . you could have another OT who is absolutely the wrong person to do that position. It’s more in attitude, and the skill set and whether it’s because they’re an OT, I don’t know. I think it’s the human qualities of an individual that will make it successful or not in terms of this position. (OT practice leader, C1)

The occupational perspective was also obscured because the position was located in a rehabilitation hospital. Colleagues and survivors in that setting were familiar with OTs working with individuals in a clinical manner. As Catherine explained, “[Karen’s current position] just seemed so far off my expectation of what an OT does” that she could not see the occupational therapist’s role within this generalist position, and admitted that that was due to her previous experiences with OTs (Catherine, Stroke survivor and peer coordinator, C1). In this context, clinical occupational therapy appeared to be the archetype of occupational practice and deviations from this were not recognized as being occupational therapy.

The second factor that obscured the occupational therapy perspective was the merging of professional and personal qualities. The blurring of Karen’s professional training and her personal qualities contributed to difficulty in distinguishing what was attributable to her occupational therapy background. Karen concluded that it was mainly her occupational therapy background that impacted how she approached this position:

It’s hard to isolate. I am an OT so it’s hard to say if I didn’t have that training would I look at things the same way or would I have the same skill set? I doubt it. . . . A lot of [OT] is common sense sometimes . . . but a lot of people don’t get it. So then you think, no, obviously a lot of the theory . . . that we learned and the approaches [we learned], other people don’t really understand or know how to apply them. So I have to think that that [background] influences me for sure. (Karen, OT, C1)

Third, Karen’s occupational therapy contribution was further obscured because many of her work activities occurred behind the scenes, with few to witness them, making her explicit
contributions less visible to others. For example, none of the three peer mentors interviewed was aware of Karen’s contribution to the peer mentoring project, and they had only interacted with her a few times after the peer mentor and the community agency had taken the leadership roles.

Uncovering the Implicit Occupational Therapy Perspective: “It’s Really Valuable That [She] is an OT”

Despite these impressions, occupational therapy approaches were implicit in much of what Karen did and some colleagues were able to comment on the unique perspective an OT brought to this position. Her manager explained that she felt OTs were well trained for such CD positions:

I think that a lot of what [OTs] learn in school is actually utilized in [Karen’s] job. . . . [For] OTs and recreational therapists, this [position] is just an extension of what you’ve always done. So it’s not with a specific client population, it’s more generalized, but it’s really the same work. (Manager, C1)

The manager explained that OTs’ understanding of physical, cognitive and emotional issues around brain injury make them particularly well suited to this position, because

More often than not, it’s social skills or it’s cognitive issues [interfering with connecting to community resources], and so I think having that combination of understanding the physical side of people as well as the cognitive side of people actually makes you have a better understanding of what would work . . . and I personally don’t believe there’s any other discipline that really has that overall view. (Manager, C1)

Karen was seen to integrate occupational therapy approaches implicitly in her holistic consideration of survivors, determining what was important for them, and keeping their experiences in mind during program development. Karen described how she maintained the client at the centre of what she was working on:

It’s definitely looking at the whole person, and looking at the environmental influences, and the social support influences . . . so, keeping [the client] central and having all the community partners and facilities and service providers around them [so that the] person is always the end product . . . that is who you’re hoping to get the most out of the system and [the] changes that you’re doing [are] all for them. (Karen, OT, C1)
Karen’s inclusion of a survivor early on in the planning process indicated her commitment to consumer involvement in shaping the project. In this way, Karen was client-centred as she coordinated the peer mentoring project, striving to empower survivors to be actively involved in programs related to them.

Karen broke down tasks for her partners and colleagues and enabled others to engage in their occupations as needed, whether that was the clinicians learning to better manage their waitlists, or the peer coordinator developing new skills. Catherine believed that Karen’s occupational therapy background gave her a better understanding of what mentors could manage during training:

It’s really valuable that Karen is an OT, that she has some understanding about stroke recovery, that she’s setting this up rather than, say, the [community agency]. . . . [The agency] wouldn’t have understood enough about what people are dealing with in terms of their own recovery, to be able to know what would be realistic to ask of mentors. . . . And Karen’s been very much an advocate of having the peer coordinator [position] and I think that’s because of her understanding from being an OT. (Catherine, Stroke survivor and peer coordinator, C1)

Working with Karen expanded Catherine’s understanding of occupational therapy, as Catherine described, “I’m learning that occupational therapy seems to go off in all kinds of different directions . . . so now [Karen being an OT] surprises me less than it did at the beginning” (Catherine, Stroke survivor and peer coordinator, C1).

Furthermore, through the peer mentoring project, mentors were enabled to engage in the meaningful occupation of contributing and giving back to others. This mentor opportunity allowed for reframing the recovery process following a stroke into experiences that can benefit another stroke survivor. It is this specific sharing that adds to the meaning and value of the mentor role. One participant explained her desire to be able to give back to someone through the peer mentoring program:

I’m hoping that I can make a difference in somebody[’s life]. . . . I’m hoping that I can use my experiences as being out back in the world after a stroke and being out of the hospital and being in this [mentor] position . . . you don’t really know what it’s like out
there in a wheelchair until you’re actually in a wheelchair, there’s a big difference. (Stroke survivor 2, C1)

The recurrent notion of survivors wanting to meaningfully engage was also central to the peer mentoring project.

4.6 Case Summary and Key Features

This case illustrated how CD activities were facilitated within an institutional setting. Within the community liaison position, competing priorities were balanced by working with the in-house community, a necessary community partnership was negotiated, survivors’ capacities to give back to others were strengthened and gradually people outside of the institution took on a leadership role in the project. These CD processes were approached from an occupational perspective which influenced how the OT worked with others, although this occupational perspective remained largely unrecognized.

Salient features of this case included: its location, the generic nature of the position, the near breakdown of the community partnership and the peer coordinator’s paid position. This case provided an example of CD within an institution. Within this setting, clinicians in the hospital, community services and stroke survivors were considered communities to be strengthened. Although in-house activities initially appeared distinct from the peer mentoring project, the two aspects of this position began to intertwine: resources were recruited from the in-house committees for the peer mentoring projects, and information from the project and the broader community were shared with the clinicians.

This case also provided an example of how an OT worked in CD in a generic, non-discipline specific position. Within the position, the unique contribution of the OT’s profession was obscured by a number of factors, resulting in some colleagues feeling that one’s professional background did not contribute to this position. Despite this conclusion, many of occupational therapy’s principles and values were demonstrated to be quietly guiding interactions with various partners.
Another interesting feature of this case was the challenge encountered during the community partnership negotiations. Because of the community agency’s fear of having the peer mentor project ‘dumped’ on them, they considered disengaging from the partnership. Although this issue was resolved and the partnership successfully continued, this partnership crisis reinforced the importance of having clearly defined roles in order to equalize perceived and real power imbalances between partners.

A final key feature of this case was the experience of the peer coordinator who journeyed through a series of roles: first as a volunteer working to organize an informal survivor support group in the community, then as a volunteer member on the planning committee, and finally as the paid peer coordinator who co-led the peer support program. She described her own recovery process that progressed as she worked with other survivors, which fostered appreciation of their shared experiences as well as provided the opportunity to share strategies with others. This journey foreshadowed the experiences of the peer mentors, who, it was anticipated, would similarly be provided with additional skills and experiences to facilitate their own recovery while also sharing their experiences with others. Multiple layers of personal and reciprocal gains were anticipated through the peer interactions, which were enabled by the liaison’s CD work.

This case demonstrated how an OT can assist an institution to first become familiar with and then build upon the strengths and resources of survivors and community agencies, challenging traditional notions of expertise. Through this institutionally-based CD initiative, the valuable contributions of survivors’ experiences were honoured and more equitable community partnerships were fostered.
CHAPTER 5: CASE 2

5.1 Introduction to Case 2

The second case is situated in the mental health field in a small Canadian city. A new health authority program, called Community Links, was established to be the central entry point to community mental health services related to employment, education, and social issues. It had a CD mandate which the OT, Carla, addressed as two primary initiatives: to work with community agencies to build upon existing programs, and to develop recovery education with the aim of empowering consumers for peer support services.

5.2 Context: “The Coming Together of Two Worlds”

The Community Links program came into being to address discord between health and community services. An introduction to this discord, consumer experiences of it, a description of community services and an outline of the development of the Community Links program follows.

A Disconnect between Health and Community Services

The two mental health sectors whose different funding and divergent approaches led to disconnect and discord are hospital-based mental health services that traditionally fell under the health authority’s mandate and funding, and community services, non-profit mental health agencies traditionally funded under social services that had recently amalgamated with the health authority. A community agency manager noted that nearly 80% of mental health services had been hospital-based, resulting in health services receiving the majority of funding and resources rendering the community sector as their “poor cousin” (Colleague, Case 2 [C2]).

This disconnect between hospital-based health services and community services was reinforced by different approaches to service: the health system, best known by the large psychiatric hospital, was guided by the medical model with strict protocols and procedures, which was contrasted with the less-structured, ongoing services of the community sector. The
medical model was criticized as being focused on illness and medication with a low expectation placed on people with mental illness and a belief that health professionals “fix” the individual rather than seeing the person as an active participant in the process. A coordinator noted that “The community views people from the institution as rigid and directive, and the institution views the community as flying by the seat of its pants and not really knowing what it’s doing.”

Consumers’ Experiences

The medical orientation of health services was considered to have negative consequences for service users. The executive director of a consumer group described her perception of the approaches and beliefs of many health workers:

I don’t know if [medical staff] think the consumers can [actually] recover. . . . It comes across [that] a lot of medical staff feel that once you’re a mental health consumer, you’re always a mental health consumer and you always need somebody to take care of you. . . . They don’t think about hopes and dreams. They think, “Let’s get you stable.” (Consumer, Executive Director of Consumer Organization, C2)

Services offered by the hospital were viewed as further disabling people by not allowing them to do things for themselves. One consumer named these as “caretaker” services:

The difference between a caregiver and caretaker is [that if I were] walking down the road and I had a rock in my shoe, [a caregiver] would say, “You can put your hand on my shoulder while you take the rock out of your shoe”. [In contrast] a caretaker would say, “Sit down and I’ll take your shoe off and take the rock out.” . . . That’s where this system is right now. (Consumer 1, C2)

This consumer explained that as a result of the current caretaker approach, she felt “I can’t do anything and I’m not expected to do anything because [staff are] going to do it for me anyway.” Consumer experiences of the mental health system spoke of a disjointed health sector, a “system without a system” (Consumer 2, C2). Active in this region was a consumer-driven organization made up mainly of volunteers with experience in mental illness. Its executive director, the only paid employee, was also a consumer. This organization facilitated provincial peer support groups, fostered partnerships and brought the “consumer voice to the table” (Executive director, Consumer group, C2) in discussions with service providers.
The Community Sector

Those in the community sector perceived their services as involving a “personal touch” with an “informal” long-term “relationship building.” A community manager describes that sector’s approach: “It is truly working with the person. Yes, [the person] might come with a diagnosis . . . but you work with the person first and get a sense of who they are and what they need”.

In the community sector, people stay “connected through the good and the bad”, and supports cover longer periods of time. As the community agency manager explained, the agency supports “people through anything and everything. And for people who don’t have anybody . . . we’ve kind of become a family to them.”

The OTs in this case were concerned that the on-going community services approach could create “institutions in the community” that foster dependence. For example, an employment program that had morphed from an innovative idea into a sheltered workshop and became an institution in the community went against occupational therapy’s intention of “enabling occupation, helping people see what skills they have. [OTs] really focus on their strengths, assisting people in doing things for themselves as opposed to doing it for them” (Manager, C2).

Carla and some of her occupational therapy colleagues were wary of supporting services that did not encourage people to develop the skills to move on. The OTs thought that both services, hospital-based and community-based, had the potential to ‘institutionalize’ people, which challenged typical notions of community and institution:

I think the [hospital] is a community; it’s an institution, but it’s also a community. . . . The danger of becoming institutionalized is when you have all your services in one community and people can’t move out . . . if all your needs are met within one community then you’re institutionalized. And institutions can be in the community [too]. . . . It’s no different than being in the psychiatric hospital. . . . But I think there’s a big danger of becoming institutionalized in the community if you don’t recognize that for what it is. It’s an illness-based . . . supported, community. (Carla, OT, C2)
Addressing the Disconnect – The Development of Community Links

Community and health services in this region were amalgamated under one health authority and, as a result of policy directives, efforts were being made to bridge the divide between them. Considered to be from two “different cultures,” their merging was viewed as “the coming together of two worlds” (Community Agency Manager, C2). A committee was formed to facilitate “enhanced coordination of community mental health services in the city’s area, with particular focus on social/recreational, education and employment opportunities for mental health consumers” (Document - Partnership Committee environment scan, October 2006).

The committee explored the current mental health services to identify and address gaps:

One gap that was clear was that there was no coordinated entry point [to service]. A lot of people simply didn’t know what was out there. There was no one place they could go to get information about what was available and get a person who could help them navigate the system and find the program or service that suited them. (Committee Coordinator, C2)

Services were seen as a “series of parallel efforts” (Document - Coordinating Committee environment scan, October 2006) that left some people without, and many people unaware of, the services available. The new mental health strategic plan emphasized the importance of collaboration, consumer involvement, and accessible services. This change in policy direction created opportunities to improve mental health services.

It’s been very exciting. It’s just constantly [changing]. . . . There’s lots of new things happening in mental health which is very refreshing. . . . I find it’s good timing . . . when people are in that change mode, it’s easier to bring in new things. (Hospital Manager, C2)

The new Community Links program, a product of this new focus, was created to bridge the identified gaps between the sectors. Consequently, it was decided to have this health authority initiative located in the same building as one of the largest community agencies.

We purposely . . . decided to co-locate [Community Links] with a different [community] agency because we thought that it enables us to see other people’s perspectives and how
they work. . . . I think it’s learning to appreciate where others are coming from.
(Manager, C2)

While the close proximity let the programs learn more about each other, differences,
particularly around perceptions of flexibility and staff training, became apparent. The community
sector saw itself as responsive to issues and the health authority as having a lot of “red tape”:

[Those working in health are required] to write up a proposal. . . . They have to do
outcomes. . . . Whereas with us [in the community], if we want to try something different,
we just do it. . . . We don’t have our hands tied so much.
(Community Agency Manager, C2)

Unions and policies were a tangible difference between health and community services
that impacted staff flexibility. For example, during a joint staff meeting the OT inquired about
changing a light bulb (Field notes, house meeting, day 1), because she was not allowed to do this
task in the hospital. This was attributed to the hospital being tied to a union and its policies:

You can’t do certain things because you’re within a unionized position . . . so who’s
going to change the light bulb? Welcome to the non-profit - you are [going to change it]!
But they weren’t allowed to do that [in their hospital structure].
(Community Agency Manager, C2)

The training level of staff and job definitions were also dissimilar between the two
sectors. A health authority manager explained that while the community sector had different
levels of education, many were not professional staff, “so the way that they worked was quite
different than us [in the hospital], which was very clinical oriented.” In contrast, in the health
services there was an emphasis on professional designations, and clearly delineated roles. The
committee coordinator, who has worked in both systems, explained this dissimilarity:

When you work in a hospital you have your expertise. . . . There’s this whole business of
assessment and you decide how many days somebody should attend a particular program.
. . . There are lots of clinical skills used in the community but . . . it’s a much less formal
process, and there’s . . . a sense of everybody is doing a bit of the same job but there isn’t
a big distinction between whether you’re a social worker or whether you’ve been a
teacher or whether you’ve come up from the ranks. (Committee Coordinator, C2)
5.3 Main Activities: Intake and Recovery Education

*Intake and Referral*

As mentioned previously, the OT’s position had two components: Community Links and Recovery Education. The two main Community Links activities were 1) conducting intake interviews with individuals with mental health issues and then referring them to appropriate services, and 2) developing new programs or working with existing community agencies to strengthen the consumer services they provide in the community.

The OT and a social worker conducted Community Links intake interviews. People with mental health issues self-referred or were sent by other organizations and learned of relevant services through the intake process. Services gaps were also addressed, such as the offering of a social group for younger people with mental health issues and a drop-in where low-cost events were shared.

Additionally, Community Links had a CD mandate to partner with local community agencies to strengthen the services they offered by “collaborating . . . to promote and support initiatives in the community” (Field notes, planning meeting, February 2008).

The staff of this new program visited local community agencies to familiarize themselves with the services offered and to identify ways to work together. Under its mandate to "assist groups to expand/explore opportunities for partnership” (Field notes, planning meeting, February 2008), Community Links brought consumers together. For example, artists with mental health issues were brought together to discuss developing an artists’ collective in the community.

*Understanding of Community Development*

For the OT in this case, CD meant building upon existing community resources that were not necessarily health related and building the capacity of individuals and agencies to develop programs, rather than creating new services.
[There are] all these different agencies and groups who are doing all kinds of things in the community. So, we don’t need to reinvent the wheel. We need to be working and partnering with them so that [we can] maybe help them to grow. (Carla, OT, C2)

In this way, Carla explained that CD meant “[figuring] out how you can help the [existing] community to be more involved . . . have a greater say and move on if they want to and [to] provide opportunities for people.”

Recovery Education

Recovery education was the second and main component of the OT’s position that integrated CD. Carla determined, based on available literature, that a recovery approach and peer support were key when working with consumers, allowing the OT to advocate for the inclusion of recovery education as a focus of this position. Recovery was seen as the journey of moving beyond mental health symptoms toward personal growth and empowerment.

The development of peer support services was central to recovery. The focus was on having consumer-survivors share their recovery stories with others. This included developing recovery education sessions and workshops aimed at developing consumers’ skill for working with peers. It was hoped that formal peer supports would develop out of these sessions.

5.4 Community Development Processes

The five main processes of the OT’s CD work are described below. Each is explained in the subsequent sections: 1) Reconsidering the role of the “professional”: Developing “Real Partnerships,” 2) Building upon consumer capacity for peer support: Becoming colleagues, 3) Changing Health Care Services from within: Developing Structures and Challenging Assumptions, 4) Bridging community and consumers: Navigating and redirecting resources, and 5) Bringing meaning and engagement: Developing an occupational understanding of communities.
1. **Reconsidering the Role of the “Professional”: Developing “Real Partnerships”**

One of the key processes in this case pertained to the relationship between the OT and consumers, which was fundamentally different from typical health professional-client interactions. During recovery-oriented CD initiatives, the OT engaged in the process of recognizing the elements of professional-driven approaches and this laid the foundation for developing “real partnerships” with consumers.

*Recognizing the Elements of Professional-Driven Approaches – Becoming a “Catalyst”*

Despite preparation, the OT’s initial attempts to work with community agencies were unsuccessful. A proposal to develop a peer support training program was rejected by a consumer-run organization because it had been initiated by a professional. The OT’s manager explained that the consumer-run organization felt it should be a “peer-driven type of service.” The decision was to have the OT take a step back, to avoid “step[ping] on anybody’s toes.”

This led to critical reflection about the OT’s professional role. The decision was made to help prepare consumers and staff for the development of peer support initiatives by focusing on recovery education first.

A second situation reinforced the OT’s change of approach. The women’s centre was a community agency that provided women with services such as a clothing exchange and regular drop-ins. During her first visit to the centre, the OT offered to augment a number of the groups they had available. In response to these suggestions, she explained that she was told, “The women here don’t like [the health authority]. They don’t like you [since you come from the health authority] and so you need to just get to know them. You’ve just got to hang out with them first”.

Carla explained the dilemma of wanting to work with communities, but not knowing how: “I’ve got all these ideas [but] I’m at the risk of offending people [in the community].” Consequently, she felt as if she was “treading water” and “out of [her] league.”
In response, the OT researched models about CD, relationship building and international development, leading to the realization that in CD the OT’s role was to work with others to build on existing resources to meet the community’s priorities.

The OT’s recovery education and CD role was different from the “professional” intake and referral role. While both considered the consumers’ experiences, the focus in the former role was on consumers’ expertise, knowledge and skills, which were shared with and guided the OT:

I think I have a different hat on when I talk to [consumers who will be co-facilitating recovery sessions]. . . . I’m trying to hear their story and hear what expertise they’re bringing to the table. . . . They’re the ones who are the experts and I’m the one trying to figure out how to facilitate their expertise; how to make them heard [by others]. (Carla, OT, C2)

The OT noted that in CD, OTs must be ready to give up aspects of their professional role. In this case it required letting go of control and working with community agencies rather than individuals. The OT wanted the consumers to participate and control the CD process so they could eventually take the lead. To that end, meetings were deliberately “understaffed” to minimize the number of professionals present.

The reflective process undertaken by the OT resulted in a clarification of the therapist role during intake and referral, and the “catalyst” role in CD. According to Carla, the professional role was characterized by key features: it involved being seen as the expert with information and resources to share, being directive, having access to personal information about the consumer, having time-limited involvement, and feeling a sense of professional responsibility towards the client. The catalyst community developer role involved listening and enabling consumer expertise to be recognized. More subtle differences were difficult to articulate:

I don’t even know how to describe [how they are different], but I think it’s a different [relationship] . . . maybe it’s a power thing, maybe it’s a boundary thing. . . . A therapeutic relationship . . . has a certain boundary . . . it’s time limited. (Carla, OT, C2)

In contrast, with consumers, she explained:

I feel like it’s more of a co-worker [relationship] and I want to know more about their life, not for a therapeutic reason, but it’d be just [for] the personal interest. [For example,]
. . . I wouldn’t want to counsel [one of my co-presenters] through [a crisis]. . . . It’s just different. (Carla, OT, C2)

Similarly, with community agencies, the focus needed to be on their strengths and resources rather than on an assumption of their priorities. Carla described her understanding of working with communities: “We don’t have to move more resources to the community, but rather we have to see the community as a resource, using what’s in the community and who they are already.” She came to recognize the different resources in the community:

Everyone in community development brings something different to the table so you have to be aware of what your skills are and what you’re bringing to the table. . . . That you are only bringing this certain piece of it and it can’t happen without all the others. . . . It can’t go ahead with just you. (Carla, OT, C2)

Carla concluded that the OT needed to bring people together rather than lead initiatives and that believing in consumers’ abilities to be experts was essential to this work. She stated: “We have to believe that [consumers] are the experts and that they can do [it]” because “peers are their own best experts.” Yet Carla admitted that this could be a challenge:

You’ve got to question yourself: how comfortable you are with peers in professional roles? . . . I have this professional in me who knows how to run a group, who knows how to deal with people who are disruptive in groups, who knows what things are appropriate and not appropriate. And one day, I’m going to have to step back . . . and not be a part of it and give that over to peers (Carla, OT, C2)

A fundamental component to Carla’s approach was her belief that “peers work best with peers at every level” (Carla, OT, C2) so, just as consumers were the best people to share their experiences with other consumers, the OT’s main role in recovery education was working with other professionals. Carla noted that she did not bring “the experience piece” to her work:

I think I know what I’m good at and what I’m not good at. I think I am good at consumer empowerment, and I know how to be an OT. But I don’t know what it’s like to be really, really, poor. I don’t know what it’s like to be really, really hungry. I don’t know what it’s like to have schizophrenia. (Carla, OT, C2)

This recognition led to the development of informal partnerships with consumers, which brought together the skills and experiences of both professionals and consumers.
Developing “Real Partnerships” – Showing “[a] Mutual Respect for the Knowledge That We Bring to the Table”

The main partnership in this case was with a consumer who was the executive director of a consumer organization. The OT and the executive director became colleagues in the planning of recovery education sessions and related activities. The partnership developed from an informal telephone call in which they enthusiastically confirmed their shared commitment to recovery and consumer empowerment, a sense of equality, and respect for each other’s contributions. The executive director explained:

We bring . . . [a] mutual respect for the knowledge that we bring to the table and you feel that. And that’s not always something that’s felt in relationships. There are other partnerships [where] I don’t always feel that we’re looked as equals. Sometimes you get the feeling of tokenism. (Consumer, Executive Director of Consumer Organization, C2)

The executive director referred to the partnership with Carla as a “real partnership” in which “I’ve always felt equal, I’ve always felt like a colleague, like a peer.”

The executive director, who also benefited from the partnership, described how she could discuss ideas with Carla as she developed the “tools” to expand her program:

We just pick up the phone. . . . I phoned her last week and I said, “Carla . . . I’d like to take the presentation to [other part of province]. What do you think?” And she’s like, “Oh that’d be great!” And, so it starts here [in the city] . . . and she’ll give me the tools I need to take it across to other regions. We bounce the ideas off back and forth and she’s great at pulling ideas together. (Consumer, Executive Director of Consumer Organization, C2)

In this partnership, the OT was a sounding board, an encourager and a synthesizer of ideas. The consumer organization also gained access to the resources of the health authority where the OT was based and where projects are often developed, trialed and then brought to different regions. The executive director noted that she learned new approaches to team work that she then brought to other partnerships:

Because of that relationship [with Carla], I’ve been able to build . . . with [another organization]. I’ve been able to [bring] the skills I’ve learned with Carla into that relationship and say, “This is a great partnership and this is what we can bring to each other.” (Consumer, Executive Director of Consumer Organization, C2)
These two partners provided a model for building genuine relationships and demonstrated how consumers could work on a team with professionals. The executive director explained:

I’m a consumer and I’m there presenting and they’re seeing that partnership [with Carla, a health professional]. . . . So presenting that to this group shows them that (a) you can start to learn to facilitate . . . so it empowers them to facilitate with Carla . . . and (b) it shows the teamwork approach and that the [health professional] staff do play a part in recovery. (Consumer, Executive Director of Consumer Organization, C2)

This partnership gave the OT the legitimacy among consumers to be able to work in recovery education. Carla was not willing to move forward in developing peer supports without their involvement in the process. Consequently, recovery education sessions were not held when the consumer co-presenter was not available (Field notes, inpatient education session, February 2008).

This partnership allowed the OT to avoid some of the bureaucratic policies and procedures associated with the health authority by letting the consumer organization take the lead on some initiatives, bypassing the need to obtain health authority approval.

Examples of this partnering include: jointly organizing a recovery training session for staff, co-leading wellness workshops for consumers, co-sponsoring a writing/storytelling workshop for consumers, developing the recovery education workshops to be presented to consumers and health professionals, and developing a recovery pamphlet. In each initiative, time was taken to ensure that all ideas were heard and integrated and that the contributions of each were respected. The executive director described this relaxed, inclusive approach:

Carla and I take seriously what each other does. . . . “What are you bringing?” “What am I bringing?” . . . And we just work out the details. . . . We might take our time. . . . We’ve been working on that booklet for, eight months now . . . . I think when it’s done, I think the end product is going to be wonderful, [because] we don’t rush things. I don’t ever feel like I’m rushed or I have to do anything . . . today for tomorrow. It’s a very relaxed relationship. (Consumer, Executive Director of Consumer Organization, C2)
2. Building Upon Consumer Capacity for Peer Support: Becoming Colleagues

The primary capacity-building initiatives in this case were related to recovery education. Peer support services were determined to be a central aspect of recovery:

The more research I did about recovery, the more it was linked with the peer support, and so I was really gung ho to develop peer support services. . . . Staff had to understand recovery and people [with mental illness] had to be empowered to the point where they felt like they could offer that kind of mentoring and leadership to others. . . . How could I help facilitate consumers to take on peer support? Because it couldn’t just be coming from me - it had to come from peers. (Carla, OT, C2)

To this end, the OT focused on enabling consumers to share their recovery stories. The executive director explained that many consumers lacked the skills to do this: “We knew that there had to be a process to get people, consumers, individuals who’ve lived with mental health issues, ready to present and be comfortable enough to help facilitate [sessions].”

This skill-developing process for recovery education and peer support was referred to as “capacity-building.” It involved developing individuals’ skills and developing community capacity. This process created opportunities for engagement and consumers began to feel like responsible colleagues. Consumers were seen to develop individual and collective capacities.

Developing Individuals’ Skills – “It Was About Being Heard . . . Being Validated.”

One capacity-building initiative was a workshop that taught consumers to write and share their recovery stories. On one level, this benefited individuals because “it was about being heard . . . being validated” (Consumer 1, C2). One consumer described the feeling of being among others who understood the experience of living with a mental illness: “When we came together [to share our stories] we realized [that] even though our stories were different, we’re kind of the same, and we can understand each other more than anybody else can understand us”. This workshop served multiple purposes. In addition to sharing personal experiences, it introduced recovery concepts and taught skills in a comfortable, supportive environment among peers. Following this, consumers were invited to participate in other recovery education initiatives.
The OT also encouraged consumers to take the lead on issues important to them. For example, a group of artists were invited to discuss their interest in creating a community art collective. Informal skill development in these sessions was enabled by the OT deliberately doing less so a leader would emerge in the group. For example, the OT spoke less and minimized eye contact with group members so they would not automatically direct their comments to her as the only professional in the room.

