Occupational Therapy

for Children in Saskatchewan

Resource Document
2020

SSOT Saskatchewan Society of Occupational Therapists

SPOT Saskatchewan Pediatric Occupational Therapy Practice Network

About This Publication

Saskatchewan Pediatric Occupational Therapy Practice Network (SPOT)
saskspot@gmail.com

Disclaimer:
The authors and publishers of this document have done their best to verify all facts and figures in this document from the most current and reliable sources available during the time of this writing. It is not the intent of this document to present any method or practice approach as more effective or superior to any other; rather the document is intended as a collection of evidence and data that can be used to inform decision-making by qualified professionals, administrators, and concerned members of the public. There is no intention on the part of the authors or publishers to provide a substitute for occupational therapy expertise in any setting where such expertise is requested or warranted.

If citing this document, please use the following:

Blight, M., Lundell, L., Clark, L., Britz, E., Dinsdale, K., Gervais, A., & Bitz, K. (2021). *Occupational Therapy for Children in Saskatchewan - Resource Document 2020.* Saskatchewan Society of Occupational Therapists and Saskatchewan Pediatric Occupational Therapy Practice Network.

Learn more at:
www.ssot.sk.ca
www.saskspot.ca

Cover art photo by Landon Parenteau on Unsplash.

SSOT Saskatchewan Society of Occupational Therapists

SPOT Saskatchewan Pediatric Occupational Therapy Practice Network

CONTENTS

Opening Remarks 6
Preface 6
Introduction 7

1 Occupational Therapy 9
The Profession of Occupational Therapy 9
Education of Occupational Therapists 10
The Practice of Occupational Therapy 11
Theory 11
Models 11
Method 13
Registration in Saskatchewan 14
Professional Development Requirements 14
Advancing Knowledge and Skills 14
Practice Networks 15
Summary 15

2 Childhood Development 16
Developmental Progression 16
Person - The Child 16
Physical 16
Cognitive 17
Social-Emotional 17
Spiritual 17
Occupations of the Child 17
Self-Care 18
Productivity 18
Leisure 18
Environment of the Child 18
Engagement of the Child 19
Disruptions in Childhood 20
Perspectives on Disability 20
Saskatchewan Perspective 22
Descriptors of Disruptions in Childhood Development 22
Summary 23

3 The Role of Occupational Therapy with Children 24
Person - The Child 24
Occupations of the Child 24
Self-Care 24
Productivity 25
Leisure 26

Environment of the Child 26
Engagement of the Child 27
Summary 27

4 Occupational Therapy Workforce in Saskatchewan 27
CIHI Data: National and Provincial Comparisons 28
Occupational Therapy Workforce Serving Children by Sector 30
Saskatchewan Health Authorities - Ministry of Health 30
Saskatchewan School Divisions - Ministry of Education 32
Saskatchewan Tribal Councils - First Nations Education 33
Occupational Therapy Private Practices and Companies 33
Workforce Demographics 34
Years of Practice 34
Hours Worked per Week 35
Location of Practice 36
Summary 38

5 Environmental Factors Influencing the Practice of Occupational Therapy with Children 39
Societal Factors 39
Provincial Factors 40
Rurality of Saskatchewan 41
Travel Considerations 42
Managing Travel Time 42
Travel Distance and Time 42
Safety with Travel 44
Workplace Factors 44
Recruitment 44
Retention 45
Satisfaction with Workload Distribution 45
Work Climate 46
Administrative Influences 47
Professional Factors 48
Professional Development 48
Professional Confidence and Identity 48
Client-centeredness 49
Autonomy in the Workplace 49
Summary 49

6 Provision of Occupational Therapy Services for Children in Saskatchewan 50
Organizational Structures Influencing Occupational Therapy Practice 50

Ministry of Health 50
Children's Therapy Services 50
Larger Urban Centres 51
Smaller Urban Centres 51
Occupational Therapy Services 51
Ministry of Education 51
Student Support Services 51
First Nations Health and Education in Saskatchewan 52
Health 52
Education 52
Ministry of Social Services 52
Inter Ministerial Collaboration 52
Autism Services 53
Acquired Brain Injury Services 53
Agencies Supporting Children and Families 53
Environments where Occupational Therapy Services are Provided 53
Funding for Occupational Therapy for Children 54
Public Funding and Services 54
Ministry of Health 54
Ministry of Education 55
Ministry of Social Services 55
Indigenous Services Canada 55
Publicly Funded Programs and Private Services 55
Jordan's Principle 55
Individualized Funding for Autism Spectrum Disorders 55
Cognitive Disability Strategy 55
Private Funding not Publicly Sourced 56
Funding Sources for Occupational Therapy Services 56
Occupational Therapy Services for Children in Saskatchewan 57
Service Delivery Models - Foundational Elements 57
Environment of the Child 57
Types of Service Delivery Models 58
Development of Service Delivery Models 58
Communication and Collaboration 58
Commonalities and Differences in Service Provision Across Sectors 58
Occupational Therapy Service Delivery 59
Structure - Service Delivery Models 60
Processes 61
Referral Sources 61
Reasons for Referral 63
Ages of Children Served 64
Profiles of Children Served 65
Outcomes of Occupational Therapy 67
Summary 68

7 Impact of Occupational Therapy for Children 68
Occupational Therapy Skills that are Valued 69
Activity Analysis 69
Adaptability 69
Adaptation 69
Client-Centred Approach 69
Collaboration 70
Transitional Support 70
Holistic Practice 71
Benefits of Utilizing the Skills of an Occupational Therapist 71
Summary 72

8 Practice Changes Related to Occupational Therapy Services for in Saskatchewan 72
Increased Complexity of Needs 72
Higher Caseload and Workload Demands 74
Changes in Service Delivery Models 74
Summary 76

9 Summary of Occupational Therapy for Children in Saskatchewan 76

10 Conclusive Messages with Recommendations 78

Closing Remarks 81
Appendices 82
Appendix A Survey 82
Appendix A1 Survey Development Process 82
Appendix A2 Summarized Questionnaire - Occupational Therapy for Children in Saskatchewan 85
Appendix B Literature Search Process 88
Appendix C Infographic Map – Canadian Institute of Health Informatics 89
Appendix D Occupational Therapy Children's Services 90
Appendix D1 Ministry of Health 90
Appendix D2 Ministry of Education 94
Appendix D3 Saskatchewan First Nations Education 97
Appendix D4 Private Practice Clinicians and Companies 99
Appendix E Practice Locations as Reported by Survey Respondents 101
References 103
Acknowledgements 113

Opening Remarks

Occupational Therapy for Children in Saskatchewan - Resource Document 2020 has been produced through the efforts of a group of occupational therapists, working together with the Saskatchewan Pediatric Occupational Therapy Practice Network (SPOT) and the Saskatchewan Society of Occupational Therapists (SSOT). The document profiles occupational therapy for children with an emphasis on services in Saskatchewan in 2019-2020. The information contained in this document is intended for a broad range of readers and can serve as a valuable resource to occupational therapists as they collaborate with caregivers, colleagues, and partners in supporting the needs of children. Occupational therapists, as a professional community, are responsible for creating, maintaining, and communicating standards of care to the public. We trust that this document is a significant contribution towards our ongoing commitment to providing effective and responsive occupational therapy service delivery for children in Saskatchewan.

Preface

In 2010, a working group within the Saskatchewan Society of Occupational Therapists prepared *Occupational Therapy for Children: Services in Saskatchewan* (SSOT, 2010). This document profiled pediatric occupational therapy services in the province and advocated for equitable access to meet the needs of children. Case studies reflected the role of occupational therapy with children in hospital, home, school, and private clinic settings.

Since 2010, external and internal forces have impacted the delivery of occupational therapy services for children in Saskatchewan. External forces include changes to structures and systems providing occupational therapy, as well as changes to funding models supporting access to occupational therapy. Internal forces include the evolution of theory and practice approaches, as well as practice changes made by therapists in response to external pressures. Leading up to 2019, several SSOT members approached SSOT council members proposing that the 2010 document be updated to reflect these changes.

In 2019, SSOT approved an update to the 2010 document to reflect current practices and services. SSOT approached the newly formed Saskatchewan Pediatric Occupational Therapy Practice Network (SPOT) to consider updating the document as a project. At a SPOT meeting in May 2019, a core group of occupational therapists from across the province volunteered to form the Pediatric Paper Working Group (PPWG). Additional occupational therapists were recruited to ensure representation from diverse backgrounds and areas of practice. In July 2019, the PPWG commenced work on the project.

Initially, the goal was to write an updated document for the purposes of advocacy and communication with decision-makers. The PPWG, in discussion with its members, and reflecting on expert advice requested from Havelin Anand, Director of Government Affairs and Policy with the Canadian Association of Occupational Therapists (CAOT), decided to address the

project from a broader perspective. This gave rise to writing a *resource document* on occupational therapy for children in Saskatchewan from which targeted documents could be developed. A plan was created for a comprehensive information gathering process, with a focus on the role of occupational therapy with children and the delivery of services to children in Saskatchewan.

The decision was made to survey all SSOT members with a licence to practice, to communicate directly with occupational therapists working with children, and to carry out a review of the literature surrounding occupational therapy for children. Information gathering, data collection, and data analyses took place from November 2019 to July 2020. The global COVID-19 pandemic reached Saskatchewan in March 2020, significantly affecting children and families. The writers remained focused on the intended framework and purpose of the document, recognizing that the pandemic was exacerbating many issues that were being addressed in the document. In June 2020, for administrative purposes, the PPWG was re-aligned from a subgroup of SPOT to a working group within the SSOT Stakeholder Relations Committee. Document writing commenced in May 2020 and proceeded through the drafting and editing stages with publication in May 2021.

Introduction

Occupational Therapy for Children in Saskatchewan - Resource Document 2020 articulates the unique perspective that occupational therapy brings to the shared concern of protecting and nurturing Saskatchewan's children. For the purposes of this document, children refer to persons from birth to twenty-one years of age. The document emphasizes the premise that children have the right to participate fully in the world where they live, learn, and play. The following premises also guided the writing of the document:

- Services for children should be child and family centred, respectful, holistic, culturally adaptable, collaborative, knowledge driven, and sustainable (Saskatchewan Government, n.d.d.).
- Social determinants of health can influence how children thrive.
- Every child has the right to equitable services to support their growth and development.
- Support and services for early child development are an investment into the future of individuals and communities.
- Children and their families benefit from timely access to therapy services and support.
- Play is an essential component of early childhood, progressing with maturation to engagement in leisure pursuits that balance with the activities of productivity and self-care.
- Illness, injury, and developmental challenges can impact a child's ability to participate in childhood occupations, broadly classified as self-care, productivity, and leisure/play.

- Occupational therapists support the health and well-being of children through engagement in occupation.
- Occupational therapists have specific expertise and perspectives to support optimal development and inclusion of children.

The resource document provides evidence-informed data obtained through various sources. Survey results were a major source of data on services, experiences, and perspectives of occupational therapists whose expertise spans decades of practice in Saskatchewan. Refer to Appendix A1 for an outline of the survey development process. In November 2019, a questionnaire (Appendix A2) was distributed to all members of SSOT with a licence to practice (SSOT & SPOT, 2019). There was a response rate of approximately 31%. Respondents included 71 occupational therapists who worked with children and 46 occupational therapists who did not work with children.

A scan of the literature occurred in 2019 and 2020. Questions and answers from the questionnaire were used to guide searches of the literature. An attempt was made throughout the document to balance the perspectives of international, national, and provincial sources to reflect the most relevant information for Saskatchewan consumers. Details of the literature search process can be seen in Appendix B.

Data from the Canadian Institute of Health Information (CIHI) was retrieved and analyzed in the summer of 2020. The occupational therapy workforce across Canada is illustrated in an infographic map in Appendix C. Through communication with occupational therapists and administrators, information was gathered on occupational therapy services in the health and education sectors, as well as private practices, across the province in 2019-2020. This information is presented in the sector charts in Appendix D.

The resource document has been compiled to draw information from when questions are posed on occupational therapy for children in Saskatchewan. The document provides a common foundation for individuals and groups to support targeted responses, advocacy efforts, and fact sharing. The compilation of data led to an awareness of areas of concern that generated conclusive messages with recommendations for the occupational therapy community.

The profession of occupational therapy and childhood development are described in the first part of the document. Childhood, a highly sensitive period in the human lifespan, is characterized in ways that emphasize the child as a person engaged in occupations in different environments. A framework for understanding disability as a disruption in childhood development and a barrier to accessing meaningful childhood occupations is presented. This model of thinking provides a foundation for understanding the role of occupational therapy with children (WHO, 2007; Townsend & Polatajko, 2013).

The document proceeds to present facts and discuss issues that affect occupational therapy services for children in Saskatchewan. The state of the occupational therapy workforce is revealed, based on national and provincial data and results from the survey. Information on the workforce serving children by sector is outlined, along with comparisons from 2010.

Environmental factors which influence occupational therapy practice for children are featured within the categories of societal, provincial, workplace, and professional. Survey findings support the discussion.

A focal point of the document is the section on the provision of occupational therapy services for children in Saskatchewan. Structures such as government ministries and associated agencies and programs that provide and fund occupational therapy in Saskatchewan are listed. A continuous quality improvement approach is referenced (WHO, 2020). Processes such as referral information and profiles of children served are described. Survey findings specific to structures and processes are presented. Outcomes that benefit the child as the consumer are emphasized as the desirable measurement of quality service provision.

Ensuing sections share the voices of the survey respondents as they describe the skills that they bring to the table, the perceived impact of their services on children and families, and the practice changes that they are experiencing. The summary reflects the focus and content of the resource document. Conclusive messages and recommendations stem from the needs of children and how occupational therapy can help address those needs. Recommendations are intended to support dialogue and the development of action plans by occupational therapists in their work with decision-makers and consumers.

1

Occupational Therapy

Occupational therapy is the art and science of fostering health and social well-being by enabling engagement in the occupations of everyday living (Townsend & Polatajko, 2013). Occupational therapy enables a just and inclusive society so that all people may participate in their occupations to their potential (CAOT, 2012). In this section, the profession and practice of occupational therapy will be discussed, including the education of occupational therapists and requirements to practice occupational therapy in the province of Saskatchewan. Professional development, ongoing training to support advanced skill development, and practice networks will be highlighted.

The Profession of Occupational Therapy

Occupation is the active doing of tasks that have purpose and meaning for the individual or group. While occupational therapists around the world often divide occupation into self-care, productivity and leisure components, occupational engagement has been universally described as “doing, being, becoming and belonging” (Whalley-Hammell, 2014, p. 40). Included are the occupations through which people take care of themselves, work, play, learn, and participate as members of their community and cultural group (CAOT, 2009). The theory and foundational belief in occupational therapy practice is that people engage in occupations.

To foster health and well-being, occupational therapists address barriers to occupation at the individual, group, community, and population level (CAOT, 2012). Acting as an expert in enabling occupation is the central role, expertise, and competence of the occupational therapist (CAOT, 2012). Whalley-Hammell (2018) further stated that all people have the inherent right to engage in occupations that contribute positively to their own well-being and to the well-being of their communities. She argued that not just ability, but *capability*, or access to occupation, be considered when thinking about barriers to occupational engagement. Not only those with disabilities but also those who are marginalized and constrained in their choices by society's inequalities, experience barriers to participation (Whalley-Hammell, 2018). Seeing and addressing those barriers is at the core of occupational therapy practice and expands the domain of occupational therapy beyond a health paradigm and a focus on disabilities to a focus on abilities and access to opportunities (Pereira, 2017). In this sense, *occupational justice*, as an expression of the human right to engage in occupations that support health and well-being, is also the concern of all occupational therapists (Pereira, 2017; CAOT, 2009b).

Education of Occupational Therapists

Education requirements for occupational therapists continue to change. Nationally identified factors that influence the need to change include health and social system reform, changing client profile and health status, growing professional knowledge base, growth of private practice, and national and international mobility (CAOT, 2018). Prior to 2008, a bachelor's degree in occupational therapy was the accepted credential for entry level occupational therapy education in Canada. In 2008, a professional master's degree became the requirement for graduation from accredited Canadian occupational therapy education programs. The shift to a master's level for entry to the profession was in response to the "intensity and breadth of education required; complexity of current practice; and system need for accountability" (CAOT, 2018). As of 2020, there are fourteen education programs (Association of Canadian Occupational Therapy University Programs [ACOTUP], n.d.) accredited by the Canadian Association of Occupational Therapists (CAOT, 2019) in Canada.

Occupational therapists are educated within national accreditation standards (CAOT, 2019) and international standards set for occupational therapy education at the university level (World Federation of Occupational Therapists [WFOT], 2016). International minimum education standards state:

- "60% of the program is comprised of a focus on occupation and occupational therapy,
- 10 to 30% of the program is focused on knowledge supporting an understanding of body structures and functions, biomedicine, psychological and sociological concepts and,
- 10-30% of the program is focused on knowledge supporting an understanding of the human and social environment, and social perspectives of health" (WFOT, 2016, p. 45-46).

Practice placements to integrate knowledge, related skills, and attitudes with practice are part of an occupational therapist's education and training (CAOT, 2019; WFOT, 2016). Educating

occupational therapists into the 21st century involves more than developing technical, clinical, and professional skills. Education includes leadership, adaptability, and the soft skills that are identified as being essential for professional practice (WFOT, 2016).

Local context relevant to occupational therapy practice is recommended to be incorporated into education programs (CAOT, 2019; WFOT, 2016). Aspects of local context include:

- "philosophy and practices of government that shape health and social service access and policies,
- demographics of the populations,
- political and economic environments,
- local health, social, and education needs,
- local occupations that contribute to health conditions and promotion of health, and
- local health, social, disability, education, employment, justice, arts and cultural sectors where an occupational therapist may work" (WFOT, 2016 p. 21).

Occupational therapists coming to work in Saskatchewan have been educated in the context of the province or country where they received their education. By having practice placements in Saskatchewan, occupational therapy students become familiar with the provincial context.

The Practice of Occupational Therapy

Occupational therapy is a profession incorporating diverse roles and skills within practice. Occupational therapists are grounded by aligning their work to theoretical models which define and expand their identity. At the same time, occupational therapists work within systems to provide services focusing on the needs of clients. Methods are implemented for accomplishing or supporting consistency in occupational therapy practice.

Theory

Meaningful occupation and occupational engagement are primary beliefs for occupational therapists and drive professional practice with clients. Occupational therapists embrace occupation as therapy to enhance the capability of clients and enable them to achieve positive functional outcomes (Nelson, 1997). When someone is having difficulty pursuing, or is not able to pursue, the occupations of life due to illness, disease, injury, impairment, congenital disorders, social injustice and/or inequalities, occupational therapy can facilitate those pursuits.

Models

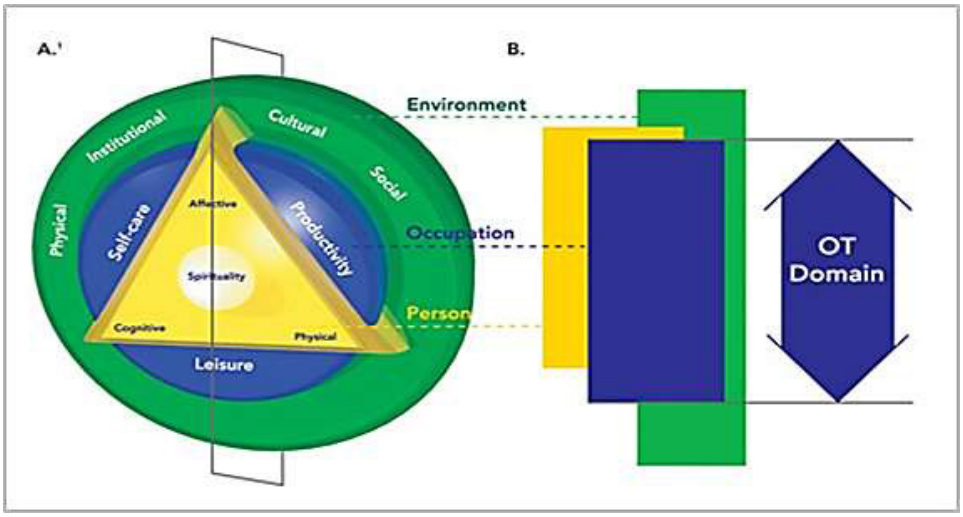
Occupational therapists practice within *theoretical models* that attempt to capture the full scope of potential involvement with a client. The Canadian Model of Occupational Performance and Engagement (CMOP-E) is one such model. The CMOP-E provides a visual representation on how occupational therapists view their role in relation to a client (see Figure 1). This model will be extensively referenced throughout this document, as it provides a central

organizing paradigm for the practice of occupational therapy that is well-respected in Canada and around the world.

The CMOP-E is made up of three components, the person, the occupation, and the environment. The model envisions health, well-being, and justice as attainable for a person through occupational engagement. The domain of the occupational therapist, in the context of a multidisciplinary team, is occupation. Occupation is the place where a person interacts with an environment (Townsend & Polatajko, 2013). The CMOP-E is an overarching model for occupational therapy practice. Service delivery and evidence-supported practice approaches are utilized within different occupational therapy practice areas with the CMOP-E as an overarching model.

Figure 1

Canadian Model of Occupational Performance and Engagement (CMOP-E)



Note. Part A - Referred to as the CMOP-E. Part B - Transactional view (Townsend & Polatajko, 2013, p. 23).

Service delivery models provide structure to the operational aspects of client contact and care. Service delivery models clarify and specify which aspects of overarching models are emphasized in practice, thus bringing theoretical and practical variables together (Kingsley & Mailloux, 2013). An important function of a service delivery model is to describe the way that an *evidence-supported approach* is chosen by the therapist to create a connection between the professional skills of the therapist and a corresponding perceived need of the client (Reason, 2012). An approach may also be termed a *frame of reference,* a *practice approach,* or a *practice model* (Rodger & Kennedy-Behr, 2017). Using practice approaches in a reasoned way, for the benefit of the client and based on the best available information from both evidence and experience (Schell, 1993), is a core competency of an occupational therapist (CAOT, 2012).

The core competencies of occupational therapists are the same across practice environments. The physical, social, cultural, and institutional environments of the clients and

funders and of the occupational therapists are diverse. Mapping these complexities and creating safe and achievable expectations for client-centred care are complex challenges. "Occupational therapists abide by ethical principles to act with integrity, accountability, and judgment in the best interests of the client, available services, and application of available evidence" (Association of Canadian Occupational Therapy Regulatory Organizations [ACOTRO], 2012, p. 18). This consideration is a core competency of occupational therapists as regulated professionals in Canada (ACOTRO, 2012).

Method

Occupational therapy services are provided to clients across the lifespan from infancy to late adulthood. With advanced knowledge in mental health and physical medicine, occupational therapists support clients in determining, developing, regaining, or maintaining the occupations of life. Occupational therapists work within environments that are relevant and meaningful to the clients, using a process of assessment and intervention, based on clinical reasoning. Occupational therapy services are offered in diverse practice settings such as home and community, institutions, industry and business, and government (CAOT, n.d.c.) and funded through health, education, social systems, and/or privately.

Occupational therapists work collaboratively with clients and team members to provide safe, effective, ethical, and client-centered occupational therapy. *Clients* are the direct recipient of occupational therapy services and may include the individual, family, caregiver, group, or organization (ACOTRO, 2012). *Interventions* enhance health, well-being, and social inclusion by addressing barriers that interfere with client engagement and performance in the occupations of life. The act of enabling engagement in meaningful occupation for individuals, groups, and communities as a *therapeutic method* is at the heart of occupational therapy practice (Nelson, 1997; Pereira, 2017). As experts in enabling occupational engagement, occupational therapists use evidence-based processes that focus on the occupations of the client as mediums and avenues for therapeutic intervention (CAOT, 2012). Function is defined by a harmonious interdependent relationship between the person, occupation, and environment (Townsend & Polatajko, 2013) and is what defines a successful outcome of a therapeutic intervention.

Occupational therapists apply knowledge gained from "physical, social, psychosocial, environmental, and fundamental biomedical and social sciences to practice" (CAOT, 2012, p. 7). Through a process based on *clinical reasoning*, assessments and interventions are directed to address barriers that interfere with client engagement and performance in the occupations of life, thereby enhancing health and well-being, participation in society, and social inclusion (ACOTRO, 2012; Pereira, 2017; Copley, 2010). These interventions may take place at the person, environmental, or occupational (task) level, and can include creating environments that are occupationally supportive as a key element of the scope of occupational therapy practice (Townsend & Polatajko, 2013). Intervention may include the use of occupational therapist assistants in service delivery. The occupational therapist is responsible to assign those activities that can be safely performed within the competency of the individual occupational therapist assistant (ACOTRO, 2019; SSOT, 2006).

There are many practice approaches or frames of reference to choose from in occupational therapy. Therapists undertake post-professional education to expand their knowledge specific to different practice approaches. They may participate in workshops, self-study, certification in particular methods, mentorship alliances, reading of contemporary evidence, and experiential learning, or may engage in online or other communities of practice to access some or all these avenues (Murray & Lawry, 2011). The continual process of professional development supports ongoing efficiency and effectiveness in clinical reasoning (Cusick & McCluskey, 2000). Professional development is a requirement to demonstrate competency to practice (SSOT, n.d.a.).

Occupational therapists enable client centered occupational engagement across all levels of society, organizational structures, or relationships (CAOT, 2012). The services of an occupational therapist are primarily received by the public through direct client interventions. Occupational therapy practice may also include education, research, policy development and professional leadership (ACOTRO, 2012; CAOT, 2012).

Registration in Saskatchewan

Since 1971, the SSOT has been the governing body responsible for regulating the practice of occupational therapy in Saskatchewan. A licence to practice in Saskatchewan is approved by SSOT following an extensive application process (SSOT, n.d.a.). Maintaining a licence to practice requires the registered occupational therapist to adhere to provincial bylaws (SSOT, 2018), a code of ethics (SSOT, 2018), and both national and provincial competency requirements (ACOTRO, 2012; SSOT, n.d.a.) on an ongoing basis. The continuing competency program (SSOT, n.d.a.) includes maintaining a minimum number of practice hours and completing a self-assessment tool from which to develop a professional development plan that may be audited to maintain a licence to practice.

Professional Development Requirements

The essential competencies document, adopted by SSOT and other Canadian occupational therapy regulators, describes a competent occupational therapist as demonstrating “the appropriate knowledge, skills, and attitudes for the occupational therapy practice context in Canada” (ACOTRO, 2012, p. 1). It is assumed that the occupational therapist will access additional professional development and training to support their ongoing work as a licensed professional (ACOTRO, 2012). Professional development, in its broadest definition, focuses on developing and improving skills.

Advancing Knowledge and Skills

Reflection and development of individualized competency plans support occupational therapists to advance their knowledge and engage in practice that is safe, ethical, and effective within a defined scope of practice (SSOT, n.d.). Advancing knowledge to increase proficiency in practice is a collaborative process between the occupational therapist and the employer to fulfill job requirements, build teams, and advance leadership skills and career opportunities.

Advancing knowledge may include networking, attending specific workshops to learn new skills, and pursuing post-professional degrees such as a research master's, clinical doctorate, or research doctorate. Therapists are responsible for developing effective and sustainable practices (CAOT, 2012) which requires advancement in knowledge and skills.