Developing Community Capacity – Individual “Engagement Leads to . . . Leadership Roles in the Community”

Such capacity-building initiatives impacted the broader community as well. Following initiatives that built individual skills, the OT invited consumers to participate in community activities. These opportunities for engagement in meaningful community activities simultaneously built capacity at the community level and led to people becoming leaders:

Engagement leads to not only being engaged with themselves and moving beyond illness, but then engagement to help themselves [look] at different roles. Eventually, hopefully, if they want to, [they will consider] work roles or other roles in the community, more leadership roles in the community. (Carla, OT, C2)

Thus the community benefited from these initiatives because leadership skills were fostered. Carla developed a series of participatory activities to help consumers learn about recovery strategies, leading some to share their experiences through recovery education talks.

Carla and a consumer co-led recovery talks given to other consumers and health professionals. The process of how the presentation would unfold and Carla and the consumer’s respective roles was discussed with the consumer. Carla explained that she aimed to “back off a little bit” with each presentation so that the consumer could take on more of a leadership role. This benefited the individual consumer as well as the collective capacity of consumers, because some were becoming co-facilitators who would, in turn, inform others about recovery approaches.
With each presentation, there was the possibility that someone would connect with, and be influenced by the message, as one consumer explained: “In the beginning I would have hoped that at least one person, even though I didn’t really believe it, that one person would have listened to my story and changed. But [now] I see a lot of people changing.” Examples of the various changes observed include: instilled hope, increased confidence, and a growing belief among consumers in their own recovery. Thus, such capacity-building initiatives had an impact on the individual sharing his/her story, they developed leadership skills and they also influenced those who heard the story. In this way, a broad range of people were affected.

The OT in this case saw her role with consumers in recovery education as a colleague and catalyst more than as a therapist. This process of capacity building pertained to the consumers’ experiences of coming to see themselves as colleagues. Recall that people in this case criticized the mental health care system for being driven by the medical model that tried to “fix” the individual. In contrast, the recovery education initiatives included consumers as equal partners. There was a sense that being asked to co-facilitate a workshop validated the consumer and acknowledged their contribution as valuable. As one consumer said: “[Carla] asked me [participant’s emphasis] to go talk to other guys, so I must be doing alright.”

One of the consumers who co-facilitated recovery education sessions spoke of overcoming her skepticism of mental health initiatives and slowly developing trust in the OT. She explained that because expectations of her were realistic, she began to believe she could meet them as a respected colleague:

I have more faith in Carla right now because I realized [in our] relationship that she has expectations of me and she expects me to do things - to show up on time, be places and stuff like that - and it makes me feel like a responsible person. (Consumer 1, C2)

This consumer noted that Carla’s approach extended to other aspects of the consumer’s life in that Carla provided “avenues” for “moving forward”:

I’d like to work as something in the mental health field. So instead of doing it [for me], [Carla] gave me avenues. [She’d say,] “I looked it up and this is where you can look it up
on the computer as well, and here’s the papers, and you can fill them out.” It gives [me] responsibility, and it gives [me] hope that there is a future. (Consumer 1, C2)

This process of capacity-building encompassed individual skill building as well as the creation of opportunities for consumers to share their experiences with others. Initially this was done with the OT’s support, but consumers gradually took the lead, becoming like colleagues to the OT. Carla described her relationship with one of the consumers:

I do consider them [the consumers] more as co-workers because that would be the hope - that they would become my co-worker, [that] the health authority would value their support enough that they would eventually pay them a wage. (Carla, OT, C2)

It was hoped that the consumers would soon become paid employees also.

3. Changing Health Care Services From Within: Developing Structures and Challenging Assumptions

It was recognized that capacity-building among consumers addressed only one aspect of the issue. The other aspect pertained to the orientation of staff, from both the health authority and community services, to recovery concepts and principles to guide services. Hospital staff were perceived to resist recovery approaches, as one of the coordinators explained:

[Health professionals] don’t want to see that they’re doing something that’s holding people back. . . . It’s easy to endorse the whole concept of recovery as long as it doesn’t involve changing your role. Whereas, really [incorporating a recovery approach] requires changing your role to see yourself as a facilitator, [recognizing] that the person [is] in charge of their decisions. (Coordinator, C2)

Staff resistance was important to address because staff in turn limit consumers’ ability to actively engage in their own recovery. The consumer group executive director explained: “Once clinicians start to really support recovery, people [with mental illness] will pick it up because they won’t have the resistance of the staff to do the things that they feel they need to do to stay well.”

This process of making changes within the health care system involved seeking strategic alliances and educating staff, which took place within the psychiatric hospital. The OT, with 10 years experience in mental health services, had access to the hospital staff and was an ‘insider’, as illustrated by her having keys for various locked doors within the hospital (Field notes, February
The main result of this process was a shift in staff attitudes which then influenced the programming offered within the hospital.

**Seeking Strategic Alliances – Developing Structures for Support**

The OT worked to convince her own manager to support CD initiatives and she worked with other managers to get “buy-in” from hospital staff for recovery education. In one situation the OT advocated for a CD fund to assist with small community initiatives. In another, she approached a manager to bring together coordinators to talk about recovery. The hospital manager described this recovery event:

> We had a half day for all patient care coordinators and managers together because we felt that . . . [it was important to] . . . bring this from the top down, that we all have to embrace [recovery] in our own philosophy and then be able to go back to our units and talk [about it]. (Hospital Manager, C2)

To plan educational events, the OT brought representatives from two consumer organizations together with hospital managers to create a recovery working group. People within the health authority who were supportive of recovery and were in positions that could encourage staff buy-in to the recovery approach were strategically sought out. In contrast with the consumer partnerships, alliances with hospital managers were therapist-led and deliberate, with the OT persuading others of the benefits of a recovery approach. Diversity in this group was also strategically addressed by choosing candidates who felt they had a stake in recovery: “I invited people who I thought would be really interested in it . . . I wanted people from different professions because I didn’t want it to seem like it’s just an OT thing” (Carla, OT, C2).

In order to develop the recovery approaches within the hospital, the OT worked with one of the managers to develop a proposal for a paid peer support worker position. At the time, Community Links was paying consumers an honorarium for participating in recovery talks, but the goal was to ensure that there were paid positions within the hospital. Through the proposal for a paid position, Carla assisted in developing structures within the health care system which formalized the involvement of peer supports. This illustrates the intersection between the
preparation of consumers through capacity-building processes with the development of structures that support the system-level influence of these changes.

*Educating Staff – Challenging Assumptions About Consumer Potential*

Hospital staff were presented with sessions similar to the consumers’ recovery session presentations in order to enhance staff understanding and use of recovery approaches in their services. Individual consumer stories were described as powerful. One consumer recovery story had a particular impact because many staff had known her during her hospital admission:

They said, “You would never believe it. It’s like night and day. If you had to tell me ten years ago that she’d be doing this now I would have said impossible . . .” I think that that’s what really makes that particular education as good as it is because . . . the person is standing there, so you can see it, it’s living proof that a person can recover.” (Hospital manager, C2)

The OT supplemented discussions about recovery by being approachable and sharing how recovery can be supported in practice. This OT, a clinician, could relate to her peers from that perspective and was described as engaging in a dialogue about recovery, rather than being abstract or directive:

I’m sure a lot of thought went into how to deliver [the recovery workshop to staff] . . . . It’s presented in a very genuine, down-to-earth practical way that people can relate to . . . . It’s not theoretical, it’s very hands on. (Hospital manager, C2)

Carla was described as “very honest . . . [sharing that initially] she wasn’t sure how [recovery] fit with her own personal philosophy” (Hospital Manager, C2). Acknowledging this uncertainty was thought to validate some hospital staff concerns and open the topic for further discussion.

The introduction of recovery education to staff required examination of underlying assumptions about how staff worked with consumers, which revealed divergent views on recovery and challenged the medical model that dominated mental health care services. In contrast, those working in the community sector considered their approaches to be comparable to the recovery approaches that were introduced. One community colleague commented, “We do recovery, but we just don’t call it that” (Community agency manager, C2). It became clear that
there were different interpretations of what constitutes recovery. For example, in hospital-based health services recovery was often considered an end point for those considered well enough to benefit from these approaches; for community agencies, recovery approaches emphasized the provision of on-going care and support. Both of these perspectives contrasted with the understanding of recovery that emphasized consumer empowerment and leadership. As the OT worked with consumers to share their empowerment and leadership vision of recovery, they brought their different perspective of recovery to both the health sector and community services by demonstrating it in action through their professional-consumer partnerships.

These alliances with managers and recovery education to staff brought changes to the hospital. Discharge preparation increased (Field notes, February 5 2008), and some staff became aware that they were not recovery-oriented. One manager noted that, “Staff have found [the recovery sessions] really powerful. I think it’s made them start to look at how they do things: [asking themselves], ‘Are we offering things that are based on recovery?’” (Manager, C2).

Avenues for change within mental health services were created through these changes in attitudes about consumers and how programming can support recovery.

4. **Bridging Sectors: Connecting and Redirecting Resources**

The OT developed a new way of interacting with consumers and community agencies while also encouraging gradual change within the main hospital of the health authority. These partnerships and alliances were then used to create bridges between health and community services strengthening consumer involvement in programs by creating opportunities for meaningful engagement in the community. Building on her associations with consumers, community agencies and health services, the OT engaged in *informally building relationships and learning about priorities and linking resources with needs*. These processes occurred within the context of her position, which was structurally part of the health authority but physically and
philosophically located in the community. This process contributed to the bridging of people and resources that met consumers’ needs and promoted engagement.

**Informally Building Relationships and Learning About Priorities – Being “Connected With the Community Partners”**

For the OT, building relationships and getting to know the community was the first step in creating bridges between the sectors. The intake and referral role and discussions with consumers helped to determine consumer priorities and interests. With community agencies, these were identified through informal visits. Carla’s approach with agencies was described by her manager as “easy-going . . . informal . . . non-threatening”. A community agency manager echoed this perception of Carla being accessible and connected: “I think the fact, honestly, that Carla has come here right; she’s not a far-off person out there in a crystal palace. . . . Carla has connected with the community partners from my perspective”.

The OT used the new Community Links program as an initial reason for meeting with agencies, to learn more about their priorities and ways they might work together. The OT strengthened the relationship with agencies by supporting their initiatives. Many community agencies were visited and the possibility for partnering was always on the agenda. Despite the deliberateness of this process, Carla referred to the resulting relationships as “flukes”, suggesting that she underestimated her role in making such connections.

**Linking Resources With Needs – “Part of My Job. . . is to Try to Help Get Some of That Money Out to the Community”**

The OT came to know the broader community and individual perspectives in a variety of ways. The priorities of the agency and its constituents were known through visits to community agencies, an understanding of some consumer concerns or experiences resulted from intake and referral work at Community Links, and consumers provided feedback on sessions presented.
This knowledge allowed the OT to act as a broker between the different groups. For example, when a consumer had suggestions for improving groups offered at a men’s shelter and the OT knew the shelter was open to developing additional programming, an attempt was made to link the consumer with the shelter’s manager. The OT described her thoughts during this linking:

> How can I bridge [them]? How can I help him [to] . . . influence the [homeless centre for men]? . . . Just the way the communities are set up, he might go to them and say you should do this . . . [and] they may not listen to him. . . . If part of my job is to help peers develop, then I see that as part of my role, helping the [homeless centre for men] to listen to him and helping him influence the [centre]. (Carla, OT, C2)

In this way, consumer perspectives were integrated into existing programs by mediating discussions between consumers and agencies, with the OT sharing the profession’s credibility with the consumer in order to ensure that his ideas were heard.

A number of artistic consumers in the community did not have access to art resources other than those offered through the psychiatric hospital-based art program. Community Links invited them to discuss their priorities and concerns around art opportunities in the community. The OT had previously visited a number of community agencies with links to the arts and she linked the artists with those agencies (Field notes, art collective meeting, Day 1). In this way, consumers were connected with each other and to the existing community resources that might help them develop an art collective. As one of her colleagues explained: “Although [Carla is] connected to [professional] staff, she’s kind of a bridge. . . . She understands [the health system] and yet she understands the not-for-profit side and the struggles in the not-for-profit, and the individual” (Consumer, Executive Director of Consumer Organization, C2).

The OT also created links between the health authority and community services. Part of that process involved redirecting resources from the well-resourced health authority to the under-funded community agencies. The power of health authority was such that Carla had to “hold [it] back” so that it didn’t overshadow the community agencies:
[The health authority] has a lot of money and part of my job, I think, is to try to help get some of that money out to the community. Maybe [the health authority doesn’t] think that’s my job, but I feel like it’s my job. (Carla, OT, C2)

The OT linked her knowledge of a cancelled hospital-based sewing program with a women’s centre with limited resources. After determining the level of interest in the idea of a sewing program, the OT negotiated the provision of resources (e.g., sewing machine, material, and staff) if the centre provided the space and participants (Field notes, February 12 2008).

At other times, the OT disassociated from the health authority, recognizing that this relationship could be a hindrance. An example of this was the development of a recovery pamphlet that did not display the health authority logo because partnership in this case would delay production:

[There would be a lot of] red tape that we would have to go through to produce this booklet [through the health authority]. . . . But if [a community agency] does it, it doesn’t have to be that meticulous and it doesn’t have to go through 70 hands before it [gets a] seal of approval. (Consumer, Executive Director of Consumer Organization, C2)

The negative connotations associated with the psychiatric hospital, and consequently the health authority, made disassociation from health services advantageous for Community Links because it was more appealing to potential participants. One of the occupational therapy assistants (OTAs) explained that

We technically still work for the [psychiatric hospital], but it’s not where we’re associated anymore. People don’t think of us as [the psychiatric hospital program] . . . which is what the goal is. . . . The stigma’s being taken away for people. . . . It makes people much more comfortable to come in and talk to us and to come do our groups. (OTA, C2)

The OT’s unique position between health and community services allowed links to be built at the individual and program level. Her manager described this process:

It’s really looking at the needs of the individuals that she sees as she’s been meeting with people through intake and referral, trying to identify what their needs are, being able to see where the gaps are in services in the community, and in . . . trying to then spearhead some of the agencies to be willing to partner with Community Links to help build or grow what they [already] offer. (Manager, C2)
In this way, the resources of the inpatient sewing group were linked with the community-based women’s centre, and the hospital-based art program members were linked with the resources of community art organizations. In-patients were linked with the consumer-run organization through recovery talks. Because members of the consumer organization co-presented with the OT, recovery talks provided the opportunity to introduce their purpose, and invite others to join them.

The OT was a health authority staff member, worked in the community, was situated between the health authority and community services and was located in the building of a large community agency. This provided an opportunity to learn about the agency, allowed for a better understanding of community, and decreased the cultural divide.

Community agencies were initially viewed as creating “mini-institutions” because they provided ongoing support and services, which created dependency by “doing for” consumers. Carla initially saw it as undoing much of the work of health services, where

[we] spend a lot of our time trying to get people away from [ongoing supports]. . . . We provide services to make people independent, so they don’t need us anymore. . . . Our energy is spent on pushing people away in some ways and here’s [the community agency] taking all the people that we were pushing away. . . . [After] all this work we’ve done to make people independent? (Carla, OT, C2)

Carla admitted to having a simplistic view of ‘community’ initially, assuming that she would tap into the mainstream community when working in CD. She came to recognize that a range of smaller communities arose from services that met people’s needs, that some people in the community may require ongoing support, and that providing a meal (which could be criticized as offering charity or “doing for”) can be very natural and appropriate within the community. She came to appreciate that such gestures could allow service providers to meet people “where they were at” and thus they contributed to building trust. Consequently, Carla came to appreciate the need for a range of services, including those of which she had been critical. In this way, she took
on a more moderate view, and was genuinely able to appreciate the strengths of a range of services. She described her newly developed stance on this:

Both [health and community services] are necessary. You don’t want people [to be] part of the healthcare institution, but once they’re out in the community they have nowhere, and they need peers and they need support, so [the community agency] has provided that community. . . . I think they’re both really necessary. (Carla, OT, C2)

As a consequence of these bridging processes, resources were redirected as needed and consumers were provided with opportunities to use their experiences and expertise to shape programs. Because links were being made between community agencies and consumers, the OT expected to step back as consumers took on more leadership roles.

5. Bringing Meaning and Engagement: Developing an Occupational Understanding of Communities

The OT saw her CD work as occupational therapy because the two aspects of the job, Community Links and recovery work, interconnected and drew upon the occupational therapy background. On top of this, information was required and her typical approach was adjusted for working in CD. The occupational therapy perspective consisted of drawing on occupational therapy knowledge, skills and approaches and expanding upon occupational therapy foundations.

Drawing on Occupational Therapy Knowledge, Skills and Approaches: “From an Occupational Therapy Perspective We Bring Purpose and Meaning and Engagement”

The OT’s CD work emphasized recovery education and building partnerships, with the hope that the community would change to provide more opportunities for consumer engagement. While she differentiated her role in intake and referral from her CD work, she saw them both relating to individual client goals:

I think [the intake part of my job and the community development initiatives are] a bit separate. I think the community development side is on a different level. I’m hoping we’re changing the communities so that people can access it more and there’s more opportunities for the people after they’ve had intake. But I see the intake more on an individual level as opposed to a community level. . . . You’re just helping that person achieve whatever goal it is they want with what’s out there. So that is where the
Community development piece fits in, because usually what they want is not out in the community. (Carla, OT, C2)

Community development was thus seen as a community-level strategy to meet the needs identified by individuals in intake and referral processes.

The OT drew upon occupational therapy knowledge, skills and approaches in a number of ways. For example, best practices in recovery were found in literature and brought an evidence-based foundation to the work. Working with individual consumers on recovery education skills during the writing workshop or wellness sessions drew upon occupational therapy skills. The OT’s familiarity and clinical understanding of mental health issues was appreciated by her consumer colleague. Tasks were analyzed, broken down and graded for others to do. Occupational assessment approaches were applied to communities:

How do you look at the needs of the community? I don’t know. I guess you just talk with people who are there. . . . You look at the same kind of aspects you’d look at the individual, I suppose. You look at their basic kind of self-care needs, just on a larger community level. . . . So whether there [are] community leisure needs. . . . You try to be a bit more general as who goes there and what the needs of that population are. (Carla, OT, C2)

Many of the profession’s values also helped the OT to embrace recovery:

I think recovery is very similar to OT [occupational therapy]. A lot of what OT speaks to, like the idea of client-centredness, empowerment, and the idea that there’s cultural and societal influences on people - all those things fit in with the recovery model. . . . OT is all about seeing the whole person and seeing their society they live in and their cultural influences and spiritual [influences]. (Carla, OT, C2)

Carla’s occupational therapy approaches were evident when she focused on a person’s or organization’s strengths in order to build on their existing capacities, and was guided by the goals and priorities of consumers or the community agency. While this approach seemed like “common sense,” Carla came to realize that it was a unique perspective in the health care field:

It seemed like such common sense. You would just help the person do whatever they wanted to do . . . but in the health care field it’s not always about that. . . . I think it’s a really important thing to bring to health care. (Carla, OT, C2)

The OT, who saw that she brought “purpose and meaning and engagement” to her individual and
community work, explained the importance of this unique perspective in CD:

There’s all sorts of great things going on in the community. So why do I think [OTs] need to be involved in community? It is because I think from an OT perspective we bring purpose and meaning and engagement. I see a lot of people disengaged in the community, and [my focus is] how to help them become more engaged. . . . I think that’s a good role for me. (Carla, OT, C2)

Expanding Upon Occupational Therapy Foundations: “I Needed to Look Somewhere Else to Figure Out How to Approach [Communities]”

Despite these many compatibilities, Carla thought there were distinct ways she was not a typical OT and there were areas to develop for the community parts of her job:

The OT piece I think is [that] people need to be engaged in meaningful activity. . . . You can’t just go in and build birdhouses or whatever . . . just to keep people occupied. They’d have to be meaningful [activities], so I think OT took me that far, but how to find out what’s meaningful to people [at the community level]? I needed to look somewhere else to figure out how to approach that. (Carla, OT, C2)

The OT sought out models that showed her how to approach communities effectively and she sought information on international CD that spoke of participation and empowerment, concluding that OTs must see how occupational therapy relates to CD because

There is a disconnect about how to engage a community into figuring out what is “meaningful” for them. That’s where a big piece of what OTs have to think about is - that relationship building. . . . I think it fits right in with client-centredness, it’s just on a different level. So, as OTs we have to think about community as a client and how to engage the community. (Carla, OT, C2)

Although OTs were considered to be good at listening one-on-one, Carla was uncertain of how OTs could apply this skill to a community. In this context, Carla needed to develop her relationship-building skills and consider client-centeredness at a different level. Carla explained that she was "looking for what’s real for people, what’s really out there in the community and what’s really meaningful.” She doubted if this was the approach of all OTs who claimed to be client-centred and felt that therapists often brought the “the bias of [their work] institutions.” She suggested that OTs tend to bring their attitudes and approaches from the institution into the community, rather than developing new ways of being that are appropriate to working with
communities. Carla also identified that the sustainability of projects needed to be considered and planned for in CD and was an area she felt needed further development.

Carla’s understanding of the notion of professionalism and the degree to which she involved consumers was also thought to be different from other OTs:

I see my professionalism differently than some OTs do, I think some OTs feel like they have to do certain things to be professional OTs. But I don’t see that as much. I don’t think I have to . . . look like a professional or I don’t have to talk to people about certain things. I just think I’m probably more relaxed than most OTs. . . . I don’t get as caught up in the whole professional thing as a lot of OTs do. . . . And I think the degree or the way I involve consumers is sometimes different than other OTs. I think I’m more comfortable with them having a bigger role in what I’m doing than other OTs are. (Carla, OT, C2)

Carla did not focus on her status as a health professional and she deliberately encouraged consumers to take on a large role in initiatives. Carla’s main consumer colleague reiterated that she did not perceive Carla as an OT, but rather as an “equal.”

My impression of Carla has never been an OT. I’ve seen her as a peer support person; I’ve seen her as a resource person, but not as an OT. . . . I know she’s OT but I see [our relationship as] very equal. I see we both bring some real elements to [our work together]. (Consumer, Executive Director of Consumer Organization, C2)

Study participants identified issues thought to limit OTs working in CD. This helped to identify key factors that supported Carla’s unique position in CD. The occupational therapy practice leader explained that OTs tended to be socialized to believe that what they offer is fabulous and it’s the answer to a lot of stuff. . . . “You’re a professional, and you have a Master’s degree!” . . . There’s a lot of privileges and obligations that go with that, and then the reality of working in the community is a different reality. (Practice leader, C2)

Previous discussions about discrepancies between health and community services have described this “different reality.” The community sector was described as having greater variability and less security because of the lack of unions. The practice leader believed that as OTs became comfortable in institutions, many were “fearful or uncomfortable with the idea of going out into the unknown” of the community. Extrapolating from this, two key features contributed to the OT’s ability to engage in CD. First, she differentiated between her professional
clinical role and her CD role, which she felt was more “relaxed” and “not as caught up in the whole professional thing.” The OT was flexible and recognized she brought only one small piece to potential community solutions, an approach that was compatible with working in the community. She had learned a different type of relationship between the consumer and health professional from her previous work with the sheltered workshop. This was reinforced during her initial, unsuccessful attempts to initiate change in the community. Second, the health authority mediated the potential job insecurity that often comes with community work by creating a position that was mandated to work in the community. In this position, Carla continued to receive the pay and security of a position in the health authority, yet had the flexibility of working with and developing the community.

5.5 Case Summary and Key Features

The historical context of a discord between health and community services surrounds this case. The health care system, from which the OT came, had a strong medical focus. In contrast, the community sector, in which the OT worked, focused on providing ongoing supports to people in the community through the Community Links program. Its primary purpose was to refer people to appropriate community services and to work with local agencies to strengthen their programs.

This case provided an example of CD used in conjunction with a recovery vision. The philosophy of recovery guided the work of the OT and CD provided strategies for strengthening recovery education. Central to this work was the initial reflective process whereby the occupational therapy role shifted from “therapist” when working in intake and referral to “catalyst” when working in recovery education.

This case illustrated the early developmental stages of a CD initiative. Through partnerships, opportunities to build individual and community capacity were created. The OT developed strategic alliances with managers and educated hospital staff. Moving between sectors,
the OT linked resources with needs to strengthen community programs. The OT drew heavily on her occupational therapy background that grounded her in meaning and engagement. She explored international development literature that helped to frame her CD work. Although CD from an occupational therapy perspective required a differentiation between the therapist and catalyst roles, clinical interactions exposed the OT to concerns shared with consumers which subsequently informed the CD work.
6.1 Introduction to Case 3

The final case examines a seniors’ health program led by Evelyn, an occupational therapist (OT), and a nursing colleague. This seniors’ health team (referred to hereafter as ‘team’) was set up to address the needs of a large seniors’ population in a mid-sized Canadian city. The team was governed by the local health authority, but was based at a community seniors’ centre. They offered health clinics “on wheels” in seniors’ residences where preventative health check-ups were performed. Programming expanded to include wellness initiatives (health information sessions and support groups) and physical activities (senior-led exercise groups and walking programs).

These programs offered seniors the opportunity to take on a range of volunteer and leadership roles in promoting community growth and development. In one instance the team liaised between older adults and local students who created decorations for the downtown area. More recently, the team expanded into another area of town, illustrating the ways in which an established program revisits processes of getting to know a community as new services are initiated.

6.2 Context: Health Services Embedded in the Community

Three factors helped shape the context of this case, ensuring that the health needs of the community’s seniors were met: the health care system within which the team was developed, the seniors’ centre where the team was based, and the seniors’ community in the area.

The Development of the Team

Approximately 8 years previous, the city health authority recognized the growing health needs of its senior population. To address these needs, it established a team based on another province’s successful model of an outreach team which included an OT and a nurse. The team’s
members were initially hired into profession-specific positions, but these eventually merged into that of a ‘Team Facilitator,’ a title they shared, with profession-specific tasks within it. This eliminated pay discrepancies.

Around the same time, the health authority developed a CD framework to guide its services. It consisted of three components: locality development, intersectoral networking and organizational capacity building. Perceptions of the extent to which the team contributed to the framework or was influenced by it ranged from the team’s practices being closely aligned with the framework guidelines, to the team’s work informing the framework; and from the OT claim of general CD principles resulting in only a marginal influence, to the reported lack of awareness of the framework guidelines by the other team member. The institutional support for CD provided by the framework supported the work of the team even though the team did not explicitly reference the document.

The team partnered with a large property owner, described as “a great supporter for all things senior”, who recognized the importance of providing health services to the growing elderly population within his buildings. In return for providing mobile health clinics at the owners’ apartment buildings, the owner granted the team onsite office space. This led to the team offering clinics in additional apartment buildings and community centres, and expanded their wellness services to include enhanced accessibility in the apartments, improvements to the grounds and exercise groups. These initiatives promoted the team within the area’s seniors’ community.

**Seniors’ Centre**

The seniors’ centre had a large membership, offering social activities, information sessions (including a monthly wellness clinic run by the team), and volunteer opportunities. The centre staff regularly met with the team to discuss program planning and joint hosting of events.
Evelyn noted that basing the team at the seniors’ centre was crucial: “It makes the most sense for us to be out here in the community attached to the seniors rather than to the healthcare building.” The seniors’ centre manager remarked that “we think of [the team members] as ours.”

The Seniors’ Community

‘Community’ in this case is defined by a geographic location; the team was mandated to provide services to seniors in one specific area of the city. One colleague maintained that the number of businesses that had closed and a rise in graffiti vandalism negatively impacted pride in the community. The manager of the seniors’ centre described area neighbourhoods as “diverse,” with “a similar demographics to the inner city” that included issues of poverty and safety.

On the main street were found local businesses, money lending agencies, strip malls, vacant lots, single-dwelling homes and high-rise apartments (Field notes, November 28 2007). The seniors’ centre manager commented that “there’s no malls down this way, there’s not a lot of restaurants down this way, it’s kind of strange.” The area’s low rent drew people on limited incomes. Limited financial resources were consequently a shared concern for a number of seniors.

A large Mennonite and Eastern European immigrant population lived in the area. Their strong work ethic and desire to give back to the community, traits ascribed to these groups by some of the research participants, may account for the area’s large number of senior volunteers, along with a strong sense of community and connection:

In the south side [of the city] it was harder to get people to volunteer . . . and it’s striking to me that volunteerism [in this area] is much easier to work with than it was down there [in the south side] . . . . [Volunteer activity] also helps build community. (Senior and board member, C3)

Some seniors faced challenges stemming from changes in their roles that resulted in the loss of productive and meaningful activities. Social isolation was cited as one such challenge:

A lot of people, as they age, were losing their mobility. . . . Not because they were physically unable to move, but because they had moved into an apartment where they
didn’t have a garden, and when you have a garden you talk to your neighbours, and so the whole issue of isolation [arises]. (Senior and board member, C3)

Some seniors felt they were “missing something” as retirement changed their roles, yet could not identify the source of the loss. Evelyn described the many changes that might impact a senior:

[For the older] generation, [the belief is] you work until you die or the old farm way of life where you kept working. . . . For folks in [the city], you were more likely to have worked at a particular job and then that job ends and [although] you still have a home to take care of, that doesn’t take up as much time . . . and as a housewife who’s widowed, all of a sudden nobody cares if you don’t put the dinner on the table at five o’clock . . . . What we get from a lot of people is that there’s something missing. (Evelyn, OT, C3)

One senior’s experience of retirement illustrates these challenges:

I didn’t know what I was going to do [moving here after retirement]. . . . I tried to adjust and it was very hard . . . . I was always self-employed, worked very, very hard, and being in family businesses, sometimes I worked seven days a week. So you know when you’re a workaholic it’s hard to adjust. . . . What was I going to do now? (Senior, C3)

6.3 Main Activities: Health Clinics and CD Initiatives

The team focused on 1) providing health clinics and individual health services to seniors in the community; and, 2) developing the local community by “mobilizing the gifts of seniors” to connect them to resources and volunteer programs. These key activities are described below.

Health Clinics

Team members spent a significant amount of time at health clinics in apartment buildings or community centres where they met with seniors individually to review medications, follow up health concerns, and make referrals. Mobility screening was conducted with any residents who indicated walking difficulties (Clinic field notes, Day 1 and 2, November 28-29 2007). Home visits were scheduled as required. For example, when one resident’s meal preparation ability was questioned, the OT offered to conduct a home visit (Clinic field notes, Day 2).

The team also advertised community health events at these clinics, such as health education talks on diabetes, arthritis, bladder control, memory, and mental health issues. Out of these events arose health-related support groups established and facilitated by the team which
featured guest speakers and the sharing of experiences: “[Most important] is what they learn from one another. That’s what we really look at, learning from one another” (Colleague, C3).

**Community Development Initiatives**

The team had taken part in various CD initiatives over the years. In particular, three initiatives demonstrate the type of CD programs that the team supported: mall walking and exercise groups, a neighbourhood beautification project, and the community network committee.

The mall walking and exercise groups were initiated in apartment buildings where there was an interest and need for accessible exercise opportunities for seniors. Mall walking programs were a strategy that encouraged seniors to stay active during the winter. The team’s initial involvement was reduced when one senior was asked to take on the task of greeting new participants.

The neighbourhood beautification project developed out of the recognition that there were limited neighbourhood resources and facilities:

> Every time we’d drive up and down the strip or . . . visit someone in their home [in the neighbourhood], we had nothing to offer them, because there was nothing happening in their neighbourhood that we could identify unless they belonged to a particular church. There really was very little for them right in their community area. (Evelyn, OT, C3)

The area in question showed recent signs of wear, despite its history of neighbourhood pride:

> The sense of pride in the community was kind of an issue. It’s a long standing community that had a lot of pride. . . . Older adults are proud to tell you . . . that’s where they were born or raised, it’s that kind of thing. But not so much anymore, because it has kind of become a low income area and [has] a lot of rundown homes. (Evelyn, OT, C3)

A committee of community members was formed to select small projects to beautify the neighbourhood, help build a sense of community and raise awareness about the team’s health services. The committee, made up of local seniors, a business owner, a city representative and school representatives, met monthly to discuss their vision for the community. Activities were prioritized, beginning with the building of flower boxes: funding was secured, senior volunteers built the boxes, and local students painted the boxes which were then displayed on the main
street. The success of this initiative led to other projects including a local newsletter, lamppost banners, a mural highlighting local sports heroes and Christmas decorations hung on the main street.

The third CD initiative was a community network committee, dedicated to awareness-raising about available community resources and addressing identified gaps in services that brought together individuals and organizations to create “caring communities” for seniors. The mission of this network was to provide “opportunities for growth and support for interdependent living and well being within [our] neighbourhoods” (Document – meeting minutes).

The network committee organized community meetings and sought out church groups, social clubs and other community organizations to share information about their respective services. For example, churches were brought together to discuss each congregation’s services for seniors. At another meeting, social coordinators from different apartment buildings gathered to share their ideas for reducing social isolation within their units. These community meetings helped make seniors aware of local resources and addressed gaps in services.

The network committee also served as a forum for bringing forward local issues. One committee member raised a concern about the lack of community resources available for her son who was living with a mental illness. This was of particular concern for her as she aged: “We’re seniors. We’re not going to live forever and we need help. . . . Something has to be done for our loved ones [with mental illness] because we’re not always going to be here and then what happens?” (Senior, C3). With the team’s support, this senior organized a workshop to address this issue, and eventually set up a support and advocacy group for family members of people with mental illness.

*Understanding Community Development*

These initiatives built upon existing community resources to address priorities identified by seniors. In each initiative, team members brought seniors together into groups with common
concerns, with the group’s activities guided by agreed-upon priorities. Therefore, although the team initiated such meetings, they responded to the community’s concerns, and succeeded in addressing individual issues while making the community a healthier and better place for seniors.

6.4 Community Development Processes

A description of historical, social, and physical circumstances of the team serves to situate the processes and interactions that shape the context of this case. Within this context, five key processes of CD emerged: 1) Fostering mutually beneficial community partnerships: “They are a part of us,” 2) Working parallel to health services: Providing innovative health services and recruiting volunteers, 3) Building upon local capacities: Tapping into seniors’ talents, 4) Establishing connections and supports: Expanding into new areas, and 5) Being “interchangeable”, yet unique: Leading from behind.

1. Fostering Mutually Beneficial Community Partnerships: “They Are Part of Us”

A range of large and small partnerships enabled the team to carry out its work. The main partnership involved the seniors’ centre, whereas the smaller ones involved property managers or local council representatives. The key sub-processes of working collaboratively and bringing different strengths fostered and strengthened these partnerships. While each partner benefited, more was achieved together than was possible alone, resulting in an apparent merging of the team with the seniors’ centre, such that they were perceived to offer “seamless” services to seniors.

Working Collaboratively – Building Upon “A Common Goal of Wanting the Best for Older Adults in the Community”

The seniors’ centre and team had a similar vision and shared values regarding health and wellness promotion among seniors in the community. The team and its partners championed
active seniors and valued their contribution to the community. Combining their efforts made sense:

I think we share a common goal of wanting the best for older adults in the community... Why would one organization, one team do everything when you know that you can work together and you complement each other with what you’re able to offer folks? It just makes sense. (Seniors’ centre manager, C3)

Similarly, the smaller teams involved felt there was a shared vision for seniors and the community. As one business owner expressed it: “It was nice to be able to sort of get [our similar visions] to work together and to see how much the same they were, so it was really good. I guess you’d call it almost like an alliance that was formed between us.”

Personal relationships were actively nurtured beyond essential partnership activities. For example, the team and the seniors’ centre staff ate meals and enjoyed social activities together. The seniors’ centre manager clearly valued these relationships:

We know... and understand one another besides just within these four walls. Everybody just seems to be on the same page and there’s just such a willingness to cooperate and work together. There’s not a lot of “this is my turf.” (Seniors’ centre manager, C3)

Relationships were also nurtured between the team and other community partners. The property manager pointed out that “you can’t regiment need” among seniors, and felt the team’s “casual” approach was similar to his own. Neither he nor the team were weighed down by bureaucracy.

Beyond the partnerships’ specific activities, partners also supported, advertised and attended the others’ events. Team members carried with them advertisements to distribute for upcoming community events. To enable this mutual support, regular communication was key:

We work together on a number of different initiatives... [and] also communicate regularly. ...It’s good for us to know what [the team is] doing in the community, it’s good for them to know what’s being planned here so that we can work together to provide the best to the older adults in the community. (Seniors’ centre manager, C3)

The team’s presence at the seniors’ centre greatly facilitated their partnership:
If we’re here less, this relationship might falter, which means we’re not going to be as good at what we’re doing in the community. . . . This [relationship with the seniors’ center] is the relationship that we have to really . . . foster because this is the one that really makes it all work. (Evelyn, OT, C3)

Building on a shared vision, fostering relationships with partners, and locating the team at the seniors’ centre created the conditions to nurture these relationships.

*Bringing Different Strengths - “Their Presence Raises Our Profile”*

Tasks were divided between partners according to their strengths. For example, one team member noted that they worked towards a “vision” of a healthy community, while the seniors’ centre implemented the activities that would help to realize this vision. The property manager felt that the team had knowledge of the “concepts” or theoretical approaches on how to address issues that matched the “needs” of the residents in his buildings. The team brought a health perspective which supplemented the social activities of the seniors’ centre. In contrast, the seniors’ centre and other community partners offered valuable resources, including “a ready-made client base”, venues for activities, funds to support new ideas, and logistical support to implement programs.

Monthly health clinics offered by the team at the seniors’ centre were believed to enhance the status of the seniors’ centre:

[The team’s] presence here makes the world out there see us as a helping agency, so their presence raises our profile. . . [we’re] not just a place where people come to play cards, or carpet bowling or . . . that kind of old folks’ stuff. [Instead] it’s a place that’s viewed as life-giving. (Board member, C3)

The team’s activities led to contact with a range of seniors from the community, resulting in widespread advertisement of the seniors’ centre activities; in one instance, the centre’s staff accessed the team’s contacts, enabling seniors to take part in a university-led research project.

Community partners benefited from working with the team: the property manager noticed that “happier,” “more contented,” and “healthier” tenants developed from the team’s activities, bringing a new stability to his tenant base. The team also benefited from these relationships:
[The team is] almost always present, taking part in [seniors’ centre events]. . . . So that’s . . . the basis of visibility. People know who they are and feel comfortable with them. That’s so important that people don’t see them as somehow very clinical. [Instead] they see them as approachable . . . so access is really important. (Seniors’ centre board member, C3)

The team drew on many volunteers and volunteer opportunities in the seniors’ centre to assist with programming. The seniors’ centre logistical support, assistance with funding requests and grant management was invaluable, particularly as the team’s health authority connection made them ineligible for some grants. Evelyn referred to this as the team’s “infrastructure.”

A consequence of the partnership with the seniors’ centre was that the team was perceived as integral to the centre and consequently the area’s seniors’ community:

Our goal is to provide as seamless a service as possible to the older adults in this community. So we want people to see us as a team, and I think they do, particularly the folks that come here. . . . They’re so much a part of the life of the seniors’ centre.

(Seniors’ centre manager, C3)

One seniors’ centre’s board member emphasized the team’s inclusive status: “They are part of us.”

2. Working Parallel to Health Services: Providing Innovative Health Services and Recruiting Volunteers

From their inception, the team offered health and wellness services to the community’s seniors. These services functioned parallel with other institution-based health services, and were therefore outside many of the typical structures and constraints of the health system. As a result, the team’s services were perceived as more accessible, caring and responsive to seniors’ needs than traditional hospital-based services: “The hospital setting is such a busy place that there isn’t enough contact with healthcare professionals to sit and talk [seniors] through things . . . [seniors] need support. [The team has] cell phones. They’re always available” (Business owner, C3).

Two features of this parallel service were coined as: “thinking [and being] outside the box” to provide community health services, and “being more than just about physical health”.

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“Thinking [and Being] Outside the Box” - Developing Responsive Services

The team was able to circumnavigate some challenges posed by typical health services, partly due to the team’s composition. The nurse team member dealt with health issues and made referrals or physician consultations when necessary. Evelyn, as the sole community OT employed by the health authority, could directly provide occupational therapy intervention rather than outsourcing care. She was able to quickly conduct home visits that would take weeks through typical health channels.

The team offered accessibility by traveling to seniors’ home and communities, and flexibility by responding formally and informally to immediate issues. The property manager of the residences noted the values of this: “There’s so much benefit to being available when you’re needed.” Furthermore, the initiatives developed, based on community requests or observed needs, spoke to the team’s responsiveness: “For [the team’s programs] they look to the community. There’s some basic stuff that they continue to do, like they’ll continue doing their clinics, the one-to-one, but certainly if the communities ask for something, they will do [it]” (Manager 1, C3).

In response to requests for increased activities in apartment buildings, the team worked with social representatives and initiated exercise programs. This flexibility was encouraged by the team’s managers, who approved of the team’s creativity in meeting seniors’ health needs:

We’ve had a lot of support from management. . . . When we were first hired, we were definitely told “think outside the box, [to do] whatever you need to do. You’ve got the support to do it. . . . We want you to try things that are new and innovative.” . . . So that’s what we did. (Evelyn, OT, C3)

The team was required to attend occasional primary healthcare meetings, since they were structurally bound to the health authority’s primary healthcare teams. Generally, the team felt this interaction was not a “good fit” because of differences in their approaches and emphasis. Furthermore, one team member felt that health authority employees tended to follow an “authoritarian” medical model, and questioned whether their managers fully appreciated the team’s community-oriented work. These reactions may have been responsible for the impression
that the team’s programs sat at the fringes of the health authority. Tension existed between traditional services and the innovative approaches of the team; Evelyn admitted that the team was “trying hard” to remain outside of the traditional health care system:

Since [the health authority] has gotten bigger . . . we’ve become worried that they might want to pull us into that system more [but] . . . we’re where we need to be. . . . If this is the kind of service that we’re supposed to be providing, then it makes the most sense for us to be out here in the community attached to the seniors rather than to the health-care building. (Evelyn, OT, C3)

When a new community health center was built, the team and the seniors’ centre feared that the team’s relocation to the new site would associate them with the health authority: “[This] would distance [the team] somewhat. They would have to work harder . . . to build relationships . . . [In the seniors’ centre] they have a base group to work with” (Board member, C3). The team’s support from management and embedded location contributed to their success.

“Being More Than Just About Physical Health” – Recruiting Volunteers

The team became known as “very dedicated caring people,” who saw the “whole person” and “believe[d] that people, in fact, can live healthy lives.” The seniors’ centre manager saw the team’s approach as fostering relationships and building trust:

I think part of the way they present themselves is being more than just about physical health . . . . If you see somebody who cares about you then you sort of trust them [to] . . . follow through with things they say they’re going to do . . . . I think they show that they want the best for you no matter what and I think that really helps with the relationships that they develop with seniors. (Seniors’ centre manager, C3)

The team brought a personal, genuine approach to their interactions with seniors, as evidenced by informal visits. Interactions with seniors often began casually, with initial contact followed up with a phone call; if necessary, a future clinic appointment for that individual was scheduled. Team members maintained contact with and discreetly monitored seniors through clinics and programs. Evelyn spoke of “keeping an eye” on one senior whose cognitive issues may have led to increased vulnerability. Evelyn chatted with the individual, asking questions regarding support and listening for any indications of concern (Field notes, November 20 2007).
Similarly, residents would drop by health clinics to say hello, and were greeted by name. Ongoing relationships were fostered by the team so that formal or informal concerns could be addressed.

The seniors’ centre manager encouraged the team to expand their services to another area of town with similar health needs. The manager supported the team’s approach and understood that time was required to learn about a community and establish trust within it:

The older generations aren’t going to just jump up and . . . take a class in yoga or seniors’ tai chi. They want to know who it is they’re dealing with, trust[ing] the fact that they’re providing them with safe care. And so a lot of what they’re doing right now in those building[s] is making those relationships. And for me, it’s something that just has to be done. (Manager 2, C3)

This manager believed trusting relationships account for the success of health initiatives:

“Networking is really what [the team is] doing, and it’s the network then that will support the programs once [the team is] gone. So those are crucial pieces that need to be put in place” (Manager 2, C3).

The emphasis on relationship-building created trust within the community, and people began to share issues beyond the original health concern that brought them to the clinic. Consequently, team members were able to address deeper social issues facing seniors:

It’s often health issues that lead to people being able to participate in other [activities or services]. . . . It seems that some people are more likely to seek out somebody for medical advice than they are to say, “I’m lonely, and I need to get involved in some kind of a program.” . . . [The team is] able . . . to see that this is somebody who could benefit from attending a meal program, somebody who could benefit from volunteering here. (Seniors’ centre manager, C3)

One team member characterized some health-oriented clinics, such as blood pressure clinics, as “lost leads”: these clinics brought people in for a health-related pretence but could ‘lead’ to questions about other issues, including those not related to health. Team members followed health-related questions with conversations about people’s interests:

When [gathering] personal stories [I ask], “What were the things you used to like to do?” “What kind of work did you used to do?” . . . And [I’m] kind of analyzing [responses] . . . [thinking for example] that’s a potential committee member. (Evelyn, OT, C3)
The information gathered permitted team members to suggest activities available in the community that matched their interests. The nurse team member described this approach with seniors as “fix them up and give them a job”.

The innovative nature of the team’s services helped them to foster relationships, to respond to immediate health concerns, and to develop trust with seniors, all of which enabled connections between individuals and the broader community. Health-focused activities of the team laid the foundation for CD initiatives.

3. Building Upon Local Capacities: Tapping into Seniors’ Talents

Capacity-building was one of the team’s main aims, focusing on “what are the strengths that already exist and how can we build upon them, whether that be individual strengths or things that are happening in the community?” (Evelyn, OT, C3).

Capacity building in this case comprised matching strengths with opportunities and developing local leadership.

Matching Strengths With Opportunities – Seniors Are Our “Greatest Resources”

Much of the team’s work revolved around uncovering and drawing upon the existing capacities among the community’s seniors. Vibrant and active seniors’ community members were, according to one team member, the team’s “greatest resources” and enhanced various health initiatives. A member of the neighbourhood beautification committee explained that the team had “their networks that they deal with. . . . When we need certain things, they have contact people” who provided skills like carpentry and gardening for creating community flower boxes.

These skills, as revealed in discussions with individuals about their interests during health clinics, were matched to identified needs. The matching process considered potential skills and seniors’ desired level of involvement.

The group of potential volunteers included artists, carpenters, former city planners, seniors with business connections and grant writers. Evelyn explained that by having many
volunteers and strengths to draw on, they “weren’t asking anybody to take on the whole thing
themselves but [rather were] . . . piecing it together. Wherever possible, finding a pair so that
nobody felt like, ‘Oh I’m the only one doing it.’” In this way, people felt their tasks were
manageable and a range of skills and capacities guaranteed progress on projects.

One committee member, alluding to the talents and resources drawn on to address issues
identified in the community, commented that: “It just seems that our needs are always met”. The
committee carried out intergenerational activities by having seniors share the local history with
students who painted historical scenes onto lamppost banners, contributing to a sense of
community pride.

Evelyn explained her approach to matching people to volunteer opportunities:

I think about: Is this a very individual or solitary activity? Is this something that could be
done in a parallel situation or [might] this person . . . function better as part of a group or
[are they] ready to fly [on their own] and they can take more independent action?
(Evelyn, OT, C3)

The team learned of seniors’ abilities and interests and, drawing from a range of possible
volunteer opportunities, suggested potential contributions that seniors could make.

*Developing Local Leadership - “It’s Really Developing a Sense of Community”*

Team members formally and informally developed local leadership. Formally, they
identified local seniors who were interested in staying active, and linked these people with a local
agency that provided exercise class leadership training and support. These seniors took on
leadership roles in their residences and community events. In one case, an individual was an
exercise leader who was asked to greet participants in a mall walking clinic, and eventually
became an “ambassador” for the walking program, providing the team with updates on the
program and its participants. Evelyn described how this senior took on a leadership role:
We started talking to her about the fact that she’s was a very outgoing person and could we possibly use those skills and get her some training, and get her doing some exercise programs in the [apartments]? . . . She would be like our ambassador for the walking program. So she is a greeter, and a lot of that she would have done naturally anyway, but this way . . . we will phone her and [ask] is anything happening there that we need to be concerned about? . . . And often she’ll just phone us up out of the blue and tell us what’s going on anyway. (Evelyn, OT, C3)

Thus, local activity leaders were developed with multiple purposes: engaging seniors in meaningful, healthy activities; sustaining programs with local volunteer leaders; and extending the team’s “reach.” Evelyn described the relationship between seniors’ interests and leadership skills: “[A] person’s interests . . . strengths and skills . . . [are] the capacity that we can build from. . . . We can take what their interests are and develop leadership from that.”

In addition to formal means of developing leadership among seniors, team members also encouraged informal local leadership. Early in the neighbourhood beautification project, the team was responsible for approximately 80% of the work. They sought to involve more people and recruited a local business owner to chair the project committee. The team informally supported the chairperson and assisted in facilitating meetings (Field notes, committee meeting, December 5 2007). A community forum was suggested to attract more interest in this committee’s events; if successful, the growing role of the community would allow Evelyn to “back off a little bit” as the committee took a stronger lead. The seniors’ centre manager concurred:

[The team] encourages seniors to take on leadership roles and take on responsibility with things. They provide them with support and direction, but they very much encourage seniors to have vision for what they want to see happen in the community as well, and get them involved that way. (Seniors’ centre manager, C3)

The team’s goal to promote meaningful engagement through seniors’ capacity-building was in response to the “something missing” in their lives that seniors felt as roles changed, which in turn was believed to lead to feelings of isolation and depression. By learning about their stories and interests, the team was able to direct seniors’ talents to personally meaningful community activities while simultaneously, and successfully, promoting socialization for seniors.
In addition to the individual benefits to seniors, people also spoke of wider community changes caused by these activities. Specifically, the neighbourhood beautification project promoted a growing sense of community:

I see more of the sense of community in this area. . . . Now it’s seniors working with kids, working with businesses. . . . All the things that we do that get different people involved … it’s sort of a taking pride in your community, getting excited about things going on in your community. [This] area is an older area of the city that has been neglected and run down and they saw it as a place where [there] could be some relatively simple things done to make the area a little bit nicer and get people excited about that. (Seniors’ centre management, C3)

4. Establishing Connections and Supports: Expanding Into New Areas

Team members worked within a web of interrelated activities that supported each other. Health clinics acted as venues to advertise events and recruit volunteers, partnerships with community agencies allowed for collaborative events and shared promotion, exercise leaders were provided with training and acted as responders for the health team, and community agencies and local groups were linked to each other through the network committee. Interconnections such as these created an elaborate network of activities and supports for seniors allowing the team members to recede into the background as “cheerleaders” of these community events.

Through the processes of building local capacity and linking community supports, the team was able to direct their energy to initiatives in new neighbourhoods. This recurring process occurred as new initiatives were first developed and then passed on to the community:

A lot of what [the team does] is put in the [programming] building blocks. . . . Then they recruit people to take on pieces of programming that they’re able to do, which builds capacity in the program itself which makes it more sustainable for that community to take on and then eventually the volunteers start to run the program themselves. [The team is] . . . still there as resources. They also check in on different programming to make sure it’s still running as it was when they set it up. (Manager 2, C3)

The health authority manager requested the team expand their services to a new area. The team was “reluctant” to do so, reporting that they felt they were spread too thinly in the current area. The community health centre hosted an open house to inform the new community of local health services. The manager described the turnout and the team’s reaction:
Of the approximately 700 [community members] we had, at least 500 were senior citizens. . . . They wanted to see the Centre, they wanted to see what it was offering them. And I think it was a bit of an eye opener for [the team] in the fact that they didn’t realize that there were that many people in the area that required service. So they got started basically from that day forward. (Manager 2, C3)

Having been made aware of the area’s needs, the team began to develop services in that area. They reengaged in processes of developing new partnerships and getting to know the new community. Supportive management and local contacts facilitated these processes.

*Developing New Partnerships – “We’re a Very Good Team”*

The team began its work in the new area by connecting with the coordinator of the local seniors’ council. Again, a shared vision between the partners was evident. For their part, the council resource coordinator espoused a similar goal for seniors but offered a different perspective:

[I’m] trying to find people who need to be doing things in a different way so they can maintain their health longer. . . . I think we’re working in the same way [as the team], but our backgrounds are very different. They’ll be looking at things from a very medical perspective, whereas I’m looking at it from a much more social perspective. (New resource coordinator, C3)

Activities that worked effectively in the original community, including health clinics and education talks, were held in the new area. The team met with the seniors’ council coordinator and the local community facilitator to plan joint initiatives and share event information. Planning meetings were initially directive, with one team member informing their new partners about the team’s health programs. As the new partners became acquainted with potential programs, they requested health events. The council coordinator concluded that this joint planning helped form a “real partnership.” Local contacts assisted the team in gaining access to new buildings and in return, the community had increased access to health services.

I’m finding that we’re a very good team, like the three of us together. I can say, “Okay, well, I can get you in here.” and I’ll go ahead and make the initial contact and say, “This is what we want to do” and then bring [the team] in and introduce them. (New resource coordinator, C3)
This partnership resembled the previous mutually beneficial partnership between the seniors’ centre and the property manager.

*Getting to Know a New Community – “Getting to Know the People and Looking at the Assets”*

The team drew on the coordinator’s knowledge of the area’s seniors to learn about the community. The new community was an older one, with many living in single dwelling homes. The seniors’ council coordinator focused on finding resources to assist people to continue to live independently in their homes, and addressed issues pertaining to transportation and meals.

In touring the new area to identify apartment buildings where health clinics could be held, one team member explained the criteria used to select sites for service provision:

> Right now we’re getting to know the people and looking at the assets. What are the strengths here? What are the people and what are their needs? What already exists? There’s a lot of church and a lot of retirement [residences]. . . . How can we build upon that? And what’s missing? (Nurse colleague, C3)

Management was supportive of the time requested by the team to develop the necessary community links, recognizing that the team had to “build their blocks” in the community through identification of ongoing activities, potential partners and advertising methods for new events.

Expansion of the team’s services into the new area was not without its challenges. The wariness felt by the team at providing services to a new area hints at tension between management priorities and the team’s priorities. The health authority manager encouraged expansion by helping the team understand the community’s needs. Alternatively, the team’s resistance to move into a new area may suggest that the team members did not feel ready to relinquish their roles in various community activities. They were still committed to health clinics and talks, and had yet to pass on community activities to other agencies or volunteers fully. Although Evelyn stated her commitment to volunteer-run groups, both team members continued to plan and coordinate many events. Consequently, one team member proposed a different approach to the new community, where the team would link people to existing services rather
than developing initiatives themselves. In this way, the team modified their original approach to working with communities so that it fit with the new context and within their own constraints.


Despite recognizing that her work may not readily appear to others to be related to occupational therapy, Evelyn saw principles of occupational therapy demonstrated in her focus on meaningful engagement: “meaningful occupations . . . that’s just what it’s all about to us.” In this case, the occupational therapy perspective involved bringing unique expertise and blurring professional roles.

**Bringing Unique Expertise: Being able to “see things” that others don’t**

Evelyn brought a distinct set of skills and knowledge to the team, specifically in falls prevention, community mobility, home visits/safety and activities of daily living. Within the clinical aspects of her work, seniors were often referred to her to address such issues. Beyond these clinical occupational therapy interventions, Evelyn was a resource for education sessions and program planning, ranging from a request for an education session on falls prevention from the seniors’ centre (Field notes, November 26 2007), to membership on a city-wide planning committee to produce falls prevention educational material (Field notes, November 19 2007 and Document – meeting agenda and minutes). Evelyn’s clinical expertise in occupational therapy was in high demand.

Complementing her occupational therapy skills and areas of expertise, Evelyn’s approach to seniors enhanced meaningful engagement in activity. Both team members inquired about seniors’ interests to link them with related volunteer opportunities, but the other team member reported that Evelyn was able to “see things” that enhanced the match between interests and opportunities. Evelyn used occupational therapy terminology to explain this ability: matching a senior with the right volunteer position is “like graded activity, but at a different level,” and task
analysis was undertaken to suggest relevant volunteer opportunities. Though the skills and
discipline of occupational therapy provided the team with benefits, disadvantages were noted.
Evelyn found that occupational therapy colleagues and conferences were less relevant to her
because of her CD work and she admitted to “making things up” as she went, due to the lack of
relevant occupational therapy models and guidelines. Evelyn stated she needed to consciously
decide to make the occupational therapy perspective explicit in her CD work. This is one reason
she valued having students, since she was required to make that explicit for them.