Competency to practice occupational therapy is more than meeting education and licensing requirements when ethical questions exist in the practice environment, as is the case when working with children. *Proficiency* in practice is a term that describes a therapist who displays competencies to deal effectively with a wider range of complexity (CAOT, 2012). Careful consideration regarding ethical practice is required when the client is a minor. Children are dependent on caregivers, and legal consent for services must be provided by legal guardians, rather than the child. Program planning becomes more complex for occupational therapists to manage the values, expectations, and beliefs of the client as child, the client as consenting adult caregiver, and the funder (Coughlin, 2018).

Practice Networks

Formalized practice networks within occupational therapy have emerged provincially and nationally since 2010. Practice networks develop when a core group of people with similar interests identify a need to create a forum for discussion (CAOT, n.d.a.). Practice networks are known to support professional development, provide mentorship, and reduce the feeling of isolation in day-to-day practice. A significant practice network relevant to Saskatchewan children is the SPOT network. SPOT was established in 2018 to provide a local forum for pediatric occupational therapy practice. Participation is voluntary and the network provides opportunities to enhance professional development and share practice knowledge.

Summary

Occupational therapy is a profession that focuses on enabling the health and well-being of clients through engagement in occupation. Occupational therapists are the providers of occupational therapy services and use models of practice that place occupation at the core of their assessment and intervention with clients. With a specialized understanding of occupation, occupational performance and engagement, occupational therapists support clients to maximize their capabilities when illness, injury, impairment, or social inequalities affect the pursuit of meaningful occupations of life. Occupational therapists are educated in Canada at a master's level. To work in Saskatchewan, occupational therapists must have a licence to practice with the SSOT and comply with essential competency requirements (ACOTRO, 2012). Pursuit of professional development to enhance knowledge and skills is necessary to support competency to practice.

2

Childhood Development

Childhood is a unique and highly sensitive period of the lifespan that is universally recognized as requiring special care and protection (UN, 1989). While parents have legal responsibilities to directly provide for the needs of their children, it is understood that society has a responsibility to support parents in this task (UN, 1989; WHO, 2007a). Numerous agencies, existing at cultural, social, institutional, and physical levels, have been developed with the expressed aim of supporting childhood development. Throughout Canada and the world, these agencies are interconnected by humanity's shared concern in raising children who will be citizens of the community (UNICEF, 2006).

Many transitions occur in childhood that make this period of the lifespan complex (Rodger & Kennedy-Behr, 2017). Childhood development will be presented showing transitions that are expected to occur in a predictable developmental progression unless there is a disruption. Barriers, perceptions of developmental challenges, and children's rights will be reflected upon through the lens of redefining disability as an interaction between a person and their environment.

Developmental Progression

Developmental progression allows children to engage in the occupations of childhood according to age and ability into their early twenties. Children are developing rapidly from a state of total dependence to relative independence, becoming contributing members of society, and potentially becoming parents of the next generation of children (Crittendon, 2015). The child's engagement in occupation fuels curiosity, experimentation, inherent challenge, and the intrinsic motivation to master their place in the world (WHO, 2007a). The occupations of childhood include "developing personal independence, becoming productive, and participating in play or leisure pursuits'' (Novak & Honan, 2019, p. 258). Children are busy living, learning, and playing, which often depends on the spark of fun and the feeling of self-worth engendered by free-flowing experimentation (Ginsburg et al., 2007). Developmental progression will be highlighted using the CMOP-E (Townsend & Polatajko, 2013) including person, occupation, environment, and engagement.

Person - The Child

Development progression in the context of the person is defined by change at the physical, cognitive, social-emotional, and spiritual levels.

Physical. Children typically develop motor skills in a predictable pattern through neurodevelopmental sequences. Head control, independent sitting, and rolling start in infancy, and by twelve months can develop into complex actions such as walking and running (Bly,

1994). Children use sensory information to motivate and guide increasingly complex movement. Controlled, voluntary movements allow the child to move freely to explore and refine physical skills through their sensory and motor systems (Polatajko & Mandich, 2004). Children develop control of their bowel and bladder muscles for independent toileting. They become proficient in using their face and tongue muscles for independent feeding. Well-developed sensory organs paired with a strong and flexible body allow children to interact with their environment functionally and safely, and with the full-bodied expressions so commonly associated with childhood (Barthel, 2004).

Cognitive. The development of basic cognitive skills begins immediately after a child is born. Cognitive skills such as recognizing and tracking faces help babies to seek out and attach themselves to caregivers who will provide safety and nourishment (Newman et al., 2015). More complex cognitive skills such as auditory input localization, cause and effect, and object permanence develop over the first year of the child's life (Parks, 1992). Basic brain functions that interpret and systemize input eventually improve and organize within the brain. The capacity for the brain to interpret and respond to environmental input can ultimately be described as learning. From a young age, cognition includes the progressive development of complex skills such as comprehension, attention, memory, understanding and producing language for communication, problem solving, and executive functioning. Cognitive skills are required for children to learn to play, engage effectively in school, and move through the transitional stages of childhood.

Social-Emotional. The social-emotional or affective development of a child begins immediately after birth with the first connection between the caregivers and the infant. In infancy, a child's occupations are primarily concerned with survival and the need for protection from danger (Crittendon, 2015). Children need safety and security to learn and grow. Infants are equipped with reflexes that work with parental instincts to ensure attachment and the establishment of a mutually responsive relationship (Newman et al., 2015). Resilience and responsible citizenship are the outcomes of a secure attachment within a community (Lorenzo et al., 2019). With stable emotional bonds, children learn to regulate emotions, build complex relationships, and engage in day-to-day tasks with confidence.

Spiritual. The spiritual core of a child is unique to the individual and is considered an essential right in terms of belief, expression, and development (UN, 1989). Spirituality does not refer specifically or exclusively to religion, but "the very essence of who we are as human beings" (Townsend & Polatajko, 2013, p. 68). Spirituality resides in the person, is shaped by the environment, and gives meaning to occupations (Townsend & Polatajko, 2013). Common spiritual influences are culture, religion, or family traditions. Spirituality is at the core of an individual's self-expression and interaction with the environment throughout the lifespan.

Occupations of the Child

The developmental progression of occupations for children may be described within the areas of self-care, productivity, and leisure.

Self-Care. Infants are born dependent on caregivers for survival. Self-care for the infant begins at birth. Within a securely attached relationship, the infant signals for and responds to care (Newman et al., 2015). Healthy self-care development for young children revolves around developing appropriate sleep/wake cycles and learning to do the basic personal tasks of eating, toileting, hygiene care, and dressing. As children get older and take on more responsibility in caring for themselves, self-care shifts to self-management (American Occupational Therapy Association [AOTA], 2015). They start to take on responsibility for instrumental activities of daily living such as helping with chores in the home, being mobile in the community, understanding and using money, and interacting in wider social circles. As children interact more independently in their community, they learn to recognize danger in the immediate environment, problem-solve, and ask for help to ensure safety.

Productivity. Productivity describes the process of "contributing to the social and economic fabric of the community" (CAOT, 2009b, p. 3). Play, academics and pre-vocational work all relate to productivity for children. For infants and young children, productivity is interconnected with learning to care for themselves at an age-appropriate rate and learning from adults and from each other through play. For preschool and school aged children, productivity typically focuses on getting an education and integrating educational instruction in and outside of school. Productivity includes contributing to the family and community by doing assigned tasks, or even paid work (Larson & Suman, 1999). From the teenage years to young adulthood, productivity includes the transition from school to work and higher educational pursuits (AOTA, 2015). Productivity for children changes as the child matures through to adulthood.

Leisure. Children of all ages engage in leisure activities for fun, recreation, and social interaction (Powrie et al., 2020). Children require the time, space, and materials to *play* without a directed agenda (Ginsburg et al, 2007). In this sense, play is defined as "a subjective experience of joy and fun, that comes from engaging in freely chosen, intrinsically motivated, self-directed meaningful occupations … and is about the process of engagement rather than the product" (Lynch & Moore, 2016, p. 519). The opportunity to engage in play is seen as crucial for children to learn about their own identities and the process of relationship building (WHO, 2007a). For teenagers and young adults of low socio-economic status, high engagement in the arts has been correlated with higher academic outcomes than those with low engagement (Catterall et al., 2012). Engagement in leisure pursuits is essential for physical, cognitive, and social-emotional development for children of any culture, developmental level, ability, and socio-economic status (WHO, 2007a).

Environment of the Child

Environments are the places and spaces where children live, learn, and play (AOTA, 2015). Throughout childhood, secure and caring home and community environments are critical for children to thrive and achieve developmental milestones (WHO, 2007a).

> "Children's early environment has a vital impact on the way their brains develop. A baby is born with billions of brain cells that represent lifelong potential, but to develop, these

> brain cells need to connect with each other. The more stimulating the early environment … the more positive connections are formed in the brain and the better the child thrives in all aspects of his or her life, in terms of physical development, emotional and social development, and the ability to express themselves and acquire knowledge" (WHO, 2007a, p. 5).

For children to engage in the occupations of childhood to their potential they require healthy physical, social, and culturally sensitive environments (WHO, 2007a). Physical environments encompass the physical places and materials, including sustainable and safe access to those places and materials (WHO, 2007a). Working parents require access to physical environments such as quality childcare to financially support their family. The social environment includes the personal relationships of a child including social interactions that influence daily life. Early caregiving attachments are necessary to support the development of healthy relationships and resilience in the face of more complex challenges (WHO, 2007a).

> "During the earliest years of life, a child's brain is developing the foundation upon which all further learning is built. Infants naturally invite adults to engage in interactions through crying, babbling, facial expressions and gestures. When adults respond back with the same vocalizing and gestures, they are playing a vital role in the development of the brain … By engaging children in conversations, reading to them, responding to their needs in sensitive ways and providing opportunities to explore the world around them, parents, caregivers … lay the groundwork children need for positive health, behaviour, learning and relationships through their life" (Saskatchewan Government, 2016, p. 3).

The cultural environment may include affiliation with race or ethnicity as well as customs and traditions. Culture adds to the meaning of life, and those caring for children are the ones who enable them to explore and engage meaningfully in their culture.

Engagement of the Child

Engagement describes active involvement or participation by the child in an activity. True engagement requires access to activities that are meaningful to the child, culturally relevant, and placed in context with family and peers. Engagement drives further growth and refinement of performance for the child (D'Arrigo et al., 2020). Children are learning and working on many skills that require significant time and practice to master (Larson & Suman, 1999). Ideally, there is an intrinsic motivation to continue to learn and work. Often a child receives a mix of extrinsic motivators associated with successful performance of the task as well as the pleasurable experience of doing the task *with* another person (D'Arrigo et al., 2020; Moore & Lynch, 2018). Engagement is what propels a child to move from one stage of development to another higher stage with more complex sets of interaction.

Engagement in occupations which support optimal child development is highly dependent on the families and the communities in which children live (WHO, 2007a). The overall development of a child is dependent upon caring adults who can provide a safe environment for children to grow, learn, and flourish. This allows children to transition from

total dependence, basic comprehension, attachment-based security, and limited personal skills to purposeful mobility, complex thinking, mature relating, and engagement in meaningful occupations. When children are provided with an environment of emotional support and stability, they can progress through a series of physical, cognitive, social-emotional, and spiritual milestones to engage successfully in the occupations of childhood.

Disruptions in Childhood

Disruptions in childhood influence critical periods of development which are rooted in the time-sensitive nature and volatility of brain development. Barriers to development and engagement can occur because of congenital or acquired disabilities. Poverty, lack of safety and stability in the home environment, and lack of access to quality early education can negatively affect a child's development (Robinson, et al., 2017). When physical, cognitive, or social-emotional development is affected by illness, disease, injury, impairment, or social inequalities, a child's ability to engage in and progress through the typical occupations of childhood is impacted.

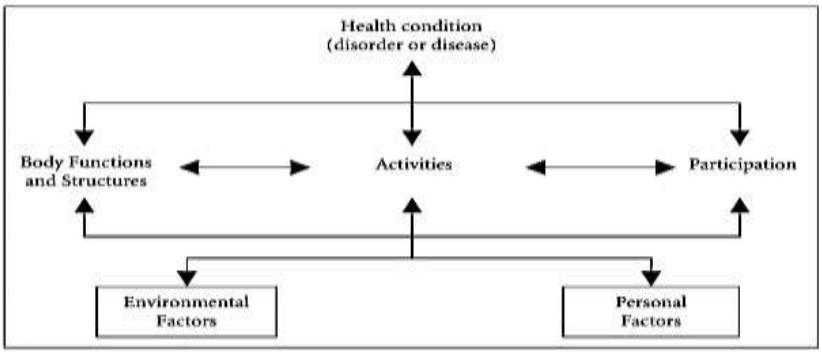
For some children, barriers to development may be the result of inequitable access to care, security, and materials (WHO, 2007a). Some families are under-supported by the community or larger society, and struggle to provide needed opportunities for learning, play, and skill development, as well as protection from recurrent traumatic events (Gronski et al., 2013). Injustices and inequalities at a cultural or societal level disproportionately affect children, as the most vulnerable members of any community (WHO, 2007a). Barriers that interrupt a child's engagement in occupations have the power to "literally *sculpt* the developing brain" (WHO, 2007a, p. 7).

Perspectives on Disability

People with disabilities have long been advocating for a shift from the perception of disability that occurs within the person to the belief that *disability* occurs in the interaction between the person and their environment (Saskatchewan Government, 2015). The World Health Organization published a model for child disability in 2007 that adheres to the perspective of disability happening to a child as opposed to within the person. The International Classification of Function for Children and Youth (WHO, 2007b) was designed so that disability can be systematically described and tracked by professionals, with consistency across countries, sectors, and disciplines (see Figure 2). The classification emphasizes that the child interacts with various environmental, social, cultural, and institutional systems.

Figure 2

International Classification of Function, Disability and Health - Children and Youth



Note. (WHO, 2007b, p. 17).

Individuals with disabilities report that the lack of accessible environments and society's perception of their abilities impact their engagement in society more than their actual physical disability (Saskatchewan Government, 2015). Environmental barriers can occur on a physical, social, institutional, or cultural level. Poverty, marginalization, displacement, and lack of access to resources are devastating for developing children and can cause as much disruption to typical development as a medical impairment.

Children are uniquely vulnerable from the perspective of disability because of the physical, emotional, and cognitive changes that they are constantly experiencing. Their sensitivity to the timing of inputs is a factor that places services to children in a special category of urgency (CAOT, 2009b). Some known vulnerabilities and tragically widespread concerns include:

- exposure to violence (Saskatchewan Government, 2010),
- unmet mental health needs of parents (Reupert et al., 2015),
- scarcity of resources (Waclawik et al., 2019), and
- unrestricted access to technology which can harm or affect children in ways that are not yet completely understood (Gottschalk, 2019).

The rights of children are more at risk when disruptions to childhood occur. Children require a community committed to supporting the rights of all children by providing resources in a timely manner to the child and the family to foster attachment, security, and opportunity. "A mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance, and facilitate the child's active participation in the community" (UN, 1989, p. 1). All children have the right to freedom of expression, a high standard of health, free education, cultural and religious freedom, opportunity for play and artistic development, safety from separation from family, and protection from other sources of harm (WHO, 2007a). Childhood is entitled to special care and assistance (UN, 1989) especially when disabilities are present.

Saskatchewan Perspective

The *Convention on the Rights of the Child* (UN, 1989) is frequently cited by agencies in Saskatchewan (Saskatchewan Advocate for Children and Youth, 2019; Saskatchewan Government, 2019; Saskatchewan Government, 2015) in the context of attempting to reduce barriers to optimize child development. Families in Saskatchewan provide primary care and nurturing to their children within the constraints of their environments. Additionally, many agencies in the province work collaboratively with families to ensure children have equitable access to these universally acknowledged rights of care for childhood (Saskatchewan Government, 2015). These include health, education, social services, not-for-profit organizations, and private health practitioners. A major goal of many organizations is to reduce the *silo* effect of various agencies operating in isolation from each other (Lorenzo et al., 2019; Saskatchewan Government, 2020a; Saskatchewan Government, 2020b; Saskatchewan Government, 2019). When organizations agree on shared values and missions, gaps in care and competing agendas are reduced and the experience of families is improved. The overall goal is for families to be supported equitably and effectively in the raising of their children.

Descriptors of Disruptions in Childhood Development

Disruptions in childhood development may include illness, disease, injury, impairment, and social inequalities. For this document, based on the needs of children, disruptions are categorized as developmental, emotional-behavioural, injury or medical related, educational (AOTA, 2015), and environmental including social inequalities. Table 1 lists the needs of children along with examples of descriptors when disruptions in childhood occur.

Table 1

Disruptions in Childhood Development

Needs of Children	Examples of Descriptors
Developmental	Autism Spectrum Disorder Down Syndrome Fetal Alcohol Syndrome Intellectual Disabilities Neuromuscular Disorders
Emotional-Behavioural	Anxiety Depression Emotional Dysregulation Impact of Trauma Mental Health Concerns Oppositional-Defiant Disorder Sensory Processing Disorder
Injury or Medical Related	Acquired Brain Injuries Cerebral Palsy Medical Conditions Orthopedic Injuries Prematurity
Educational	Attention Deficit Disorder Learning Disabilities Literacy-Based Concerns
Environmental including Social Inequalities	Ethnicity Gender issues Homelessness Isolation Poverty

Note. Examples only.

Summary

Given appropriate care and support, children develop skills to care for themselves, engage in play, and contribute productively to society. Services which support children in the context of family and community are of critical importance. Barriers are reduced when communities are committed to supporting the rights and development of children. Disruptions in childhood can occur, affecting a child's developmental progression and impacting the family caring for the child. Communities can reduce the impact through creative adaptation and enhanced support. When additional services are required, therapeutic interventions such as occupational therapy may be considered to support the long-term development of the child within the family.

3

The Role of Occupational Therapy with Children

Occupational therapists are critical members of any team dedicated to promoting the rights, health, and welfare of the child (Whalley-Hammell, 2018; Lamb & Metzler, 2014; Rexe et al., 2013). Roles of communicator, collaborator, practice manager, change agent, scholarly practitioner, and professional (CAOT, 2012) support work with children in the context of family, team, and community. The therapist ensures that children are engaged in occupations that are meaningful to them, as the core therapeutic medium and primary outcome measure for successful intervention (Nelson, 1997). This section will describe occupational therapy with children, using the framework of person, occupation, environment, and engagement, as illustrated in Figure 1 CMOP-E (Townsend & Polatajko, 2013).

Person - The Child

Foundational to supporting the needs of the child is an understanding of the child's physical, cognitive, and social-emotional development (AOTA, 2015), as well as what is meaningful and valued by the child based on culture. The occupational therapy process determines the child's level of development and an occupation-centred approach to help the child overcome barriers in participation (Rodger & Kennedy-Behr, 2017). This process guides the occupational therapist's therapeutic intervention plan, which may include coaching, consultation, education, caregiver support, collaboration with other team members, and direct intervention with the child (AOTA, 2018; AOTA, 2015; CAOT, 2009b; Ahmadi Kahjoogh et al., 2019). Supporting the caregiver to understand and promote the child as an active agent in their own development is an important communicative and collaborative role of occupational therapists (Killeen et al., 2018; Reupert et al., 2015; Shepherd et al., 2007). Client-centred care may mean direct intervention with the child, as well as supporting and empowering families, agencies, and communities to provide the necessary resources to achieve optimal child development (CAOT, 2012).

Occupations of the Child

Self-Care

Self-care occupations that are commonly addressed by occupational therapists include the personal tasks of eating, toileting, hygiene care, dressing, and sleeping. Children with compromised motor, sensory, and cognitive development may experience altered patterns of participation and progression in self-care occupations. Occupational therapists suggest and demonstrate ways to adjust the tasks to be more manageable for both child and caregiver. Through practice and adaptive approaches, children can be supported to achieve maximum independence in their self-care activities.

Helping a child develop the skills needed for healthy patterns of self-care and eventual self-management is a complex process. Improving the understanding and sense of empowerment of the caregivers who are involved day by day is beneficial (Reupert et al., 2015). Using a gradual teaching process to build towards self-management allows for release of responsibility to the child, either in fulfilling self-care functions or in asking for and directing the help needed. Care needs are reduced when the child is enabled to achieve maximum independence (Dahl-Popolizio et al., 2017). This can be supported by problem-solving, coaching, consulting, or provision of equipment (Shepherd et al., 2007). Occupational therapists may work to help parents and other caregivers understand the parameters of ability, rather than the constraints of disability, and so reframe self-care as a developmental learning process, even when significant delays and differences exist (Pereira, 2017).

Productivity

The occupation of productivity is the ability to generate, create, or enhance a product to achieve a specific goal. Participation in occupations that are activity-based has a positive effect on the overall development of the child (Arbesman et al., 2013). For a child experiencing disruptions in the developmental trajectory, occupational therapy interventions support achievements in productivity which are meaningful to the child. Productivity may include carrying out daily routines and home tasks associated with belonging to a family. Having responsibilities can enhance the child's sense of belonging and connectedness to the family and home. Occupational therapy interventions support caregivers to determine developmentally appropriate responsibilities and tasks, as well as the foundational steps to promote success.

For the preschool and school aged children, occupational therapy interventions may include supporting educators in adapting or modifying curricula and group-based activities to support inclusion. For a child to engage authentically in the occupation of learning is a shared goal of educators and occupational therapists (Grajo et al., 2020; Hasselbusch et al., 2012; Rourk, 1996). Occupational therapy can help educators to frame a *just right challenge* within the learning environment, so that a student experiences a sense of mastery and success at school. Both student and teacher are supported in their relationship, and the child can respond with greater effort, thus accessing higher quality learning.

Occupational therapy interventions shift as the child ages. When *major life transitions* are anticipated, intervention planning is a collaborative effort with the child, parents, school team, and interagency personnel. Transitions may include home to school, elementary to high school, secondary to post-secondary, and student to employable young adult. Transitional support to navigate the community and engage in a vocational future becomes a focus of intervention to enhance the child's quality of life (AOTA, 2015). This supports the premise that "making sure all children get a good start in life leads to a better quality of life for Saskatchewan people" (Saskatchewan Government, 2016, p. 2).

Leisure

For children with developmental challenges, there may be barriers to accessing or participating in meaningful leisure activities. Occupational therapists support children to develop the sensory, motor, and attending skills to participate in leisure and play activities to their maximum ability. Reduction in barriers may be addressed with adaptive approaches and assistive devices. Alternatively, the occupational therapist can encourage basic play skills such as interacting with play partners, turn taking, sharing, sequencing tasks, and using imagination, when these skills are delayed or disrupted by environmental or personal factors (Killeen et al., 2018; Pihlar, 2012). Addressing barriers to participate in leisure activities is at the heart of occupational therapy intervention (Killeen et al., 2018).

Play, in the context of leisure skills, is sometimes identified within occupational therapy practice as "the forgotten occupation" (Moore & Lynch, 2018; Lynch & Moore, 2016). In Western culture, productivity and independence are highly valued. Occupational therapy services aimed at promoting increased function in self-care and productivity may be seen by funders, employers, and families as somehow more valuable than play (Moor & Lynch, 2018; Lynch & Moore, 2016; Ginsburg et al., 2007). Powrie et al. (2020) highlighted the importance of the occupation of leisure for children. Meaningful functional outcomes were measured to last beyond the leisure activity (Powrie et al., 2020), suggesting generalization of skills to other occupations. Children may choose different leisure pursuits for escape, exploration, exchange, and expression. The results suggest that the occupation of leisure should not be neglected in the role of occupational therapy intervention for children (Lynch & Moore, 2016; Chen & Chippendale, 2018; Lorenzo et al., 2018).

Environment of the Child

Occupational therapy addresses the impact of the environment on the child's ability to engage successfully in occupations (AOTA, 2015). The *enabling occupational engagement* lens helps to create the ultimate physical and social environment to enhance opportunity and functional outcomes for the child in a culturally safe manner (CAOT, 2011). This may involve working with families, childcare agencies, community agencies, and educators at a direct, team-based, community, or policy level. Accessibility, safety, participation, and inclusivity as design principles are all key factors which can make the difference between a child experiencing an environment feeling impaired or disabled, or feeling empowered and included (Lorenzo et al, 2019; Teeters Myers et al., 2011).

Occupational therapists use their knowledge to assist in making modifications, accommodations, and adaptations to existing spaces where the child lives, learns, and plays (AOTA, 2018), or in designing new universally inclusive spaces with community policy makers (Killeen et al., 2018). Providing and adapting equipment to compensate for disability or inequity is a role of occupational therapists (Pihlar, 2012). This may include seating and positioning aids, compensatory aids for sensory deficits or impairments, and adding communicative cues and multisensory aids to allow navigation of shared spaces. To support maximum participation for

the child, the occupational therapist may suggest new ideas for the environment or may use the existing environment to suggest novel ways of interaction (Novak & Honan, 2019).

Engagement of the Child

Engagement describes the child's active involvement or participation in an activity. Engagement is what brings meaning to the activity. Regardless of ability, when a child is thriving and has a sense of belonging, the level of engagement in the occupations of self-care, productivity and leisure is enhanced. Therapeutic interventions at the level of engagement may include adaptations designed to help the child feel safe while providing meaningful experiences that the child wants to repeat and master within their own capabilities (D'Arrigo et al., 2020). Occupational therapists support engagement by connecting with the child and exploring opportunities for accessing activities the child may be driven to pursue. Drive and desire provide meaning to occupational pursuits and give children a sense of fulfillment when participation is feasible or mastery is achieved (Polatajko & Mandich, 2004; Rodger & Kennedy-Behr, 2017).

Summary

The role of occupational therapy is to provide services to enable meaningful engagement in occupations for children to achieve maximum independence. Interventions are planned and implemented around the person, occupation, and environment to positively influence the child's health and well-being as the child grows into adulthood. Occupational therapists use a comprehensive understanding of the interplay between typical child development, the environment, and the need for engaging in occupation, to analyze problems and to think of solutions. Children are enabled to reach their potential in the occupations of self-care, productivity and leisure in home, school, and community environments. From infancy to young adulthood, occupational therapists support interventions emphasizing engagement as an essential outcome.

4

Occupational Therapy Workforce in Saskatchewan

The needs of children and occupational therapy as a profession define the foundation for occupational therapy services for children. The provision of occupational therapy services to Saskatchewan children is predicated on an adequate workforce to provide an accessible, equitable and quality service.

> "The labour market for occupational therapists is particularly complex because the supply of and demand for occupational therapists are highly regulated by governments … This makes any forecast of demand or supply difficult because government policies

and health care funding priorities can and do change" (QED Information Systems Inc.[QED], 2016, p. 6).

Using data from the Canadian Institute of Health Informatics (CIHI), data gathered on occupational therapy services for children in various sectors of the workforce, and results from the survey (SSOT & SPOT, 2019), the following analysis of the occupational therapy workforce in Saskatchewan is provided.

CIHI Data: National and Provincial Comparisons

The CIHI databases provide snapshots of national and provincial health human workforces and allow for accurate comparisons across provinces and against the Canadian average. The 2009 and 2019 CIHI figures show that the occupational therapy workforce in Saskatchewan on a per capita basis continues to fall behind the Canadian average and the other western provinces. The CIHI 2019 per capita coverage by Saskatchewan occupational therapists does not even reach the coverage that other western provinces had in 2009 (see Table 2).

Table 2

Occupational Therapy Workforce per 100,000 for Western Provinces and Canada: 2009 and 2019 and the Percentage Change during this Period

	Manitoba	Saskatchewan	Alberta	B.C.	Canada
2009	41	25	41	36	39
2019	51	31	53	50	51
Changes in per Capita	**24%**	**24%**	**29%**	**39%**	**31%**

Note. Represents overall workforce, not specific to services for children (CIHI, 2010; CIHI, 2020a).