Blurring Professional Roles: Distinct Approaches

A blurring between the team members’ roles made it difficult to distinguish between
professions. One health authority manager observed that seniors’ general health concerns meant
that either health professional could respond to their needs. Evelyn’s set of generalist skills
tended to be more evident when working at the community level. In particular, Evelyn developed
skills and knowledge in seniors’ health issues including medications. At health clinics, Evelyn
reviewed medications and consulted with the nurse on medication options (Field notes, clinic,
November 20 2007). She also consulted with people about their weight and nutrition, thus
utilizing general health skills. One health authority manager commented

I’m a nurse looking at an OT [conducting general health assessments] thinking, “Wow,
that’s pretty good,” because that’s something that takes years in a nursing school to
[develop] that type of assessment skill, whereas [Evelyn’s nurse colleague] has picked up
a lot of the OT skill from Evelyn. (Manager, C3)

This blurring was reflected in their equivalent job descriptions.

Team members were perceived to be “interchangeable” and “inseparable,” acting as a
“unit” with shared skills and knowledge. The seniors’ centre manager stated, “It is so hard to
separate the two.” Another health authority colleague compared the team to a long-married
couple in which the pair “start[s] blending.” The team acknowledged this phenomenon: “[If] I
slow down for a while, Evelyn takes over, then I take over. We work in tandem . . . all the time.”
Although their skills and knowledge seemed to merge so that each member could take on the other’s job, the team employed unique interpersonal approaches. One team member was dynamic, outgoing, and inspiring, with one business owner characterizing her as “a huge motivator. . . . If there is a job and it need to be done, she’s right there doing it, which is wonderful.” In one instance, this team member walked into a flu shot clinic and encouraged all those in line to do exercises. Many people found this enthusiastic approach important to the team’s success. In contrast, Evelyn was described as “laid back,” “stable, even” and more “behind the scenes.” Evelyn worked with seniors to develop proposals and write letters. Drawing on her eye for detail, she raised questions and critically considered the consequences of actions. The team members’ different approaches balanced each other. A colleague from the community explained that Evelyn did not need to be a “star” and was content with the other team member taking a more visible role in some activities. The team’s manager explained that although at times she was quieter, “when Evelyn speaks, people listen.” The other team member regularly acknowledged Evelyn’s contributions to the team. These comments demonstrate how Evelyn “led from behind” in supporting others to take the lead in activities, and created inclusive environments where others felt empowered to lead and participate.

6.5 Case Summary and Key Features

This case features a strong integration of the team and the seniors’ centre. Shared values, shared space and mutual benefits brought the partners together, helping to nurture and sustain the partnership through regular meetings and joint initiatives. This partnership saw the team as an integral part of the seniors’ centre: visible, accessible and drawing on administrative supports, all of which enabled other community partnerships featuring a range of activities. Participants believed that the team would not have been as effective if it were located closer to the health authority. It was speculated that an offsite location would distance the team from the community and partners essential to their work.
The second key feature of this case was its duration: the team worked with one community for 8 years. The timeframe allowed the team to develop a number of ongoing initiatives, to recruit volunteers to assist in their running, and, in later years, to begin expanding their services into a new area of town. This case demonstrated early phases in establishing community supports, and explored the rebuilding of these processes in a different community. In this case, ‘community’ was broadly understood to be geographically oriented. The team was mandated to serve seniors in one area where some seniors might not be receiving other health services. The definition of community referred to the area in which these seniors were located, rather than presuming shared interests or experiences.

The team delivered health services to the community that functioned alongside typical health services, such as the regular health clinics offered at apartment buildings in the area. Although oriented to the health of individuals, the team developed CD initiatives that went beyond health concerns. The team inquired about people’s interests and was able to link people with community events seeking volunteers. In this way, clinical initiatives acted as a gateway to volunteer opportunities, capacity-building initiatives and ultimately to the meaningful engagement of individuals and the sustainability of community-run initiatives.

Finally, this case demonstrated blurred roles between an OT and a nurse. Although individual distinctions between their skills and approaches were evident, at the community level, team members were seen as interchangeable, taking on tasks of the other’s profession. Consequently, team members were differentiated on the basis of their individual personal approaches rather than their training. Evelyn was described as a behind-the-scenes worker who ensured background information was gathered and documented, while the other team member held a much more visible position within the community.
CHAPTER 7: CROSS-CASE INTERPRETATION

7.1 Introduction and Chapter Overview

In this cross-case analysis, I identify and explore broader concepts that assist in our understanding of community development (CD) from an occupational therapy perspective, and abstract from the particulars of the cases to generate a framework.

Community development in occupational therapy, as exemplified in these three cases, can be understood as a process of the OT aligning and strategically using the professional and personal self in order to enable more equitable sharing of power between health services, community agencies and consumers, who have been vulnerable to disengagement from meaningful activities as a consequence of their health status, thereby contributing to the creation of opportunities for meaningful engagement with(in) communities. This process includes the integration of the OTs’ professional background - with its ascribed power and privilege - and their acknowledgement of the value of people’s meaningful involvement in the programs and services through which they are affected.

Building upon this strategic use of self and a strong commitment to consumer involvement, I have conceptualized CD from an occupational therapy perspective as being comprised of four main CD strategies that contribute to the shifting of power between health services and the community. These four CD strategies were: 1) building consumer and community capacity, 2) nurturing community partnerships, 3) influencing the health care system, and 4) linking sectors and resources.

This chapter examines the contextual influences and facilitating factors that created the impetus for CD. An understanding of the contexts from which CD emerged helps to clarify how it is understood within this study. Following this is a discussion on how the occupational therapy perspective brought to CD involved the aligning and strategic use of self in order to address power inequities. The four main strategies used in CD, the values upon which they were based,
and how the underlying process of shifting power manifested in each will then be presented. This underlying shifting of power manifested in the changes within different sectors: consumers reclaimed their legitimacy as valuable contributors, community agencies gained as well as shared resources during partnerships, the health authority gradually came to include diverse perspectives in health, and the OT became less central in CD. The factors that contributed to variations within these strategies and their outcomes will be discussed. Lastly, a diagram depicting the contexts, strategies and underlying processes is presented as one way of conceptualizing CD from an occupational therapy perspective.

7.2 Contextual Influences on Community Development Strategies and Processes

Community development initiatives were greatly influenced by the health context from which they emerged and the community context in which they functioned. CD initiatives were instigated by health authorities to address gaps in their services. These gaps, which arose from historical tensions within and between health and community services, are described below.

Gaps in Services that Necessitate a Community Development Approach

The CD initiatives in the three cases took place at the intersection between health services and the community. Each of the respective health authorities recognized the importance of bringing health services to the community. This gap in service pertained to people who were inadequately prepared for discharge from the hospital or to those who were not involved in health services because they had “fallen through the cracks” of disconnected services. Similarly, service gaps were anticipated as a population grew. The three health authorities had mandates to address gaps in health services within the community.

Historical Tensions: An Impetus for Change

Community development within these cases grew out of historical tensions within health services and between health and community services. Between health services and their users,
there was a history of professional dominance in which clinical expertise was highly valued and services users were traditionally viewed as passive recipients of this expertise. This professional dominance contributed to power inequities between health professionals and consumers. This tension was most openly acknowledged in Case 2, in which the dominant medical model was criticized for excluding survivors from actively participating in their recovery. This tension was less overtly named but still present where stroke survivors recounted negative inpatient experiences that impacted some of their comfort and confidence in returning to their home communities. The emphasis on professional knowledge was also present in Case 3; however, many program participants were not current or previous institutional health service users. Rather, they were involved in preventative services and thus did not share negative experiences of health services as a dominant concern.

There were also problematic relations between consumers and their communities. Some consumers had difficulties fully integrating into their communities: few had paid employment, familial support was variable, and many faced challenges in their daily life. For some, their communities were not perceived as supportive or welcoming. Although community services were available, they did not necessarily address the issue of people’s meaningful involvement.

The final historical tension was the perpetual disconnect between health and community services. These two sectors had different service foci, utilized incompatible approaches and had inequitable access to resources. In each of the three cases, the health sector focused mainly on time-limited, medically-oriented, individual interventions. In contrast, community services provided ongoing social supports. Additionally, in all cases, health services had more resources than the community sector.

Figure 3 below summarizes the key tensions between the health, community and consumer sectors, with the circle size representing their relative power.
Mediating contextual facilitators were present to support the development of new community-oriented initiatives. Specifically, the initiation of CD projects was supported by health trends, such as chronic disease self-management and new health policies that demanded the active involvement of families and consumers. Building on these general trends, each of the health authorities had a mandate to develop services in the community. Although this mandate was stated with varying degrees of specificity (ranging from a CD framework in Case 3, to general statements of intent in the other cases), each health authority dedicated part of a staff position to addressing community-oriented priorities. The positions were created to be flexible enough to respond to emerging community issues.

Another factor that supported the development of community-oriented programs was the willingness of community agencies to work with health services. In each case, willing community partners were present, some of whom had recently undergone leadership changes that resulted in their openness to creating new alliances. Additionally, each of the CD projects emerged from priorities identified by community members. The willingness of the health authority to be
directed by community concerns thus strengthened these projects. There were also community-based, consumer-oriented initiatives in existence prior to the health-initiated CD projects, which provided partners, community leaders, and program participants. In this way, the CD initiatives in this study built upon existing community programs and priorities. Figure 4 below summarizes these key facilitators.

Figure 4: Contextual Facilitators of Community Development

Understanding Community Development

The CD initiatives aimed to build on existing resources in the community, often working in partnership with community agencies and consumers. OTs explained that their main focus was to work in partnership with community agencies and consumers to either respond to their identified priorities or to strengthen existing initiatives, rather than to create new services. Therefore, one of the goals was to enhance the relevance of health services to those in the community.

These CD initiatives also aimed to enhance the accessibility and availability of health services in the community. This was related directly to those health services that promoted
enhanced accessibility to necessary services within the community, or to those services supported by health that promoted wellness and involvement in the community. Through the CD initiatives, health-related services and resources were either brought into the community or made more available. Even in Case 1, where the peer mentoring project remained in the hospital for practical and financial reasons, efforts were made to strengthen the connection between the hospital and the community agency. In Cases 2 and 3, the physical location of the OT’s position was actually moved outside of the hospital, with the aim of making those services more accessible to potential service users.

The OTs brought a deep commitment to the valuable contribution of community members. This is seen in the central involvement of consumers in the development of the program. The skills and experiences of people who were living with various health conditions were considered essential to CD projects. Current or potential service users initiated projects, assisted in their development, and were central to their implementation. The OTs also worked to support consumers and community agencies to take on more roles in projects, striving for the sustainability of the project beyond the OT’s direct involvement.

In this study, CD referred to efforts by the OTs, coming from within the health care system and in collaboration with others, to create meaningful opportunities for consumer involvement within community. They aimed to achieve this by responding to the communities’ priorities, working in collaboration with community agencies and service users, and by promoting the active inclusion of people throughout the process.

### 7.3 Occupational Therapy Perspective

**Drawing on Occupational Therapy Skills and Knowledge**

This research aimed to explicate an occupational therapy perspective within CD. In each case, the compatibility between occupational therapy and CD was identified: the OTs drew on their clinical experience and the clinical aspects of their current position; they applied their
expertise at the community level; they adapted existing individual-focused frameworks to
communities, and developed new skills. In all cases, the OTs’ previous clinical experience was
important. In two of the cases, a proportion of the position required occupational therapy clinical
intervention with individuals. These more traditional occupational therapy approaches contributed
directly to the CD initiatives by fostering relationships with service-users - who might become
involved in the community initiatives - and afforded the OT the opportunity to learn about their
issues and priorities, which helped shape initiatives. Through the clinical component of their
work, the OTs learned about shared issues among consumers, such as the need for collective art
opportunities in the community in Case 2. Additionally they learned about individual interests
and skills that were matched with community opportunities, as in Case 3. Although Case 1
differed in that the OT did not have an individual-oriented clinical component to her position, she
worked with clinicians to influence their clinical work. Thus, a clinical background was still
required for the position; an understanding of the physical and cognitive consequences of brain
injury was required to address clinical issues in the hospital and to plan for the functional issues
faced by survivors during the peer mentoring project.

The CD initiatives similarly drew on the skills, knowledge and approaches from the OTs’
professional background. They applied their clinical understanding of disabilities beyond
individual interventions, and shared them at a community level. Examples of community-level
application of occupational therapy expertise included: contributing to a city-wide falls
prevention initiative, conducting recovery education sessions with hospital and community
workers and creating a resource guide of community brain injury services. Some typical
occupational therapy approaches were adapted to the community level as well. For example, the
OTs adapted their framework for assessing individuals, which looked at individual occupational
performance, to small communities of interest, in which the collective occupational opportunities
available to that group were considered. At the community level, environmental factors were
explored in greater depth because a change in the environment impacted many community members. As well, shared occupational issues became the focus at the community level.

The OTs’ skill in analyzing and breaking down tasks was applied to groups and communities. Broad initiatives were broken down into manageable tasks that could then be taken on by others. This was seen in Case 2 where the large task of creating peer support services was broken down into smaller steps, the first of which was the writing and story-telling workshop for consumers. Similar strategies were used in Cases 1 and 3 during committee activities.

The OTs were also required to develop new skills and knowledge. In Case 1, the OT adapted group facilitation skills to work with clinicians and was required to learn more about the legalities of partnerships. In Case 2, the OT specifically identified the need to find models to help guide work with communities. In Case 3, the regular community health clinics necessitated that the OT further develop expertise in skills related to working with seniors, such as checking blood pressure and monitoring medications.

**Aligning and Strategically Using Professional and Personal Self: Anchoring, Centering and Relinquishing**

In the daily practices employed by the OTs to integrate occupational therapy and CD, a process of aligning and strategically using the professional and personal self became apparent. This process of aligning and using the professional and personal self consists of three interrelated strategies: anchoring, centering and relinquishing, which, in turn, contribute to a key underlying process of sharing and shifting power.

**Anchoring**

*Anchoring* refers to the deliberate attachment or affiliation of the new CD tasks with well-known aspects of occupational therapy. Community development from an occupational therapy perspective is ‘anchored’ to well-known skills and abilities of OTs so that they are accepted as legitimate initiatives for the OT. This was in part an internal process that assisted the
OT in identifying the links between CD and OT, but for the most part, anchoring aimed to make this connection clear to others, in particular to other health professionals. In these cases, CD initiatives were anchored to OTs’ well-known understanding of community resources (Case 1), to recovery approaches (Case 2), and to falls prevention and functional mobility (Case 3). The dual focus of the CD positions in each case supported the process of anchoring, as the OT maintained involvement in activities that drew on their recognized professional expertise.

Centering

In contrast to anchoring, centering was more personal: it was a process in which the OT focused on and internalized key concepts that helped to clarify this new area of CD. For the three OTs, centering involved grounding their CD work in people’s meaningful engagement. For the OTs in Cases 2 and 3, this was explicitly stated and affirmed. In Case 1, although the OT spoke of this focus on consumer engagement, tentativeness around linking occupational therapy and CD suggested the link was implicit and the process of centering was ongoing. This may be attributed to the institutional context of the case, which highly valued clinical expertise and may have necessitated considerable anchoring in more traditional aspects of occupational therapy.

With centering came an ethical recommitment to values that were viewed as core to both occupational therapy practice and CD. The OTs held similar values that influenced their work. For example, they valued experiential knowledge and peer learning; they were committed to meaningful engagement; they respected people and believed in the potential of individuals and communities to change, which instilled hope; they believed in the importance of equitable, collaborative relationships with individuals and organizations; they recognized and valued the resultant interdependence between partners; they valued the environment as an enabler of engagement; they valued and built upon the strengths of partners; and, they were committed to planning for sustainability.
With the process of centering came a sense of returning to what occupational therapy was meant to focus on: enabling meaningful engagement. Despite this, the OTs described a growing distance between themselves and other OTs. Professional conferences no longer spoke to issues that were relevant to their CD work, and occupational therapy meetings discussed clinical issues which were not pertinent to their daily CD practice. Thus, with this process of centering on meaningful engagement and the recommitment to underlying values, also came a disassociation from mainstream occupational therapy practice. One identified strategy to mitigate this included taking on occupational therapy students, which helped the therapist explicate the link between occupational therapy and CD not only for themselves, but also for the students, which encourages students to integrate these values and pass them along.

Reinquishing

The OTs had a strong commitment to and grounding in a defining concept - meaningful engagement - and thus could partake in relinquishing rigid role boundaries. With this, the OTs took on new roles, which contributed to role blurring. With centering came a confidence in the unique and valuable perspective one brings, which then provided a stable basis from which to take on new tasks as well as relinquish control to others. There was openness to different perspectives and approaches, and growing appreciation that a health professional only brings one of many perspectives to the table. This included letting go of externally imposed notions of what it meant to be an OT. This required the OTs to give up control because of the recognition that consumers were experts on their experiences. This letting go was most clearly articulated in Case 2, where the OT differentiated between her professional clinical role and her role as catalyst. Neither she nor her consumer colleagues emphasized professional background. Similarly, in the other cases, others knew the OTs’ professional designation, depending on the person with whom the OT was working. When working within a hospital setting or providing individual interventions, it was more likely that people knew the professional background of the OTs; when
working in CD, this was less likely. This suggested a diminishing importance of professional designation in CD.

Sharing and Shifting Power

The OTs moved between the role of professional and that of catalyst and colleague. Their different roles afforded them access to different resources and relationships. As clinicians, the OTs were afforded power that comes with the ascribed legitimacy given to health professionals. Consequently, they had access to the health care system and the privileges associated with that. As health professionals, the OTs had greater decision-making power and resources because they had easy access to decision-makers within the health authority; they were able to draw on the experience and expertise of other health care professionals; and they had access to the various resources within the health care system, including rooms, funds and services. The power and legitimacy that came with being a health professional was purposefully shared with consumers or community agencies.

In some settings, however, this association with health care also brought with it potential feelings of distrust among previous services-users who felt their experiences were discounted within the health care system. The early rehabilitation experiences of some of the stroke survivors in Case 1 provide an example of this. In such contexts where consumers perceived the distribution of power between themselves and health professionals as inequitable, the OT was required to gain legitimacy with consumers and community agencies. In such situations, the consumers and their advocacy groups, as well as community organizations, had power - through the credibility they held with others in the community - they could share with the OT through collaborations. Such sharing of community legitimacy with the OTs occurred when the OT was in the role of colleague or catalyst. In these roles, OTs were in closer association with community members and community organizations. Consequently, the OTs gained the trust of consumers and community service providers, and consequently gained credibility with them. With this credibility
the OT gained access to the various resources in the community. For example, it was through the OTs’ association with community agencies that they became known within the community and it was through such partnerships that program funding was sought. Thus the OTs moved between various roles and sectors, strategically using the professional self when required to access health authority resources: at times the OTs emphasized their professional background and title, and at other times, they de-emphasized that background, choosing instead to focus on the development of equitable relationships with consumers and community members.

Through the strategic use of the professional and personal self, the OT’s power was used for the benefit of the CD initiatives and the community served, while the development of authentic relationships with consumers also brought renewed community legitimacy to the OT. Drawing on their ethical commitment to values of consumer involvement and equitable relationships, the OTs worked towards using their power justly.

**Strategic Use of Professional and Personal Self**

This process of aligning and strategically using one’s professional and personal self in order to share and shift power was woven throughout the key strategies of CD. The process of CD consisted of four main strategies that were planned activities explicitly aimed at developing communities: building community capacity, nurturing community partnerships, influencing the health care system, and linking sectors and resources. Each of these strategies fed into underlying changes in power that contributed to the programs’ outcomes at the individual and community levels. Key values guided the strategies and the OTs shifted between various roles, strategically using their professional and personal selves to foster the underlying change processes that contributed to the development of the local community.
7.4 Strategies and Underlying Processes of CD from an Occupational Therapy Perspective

1. Building Consumer Capacity: Reclaiming the Contributor Role

The strategy of consumer capacity building was built on the value of experiential knowledge, peer learning, and meaningful engagement. Through this strategy, consumers reclaimed their role as valued contributors.

Across the cases, capacity-building occurred at both the individual and collective level. At the individual level, the foundation of capacity-building was the recognition of the value of people’s individual and collective experiences as survivors. These experiences were considered to be an existing strength that could be built upon. These existing strengths were first named by the OTs to assist people in recognizing what they had to offer. These were then strengthened through a range of activities that developed ways to share these skills with others. It was through this process of preparing people to share their experiences and skills that collective capacity was built: through the individual’s skills shared with others, the group or community had newly developed resources to draw upon.

At the individual level, the development of skills that were shared with others provided valuable opportunities for meaningful engagement. Many of the program participants in this study had lost valuable contributor roles. Few were employed or were regular volunteers outside of their involvement with the CD initiatives. Through skill development and the opportunity to share those skills, first with their peers and then with others, people were able to re-develop their role as a contributor. With this came the external recognition of the value of their experiences. Consumer experiences were afforded credibility and legitimacy within the health system and the community, which historically was not the case. Experiential knowledge was thus becoming a legitimate “expertise” within health, and service users became colleagues who could contribute that expertise formally within the health care system, and informally with peers and the
community. These capacity building processes therefore involved inviting people who were historically receivers of care into the active roles of mentor, educator and leader.

Within the strategy of capacity-building, the OTs took on a variety of roles. Primarily, the OTs took on the role of colleague and mentor, building upon the consumers’ strengths. The OTs supported consumers as an informal coach and advocate during skill development. The OTs drew upon their occupational therapy background, and relinquished the control afforded them in typical professional-client relationships to foster more equal relationships. It is through capacity-building and this collegial relationship with consumers that the OTs were able to use their legitimacy as health professions to benefit consumers by formally acknowledging their strengths and the contributions they make to health services. By bringing consumers together in various capacity building activities, it was anticipated that a united voice would develop, directing additional initiatives.

2. **Nurturing Community Partnerships: Sharing Power**

The strategy of nurturing community partnerships was founded upon the values of equity, interdependence, and collaboration. Across the cases, the importance of nurturing community partnerships and primary relationships with partners was evident. Community agencies and service users were the main partners. The partnerships were based on shared values and goals, and the belief that each partner makes a unique contribution.

From the standpoint of the OTs, it was important to recognize the actual and perceived power they brought to such partnerships because of the historical dominance of the health system. This afforded them decision-making power and access to resources. Power and control needed to be shared so that the health care system recognized their need to rely on community partners for vital contributions to the partnership. It was important that this interdependence among partners was present and acknowledged, because with it came mutual vulnerability and risk. Mutual vulnerability helped to bring equity into partnerships where traditionally there were significant
power imbalances. A clear example of this occurred in Case 1, when the partnership almost broke down. This near breakdown can be attributed to unacknowledged power imbalances between the rehabilitation center and the community agency. In Case 2, some of the false starts with the community can also be attributed to the OT initially focusing on what she had to offer agencies, without also recognizing what the community had to offer. Consequently, there was no mutual benefit or shared risks, and the partnership nearly failed. In contrast, the main partnerships in Cases 2 and 3 clearly acknowledged the mutual benefits gleaned from the partnership and were considered valued partnerships.

In addition to partnering with community agencies, the OTs in these cases also worked very closely with previous services users (i.e., people with brain injuries or people living with mental illness) or potential service users (i.e., older adults). These individual relationships mirrored many of the key elements of partnerships in that there were shared values and goals, and each partner’s contribution was valued. These relationships were therefore characterized by a feeling of equality between colleagues who brought different sets of skills and experiences to a project. Survivors and older adults were not considered the OTs’ clients or patients in CD initiatives; rather, they were colleagues or partners who were central to the implementation of the project. This shift from being a client to being a partner opened the doors for mutual benefit.

With these relationships, the OT and the project gained legitimacy within the community because of the involvement of people with experiential knowledge of living with a disability. This was strongest in Case 2, where the OT was not ethically willing to move forward in recovery education without consumer involvement. But similar ideas were evident in Case 1, where the peer mentoring project was perceived as credible by participants because it involved a survivor and it was endorsed by the rehabilitation centre. In Case 3, there was a general sense of legitimacy gained through the seniors’ team’s active involvement in the community.

These organizational and individual partnerships brought many benefits to the CD projects. Because of the active involvement of community members in projects, these initiatives
were responsive to the priorities of the community. Consequently, these programs were accessible and relevant. The partnerships also enabled the OTs, as health authority employees, to navigate around some of the systemic challenges that came with a position within the large, bureaucratic health care system. Community partnerships provided a “front” that enabled creative solutions that may not be allowed within the health care system. Lastly, there was a sense of shared legitimacy, in that the OTs brought the endorsement of the health care system, and through partnerships and relationships, the OTs gained legitimacy among community groups.

Within this strategy of partnership building, the OTs strategically used their professional and personal selves as they shifted roles in order to promote power sharing. One of the main roles taken on was that of collaborator as the OT brought together and worked with others. In committees, the OTs took on the role of leader or facilitator, guiding group processes. Because divergent ideas and approaches need to be mediated, the OTs negotiated between partners. They were considered particularly adept at this because they had an in-depth understanding of diverse perspectives. In being responsive to the communities’ priorities, the OTs relinquished their leadership roles to become followers and supporters.

3. Influencing the Health Care System: Embracing Diverse Health Perspectives

The strategy of influencing the health care system was founded on an appreciation of the impact of the environment on people’s ability to participate, and the value of experiential knowledge as an important component of health care. Based on these values, efforts to change the health care system gradually shifted power within health so that diverse perspectives and knowledge were acknowledged.

Although the OTs’ positions were all within health, and thus they came to their work from an ‘insider’ perspective, each OT had a different way of working with the health system. This variation was related to the OTs’ location to typical health services. In Case 1, the OT was embedded in the rehabilitation centre and, consequently, the clinical community within the
hospital was one of the communities to be developed. To this end, the OT provided community information to clinicians. This contrasted with the OT in Case 2 who made a more deliberate effort made to change the attitudes of professionals in the health care system. In contrast to both of these cases, rather than trying to change others’ approaches to health services, the team in Case 3 was essentially working parallel to typical services.

The physical location of the OT and the strength of the affiliation with the health care system influenced how the OTs interacted with health services. In Case 1, the OT was embedded in the hospital and thus strongly affiliated with it, working within the constraints of the current system but gradually instigating small changes that were acceptable to colleagues and management. In Case 2, the OT was located outside of the hospital and deliberate efforts were made to distance this position from the hospital. Consequently, the OT was able to enter into the hospital not only as an insider and long-time health authority employee, but also as an outsider who was taking on new roles in the community. This distance and freedom, combined with a clinical background, enabled the OT to challenge approaches within health care. The OT was able to share with clinicians new ways of including consumers in their health services.

Finally, in Case 3, the seniors’ team was deeply embedded in the community agency and had very minimal interaction with other health services. Within this case, the team did not explicitly attempt to change how others were providing health care. In fact, they actively sought not to join the other health providers when a community health centre was built. Instead, the team modified their program as they went, responding to the needs of the community. In this way, they illustrated the provision of parallel health services that changed the health system by providing additional, innovative services within the community.

Through these various approaches, the OTs shifted power within the health care system such that consumer and community perspectives were recognized as a valuable component of health. Based on a commitment to the value of consumer involvement, along with the recognition that system changes were required to provide opportunities for consumer involvement, the
changes encouraged through this strategy brought consumer and community perspectives into the health care system.

The strategic use of professional self was very apparent since the OTs’ clinical background and experience provided a basis for engaging with other health professionals. As insiders of the health care system, the OTs in Cases 1 and 2 were able to initiate small changes within the health care system by influencing the practices of other professionals. The OTs drew on their clinical expertise and experience, using the credibility associated with being a clinician to advance CD. They also took on the role of mediator between health and the community. As such, the OT acted as a translator between these two sectors. Through the CD initiatives, the OTs learned of the priorities and issues within the community. To varying degrees, the OTs became a part of the communities they worked with and thus had a dual status as a trusted supporter of community perspective(s), while still maintaining their insider status within health. The aligning of the professional self, which enabled access to health care services and resources, with the personal self, which was deeply committed to key values, required the OTs to move constantly between the community and health sectors, strategically using their insider status as required to advance their aim of consumer engagement.

4. **Linking Sectors and Resources: Strengthening Existing Resources**

The strategy of linking sectors and resources was founded on a strength-based approach that strove for the equitable distribution of resources and the sustainability of the projects. As sectors and resources were linked, the OTs gradually gave up some of their power and control as others took over projects. In all three cases, the OTs connected people to services that supported their contribution to the various projects when the OTs were less involved. There were premeditated plans for the OTs to gradually work themselves out of duties. This included the creation of structures, such as paid consumer positions or advisory committees, and the linking of needs to available resources in the community. This also involved the re-establishment of
relationships between sectors and individuals. During this, the OTs deliberately stepped back, further relinquishing their control.

Because of the different stages of development of the projects across the cases, there was some variation in the extent to which this bridging and stepping back occurred. In Case 2, which was a newly developing project, the OT was still very central to the CD initiatives and had yet to step back. This stage of project development was conceptualized as ‘emerging’, since at this stage, the OT emphasized relationship building while planning for the eventual passing on of tasks. In Case 1, the project had been in development for about 1.5 years and the OT was in the process of confirming the structures to support others taking it over. This was identified as the ‘establishing’ stage. At this stage in Case 1, established structures were in place for the project to continue without the ongoing involvement of the OT. Structures such as the planning committee, the paid coordinator position and the program plan were in place and partners were becoming familiar with the tasks they were to take on. In Case 3, the longest-running program, the OT had stepped back from certain programs that volunteers or other community agencies were now running and was beginning new programs. The OT has moved from the establishment of structures and supports to the expansion of services in new areas. This stage was labelled the ‘expanding’ stage. Tensions surrounded this expansion of services because of the connections that existed with community members; the OT had become a part of the community and it was difficult, both professionally and personally, to decrease that involvement.

As the OTs built upon existing resources to support the consumers and the initiatives, the strategic use of professional and personal self was evident. As health authority employees, the OTs were aware of the various resources and initiatives underway within the hospitals. From an insider’s perspective, the OTs matched existing resources to identified community priorities, or redirected resources so that they are more equitably shared between the sectors. They explicitly drew upon their occupational assessment skills in order to gain an understanding of the needs and strengths of the various sectors involved in CD initiatives.
The OTs act as bridges between sectors, linking identified needs to available resources, with the intention that connections made would be maintained by others. Again, the OTs took on a mediator or translator role between the various sectors that were being bridged.

7.5 Outcomes of Community Development From an Occupational Therapy Perspective

Outcomes of CD initiatives occurred at the individual and collective level. In addition to intended CD outcomes, there were also unintended outcomes - some positive and some that highlighted potential tensions.

At the individual level, each of the three CD initiatives examined in this study aimed to impact the health and well-being of community members who were previous or potential services users. Personal benefits anticipated from engagement in the CD initiatives included: enhanced self-esteem, skill development and advocacy skills (Case 1), enhanced consumer leadership in peer support services (Case 2), and maintained and improved health and independence of seniors (Case 3). During capacity-building, the information and learning gained enabled individuals to further progress along their personal recovery journeys. Participation in initiatives that were meaningful for individuals built confidence and assisted consumers in recognizing their contributions. Informal peer supports strengthened this process and the supports developed through linking sectors and resources assisted in maintaining individual benefits.

Individual outcomes were linked to community-level outcomes through peer interactions, in which participants were encouraged to share their learning and experiences with peers and eventually others. Capacity-building, which encouraged peer interactions and fostered leadership development, thus bridged individual benefits and broader community-level outcomes. In addition to these outcomes, each program also hoped to impact beyond the individual program participants. For example, Case 1 aimed to build the capacity of the stroke community through the peer mentoring project, while Case 2 explicitly aimed to improve services provided in the
community. Case 3 included similar outcomes and added the anticipated outcome of creating healthy and welcoming communities. Broader community-level outcomes were affected by CD strategies that worked with organizations and systems. Specifically, nurturing community partnerships built the capacities of community agencies so that they were able to offer more relevant, consumer-oriented services. Similarly, health care services and providers, including the OTs, were able to provide more responsive services. Through these partnerships, the underlying process of sharing power occurred, which resulted in the enhanced profile of community agencies. The vulnerability of community agencies, in particular their limited resources, were mitigated through the partnerships. These partnerships also served to role-model how health, consumers and community agencies worked collaboratively.

Stemming from the strategy that aimed to influence the health care system, a key outcome beyond the individual was the development of relevant health services that integrated experiential knowledge and recognized engagement and giving back as a means of maintaining and promoting health. As health services integrated aspects of CD into their ongoing mandate, the community’s trust in health care services was strengthened. Targeted changes within the health care system - for example, the development of paid consumer positions, and redirected funding - established structures that provided ongoing support of CD initiatives.

As resources and sectors were linked, outcomes had further reach within the community. As more people became involved in initiatives, a sense of community and pride developed, as was evident in Case 3. With the broadening of involvement of people in such CD initiatives, awareness about available services grew, as did awareness of the contribution of consumers to these services. Through this, negative perceptions of service-users or seniors as non-productive members of communities were challenged.

While illustrating these planned and generally positive CD outcomes, the cases also illustrated points of tension where the inability to reconcile could have negative outcomes. Further loss in consumer self-confidence, the perpetuation of professional dominance in
relationships, partnership breakdown and the continuation of the institution and community divide were possible if inequities regarding decision-making power, resources and vulnerabilities were not acknowledged and addressed. One of the key strategies used to mitigate these tensions was critical reflection on the part of professionals, during which time they recognized the power afforded their position and how they aimed to manage that. Strategies to do this within the three cases include: formalizing agreements with community partners, differentiating between the clinical and community developer role and regular reaffirmation of the OTs’ core principles.

The occupational perspective, which was the main contribution of the OT, became invisible by the very nature of the work the OTs did. By actively working to remain in the background and enabling others to develop the skills to take over, much of the OT’s occupation-based work remained invisible to participants or colleagues.

Ultimately, these cases illustrated that the process of CD from an occupational therapy perspective built upon the clinical connections and experience of these OTs to create opportunities for people to meaningfully engage with peers and professionals. At the individual level, this engagement was facilitated through relationships and capacity building; at a broader level, engagement was facilitated by deliberately shifting power within health care and community services. As they worked at the individual and systems level with a range of partners, these OTs drew from and built upon their occupational therapy skills, knowledge and values, revealing the less visible aspects of how CD from an occupational therapy perspective occurs in practice.

7.6 Pictorial Representation of CD From an Occupational Therapy Perspective

Integrating the concepts described above, a pictorial representation of CD from an occupational therapy is presented in Figure 5. The three background circles represent the main contextual spheres in which CD occurred in this study: health services, community agencies and consumers. The gaps and historical tensions described previously are shown to have decreased
through the process of CD, as depicted by the circles’ close proximity. The central triangle represents a main underlying process of CD from an occupational therapy perspective: the strategic use of self. Two main aspects of this process, power sharing and meaningful engagement, are highlighted. The four key CD strategies are visible within the central triangle, illustrating that the strategic use of self encompasses and manifests through these CD strategies. The three points of the triangle allude to the three interrelated strategies OTs employ during the strategic use of self: anchoring, centering and relinquishing.

**Figure 5: Community Development from an Occupational Therapy Perspective**
CHAPTER 8: DISCUSSION & CONCLUSION

8.1 Chapter Overview

This study answered the research question: *How does the process of community development (CD) from an occupational therapy perspective occur in practice?* In this chapter, research sub-questions are revisited to synthesize the key findings of this study, which are related to extant literature. Specifically, the cross-case analysis, including contextual factors, key strategies, underlying processes, and the occupational therapy perspective are considered in relation to CD and occupational therapy literature. Additionally, the research findings contribute new ideas that extend models pertaining to CD from an occupational therapy perspective. Following the identification of this study’s limitations, I conclude this thesis with suggested implications for practice, education, and potential future research.

8.2 Revisiting the Research Questions

Six sub-questions guided the research in this study, and helped to answer the overarching research question; these sub-questions were:

a) What are the central strategies and activities of the CD process within practice?

b) What are the intended and actual outcomes of this process?

c) How do OTs facilitate this process?

d) How are key concepts, values and approaches of occupational therapy integrated into CD practice?

e) How do contextual factors enable the CD process?

f) What are key points of tension encountered by OTs in daily practice and how are these managed?
The framework generated through cross-case analysis addresses these questions. A summary of these findings in answer to the above questions is provided below.

Key Strategies, Phases and Outcomes of Community Development From an Occupational Therapy Perspective

OTs in this study employed four strategies: 1) building consumer capacity, 2) nurturing community partnerships, 3) influencing health services, and 4) linking sectors and resources. CD initiatives were intended to enhance individual skills and create opportunities for meaningful and collective engagement through peer-oriented activities. Along with these individual outcomes, community change occurred in the delivery of community and health services and the sectors’ collaboration. Underlying these changes was the process of shifting and sharing power. OTs facilitated power-sharing through the strategic use of their professional and personal selves, conceptualized to contain three sub-processes: anchoring to clinical skills and credibility, centering on meaningful engagement while reaffirming central values, and relinquishing aspects of one’s role as a professional. These sub-processes allowed OTs to navigate various sectors, genuinely engage with partners and colleagues, and use their legitimacy to benefit the CD project.

This research also proposed one way to conceptualize the three phases of CD initiatives: emerging, establishing and expanding. During each phase, OTs drew upon CD strategies determined by the context of the program.

Contextual Factors and Tensions Impacting Community Development From an Occupational Therapy Perspective

Contextual factors in the three cases impacted the implementation of strategies, with program location as the dominant factor in how strategies were used. The initiative that was located outside of the typical parameters of health services, with the support of the health authority’s CD framework, had greater flexibility to respond to community-identified priorities. The initiative that was located within the rehabilitation centre was largely shaped by the resources
and priorities of the centre, with significant negotiation required to maintain the community partnership. Despite nuances in implementation, all cases aimed to engage consumers meaningfully in initiatives that affected their health and well-being.

An Occupational Therapy Perspective: Facilitating Community Development Through the Strategic Use of Self

Using their professional background, OTs *anchored* their CD work to well-known occupational therapy expertise areas, *centered* on meaningful engagement and *relinquished* rigid boundaries of professional roles. These processes permitted OTs to build upon, deepen and extend their roles in CD with the ultimate aim to create opportunities for meaningful engagement with(in) communities. A strong ethical commitment to core values, in particular the value of experiential knowledge and engagement, was necessary for meaningful engagement.

Power dynamics needed to be negotiated in order for OTs to engage with different sectors through CD strategies. Thus, the occupational therapy perspective in each case shared a foundation of meaningful engagement despite manifested differences. OTs facilitated CD by strategically using their professional and personal selves to shift and share power in order to negotiate the underlying power inequities that existed. OTs were tasked with bridging health, community services and consumers. This bridging was facilitated by the conscientious consideration of power inequities between oneself and community members, and deliberate efforts to develop consumer capacity, change attitudes, nurture partnerships and establish ongoing supports for consumer participations. OTs needed to maintain their credibility in health and gain legitimacy with consumers across sectors. This required distinction between OTs’ roles as clinicians and professionals from catalysts and colleagues, which enabled relinquishing wherein OTs let go of aspects of professional roles in order to take on new roles.

Through these four strategies, OTs strategically used their professional and personal selves to address power inequities that interfered with consumers’ meaningful engagement in
community and health services. The extent to which this study’s findings confirm, refute or supplement existing literature is discussed below.

8.3 Consideration of the Findings in View of the Community Development Literature

Several CD models identified in the literature parallel the features of CD from an occupational therapy perspective as conceptualized in this study, suggesting that features found in the literature were present in OTs’ approaches.

Community Development Models

Capacity building, nurturing partnerships and linking resources are strategies that correspond with the overlapping stages of the CD continuum that address individual and then collective issues (Jackson et al., 1989; Labonte, 1994). In this study, individual skill development and trust were built during consumer capacity-building activities, as shown on the CD continuum. Similarly, during capacity-building strategies in the current research, peers are brought together to share their experiences with others, consistent with the small group development stage of the CD continuum (Jackson et al.). The strategies of nurturing partnerships and linking resources and sectors correspond with later stages along the continuum. For example, the third and fourth stages of the CD continuum are characterized by linking groups and building coalitions or partnerships for broader community change (Jackson et al.), which are also evident in the current research as partnerships between community agencies and consumers are developed.

Despite these similarities, discrepancies are found in relation to the final stage of the CD continuum, characterized by political action, emphasizing sustainable efforts and ongoing participation of community members in decision-making (Jackson et al., 1989; Labonte, 1994). Although sustainability and consumer participation during program planning and implementation were intended during this study’s cases, only one survivor was actively involved in the planning
and implementation of the peer mentoring project in Case 1, and plans for consumer leadership in Case 2 had yet to be realized. Only the longest-standing case saw sustainable changes within the broader community, corresponding to the CD continuum’s later stages. This suggests considerable time and effort may be necessary for CD projects initiated from within the health sector to progress to later continuum stages. Research on the organizational capacity of regional health authorities (RHAs) to implement CD in Canada identifies a number of organizational level factors that can either facilitate or hinder RHAs’ ability to engage in CD (Germann & Wilson, 2004). This literature suggests that challenges in establishing sustainable CD efforts within the current study may be a function of the cases’ institutional setting.

Consideration of Laverack’s empowerment domains (2001; 2005) in relation to activities of the three OTs in this study may provide insight into this. Laverack identified nine community empowerment domains that he mapped onto a CD continuum: 1) community participation, 2) problem assessment capacities, 3) local leadership, 4) organizational structures, 5) resource mobilization, 6) links with other organizations and people, 7) ability to ask ‘why’ questions, 8) community control over program management and 9) equitable relationship with outside agents. This study demonstrates that OTs employed many domains in their strategies; for example, consumer participation was fostered during capacity-building opportunities, which also developed local leadership. Other domains, such as organizational structures and resource mobilization, were realized in the strategy linking resources.

Although contributing to six of nine domains, OTs in this study did not explicitly work towards developing problem assessment capacities, nor did they promote community control over program management. This may explain why broad community changes are less evident in these cases. A focus on developing critical perspectives and problem-solving abilities may be necessary for OTs working in CD within health authorities to create systemic change. As well, explicit efforts aimed at promoting consumer control over program management may be required.
It is interesting to note that this study’s strategies correspond with many of the Ottawa Charter for Health Promotion strategies (WHO, 1986), although health promotion was a stated framework in only one of the three cases in this study. The cases employed four of the following five Ottawa Charter health promotion strategies: create supportive environments, strengthen community action, develop personal skills, reorient health services and build healthy public policy (WHO). In this study, OTs created supportive environments as they facilitated peer activities, strengthened community action by involving consumers, developed personal skills through capacity-building, and worked in various ways to reorient health services. None of the OTs explicitly built healthy public policy. Only Case 3’s health authority had a clear CD framework, which may represent healthy public policy, and it was only in this case that broader community level changes were noted. This suggests that such policies can support OTs’ CD work and thus should be implemented in CD initiatives. In particular, this study illustrates the importance of meaningful engagement as a means towards maintaining health through active community participation.

In relation to Rothman’s taxonomy of CD that differentiates between social planning, social action and locality development (1987), all of these approaches were found in this study’s cases, substantiating Rothman’s revised understanding of the mixing of these approaches (Rothman, 1996). Social planning approaches, which tend to be “top-down” and emphasize professional expertise (Rothman & Tropman, 1987), were evident in the OT-initiated activities across the three cases. Social action approaches, which work towards the just allocation of resources (Rothman & Tropman), are seen in power shifts between health and community. Similarly, elements of locality development, in which participants are engaged as active citizens and the professional acts as a catalyst (Rothman & Tropman), were also evident in the small group development work done with consumers in the three cases.

Though these CD approaches are mixed throughout the study’s cases, it is also possible to label each case as predominant in one approach. Case 1 is most congruent with a social
planning approach, located at a rehabilitation centre and valuing professional expertise and managerial influence. Case 2, with the OT’s strong commitment to consumer empowerment and challenge to longstanding practices within the psychiatric hospital, is more compatible with social action. Case 3 is the only case where community was defined in terms of geography, and aims to strengthen that community were congruent with a locality development approach.

The three general phases of CD initiatives proposed in this research – emerging, establishing and expanding – differ significantly from linear models found in the literature. Nor were these stages clearly delineated in the cases of this study; instead, projects evolved over time as OTs gradually understood their role in CD and learned of community partners’ priorities. Thus, this study’s initiatives illustrate a responsive, flexible CD approach without planned stages. This is likely related to each OT’s admission of figuring out how to engage in CD as they went along, as other Canadian OTs working in CD report (Lauckner et al., 2007).

Nursing literature provides examples of similar attempts to outline CD phases. For example, Ploeg (1999) conceptualized five CD stages in her case study of two CD projects with seniors, the early stages of which correspond with this study’s ‘emerging’ phase: 1) building agency commitment for action, 2) building community commitment for action, 3) building capacity for action, 4) taking action and 5) ending. Ploeg’s second stage captures the identified need in this study for CD support among other health professionals, most clearly illustrated in Cases 1 and 2. Also similar to Ploeg’s conceptualization, the current research identified the cyclical nature of CD initiatives, but unlike Ploeg’s stages, this study has no ‘ending’ stage. When responsibility for a project was handed over or ended, OTs worked with communities to identify other issues, as in the ‘expanding’ phase. A potential benefit, therefore, of OTs with a CD mandate employed by health authorities are ongoing relationships between health services and communities.

This research supports a recent Canadian public health nurse study that identifies the main themes in working with communities as building capacity for partnership and citizen
control and four sub-themes that are evident in the current study: 1) building trusting relationships and rapport, 2) building personal confidence and skills, 3) engaging in empowering educational strategies, and 4) connecting with a broader social network (Aston, Meagher-Stewart, Edwards, & Young, 2009). A notable discrepancy between the current study and Aston and colleagues’ work is their inclusion of an additional sub-theme, working within a population health promotion perspective, which was not identified in the current study. The absence of this population health promotion perspective in the current study may highlight the lack of a broad framework for CD from an occupational therapy perspective.

Defining ‘Community’

How one defines community influences one’s approach to CD; OTs in this study demonstrate a complex understanding of communities, which contrasts literature stating health professionals emphasize geography and target groups (St. John, 1998; Jewkes & Murcott, 1996; Levin & Herbert, 2001). The current research shows the OTs considering communities’ contexts, fostering a sense of community and striving to connect communities, hence emphasizing communities’ “connectedness” (St. John) and multidimensional nature (Walter, 1997).

In two cases, OTs reported that clinicians within existing health institutions were communities they sought to develop. This conceptualization, where community includes clinicians and consumers, and institutions and community resources, challenges notions that CD typically occurs outside of institutions and excludes clinicians or providers, who are typically viewed as CD facilitators rather than recipients.

This study demonstrates that previously distinct communities were brought together through the process of linking services and resources. In CD, Gilchrist (2004) emphasizes the centrality of networking, which refers to “the creation, maintenance and use of links and relationships between individuals and/or organizations” (p. 55). Building upon their strategic use
of self that affords them entry into different spheres, the OTs in the current study demonstrate their abilities as skilled networkers between sectors.

The notion of community expands to include professionals and consumers who are brought together to address shared issues of concern around service delivery. The cases in this research therefore illustrate how community-based initiatives that are supported by health professionals contribute to CD.

*Power and Community Development*

One issue identified in CD literature is reflexivity (Ife, 1999; Camiletti, 1996) and how health professionals use and share their power (Laverack, 2005; Labonte, 1994; Skelton, 1994). Thompson (1998) proposes that health professionals must recognize their prerogative to condone existing inequalities or challenge oppressive practices (cited in French & Swain, 2001). The current research identifies a key underlying process related to the use of power: *aligning and strategically using the professional and personal self in order to encourage more equitable sharing of power*. OTs’ CD strategies show how a health professional in a ‘power-over’ position can use his/her influence to foster ‘power-with’ relationships (Laverack, 2005; Labonte, 1994).

Cheek (2000) cites Michel Foucault’s work to understand power within nursing research, explaining that knowledge from one discourse (i.e., ways of thinking and speaking about aspects of reality), such as the medical understanding of the body, gains prominence through socio-historical influences. Just as understandings of nursing frame how nurses view themselves and are viewed by others (Cheek), OTs are similarly viewed within and influenced by the predominant medical model (Cloutson & Whitcombe, 2008; Mortenson & Dyck, 2006). OTs in this study illustrated the negotiation of these discourses.

The sub-process of anchoring OTs within dominant discourse gives them legitimacy as professionals within a health care system that values medical expertise. In contrast, centering and relinquishing processes aim to strengthen discourses that emphasize doing as a means for health
(Law, Steinwender, & Leclair, 1998; Wilcock, 1998), and consumers as essential, active contributors to their own and others’ health. OTs’ ethical values were central to the negotiation of these power dynamics. This research yields detailed examples of OTs navigating discourses to transition from ‘power-over’ to ‘power-with’ within CD initiatives.

**Context: Bridging Health and Community**

This study illustrates OTs’ methods of employing CD approaches within a health authority. OTs were tasked with bridging long-standing divides between the health and community sectors. The challenges of working across sectors in the community are many, as are the challenges of community partnerships (Poland et al., 2005). In a large multi-site qualitative case study examining hospital-community collaborations, Poland and his colleagues identified a number of organizational barriers and facilitators to collaboration that align with this study’s findings. Specifically, their research found stark cultural differences between community and hospitals, with hospitals characterized by individual-focused, biomedical interventions that emphasize professional expertise (Poland et al., p. 132). Hospital-based champions were essential as ‘cultural interpreters’ who were accountable to both their employer and the community (Poland et al.). Within this role, champions worked towards bridging this identified divide by building the legitimacy of community work within the hospital while under the threat that such community work may be terminated because it was not considered central to the hospital’s mandate (Poland et al.). This cultural divide was similarly identified in the current study where OTs acted like the champions in Poland’s study.

Poland and his colleagues (2005) also spoke of power issues, revealing that many community organizations were hesitant to partner with such dominant partners as hospitals. These partnerships were often viewed as ‘unequal’, and needed to develop trusting relations (p. 133), similar to the strategy ‘nurturing community partnerships’ observed within this research. OTs in
the current study implemented a range of strategies, including memos of understanding, informal relationship building, and co-location of programs to address such inequalities.

8.4 Consideration of the Findings in View of Occupational Therapy Literature

The findings of this research propose a CD framework that integrates an occupational therapy perspective. Parallels are evident between this study’s cases and the literature’s examples of OTs engaging in CD. These similarities support the applicability of this study’s findings to other cases, which is a type of generalizability referred to as theoretical generalizability or transferability (Krefting, 1991; Streubert & Carpenter, 1999). Unique features of CD from an occupational therapy perspective were identified in light of existing occupational therapy models, and findings suggest methods to adapt and extend these models for enhanced applicability.

Existing Examples of OTs Engaging in Community Development

Similar elements were found in the cases described in this study and existing literature examples of Canadian OTs engaging in CD. Shared elements include: similar program participants, largely people with disabilities (Westmorland, 1996; McComas & Carswell, 1994; Trentham et al., 2007) and their families (Thibeault & Forget, 1997; Wynn et al., 2006), or seniors (Letts, 2003); a range of partners including community agencies (Wynn et al., 2006; Westmorland, 1996; Banks & Head, 2004), business owners (Westmorland, 1996), consumer organizations (McComas & Carswell, 1994; Westmorland, 1996) and other service providers (McComas & Carswell, 1994; Thibeault & Forget, 1997); the gathering of community priorities through informal community needs assessments (Banks & Head, 2004; Klinger & Bossers, 2009); and, the implementation of a range of initiatives, such as the creation of resources (Banks & Head, 2004), program development (Trentham et al., 2007), and education (McComas & Carswell, 1994; Wynn et al., 2006; Thibeault & Forget, 1997).

Contrary to the literature, this study broadened the focus of inquiry to explore the relationship of non-CD and CD tasks. This research thus provides a new perspective into what
can be considered precursors or support activities for CD initiatives, and provides insight into non-academic contexts supportive of CD. This research describes how CD occurred within a clinical context supported by local health authorities, rather than the literature’s bias towards academic-community partnerships or academic-initiated programs (e.g., Banks & Head, 2004; Letts, 2003; McComas & Carswell, 1994; Thibeault & Forget, 1997; Trentham et al., 2007; Wynn et al., 2006). Thus, although this study’s cases are similar to examples in the literature, a broader view of CD is taken, including activities that support CD initiatives and efforts to influence attitudes and practices within health institutions. The importance of environment in enabling occupational engagement is well supported in the literature (Baum & Law, 1998; Law, 1991; Letts, Rigby, & Stewart, 2003); this study concurs in conceptualizing strategies for the broader service delivery environment.

Also in contrast to the literature, OTs in this study did not explicitly draw on occupational therapy models to guide their work; instead, they tended to focus on key values and concepts from their occupational therapy background to guide their work.

An Occupational Therapy Perspective Within Community Development

The processes of anchoring, centering and relinquishing identified in this study describe how OTs integrate their perspective into CD initiatives. At times, OTs anchored their CD work to well-known areas of occupational therapy expertise in a reiterative manner; at other times, they centered themselves on meaningful engagement and core values.

OTs’ emphasis on meaningful engagement relates to the well-known CD concept of participation, but adds the subjectively-experienced notion of ‘meaning’ and the broader notion of health and well-being through ‘doing’ for both the individual and community. Wilcock (1998) explains that through doing, people are afforded opportunities for being their true selves and becoming competent, social beings who grow and fulfill their potential for transformation and growth. The multiple layers of individual and community changes shown in this research provide
evidence of the connection between “doing well, well-being, and becoming healthy” at both the individual and societal level (Wilcock, 1998, p. 253).

Through centering, OTs were able to relinquish other aspects of their professional role that were not conducive to CD. In strategically moving between their professional and personal selves, OTs returned to anchoring to draw on their credibility and experiences as clinicians that afforded them access to resources. They also repeatedly returned to the process of relinquishing in order to share resources and power with others.

These processes provide additional insight into Canadian OTs’ experiences in CD described by Lauckner et al. (2007). In their research on OTs’ experiences and understanding of CD, four themes were identified: 1) uncertainty, 2) resourcefulness, 3) reflection and reconciliation, and 4) expanding one’s role (Lauckner et al.). Although these themes were identified as cyclic in nature, the current research proposes that, in clinical settings, the OTs did not simply ‘expand’ their role, but rather moved between more traditional roles that were required in their clinical work and their community developer role, which was that of a catalyst and colleague. It is through strategic role shifts that OTs in this study were able to share power.

Although empowerment is an important concept in occupational therapy in general (Townsend & Polatajko, 2007), and among OTs engaging in CD (Lauckner et al.; Townsend, Cockburn, et al., 2007), this study describes how OTs contribute to empowerment processes at both the individual and collective level (through capacity-building) and at systems level (through partnerships and influencing the health care system).

The sub-process of centering was based on OTs’ reaffirmation of their commitment to core values. Values shared by this study’s OTs included: belief in the value of experiential knowledge; commitment to meaningful engagement; belief in individual and collective potential for change; commitment to equitable partnerships; a recognition of interdependence between partners based on different strengths and vulnerabilities; the importance of the environment in
supporting engagement; commitment to a strength-based approach; and, commitment to planning for sustainability, such that projects can continue with minimal OT input.

Many of the core values identified in the current research are compatible with the enablement foundations in Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-being, & Justice Through Occupation (Townsend & Polatajko, 2007): choice, risk, responsibility; client participation; vision of possibility; change; justice; and, power-sharing (Townsend, Beagan, et al., 2007). The foundation of client participation is evident within the current study; however, the term ‘client’ was not used by the OTs in the current study. In their CD roles, consumer-survivors or seniors were not viewed as the OTs’ clients, but rather were considered partners or colleagues. This discrepancy supports others who question the underlying power inferences associated with the term ‘client’ (Turner, 2002; Siegfried, Ferguson, Cleary, Walter, & Rey, 1999).

Issues of choice, risk and responsibility are evident in the current study; however, rather than these issues pertaining mainly to clients, community partners and the OT were also required to take risks. This was particularly present during the negotiation of community partnerships, where interdependence required for genuine partnerships left the OT vulnerable because of less control than in typical client-therapist interactions. Other noticeable enabling foundations included change and visions of possibility, as well as power-sharing. Acting as conduits for the institutional power of the health authority, OTs also shared individual power with consumer-survivors and partners. Power sharing was evident in community partnerships and the linking of resources and sectors, in which health authority resources were redirected to community initiatives.

The final enabling foundation, justice, was alluded to in the OTs’ core values, corresponding to Townsend and Wilcock’s (2004) occupational rights: 1) the right to experience occupations as meaningful, 2) the right to develop through participation in occupations for health and social inclusion, 3) the right to exert individual or population autonomy through choice in
occupations, and 4) the right to benefit from the fair privileges for diverse participation in occupations (p. 80). OTs in this study promoted the participation of consumer/survivors in meaningful occupations that contributed to others, which were occupations that they had largely been excluded from, particularly within the health care system. In occupational therapy, ‘productive’ occupations refer to those that contribute to the social and economic fabric of society, through paid or unpaid work (CAOT, 2002). Paid and unpaid work provides meaning, develops self-identity and fosters a sense of accomplishment (Rebeiro & Allen, 1998; Krupa, 2004). By contributing to others, consumers in this study played an active role in their own well-being while making social and economic contributions to their community, whether the survivor community or their local community.