The shortfall in the occupational therapy workforce in Saskatchewan has been commented on over many decades and "to reach the national average, Saskatchewan's occupational therapist workforce would need to increase by more than a third – the equivalent of 132 individuals" (QED, 2016, p. 15). This shortfall is emphasized in the report on the Canadian occupational therapy workforce (CIHI, 2020a) through an infographic map (Appendix C). The map shows that the only area in Canada with a lower per capita coverage than Saskatchewan is Nunavut.

Saskatchewan's percentage of change in per capita coverage was also one of the lowest when comparing the differences between the 2009 and 2019 figures (CIHI, 2010; CIHI, 2020a). The gap of per capita accessibility to occupational therapy services is growing wider between Saskatchewan and the rest of Canada. This challenge directly impacts having an adequate workforce for provision of occupational therapy services for children in Saskatchewan.

The lower per capita workforce in Saskatchewan is symptomatic of a worldwide shortage of occupational therapists. Estimates indicate that there should be approximately 750 occupational therapists per 1 million persons (Richards & Vallée, 2020). Even in high-income

countries where there are approximately 420 occupational therapists per one million persons, the number of Saskatchewan occupational therapists per one million persons falls well below the figure of 750 (Richards & Vallée, 2020). As of June 2020, Saskatchewan had 377 occupational therapists for a population of just over one million people. For a province in a high-income country, this falls short of the WFOT figures of 420 occupational therapists and far short of the Canadian figures of 510 occupational therapists per one million persons (CIHI, 2020a). In summary, the per capita workforce in Saskatchewan is not only much lower than the Canadian average, but also lower than the average across the world for high income countries.

The occupational therapy workforce in Canada is distributed unevenly across the different areas of care. In Saskatchewan, a much smaller proportion of the occupational therapy workforce is targeted at mental health services compared to other provinces (see Table 3). This is especially problematic in services for children, given that a 2014 report on the status of mental health and addiction in the province recommended there was a need to "deliver programs and services that promote better emotional health for children and youth in schools and other places where they spend time" (Stockdale Winder, 2014, p. 13).

Saskatchewan occupational therapists are cognizant of the deficit in the provision of their services within the mental health field. In a 2016 study, mental health was mentioned by almost all occupational therapists as the area having the greatest need and six out of ten therapists projected mental health as the fastest growing area of practice in the next five years (QED, 2016). While mental health is recognized as a rapidly growing occupational therapy service area in Canada, the workforce in Saskatchewan is below other provinces in meeting the needs of individuals including children.

Table 3

Comparison of Areas of Care and Workforce Location

	Manitoba	Saskatchewan	Alberta	B.C.	Canada
Mental Health	15.7%	3.6%	9.7%	11.8%	11.3%
Physical Health	52.4%	55.2%	46.9%	55.3%	51.2%
Other Direct Service	15.5%	17.9%	26.6%	19.6%	20.5%
Other	15.5%	23.3%	16.8%	13.3%	17.1%
Urban setting	90.5%	88.6%	92.3%	95.7%	94.6%
Rural/Remote setting	9.5%	11.4%	7.7%	4.3%	5.4%

Note. Represents overall workforce, not specific to services for children. Percentages created from 2016 data (CIHI, 2017).

Community supports and school-based care were also identified as areas with high needs. In 2016, these areas were mentioned by occupational therapists as having the potential to grow rapidly in the next five years (QED, 2016, p. 40). There are indications that steady growth in the youth population will continue as indicated in the following excerpt:

> "The number of school-aged children will increase in the coming years … Even maintaining the current per-student level of therapy services in the education system will require more occupational therapists" (QED, 2016, p. 48).

An increase in the occupational therapy workforce is needed to keep pace with the growth of the Saskatchewan population across all age categories, including that of children. The shortage of occupational therapists significantly affects services to children.

Compared to the Canadian average, Saskatchewan occupational therapists have a slightly higher percentage of the workforce employed in rural settings (see Table 3) compared to other western provinces and the Canadian average. There is also a higher percentage of the workforce in hospitals and long-term care than in other provinces (see Table 4). Children may be cared for in hospitals, home and community environments, and long-term care settings.

Table 4

Comparison of Percentage of Workforce in Various Settings

	Manitoba	Saskatchewan	Alberta	B.C.	Canada
Hospitals	43.8%	52.1%	30.9%	35.8%	47.9%
Community	29.3%	32.8%	38.6%	46.2%	41.1%
Long-Term care	3.5%	8.4%	5.0%	5.6%	4.9%
Other	17.7%	5.6%	17.8%	12.0%	9.4%
Not stated	5.7%	1.1%	7.8%	0.4%	-

Note. Percentages created from 2019 data (CIHI, 2020a). Figures may include services for children.

Occupational Therapy Workforce Serving Children by Sector

The occupational therapy workforce serving children in Saskatchewan is employed or contracted through several organizational structures. In the 2010 document (SSOT, 2010), information was presented on the occupational therapy workforce serving children within the sectors of Health Regions (Ministry of Health), School Divisions (Ministry of Education), Saskatchewan Tribal Councils, and Private Practitioners and Companies. In 2020, data was gathered on the occupational therapy workforce in the above-noted sectors through personal contact with service providers and administrators. Sector data is presented in Appendix D. In this segment, comparisons have been made between the 2010 and 2020 figures using full time equivalent (FTE) figures and descriptors.

Saskatchewan Health Authorities - Ministry of Health

In 2017, the thirteen health regions were amalgamated into two regions, the central Saskatchewan Health Authority, and the far northern Athabasca Health Authority. For the purposes of this discussion, reference to health areas will reflect the terms for former health regions. In 2010, there were approximately 24.4 FTE occupational therapist positions for children's services in the health sector. Data collected in 2020 indicates that there are approximately 36.65 FTE positions dedicated to children's health services across the province. This represents an increase of 12.25 FTE occupational therapist positions, a 30% growth over the decade. During this time there has been a 13.5% growth in population (Saskatchewan Government, 2020c).

The Saskatoon health area experienced a significant change created by the addition of 5 FTE positions with the opening of the Jim Pattison Children's Hospital in 2019. In addition, there have been increases in FTE positions in the Moose Jaw, North Battleford/Lloydminster, and Swift Current health areas. Occupational therapist positions to support services for children with autism account for a large degree of the growth. Occupational therapy services for children in the Regina, Prince Albert and Yorkton health areas have remained relatively the same. Dedicated occupational therapy services for children remain limited to non-existent in many areas of the province, as can be seen in the comparative data for 2010-2020 (see Table 5). The data would include the occupational therapy workforce providing services to children from First Nations in provincial healthcare facilities.

Table 5

Comparison of Workforce in 2010 and 2020 for the Saskatchewan Health Sector

2020 Zones in Saskatchewan	2010 OT FTE	Former Health Regions from 2010 with 2019 Population Figures	2020 OT FTE
Far North	0.07	Northern Health Regions (3) - 37,286	-
North	-	Kelsey Trail (Tisdale) - 40,423	Autism Services - 0.5 Adult Services provide Pediatric Early Development Services
	0.8	Prairie North (North Battleford, Lloydminster, Meadow Lake) - 76, 985	North Battleford: Autism Services - 1.0 Pediatric Services - 0.7 Lloydminster: 0.8 Meadow Lake: 0.4
	1.9	Prince Albert Parkland (Prince Albert) - 78, 645	Pediatric Services - 1.2 Autism Services - 0.8 Casual Outpatient Services
Saskatoon	8.6	Saskatoon Health Region (Saskatoon) - 372,794	Pediatric Services - 14.1 Autism Services - 1.0
Central	-	Heartland (Rosetown) - 42,749	-
	2.1	Sunrise (Yorkton) - 56,075	2.0
Regina	10.25	Regina Qu'Appelle (Regina) - 300,166	Pediatric Services - 10.0 Autism Services - 1.0
South	0.045	Cypress (Swift Current) - 44,422	Autism Services - 1.0
	0.5	Five Hills (Moose Jaw) - 55,286	Autism Services - 1.5 Outpatient Pediatrics - 0.5
	0.135	Sun Country (Weyburn) - 57,231	0.15
Totals	**24.4**		**36.65**

Note. Zones in Saskatchewan (Saskatchewan Government, n.d.j.). 2010 OT FTE (SSOT, 2010). Former Health Regions from 2010 with 2019 population figures (SSOT, 2010; CIHI, 2020a). See Appendix D1 for comprehensive information relating to 2020 data (SSOT & SPOT, 2019).

Saskatchewan School Divisions - Ministry of Education

In 2010, there were 29 school divisions in Saskatchewan (SSOT, 2010). Two small school divisions amalgamated with larger divisions and there are now 27 school divisions in the province (Saskatchewan Government, n.d.i.). Table 6 shows the similarities and differences when comparing 2010 and 2020 data for 21 of the 27 school divisions.

Table 6

Comparison of the Workforce in 2010 and 2020 for Saskatchewan School Divisions

2010				2020		
OT FTE	**Enrolment**	**OT to Student Ratio**	**School Division**	**OT FTE**	**Enrolment**	**OT to Student Ratio**
1.7	6,122	1: 3,601	Chinook	1.0	5,859	1: 5,859
0.6	1,706	1: 2,843	Christ The Teacher RCSSD	0.4	1,767	1: 4,417
1.7	5,812	1: 3,418	Good Spirit	1.05	6,015	1: 5,728
2.0	6,464	1: 3,232	Horizon	2.0	6,215	1: 3,107
0.25	1,968	1: 7,872	Light of Christ RCSSD	0.25	1,940	1: 7,760
1.5	5,530	1: 3,686	Living Sky	2.5	5,196	1: 2,078
0.4	1,443	1: 3,607	Lloydminster Public	1.0	4,222	1: 4,222
1.0	5,146	1: 5,146	North East	2.0	4,736	1: 2,368
0.3	4,168	1: 13,893	Northern Lights	0.45	4,056	1: 9,013
1.0	4,752	1: 4,752	Northwest	2.0	4,530	1: 2,265
1.0	6,682	1: 6,682	Prairie South	0	6,858	0: 6,858
3.6	9,297	1: 2,582	Prairie Spirit	4.0	1,1312	1: 2,828
3.3	7,894	1: 2,392	Prairie Valley	1.5	8,442	1: 5,628
0.25	2,993	1:11,972	Prince Albert RCSSD	0.2	3,087	1:15,435
1.0	9,317	1: 9,317	Regina RCSSD	0	11,683	0:11,683
3.0	19,516	1: 6,505	Regina Public	2.8	24,005	1: 8,573
0.7	8,694	1:12,420	Sask. Rivers	1.7	8,547	1: 5,027
0.8	19,861	1: 24,826	Saskatoon	0.75	25,736	1: 34,314
1.0	7,793	1: 7,793	SE Cornerstone	2.0	8,221	1: 4,110
2.0	1,4337	1: 7,168	St. Paul's RCSSD	2.6	19,389	1: 7,457
0.6	4,479	1: 7,465	Sun West	1.0	5,553	1: 5,553
27.7	**153,974**	**1:5,558.62**	**Totals**	**29.2**	**177,369**	**1:6,074.28**

Note. See Appendix D2 for comprehensive information relating to the 2020 data. Comparative data was not available for 6 school divisions: Conseil des écoles fransaskoises, Creighton, Holy Family RCSSD, Holy Trinity RCSSD, Ile a la Cross, Lloydminster RCSSD (SSOT, 2010; SSOT & SPOT, 2019; Saskatchewan Government, n.d.i.).

In 2010, there were approximately 27.7 FTE occupational therapist positions providing services to the 21 school divisions with a total enrolment of 153,974. This indicated a ratio of one occupational therapist for every 5,558.62 students. In 2020, there are approximately 29.2 FTE occupational therapist positions serving the same 21 school divisions with an enrolment of 177,369. This indicates a ratio of one occupational therapist for every 6,074.28 students. The

FTE numbers reflect both filled and unfilled positions. Since 2010, in these 21 school divisions, there has been an increase in the student population of 23,395 (15%) and a corresponding increase of only 1.5 FTE occupational therapist positions (5%) (SSOT, 2010; SSOT & SPOT, 2019; Saskatchewan Government n.d.i.). These figures raise further concerns regarding the accessibility of occupational therapy services to children in schools in Saskatchewan.

The enrolment figures do not include pre-kindergarten students. There is inconsistency across school divisions and health-based regional services regarding the provision and transfer of occupational therapy support for pre-kindergarten students. In some school divisions the school-based occupational therapist provides services to pre-kindergarten students. In other school divisions pre-kindergarten students receive occupational therapy services through SHA. Based on this variance across the province, the actual occupational therapist to student ratio may in fact be larger than stated.

Saskatchewan Tribal Councils - First Nations Education

As outlined in Appendix D3, there is a broad variance in occupational therapy service provision in First Nations education. At time of writing, several administrations were without occupational therapy services and were actively seeking or considering occupational therapy services. A comparison of the 2010 data with 2020 data is limited as there have been changes in the structure of First Nations education in Saskatchewan and a comprehensive approach to data collection was not undertaken in 2010 (see Table 7).

Table 7

Occupational Therapist Full Time Equivalent Funded by Saskatchewan First Nations Education: Comparing 2010 and 2020

Zones in Saskatchewan in 2020	OT FTE in 2010	OT FTE in 2020
Far North – west	0.8	0.4
North – west	0.08	0.5
North – central	-	0.08
Saskatoon	1	0.45
Central – east	-	Variable
South – east	-	0.15
Totals	**1.88**	**1.58 +**

Note. Zones in Saskatchewan in 2020 (Saskatchewan Government, n.d.j.). OT FTE is based on 180-day school year. See Appendix D3 for details relating to 2020 data. Only zones with data are reported in this table. FTE in 2020 is a low estimation due to variable FTE reported. Includes referrals through health (SSOT, 2010; SSOT & SPOT, 2019).

Occupational Therapy Private Practices and Companies

There has been a steady growth in private practice occupational therapy services for children in Saskatchewan over the past ten years (see Table 8). Based on data collected, the number of occupational therapists in private practices has increased significantly from

approximately 4.25 to 13.25 FTE. Some practitioners declined to provide information on the extent of their practices, so the figure of 13.25 FTE can be considered a conservative estimate of the FTE of private practitioners providing services to children in the province.

Table 8

Privately Funded Occupational Therapist (Full Time Equivalent – FTE) Listed by Zones in Saskatchewan: Comparing 2010 and 2020

Zones in Saskatchewan in 2020	OT FTE in 2010	OT FTE in 2020
Far North	-	-
North – west, central, east	0.8	1.9 to 2.1
Saskatoon	3.15	8.0
Central – west, east	-	-
Regina	0.3 to 0.4	2.2 to 2.75
South – west, central, east	-	0.4
Totals	**4.25 to 4.35**	**12.5 to 13.25 +**

Note. Zones in Saskatchewan in 2020 (Saskatchewan Government, n.d.j.). See Appendix D4 for more details relating to 2020 data. The primary zone is reported when OT services are offered across zones. OT FTE may overlap with health and education data (SSOT, 2010; SSOT & SPOT, 2019).

Workforce Demographics

The SSOT membership was surveyed to provide workforce information related to years of occupational therapy practice, FTE or hours worked per week, and practice location (SSOT & SPOT, 2019). A total of 117 occupational therapists responded with 71 respondents reporting working with children.

Years of Practice

The number of years of practice for all respondents reflected a relatively equal split between those with nine years or less and those with 10 – 21 years of experience. A smaller group of respondents had 22 or more years of experience (see Table 9). A different picture emerges when reviewing the number of years of practice that included working with children. Two-thirds of the respondents have spent less than 10 years working with children, with most respondents having spent less than five years. The number of respondents with 22 or more years working with children drops to 10% (see Table 10). These figures may indicate that the workforce of occupational therapists providing services to children in Saskatchewan is less experienced than the total workforce.

Table 9

All Respondents - Years of Occupational Therapy Practice

Years of Practice	% of Total	Collapsed % figures
Less than 2	3.42	**36.76%**
2 – 5 years	8.55	
6 – 9 years	24.79	
10 – 13 years	9.40	**41.02%**
14 – 17 years	14.53	
18 – 21 years	17.09	
22 – 24 years	4.27	**22.22%**
25 – 28 years	5.98	
29 – 32 years	5.13	
More than 32	6.84	

Note. Percentages add up to 100 (SSOT & SPOT, 2019).

Table 10

All respondents - Years of Practice that included Working with Children

Years of Practice	% of Total	Collapsed % Figures*
None	13.68	**67.53%**
Less than 2	24.79	
2 – 5 years	16.24	
6 – 9 years	12.82	
10 – 13 years	9.40	**22.22%**
14 – 17 years	6.84	
18 – 21 years	5.98	
22 – 24 years	2.56	**10.25%**
25 – 28 years	1.71	
29 – 32 years	3.42	
More than 32	2.56	

Note. Percentages add up to 100 (SSOT & SPOT, 2019).

Hours Worked Per Week

When looking at the amount of time that respondents worked, 75% of respondents were working at least 30 hours a week with fewer than 10% working 11 hours or less a week. The data presents differently when reviewing the amount of time that respondents worked with children. In that situation, approximately 50% worked at least 30 hours, while almost 25% were working 11 hours or less a week (see Tables 11 and 12). This indicates that occupational therapists working with children tend to work reduced FTE positions.

Table 11

Average Time per Week Providing Occupational Therapy Services

Average Time per Week	% of Total	Collapsed % figures
0.1 FTE or 3.7 hours or less	3.42	**7.69%**
0.2 FTE or 7.5 hours	4.27	
0.3 FTE or 11.5 hours	0	
0.4 FTE or 15 hours	1.71	**16.24%**
0.5 FTE or 18.75 hours	8.55	
0.6 FTE or 22.5 hours	1.71	
0.7 FTE or 26.25 hours	4.27	
0.8 FTE or 30 hours	9.40	**76.07%**
0.9 FTE or 33.75 hours	1.71	
1.0 FTE or 37.5 hours	64.96	

Note. Percentages add up to 100 (SSOT & SPOT, 2019).

Table 12

Average Time per Week Providing Occupational Therapy Services to Children

Average Time per Week	% of Total	Total #	Collapsed % Figures
0.1 or 3.7 hours or less	12.68	9	**23.95%**
0.2 FTE or 7.5 hours	7.04	5	
0.3 FTE or 11.5 hours	4.23	3	
0.4 FTE or 15 hours	2.82	2	**21.14%**
0.5 FTE or 18.75 hours	9.86	7	
0.6 FTE or 22.5 hours	4.23	3	
0.7 FTE or 26.25 hours	4.23	3	
0.8 FTE or 30 hours	5.63	4	**54.91%**
.9 FTE or 33.75 hours	4.23	3	
1.0 FTE or 37.5 hours	45.05	32	
Total Number of Respondents	-	**71**	-

Note. Percentages add up to 100. (SSOT & SPOT, 2019).

Location of Practice

Respondents were asked to describe their locations of practice (Appendix E) from which eight geographical categories were defined (see Table 13).

Table 13

Where Survey Respondents Practice in Saskatchewan

Geographical Category	Work with Children	Do not work with Children
Regina	16	12
Saskatoon	26	19
Northeast Quadrant (NE)	7 (9)	3 (5)
Northwest Quadrant (NW)	7 (8)	2 (3)
Southeast Quadrant (SE)	8 (11)	3 (4)
Southwest Quadrant (SW)	6 (9)	5
Northern Saskatchewan	0 (5) *	None
First Nations	0 (5) *	None
Total Number of Respondents	**70** (out of 71**)	**44** (out of 46***)

Note. Bracketed number (#) indicates total number of responses for that quadrant; however, they are not included in the quadrant total as they are accounted for elsewhere in the chart, primarily Regina or Saskatoon. *Respondents included either First Nations or Northern Saskatchewan locations along with another geographical category, and therefore are already counted in the total. None of the respondents indicated working exclusively in Northern Saskatchewan or on First Nations. **One respondent listed "all of Saskatchewan." This response could not be categorized in this chart. ***One respondent listed "Chronic Disease Management" and another listed "rural Saskatchewan." These two responses could not be categorized in this chart. (SSOT & SPOT, 2019).

The survey responses reflected that there are occupational therapists practicing in all areas of the province. The data indicated that respondents working with children are more widely spread in rural areas of the province than respondents who did not work with children. The practice locations for all practicing occupational therapists in Saskatchewan were obtained from the SSOT database as of June 19, 2020. When this information was placed into the same geographical categories as identified in Table 13, results showed that there was a relatively even response rate across the categories, ranging from 24% in the Northwest to 44% in the Southwest (see Table 14).

Table 14

Percentage of Saskatchewan Occupational Therapists who Responded to the Survey

Geographical Category	Practicing OTs In Saskatchewan	# of Respondents To Survey	% of SSOT Practicing Members who responded to the Survey
Regina	87	28	32%
Saskatoon	153	45	29%
Northeast (NE)	31	10 (14)	32% (45%)
Northwest (NW)	37	9 (11)	24% (30%)
Southeast (SE)	42	11 (15)	26% (36%)
Southwest (SW)	25	11 (9)	44% (36%)
Northern Saskatchewan	1	0 (5) *	0
First Nations	1	0 (5) *	0
Totals	**377**	**114**	-

Note. Data not specific to children (SSOT & SPOT, 2019). Number of practicing OTs in Saskatchewan obtained through SSOT, June 2020. See Table 13 for key to bracketed numbers and asterisks.

Summary

The 2020 occupational therapy workforce data for Saskatchewan, as documented in this section and in the tables in Appendix D, clearly demonstrates that the number of occupational therapists remains inadequate to meet provincial needs. The lack of an adequate occupational therapy workforce has existed for decades.

> "If an urban region is having trouble finding the therapists it needs at a time when it's estimated Saskatchewan needs at least 140 more OTs, residents of rural areas who require help are in even worse shape. It's long past time for politicking on this issue" (Star Phoenix, 2012, p. 47).

The occupational therapy workforce shortage affects services in all areas of care, including services to children. Except for the increased designated positions for the new children's hospital and the increase in FTE for private practitioners, there does not appear to be a marked change in occupational therapist FTE positions providing services to children and youth in Saskatchewan. The notable decrease in the ratio of occupational therapists to students in the education system is a concern.

The gap between the workforce levels existing in Saskatchewan and the workforce levels in the rest of Canada continues to widen. To lessen this gap, there is a need to look at what environmental factors influence occupational therapy practice and the impact on occupational therapy service provision in Saskatchewan. At a minimum, children, caregivers, and those working with children in the community would benefit if the occupational therapy workforce were expanded to reach the workforce levels seen across the rest of Canada.

5

Environmental Factors Influencing the Practice of Occupational Therapy with Children

Environment, broadly defined, refers to the surroundings and conditions in which a person functions. The person referred to within this section is the occupational therapist. Environmental factors that influence occupational therapists in their practice to provide services for children will be highlighted within the categories of societal, provincial, workplace, and professional. The categories evolved from the survey and corresponding literature.

Societal Factors

In the past decade, society in the context of Saskatchewan, Canada, and the world has undergone many changes that have affected the ability of children to engage freely in occupations that support growth and development (UNICEF, 2006). These societal factors have influenced the present and future practice of occupational therapists working with children. Some societal factors that relate to the direct impact on services for children will be discussed.

Technology has become an influencer of occupational therapy practice. The emergence of the internet has expanded communication, including accessibility to remote areas which has been essential during the global COVID-19 pandemic. Advances in technology continually open opportunities for access, service delivery, and learning for everyone (SSOT, 2020; WFOT, 2014; CAOT, 2011).

The workforce for occupational therapy services is dependent on funding. With the amalgamation into one primary health region for the central to southern parts of the province, an amalgamation of funding has also occurred. A map of therapy services in Saskatchewan (Saskatchewan Government, n.d.d.) outlines the variety of occupational therapy services coordinated to be responsive to the needs of the children and their community. The changes to organizational structures and funding influence occupational therapy service delivery and respondents identified challenges with understanding how this map corresponds to current services and funding (SSOT & SPOT, 2019).

The provincial education system along with Tribal Education Councils and individual First Nation schools are influential institutional factors for occupational therapy practice. The Saskatchewan Ministry of Education has directed educators to provide opportunities for learning to all children, regardless of medical or developmental issues, in their inclusive education plan (Saskatchewan Government, 2017). Individual community schools have an option to work within First Nations education authorities as part of the education transformation to enhance working together for First Nations students (Canada Government, n.d.d.). Occupational therapy practice is influenced by institutional factors that promote inclusive education and community operated education.

Needs of children and families continually change and influence new funding or changes to funding as related to occupational therapy services (SSOT & SPOT, 2019). A 2012 campaign lobbying for occupational therapy services throughout Canada was spearheaded to support this continual change (Rexe et al., 2013). The campaign recognized the rising costs of healthcare, influencing a need to re-evaluate healthcare coverage in the insurance industry. This may directly correlate with the workforce growth in the private practice sector for occupational therapists working with children, as previously mentioned in the workforce sector. The practice of occupational therapy is influenced by ever changing availability of funding.

The recognition of mental health and treatment of mental illness has become an everyday discussion in society (Stockdale Winder, 2014; CAOT, n.d.c.; WFOT, 2019). Discussions that directly influence occupational therapy practice with children include:

- an increase in the incidence and widespread recognition of effects of cyber-bullying (Canada Government, n.d.f.),
- social media influences (Gottschalk, 2019),
- an increase in awareness of the devastating effect of a lack of supports leading potentially to suicide in young people,
- recognition of the need for increased support for literacy for everyone (Saskatchewan Government, n.d.j.) - Saskatchewan has seen an increase in immigration from 7,204 in 2009-2010 to 13,910 in 2018-2019, and
- increased recognition of the effects of marginalization including aspects of identity such as gender and ethnicity.

The increased awareness of mental health within our society has impacted the practice of occupational therapy and emphasized the complexity of occupational therapy services for children.

In Canada, a special area of concern is the work that needs to continue with Indigenous peoples. The effect of historical trauma and colonialism on children is well-documented. Many health status outcomes of Indigenous peoples are below the national average because of systematic barriers to healthcare access (CAOT, 2018).

In summary, societal factors have an influence on the practice of occupational therapy and impact the services that are available to children. The influence varies for each child in the context of family and community environments where they live, learn and play. Parallel to this, the influences vary for individual occupational therapists practicing in Saskatchewan (SSOT & SPOT, 2019). Societal factors continually change influencing occupational therapy practice to be responsive and adapt accordingly.

Provincial Factors

Saskatchewan has environmental factors that impact occupational therapy practice with children (SSOT & SPOT, 2019). The location of occupational therapists results in an environmental factor that has been previously discussed. In this segment, the provincial environment will be described from the concepts of *rurality* and travel as it relates to occupational therapy practice.

Rurality of Saskatchewan

Saskatchewan is considered a rural province. As of January 1, 2020, census data indicates the population of Saskatchewan to be 1,181, 666 (Saskatchewan Government, n.d.c.). Thirty-eight percent (38%) of the population live in the larger urban centres of Regina and Saskatoon. The remaining 62% of the population live in smaller cities, towns, and communities throughout the province. While the cities of Prince Albert and Moose Jaw each have populations over 30,000, the cultures of these centres fall into the category of *rurality* more so than urban. *Rurality* can be described as the combination of specific characteristics of a place including the size of the population, the density of population, access to services, and particular socio-economic variables such as occupation (Roots et al., 2014). Survey respondents described this as “rural challenges'' (SSOT & SPOT, 2019) which will be discussed further in the following segments on workplace and professional factors. There is connectivity between urban and rural, as services in the urban centres are influenced by the needs of rural communities and vice versa. The *rurality* of the province has subsequent impact on the larger urban centres which tend to be hubs for specialists and access to other services not available in the smaller communities (SSOT & SPOT, 2019).