In light of literature on occupational justice, OTs in this study displayed an implicit justice perspective: recognizing systematic injustices experienced by people with disabilities, expressing positive regard for people just as they are, expressing and acting on the belief that people should have a place and be able to participate in society, and critically reflecting on unchallenged social norms (Townsend, Beagan, et al., 2007, p. 106).

*Canadian Model of Client-Centred Enablement*

This study revealed that the process of CD from an occupational therapy perspective was not explicitly guided by existing occupational therapy models, raising further question regarding the applicability of the current theoretical basis of occupational therapy to CD. Aspects of the processes identified in this study are captured by the Canadian Model of Client-Centered Enablement (CMCE) (Townsend, Beagan, et al., 2007), rendering this model compatible with CD practice.

Enabling refers to “an interwoven spectrum of key and related enablement skills which are value-based, collaborative, attentive to power inequities and diversity, and charged with visions of possibility for individual and/or social change” (Townsend, Beagan, et al., 2007, p.
111). Of the three models discussed in *Enabling II*, the Canadian Model of Client-Centered Enablement (CMCE) best captures the CD process conceptualized in this research, where OTs’ enabling skills were displayed (Townsend, Beagan, et al., p. 110). For example, OTs applied *adapt* and *design/build* skills as they adjusted activities and environments for consumers during capacity-building activities. The OTs *coached* consumers and colleagues through challenging tasks, which at times also involved *educating*. They *coordinated* CD initiatives, *collaborated* with consumers and community agencies and they *consulted* with colleagues, both those in the health authority and those in the community. OTs *advocated* for the recognition of consumer contributions and ultimately worked to *engage* people in CD activities.

In contrast to more typical client-therapist relationships, however, OTs in this study developed collegial relationships with consumer-survivors, which led to OTs *being enabled*, in addition to enabling. The partnerships were reciprocal as capacity was built, power was shared, and consumers took on greater roles in program planning and implementation. This research thus proposed that in addition to core enabling skills, the willingness to grow – in effect, to be enabled – is a CD skill for OTs working with communities. Lastly, enablement is recognized as a largely invisible process that risks being taken for granted or undervalued (Townsend, Beagan, et al., 2007), when in fact “invisible enablement may actually be an indicator of success” (Townsend, Beagan, et al., p. 114). This corroborates OTs’ increasing invisibility as they worked behind the scenes and stepped back once consumers were linked with community supports.

**Canadian Practice Process Framework**

The Canadian Practice Process Framework (CPPF) (Polatajko, Craik, Davis, & Townsend, 2007) captures the CD processes to a lesser extent; however, this model can be strengthened through incorporation of the findings of this research. Although the CPPF claims to be relevant to CD and individuals (Craik et al., 2007), the applicability of the CPPF’s clearly defined action points to this study’s cases proves difficult. Firstly, OTs tended to work with
people or partners, rather than ‘clients’, thus the very terminology of the CPPF is inconsistent with CD approaches. The CPPF also tends to be therapist-driven, with assessments dependent on ‘occupational therapy expertise’ (Davis et al., p. 258); this contradicts the approach of OTs in the current study who aimed to be directed by the community.

The CPPF’s general action points can be loosely applied to the activities of the OTs in this study, though the points were not well-defined, nor linear in practice. For example, the ‘enter/initiate’ action occurred differently with each person or agency. This included informally speaking with agency representatives at conferences and informally speaking to business owners. The action point of ‘setting the stage’ includes relationship building and identifying how partners will work together, which were important elements in this study. ‘Assessment’ was often informal and ongoing, although some formal community needs assessments were made by others prior to CD initiatives. For example, in Cases 1 and 2, committees identified community needs and resources that directed CD initiatives. As with the ‘assess’ action point, other CPPF action points were less defined, and the final exit point was never fully realized, since OTs remained involved with CD initiatives.

The study’s findings contribute valuable insights into the contextual features of the CPPF, in particular the practice context and the frame(s) of reference. CD initiatives in this research were contextually bound, with strategies dependent on project location as well as historical relations between the health authority, community agencies and consumers. Thus, this study provides examples of historical and community-related contextual elements to consider when working in CD: historical tensions between health and consumer groups, health and community services, and community services and consumers; cultural features of the local community; institutional priorities; managerial support; program history; and community agency resources. Because these contextual features extend what is typically considered the ‘practice’ setting, the CPPF might better capture these by labeling this feature of the model ‘institutional and community context(s)’. 
Within the CPPF, community-based approaches, including CD, health promotion and community-based rehabilitation, are sample frames of reference that OTs can use when working with communities (Polatajko, Cantin, et al., 2007). OTs in this study also proposed strength-based, capacity-building, and international development approaches to guide CD work. In addition to OTs’ frames of reference, this research identified consumer experiences that influence CD process(es). When considered collectively, consumer perspectives and their historical relations could also constitute community frames of reference as important as OTs’ models. To capture the importance of these collective consumer experiences, it is suggested that communities’ frame(s) of reference be explicitly included in the CPPF.

**Canadian Models of Occupational Performance and Engagement**

The CMOP-E visually represents interactions between the person, occupation and environment that portray occupational performance and engagement (Polatajko, Townsend, & Craik, 2007). OTs in this study did not explicitly mention this model but referred to its key components (person, occupation and environment). At times, OTs inferred that their CD work was similar to their work with individuals; to this end, OTs explained that they considered the community’s collective occupational issues and shared environments. In its present form, the CMOP-E does not speak to collective occupations or shared environments.

Of the triad of occupations identified in the CMOP-E (self-care, leisure and productivity), productive occupations appeared to best capture community members’ roles in CD initiatives. However, the lack of an explicit reference to this by the OTs questions this classification’s applicability to CD. Others in occupational therapy have critically examined this triad (Hammel, 2009) and proposed alternative conceptualizations of occupations based on the subjective experience and benefit gained from engagement (Hammel; Thibeault, 2009). Of particular relevance to CD is the proposed conceptualization of occupations that connect people, fostering a sense of belonging, and that enable people to contribute to others (Hammel; Thibeault).
Integrating Hammel’s and Thibeault’s suggestions, one potential classification of occupations with greater relevance to CD (and arguably greater applicability to occupational therapy in general) includes connecting occupations, contributing occupations, restoring occupations, uplifting occupations, and ‘doing’ occupations (Hammel; Thibeault).

Connecting occupations emphasize a sense of belonging and shared experiences (Thibeault, 2009); contributing occupations provide the opportunity for people to give back to and be valued by others (Thibeault; Hammel, 2009). Although many contributing occupations foster connectedness and belonging (Hammel), this research suggests occupations that foster connectedness (i.e., hearing other consumers’ experiences) without actively contributing to others. Restoring occupations include prayer, meditation, creative arts and enjoying nature (Hammel), or involve contemplation and creation (Thibeault). Uplifting occupations pertain to those who have encountered significant crises; they link with the past and provide hope for engaging in similar occupations again, thus contributing to a sense of life coherence or continuity (Hammel). ‘Doing’ occupations include self-care and productive activities that are undertaken out of a sense of commitment, routine or accomplishment (Hammel). These ‘doing’ occupations are differentiated from contributing occupations because they are not necessarily “interesting, fulfilling or rewarding, but instead might be mundane or boring, associated with responsibility or duty” (Hammel, p. 111). Connecting, contributing and uplifting occupations are evident in this research: for example, the value of contributing occupations is evident in survivors’ desires to give back to others. Similarly, the value of uplifting occupations is seen as survivors seek to reclaim their previous status as valued contributors.

*Proposed Model Modifications*

One potential application of the CMOP-E (Polatajko, Townsend, & Craik, 2007) to communities is to conceptualize a community comprised of individuals, each of whom can be depicted by the CMOP-E illustration, as depicted in Figure 6 below.
The individuals at the centre represent a community, or a group of individuals who share a geographic location, have some shared values and interests and self-identify as belonging to the community (Labonte, 1997). Sub-groups within the community are illustrated by the clustering of individuals, and may contribute differently or have different priorities than other groups in the community. This depiction of sub-groups acknowledges the diversity within communities of which OTs must be aware. This modified CMOP-E capitalizes on the broad notion of engagement by focusing on occupational opportunities that individuals within the community
may or may not choose. The combined occupational categories proposed by Hammel (2009) and Thibeault (2009) are depicted as occupational opportunities within the community.

This conceptualization of community from an occupational therapy perspective can then be integrated into the CPPF, along with the suggested modifications. Pictorially, this could be depicted as illustrated in Figure 7. The general sequence and stages of the CPPF are retained; however, to bring community to the forefront, the adapted CMOP-E depiction of a community is used. Including the CMOP-E maintains both individual and collective occupational issues within communities. The OT is depicted by a CMOP-E diagram to show that the OT is one of many occupational beings engaged in the enabling CD process. The OT’s location within the community changes throughout different action points to represent different roles within the group, at times leading and at other times facilitating activities.

At the onset of the process, the OT is illustrated as being separate from the community, yet aware of community issues. Through relationship-building, the OT may begin to work with the community in the first action point. Setting the stage is characterized by partnership negotiations, central to CD processes in this study. The subsequent action points of assessment, plan, implementation and monitor/modify are similar to the CPPF, except that decision-making is in partnership between the OT and community representatives and ultimately led by the community in an explicitly collaborative manner. The four CD strategies in this study are depicted as occurring at the implementation point; however, elements of the strategies are occurring throughout the process. In the evaluation stage, outcomes and processes related to the community’s goals and the extent to which community members felt actively involved in the process are evaluated. The conclude/exit stage has been altered to capture the potential ongoing, but changed, partnership between the OT and the community as participants are linked with other communities or agencies to sustain change.
It is important to note that the community’s occupational opportunities (depicted by the circle surrounding the individuals) gradually grows through the CD process; indeed, the process itself offers a range of occupational opportunities for the participants. Of particular relevance to CD are contributing, connecting and uplifting occupations. The option for individual interventions, as illustrated by the individual moving outside of the community grouping, is retained in the modified model; this captures the individual interventions provided by OTs in this study.
Lastly, in the modified CPPF, the two overlapping circles represent the frames of references brought to the CD process from OTs and community members, cementing the community as a main partner in the CD process.

8.5 Limitations of Research

Although a larger number of cases in this study might allow for a broad applicability of findings to a wider range of settings, I chose to balance breadth with depth, selecting three diverse cases that enabled in-depth exploration of each.

Although I was immersed in each case for 3 weeks, this duration is limited considering how long the initiatives had existed. Although efforts were made to gather relevant historical data, findings must be considered a snapshot within ongoing CD initiatives; longer involvement with the projects could yield different understandings.

Despite the use of maximum variation sampling to identify diverse cases, inclusion criteria steered case selection towards government/health authority-funded initiatives. Consequently, this research focused on CD within the context of urban area health authorities, and does not include OTs working outside of the health system or in rural areas. Furthermore, there was minimal ethno-cultural variation among the participants, thus this study does not address cross-cultural issues that can affect CD work.

8.6 Implications

This research has potential implications for practice, education, health policy and management, and research. This research provides evidence that enabling, proposed as the core competency of OTs (Townsend & Polatajko, 2007), is relevant to OTs working in CD. Congruency between OTs’ roles identified in the current research and enabling foundations and skills suggests that the new Canadian Model of Client-Centred Enablement (CMCE) (Townsend, Polatajko, et al., 2007) is relevant to CD, as was intended (E. Townsend, personal
communication, September 29, 2009). It is anticipated that the conceptualizations developed in this study will guide the practice of OTs working in CD by making potential strategies explicit. In particular, contextual factors identified in this research sensitize OTs to historical tensions that may impact CD. Four strategies suggest activities for OTs to focus on, which vary depending on OTs’ contexts and location within the health authority. This research offers an expanded view of CD strategies that includes working with health institutions and health professionals, as well as community partners; as such, this research provides a framework capturing a broad range of CD activities that OTs are engaged in, but have yet recognized as relating to CD.

The potential invisibility of OTs’ work in CD emphasizes the importance of articulating the ways in which CD enables occupation and is thus a viable occupational therapy approach. Although OTs may become invisible in enabling consumers to lead CD activities, the rationale for doing so, and its contribution to health, need not be equally invisible. Indeed, if additional health authority-funded CD positions are one way for CD from an occupational therapy perspective to occur, the connection between meaningful engagement, CD and health and well-being must be clearly stated.

The process of the strategic use of self brings underlying processes of power sharing to the forefront, requiring that OTs acknowledge and constructively use power. This research indicates OTs need to be aware of individual and organizational power, as well as underlying dynamics. A reflexive approach, an ethical commitment to core values, and the strategic use of self mediates these power dynamics. This research encourages therapists to consider how the language of ‘partner’ and ‘colleague’ might impact their daily practice. OTs working in CD are also encouraged to broaden their understanding of productive occupations to consider occupations that afford opportunities for connection, contribution and hope.

These same concepts and processes are also relevant to OTs’ education. This research provides one potential framework that can assist students in conceptualizing future CD roles. Early introduction and integration of core CD values could foster occupational therapy students’
‘centering’ process more fully, resulting in a solid foundation of meaningful engagement with individuals and communities. Rather than needing to anchor with other well-known areas of occupational therapy, the inclusion of CD concepts and strategies in occupational therapy education could see CD emerging as one well-known occupational therapy area. For example, occupational therapy curricula could be further strengthened by the inclusion of health promotion and CD models such as ecological approaches (McLeroy, Bibeau, Steckler & Glanz, 1988). Exposure to a range of CD approaches with the opportunity to learn from OTs engaging in CD may further develop students’ abilities to centre on meaningful engagement.

With regard to policy and management, this research illustrates how CD policy can support the work of OTs in CD. In light of the literature, the current research also identified the absence of OTs working towards the development of policies. The explicit integration of CD concepts and strategies in policies will prioritize consumer participation and engagement as standard practice in health and community services. Health promotion frameworks that go beyond the interactions between health professionals and service users to identify broader socio-ecological influences on health (for example, see McLeroy et al., 1988) may assist in further advancing these discussions at the policy and organizational levels. OTs working in CD can be instrumental in shaping such policies and implementing them in daily practice. This research indicates that dedicated, flexible and supported CD positions contribute to CD initiatives.

As with most research, this study leads to more questions than answers. Modifications to existing models provide a starting point for further discussions of how CD plays out within the daily practice of OTs. The extent to which the proposed models inform practice requires further critical examination. This study also identified the process of ‘relinquishing’ as central to CD work, which can involve the blurring of roles with other professionals. With the current emphasis in Canadian health care on interprofessional collaboration and learning, this study indicates that CD may be a rich field in which to explore collaboration with community members, consumers and other service providers. Research exploring how interprofessional collaboration in the
community differs from and supplements more traditional interprofessional research may provide additional insight into the ‘patient-centered’ component of practice.

Future research can examine how CD from an occupational therapy perspective occurs within rural and culturally diverse settings. An exploration of how CD processes from an occupational therapy perspective occur in fieldwork may also be useful. Fieldwork may be another context through which ‘institution-based’ OTs fieldwork coordinators can share resources with communities, including agencies, clinicians and consumer groups. This research’s proposed CD framework can be evaluated for its applicability in guiding fieldwork initiatives.

This research did not specifically examine the interplay between existing grass-roots, consumer-led initiatives and new health authority initiatives, which warrants further examination. As well, although outcomes at both the individual and community level were reported in the current study, further research to measure changes will provide evaluation tools for OTs to judge the effectiveness of their programs. Lastly, a key feature of this research pertained to the active and largely voluntary involvement of consumers in program development and implementation. It was anticipated that such involvement would have continued positive impact on consumers’ health and well-being, but further research could support the extent to which volunteering for CD initiatives positively impacts mental health and social inclusion (Farrell & Bryant, 2009).

8.7 Conclusion

This research has afforded a window into how CD from an occupational therapy perspective occurs in daily practice. Although this study’s cases presented different manifestations of CD, commonalities among the OTs’ values and approaches are evident. CD from an occupational therapy perspective was context-dependent, with existing service gaps, historical tensions and emerging community initiatives influencing how the initiatives unfolded. Within this study, CD was conceptualized as involving four key strategies and an underlying process: 1) building consumer and community capacity, 2) nurturing community partnerships, 3)
influencing the health care system, and 4) linking sectors and resources, with the underlying process of aligning and strategically using the professional and personal self in order to enable equitable power sharing between health services, community agencies and consumers, contributing to the creation of opportunities for meaningful engagement within communities. The strategic use of self to share power was central to the CD strategies and the subsequent changes reported. Within this underlying process, OTs engaged in a process of anchoring their CD work to well-known occupational therapy areas of expertise; they centered in on core values, in particular meaningful engagement, and they relinquished roles and power.

This research contributes to our understanding of how OTs can partner with consumers, community agencies and other health providers to enable meaningful engagement at the individual and community level. This study illustrates how OTs can be leaders within health authorities to initiate and facilitate CD with people with disabilities and/or chronic conditions. CD from an occupational therapy perspective involves the recognition of historical power differences, the use of self that is based on a recommitment to core values around meaning, equity and justice, and the assumption of new ways of being with consumers and community services. Through this work, power is shifted to consumers who become valuable resources within health and community services, benefiting their own and others’ health and well-being. Through individual meaningful engagement arises the opportunity to share with others, contributing to the development of communities. OTs in this study illustrated how the complex process of CD from an occupational therapy perspective occurs in daily practice to affect such changes.
References


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January 6, 2010

Heidi Lauckner

Dear Heidi,
According to your e-mail request, you are asking permission to include the following figures in your doctoral dissertation:

- Figure 1.3: The Canadian Model of Occupational Performance and Engagement (CMOP-E), p.23.
- Figure 4.3: Canadian Model of Client-Centred Enablement (CMCE), p.110.
- Figure 9.1: Canadian Practice Process Framework (CPPF), p. 233.


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Thank you
Yours sincerely,

Brenda Lammi
Professional Development Manager
Appendix B: Ethics Approval Form

March 29, 2007

Ms. Heidi Lauckner
School of Rehabilitation Therapy
Queen’s University

Re: "Towards a framework for understanding community development from an occupational therapy perspective: Explicating the links between occupation, community and health"

Dear Ms. Lauckner,

I am writing to acknowledge receipt of your recent ethics submission for the above-named study. I have reviewed these materials and do not feel that it is necessary for the study to undergo a full REB review. I have therefore given the study an expedited review and an approval sheet is appended for your records. This study will be reported to the Research Ethics Board.

Yours sincerely,

Albert Clark, Ph.D.
Chair
Research Ethics Board

AFC/kr

c.c.: Dr. Terry Krupa, School of Rehabilitation Therapy
Dr. Margo Paterson, School of Rehabilitation Therapy
QUEEN'S UNIVERSITY HEALTH SCIENCES & AFFILIATED TEACHING HOSPITALS RESEARCH ETHICS BOARD

Queen's University, in accordance with the "Tri-Council Policy Statement, 1998" prepared by the Medical Research Council, Natural Sciences and Engineering Research Council of Canada and Social Sciences and Humanities Research Council of Canada requires that research projects involving human subjects be reviewed annually to determine their acceptability on ethical grounds.

A Research Ethics Board composed of:

Dr. A.F. Clark  Emeritus Professor, Department of Biochemistry, Faculty of Health Sciences, Queen's University (Chair)
Dr. S. Burke  Emeritus Professor, School of Nursing, Queen's University
Rev. T. Define  Community Member
Dr. M. Evans  Community Member
Mr. C. Kenny  Community Member
Ms. C. Knott  Research & Evaluation, Southeastern Regional Geriatric Program, Providence Continuing Care Centre – St. Mary’s of the Lake Hospital Site
Dr. J. Low  Emeritus Professor, Department of Obstetrics and Gynaecology, Queen’s University and Kingston General Hospital
Dr. W. Racz  Emeritus Professor, Department of Pharmacology & Toxicology, Queen’s
Dr. H. Richardson  Assistant Professor, Department of Community Health & Epidemiology Project Coordinator, NCIC CTG, Queen’s University
Dr. B. Simchison  Assistant Professor, Department of Anesthesiology, Queen’s University
Dr. A.N. Singh  WHO Professor in Psychosomatic Medicine and Psychopharmacology Professor of Psychiatry and Pharmacology Chair and Head, Division of Psychopharmacology, Queen’s University Director & Chief of Psychiatry, Academic Unit, Quinte Health Care, Belleville General Hospital
Dr. E. Tsai  Assistant Professor, Department of Paediatrics and Office of Bioethics, Queen’s University
Ms. K. Weisbaum  LL.B. and Adjunct Instructor, Department of Family Medicine (Bioethics)

has examined the protocol and consent form for the project entitled "Towards a framework for understanding community development from an occupational therapy perspective: Explicating the links between occupation, community and health" as proposed by Ms. Heidi Lauckner, Dr. Terry Krupa and Dr. Margo Paterson of the School of Rehabilitation Therapy of at Queen’s University and considers it to be ethically acceptable. This approval is valid for one year. If there are any amendments or changes to the protocol affecting the subjects in this study, it is the responsibility of the principal investigator to notify the Research Ethics Board. Any unexpected serious adverse event occurring locally must be reported within 2 working days or earlier if required by the study sponsor. All other serious adverse events must be reported within 15 days after becoming aware of the information."

Chair, Research Ethics Board  Date

March 30, 2007

REH-398-07 EX
Appendix C: Recruitment Letter

June 1st, 2007

Dear Colleague,

RE: Seeking OTs working in Community Development

I have used the OT networker from the CAOT website to find OTs who might be working in community development (CD). You indicated that you are working in CD, providing direct services in your primary position. I’m writing to let you know about a research project I’m working on.

I am a PhD candidate at Queen’s University working under the supervision of Dr. Terry Krupa and Dr. Margo Paterson. My research project is entitled: “Towards a framework for understanding community development from an occupational therapy perspective: Explicating the links between occupation, health and community.” This study will involve the in-depth exploration of examples of occupational therapists (OTs) who are working in community development (CD).

For the purpose of this research, CD refers to projects or initiatives that incorporate the key features and principles of CD from the literature, including that the initiatives:

- emphasize the process of working with communities
- focus mainly at the community level (rather than the individual level),
- are community-driven (in that the community identifies priorities and strategies),
- strive for the active participation of community members,
- aim to build on strengths and resources within the community, and
- attempt to address inequities through social action and empowerment

Some examples of OTs working in CD may include (but are not limited to): working with vocational services and employers to increase accessibility to employment for people with disabilities; working within health promotion with seniors or consumer/survivors to create awareness among the broader community; or promoting economic development within a community through income generating programs. Because OTs can engage in CD in a variety of settings, I am looking specifically for OTs that are explicitly using CD approaches and principles in their work.

I am looking for OTs who are working in CD, as described above. If you are indeed working in a CD initiative in the position of an OT (i.e., you are registered with the regulatory board), I would be very interested in gathering a brief description of the work that you do. Key information that would be of interest to me can be found in the questions at the end of this letter.
This information will provide me with an overview of where OTs are working in CD. Based on the information gathered, I will invite three OTs to participate in my research project. The research project will involve interviews with the OT, program participants and observation of some of the program activities. More information about the study will be forwarded to those invited to participate and those requesting further information. By providing information about your project in response to this letter, you are under absolutely **NO obligation** to participate in the study. The specific details you provide will not be included in my research. Rather, this is simply a way to gather information in order to identify which settings/populations would best be included in the study to demonstrate the range of CD work done by OTs. This research project has obtained approval from the Queen’s Research Ethics Board.

Any questions or concerns about this study can be directed towards my supervisors (Dr. Krupa: telephone - 613- 533-6236, email - krupat@post.queensu.ca and Dr. Paterson: telephone - 613-533-6094, email - margo.paterson@queensu.ca) or Dr. Albert Clark, Ethics Coordinator of the Research Ethics Board of Health Sciences (telephone: 613-533-6081).

Thank you very much for your time in completing these questions. I would appreciate hearing from you by June 15th. I will follow-up on this request in a week if I have not heard from you and I hope to identify potential OTs to be invited to participate in the study by the middle of July. If you have any further questions about this project, please do not hesitate to contact me at the number or email below. I look forward to hearing about your work! Also, if you are aware of any other OTs who are working in community development, I’d be very interested in getting in contact with them. Thank you!

Sincerely,

Heidi Lauckner, OT Reg (ON)
MSc (Rehab), PhD (Candidate),
School of Rehabilitation Therapy
LD Acton Building, George Street,
Queen's University
Kingston, ON
K7L 3N6
Home office phone: (613) 542-9029
1hl7@qlink.queensu.ca
OT CD Initiative Description

Please answer the following questions to provide an overview of the work you are currently doing in community development (CD). If you are working in more than one job, please respond in relation to the position that is most related to CD, as described in the letter above. Please return this information to Heidi Lauckner at 1hl7@qlink.queensu.ca by June 15th, 2007. Thank you for your time!

Involvement in CD

1. Based on the principles of CD outlined above, do you feel you are an OT currently engaging in CD?
   □ Yes       □ No       □ Not sure

Participants and CD Program

2. Which age group would best describe the primary participants of your community development initiative?
   □ Pediatrics (<10 years) □ Adolescents (11-18 years) □ Adult (19-60 years)
   □ Seniors (>60)          □ Mixed

3. Which of the following best describes the participants of your CD initiative?
   □ Family members/caregivers □ People with chronic health conditions
   □ Indigenous people        □ People with cognitive disabilities
   □ People experiencing homelessness □ People with physical disabilities
   □ People experiencing mental illness □ People within a defined geographic area
   □ People labeled “at risk” □ Other (please describe) _______________

4. Please describe the main goals of the CD project(s)/program(s) you are currently involved in.

5. Please describe some of the main activities/events of your community development initiative.

Setting

6. What would best describe the community in which you practice community development?
   □ rural or small town (population <10 000) □ urban (population >10 000)
7. In what province are you currently practicing community development?
   □ BC □ YK □ NU □ AB □ SK □ MB □ ON □ PQ □ NB □ PE □ NS □ NL

8. Which one of the following settings would best describe your work setting/employer?
   □ Adult rehabilitation clinic □ Geriatric centre
   □ General hospital □ Private practice
   □ Home care □ School system
   □ Mental health centre □ Other (please describe)
   □ Pediatric rehabilitation centre
   □ Community agency/organization
   □ Community health centre

Position/experience
9. Please indicate if your CD position is full or part-time.
   □ full time (>30 hours/week) □ part time (# of hours per week ________)

10. How many years experience do you have in CD as an occupational therapist?
    □ <1 □ 1-3 □ 4-6 □ 6-10 □ >10 years

11. How long have you been involved with this CD program/organization?
    □ <1 □ 1-3 □ 4-6 □ 6-10 □ >10 years

Other
12. Please include any other comments or additional information about your program that will help me understand the CD work you are currently doing.

Contact Details (optional)
13. It is possible that I may require some clarification on the information you provided or I may want to provide you with further information about the study. If you are willing to be contacted for these reasons, please provide your name and contact details below:
   Name: _________________________  Email address: _________________________
   Telephone: ______________________  Mailing Address: ______________________

14. If you know of any other OTs working in CD, I would welcome being in contact with them. Please feel free to forward their contact details to me or forward this email to them.
   Name: _________________________  Email address: _________________________

Thank you again for your time!
August 27 2007

Dear Occupational Therapist working in Community Development,

RE: An invitation to participate in the study “Towards a framework for understanding community development from an occupational therapy perspective: Explicating the links between occupation, health and community”

BACKGROUND INFORMATION
You are being invited to participate in a research study directed by myself, Heidi Lauckner, which aims to describe the process of community development from an occupational therapy perspective. I am a Rehabilitation Science Doctoral student at Queen’s University, supervised by Dr. Terry Krupa and Dr. Margo Paterson and I will be conducting this study, which is entitled “Towards a framework for understanding community development from an occupational therapy perspective: Explicating the links between occupation, health and community”. Ms. Lauckner will review this consent form with you and describe procedures in detail and answer any questions you may have. This study has been reviewed for ethical compliance by the Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board.