Therapists working in rural areas tend to provide services for a wide geographical area and require a broad range of skills and knowledge from many areas of practice (SSOT & SPOT, 2019; Roots et al., 2014). Features that influence occupational therapy services delivered in rural practice include diversity of clients, variety of service models, limited resources, access to professional development, high prevalence of chronic diseases and traumatic injuries, and a high proportion of Indigenous peoples (Roots et al., 2014). Survey respondents identified similar features within their responses, but the features were not isolated to rural practice (SSOT & SPOT, 2019) as many similar challenges occur in the urban centers.

The *rurality* of Saskatchewan has an impact on occupational therapy practice. Research on the *rurality* of occupational therapy practice has been completed within the last decade and provides insight on how occupational therapy practice may be changed from an education perspective (Winn et al., 2015; Roots et al., 2014; Wielandt & Taylor, 2010). Having *roots* is one of the main indicators of an occupational therapist working and staying in a rural or remote area (Winn et al., 2015). The completion of both academic and clinical education in a rural setting has been positively associated with an increased likelihood of an occupational therapist choosing to practice in a rural area upon entry to practice (Winn et al., 2015). Place-based education is a concept that has resulted in satellite campuses being set up in communities to offer education closer to home within rural areas. This may serve as a recruitment/retention strategy to increase workforce when *rurality* impacts occupational therapy practice. *Rurality* was a commonly mentioned theme that is impacting occupational therapy practice for children in Saskatchewan (SSOT & SPOT, 2019).

Travel Considerations

When providing services for the children of Saskatchewan, the delivery model, broadly speaking, is either care in place, or care within a clinic or hospital setting. The type of service required determines if the client travels to the occupational therapist or the occupational therapist travels to the client. Using a client centered approach to planning therapeutic intervention, the needs of the client will help determine the best place for provision of services (Kingsley & Mailloux, 2013). This is consistent with survey responses which identified providing services within the environments where children live, learn, and play is the preferred approach (SSOT & SPOT, 2019). Travel for the therapist may be perceived as less of a concern when this can occur. Furthermore, some survey respondents indicated that travelling provides a time to reflect and de-stress.

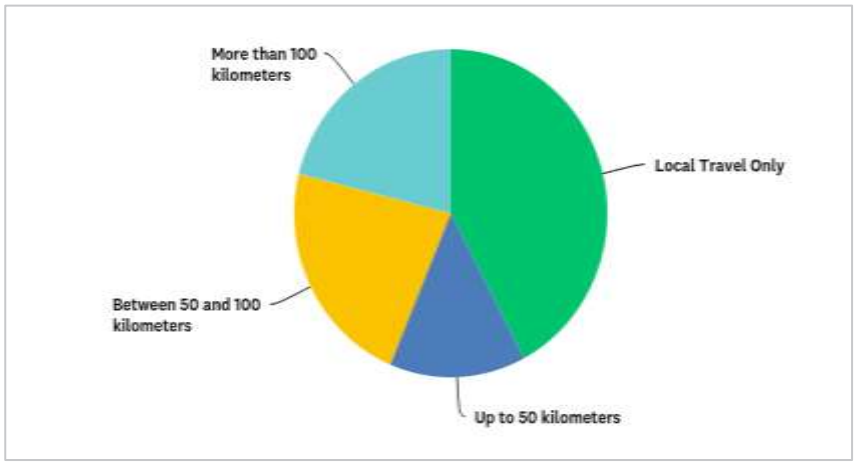
Managing Travel Time. Travel may pose challenges for the client and the therapist (SSOT & SPOT, 2019). The survey did not collect data from the perspectives of the clients directly. Survey respondents reported extensive travel in their practice leads to fewer clients being seen in a day, shorter visits, and minimal direct care in exchange for consultation or monitoring (SSOT & SPOT, 2019). When the child and family travel, they may have numerous appointments scheduled which may impact the child's overall performance for their intervention. Travel can impose challenges.

Improving access to services requires more than increasing the number of occupational therapists and may include initiatives such as telepractice to help manage travel time when appropriate (SSOT & SPOT, 2019). Survey respondents identified the use of telehealth, video conferencing, teleconferencing, and other web-based platforms as methods to minimize time for travel in their practice. The respondents indicated that these platforms were primarily used for meetings and not direct care. However, during the global COVID-19 pandemic, occupational therapists have increased their usage of video and tele-conferencing methods to provide occupational therapy services for children. The positive impact telepractice has on occupational therapy service delivery in a rural province is anticipated to evolve.

Travel Distance and Time. Actual travel for occupational therapists in their practice was analyzed by distance traveled and time spent travelling each month to provide occupational therapy services to children. Figures 3 and 4 provide a visual representation of travel distance and time to provide occupational therapy services to children in the province. More time spent travelling typically corresponds with longer distances travelled.

Figure 3

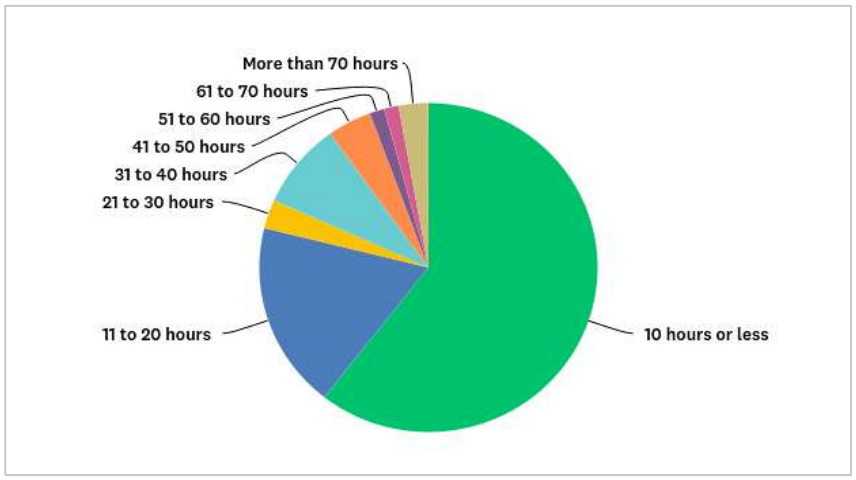
Average Travel Distance One Way Related to Occupational Therapy Services for Children



Note: (SSOT & SPOT, 2019).

Figure 4

Travel Time in a Month Related to Occupational Therapy Services for Children



Note. (SSOT & SPOT, 2019).

The majority of survey respondents who work with children reported some travel within their work. Local travel was reported by 56% of the respondents while almost 30% of the respondents reported travelling more than 50 km. Survey results indicated that 60% of the respondents work with children in the large urban centers of Saskatoon and Regina compared to 40% who work in the other quadrants with smaller urban centers and rural communities. The survey results confirm that occupational therapists who practice in the urban centres have considerably less travel time and mileage than occupational therapists in rural practice.

Safety with Travel. Equally important to travel time for the client or the therapist is safety during travel (SSOT & SPOT, 2019). There are many risks to consider when travelling in rural Saskatchewan such as road integrity, road maintenance, gravel roads, sparsely travelled roads, seasonal conditions, and wildlife. The risks may result in unpredictable weather and road conditions that influence a need to manage travel time and distance for clients as well as the travelling therapist to minimize stress and safety concerns (SSOT & SPOT, 2019; Boshoff & Hartshorne, 2008). Safety with travel in different zones of the province influences how occupational therapy services are delivered.

Workplace Factors

Survey respondents identified several workplace factors that influence the recruitment and retention of occupational therapists and thereby affect the practice environment (SSOT & SPOT, 2019). Recruitment and retention of occupational therapists to Saskatchewan are not new challenges in the workplace in Saskatchewan (SSOT, 2010). This segment will emphasize retention and intrinsic workplace factors that have been categorized into job satisfaction, work climate, and influences by administration. Information on extrinsic factors was not gathered in the survey. Mills and Millsteed (2002) identified that the appeal for rural living occasionally does not result in the therapist settling into the lifestyle nor developing friendships external to work. Family related factors such as a spouse transferring for work, a spouse unable to secure employment, and homesickness may impact retention (Mills & Millsteed, 2002; Newton-Scanlan et al., 2010). Recruitment and retention will be discussed separately to emphasize the differences and the impact on occupational therapy practice with children in Saskatchewan, based on survey responses (SSOT & SPOT, 2019).

Recruitment

Survey respondents frequently identified that there is a shortage of occupational therapists throughout the province. One respondent articulated that one of the barriers is “growth – it is incredibly challenging to recruit occupational therapists to meet demands. The work is there – I simply cannot access the OTs” (SSOT & SPOT, 2019). The literature clearly documents that education on rural practice in education programs is essential to recruitment (WFOT, 2016). As of 2020, there continues to be no educational program for occupational therapists in Saskatchewan. Occupational therapy students from the University of Alberta complete, on average, 60 fieldwork placements each year in Saskatchewan. Occupational therapy students from the University of Manitoba complete 22 to 29 placements per year in Saskatchewan. Often one or two placement offers per fieldwork period go unfilled due to the geographical location of the workplace site or the practice area not being a match for what the student requires for either university. Post-graduation statistics, over the last three years, show approximately 72% of Saskatchewan residents who studied occupational therapy at the University of Alberta returned to Saskatchewan to work (CIHI, 2020b). Challenges with recruitment and shortages of occupational therapists impact occupational therapy practice and the delivery of services.

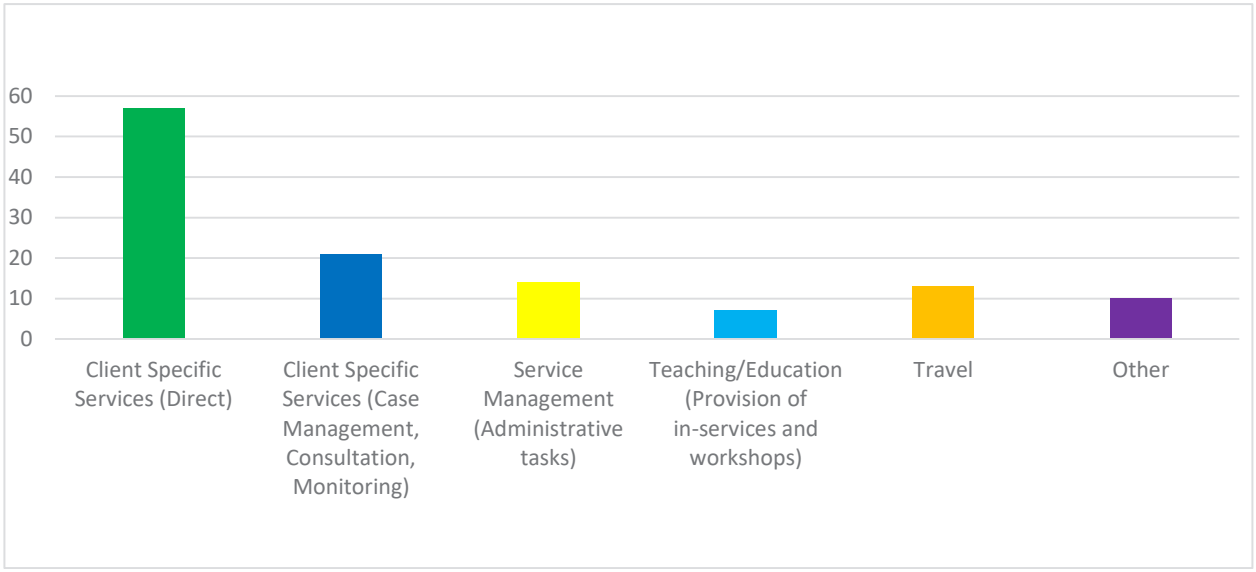
Retention

Recruitment of a professional is the first step in the hiring process. Retention of a professional is the next challenge. Satisfaction with workload distribution, work climate, and influences by administration were identified as important aspects for retention of occupational therapists in Saskatchewan and will be further discussed (SSOT & SPOT, 2019).

Satisfaction with Workload Distribution. Survey respondents were asked to estimate the percentage of time spent on direct and indirect services with children (see Figure 5).

Figure 5

Percentage of Time for Direct and Indirect Services with Children

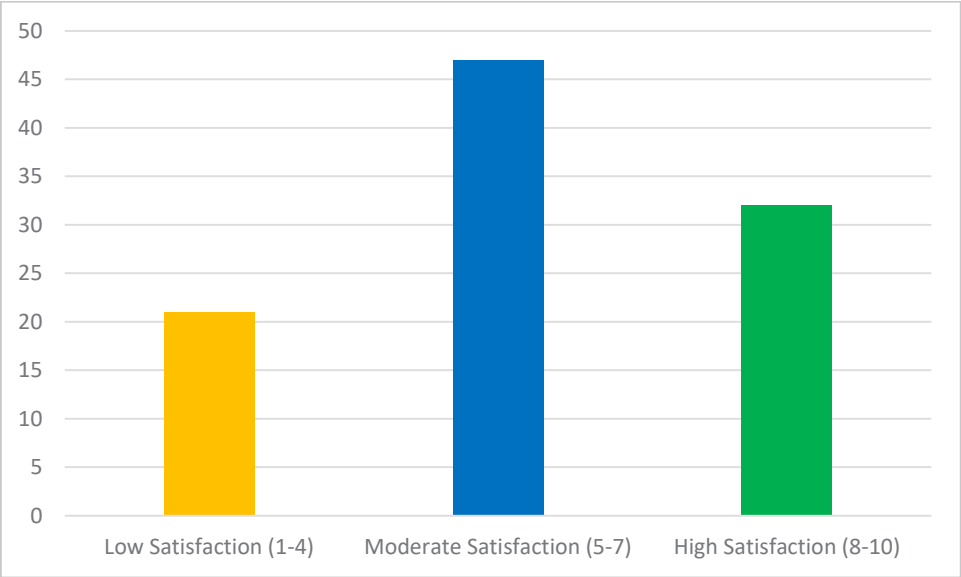


Note. Based on estimated percentages (SSOT & SPOT, 2019).

Survey respondents were then asked to rate their satisfaction level with their distribution of time on a scale of 1 to 10 (SSOT & SPOT, 2019). The results indicated that 32% of respondents reported high satisfaction, 47% reported moderate satisfaction, and 21% reported low satisfaction (see Figure 6).

Figure 6

Satisfaction with Workload Distribution



Note. (SSOT & SPOT, 2019).

Factors that influence occupational therapists to leave or remain in their current job have been studied (Freda, 1992). More than half of the survey respondents reported that they spend most of their time providing client-specific occupational therapy services (SSOT & SPOT, 2019). This correlates with moderate to high job satisfaction. Direct time spent with the client was reported to be the most rewarding aspect of the job (Freda, 1992) which is consistent with the survey results.

Work Climate. Work climate has been described as essential to retention (SSOT & SPOT, 2019). Healthy work environments are important to all employees when choosing to remain at their place of employment (Canada Government, n.d.b.). An intrinsic factor that negatively influences work climate is the continual level of change in the workplace (Lavoie-Tremblay et al, 2010). Continual reorganization influences delivery of services and funding priorities. Survey respondents identify that there are unmet needs of children who do not fit mandates yet who could benefit from services. This disparity negatively influences job satisfaction. Difficulties with recruitment, vacancy management, and budget changes continually influence the services the survey respondents provide. This in turn can affect the work climate and the satisfaction with workload distribution.

There is recognition that different strategies are beneficial for different generations of employees to support retention and job attachment (Lavoie-Tremblay et al., 2010). This helps when analyzing the different strategies for retention suggested by survey respondents (SSOT & SPOT, 2019). The following examples are extrapolated from Lavoie-Tremblay et al. (2010) to explain intergenerational differences in the work climate.

- *Baby boomers* (born between 1946 to 1963) perceive more conflict in the workplace. They equate work to self-worth and work more individually. Termination of employment often corresponds to retirement.
- *Generation Y* employees (born between 1981 to 2000) perceive a job as an opportunity for lifelong learning and are continually looking for new challenges. Termination of employment often corresponds to looking for new challenges.

As previously mentioned in the workforce section, many occupational therapists working with children in Saskatchewan may fall within the *Generation Y* group. This information may be interpreted that a supportive work climate is essential for all occupational therapists but that generational differences impact professional development plans and retention.

Administrative Influences. Occupational therapists work within many different supervisory and management models. Survey respondents reported varying degrees of supervision from infrequent access to a supervisor to regular supervision where referral management and finances are the primary focus (SSOT & SPOT, 2019). Supervisory approaches have a direct influence on workplace satisfaction which correlates with retention (Hills et al., 2013).

Inclusive management styles have been identified as an effective management approach (Hills et al., 2013; SSOT & SPOT, 2019). An inclusive management approach supports career guidance by facilitating creativity, increasing work responsibility, and integrating new technologies like social networking into practice. This approach facilitates professional development and fosters retention in the profession. Inclusive management supports generational differences among therapists in a workplace.

Survey respondents were generally satisfied with workload distribution as previously noted. However, large caseloads affect the provision of services, negatively impact work-life balance (SSOT & SPOT, 2019), and in turn influence job satisfaction (Mason & Hennigan, 2019). Less direct time with clients because of large caseloads strongly influences job satisfaction in the workplace (SSOT & SPOT, 2019).

Survey respondents expressed concern that a lack of occupational therapists, vacant positions, and positions not posted, result in stretching roles to other health professionals by administration to fill gaps that exist (SSOT & SPOT, 2019; Roots et al., 2014). Limited exposure to occupational therapists results in a lack of awareness of occupational therapy (SSOT & SPOT, 2019; Wielandt & Taylor, 2010). Therapists may need to limit their scope of practice to assessments and written reports with no time available for therapeutic intervention, as well as experience gaps in services with waitlists. Shortages of occupational therapists per capita, as previously documented in the workforce section, may result in higher caseloads, changes to the scope of practice, and type of services available, all of which affect job satisfaction and in turn retention.

Occupational therapists are able to work to their maximum scope of practice (ACOTRO, 2012) with effective caseload management skills and administrative support. Working to a

maximum scope of practice may require the use of support staff as part of the service delivery model. Management and organization of appropriate referrals to occupational therapy requires an awareness of the profession (SSOT & SPOT, 2019; Wielandt & Taylor, 2010) including the services available within the funding system.

Professional Factors

Professional factors are directly linked to work satisfaction and retention. Several professional factors were identified by respondents as contributing to a positive practice environment. Identified professional factors include professional development, professional confidence and identity, client-centeredness, and autonomy in the workplace.

Professional Development

Building knowledge is essential to professional development (CAOT, 2012). Survey respondents shared that this is supported by attending workshops, courses, and webinars, and providing educational sessions to staff (SSOT & SPOT, 2019). Relationships between colleagues and networking are also important aspects of professional development (SSOT & SPOT, 2019; Murray & Lawry, 2011). Professional collaboration can help reduce feelings of isolation in practice and contribute to building knowledge amongst practitioners (Basyk et al., 2015). Exposure to rural learning opportunities and positive rural learning experiences have shown to result in improved recruitment and retention (Roots et al., 2014). Professional development supports healthy work environments through relationships with colleagues and engagement in professional growth opportunities (SSOT & SPOT, 2019; Freda, 1992).

Professional development and interdisciplinary collaboration have been cited as essential to effective practice; however, access to both remains a barrier in Saskatchewan. Taking time to attend professional development courses may result in a backlog of work upon return (SSOT & SPOT, 2019). Working in isolation with a wide scope of practice presents additional challenges to maintain competence and standards of practice (SSOT & SPOT, 2019; Roots et al., 2014). The SPOT Practice Network was established in 2018 as a means of supporting much needed professional development and collaboration.

Professional Confidence and Identity

Professional confidence is a dynamic, maturing personal belief held by a professional that includes an understanding and belief in the role, scope of practice, and significance of the profession (Holland et al, 2012). Important components to achieving professional confidence and identity include the development of professional working relationships and supportive environments (SSOT & SPOT, 2019; Holland et al., 2012). As previously noted in the workforce section, there is growth in some sectors which builds a foundation to understand the role of occupational therapy (SSOT & SPOT, 2019). In other sectors that use consultation services and varying contracts, professional identity is less clear which challenges therapists to continually educate others on the profession and role of occupational therapy. Professional development

and knowledge translation on the role of the profession are crucial aspects when advocating for an occupational therapist on the team.

Client-centeredness

Survey respondents indicated the ability to *provide client and family centered care* links directly with satisfaction in their jobs (SSOT & SPOT, 2019). The importance of including the family as a member of the team in the development of goals and building long term relationships with families to respond to the changing needs of the child was emphasized. The survey respondents stressed the importance of doing what is best for the family and child to achieve desired outcomes. Within the literature, meaningful relationships formed with clients and families and helping clients achieve goals are directly linked to job satisfaction (Moore et al., 2006) and therefore retention.

Autonomy in the Workplace

Whether in rural or urban practice, having autonomy was cited by survey respondents as a strength within the system that they provided services to children. Autonomy was cited with scheduling and how services are delivered to include flexible, adaptive, and responsive service provision (SSOT & SPOT, 2019). Having autonomy and the ability to plan the workday and treatment sessions are linked to job satisfaction (Moore et al., 2006). In addition, Roots et al. (2014) identified that for occupational therapists to be successful in rural practice, they must be self-directed, resourceful, and seek out professional networks, which is synonymous with autonomy and may be generalized in the context of Saskatchewan and urban practice.

Given the *rurality* of Saskatchewan, occupational therapists often work in sole charge positions which require a high level of autonomy, skills in the management and organization of diverse caseloads, effective communication skills, reflective practice, and flexibility to adapt programs to the rural context (SSOT & SPOT, 2019; Roots et al., 2014). Sole charge therapists are considered generalists; however, some may argue that advanced knowledge and skills are required in sole charge practice (SSOT & SPOT, 2019; Roots et al., 2014). Establishment of contacts and support networks is essential (Wielandt & Taylor, 2010) to minimize feelings of professional isolation. Professional factors have a significant influence on the sole charge practitioner and have a high level of importance in this type of service model.

Summary

Environmental factors, whether societal, provincial, workplace and/or professional, influence the practice of occupational therapy with children in Saskatchewan. It is essential that the factors are not viewed in isolation when planning occupational therapy services for children. Recruitment and retention are of paramount importance to support consistent access to occupational therapy services. Advancements in technology may reduce the limitations Saskatchewan faces with the *rurality* of the province. However, access to professionals to deliver services face to face or by way of technology cannot be overlooked.

6

Provision of Occupational Therapy Services for Children in Saskatchewan

Occupational therapy service delivery places the child as the consumer within the context of family and community. Practice methods and service delivery models vary according to the organizational and funding structures that occupational therapists work within. This section will focus on where and how occupational therapists in Saskatchewan provide services to support child-centred outcomes. The provision of occupational therapy services to children in 2019-2020 will be described, based on the survey results and data collected on occupational therapy services across the province in various sectors (SSOT & SPOT, 2019). Information from the literature will be used to suggest ways that administrators, funders, and occupational therapists can use a common language to discuss effectiveness of service provision, based on the shared concern of meeting the needs of children as the consumers.

Organizational Structures Influencing Occupational Therapy Practice

Occupational therapists in Saskatchewan work within a network of organizational structures and systems designed to support children and families. These structures and systems are funded and administered by various levels of public government and private agencies. While each organization or agency operates with specific mandates and criteria, upholding the rights of children to health, well-being, and inclusion in a fair and just society is common to all. By understanding the structures and connections between government ministries, agencies, and programs, occupational therapists can be better informed when providing services to children and their families within a team framework. In the context of children, the sectors of health, education, and social services will be outlined at the government level, including how First Nations are supported in Saskatchewan.

Ministry of Health

The Ministry of Health is responsible for funding and managing the Saskatchewan health care system (Saskatchewan Government, n.d.g.). Under the Ministry of Health, the Saskatchewan Health Authority (SHA) is responsible for the coordination and delivery of health services across the province (SHA, n.d.a). Services include inpatient acute and rehabilitation care, specialized outpatient services, home care, and community-based programs. In the far northern part of Saskatchewan, the Athabasca Health Authority (AHA) provides an integrated First Nations health service (AHA, n.d.). AHA receives funding from federal, provincial and First Nations sources to provide community-based care, long-term care, and acute care services to residents in the Athabasca Basin.

Children's Therapy Services. Therapy services for children in the health sector are structured with specialized services, as defined by the SHA, in the larger urban centres and regionally based services in smaller urban centers. Children from throughout the province can access services in the larger centres based on level of need (Saskatchewan Government, n.d.d.).

Larger Urban Centres. Pediatric teams, including occupational therapists, are in facilities in the larger urban centres of Saskatoon and Regina (SHA, n.d.b.). The Jim Pattison Children's Hospital in Saskatoon supports children from across the province, as part of the overall strategic health care mandate. The Kinsmen Children's Centre in Saskatoon provides clinical and therapy services for children through the Alvin Buckwold Child Development Program. The Irene and Leslie Dubé Centre for Mental Health in Saskatoon serves children requiring mental health assessment and treatment services. The Wascana Rehabilitation Centre in Regina provides services for children in the southern part of the province through the Children's Program and the Neonatal Follow-Up Program.

Smaller Urban Centres. Regional health facilities in the smaller urban centres offer varying degrees of therapy services to children and families. Children from rural communities may receive outreach-based occupational therapy services at health facilities in communities closer to home, as well as home-based services. Many smaller communities, including First Nations communities, have health clinics providing primary care to children and families (SHA, n.d.b.; AHA, n.d.).

Occupational Therapy Services. Occupational therapy services for children in the health sector in 2020 is summarized in Appendix D1. The summary provides information on occupational therapy services at facilities in the larger urban centres. In the smaller urban centres, at the regional level, the availability of occupational therapy services depends on whether there is a defined children's therapy service and the mandates of the service including referral criteria. The availability of occupational therapy services for children in the regional healthcare centres and smaller communities varies greatly across the province.

Ministry of Education

In Saskatchewan, kindergarten to grade twelve education is a shared responsibility between the Ministry of Education and elected boards of education at the school division level. There are twenty-seven school divisions in Saskatchewan including eighteen Public School Divisions, eight Separate School Divisions, and one Francophone School Division (Saskatchewan Government, n.d.i.). The Ministry follows the principles of a needs-based approach that focuses on the strengths, interests, and needs of each student.

Student Support Services. Students with additional needs are supported in inclusive settings by collaborative teams that include parents or guardians, education professionals, and other service providers (Saskatchewan Government, n.d.h.). The board and administrators of school divisions determine how student support services will be structured and resourced, including support for children with intensive needs. Guiding documents suggest that the Ministry endorses models that emphasize adjustments to teaching practices and the systems supporting children in school, while not ruling out the need for intensive developmental or therapeutic services at the child level (Saskatchewan Government, 2015a; 2017; 2019).

Student support teams exist in each school division and are the avenues for occupational therapists to work with and on behalf of students in the education system. There is no provincial mandate on occupational therapy services in the education sector. School divisions are autonomous in determining the extent to which occupational therapy services are provided within the student support framework. Occupational therapy services in school divisions in 2019-2020 vary greatly across the province, as illustrated in Appendix D2.

First Nations Health and Education in Saskatchewan

Health. Health care services on First Nations in Saskatchewan are funded federally and operate in conjunction with the provincial health care system. The Non-Insured Health Benefits (NIHB) program provides coverage for health services for First Nations clients based on eligibility (Canada Government, n.d.c.). Occupational therapy services within the system of health care on First Nations was not specifically surveyed. Health sector data in Appendix D1 would include children who live on First Nations and who access occupational therapy services in provincial health care facilities.

Education. First Nations in Saskatchewan have autonomy in the provision of education for their children. Historically, Tribal Councils have pooled professional resources among several Bands to provide access to educational supports, including therapies for children attending schools on First Nations. Based on the structure of First Nation education in Saskatchewan, data was collected on occupational therapy services in First Nations schools (Canada Government, n.d.e.). As illustrated in Appendix D3, the level of occupational therapy services in First Nations Schools varies across the province.

Ministry of Social Services

The Ministry of Social Services invests in programs for people in the areas of income support, child, and family services, supports for persons with disabilities, and affordable housing (Saskatchewan Government, n.d.i.). Programs and services which are of interest to occupational therapists in their provision of services to children and families include the Cognitive Disability Strategy (CDS) (Saskatchewan Government, 2015), and Community Living Service Delivery (CLSD) (Saskatchewan Government, n.d.h.). The CDS addresses unmet needs of families with a child who has a cognitive disability, including assessment, training for service providers, prevention initiatives, and program opportunities. The CLSD program strives to ensure that people with intellectual and developmental disabilities live and function as independently as possible within their own communities, and that their physical, emotional, and social needs are met. Occupational therapy may be accessed by families or caregivers through funding strategies which support independence in activities of daily living, accessibility, and inclusion.

Inter Ministerial Collaboration

Government ministries work collaboratively in the development and administration of programs to meet the needs of children and families in the province. Two programs of

particular relevance to occupational therapists are Autism Services and Acquired Brain Injury Services.

Autism Services. The Ministries of Health, Social Services and Education support services and programming for children with autism spectrum disorders (Saskatchewan Government, n.d.b.). Since 2010, teams and services for children with autism spectrum disorders have emerged throughout the provincial health system. As noted in Appendix D1, the age range of children qualifying for services and the extent of occupational therapy services vary across the province.

Acquired Brain Injury Services. The provincial Acquired Brain Injury Outreach Support Program is part of a comprehensive strategy managed by the Saskatchewan Health Authority and funded by Saskatchewan Government Insurance. Referrals are accepted from health facilities, rehabilitation programs, schools, and community agencies (Saskatchewan Government, n.d.a.). Outreach teams, consisting of rehabilitation professionals experienced in the field of acquired brain injury, are in the north, south, and central regions of the province. Services are available to people of all ages, including children and their families**.**

Agencies Supporting Children and Families

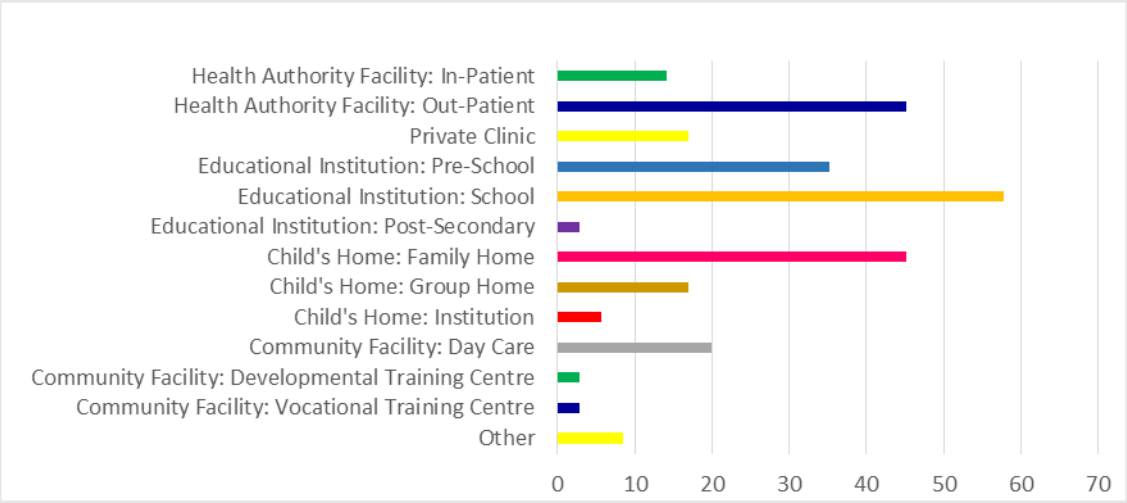
Familiarity with the mandates, services, and programs offered through provincial and community-based agencies is of importance to occupational therapists in the delivery of services to children and families. Agencies may include public-private partnerships, charitable service organizations, cross-sectoral networks, and locally run faith-based or cultural outreach efforts (Moose Jaw Autism Spectrum Disorder Program, 2020). In the provision of services to children, essential services frequently accessed by occupational therapists in the health sector include the Saskatchewan Aids to Independent Living Program (Saskatchewan Government, n.d.k.), Special Needs Equipment Program (SaskAbilities, n.d.), and Specialized Seating Program (SaskAbilities, n.d.). By understanding the services of provincial and local agencies, occupational therapists can support children and families in accessing resources to meet their needs.

Environments Where Occupational Therapy Services are Provided

In the survey, occupational therapists were asked to indicate where they provide services to children according to the categories presented. Some of the categories referred directly to ministerial structures and systems while others referred to places where children live, learn and play. Figure 7 illustrates where occupational therapists provide services to children.

Figure 7

Where Occupational Therapy Services are Provided to Children



Note. (SSOT & SPOT, 2019).

Results indicated that occupational therapists provided services to children most often in the context of the child's natural environments of school and home, as well as in health-based outpatient facilities. Occupational therapy services were also provided in community daycares and group homes. Service provision within vocational and developmental training centres, as well as within post-secondary institutions, appears to be limited. The extent of where occupational therapy services is provided may not have been fully captured in the survey. Therapists may also have been providing services in other locations as an extension of the primary location identified.

Funding for Occupational Therapy for Children

Occupational therapy services for children in Saskatchewan are funded publicly through the provincial Ministries of Health, Education, and Social Services, or through federal programs (SSOT & SPOT, 2019). Privately contracted occupational therapy services may be funded through insurance plans, federally or provincially sourced funding programs including diagnosis-specific funding provided to families, and clients paying out of pocket.

Public Funding and Services

Ministry of Health. The Saskatchewan Health Authority oversees all provincial and regional health care services, except for those under the jurisdiction of the Athabasca Health Authority. Under these authorities, occupational therapists may be hired within teams to provide services for inpatient or outpatient care or community-based programs. Teams have different levels of resource allocation and service directions, based on priorities identified by the health authority (Saskatchewan Government, 2020a).

Ministry of Education. School divisions in the province are funded through the Ministry of Education. Occupational therapists working for and within school divisions are hired as out of scope or through the Canadian Union of Public Employees (CUPE), or as private contractors. Occupational therapists are not eligible to become members of the Saskatchewan Teachers Federation.

Ministry of Social Services. Occupational therapists are not well represented in the Ministry of Social Services, based on information obtained from the survey (SSOT & SPOT, 2019). The Ministry relies on contracted agreements with private occupational therapists to provide services to children through agencies supported by the Ministry. Occupational therapists may provide services to partner agencies such as Eagle's Nest, Ranch Ehrlo, Hope's Home, and Kin Enterprises (Saskatchewan Government, n.d.f.). Permanent positions for occupational therapists remain limited. This may reflect an assumption that occupational therapy practice consists of direct therapy service provision only, rather than potential expansion to collaborative-consultation roles which would align well with the objectives of the Ministry (Saskatchewan Government, 2020b).

Indigenous Services Canada. Indigenous Services Canada (ISC) is a federally administered program that addresses the needs of First Nations, Inuit, and Métis people. The vision of ISC is to support and empower Indigenous peoples to independently deliver services and address the socio-economic conditions in their communities (Canada Government, n.d.c.). In this regard, ISC works with local partner agencies, including provincially run health, education, and social services agencies. Funding relationships between Indigenous Services Canada and occupational therapists exist at provincial, regional, and community levels.

Publicly Funded Programs and Private Services

Jordan's Principle. In 2016, the Canadian Human Rights Tribunal (CHRT) determined that the approach to services for children on First Nations by the Government of Canada was discriminatory and upheld a renewed approach through the development of Jordan's Principle (Canada Government, n.d.c.). Families and agencies can apply to Jordan's Principle to fund specific supports that will reduce inequities in care. This can include access to occupational therapy. Occupational therapy services are dependent on the needs of the child and may range from assessment to equipment to intensive treatment.

Individualized Funding for Autism Spectrum Disorders. Commencing in 2016, families in Saskatchewan have been able to receive individualized funding for a child under the age of six with a diagnosis of autism spectrum disorder (Saskatchewan Government, n.d.b.). The program provides parents with funds to purchase services that they feel best suits their child's needs. This can include private occupational therapy services.

Cognitive Disability Strategy. This cross-sectoral strategy was launched in 2005 by the government of Saskatchewan and is administered by the Ministry of Social Services. The aim of the CDS is to address unmet needs of families with a child who has a cognitive disability

(Saskatchewan Government, n.d.l.). Consultants work with families to access services locally. Services may include private occupational therapy. This strategy is income-indexed, resulting in funding support being unavailable to some families with children who have cognitive disabilities.

Private Funding Not Publicly Sourced

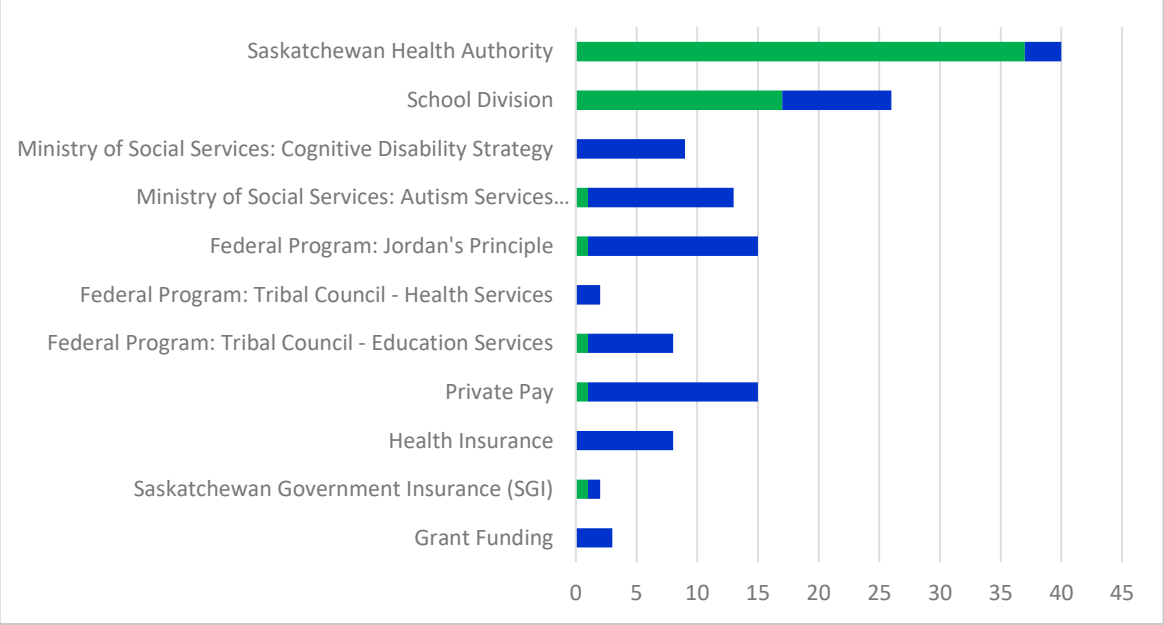
When families want to access occupational therapy services that are not available through publicly funded sources, they must look elsewhere for funding or pay out of pocket for private services. In Saskatchewan, options for funding support for families accessing private services include personal health insurance plans, employer health and benefit plans, and situation-specific subsidies or grants. In specific cases, Saskatchewan Government Insurance (SGI) may be a third-party payer for services.

Funding Sources for Occupational Therapy Services

In the survey, occupational therapists were asked to identify the funding sources for occupational therapy services for children according to the categories presented, as well as whether they were employed or contracted privately. Funding sources for occupational therapy services for children are illustrated in Figure 8.

Figure 8

Sources of Funding that include Employed or Contracted by the Funder



Note. Employed Contracted Privately (SSOT & SPOT, 2019).

Survey results identified the Saskatchewan Health Authority (SHA) as the most frequent funder of occupational therapy services for children, followed by school divisions. As some school divisions contract their occupational therapy services through the SHA, the funding

source may not directly reflect the place of service delivery. Similarly, in some areas of the province, birth to age 5 programs based in schools are served by therapy teams that are funded through the SHA. Programs through the Ministry of Social Services and the federal government were also measurable sources for funding, along with private pay and health insurance plans. Saskatchewan Government Insurance and grant funding accounted for only a small percentage of the funding sources.

Most of the occupational therapists working in health facilities were employed, as were approximately 65% of those working in school divisions. This trend is illustrated in the health and education sector charts in Appendices D1 and D2, respectively. Occupational therapists were privately contracted for approximately 35% of occupational therapy services in the health and education sectors, as well as for the majority of other agencies and programs listed. This corresponds to the growth in private practice services over the past decade as described in the workforce section and in Appendix D4.

Occupational Therapy Services for Children in Saskatchewan

The organizational structures and funding sources that occupational therapists work within have been described. In this segment, the provision of occupational therapy services will be discussed. Information on service delivery models will be outlined, and commonalities and differences in service provision across sectors will be featured. Data specific to occupational therapy service delivery in Saskatchewan will be presented within the framework of structures and processes, with reference to outcomes.

Service Delivery Models - Foundational Elements

Occupational therapy service delivery models bridge practice theories with the realities of the practice environment, the needs of the clients, and the expertise of the service provider. Each provider of occupational therapy services for children in Saskatchewan, whether employed or privately contracted, utilizes a professional service delivery model. Service delivery models will vary as there is no one evidence-supported or effective service delivery model (WFOT, 2020). Service delivery models support meaningful dialogue between occupational therapists and stakeholders. Foundational elements include regard for the environment of the child, collaboration among service providers, and development of a model based on understanding the objectives of different types of models.

Environment of the Child. Central to the development of occupational therapy service delivery models is the provision of therapy in the context of the child's environment (Kasovac et al., 2019, Pihlar, 2012). To support progress and success for the child, the role of occupational therapy is to assess and intervene in the domain of occupation where the child lives, learns, and plays. The ability of the occupational therapist to provide collaborative, comprehensive, and effective services depend on the therapist being able to work directly in the child's home, classroom, peer group, or community setting.

Types of Service Delivery Models. Models of service delivery utilized by occupational therapists working with children in Saskatchewan may range from client-centred models of case management, consultation, direct service, and monitoring to system-focused models of service management and provision of in-services and workshops (SSOT & SPOT, 2019). Direct and consultative models include supporting caregivers in their roles. *Consultation* may also be applied in a collaborative sense, where the role of the occupational therapist shifts from that of expert to a peer mentor role. Consultation may be coaching and supporting parents, caregivers, teachers, and other team members, and may represent an enhancement, rather than a reduction, of the strategic use of therapist expertise (Clough, 2017). A strength of the profession lies in understanding the extent and application of the consultation approach (CAOT, 2012). Within a team framework, a blend of models may be utilized to provide the most effective occupational therapy service for the child and family.

Development of Service Delivery Models. Quality indicators of service delivery include achieving person-centred services, responding to the impact of disability, protecting human rights, and recognizing that accessibility and inclusion benefit everyone (Saskatchewan Government, 2015). Occupational therapists apply clinical reasoning and judgment, based on experience with the child and family, as to which service delivery model and approaches are manageable and effective (Copley, 2010). The creation of an occupational therapy service delivery model is based on the principles of best practice, the mandate of the system that the therapist works within, and work environment factors such as client caseloads, personnel resources, and level of team collaboration. Service delivery models are most effective when the logistics of time, space and funding intersect with the interests, expertise, and resources of a clinician to provide valued support for children, families, or communities (Reason, 2012).

Communication and Collaboration. Effective service provision requires occupational therapists to communicate with organizations and funders to develop and update the service delivery model to align with current evidence, practice realities, and goals of the organization (CAOT, 2012). When concurrent services are provided for the child by occupational therapists from different organizational systems, the benefits and risks involved need to be communicated with the parents. The effectiveness of interventions for any child is enhanced when both the child and family have access to collaborative teams supporting the occupations of childhood across environments (Saskatchewan Government, n.d.d.).

Commonalities and Differences in Service Provision Across Sectors

Occupational therapists emphasize occupation as the defining characteristic of how assessment is structured, and how interventions are provided. The Canadian Model of Occupational Performance and Engagement (CMOP-E) provides a consistent framework and theoretical base for occupational therapy practice (Townsend & Polatajko, 2013). While all occupational therapists will reference this model within their practice, the work they do with children or on behalf of children may look different based on the organization and funding structures they work within. The approach to occupational therapy services in the sectors of

health, education and social services in Saskatchewan will be presented. Commonalities and differences that exist between the different sectors will be highlighted.

Within the sector of health, occupational therapists work with the child directly by assessing or providing treatment in hospital or clinic settings, the child's home, or in the community. Goals of occupational therapy in the health sector focus on reducing functional impairment, remediating the effects of a condition or injury, building skills for activities of daily living, and supporting the caregivers. In the larger urban healthcare settings, roles may include collaboration with regional or rural therapists across large geographical areas (SHA, n.d.b.).

In the education sector, occupational therapists fulfill roles relative to the needs of children, using service delivery models negotiated at the administrative level. Evidence-based approaches may emphasize collaboration and consultation with teachers to support inclusion in the natural settings of school (Missiuna et al., 2012). Providing specialized or intensive approaches directly to the child in school enables engagement in the occupations of being a student in the context of peers and the school environment. Consistent with practices in other sectors, occupational therapists in the education sector in Saskatchewan work within an interdisciplinary team approach, which includes parents and guardians as integral team members (Saskatchewan Government, 2017).

Occupational therapists employed or contracted in the social services sector provide services that range from direct to consultative in home and community settings. They may be requested to assist in reducing functional barriers in the institutional, cultural, or social environments of children (Muhajarine et al., 2014). Occupational therapy services that adjust the environment, rather than the child, may prevent a child from experiencing a disability (WHO, 2007b). Saskatchewan is strengthened by cultural and social diversity. Ensuring barrier-free access to needed resources is highly valued in our society. Provision of services within marginalized communities requires special consideration, support, and sensitivity on the part of occupational therapists and their employers, funders, and supervisors (Whalley-Hammell, 2018; Canada Government, n.d.a.). The occupational therapy vision of occupational justice aligns with aspirational goals in the social services sector.

Occupational therapy approaches and roles across the sectors of health, education, and social services have been noted. While there are differences, a holistic approach to supporting the child in the context of family and community is common to all sectors and aligns with the occupational therapy performance and engagement model of reducing barriers at the person, task, and environmental levels. Collaboration among occupational therapists and other team members is an essential commonality, allowing consumers to understand the roles of occupational therapy and how the needs of a child can be met in a complementary manner.

Occupational Therapy Service Delivery

The quality of occupational therapy service delivery can be described in terms of *structures, processes, and outcomes* (WFOT, 2020). Structures are the organizations and systems through which children access occupational therapy. Processes are the ways in which

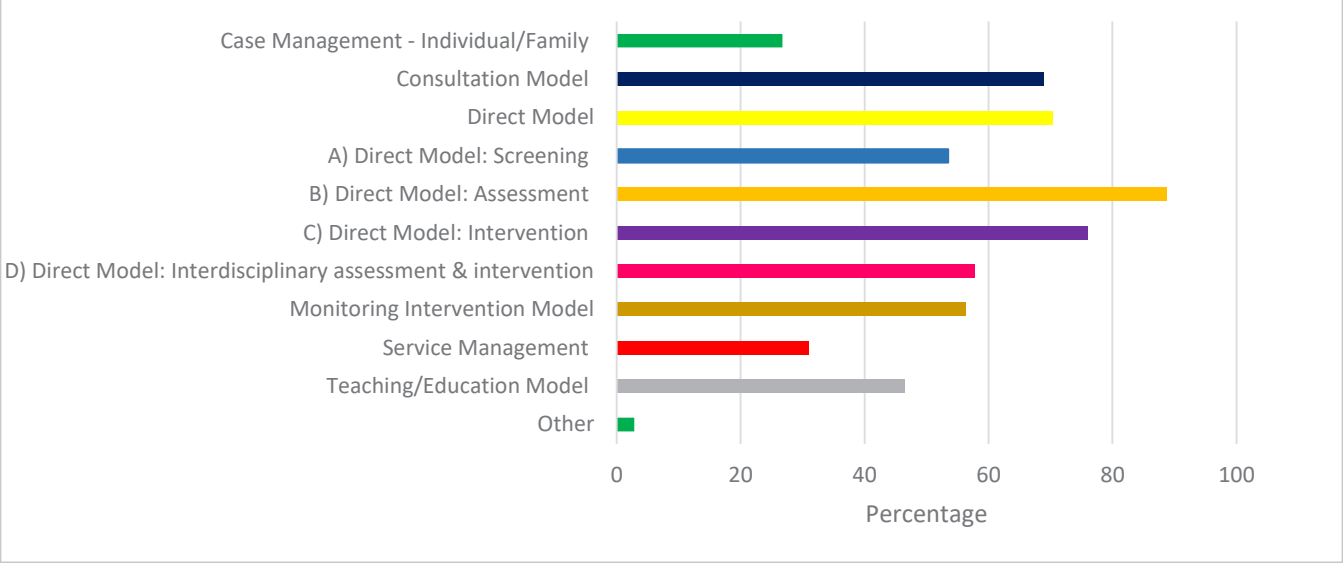
services are initiated, maintained, and evaluated. Outcomes are measurable and connected to the priorities of the consumer or child during an evaluative process.

Quality service delivery evolves when structures and processes support interventions that result in positive outcomes for the child. Aligning structures and processes to funding priorities does not necessarily mean that outcomes improve for the child. Changes at the structure or process level can affect outcomes. The survey provided data on structures and processes related to the delivery of occupational therapy services for children in Saskatchewan (SSOT & SPOT, 2019). The results highlighted areas where occupational therapy services are represented and where gaps in services exist. Outcomes relating to consumer experiences were not directly measured in the survey.

Structure - Service Delivery Models. In Saskatchewan, professional, workforce, and environmental factors directly influence how service delivery models are developed and how services are structured. In the survey, occupational therapists were asked to identify the service delivery models and components of service that best described their practice with children from options presented (see Figure 9).

Figure 9

Service Delivery Models used in Occupational Therapy Practice with Children



Note. Refer to Appendix A2 (SSOT & SPOT, 2019).

Results indicated that 80% to 90% of the respondents provided a direct model of service delivery with children and families (SSOT & SPOT, 2019). Individual assessment and individual, group and family-based intervention were the primary areas identified under the direct service model. This model correlated highly with job satisfaction, as described in the previous section on environmental factors influencing occupational therapy practice for children. Approximately 70% of respondents indicated that they provided consultative services and 55% indicated that they provided monitoring-based intervention.

Case management services were provided by approximately 30% of the respondents (SSOT & SPOT, 2019). A similar percentage of respondents carried out service management duties. Approximately 45% of the survey respondents are involved in teaching and providing in-services and workshops as part of their occupational therapy practice with children. Respondents also identified parent education and consultation, as well as intensive coaching support for education personnel. Results illustrated the integration of different service delivery models and supported the scope of practice that occupational therapists are educated to provide.

Service delivery models not specifically measured in the survey (SSOT & SPOT, 2019) include those that focus on supporting:

- caregivers in their roles as caregivers and thereby indirectly supporting the child (Killeen et al, 2018; Shepherd et al., 2007; Reupert et al, 2015),
- communities in caring for children (Brunton, 2017; Lorenzo et al., 2018), and
- agencies in efforts to promote occupational inclusion and justice (CAOT, 2011).

Service delivery can shift back and forth from face-to-face client contact to collaboration combined with consultation, to utilizing telepractice to connect with children, families, and service team members (SSOT, 2020; CAOT, 2011).

Processes. This part will describe how children access occupational therapy services in Saskatchewan and the profiles of the children receiving services (SSOT & SPOT, 2019). The criteria for accepting referrals, the method of accessing services, and the types of children eligible to receive services are dependent on the administrative system within which the occupational therapist is employed or contracted, and the funding source for services. Using referrals as a process to initiate service delivery may implicitly assume that the child will be the direct recipient of services, and thus preclude environmental or systemic support (Farre & Rapley, 2017). In some systems, services are not provided based on a referral; rather occupational therapists are an inclusive part of the team supporting the system. For the purposes of this analysis, the common sources of referral will be highlighted together with the reasons for referral. This will be followed by information on the profiles of children receiving services.

Referral Sources. Occupational therapists were asked to identify how children accessed occupational therapy services by listing up to three main referral sources (SSOT & SPOT, 2019). The referral sources were grouped into categories (see Table 15).

Table 15

Sources of Referrals for Occupational Therapy Services

Educators/Programs	**42**
Teachers/Principals/Inclusion Staff	38
Kindergarten Screening/Early Childhood Intervention Program (ECIP)	4
Medical Professionals	**38**
Physicians	23
Pediatricians	7
Psychiatrists/Psychologists	4
Other Specialists	4
Therapists	**27**
Hand Therapists	1
Speech & Language Pathologists	12
Physical Therapists	4
Other Therapists	10
Other Health Care Professionals	**28**
Autism Consultant	1
Nurses: Community/Public Health	9
Social Workers/Case Managers	5
Team members/Colleagues	13
Organizations/Programs	**15**
Health Authority/Health Services	4
Saskatchewan Government Insurance (SGI) and other 3rd Parties	2
Social Services	2
Child & Youth Mental Health	2
Cognitive Disability Strategy	2
Tribal Council	1
Jordan's Principle	2
Community	**39**
Parents	28
Self-referral	6
Day Cares	3
Group Homes	2
Total Number of Referral Sources	**189**

Note. Every respondent could list up to three main referral sources. 100% Respondents = 71 listed one main referral source. 92.96% respondents = 66 listed two main referral sources. 73.24% Respondents = 52 listed three main referral sources. Total of 189 main referral sources listed (SSOT & SPOT, 2019).

The distribution of referral sources suggested a growing awareness of occupational therapy services in many areas of the public as well as the health sector. Educators were the highest source of occupational therapy referrals, followed by parents, and then physicians. The emergence of occupational therapy as a perceived critical discipline on educational teams is reflected in this data and correlates with the number of occupational therapists working in the education sector. Other therapists and health care professionals were also frequent sources for

referrals. Relatively low referrals from community sources may correlate to a lack of awareness of the benefits of occupational therapy services outside of the health and education sectors.

***Reasons for Referral*.** Occupational therapists were asked to list up to three main reasons for referrals (SSOT & SPOT, 2019). Responses were categorized as noted in Table 16.