PURPOSE OF THE STUDY
The purpose of this multiple case study is to develop a framework that describes how occupational therapy and community development are integrated in practice in order to promote health at the community level. Specifically, this study aims to look at the processes, or changes over time, of community development from an occupational therapy perspective. The information gathered from this study will assist in describing how occupational therapists facilitate community development. The information gathered in this study could be used for the training of occupational therapy students, by therapists currently working in the field to reflect on their current practices, and to create awareness among others working in community development about the contribution of occupational therapists to this field.
WHY YOU ARE BEING INVITED TO PARTICIPATE

You are being invited to participate in this study because the community development project you are involved in integrates both community development approaches and occupational therapy (since you are working in the capacity of an occupational therapist) and the project provides an example of how community development from an occupational perspective occurs in practice in one particular setting.

WHAT IS REQUESTED FROM YOU

If you agree to take part in this study, I will visit your program over the period of 3 weeks in order to learn about the program and your experiences in it. This will involve me observing how the program runs, who does what and how the people in the program interact. As the facilitator of this program, I would also like to have one-on-one interviews with you. Some preliminary interviews may be conducted over the phone. Over the span of the 3 weeks, I will observe approximately 10 hours of program activities (such as meetings, interactions between the OT and participants, program events, etc.). During this time, I will be taking notes. I would like to have four or five, one-on-one interviews of approximately one hour each with you over. These interviews will be arranged at a time and place that suits you. I will be asking about the history of the program, what has happened over the course of the program, what some of the main events have been, how you feel occupational therapy skills and knowledge are integrated into daily practice, what challenges, if any, have occurred and how things have change at all over the course of the program. All interviews will be audio-taped and transcribed by myself or a professional transcriber. I will also be looking at documents related to the program, such as brochures, project reports, and meeting minutes. I will be asking you to assist me in locating these documents as well as to identify key colleagues and participants I could also interview in order to understand different perspective of the program. Depending on what would be needed to help me understand your program, I would be interested in speaking with a couple of your colleagues and/or manager (for approximately two, one-hour interviews each) and 3-4 program participants (for approximately two, one-hour interviews each). Once I have completed a description of the case, I will ask that you review it to ensure I have captured it correctly.

RISKS AND BENEFITS

There are no foreseeable risks associated with your participation in this study. While you may not directly benefit from taking part in this study, the responses received from you will assist me in better understanding the work the OT does and how community development occurs in the
program. I will be looking at a number of different such CD programs and from them, I hope to identify some common elements that other OTs can include in similar programs. The information gathered in this study will be used to inform the future education of OTs and their practice.

CONFIDENTIALITY
All information shared by you will be kept confidential and secure. The interview responses will be stored in a locked file and will only be available to the principal investigator and her advisors. Your name and the location of the program will not be associated with your answers. A general description of the program will be developed, however identifying information will be removed or changed. The program and you will be identified with pseudonyms. Although the information obtained from this study may be published in journals, presented at conferences, or used in the training of students, no identifying information will be included.

VOLUNTARY NATURE OF THE STUDY
We hope that you will fully participate in this study, but your participation is completely voluntary and as such, you can refuse to answer any questions. You are welcome to withdraw from the study at any time without consequences.

COMPENSATION
Your time is highly valued and we appreciate your commitment to volunteer for this activity. Unfortunately, we do not have the resources to compensate any of the participants of this study.

FURTHER INFORMATION
At any time you can contact the principal investigator, Heidi Lauckner (613-542-9029, 1hl7@queensu.ca), the research advisors (Dr. Terry Krupa, 613-533-6236, krupat@post.queensu.ca or Dr. Margo Paterson, 613-533-6094, margo.paterson@queensu.ca) or the Ethics Coordinator of the Research Ethics Board of Health Sciences (Dr. Albert Clark, Chair, 613-533-6081), should you have any questions regarding this study. If you are interested in the outcomes of the study, you can request a one-page summary from the principal investigator.
Thank you for considering this invitation to participate in this study. Please raise any questions or concerns you may have about this study to the principal investigator. Once your questions have been answered to your satisfaction and if you are still willing to participate in the study, please read, sign and return one copy of the consent form below.

Sincerely,

Heidi Lauckner, BSc. (OT), MSc(Rehab), PhD (Candidate), OT Reg. (ON),
Principal Investigator

PARTICIPANT CONSENT FORM – PARTICIPANT COPY

Please retain for your information

I have read and understood the letter of information and consent form of this study. I have had the purposes, procedures, and terms explained to me. I have been given sufficient time to consider the above information and to seek advice if I chose to do so. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form. I will retain one copy of this consent form for my information. The other copy of the consent form can be returned to the principal investigator via the enclosed envelope.

If at any time I have further questions, problems or adverse events, I can contact:
Heidi Lauckner at 613-542-9029, 1hl7@queensu.ca , OR
Dr. Terry Krupa, 613-533-6236, krupat@post.queensu.ca OR
Dr. Margo Paterson, 613-533-6094, margo.paterson@queensu.ca; OR
Dr. Albert Clark, Chair, Queen’s University Health Sciences and Affiliated Teaching Hospital Research Ethics Board at 613-533-6081

By signing this consent form, I am indicating that I agree to participate in this study, which involves having the CD program I am involved with be observed over a 3 week period and participating in interviews with the principal investigator.

Name of Participant (please print) ____________________________

________________________    _______________
Signature of Participant   Date

________________________    _______________
Signature of Witness     Date
PARTICIPANT CONSENT FORM – RESEARCHER COPY

Please return to Heidi Lauckner (School of Rehabilitation, L.D. Acton Building, George Street, Kingston, Ontario, K7L 3N6)

I have read and understood the letter of information and consent form of this study. I have had the purposes, procedures, and terms explained to me. I have been given sufficient time to consider the above information and to seek advice if I chose to do so. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form. I will retain one copy of this consent form for my information. The other copy of the consent form can be returned to the principal investigator via the enclosed envelope.

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Dr. Albert Clark, Chair, Queen’s University Health Sciences and Affiliated Teaching Hospital Research Ethics Board at 613-533-6081

By signing this consent form, I am indicating that I agree to participate in this study, which involves having the CD program I am involved with be observed over a 3 week period and participating in interviews with the principal investigator.

Name of Participant (please print) ______________________________________________________

________________________    ________________
Signature of Participant   Date

________________________    ________________
Signature of Witness    Date

STATEMENT OF INVESTIGATOR:
I have carefully explained to the participant the nature of the above research study. I certify that, to the best of my knowledge, the participant understands clearly the nature of the study and demands, benefits, and risks involved to those involved in this study.

________________________    ________________
Signature of Principal Investigator   Date
August 27 2007

Dear Colleague,

RE: An invitation to participate in the study “Towards a framework for understanding community development from an occupational therapy perspective: Explicating the links between occupation, health and community”

BACKGROUND INFORMATION

You are being invited to participate in a research study directed by myself, Heidi Lauckner, which aims to describe the process of community development from an occupational therapy perspective. I am a Rehabilitation Science Doctoral student at Queen’s University, supervised by Dr. Terry Krupa and Dr. Margo Paterson and I will be conducting this study, which is entitled “Towards a framework for understanding community development from an occupational therapy perspective: Explicating the links between occupation, health and community”. Ms. Lauckner will review this consent form with you and describe procedures in detail and answer any questions you may have. This study has been reviewed for ethical compliance by the Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board.

PURPOSE OF THE STUDY

The purpose of this multiple case study is to develop a framework that describes how occupational therapy and community development are integrated in practice in order to promote health at the community level. Specifically, this study aims to look at the processes, or changes over time, of community development from an occupational therapy perspective. The information gathered from this study will assist in describing how occupational therapists facilitate community development. The information gathered in this study could be used for the training of occupational therapy students, by therapists currently working in the field to reflect on their current practices, and to create awareness among others working in community development about the contribution of occupational therapists to this field.
WHY YOU ARE BEING INVITED TO PARTICIPATE

You are being invited to participate in this study because the community development project facilitated by the occupational therapist (OT) in your program integrates both community development approaches and occupational therapy and the project provides an example of how community development (CD) from an occupational perspective occurs in practice in one particular setting.

WHAT IS REQUESTED FROM YOU

If you agree to take part in this study, I would like to learn about the initiative facilitated by the OT and your perspectives on how he/she engages in community development. While I am visiting the CD program over the period of 3 weeks, I will be observing how the program runs, who does what and how the people in the program interact. I will arrange observations sessions with the group ahead of time through the OT. Over the span of the 3 weeks I will observe approximately 10 hours of program activities (such as meetings, interactions between the OT and participants, program events, etc.). During this time, I will be taking notes. I’m going to be looking at the processes that are going on and what people are doing in general. I am mainly interested in what the OT does and how he/she interacts with the group and how the group responds. I will also like to speak individually with you as the colleague of the OT involved in this program. One-on-one interviews will take approximately one hour each. I hope to have approximately 2 interviews with you over the 3 weeks I am visiting the program. These interviews will be arranged at a time and place that suits you. I will be asking about the history of the program, your involvement in the program, how you and the OT work together, what some of the main events have been, what challenges have occurred and how things have change at all over the course of the program. All interviews will be audio-taped.

RISKS AND BENEFITS

There are no foreseeable risks associated with your participation in this study. While you may not directly benefit from taking part in this study, the responses received from you will assist me in better understanding the work the OT does and how community development occurs in the program. I will be looking at a number of different such CD programs and from them, I hope to identify some common elements that other OTs can include in similar programs. The information gathered in this study will be used to inform the future education of OTs and their practice.

CONFIDENTIALITY

All information shared by you will be kept confidential and secure. The interview responses will
be stored in a locked file and will only be available to the principal investigator and her advisors. Your name or the location of the program will not be associated with your answers. A general description of the program will be developed, however identifying information will be removed or changed. The program and you will be identified with pseudonyms. Although the information obtained from this study may be published in journals, presented at conferences, or used in the training of students, no identifying information will be included.

VOLUNTARY NATURE OF THE STUDY
We hope that you will fully participate in this study but your participation is completely voluntary and as such, you can refuse to answer any questions. You are welcome to withdraw from the study at any time without consequences.

COMPENSATION
Your time is highly valued and we appreciate your commitment to volunteer for this activity. Unfortunately, we do not have the resources to compensate any of the participants of this study.

FURTHER INFORMATION
At any time you can contact the principal investigator, Heidi Lauckner (613-542-9029, 1hl7@qlink.queensu.ca), the research advisors (Dr. Terry Krupa, 613-533-6236, krupat@post.queensu.ca or Dr. Margo Paterson, 613-533-6094, margo.paterson@queensu.ca) or the Ethics Coordinator of the Research Ethics Board of Health Sciences (Dr. Albert Clark, Chair, 613-533-6081), should you have any questions regarding this study. If you are interested in the outcomes of the study, you can request a one-page summary from the principal investigator.

Thank you for considering this invitation to participate in this study. Please raise any questions or concerns you may have about this study to the principal investigator. Once your questions have been answered to your satisfaction and if you are still willing to participate in the study, please read, sign and return one copy of the consent form below.

Sincerely,

Heidi Lauckner, BSc. (OT), MSc(Rehab), PhD (Candidate), OT Reg. (ON), Principal Investigator
PARTICIPANT CONSENT FORM - Participant Copy

Please retain for your information

I have read and understood the letter of information and consent form of this study. I have had the purposes, procedures, and terms explained to me. I have been given sufficient time to consider the above information and to seek advice if I chose to do so. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form. I will retain one copy of this consent form for my information. The other copy of the consent form can be returned to the principal investigator via the enclosed envelope.

If at any time I have further questions, problems or adverse events, I can contact:
Heidi Lauckner at 613-542-9029, hl7@qlink.queensu.ca, OR
Dr. Terry Krupa, 613-533-6236, krupat@post.queensu.ca OR
Dr. Margo Paterson, 613-533-6094, margo.paterson@queensu.ca; OR
Dr. Albert Clark, Chair, Queen’s University Health Sciences and Affiliated Teaching Hospital Research Ethics Board at 613-533-6081

By signing this consent form, I am indicating that I agree to participate in this study, which involves having the CD program I am involved with be observed over a 3 week period and participating in interviews with the principal investigator.

Name of Participant (please print) ________________________________

_________________________________ ________________
Signature of Participant Date

_________________________________ ________________
Signature of Witness Date
PARTICIPANT CONSENT FORM – Researcher Copy

Please return to Heidi Lauckner (School of Rehabilitation Therapy, L.D. Acton Building, George Street, Kingston, Ontario, K7L 3N6)

I have read and understood the letter of information and consent form of this study. I have had the purposes, procedures, and terms explained to me. I have been given sufficient time to consider the above information and to seek advice if I chose to do so. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form. I will retain one copy of this consent form for my information. The other copy of the consent form can be returned to the principal investigator via the enclosed envelope.

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Name of Participant (please print) ___________________________________________

________________________    ________________
Signature of Participant   Date

________________________    _______________
Signature of Witness    Date

STATEMENT OF INVESTIGATOR:
I have carefully explained to the participant the nature of the above research study. I certify that, to the best of my knowledge, the participant understands clearly the nature of the study and demands, benefits, and risks involved to those involved in this study.

________________________    _______________
Signature of Principal   Date
August 27 2007

Dear Program Participant,

RE: An invitation to participate in the study “Towards a framework for understanding community development from an occupational therapy perspective: Explicating the links between occupation, health and community”

BACKGROUND INFORMATION

You are being invited to participate in a research study directed by myself, Heidi Lauckner, which aims to describe the process of community development from an occupational therapy perspective. I am a Rehabilitation Science Doctoral student at Queen’s University, supervised by Dr. Terry Krupa and Dr. Margo Paterson and I will be conducting this study, which is entitled “Towards a framework for understanding community development from an occupational therapy perspective: Explicating the links between occupation, health and community”. Ms. Lauckner will review this consent form with you and describe procedures in detail and answer any questions you may have. This study has been reviewed for ethical compliance by the Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board.

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are involved in integrates both community development approaches and occupational therapy and the project provides an example of how community development from an occupational perspective occurs in practice in one particular setting.

**WHAT IS REQUESTED FROM YOU**
If you agree to take part in this study, I would like to learn about the program and your experiences in it. While I am visiting your program over the period of 3 weeks, I would like to observe how the program runs, who does what and how the people in the program interact. I will also speak to some participants individually to learn about their experiences in the program. I will arrange observation sessions with the group ahead of time through the occupational therapist (OT). Over the span of the 3 weeks I will observe approximately 10 hours of program activities (such as meetings, interactions between the OT and participants, program events, etc.). During this time, I will be taking notes. I’m going to be looking at the processes that are going on and what people are doing in general. I am mainly interested in what the OT does and how he/she interacts with the group and how the group responds. One-on-one interviews will take approximately one hour each. I hope to have approximately 2 interviews with you over the 3 weeks I am visiting the program. These interviews will be arranged at a time and place that suits you. I will be asking about the history of the program, what has happened over the course of the program, what some of the main events have been, what challenges, if any, have occurred and how things have change at all over the course of the program. All interviews will be audio-taped.

**RISKS AND BENEFITS**
There are no foreseeable risks associated with your participation in this study. While you may not directly benefit from taking part in this study, the responses received from you will assist me in better understanding the work the OT does and how community development occurs in the program. I will be looking at a number of different such CD programs and from them, I hope to identify some common elements that other OTs can include in similar programs. The information gathered in this study will be used to inform the future education of OTs and their practice.

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or changed. The program and you will be identified with pseudonyms. Although the information obtained from this study may be published in journals, presented at conferences, or used in the training of students, no identifying information will be included.

VOLUNTARY NATURE OF THE STUDY
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Your time is highly valued and we appreciate your commitment to volunteer for this activity. Unfortunately, we do not have the resources to compensate any of the participants of this study.

FURTHER INFORMATION
At any time you can contact the principal investigator, Heidi Lauckner (613-542-9029, 1hl7@queensu.ca), the research advisors (Dr. Terry Krupa, 613-533-6236, krupat@post.queensu.ca or Dr. Margo Paterson, 613-533-6094, margo.paterson@queensu.ca) or the Ethics Coordinator of the Research Ethics Board of Health Sciences (Dr. Albert Clark, Chair, 613-533-6081), should you have any questions regarding this study. If you are interested in the outcomes of the study, you can request a one-page summary from the principal investigator.

Thank you for considering this invitation to participate in this study. Please raise any questions or concerns you may have about this study to the principal investigator. Once your questions have been answered to your satisfaction and if you are still willing to participate in the study, please read, sign and return one copy of the consent form below.

Sincerely,

[Signature]

Heidi Lauckner, BSc. (OT), MSc(Rehab), PhD (Candidate), OT Reg. (ON), Principal Investigator
PARTICIPANT CONSENT FORM – Participant Copy

Please retain for your information

I have read and understood the letter of information and consent form of this study. I have had the purposes, procedures, and terms explained to me. I have been given sufficient time to consider the above information and to seek advice if I chose to do so. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form. I will retain one copy of this consent form for my information. The other copy of the consent form can be returned to the principal investigator via the enclosed envelope.

If at any time I have further questions, problems or adverse events, I can contact:
Heidi Lauckner at 613-542-9029, 1hl7@queensu.ca , OR
Dr. Terry Krupa, 613-533-6236, krupat@post.queensu.ca OR
Dr. Margo Paterson, 613-533-6094, margo.paterson@queensu.ca; OR
Dr. Albert Clark, Chair, Queen’s University Health Sciences and Affiliated Teaching Hospital Research Ethics Board at 613-533-6081

By signing this consent form, I am indicating that I agree to participate in this study, which involves having the CD program I am involved with be observed over a 3 week period and participating in interviews with the principal investigator.

Name of Participant (please print) ____________________________

________________________    ________________
Signature of Participant   Date

________________________    ________________
Signature of Witness    Date
PARTICIPANT CONSENT FORM – Researcher Copy
Please return to Heidi Lauckner
(School of Rehabilitation, L.D. Acton Building, George Street, Kingston, Ontario, K7L 3N6)

I have read and understood the letter of information and consent form of this study. I have had the purposes, procedures, and terms explained to me. I have been given sufficient time to consider the above information and to seek advice if I chose to do so. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form. I will retain one copy of this consent form for my information. The other copy of the consent form can be returned to the principal investigator via the enclosed envelope.

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By signing this consent form, I am indicating that I agree to participate in this study, which involves having the CD program I am involved with be observed over a 3 week period and participating in interviews with the principal investigator.

Name of Participant (please print) ___________________________________________

________________________    ________________
Signature of Participant   Date

________________________    _______________
Signature of Witness    Date

STATEMENT OF INVESTIGATOR:
I have carefully explained to the participant the nature of the above research study. I certify that, to the best of my knowledge, the participant understands clearly the nature of the study and demands, benefits, and risks involved to those involved in this study.

________________________    _______________
Signature of Principal Investigator   Date
### Appendix E: Case Study Protocol for Individual Cases

<table>
<thead>
<tr>
<th>Question asked of the case/main information to gather</th>
<th>Main Sources of information</th>
<th>Data collection Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Context/History</strong></td>
<td><strong>Program documents</strong> (description, brochures, meeting minutes), Program Manager/Staff /OT/participants</td>
<td><strong>Document review, semi-structured interviews,</strong></td>
</tr>
<tr>
<td>What is the general history of the CD program and the specific initiative (including organizational, systems, funding)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Why was the initiative developed?</td>
<td></td>
<td></td>
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<tr>
<td>What are the initiative’s goals and main activities?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are the key community issues that the program intends to address?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Why was an OT involved in this program?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How did the OT view community development and working with communities at the onset of the project/initiative?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CD Process</strong></td>
<td><strong>OT, manager/staff program, program participants, interactions/meetings, program documents</strong></td>
<td><strong>Semi-structured interview, document review, direct observation, participant observation,</strong></td>
</tr>
<tr>
<td>What are the main program elements/features?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What were the major events or benchmarks in the CD process?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who were the key players in these main events and what were their roles?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What were some of the perceived obstacles in the process, both internal to the group (relationships, power issues, etc.) and external (communications with those outside the group, funding, etc.)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What did the OT do to facilitate the CD process?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How have participants and the wider community been affected, if at all, by their involvement in the process?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What key principles appear to guide the process?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How did the relationship between and the roles of the OT and the participants change over time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Integration of OT Perspective</strong></td>
<td><strong>OT, manager/staff program interactions/meetings, program docs</strong></td>
<td><strong>Semi-structured interview, document review, direct observation,</strong></td>
</tr>
<tr>
<td>How are key concepts from OT, such as occupation and client-centeredness perceived, talked about and acted upon in the program?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How are OT values and beliefs enacted (or not) in the CD process?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What models do OTs seem to draw on and how are they used?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix F: Interview Guides

Interview Guide for Occupational Therapist

Introduction

I’m interested in learning about the CD initiatives you are involved in and how you, as an OT, engage in community development on a daily basis. So, over the course of my discussions with you, I’m hoping to gain an understanding of:

- the background/context of the CD initiatives you are involved in
- how the CD initiative and your work with the community unfolded/evolved over time, including formative events (both challenges and successes)
- how you engage in your CD work on a daily basis (i.e., what you actually do with communities) and how your work has changed overtime
- To what extent and in what ways you draw on your OT background to understand and engage in your daily CD work; what helps and what is difficult about integrating OT and CD

Program Background/Context

1. First of all, can you give me an overview of the organization/program you work in?
   - History of Organization
   - Aim/objectives/mission
   - Clientele/target group
   - Key programs and how they relate to each other
   - Funding, staff

2. Where and how do your CD initiatives fit into the larger organization/program in terms of aims and historically?
   - Names of each initiative
   - Aims/objectives (similar or different from overall organization’s)
   - Intended clients/participants
   - Key activities/Staff
   - How they fit with each other?
   - Timeline of key events of each CD initiative

3. Which of the CD initiatives you are currently involved in best demonstrate the work you do as an OT in CD?
   - Your thoughts/rationale behind your choice?

Initial development of CD initiatives

4. Tell me about the initial development of (each of) the CD initiative(s) you are involved in within this program/organization.
   - When did it start?
   - What needs did it originally aim to address?
   - Who was involved in the development of the program and what did they contribute?

5. Describe how you initially became involved in/developed the CD initiatives.
- What lead to/initiated the CD initiative?
- What were your initial thoughts and feelings when you first became involved?
- What were your initial expectations or concerns about the CD initiative?
- What were some of the key issues/decisions you and others were considering during the planning phase?

6. What was going on in the community and/or the organization when the CD initiatives were developed?
- Funding/economic
- Organizational changes
- Political issues
- Cultural
- Historic factors that contributed to this program/initiative?

7. What else about this community, this organization or the environment at the time may help me understand the background of the CD initiatives?
- Main strengths and issues of the community?
- Previous programs/initiatives and what was learned?
- Others I can talk to or things I can look at to gain a better understanding of the background?

**The Beginning**

8. Tell me about what was going on and what you were doing when the CD initiative first started.
- What did a typical day look like?
- What did you perceive as your main role at that time? What other things did you do?
- What were the participants doing?
- What were your main aims/intentions/expectations at that time?
- Who were you working with and how did that work?
- How did you see the situation of the participants/community at that time?
- How do you think the participants viewed you at the time?
- What factors influenced your actions/decisions at that time?
- What were important events/changes that you were looking for/saw in the early phases?
- What program/organizational issues were influential at that time?
- Looking back now, what were some of the lessons learned during those initial stages?

**The Middle**

9. What changes or events happened next in the CD initiative? (repeat for different phases/events of the process, including middle and end of process if applicable)
- What happened?
- Who was involved?
- How did participants respond?
- What else was going on at that time in the organization or community that may have influenced the initiatives?

10. How did your role change and/or stay the same as the initiative continued?
- How did your thinking, aims, etc. change over time, if at all?
- How did others respond to changes?
- What changes/shifts did you observe in the people around you?

11. Describe any milestones or significant events (both positive and negative) from that time.
   - What happened?
   - What did you do? What were you thinking?
   - How did others respond?
   - What was the outcome/consequence?

12. Can you think of a time when there was a challenge or conflict that the community faced during the initiative?
   - What was going on? What contributed to this challenge?
   - What did you do and what happened?
   - What did others do?
   - How was it resolved or not?

13. How do you feel the community/participants of the program have changed, if at all, over the course of the initiative?
   - How do these compare to what you expected?
   - Were there any unanticipated changes?
   - What things might I see/observe that would illustrate some of these changes?
   - What hasn’t seemed to change?
   - Can you describe some examples of this?

14. What were some key challenges and successes you’ve faced so far in the CD initiative?
   - What led to these challenges/successes?
   - How did you manage the challenges? What helped?
   - How did the community respond/change following these events?

15. What are some of the key lessons you’ve learned from the CD initiative so far?

**Current CD activities**

16. Describe the current activities of the CD initiatives and what you are doing in them.
   - How would you describe a typical day for you now? What are you doing and thinking?
   - How would you describe your main roles/activities now? What activities would I see you doing?
   - Who are you working with and what are they doing?
   - What are the participants doing?
   - What changes have you seen in your roles/activities and those of others (participants and staff)?

17. What are your current aims/hopes/expectations for the CD initiative?
   - How do these influence your daily actions?

18. Which upcoming events/activities would be good for me to observe and what do you expect me to see?
19. What changes/development do you expect to see in the future in this CD initiative?
   - What would I see if I were here next year, in 5 years?
   - What are the main factors that you feel would enable that or hinder that from happening?

   **Integration of OT background**

20. What key aspects of your OT background (training and experience) do you draw on in your
day to day CD practice?
   - Skills? Knowledge? Values? Previous experience?
   - Can you provide some examples of how these play out in your daily practice?

21. What other experiences, training, etc. do you draw on in your day-to-day CD practice?

22. What key concepts and/or models do you use in your CD practice?
   - Can you provide some examples of how the incorporation of these plays out in your
   practice?
   - How have the concepts/models been adapted to suit working with communities?
   - How did the participants respond?
   - Consider things like client-centeredness, occupation, environment, PEO, CMOP, enablement

23. How do you perceive your contribution to the CD initiative to be similar to and/or different
from your colleagues?

24. Using examples from your daily practice, tell me about how your CD work is similar to or
different from more typical OT work.
   - Can you provide examples?
   - What would I see you doing if I were there?
   - What are you thinking in those situations?

25. How do you understand the relationship between occupation and the community within your
CD initiative?
   - What affects a community’s occupation?
   - What facilitates this and what hinders it?
   - How do community occupations change over time?
   - How does the CD initiative address occupation, if at all?

26. What are some of the challenges you’ve encountered pertaining to the integration of OT and
CD in your daily practice?
   - Can you describe some examples of these?
   - What happened?
   - How did you manage these?
   - What was the result?

27. How has your understanding of OT and CD changed, if at all, over the course of this
program?
   - What events do you think contributed to these changes?
   - How have these changes influenced your practice?

28. Are there any other comments you have about how you integrate OT and CD in practice?
Interview Guide for Colleagues

Background/Experience

1. What is your background in CD?
   - Professional training?
   - Years experience?

2. What is your current role in this program?
   - Main responsibilities and activities?

3. How long have you worked with the OT?
   - When did you first get to know the OT?
   - What was your experience with OTs prior to that time?
   - What were your expectations of working with an OT?

4. How would you describe your relationship with the OT?
   - Communication style and frequency?
   - Frequency of working together?
   - What shared activities? What separate activities?

CD Process

5. Tell me about the changes you see the community going through in this CD program.
   - What are the first things the OT (and you) and the community do?
   - What are some of the main events/activities in the middle of the program?
   - How does the program move towards completion?
   - Who is doing what at the different points of the process?

6. What changes do you see happening over time within the community?
   - What were the main issues they faced at the beginning of the program?
   - How have these changed at all?
   - What do you feel has contributed to these changes?

Working with OT

7. How does the OT facilitate the CD process?
   - What do you see the OT doing in the CD program?
   - Can you give some examples of how she acts and what she says?
   - How do the community members respond?

8. How do you feel the OT works similarly to or differently from how you work in CD?
   - What are your main activities and roles?
   - How do you approach the CD process?
   - How does the OT approach the CD process?
   - Can you give some examples of how you and the OT work similarly and/or differently?

9. What unique contribution does the OT make, if any, to the CD process?
   - How does she approach things differently?
- How does she view things differently?

10. What have been some of the challenges of working together in CD?
   - Can you describe some examples of how these play out in practice?

11. What factors make working together in CD easier?
   - Can you describe some examples of these?
Interview Guide for Program Manager

Program history/Context

1. Please tell me about your organization, including its overall aim and the programs it offers.
   - Main clients and staff
   - Aims/foci of different programs offered
   - Duration that programs have run
   - General description of the community the organization is in

2. Please tell me a bit about the community issues your organization aims to address.
   - What was going on in the community when this program was developed?

3. What led to the development of the CD program that the OT is involved in?
   - When did it start?
   - What needs did it originally aim to address?
   - What was going on in the community and the organization when this program was developed?
   - Who was involved in the development of the program and what did they contribute?