Table 16

Reasons for Referrals for Occupational Therapy Services

Emotional/Behavioural	**73**
Sensory-based Dysregulation	41
Behavioural/Social/Attentional Issues	29
Mental Health Concerns	3
Developmental/Diagnostic	**49**
Developmental Delay	22
Autism Spectrum Disorder	17
Neurological Disorders	3
Developmental Conditions (e.g. Plagiocephaly, Premature births, Genetic Disorders, Congenital Deformities)	7
Injury and Medical Related	**12**
Orthopedics	1
Arthritis and Chronic Diseases	2
Burns and Pressure Relief	2
Trauma/Brain Injury	4
Upper and Lower Extremity Injuries	3
Functional Skill Development	**51**
Fine and Gross Motor Skills	31
Cognitive/Functional Assessment	1
School Performance/Learning Accommodations	2
Feeding and Swallowing	8
Activities of Daily Living/Independent Living Skills	8
Transfer-Lifting-Repositioning	1
Equipment/Design Related	**23**
Equipment/Assistive Technology	14
Wheelchairs/Seating	2
Orthotics and Splinting	1
Classroom Design and School Programming	3
Home Assessments/Transition Planning	2
Kinsmen Foundation Requests	1
Total Responses	**208**

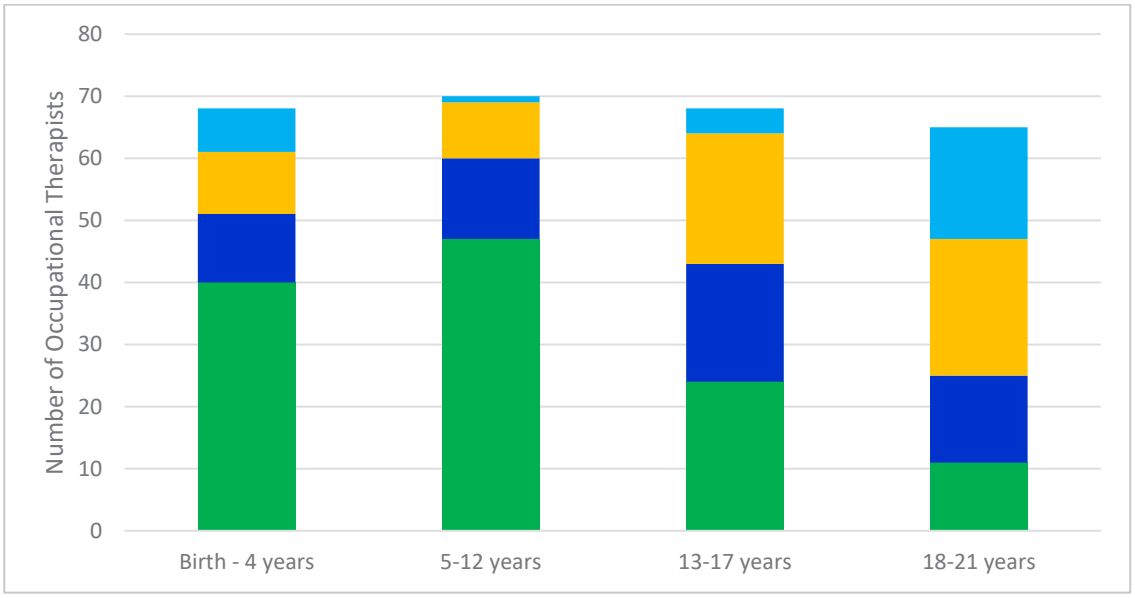
Note. Each respondent working with children was asked to list up to three most common reasons for referrals. 100% Respondents = 71 listed one most common reason for referrals, 98.59 % respondents = 70 listed two most common reasons for referrals, 94.37% respondents = 67 listed three most common reasons for referrals. Total of 208 most common reasons for referrals listed (SSOT & SPOT, 2019).

The most common reasons for referrals were in the areas of emotional/behavioural, developmental/diagnostic, and functional skill development. The high number of responses in the category of emotional/behavioural indicated a growing awareness of the benefits of having an occupational therapist on the team to address the needs of children with sensory based dysregulation, behavioural, social, and attentional issues, and mental health concerns. Referrals related to injury or medical needs, and equipment and design, were mentioned less frequently. Based on the reasons for referrals, occupational therapy is a recognized service to reduce the effects of disability on function at the person level by remediating the deficit. Insufficient data was retrieved to gain an understanding of the role of occupational therapists with teams working to prevent or mitigate risks to children, such as those addressing mental health, suicide, trauma, and adverse childhood events at a community or societal level (SSOT & SPOT, 2019).

Ages of Children Served. Respondents were asked to indicate the age ranges of the children they provided occupational therapy services to, and the frequency of their work in each age range. Results are illustrated in Figure 10.

Figure 10

Age Ranges of Children Seen and Frequency of Services



Note. Frequently (once a week or more) Periodically (not more than once or twice a month) Rarely (once every couple of months or less) Never (SSOT & SPOT, 2019).

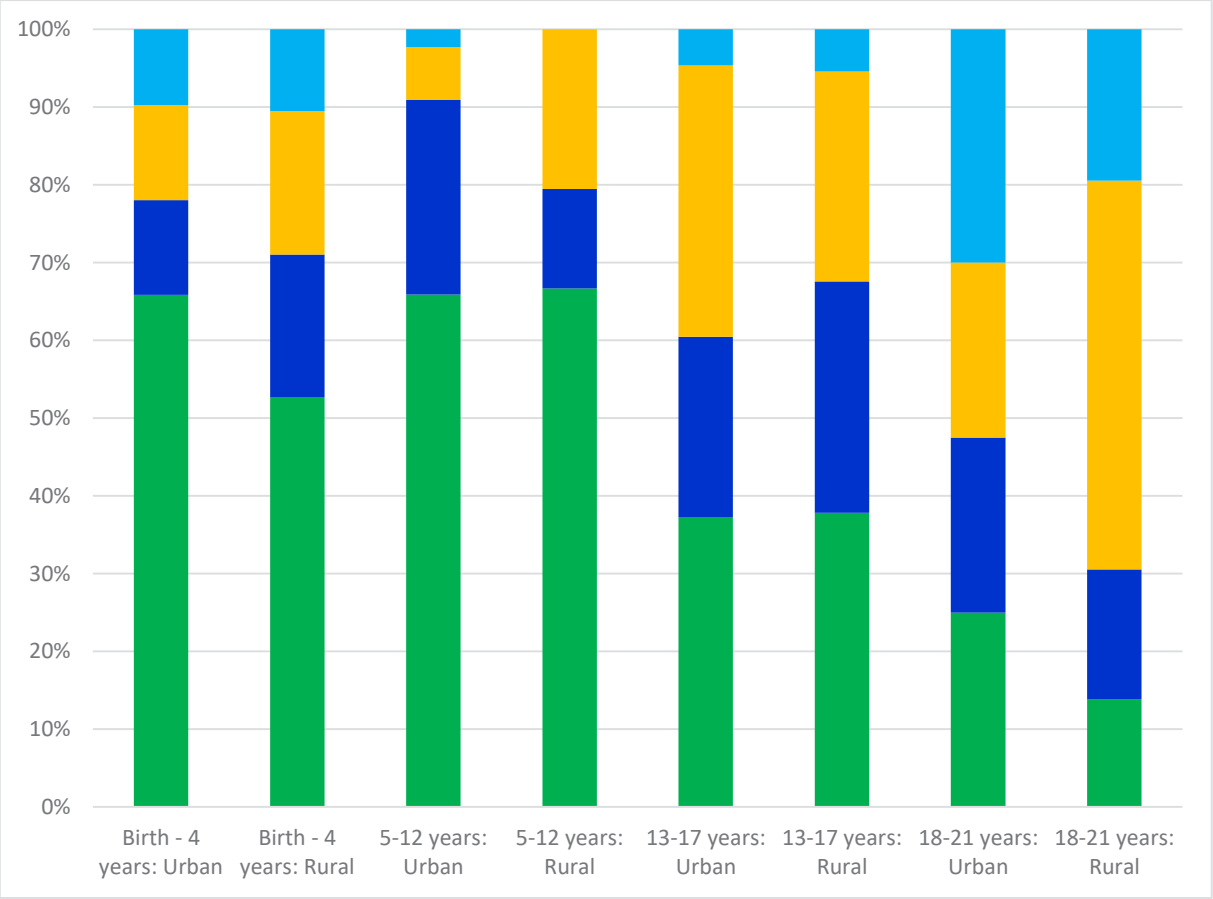
Results indicated that more occupational therapy services are directed towards early intervention than transition to young adulthood. Respondents provided services to children in the 5 to 12-year age range most frequently and this may correspond with educators being the largest referral source. Children in the birth to 4-year range were also seen at a high level of frequency. Children in the 13 to 17-year range tended to receive occupational therapy services on a periodic or rare basis. Children in the 18 to 21-year range were less likely to receive services from an occupational therapist. This could lead to a potential gap in service provision

for youth at a time when a robust transition from team-based developmental supports to adult based services is required.

The frequency of services by urban respondents and rural respondents in relation to the age ranges of children is illustrated in Figures 11. Results indicated a variance in the 18- to 21-year-old age category. Thirty percent of occupational therapists working in an urban setting and 19.44% of rural therapists indicated that they had never worked with children in this age range. These results may indicate that rural therapists are more likely to work with children in the transition to young adulthood than their counterparts in the urban areas.

Figure 11

Age Ranges of Children and Frequency of Services – Comparison Urban and Rural Respondents



Note: Frequently (once a week or more) Periodically (not more than once or twice a month) Rarely (once every couple of months or less) Never (SSOT & SPOT, 2019).

Profiles of Children Served. Children referred to occupational therapy usually have a pre-identified barrier or problem that results in someone advocating for support from a professional. These needs relate most often to disabilities but can include socio-economic difficulties or environmental barriers to inclusion. The needs of children most addressed in Saskatchewan based on the survey results are illustrated under profile categories in Table 17.

Table 17

Frequency of Profile Categories of Children Served by Occupational Therapists

Profile Category	Description	# of Respondents	% of Most Frequent Rating	% of 2nd Most Frequent Rating	Total % of 2 Most Frequent Ratings
Developmental	Autism Spectrum Disorder, Intellectual Disabilities, Neuromuscular Disorders	70	63%	24%	87%
Emotional-Behavioural	Mental Health Concerns, Anxiety, Depression, Sensory Processing/ Emotional Dysregulation	68	26%	34%	60%
Injury or Medical Related	Acquired Brain Injuries, Orthopedic Injuries, Medical Conditions	68	18%	10%	28%
Educational	Learning Disabilities, Literacy-Based Concerns	67	7%	7%	14%
Other	Please specify	10	-		

Note. Number of respondents is out of 71. The percentages in the columns do not equal 100% as some respondents gave two profile categories the same frequency rating and some frequency ratings were not selected. (SSOT & SPOT, 2019).

The profile categories of developmental and emotional/behavioural were the primary categories driving occupational therapy service delivery for children. This correlated with the results which indicated that emotional/behavioural and developmental/diagnostic were the most common reasons for referrals for occupational therapy services. The categories of injury/medical and educational were also represented in the profile categories.

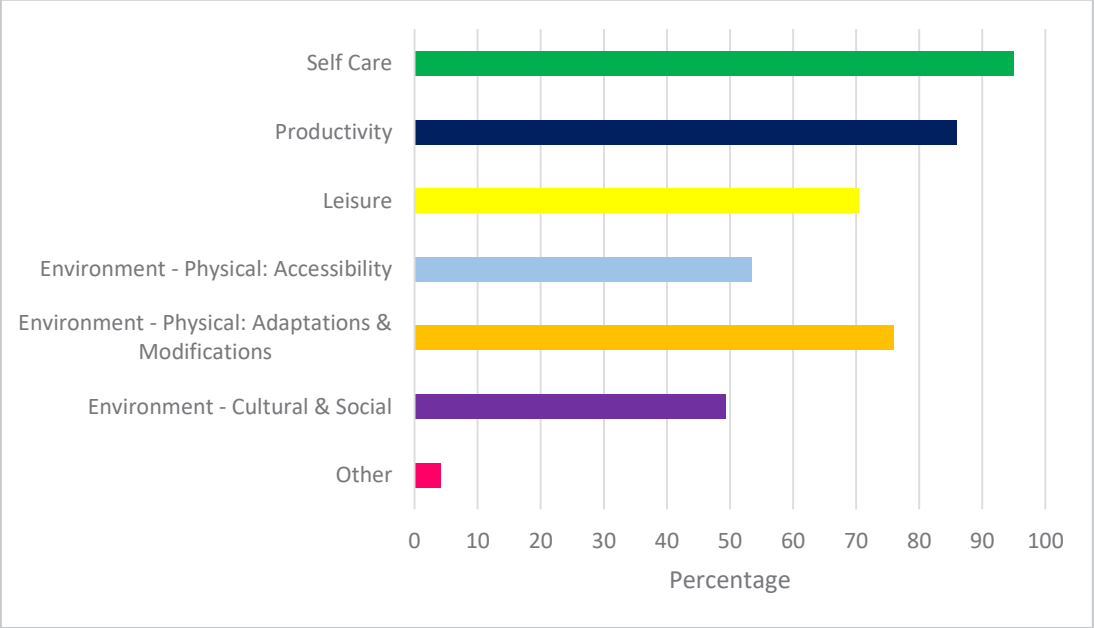
Lack of equitable access to occupational therapy services in the areas of autism spectrum disorders, sensory processing disorders, and learning disabilities was identified in the SSOT 2010 document. Services in child and youth mental health were described as “extremely limited” (SSOT, 2010, p. 13). Responses indicated that the profiles of children who are accessing occupational therapy services have shifted markedly to encompass both developmental and emotional/behavioural concerns (SSOT & SPOT, 2019). The role of occupational therapy in supporting children with mental health concerns is also becoming more understood.

Other responses referred to children who were experiencing challenges in their environments. The occupational therapist was asked to determine the source of the challenge and to find a solution to help the child. By applying problem solving and solution focused skills, the occupational therapist addressed barriers and supported the child to engage in meaningful occupation.

Outcomes of Occupational Therapy. Outcomes of occupational therapy are a direct result of interventions. Assessing outcomes is most beneficial with consumer dialogue which was outside the scope of this resource document. Occupational therapists were surveyed as to the areas of occupational performance and environmental aspects that they address in their interventions (see Figure 12).

Figure 12

Occupational Areas of Performance and Environmental Aspects



Note. See Appendix A2 *(*SSOT & SPOT, 2019).

The occupations of self-care and productivity were primary areas that respondents identified as addressing in their interventions with children. Ninety-five percent of respondents identified the occupation of self-care while 85% of respondents identified productivity. Seventy percent of respondents indicated that they addressed the occupation of leisure with children. While respondents may have included *play* within the leisure category, play may also have been included under the productivity category for very young children. Most respondents indicated that they addressed environmental and accessibility barriers on an individual case by case basis rather than on a broader universal design basis. Other interventions identified were environmental adaptations and modifications based on sensory, social, and positioning needs.

Outcomes of occupational therapy interventions are reflected in changes observed and quantified by increased engagement and performance of meaningful occupations by the child. Survey results identified the percentage of work within the occupations of self-care, productivity, and leisure and suggested that Saskatchewan occupational therapists are working at the occupation level (Townsend & Polatajko, 2013). Surveying clinical outcomes of occupational therapy service delivery methods and client-centred interventions may be an important area of future study. Survey results on the impact of occupational therapy for children and the practice changes experienced by occupational therapists are presented in the next two sections.

Summary

In the provision of occupational therapy services to children, the child is viewed as the consumer within the context of family and community. In Saskatchewan, occupational therapists, employed or privately contracted, provide occupational therapy services for children within organizational structures and programs administered and funded through provincial ministries of health, education, and social services, and federal Indigenous services. Bridging practice theories with the practice environment, occupational therapists implement service delivery models to provide services to children and foster dialogue with administrators. Data on occupational therapy service delivery is presented within the framework of structures and processes to support child centred outcomes. While a broad range of occupational therapy services are being provided to children across diverse environments, variances and inequities exist in the province of Saskatchewan.

7

Impact of Occupational Therapy for Children

In the survey, occupational therapists were invited to reflect on the impact of their practice on clients (SSOT & SPOT, 2019). Consumers and allied team members were not directly surveyed. To bridge the gap between subjective views by providers on the impact of services and corresponding views by consumers, literature was referenced to validate the reflections of the survey respondents. In the context of this document, impact may be considered reflective of the outcomes of service delivery.

Occupational therapists were asked to describe what occupational therapists bring to the table that stands the discipline apart from other disciplines, and what clients, families and team members say they value about occupational therapy services (SSOT & SPOT, 2019). While not all occupational therapists who responded to the questions worked directly with children, common skills were conveyed, including activity analysis, adaptability, adaptation, client-centred approach, collaboration, transitional support, and holistic practice. This section will discuss the skills that are valued and promote the inclusion of occupational therapists on teams

that provide services to children. The benefits of utilizing the skills of an occupational therapist will be highlighted.

Occupational Therapy Skills that are Valued

Activity Analysis

A foundation of occupational therapy practice is activity analysis to support the process of working towards functional outcomes for the client. Activity analysis involves breaking down an activity, identified as important to the client, into small increments systematically and measurably. Survey respondents identified that this skill positively impacts the services they can provide to children and their families (SSOT & SPOT, 2019). Occupational therapists analyze tasks and activities relevant to occupational engagement issues within all aspects of their practice (CAOT, 2012). Occupational therapists focus on the current abilities of the child in relation to the roles and *occupations* they want to pursue by analyzing the abilities of the child and the skills necessary to engage in the *occupations*. For some children, this means learning new skills; for other children, this means being able to return to meaningful activities in their lives.

Adaptability

Adaptability is being able to use an activities-based approach to find *practical and functional solutions* to support client participation in the environments where they engage in the *occupations of life.* Survey respondents reflected that families valued the ability of the occupational therapist to be adaptable and "think outside the box" (SSOT & SPOT, 2019). Adaptability supports the formulation of practical strategies to work towards meaningful goals for the families. Focusing on real-life practice, which is a strength of occupational therapy practice, activity-based interventions deliver broader gains for the child (Novak & Honan, 2019).

Adaptation

The ability of the occupational therapist to adapt tasks, equipment, and the environment was reported by survey respondents to stand the occupational therapy profession apart from other professions (SSOT & SPOT, 2019). Adaptation of tasks, equipment, and the environment is a tangible part of the services that occupational therapists provide. Adaptation leads to finding practical and functional solutions for the child to thrive at home, school, and in the community. For example, the occupational therapist may recommend and fit a bath seat to enable a child to sit and play in the bathtub or adapt a bicycle to enable a child to join in an activity with siblings and peers. Adaptations can help to maximize the child's participation in the occupations of life and potentially reduce the care demands placed on the caregivers.

Client-Centred Approach

Survey respondents reported that parents and other team members view occupational therapists as providing a client-centred approach with an emphasis on building therapeutic relationships for children and families (SSOT & SPOT, 2019). Through a client-centred decision-

making approach, occupational priorities are addressed through developmentally appropriate activities in environments where the child lives, learns, and plays. Decision making for the occupational therapist is based on the client's knowledge in conjunction with the occupational therapist's knowledge (CAOT, 2009). Foundational to occupational therapy practice, client-centered approaches embrace culture (ACOTRO, 2012) and identify that the client extends beyond the child to the family and community.

Collaboration

Survey respondents indicated that collaboration allows families to feel supported in addressing problems, navigating systems, and finding solutions (SSOT & SPOT, 2019). Collaborative decision-making approaches underlie the positive impact of occupational therapy for children (Novak & Honan, 2019; SSOT & SPOT, 2019). Parent partnership and collaboration within occupational therapy intervention are deemed effective and embrace the principles of family centred care (Novak & Honan, 2019). Through collaboration within interagency teams, occupational therapists support children to transition from infancy to young adulthood with the highest level of ability. An example of collaboration may be viewed through the lens of collaborative treatment of anxiety in children (Higa McMillan et al., 2016). Research supports the efficacy of intervention utilizing functional outcomes as a measure of health improvement (Higa McMillan et al., 2016) versus medication alone.

Transitional Support

Survey respondents identified transitional support as valued in their occupational therapy services when helping children strive to their highest level of ability (SSOT & SPOT, 2019). In the developmental progression from infancy to young adulthood, there are several distinct transition periods. For many children with disabilities, transitions can be especially difficult, necessitating the need for professionals such as occupational therapists to be involved. The following are some examples of transitional support where an occupational therapist may be beneficial on the team.

It is well documented in the neonatal intensive care literature that families are an integral part of care for their infants in the hospital. Parents benefit from the support of a family centered team. An occupational therapist may be part of the team to ensure developmentally appropriate care and for transitional support upon discharge (Craig et al., 2015). The transition from infant and preschool years to school is considered a major life transition (SSOT & SPOT, 2019). School-based occupational therapists contribute to transition teams. Occupational therapists promote functional abilities and participation in daily routines as the student transitions to higher expectations within new environments (AOTA, 2018).

As well, the transition from school to employment or higher education is a major turning point in the lifespan (SSOT & SPOT, 2019; AOTA, 2018). Transitions from education to employment for youth with mental illness have been studied (Gmitroski et al., 2018). Barriers and facilitators on how the student transitions have been identified. For example, employment

success for transitioning youth was based on integrated health and social services, *age-exposure* to employment supports, self-awareness, and sustained support over the career trajectory. The impact of occupational therapy services can influence employment success identifiers, especially when interagency collaboration is in place to support transitioning youth into adulthood.

Holistic Practice

Survey respondents highlighted that their ability to practice holistically has a positive impact on the clients they provide services to. Occupational therapists described their ability to practice holistically as distinctive and appreciated by their clients. The term holistic is extensively documented in the literature across many professions regarding promoting health and well-being. Occupational therapists are educated to practice from a holistic approach. From an occupational therapy perspective, a holistic approach encompasses the mental, physical, spiritual, and environmental needs of the client (CAOT, n.d.a.). A holistic approach to occupational therapy service delivery is valued by children, caregivers, and other service providers.

Benefits of Utilizing the Skills of an Occupational Therapist

Survey respondents identified cost benefits by having an occupational therapist on the team (SSOT & SPOT, 2019). Occupational therapy focuses on the current abilities of the child and their occupations of life. By helping children to develop skills and pursue meaningful daily life activities, they become more independent and less reliant on external support. The reflections of the survey respondents were affirmed by evidence that shows the cost effectiveness of occupational therapy interventions in treating or preventing injury (Rex et al., 2013). Improvement in health outcomes in areas such as prevention of falls, musculoskeletal injury, stroke rehabilitation, early intervention in developmental disabilities, and respiratory rehabilitation were reported (Rexe et al., 2013).

In addition, Rogers et al. (2017) has captured data suggesting that higher spending on occupational therapy is associated with lower readmission rates for adults with heart failure, pneumonia, and acute myocardial infarct. The study identified the need to determine if the client can be discharged safely to the home environment, including understanding functional deficits and social factors. Evaluating the environment, equipment, and the client's regard for safety is a foundation of occupational therapy education and practice. There are potential limitations in how the results may be generalized to other diagnostic groups and populations. However, it is important to note that the value of occupational therapy has been determined from a cost-effective perspective (Rogers et al., 2017) and this is an important consideration in services for children as well.

Survey respondents indicated that parents expressed appreciation for occupational therapy services and recognized that occupational therapy interventions increased the quality of life for their child and family (SSOT & SPOT, 2019). However, the potential value of occupational therapy does not appear to be well understood by consumers. Some parents were

unaware that occupational therapy services existed prior to their child being referred for occupational therapy. Dahl-Popolizio et al. (2017) states that awareness of the role of occupational therapists and understanding the scope of occupational therapy practice are areas for continued growth. Occupational therapists continue to practice in a profession that is not well known to the public and thus potentially underutilized.

Summary

Occupational therapists identified common skills that positively impact the services they provide to clients (SSOT & SPOT, 2019). With an in-depth understanding of physical, neurological, mental, and cognitive development, the occupational therapist practices holistically to help clients improve function in their occupations of life in the environments where they live, learn, and play. The skills of activity analysis, adaptability, and adaptation positively impact the client-centered services that children receive. The literature confirms that an activity-based approach, in collaboration with the child, parents, and interagency teams, has a positive impact on the functional outcomes for the child. Limited awareness of what occupational therapy services offer, combined with lack of access, may limit the impact and potential benefits to the child and the team process. When families and team members are aware of occupational therapy services, they reportedly value having access to an occupational therapist on the team.

8

Practice Changes Related to Occupational Therapy Services for Children in Saskatchewan

Changes that influence occupational therapy for children have been discussed in the areas of workforce, environment, funding, and services. Respondents to the survey (SSOT & SPOT, 2019) specifically identified practice changes over the past five years. Sixty-five per cent of respondents reported that their practice had changed while 21% reported that their practice had not changed. The question was reported to be not applicable for 14% of respondents. Upon analysis, three major themes emerged from the identified practice changes: increasing complexity in needs, higher caseload and workload demands, and changes in service delivery models. Each theme will be discussed, with complementary information from occupational therapy practice literature either validating or negating opinions gathered from the survey.

Increased Complexity of Needs

Occupational therapists reported seeing an increase in complex needs in the children they were treating (SSOT & SPOT, 2019). Referrals identified rising intensity and frequency in autism spectrum disorder, mental health needs, complex social needs, intellectual disabilities,

neuromuscular disorders, and acquired brain injuries. The increase in frequency may be related to an overall increase in the incidence of some diagnoses in the population.

Several survey respondents indicated that the number of children with autism spectrum disorder (ASD) or suspected ASD on their caseload had significantly increased (SSOT & SPOT, 2019). The Government of Canada (2018) indicated that between 2000 and 2015 the number of Canadian children diagnosed with ASD consistently increased from year to year. In 2019-2020, an estimated 1 in 66 Canadians ages 5 to 17 received a diagnosis of ASD (CanChild, n.d.). Occupational therapists are often consulted to provide assessment and intervention for children with ASD. An increase in the number of children with ASD in Canada directly impacts the demand for occupational therapy services.

Survey responses suggested that an increase in referrals for children with highly complex needs may also be related to the ability of the parents to advocate for children to receive additional community services through enhanced government funding. One respondent noted an "increase in referral rates … querying autism so that they may potentially have access to OT under autism services" (SSOT & SPOT, 2019). Another respondent indicated that there was a "change in [the] role of public OT services once individualized funding [was] provided" (SSOT & SPOT, 2019; Saskatchewan Government, n.d.b.). In 2016 Jordan's Principle Funding was endorsed by the Canadian Human Rights Tribunal (Canada Government, n.d.c.). The federal government announced the creation of the Autism Spectrum Disorder Strategic Fund (Canada Government, 2018). In Saskatchewan, the Cognitive Disability Strategy continues to evolve, administered through the Ministry of Social Services (Saskatchewan Government, 2015). These funding strategies seek to provide enhanced and equitable therapy services, including occupational therapy, for specific populations. Occupational therapists are increasingly seen as desirable service providers by the public for children with complex neurological needs such as ASD and other cognitive disabilities.

In addition to an increase in children with developmental and neurological diagnoses, survey respondents discussed the recognition and treatment of complex mental health concerns in children (SSOT & SPOT, 2019). Expanding mental and emotional health services for all people has been a primary goal of the provincial health care system (Saskatchewan Government, 2020; Stockdale Winder, 2014). Clients with mental health and trauma-related needs have increased. This increase corresponds to mental health concerns and childhood trauma identified as major public health issues requiring action (Saskatchewan Government, 2020; Saskatchewan Advocate for Children and Youth, 2019). Toxic stress syndrome is a common consequence of children experiencing recurrent traumatic events in childhood (Gronski et al., 2013). Children with toxic stress syndrome have a higher risk for lifelong physical, emotional, and mental health concerns and subsequent economic issues. The position of occupational therapists to provide services to these children can be described as proactive and preventative. Occupational therapists are in a position to address complex social and emotional needs when the structures and funding support inclusion of occupational therapy to the maximum scope of practice in the service model.