4. How have the program’s aims and activities changed over time?
   - What has contributed to that change?

5. How has the community changed, if at all, over the course of the program?
   - What changes?
   - Examples?
   - What do you feel has contributed to this change?

Rationale for involving OT

6. When and how was it decided that an OT would be involved?
   - How familiar were you with OTs when this program began?
   - What did you think the OT could contribute to the program at that time?

7. Looking back now on the program, what do you feel the OT has brought to the program?
   - Can you provide some examples?
   - What did the OT do?
   - How did others respond?

8. In what ways do you see the OT engaging with the community in similar ways to and different ways from other colleagues in this organization?
   - Can you provide some examples?
   - What was the OT doing?
   - How was it different?
   - How did others respond?

9. What have been some challenges, if any, in having an OT working on the project?
10. What have been the benefits, if any, of having an OT working on this project?

11. Can you describe some recent interactions you’ve seen or participate in with the OT that seems to capture or exemplify how she integrates her OT background with what she does?
   - Describe the situation.
   - What was unique about what the OT did or said?
   - How did others respond?
Interview Guide for Program Participants

Reason for involvement in Program

1. How did you first become involved in this program?
   - What was going on in your life at the time?
   - How did that relate to what this program offered?
   - What did you think you might get from participating in this program?

CD process

2. Tell me about when you first became involved in the program. How did the program start off?
   - Who was doing what activities?
   - How were they leading those activities?
   - What were you and the other participants doing?
   - What were you thinking and feeling at that time?

3. What happened next in the program? (repeat for example of activities/events from the middle and end of program)
   - What activities/events followed?
   - Who led those?
   - What did others do?
   - How were you feeling during those events?
   - What were you expecting and what happened?

4. Who else was involved in the process and what did they do?

5. What was your role in the CD project?
   - What were the roles of other participants?
   - How did you feel taking on these roles?
   - What helped you take on these roles?
   - What was challenging about these roles?

6. As you look back now on the program, what other events stand out in your mind?
   - Can you describe each one?
   - What factors affected/contributed to this event?
   - How did this event affect what happened, either positively or negatively?
   - What were you thinking and feeling during these events?
   - What was the OT doing at these times? How did others respond?

Perceived role of OT

7. What has been the OT’s role during the CD process?
   - What has she done at different times in the program?
   - Can you provide some examples?
   - How did these things affect you? How did you feel and what did you do in response?
8. In what ways did you feel that the OT worked similarly or differently than the other people working here?
   - Examples?
   - How did you feel? What did you do?

9. While working with the OT, did you get a sense of what was important to her? What were some of those things?
   - Can you provide some examples of how that played out in the program?

10. What else stands out for you about the OT you worked with?

**Perceived outcomes of program**

11. How do you feel you have changed, if at all, over the course of the program?
    - Can you provide an example?
    - What lessons have you learned?
    - What skills have you learned and how?

12. How do the results of this program fit with what you expected?

13. How has your relationship with the OT changed over the program?
    - Can you describe some examples of this change?

14. How has your relationship with other participants changed?
    - Can you provide some examples of this?

15. How has your relationship with the wider community changed?
    - In what ways were you involved in the community before and how does that compare with now?
    - Can you describe some examples?
What things do you feel contributed to these changes?

16. What else stands out for you from the CD program?
Appendix G: Data Summary of Individual Cases

Below is a summary of the data collected at each of the three cases.

Case 1: Peer Mentoring

Over the course of 13.5 days on site, a total of 14 people were interviewed, 29 hours of observation were conducted and 39 documents were reviewed. Below are charts summarizing the data collected at this case:

**Case 1: Summary of Interviews (Total people interviewed = 14)**

<table>
<thead>
<tr>
<th>People Interviewed</th>
<th># of Interviews</th>
<th>Key Topics Discussed</th>
</tr>
</thead>
<tbody>
<tr>
<td>OT</td>
<td>7</td>
<td>• Background on projects  &lt;br&gt;• Link with OT  &lt;br&gt;• Intended outcomes  &lt;br&gt;• Thought processes re: partnerships</td>
</tr>
<tr>
<td>Manager</td>
<td>2</td>
<td>• Decisions re: the position and how projects determined  &lt;br&gt;• Institution’s/management’s perspective on CD and linking with communities  &lt;br&gt;• Qualities of the OT and OT background brought  &lt;br&gt;• Challenges of working with community partners</td>
</tr>
<tr>
<td>Centre Colleagues:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educator</td>
<td>2</td>
<td>• What qualities/skills OT brings to committees  &lt;br&gt;• Stages/phases/key events of projects  &lt;br&gt;• Discharge committee and day-to-day activities of OT  &lt;br&gt;• Other colleague’s experience in the position OT’s contribution to the outpatient team  &lt;br&gt;• History and process of peer mentor project  &lt;br&gt;• History and vision of the position &amp; how different from other positions</td>
</tr>
<tr>
<td>PT</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>SLP</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2 Recs</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2 OTs</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Com partn. Peer co-</td>
<td>1</td>
<td>• Community agency perspective on peer mentoring and working with the OT  &lt;br&gt;• Survivor perspective and process of being the one helped to being in paid position  &lt;br&gt;• Experience to date of peer mentoring, wanting to give back</td>
</tr>
<tr>
<td>ordinator 3 Partic’ts</td>
<td>2</td>
<td></td>
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<tr>
<td></td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>
Case 1: Summary of Observations (Total Observation = 29 hours)

<table>
<thead>
<tr>
<th>Type of Observation</th>
<th>Duration</th>
<th>Key events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structured/planned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Mentoring:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training Sessions</td>
<td>3 x 3 hs</td>
<td>• Intro mentoring session run by peer coordinator and 2 sessions run by clinicians</td>
</tr>
<tr>
<td>Steering Meeting</td>
<td>1 x 1 h</td>
<td>• Monthly steering committee involving the “passing of the torch” to agency and peer coordinator</td>
</tr>
<tr>
<td>Presenter debriefing</td>
<td>1 x 30 mins</td>
<td>• Peer coordinator prepping presenters</td>
</tr>
<tr>
<td>Discharge Planning</td>
<td>1 x 1 h</td>
<td>• OT facilitating planning meeting</td>
</tr>
<tr>
<td>Committee meeting</td>
<td>3 x 1 h</td>
<td>• Information sessions in the unit that the OT coordinates and she assisted with one and co-facilitated another</td>
</tr>
<tr>
<td>Information sessions</td>
<td></td>
<td>• OT facilitating an “in-house” team re: managing their waitlist</td>
</tr>
<tr>
<td>Outpatient:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team meetings</td>
<td>2 x 1 h</td>
<td>• Co-presenting with educator on the OT approach to ABI to a community agency</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td>• OT was a member of a committee dealing with the development of a new community service</td>
</tr>
<tr>
<td>Community presentation</td>
<td>1 x 1.5 h</td>
<td></td>
</tr>
<tr>
<td>Day program meeting</td>
<td>1 x 1 h</td>
<td></td>
</tr>
<tr>
<td>Informal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In OT’s office</td>
<td>Approx. 10 hours</td>
<td>• Observation of OT during telephone conversations, informal discussions with colleagues, working at computer, compiling resources, interacting with clients</td>
</tr>
</tbody>
</table>
## Case 1: Summary of Documents Reviewed (Total documents = 39)

<table>
<thead>
<tr>
<th>Type of document</th>
<th>#</th>
<th>Main Topics</th>
</tr>
</thead>
</table>
| Peer Mentor:        |        | • Discussions around funding, presenters, interviews, Communications between OT and committee members
| minutes/agendas     | 14     | • Summary of project submitted for funding
| Emails              | 6      | • Job description of peer coordinator
| Training manual     | 1 binder | • Agreement between centre and community agency
| Grant proposals     | 4      | • Background project that identified peer mentoring as a need
| Job description     | 1      | • Background on previous information sessions provided to clients
| Contract            | 2      | • Current schedule of sessions
| “missing links”      | 3      | • Resource book compiled by OT
| Discharge Minutes   | 2      | • Background on previous information sessions provided to clients
| Info session schedule | 1     | • Current schedule of sessions
| Resource book       | 1      | • Resource book compiled by OT
| File on previous sessions | 1 | |
| Other               |        | • Provides overview of position
| Job description     | 1      | • Provides information about the context of the centre and the changing health care context
| Facility presentation | 1    | • Provides overview of different projects the OT is involved in.
| List of CD projects | 1      | • Provides overview of different projects the OT is involved in.
Case 2: Mental Health

Over the course of 14 days on site, a total of 14 people were interviewed, 33 hours of observation were conducted and various documents were reviewed, including: background information on partnership committee, recovery presentations, educational materials, etc. Below are charts summarizing the data collected at this case:

Case 2: Summary of Interviews (Total people interviewed = 14)

<table>
<thead>
<tr>
<th>People Interviewed</th>
<th># of Interviews</th>
<th>Key Topics Discussed</th>
</tr>
</thead>
</table>
| OT                 | 4              | • Background on projects  
|                    |                | • Link with OT  
|                    |                | • Thought processes re: working with consumers as key partners  
|                    |                | • How individual intake fits with broader CD activities  
|                    |                | • Similarities/differences with others (SW, com service)  
|                    |                | • Philosophy/approach when helping to develop new program in the community  
| Manager            | 1              | • Background/history of development of community links  
|                    |                | • Perceived differences between OT and others in program  
|                    |                | • Background/context of moving program into community to co-locate with a community agency  
| SW Hospital manager | 1              | • Perceived unique contribution of different professions to CD/how similar/different  
|                    | 1              | • How OT approached hospital to include recovery education  
| OT colleague       | 1              | • How current program similar/different to previous OT program  
| OTAs (2)           | 1              | • How OT integrates CD into practice  
| OT practice leader | 1              | • Background to OT position  
| Community Partners: Consumers(2) | 3 | • How OT and consumer work together in recovery education  
|                    | 1              | • How partnership between OT and consumer organization developed over time  
| ED of consumer org | 1              | • How community services organizations and health services approach mental health issues similarly or differently  
| Manager of com agency | 2 | • Background on partnership program that generated the community links program  
| Partnership coordinator | 1 |
Case 2: Summary of Observations  
(Total Observation = 33 hours)

<table>
<thead>
<tr>
<th>Type of Observation</th>
<th>Duration (hours)</th>
<th>Key events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Art collective meeting</td>
<td>2</td>
<td>• Initial meeting facilitated by OT and SW and second meeting facilitated by consumer</td>
</tr>
<tr>
<td>Info sessions re: community link</td>
<td>4.5</td>
<td>• Overview of how com links fits with different agencies</td>
</tr>
<tr>
<td>Recovery discussions with consumer</td>
<td>2</td>
<td>• OT engaging with consumers as partners</td>
</tr>
<tr>
<td>Recovery session without consumer</td>
<td>1</td>
<td>• Examples of team dynamics, mission statement, discussion of lack of clarity re: roles</td>
</tr>
<tr>
<td>Community Links meetings</td>
<td>9</td>
<td>• Insight into tension between community service organization/culture and that of health care</td>
</tr>
<tr>
<td>House meeting</td>
<td>1</td>
<td>• Differences in how OT and SW approach intake; link between individual services and CD initiatives</td>
</tr>
<tr>
<td>Intakes with clients (by OT or by SW)</td>
<td>3</td>
<td>• Informal connections made by OT with community agencies that lead to discussions of a sewing group and individual referrals</td>
</tr>
<tr>
<td>Women Centre drop in with OT</td>
<td>4.5</td>
<td>• Partnership between OT and consumer</td>
</tr>
<tr>
<td>Recovery session with consumers</td>
<td>2</td>
<td>• OTA group</td>
</tr>
<tr>
<td>Events group</td>
<td>2</td>
<td>• How OT works collaboratively with consumer group</td>
</tr>
<tr>
<td>Recovery group meeting with OT and ED</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
**Case 2: Summary of Documents (Total documents = 34)**

<table>
<thead>
<tr>
<th>Type of document</th>
<th>#</th>
<th>Main Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting agendas/minutes</td>
<td>3</td>
<td>• Original meeting with consumers and OTs re: starting an art collective</td>
</tr>
<tr>
<td>Recovery group materials</td>
<td>5</td>
<td>• Recovery presentations, recovery pamphlet, recovery meeting minutes</td>
</tr>
<tr>
<td>Focus group</td>
<td>2</td>
<td>• Findings of community focus groups</td>
</tr>
<tr>
<td>Ads for groups</td>
<td>4</td>
<td>• Example of OT advertising group for consumers</td>
</tr>
<tr>
<td>Partnership program documents</td>
<td>12</td>
<td>• Provides background re: need for community links and overview of organizations/programs in the community</td>
</tr>
<tr>
<td>OT mental health services document</td>
<td>1</td>
<td>• Recommendations for mental health OT services</td>
</tr>
<tr>
<td>“events” calendar</td>
<td>1</td>
<td>• Example resource developed by OTAs</td>
</tr>
<tr>
<td>Community links pamphlet &amp; mandate</td>
<td>2</td>
<td>• Overview of program</td>
</tr>
<tr>
<td>Peer support project proposal</td>
<td>1</td>
<td>• Example of OT writing proposal to encourage development of peer support</td>
</tr>
<tr>
<td>Wellness plan</td>
<td>1</td>
<td>• Overview of WRAP workshop that OT assisted ED with</td>
</tr>
<tr>
<td>Health Authority strategic plan</td>
<td>2</td>
<td>• Overview of mission and plan of health authority</td>
</tr>
</tbody>
</table>
Case 3: Senior Volunteers

Over the course of 12 days on site, a total of 14 people were interviewed, 33 hours of observation were conducted and various documents were reviewed, including: committee binders (2), educational advertisements (20), policies/presentations/planning documents (12), job descriptions and orientation information (3). Below are charts summarizing the data collected at this case:

Case 3: Summary of Interviews (Total people interviewed = 14)

<table>
<thead>
<tr>
<th>People Interviewed</th>
<th># of Interviews</th>
<th>Key Topics Discussed</th>
</tr>
</thead>
</table>
| OT                  | 3               | • Background on projects  
|                     |                 | • Link with OT  
|                     |                 | • Thought processes re: link between clinics and CD initiatives  
| Managers (2 – at different levels) | 2               | • Background and link between OT/nurse team and wider health authority activities  
|                     |                 | • History of health authorities CD framework and work of OT/nurse team  
|                     |                 | • Perceived contribution of professional backgrounds to CD activities  
|                     |                 | • Amount/type of support provided to team  
|                     |                 | • Perceived challenges faced by the team  
| Health Colleagues: Nurse | 12 (short) | • Background on projects  
| Other team          | 1               | • Perceived contribution of professional and personal background to CD activities  
| Community Facilitator | 1               | • Shared philosophies and approaches to CD  
|                     | 1               | • Similarities/differences between health teams  
|                     | 1               | • How the team initiates services/programs in a new area  
|                     | 1               | • How programs change over time  
| Community Partners: Senior Center | 2               | • How OT/Nurse team developed partnerships  
| Property Manager    | 1               | • History/key events of projects (clinics, partnership with senior centre, committee)  
| Board member        | 1               | • Similarities and differences in how the OT and nurse approach community; unique contribution of each  
| Business owner      | 1               | • Changes over time in the committees/programs and the community  
| Resource Coordinator| 1               |  


### Program Participants:
- Walking leader: 1
- Wellness group: 1
- Volunteer: 1

- Process of becoming involved in committees
- Perceived role/contribution of OT/nurse team
- Similarities and differences in approaches of OT nurse
- Perceived changes over time in the committee and in the community

### Case 3: Summary of Observations  (Total Observation = 33 hours)

<table>
<thead>
<tr>
<th>Type of Observation</th>
<th>Duration</th>
<th>Key events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking program</td>
<td>2 x 30 minutes</td>
<td>• Nurse colleague consulting with school liaison person re: launch</td>
</tr>
<tr>
<td>Falls prevention committee</td>
<td>2 hours</td>
<td>• OT contributing to meeting</td>
</tr>
<tr>
<td>Clinics</td>
<td>5 x 2-3 hours each</td>
<td>• OT and nurse doing one-to-one consultations; observation of apartment buildings</td>
</tr>
<tr>
<td>OT student orientation</td>
<td>2 hours</td>
<td>• Orientation/history to program</td>
</tr>
<tr>
<td>Seniors Council meeting</td>
<td>1 hour</td>
<td>• Nurse at senior council meeting</td>
</tr>
<tr>
<td>Beautify meeting</td>
<td>1 hour</td>
<td>• Nurse and business owner at committee meeting</td>
</tr>
<tr>
<td>Meeting with resource coordinator and com facilitator</td>
<td>1 hour</td>
<td>• Nurse and OT consulting re: set up of new programs</td>
</tr>
<tr>
<td>Meeting with com agency</td>
<td>1 hour</td>
<td>• Discussion re: how to support exercise leaders and how to work together</td>
</tr>
<tr>
<td>Presentation about CD framework</td>
<td>2 hours</td>
<td>• Overview of CD framework of health authority</td>
</tr>
<tr>
<td>Falls prevention with police academy</td>
<td>1 hour</td>
<td>• OT conducting falls prevention session with seniors</td>
</tr>
<tr>
<td>Arthritis info session</td>
<td>1 hour</td>
<td>• Introduction to other senior teams</td>
</tr>
<tr>
<td>Management meeting</td>
<td>1 hour</td>
<td>• How senior team fits (or not) with Primary Care</td>
</tr>
<tr>
<td>Primary care meeting</td>
<td>1 hour</td>
<td>• Local businesses, accessibility</td>
</tr>
<tr>
<td>Community walk</td>
<td>30 minutes</td>
<td>• Overview of program and how OT/Nurse work with com facilitator</td>
</tr>
<tr>
<td>Meeting with new com facilitator</td>
<td>30 minutes</td>
<td>• OT and nurse co-leading discussion re: winter activities with one senior present</td>
</tr>
<tr>
<td>Active living committee</td>
<td>1 hour</td>
<td>• OT making telephone calls, stats, etc…</td>
</tr>
<tr>
<td>Informal observation of OT in office</td>
<td>1 hour</td>
<td></td>
</tr>
</tbody>
</table>
### Case 3: Summary of Documents (Total documents = 37)

<table>
<thead>
<tr>
<th>Type of document</th>
<th>#</th>
<th>Main Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open doors committee binder</td>
<td>1</td>
<td>• History of open doors committee and families for mental wellness support group</td>
</tr>
<tr>
<td>Beautify Pinewood binder</td>
<td>1</td>
<td>• History and projects of Beautify committee</td>
</tr>
<tr>
<td>Orientation binder</td>
<td>1</td>
<td>• History of position</td>
</tr>
<tr>
<td>Job descriptions</td>
<td>2</td>
<td>• How job description changed over time</td>
</tr>
<tr>
<td>Program advertisements</td>
<td>20</td>
<td>• Range of programming offered each month</td>
</tr>
<tr>
<td>CD policy</td>
<td>2</td>
<td>• Background on health authority CD framework</td>
</tr>
<tr>
<td>Presentations</td>
<td>7</td>
<td>• Overview of how project is explained to others</td>
</tr>
<tr>
<td>Strategic plans</td>
<td>3</td>
<td>• Deliberate plans made at beginning of program and more recently</td>
</tr>
</tbody>
</table>
Appendix H: General Field Note Observation Guide

Grand Tour Guide

Aim: to guide initial observations/shadowing in the first week so I can gain an overview of the different activities/events, actors and purposes of the CD initiative and begin understanding how these activities fit in with the sequence/stages of the CD process

<table>
<thead>
<tr>
<th>To be Described</th>
<th>To be considered…Questions to ask myself during and after observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>What</strong> are the main events/activities related to the CD initiative that the OT is involved in?</td>
<td>What are possible key/defining aspects of these different activities/events?</td>
</tr>
<tr>
<td>• <strong>What</strong> are all the activities the OT does in a <strong>typical day</strong>?</td>
<td>When do these occur (during the day, and in relation to other activities)?</td>
</tr>
<tr>
<td>• <strong>What</strong> are the key interactions between the OT and participants?</td>
<td>Who is involved?</td>
</tr>
<tr>
<td>• <strong>Who</strong> are all the people involved in the CD events/activities with the OT?</td>
<td>What processes might these events be a part of?</td>
</tr>
<tr>
<td>• What are the explicit goals of different CD activities? (why)</td>
<td>Which would seem to provide opportunity to see/understand processes (i.e., involve interactions, allow for change over time)?</td>
</tr>
<tr>
<td></td>
<td>Who might be able to provide some background and context to these key activities?</td>
</tr>
<tr>
<td></td>
<td>What are different people doing in the different events?</td>
</tr>
<tr>
<td></td>
<td>What different roles/functions seem to be taken on and how do these change?</td>
</tr>
<tr>
<td></td>
<td>How might these people influence CD processes?</td>
</tr>
<tr>
<td></td>
<td>Which of these people would provide diverse perspectives on the CD activities/processes?</td>
</tr>
<tr>
<td></td>
<td>What rationale/purpose is provided for different activities, by different participants?</td>
</tr>
</tbody>
</table>
**Focused Observation Guide**

**Aim:** to guide specific observations of meetings, interactions and events identified by myself or an informant as important in understanding the CD initiative with the intent of describing key activities, events, and actors in the CD process and how these unfold/change overtime

<table>
<thead>
<tr>
<th>To Describe</th>
<th>Focused and Interpretive Questions to Ask Myself during and after observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Stated <strong>purpose/nature</strong> of the interaction</td>
<td><strong>Why did I (or an informant) think this would be useful for me to observe? What stage/phase of the process might this be?</strong></td>
</tr>
<tr>
<td>• <strong>Physical</strong> setting and who present</td>
<td><strong>Where are we in relation to other programs/activities? How are people organized/positioned? Who isn’t here? How might the setting/set up suggest structural/systemic influences? Who is guiding/leading? Does this change over time?</strong></td>
</tr>
<tr>
<td>• What the OT is doing and saying</td>
<td><strong>Where is she in relation to others? Who is she directing her words/actions to? What precedes and follows her actions? Does she explain/provide rationale for what she does in context? Later on ask: what were you thinking/considering when….? What were you hoping to accomplish/achieve when? How did the response compare with your expectations? What isn’t said/done?</strong></td>
</tr>
<tr>
<td>• What <strong>participants</strong> and/or colleagues are saying doing</td>
<td><strong>What roles/duties do they take on? How is this decided? Who helps whom? What changes over the duration of the observation? How does the OT respond? What is the nature of the interaction between the OT and others?</strong></td>
</tr>
</tbody>
</table>
Appendix I: Excerpts of Summaries of Preliminary Data Analysis Memos

Case summaries were compiled following data collection at each case. They served as memos for myself. Each summary included a description of the position and key projects, a diagram of the key case elements as proposed by Stake (2006), preliminary reflections on the research sub-questions and emerging issues unique to each case. These case summaries were discussed with my supervisors and committee members following data collection at each case. The following are excerpts from the summary of Case 1 compiled on November 8, 2007.

Summary of Case 1 – Compiled November 8 2007

1. Brief Description of Case – the position and the projects

The OT, Karen, has been in the position of a “community liaison coordinator” for about one year. This is a generic (non-discipline specific), non-clinical, project-based position within the acquired brain injury (ABI) program in a large rehabilitation centre in Canada. The main aim of the position is to facilitate the integration of clients into the community upon discharge from the rehabilitation centre. The job description is broad, including a range of tasks, such as: conducting follow-up assessments with clients in the community, linking clients with services/resources in the community, developing community resources, enhancing inter-agency/community relationships, advocacy, participating in quality assurance and conducting interdisciplinary research and special projects. The position is flexible and has evolved over time, with each person in the position focusing on different projects. Karen worked as an occupational therapist in the rehabilitation centre for 10 years before applying to this position just over a year ago. In her current position, Karen is involved in a number of projects including:

a) Coordinating the Peer Mentor Committee (consisting of rehab centre staff, a community agency and a peer coordinator) that has worked for almost one year in the planning of a peer mentoring project involving the training of 10 stroke survivor mentors who will be partnered with recently discharged clients.

b) Leading an “in-house” Discharge Planning Committee that aims to increase access to and awareness of community resources for clients discharged to the community. The main activities related to this committee are: developing a discharge passport to summarize recommendations and resources upon discharge, developing an ABI resource list of all related community resources, organizing weekly information sessions in which community agencies come into the centre to talk about the services they provide, facilitating the use of a shared office space in the rehab centre where community agencies can provide information to clients.

c) Facilitating an outpatient Team in order to assist with the better management of their waitlist. Although both Karen and her manager feel that this role isn’t community development related, there appear to be some links between this function and the peer mentoring project.

d) Other projects/activities
2. Diagram of Case 1

Below is a diagram depicting the main information gathered in this specific case and its emerging issues.

Emerging issues specific to this case:

1. What is more important/relevant to CD, the “position” (a non-clinical, project-based position) or the projects or the OT?
2. What does an OT bring to a generic position that is either similar to or different than non-OTs?
3. Are personal qualities or professional training or clinical experience most important in promoting CD?
4. How do clinical, in-house projects/meetings influence the CD process?
5. In what ways does an OT in a generic institution-based community-oriented position promote CD through partnerships?

Main information gathered at all sites:

1. **Identifying boundaries/locus of the Case** - What are the key community development initiatives or related initiatives that the OT has been and currently is involved with?
2. **Historical/Contextual factors** - What was going on around the time that the initiatives were first developed?
3. **Rational for OT involvement** - What was the rationale for the involvement of the OT initially?
4. **Goals of CD initiatives** - What are the overall goals and main strategies/activities of the CD initiatives?
5. **OT-CD process** - How does CD process unfold in practice?
6. **Outcomes/changes** - What were intended and unintended outcomes/changes of the CD process?
7. **OT concepts** - How are OT concepts and approaches integrated in CD?
3. Preliminary Ideas about Emerging Issues

Formal data analysis has not yet begun. Thus far, I’ve memoed ideas while in the field and I’ve done some preliminary memoing as I’ve reviewed the completed transcripts (14 reviewed). At this stage, I only have my initial impressions and thoughts that have developed based on my interactions and reflections. Below, I’ve summarized some of my preliminary impressions and ideas. I’ve tried to organize them in response to the research questions of this study.

Sub-Question

What are the key phases, processes and benchmarks of the CD process?

- Possible phases within the Peer mentoring may revolve around: identifying a need or gap, gathering background information, bringing people together and developing partnerships (both on a personal/informal level and at an institutional/formal level), breaking down tasks and plans (for the committee), delegating tasks, providing assistance to individual committee members as required, ensuring communication and feedback, perhaps something around having the larger picture in mind
- Beyond the peer mentoring project, there seems to be an interplay between the different projects the OT is involved in, with each of them feeding into each other (i.e. Karen advertises the information sessions from the D/C planning committee to the outpatient team and she recruits potential mentors and trainers from the outpatient team)

How does the community change during the CD process?

- The OT refers to both the clinicians in the rehab centre and community agencies/clients as the communities she works with. The participants and peer coordinator within the peer mentoring project appear to be developing knowledge and skills, building social networks and re-establishing meaningful, “providing/giving” roles. The community agency is developing the capacity to run a project (with support) that it otherwise would not be able to do (because of lack of resources and expertise). The clinicians seem to feel a sense of achievement with the productivity of the committees and teams that the OT facilitates. With regards to the information sessions (where community agencies come into the hospital unit), the clients within the hospital are learning about the resources and agencies in the community. The community agencies are getting to know the needs and abilities of the clients they will be soon serving.

How do contextual factors influence the CD process?

- The flexibility and structure of the position and the support of management seem to be central to the projects the OT is working on. As well, the OT’s clinical experience in the centre seems to enables her to move between the clinical “in-house” projects and community activities with ease. There appear to be trends in health care that support, from a business case, the importance of developing community services to meet the needs of clients being discharged. There are also financial issues that either support projects or hinder them (a similar peer mentoring project was attempted 2 years ago but it failed due to the lack of funding)
Appendix J: Emerging Cross-Case Issues

During the cross-case analysis, the following issues were identified as relevant across the cases and aided in structuring data analysis:

1. How does the location of each position and CD initiative influence the strategies and processes of CD?

2. How do OTs negotiate community partnerships to foster collaboration in community development initiatives?

3. What does the dual role of the OTs’ positions reveal about potential competing forces in health and community sectors and how does this impact CD processes?

4. How does the relationship between the OT and consumers in CD differ from more typical client-therapist interactions and what are the consequences of such relationships?

5. To what extent and how do OTs bring a unique, yet at times not widely acknowledged, perspective to CD, particularly in situations where CD is seen as a ‘generic’ position?