Higher Caseload and Workload Demands

Themes emerging from the survey indicated that the caseloads of occupational therapists in Saskatchewan are growing with minimal increase in positions to address the increased demand for service (SSOT & SPOT, 2019). This discrepancy has resulted in gaps in service delivery, described as longer waiting times, fewer follow-up visits, changes in service delivery model such as using a consultation model instead of providing direct care, and inequitable access to therapy services.

Prioritizing early intervention is one way that survey respondents attempted to manage caseload size (SSOT & SPOT, 2019). The responses of occupational therapists echoed the results of a study that stated occupational therapists provide more services to pre-school and elementary students than to middle and high school students (Spencer et al., 2003). However, research indicated that individuals with disabilities had lower rates of high school graduation, employment, post-secondary education, and residential independence compared to their peers without disabilities (Spencer et al., 2003). Areas of concern noted in the survey included the lack of transition services designed to help people with disabilities transition between major life stages, and the prioritization of preschool age children only. This limits the capacity of the occupational therapist to advocate and be change-makers for youth with disabilities.

Another method of prioritization described by therapists is to provide service to children with the most intensive needs, leaving children with mild to moderate needs with minimal to no access to occupational therapy services (SSOT & SPOT, 2019). One respondent stated that "children with mild to moderate needs (e.g., learning disabilities) who used to receive occupational therapy services … are receiving less occupational therapy services now, thus reducing their potential for progress" (SSOT & SPOT, 2019). This difficulty has been reflected in other Canadian studies looking at service delivery models, particularly in schools. Due to long waitlists, teachers were reported as hesitant to refer students for occupational therapy services unless there was a significant need (Wilson & Harris, 2018). Lack of available therapy for children whose needs are classified as mild to moderate has led to a decrease in advocacy for services by their teachers and caregivers.

Millar et al., (2013) noted that equitable access, timeliness of service, and family-centred care are key factors of high-quality occupational therapy service delivery and are valued by service users. Extensive wait times lead to high levels of dissatisfaction by service users. Achieving these key factors continues to be a challenge for many occupational therapists, especially those working with and for children (SSOT & SPOT, 2019; Millar et al., 2013).

Changes in Service Delivery Models

To help meet the needs of children, their families, and the community, survey respondents indicated changes in service delivery models in response to outside forces (SSOT & SPOT, 2019). Many respondents indicated that they have had to make changes in their service delivery model by increasing use of a consultative model and decreasing direct services with

reduced frequency of services. Reasons reported for the change included financial barriers, positions that have been cut, increasing numbers of referrals, and higher caseload numbers. These reasons reflect priorities of funders, rather than a concern for outcomes of service provision for children.

In addition, survey respondents indicated that they had changed their practice in objective ways (SSOT & SPOT, 2019). One respondent indicated that to accommodate a growing caseload, she had to rely more heavily on parent coaching and education, using a consultative model. Another respondent described moving to a block treatment model from ongoing service provision. Respondents also indicated that they had had to make changes from providing direct therapy to being proficient teachers for families or caregivers. One respondent described the change.

> "I now understand my role as being a therapist, providing occupational therapy to the school division so they can better complete their occupational performance challenges of effective inclusion. I work at the level of the staff and use my interactions with the children as a coaching opportunity to increase the capacity of educators to include differently-abled children, rather than looking to increase the capacity of the children to change to align with the constraints of the school" (SSOT & SPOT, 2019).

Studies assessing the effectiveness of service delivery models in different contexts provide useful information for occupational therapists struggling to adjust to constraints in practice. For instance, using a *collaborative consultative approach*, as opposed to consultation alone, may improve inclusion, support better overall outcomes for students, and enhance collaboration amongst teachers and therapists working with the child within the classroom (Kasovac et al., 2019). This service delivery model has been contrasted with *direct service models*, which imply treatment of individuals or groups, commonly in a separate room within the school. Collaborative consultative models combine both collaboration and consultation and include such evidence-based approaches as Response to Intervention (RTI) and Partnering for Change (P4C) (Wilson & Harris, 2018). Combining collaboration with consultation has been shown to lead to increased effectiveness of suggested interventions, due to teacher involvement and capacity building within the classroom (Wilson & Harris, 2018). Moving from providing direct therapy in school to a collaborative consultation model could be considered an example of shifting to a different service delivery model based on evidence and client feedback. The desired outcome is improved support for the child in context.

While a collaborative consultative approach is recognized in the literature as an effective strategy in schools based on student outcomes, the time it takes to establish and implement is higher than may be assumed (Rourk, 1996; Clough, 2017). In their study, Wilson, and Harris (2018) identified the importance of building relationships with teachers. They also identified the potential benefits to students stemming from occupational therapists becoming part of the school community and by reducing barriers to teachers accessing occupational therapy services.

Occupational therapists in Saskatchewan expressed frustration when time constraints reduced the ability to provide quality services to individuals, and outcomes such as reducing waitlists or seeing large numbers of clients were prioritized instead (SSOT & SPOT, 2019). Administrators who choose to use consultation to provide services to larger caseloads, while potentially saving money, may not receive the benefits of a robust service delivery that maximizes outcomes for the child. Occupational therapists, employers, and funders need to determine the best service delivery model to meet the needs of children, their families, and the community.

Summary

Occupational therapists reflected on ways that their practices had changed over the past five years (SSOT & SPOT, 2019). They reported an increase in the complexity of needs in children and higher caseload and workload demands, resulting in the need to make changes to service delivery models. As the needs of children became more complex, the demands on therapists involved in their care grew. These practice changes suggested the need for internal advancement of skills and knowledge and evidence-informed ways to adapt to changing societal demands external to the profession.

9

Summary of Occupational Therapy for Children in Saskatchewan

This document has been written as a resource for individuals or groups who work with children in Saskatchewan, from the perspective of occupational therapists. *Occupational Therapy for Children in Saskatchewan - Resource Document 2020* describes how occupational therapy meets the needs of children, progressing from universal shared understandings to specific issues relevant to occupational therapists working in the province of Saskatchewan. The purpose of the document is to provide current evidence-informed data and observations that support productive dialogue between occupational therapists and decision-makers, as well as consumers.

The practice of occupational therapy is based on a belief that meaningful occupation and occupational engagement enhance the capabilities of clients and lead to positive functional outcomes. Occupational therapists use clinical reasoning to draw from evidence when choosing methods to assist clients. Models of practice are used to guide processes of assessment and intervention. The model used to organize practice information in this document is the Canadian Model of Occupational Performance and Engagement (Townsend & Polatajko, 2013).

Occupational therapists are educated at a master's level in Canada. All occupational therapists working in Saskatchewan are educated out of the province. A licence to practice with the SSOT is compulsory for occupational therapists to practice in Saskatchewan. Therapists

must adhere to continuing competency requirements on an ongoing basis to maintain licensing by SSOT.

Childhood as a unique part of the lifespan is seen by occupational therapists through a rights-based and inclusionary lens. Barriers to full participation in the occupations of childhood are a key area of interest to occupational therapists. Children are uniquely vulnerable, and their dependence on families has implications for obtaining informed consent. Knowledge of developmental progressions, critical periods, and the transitions of childhood are necessary to understand disruptions to these experiences. Occupational therapists who work with children must use a range of highly complex skills to support children in carrying out daily occupations across environments and within developmental sequences. Engagement in occupations that are meaningful to the child in context is the desired outcome.

The occupational therapy workforce is dependent on funding and an adequate supply of occupational therapists. There has been significant growth in occupational therapy services in the private practice area since 2010. In the health sector, there has been moderate growth in the workforce while in the education sector there has been only minimal growth in the number of occupational therapist positions in the same span of time. Disparities have been identified in the level of occupational therapy services for children across the province. The workforce in Saskatchewan is well below Canadian workforce numbers. Workforce realities are further complicated by the environments that occupational therapists work within, as influenced by societal, provincial, workplace, and professional factors. Society continues to shift, sometimes rapidly, in the use of technology by individuals and professions. Service delivery is influenced by the *rurality* of Saskatchewan and challenges with retention of occupational therapists. Environmental factors, both external and internal to the workplace, impact occupational therapy service delivery, and this in turn affects how children experience services.

In the provision of occupational therapy services to children in Saskatchewan, structures where services are provided and funded are broadly categorized under health, education, social services, Indigenous services, and private practice. Since 2010, occupational therapists have increased their presence in some structures and through various changes in funding models. Service delivery models are at the intersection of the mandate of a funding organization, the skills of the occupational therapist, and the needs of the consumer. Elements critical to effective service provision include access to the child in context, timeliness of services, inter-sectoral collaboration, and the ability to prioritize based on the needs of the child. Processes in the provision of services are expressed through referral sources, reasons for referral, age ranges, and profiles of children served. Continuous quality improvement is a shared responsibility between the service provider and the funder. Outcomes that benefit children must be the key criteria for changes in service delivery.

The impact of occupational therapy focuses on skills that occupational therapists embody in their work and perceive to be valued by consumers. These are activity analysis, adaptability, adaptation, client-centred approach, collaboration, transitional support, and holistic practice. Practice changes have occurred throughout the last decade, influencing the ability of occupational therapists to use these skills effectively with children. Changes include more referrals for children with increased complexity of needs, higher caseloads resulting in

higher workloads, and changes in service delivery models based on both external pressures and the evolving application of theory to practice.

This resource document serves as a bank of relevant, timely, and evidence-informed data to support ongoing efforts to improve occupational therapy services for children. The delivery of services is influenced by societal, institutional and practice changes. As the profession continues to evolve and adapt to the changing landscape, the document will further serve as an impetus for continued reflection, research, and development of responsive practices by occupational therapists and the organizations they work within. Child-centred approaches and collaborative efforts between therapists and consumers will enhance the provision of services throughout Saskatchewan and support positive outcomes for children.

10

Conclusive Messages with Recommendations

Conclusive messages emerged from the data collected on occupational therapy for children in Saskatchewan. The messages target areas that require attention by the occupational therapy community to support and enhance services to meet the needs of children and families. Background information and a list of recommendations are provided for each message, allowing for accountability in follow-up projects, whether implemented at an individual, group, workplace, or organizational level.

Message A
Services for children are strengthened when stakeholders have a clear understanding of the scope and role of occupational therapy.

Occupational therapy continues to be less well known than other professions. The diversity within the profession, while lending itself to supporting a broad range of children's occupations, does not communicate the focus of occupational therapy to others in an easily definable way. Stakeholders would benefit from a greater understanding of the unique contribution and knowledge occupational therapists can provide when children experience disruptions in development.

Recommendations

1. Develop materials for stakeholders describing where and within what types of service delivery models occupational therapists work with children in the sectors of health, education, and social services.
2. Develop materials for stakeholders highlighting examples of innovative approaches to occupational therapy service delivery for children and families.

3. Propose a mechanism by which occupational therapists could converse with stakeholders/administrators beyond the employee/contractor level regarding contributions of occupational therapists to enhance services for children across the sectors of health, education, social services, and private practice.
4. Obtain feedback from consumers and allied team members on the impact of occupational therapy services for children across different service delivery models. Compare the consumer information with information gathered from occupational therapists.

Message B
Access to occupational therapy services across the province is inequitable.

Access to services is dependent on an adequate number of occupational therapy positions, matched with a consistent workforce of occupational therapists. Challenges with recruitment and retention influence services available. All occupational therapists working in Saskatchewan are educated outside of the province. Access to occupational therapy services for children relies on intersectoral communication and collaboration.

Recommendations

1. Gather information from occupational therapists who work with children to determine what factors influenced their decision to leave the province or change their practice area.
2. Develop materials to support retention and vacancy planning to assist administrators in minimizing inequitable access to occupational therapy services for children.
3. Develop and distribute materials regarding the availability and level of occupational therapy services for children across sectors.
4. Promote awareness of the scope of knowledge occupational therapists are educated in to expand the traditional roles that occupational therapists use to work with children in Saskatchewan.
5. Develop materials to assist administrators to support mentorship and professional development of their occupational therapy staff within the complexities of working with children and their families.
6. Continue collaborative relationships and discussions with government representatives as to how an education program for occupational therapists in Saskatchewan could support their current initiatives and plans.

Message C
Professional collaboration and intersectoral communication are integral to the provision of services for children and families.

Families benefit from support to function and develop a sense of belonging when raising children. This support is critical when disruptions in childhood development occur. Family-centered care and optimizing the child's development require the right services at the right time. Achieving the best outcome for the child requires professional collaboration with colleagues across organizations involved in service delivery for the child.

Recommendations

1. Develop materials, specific to Saskatchewan, to distribute and communicate with parents, teachers, and care providers to identify the benefits of having an occupational therapist on their child's team in the environments where they live, learn, and play.
2. Advocate for occupational therapists to communicate intentionally with their colleagues across organizations to facilitate the continuity of care during developmental transitions for the child and family in their journey towards health and well-being.

Message D
The confidence and identity of occupational therapists directly correlate with continuous professional development opportunities.

Professional factors can influence satisfaction in the workplace and directly correlate with retention and career advancement to support professionals to remain in Saskatchewan.

Recommendations

1. Gather and distribute information to stakeholders to promote awareness of volunteer activities and practice networks or forums that individual occupational therapists participate in to support their practice with children (e.g. SPOT Practice Network, CAOT Issue Forums).
2. Develop materials to advocate for adequate release time for professional activities. These could include: education, collaboration with colleagues in occupational therapy and allied professional groups, and participation in professional learning communities, with the intent to advance knowledge and build capacity essential for occupational therapy service delivery.
3. Develop a mechanism within the province of Saskatchewan to support professional development for occupational therapists to pursue non-traditional or emerging roles that support the needs of children.

Message E
The benefits and cost-effectiveness of occupational therapy services for children are not fully understood by the public.

The extent to which occupational therapy interventions reduce the financial impact of children requiring health, educational or psychosocial support is not fully understood. The value of having occupational therapists on teams is beginning to be evaluated but not specifically related to children and families in Saskatchewan. Evaluation of cost-effectiveness of services based on the needs of children is warranted.

Recommendations

1. Facilitate discussions with, and gather information from, children, parents, guardians, teachers, and other stakeholders, regarding outcomes of occupational therapy interventions for children across sectors.
2. Gather information regarding the use of support personnel in occupational therapy services for children across Saskatchewan. Develop materials for occupational therapists and stakeholders to reference regarding the impact support personnel have on occupational therapy services for children.

Closing Remarks

Occupational therapists are passionate about influencing the world to be more inclusive, accessible, and open to people of diverse abilities and interests. This statement holds true for Saskatchewan occupational therapists who support children with challenges to reach their potential in childhood occupations and to experience inclusivity in their home, school, and community environments. When there is service stability, occupational therapists are in a better position to advocate for and provide services that have a lasting impact on the lives of children and their families in Saskatchewan. The vulnerabilities and needs of children and their families have been put into sharper focus by the societal responses to the global COVID-19 pandemic. The impact of the pandemic could be the subject of future research and writings. The authors hope that the information provided in this resource document will help to reduce the gaps between what our society wants for our children and what they actually experience.

Appendix A
Survey

Appendix A1 Survey Development Process

Over a ten-month period, a survey was developed, circulated to practicing SSOT members and responses analyzed. An overview of the process taken for the survey is provided through a month-by-month listing of activities. This is followed by a description of the limitations of this survey and the lessons learned which might be of interest for any similar projects.

An Overview of the Survey Process

July 2019: Initial Draft

An initial draft of questions was created from reviewing the 2010 SSOT document and the 2018 survey of pediatric SSOT members (SSOT Pediatric Interest Survey – Fall 2018). Microsoft Office Word was used to format the initial draft questionnaire, as it was easily accessible to everyone.

August 2019: Group Discussion on Initial Draft

The PPWG reviewed the initial draft, and several open-ended questions were reworded to be closed ended. The decision was made to use the SSOT subscription to the cloud-based service of *Survey Monkey* for the survey process. A time frame was outlined and a survey sub-group was created. A draft questionnaire was circulated to a group of occupational therapists and non-occupational therapists for initial testing and feedback of how questions were interpreted.

September 2019: Internal Piloting

It was decided to conduct an initial pilot on the questionnaire using the PPWG group. After discussion, the survey timeline was adjusted. Later in the month, feedback from this internal pilot led to further changes being made to the questionnaire.

October 2019: External Piloting and Switch to Survey Monkey

The decision was made to carry out an external pilot with a small group of occupational therapists who work with children in the Saskatchewan Health Authority. Following this pilot, the questionnaire was sent to the SSOT Executive Director who transferred it to *Survey Monkey* (Personal Plan – Advantage version). This process required reformatting some questions to accommodate the program layout. As questions had been changed, an additional internal pilot was carried out to ensure the original intent of the questions was not lost.

Following this additional pilot, the questionnaire was further refined. Technical checks of the survey process were carried out to ensure that:

- All mandatory questions had to be completed.
- Respondents not practicing with children were able to skip over the questions specifically for respondents working with children.

November 2019: Finalization of Questionnaire and Commencement of Survey

The introduction and covering email were further developed and given final approval by the PPWG. Finally, the questionnaire was presented to SSOT council members who then approved the questionnaire for distribution. On November 20, 2019, the questionnaire was circulated by SSOT staff to the SSOT membership. The deadline for response was stated as December 9, 2019.

December 2019: Posting of Survey Results on Google Drive

A reminder about the survey was included in the December SSOT News email to the membership. On December 5, 2019, a final email reminder was circulated to the general membership with an additional email reminder going out to the Saskatchewan Pediatric OT network (SPOT) on December 9, 2019. On December 10, 2019 at noon, the survey was officially closed by the SSOT administration.

The Executive Director of SSOT reported that there were 174 responses, 96 from respondents who worked with children and 78 from those whose practice did not include children. Unfortunately, it was found that only 118 of the responses were marked *complete* and one of those had to be removed as the respondent practiced in another province. This meant that approximately one-third of the responses were marked as *incomplete*.

At this point in the process, it was decided that a member of the survey sub-group would be granted direct access to the *Survey Monkey* database, as the anticipated workload would be too much for the SSOT Executive-Director. In addition, it would allow for a timelier review of the data. This individual posted the initial data to Google Drive with access limited to members of the PPWG group. She would also become the facilitator and coordinator for the analysis process. Analysis of individual questions was assigned to small groups from within the PPWG group.

January 2020: Decision Made on Incomplete Responses

Further discussion was held on the status of the *incomplete* responses. The decision was made to only analyze completed responses (see later segment on lessons learned). SSOT council confirmed this decision on March 14, 2020, and all incomplete responses were immediately destroyed through deletion of the data from the *Survey Monkey* database and Google Drive.

January - May 2020: Analysis of Responses

Survey Monkey was able to create visual images of the data from the closed-ended questions. However, the open-ended questions required a great deal more effort for analysis. Discussion was started on the process of analysis of the open-ended questions. These types of questions fell into two categories: questions soliciting opinions; and those where the individual responses could be clustered into tables (e.g., locations of practice). The open-ended questions for the former category were reviewed, and themes identified which were then *tagged* using *Survey Monkey's* tagging system. Tables were created from the responses for the open-ended questions in the second category.

To facilitate the process of thematic analysis, individual question responses were posted to Google Sheets (one sheet for each question) for review by teams consisting of at least two team members. Teams reviewed the responses for all the questions, discussed themes, and then listed the general themes onto the spreadsheet. Following this, each individual response was assigned corresponding theme numbers.

Following completion of the initial thematic analysis, the individual responsible for managing the *Survey Monkey* database reviewed all the themes that emerged and narrowed down overlapping themes to create a master list of themes for which corresponding tags were created in the database. The individual tags were then cross-referenced with those themes identified by the teams in Google Sheets, and each question was individually labeled with a corresponding tag.

Lessons Learned and the Resulting Limitations of the Survey

Issues with Switching from *Word* Format to *Survey Monkey*

The original decision to draft the questionnaire using *Word* was made because everyone involved had access to *Word*. The *Survey Monkey* software was only available from the SSOT administration staff. None of the individuals involved in developing the survey were aware of the limitations of the version of *Survey Monkey* which was to be used.

The switch between formats created some major problems. Some of the questions could not be easily transferred into the new format. The way they had been viewed within *Word* had to be changed which created differences in how a respondent might understand and respond to the question. These questions then had to be redesigned to achieve the original intent.

All Members Surveyed

The questionnaire was inadvertently sent out to *all* SSOT members instead of practicing members only. This was an unfortunate error in communication between the PPWG and SSOT staff who distributed the questionnaire. Fortunately, the situation was easily addressed because people who were not actively practicing (e.g., students and non-practicing members) would have realized this was not a questionnaire they could or should be answering. In addition, questionnaires submitted by people who did not meet the criteria of practicing in Saskatchewan were easily identified and removed.

Complete and Incomplete Responses

As was described earlier (see January 2020), there was a major issue with the number of incomplete questionnaires that had been submitted. A further examination of the *incomplete* questionnaires appeared to reflect that the respondents had stopped answering questions at certain common points in the questionnaire, generally when there was a need to press *next*. Unfortunately, it could not be ascertained whether the respondents had:

- decided not to continue and thought by closing the page they had not submitted the questionnaire,
- thought they had come to the end of the questionnaire and it was submitted,
- decided to answer some of the questions and come back and do the rest at a more convenient time. They did not realize that by answering some of the questions and closing the questionnaire, that their initial responses would be submitted.

This lack of clarity of the wishes of the respondents resulted in the loss of a substantial number of partially completed responses following the decision of SSOT council to have these incomplete responses destroyed.

Type of Questions and Length of the Questionnaire

The desire by the PPWG to acquire detailed information led to a questionnaire that was lengthy and required effort in reflecting on experiences when responding to most of the open-ended questions. The length and the number of open-ended questions possibly affected the low response rate.

Analysis Shortcomings of Basic Version of *Survey Monkey*

It was not thought necessary to analyze the data from the pilot questionnaires, as the focus of attention was on whether the question elicited the information that was needed. However, this turned out to be a mistake because it was only when the analysis was in progress that it became clear that some of the cross referencing was not easily achievable with this version of *Survey Monkey*.

Appendix A2 Summarized Questionnaire
Occupational Therapy Services for Children

All practicing SSOT members whether working children or not, are urged to take the time to complete this Survey Monkey Questionnaire. The information emerging from this Questionnaire will provide a profile of occupational therapy practice for children in Saskatchewan. The results will be used to focus SSOT's interactions with stakeholders. Please complete the Questionnaire by December 9, 2019. Throughout this Questionnaire, the term "children" refers to individuals from birth to 21 years of age.

1. Indicate how many years you have practiced OT.
2. Indicate how many years your OT practice has included working with children.
3. Indicate, using full time equivalency (FTE) or hours, your current average work time per week as an OT.
4. Indicate the location(s) where you practice OT (e.g. names of cities, towns, rural municipalities).
5. Do you current work with children?
6. Indicate, using full time equivalency (FTE) or hours, the average amount of time per week that you currently provide OT services to children.
7. Indicate the average distance that you travel one way to provide OT services to children. Options – local travel only, up to 50 km, between 50 and 100 km, and more than 100 km.
8. Indicate the average number of hours that you spend travelling in a month to provide OT services to children. Options – 10 hours or less, 11 to 20 hours, 21 to 30 hours, 31 to 40 hours, 41 to 50 hours, 51 to 60 hours, 61 to 70 hours, or more than 70 hours.
9. What impact does travel have on your service delivery?
10. How do you manage your travel time (e.g. scheduling, use of technology)?
11. Indicate where you provide OT services to children. Check all that apply:
    - Health Authority Facility: In-patient
    - Health Authority Facility: Out-patient
    - Private Clinic
    - Educational Institution: Preschool
    - Educational Institution: School
    - Educational Institution: Post-Secondary
    - Child's Home: Family Home
    - Child's Home: Group Home
    - Child's Home: Institution
    - Community Facility: Day Care
    - Community Facility: Developmental Training Centre
    - Community Facility: Vocational Training Centre
12. Indicate age ranges of children you provide OT services to and the frequency of your work in each of the age ranges.

	Frequently (once per week or more)	**Periodically (not more than once or twice a month)**	**Rarely (once every couple of months or less)**	**Never**
Birth - 4 years				
5 - 12 years				
13 - 17 years				
18 -21 years				

13. Identify the source of funding for your OT services to children and whether you are employed or contracted privately by the funder. Check all that apply.
    - Saskatchewan Health Authority
    - School Division
    - Ministry of Social Services: Cognitive Disability Strategy
    - Ministry of Social Services: Autism Services Individualized Funding
    - Federal Program: Tribal Council – Health Services
    - Federal Program: Tribal Council – Education Services
    - Private Pay
    - Health Insurance
    - Saskatchewan Government Insurance (SGI)
    - Grant Funding
14. In your OT practice with children, list the three most common reasons for referral.
15. In your OT practice with children, list the main referral sources.
16. From the list below, indicate the service delivery models and components that best describe your OT practice with children. Check all that apply.
    - Case Management – Individual/Family (Coordination of service delivery, meetings, documentation, phone calls).
    - Consultation Model – (Collaboration and education with parents, service providers and outside agency personnel, meetings, documentation)
    - Direct Model (including preparation and documentation) A) Direct Model: Screening (individual, classroom); B) Direct Model: Assessment (individual); C) Direct Model: Intervention (individual, small group, family); D) Direct Model: Interdisciplinary assessment and intervention
    - Monitoring Intervention Model: (Following assessment, setting up programs for others to implement; periodic monitoring/collaboration, documentation)
    - Service Management (Administrative tasks and meetings, therapy service coordination, materials and supplies, quality assurance programming)
    - Teaching/Education Model (Preparation and provision of in-services and workshops to team members and outside agencies)
    - Other
17. If you answered “Other” in question #16, please describe the service delivery model/component.
18. Estimate the percentage of time that you spend on average in the following aspects of service delivery to children. The numbers need to add up to 100.
    - Client Specific Services (Case Management, Consultation, Monitoring)
    - Client Specific Services (Administrative tasks)
    - Teaching/Education (Provision of in-services and workshops)
    - Travel
    - Other
19. Referencing your response to question #18, on a progressive scale of 1 to 10, with 10 being most satisfied, indicate the level of satisfaction that you experience with your distribution of time.
20. What is the main factor(s) influencing the satisfaction level you indicated on the scale in question #19?
21. In order of frequency with 1 being the most frequent, indicate which categories best describe the profiles of the children you provide OT services to.

- Development (e.g. Autism Spectrum Disorder, Intellectual Disabilities, Neuromuscular Disorders)
- Injury or Medical Related (e.g. Acquired Brain Injuries, Orthopedic Injuries, Medical Conditions)
- Emotional-Behavioural (e.g. Mental Health concerns, Anxiety, Depression, Sensory Processing/Emotional Dysregulation)
- Education (e.g. Learning Disabilities – literacy based concerns)
- Other

22. If you indicated "Other" in question #21, please specify.
23. Indicate the occupational performance areas and environmental aspects that you address in your work with children? Check all that apply.
    - Self-Care
    - Productivity
    - Leisure
    - Environment – Physical: Accessibility (e.g. buildings, playgrounds)
    - Environment – Physical: Adaptations and Modifications (e.g. home, classroom, vehicles)
    - Environment – Cultural and Social (e.g. diversity, inclusion, participation, reconciliation)
24. Within the system that you provide OT services to children, what is the main strengths?
25. Within the system that you provide OT services to children, what are the main shortcomings or challenges?
26. Reflecting on your responses in this Questionnaire, has your OT practice with children changed in any way over the past 5 years? Indicate – yes, no, or not applicable (e.g. limited experience with children to date.
27. If you answered YES in question #26, describe how your practice has changed.
28. Provincially, what would you identify as the main barriers for children in accessing effective occupational therapy services?
29. What do you suggest would be needed to provide more effective and accessible OT services to children at a provincial level?
30. If you had additional funding for children's OT services, what would you recommend be prioritized and why?
31. Please use this space to make additional comments related to the provision of OT services to children in Saskatchewan.
32. (Optional Question) What do we as OTs bring to the table that stands our discipline apart from other disciplines?
33. (Optional Question) Within your OT practice, what do your clients, families and team members say they value about OT services.
34. (Optional Question) Recruitment and retention of OTs is a long-standing concern across all areas of practice in Saskatchewan. What do you see as potential solutions to this concern?
35. (Optional Question) Indicate your name and the location where you live.

Appendix B
Literature Search Process

Searching the literature was organized into four informal phases to support the writing of this 2020 document. The process started in July 2019 and ended with the publication of the document.

Phase 1

A subgroup was established to review references utilized in the 2010 document. Initial focus was to search for updated references, then search provincial documents as well as national and international documentation relevant to children and occupational therapy.

Phase 2

Topics relevant to the 2019 survey questions were utilized to complete a literature search through CINAHL, PubMed, PsychINFO, Medline, Wiley Publishing, SHIRP, Cochrane Database, CAOT journal access, Sage Journals, and Google Scholar utilizing key words. Later these keywords would be aligned with the themes compiled from the survey results to continue the search. Documents were organized on Google Drive corresponding to headings being considered for the 2020 document.

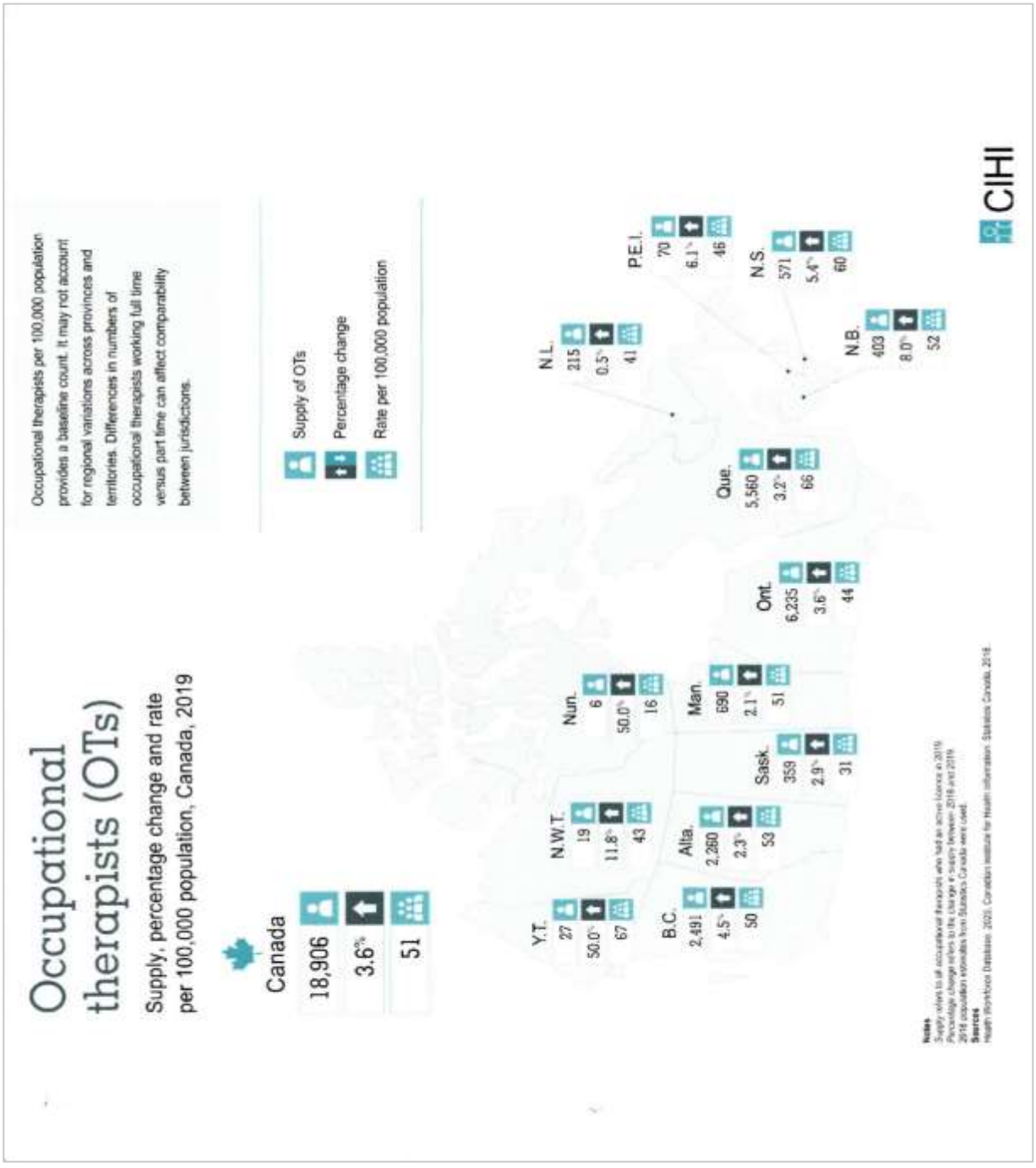
Phase 3

Prior to draft writing, working group members were requested to read literature and comment on themes relevant to the topic they were writing on. The read/comment process was intended to intertwine survey results with literature relevant to occupational therapy services for children and support the draft writing process.

Phase 4

Upon completion of compiling a draft 1 of the 2020 document, the literature referenced in this draft was reviewed to monitor for duplication. Documents posted on Google Drive but not referenced were then reviewed for relevance and consideration for inclusion into the 2020 document during the later draft writing process.

Appendix C
Infographic Map Canadian Institute of Health Informatics



Note. (CIHI, 2020a).

Appendix D
Occupational Therapy Children's Services

Appendix D1 Saskatchewan Health Authority (SHA) - Ministry of Health

Reflects data collected from May through November 2020.
Data obtained from communication with occupational therapists in the respective health areas.

SHA Health Area (OT FTE Positions)	OT Positions and Services Based on Full time Equivalent Positions
Athabasca Health Authority (Communities in the far north)	Survey results indicate that OT services are being provided in AHA. Specific information not obtained.
Buffalo Narrows Area (formerly in Keewatin Yathe Health Region)	No information obtained
LaRonge Area (formerly in Mamawetan Churchill River Health Region)	No information obtained
Lloydminster Area (formerly in Prairie North Health Region) 1.2 OT FTE positions	• 0.8 position in Lloydminster • 0.4 position in Meadow Lake • Staff from Lloydminster travel to Meadow Lake Children's OT services include: • Feeding team (travels to Lloydminster as caseload requires & for building capacity within Lloydminster team) • Team assessments/ reviews • Individual assessments/ reviews/ treatment • Pre-Kindergarten and daycare visits if indicated for assessment of environmental and social considerations
Moose Jaw Area (formerly in Five Hills Health Region) 2.0 OT FTE positions	• 1.5 positions on the Autism Spectrum Disorder (ASD) team. The OTs in the ASD program see children birth-18 years of age. Priority is given to early intervention birth-8 years of age. • 0.5 position in Public Health Outpatient Pediatrics. • The OT sees children birth-5 years of age.

SHA Health Area (OT FTE Positions)	OT Positions and Services Based on Full time Equivalent Positions
North Battleford Area (Formerly in Prairie North Health Region) 1.7 OT FTE positions	• 1.0 position for pediatric services for ages birth to school entry. Incumbent is also a senior OT, with approximately 0.3 allocated for senior duties. *Note:* OT filling this position was reallocated to acute care due to lack of staffing; no pediatric services were being offered at time of data collection. • 1.0 position – Autism Spectrum Disorders (ASD) - for ages up to 18 years. Currently unfilled. Consultative services have been provided by ASD OT based in Lloydminster.
Prince Albert Area (formerly in Prince Albert Parkland Health Region) 2.0 OT FTE positions	• Therapies Department (Victoria Hospital): 1.0 pediatric outpatient OT serving birth to school entry. Casual OT as needed for outpatient pediatric at-risk screens. Administration of ADOS by an OT from a different department, as needed (service on hold) • Mental Health Outpatients Department (Victoria Square): 0.8 community Autism Services, serving children birth to 19 years. 0.2 Child and Youth Development Clinic, kindergarten-24 years, primarily supports assessments for FASD, DCD and ASD. OT is trained in ADOS administration. (ADOS: Autism Diagnostic Observation Schedule)
Regina Area (formerly in Regina Qu'Appelle Health Region) 11 OT FTE positions	• 7.74 positions at Wascana Rehabilitation Centre (WRC) - Children's Therapy Program. Occupational therapists work with children on site at WRC as well as in home, day care, preschool, and school environments. Staff provide primary therapy services to children in the Regina area, are assigned to specialty teams (Assistive Technology Team, Seating Team, Feeding and Swallowing Team), and provide Tertiary services for children living outside of the Regina area. Support is also provided for clinics serving clients with Down Syndrome, Muscular Dystrophy, Spina Bifida, Cerebral Palsy. • The Developmental Assessment Clinic (DAC) has been moved from Regina General Hospital to WRC and is newly called the Neonatal Follow-Up Program (NFUP). FTE position from RGH did not transfer to WRC; any occupational therapy services required by this program may be picked up by occupational therapists from the Children's Program. • 0.4 position at Regina General Hospital - inpatient services to children's unit and Neonatal Intensive Care Unit. • 1.0 position with Child & Youth Mental Health Services • 1.0 position with Child & Youth Autism Services • Approximately 50% of 0.9 FTE – South Saskatchewan Acquired Brain Injury Outreach Team. • 0.5 position – Home Care based services for former Regina Qu'Appelle Health Region.
Rosetown Area (formerly in Heartland Health Region)	• Currently no pediatric services. • Children requiring services are referred to Alvin Buckwold Child Development Program in Saskatoon. • The community inclusion support service team helps the family look for private services if the child has a cognitive disability and the family income tests into funding through Cognitive Disability Services (CDS). • Minimal direct therapy provided by schools.

SHA Health Area (OT FTE Positions)	OT Positions and Services Based on full time equivalent positions
Saskatoon Area (formerly in Saskatoon Health Region) 15.1 OT FTE positions	Jim Pattison Children's Hospital: • 5.5 positions (1.0 senior, 1.0 Pediatric Outpatient Unit, 2.0 Pediatric Inpatient unit, 1.0 Pediatric Intensive Care Unit and 0.5 for Pediatric Hand Therapy). • Therapists participate in the Neonatal Intensive Care Unit (NICU) follow up clinic and Juvenile Idiopathic Arthritis (JIA) clinic. Alvin Buckwold Child Development Program: • 6.4 positions. (1.0 senior, 5.4 Staff). • 2.0 positions in Primary Health with the school wellness team to provide services to 3 elementary schools in the core area. Mental Health: The 0.2 position that had been dedicated to the Child and Youth Program (CYP) has not seen a change officially. There are times when more time is dedicated to the CYP, and at other times those referrals may be deemed low priority when factoring in the rest of the needs and priorities at The Irene & Leslie Dube Centre for Mental Health. Community (Homecare): Limited OT services to pediatric clients as referrals come up. Autism Services: 1.0 position, currently unfilled (OT on maternity leave)
Swift Current Area (formerly in Cypress Health Region) 1.0 OT FTE Position	No dedicated pediatric OT services under Therapies Autism Services: 1.0 position with long waitlist. No expectation to provide pediatric therapies outside of the autism program. Assessment and consultative pediatric OT services may occur as time permits for children post traumatic events or surgery. Community Homecare: Home accessibility services provided for the pediatric population by Homecare OT on a very limited basis.
Tisdale/Melfort/ Nipawin Area (formerly in Kelsey Trail Health Region - KTHR) 0.5 OT FTE Position	Pediatric services follow former Kelsey Trail Health Region boundaries: • 0.5 Occupational Therapist for children in the Autism Program. • PEDS Team (Pediatric Early Development Services Team) – as a team, pediatric OT, PT and SLP will assess babies born prematurely/with a diagnosis/at risk at ages 3, 6, 9 and 12 months; most referrals are received through public health. PEDS Team assessments are done ten days per year (one day per month excluding July and August). • No dedicated OT position for children's services outside of the Autism program within the former KTHR. • Minimal services are provided to children on an as needed basis as feasible by OTs in the former KTHR; these services are typically outpatient and in Melfort.

SHA Health Area (OT FTE Positions)	OT Positions and Services Based on full time equivalent positions
Weyburn/Estevan Area (formerly in Sun Country Health Region) 0.15 OT FTE allocation through adult services	• No dedicated pediatric OT position • Limited services by OTs working in adult services to pediatric clients: 0.15 position approximately • Some children with intensive needs travel to Wascana Rehabilitation Centre for OT services or may need to look for private options (e.g. eligible for ASD funding)
Yorkton Area (formerly in Sunrise Health Region) 2.0 OT FTE positions	• 2.0 positions. This includes 0.4 position contracted service to Christ the Teacher Catholic School Division. • Outpatient OT services are provided to children from birth to school entry through the Children's Therapy Program. • Children aged 6-18 years may be provided one-time assessments and follow up treatment for acute and post-operative therapy. • Inpatient services may be provided to children while in hospital with a referral from the attending physician.

Summary of OT Positions in SHA Health Areas **Approximately 36.65 OT FTE Positions**	Per data collected: • There are dedicated OT services for children in the following health areas: Lloydminster, Moose Jaw, North Battleford, Prince Albert, Regina, Saskatoon, Swift Current and Yorkton. • There are approximately 36.65 full time equivalent OT positions. This number includes positions that are currently unfilled. • In some cases, services are provided to children by therapists working in acute and outpatient care on an as needed basis.

Note. Positions are filled unless otherwise stated. (SSOT & SPOT, 2019).

Appendix D2 School Divisions - Ministry of Education
Public, Separate and Francophone: 2019-2020 School Year

Reflects data collected from May through June 2020.
Data obtained from the occupational therapists and school division student support administration.

School Division (Head Office)	2019 Student Enrolment K to Grade 12	OT Positions and Contract Services Based on full time equivalent positions
Chinook (Swift Current)	5,859	1.0 position Therapist on leave January 2020 - January 2021 Recruiting for the leave
Christ the Teacher RCSSD (Yorkton)	1,767	0.4 contract service through Children's Therapy Program, Saskatchewan Health Authority, Yorkton area
Conseil des écoles fransaskoises (Regina)	1,727	Private contracts with three providers for up to 30 days of service in total
Creighton (Creighton)	427	Currently looking for part time OT services
Good Spirit (Yorkton)	6,015	1.0 position Private contract services for 75 hours
Holy Family RCSSD (Weyburn) (St. Augustine School Division amalgamated)	1,344	Private contract services open-ended based on need
Holy Trinity RCSSD (Moose Jaw)	2,324	Currently no OTs employed or contracted
Horizon (Humboldt) (Englefeld Protestant Separate SD amalgamated)	6,215	2.0 positions
Ile-a-la-Crosse (Ile-a-la-Crosse)	345	Contract services from Northwest School Division for 10 contact days and 2 indirect service days
Light of Christ RCSSD (North Battleford)	1,940	Private contract services for 45 days Currently unfilled - looking to contract services
Living Sky (North Battleford)	5,196	2.5 positions Currently staffed at 1.5 until January 2021 due to 1.0 FTE therapist on leave
Lloydminster RCSSD (Lloydminster, Alberta)	2,850	1.0 position

School Division (Head Office)	2019 Student Enrolment K to Grade 12	OT Positions and Contract Services Based on full time equivalent positions
Lloydminster Public (Lloydminster, Alberta)	4,222	1.0 position
North East (Melfort)	4,736	1.0 position Recruiting for a second 1.0 position
Northern Lights (LaRonge)	4,056	Private contract services for 90 days
Northwest (Meadow Lake)	4,530	2.0 positions
Prairie South (Moose Jaw)	6,858	Currently no OTs employed or contracted.
Prairie Spirit (Warman)	11,312	4.0 positions. Currently staffed at 2.6 positions. From September 2020-December 2020 will be staffed at 3.2 positions. Returning to full staff in January 2021.
Prairie Valley (Regina)	8,442	1.5 positions, provided by three therapists, 0.5 each
Prince Albert RCSSD (Prince Albert)	3,087	Private contract services - part time hours. For 2020-2021 school year, looking to fill this private contract as current provider no longer available
Regina RCSSD (Regina)	11,683	Currently no OTs employed or regularly contracted
Regina Public (Regina)	24,005	2.5 positions, served by four OTs, one being full time. Additional 0.3 for 2019-2020 year through federal funding for early learning intensive support program.
Saskatchewan Rivers (Prince Albert)	8,547	Private contract services with two providers: One contract at 176 to 186 days per year, and second contract at 144.5 days per year (this contract increasing to 176 to 186 days per year for 2020-2021 school year)
Saskatoon Public (Saskatoon)	25,736	Private contract services for 130 days
South East Cornerstone (Weyburn)	8,221	2.0 positions - One OT on leave as of June 2020 Recruiting for the leave.
St Paul's RCSSD (Greater Saskatoon) (Saskatoon)	19,389	2.6 positions
Sun West (Rosetown)	5,553	1.0 position - Filled by two OTs - 0.8 and 0.2 0.8 position – OT on leave since September 2019. Position posted previously but not currently posted because could not fill. Private contract for high priority cases while position unfilled approximately 1 day/week.

Total Number of School Divisions 27	Total Enrollment K-12 186,386	21 out of the 27 school divisions have occupational therapist positions and/or contracted OT services. Approximately 29.2 OT FTE positions

Notes: Enrolment numbers are based on headcounts from the Student Data System (SDS) as of September 30, 2019. Enrolment includes all residency, +22, home-based and homebound students. Enrolment does not include Pre-Kindergarten students. (Saskatchewan Government, n.d.i.). OT positions and contract services are filled unless otherwise stated. (SSOT & SPOT, 2019).

Appendix D3 Saskatchewan First Nations Education

Reflects information collected from May through July 2020.

First Nation Aggregate (Tribal Council/Education Authority/Alliance) (Head Office)	Occupational Therapy Services
Athabasca Education Authority (Prince Albert)	No services presently Interested in providing OT services
East Central Education Authority (James Smith Cree Nation / Cumberland House)	No information obtained
File Hills Qu'Appelle Tribal Council (Fort Qu'Appelle)	Private contract services Amount of time not obtained
Meadow Lake Tribal Council (Meadow Lake)	Private contract services for 80 days
Saskatoon Tribal Council (Saskatoon)	Private contract services for 86 days
Touchwood Agency Tribal Council (Punnichy)	Contract services to George Gordon School through Horizon School Division. Services received through Jordan's Principle funding at one school
Treaty Education Alliance (Fort Qu'Appelle)	Services have been provided through Tiny Eye. Amount of time has been cut due to funding and will be pursued on a case-by-case basis.
Treaty Six Education Council (North Battleford)	Private contract services being explored
Yorkton Tribal Council (Yorkton)	Private contract services Amount of time not obtained

Note: Individual aggregates will include more than one community or member nation. Data does not specify communities. Jordan's Principle funding of occupational therapy services is not represented, although it is known that services may be provided on an individually approved basis. (Canada Government, n.d.e.; SSOT & SPOT, 2019).

Independent First Nations	Occupational Therapy Services
Carry the Kettle First Nation (Sintaluta)	Planning to contract services privately
Cowessess First Nation (Cowessess)	Private contract services for 20-30 days
Fishing Lake First Nation (Wadena)	No services provided. Expressed interest in pursuing if needed
Lac La Ronge Indian Band (La Ronge)	May be pursuing services
Little Red Education Authority (Little Red River)	No information obtained
Montreal Lake (Montreal Lake)	No information obtained
Moosomin (Cochin)	No Information obtained
Onion Lake First Nation (Onion Lake)	Private contract services for 100 days
Pasqua (Pasqua)	No information obtained
Peter Ballantyne Cree Nation (Prince Albert)	No information obtained
Red Earth Cree Nation (Red Earth)	No information obtained
Shoal Lake Cree Nation (Shoal Lake)	No information obtained
Sturgeon Lake First Nation (Prince Albert)	Private contract services for 15 days
Thunderchild First Nation (Turtleford)	Contract services through Tiny Eye
Wahpeton Dakota (Wahpeton)	No information obtained
Whitecap Dakota First Nation (Whitecap)	No services provided
Witchekan Lake First Nation (Spiritwood)	No information obtained

Note: Independent First Nations are responsible for their own governance including education. They are not a member nation within an aggregate (Canada Government, n.d.e.; SSOT & SPOT, 2019).

Appendix D4 Private Practice Clinicians and Companies

Zone	OT FTE	Location of Services	Funding Source
Saskatchewan Rivers School Division	0.8	School based	SRSD contract - Ministry of Education funding
Prince Albert and surrounding area	0.2	Clinic based Under age 6 years of age	Extended Health Benefits Employer Family Assistance Program Jordan's Principle Cognitive Disability Funding Ministry of Social Services Individualized Funding (ASD)
Regina and surrounding areas	0.5	Clinic based Home based	Private Pay Jordan's Principle Ministry of Social Services
Carlyle to Assiniboia – South Central	0.4	Home based Specialty Autism Note 0.2 FTE OT assistant	Individualized Funding (ASD) Employer Family Assistance Program Private Pay
Saskatoon and surrounding area	2.0	Clinic based Home based School based Institution based	Private Pay Group insurance Cognitive Disability Strategy Individualized Funding (Autism) Jordan's Principle Ministry of Social Services
Regina	0.5	Clinic based Home based	Jordan's Principle Cognitive Disability Private Pay Insurance
Saskatoon	0.1	Home based Inservices	Jordan's Principle Cognitive Disability Private Pay Insurance
Regina and Southern Saskatchewan	0 to 0.1	Home based School based Inservices	Private pay Jordan's Principle CEF School Division
Weyburn, Regina, Moose Jaw and surrounding area	0.2	Clinic based Home based School based Inservices	Private Pay Jordan's Principle First Nations Funding Individualized Funding (ASD)
Saskatoon and surrounding area; First Nations; Far North	5.7	Clinic based School based service	Jordan's Principle Cognitive Disability Funding Individualized Funding (ASD) Private Pay Insurance Funding from school budgets

Zone	FTE	Location of Services	Funding Source
Regina and surrounding area	0.5 to 0.7	Clinic based Home based School based Daycare based	Private Pay Insurance Individualized Funding (ASD) Jordan's Principle Cognitive Disability Funding
Shell Lake Area/Prince Albert/First Nations communities	0.4 to 0.6	Home based School based	Jordan's Principle CES – School Division Private Pay Insurance Treaty 6 Education Council
Saskatoon and surrounding area	0.2	Home based	Individualized Funding (ASD funding) Private Pay
Onion Lake	0.5	Clinic based School based	Onion Lake First Nations Education Jordan's Principle Onion Lake Health
Regina Area Moose Jaw Humboldt Area	0.5 to 0.75	Home based	Jordan's Principle Cognitive Disability Funding Individualized Funding (ASD) Private Pay Insurance
Total	**12.5 to 13.25 +**	-	-

Notes: Reflects data collected from May through July 2020. This is a fluctuating level of service dependent on the needs identified. Respondents were asked to reflect on services delivered prior to the Covid-19 pandemic (January 2020 and earlier). Some numbers are duplicated in the Appendices for School Divisions and First Nations Schools. Information obtained from SSOT Private Practice List, emails, and phone inquiries. Some OTs declined to participate which will reflect the numbers are a minimum of actual. Additional Information regarding funding source added to correspond with data collected in the survey. Services offered include assessment, treatment, consultation, and education to caregivers/staff (SSOT & SPOT, 2019).

Appendix E
Practice Locations as Reported by Survey Respondents

The 71 occupational therapists working with children (YES) identified a total of 88 locations. The 46 occupational therapists who do not work with children (NO) identified a total of 22 locations. As there were different interpretations of the question, this listing does not represent all the locations where survey respondents worked within the province, only the locations that they identified in the survey.

Geographical Category	**YES**	**NO**	**Specific locations** (YES)		**Specific locations** (NO)
Regina	16	12	-		-
Saskatoon	26	19			
Northeast Quadrant (NE)	7 (9)	3 (5)	Humboldt + 200 km radius Melfort	**Prince Albert**	Cudworth Hudson Bay Kelvington Middle Lake Porcupine Plain **Prince Albert** Tisdale Wakaw
Northwest Quadrant (NW)	7 (8)	2 (3)	Blaine Lake Clavet Dorintosh Edam Glaslyn Goodsoil Hanley Hillmond Kerrobert Laird Lashburn Leask **Lloydminster** Loon Lake Macklin Maidstone	Marsden Marshall **Martensville** Meadow Lake Onion Lake Neilburg Northwest S. D. Paradise Hill Pierceland Rapid View Rural Municipality of Spiritwood St. Walburg Turtleford Unity Waldheim Wilkie	Hepburn **Lloydminster** **Martensville** North Battleford Warman

Geographical Category	YES	NO	Specific locations (YES)		Specific locations (NO)
Southeast Quadrant (SE)	8 (11)	3 (4)	Broadview Canora Carievale Churchbridge Esterhazy Estevan + area Fillmore Former Sunrise Health Region Good Spirit S.D. Grayson Invermay Kamsack Lampman Langenburg	Melville Moosomin Norquay Prairie Valley S.D. Preeceville Rocanville Saltcoats South East Cornerstone S.D. Springside Stockholm Sturgis **Yorkton** + area **Weyburn** Whitewood	**Weyburn** **Yorkton**
Southwest Quadrant (SW)	6 (9)	5	Assiniboia Former Cypress Health Region Gravelbourg **Herbert + area**	Maple Creek **Moose Jaw** Shaunavon **Swift Current**	**Herbert** Mankota **Moose Jaw** Ponteix **Swift Current**
Northern Saskatchewan	0 (5)*	None	Athabasca Health Authority Beauval Buffalo Narrows Ile-a-la-Crosse	La Loche La Ronge Northern Lights S. D.	No locations mentioned
First Nations	0 (5)*	None	First Nations Schools First Nations communities (Saskatoon area) File Hills Qu'Appelle Tribal Council Standing Buffalo	Kahkewistahaw Muscowpetung Ochapowace Yorkton Tribal Council	No locations mentioned
TOTAL Number of Respondents	**70** (out of 71**)	**44** (out of 46***)	-		-

Notes: Bracketed number (#) indicates total number of responses for that quadrant. They are not included in the quadrant total as they are accounted for elsewhere in the chart, primarily Regina or Saskatoon. * Respondents included either First Nations or Northern Saskatchewan locations along with another geographical category and are already counted in the total. None of the respondents indicated working exclusively in Northern Saskatchewan or on First Nations. ** One respondent listed "all of Saskatchewan." This response could not be categorized in this chart. *** One respondent listed "Chronic Disease Management" and another listed "rural Saskatchewan." These two responses could not be categorized in this chart. (Locations identified by both YES and NO respondents are **bolded**. YES indicates respondents that do work with children. NO indicates respondents that do not work with children) (SSOT & SPOT, 2019).

References

Ahmadi Kahjoogh, M., Kessler, D., Ali Hosseini, S., Rassafiani, M., Akbarfahimi, N., Reza Khankeh, H., & Biglarian, A. (2019). Randomized Controlled Trial of Occupational Performance Coaching for Mothers of Children with Cerebral Palsy. *British Journal of Occupational Therapy*, *Vol 82*(4), 213-219. Sage Publishing. http://dx.doi.org/10.1177/0308022618799944.

American Occupational Therapy Association. (2018). *Transitions for Children and Youth: How Occupational Therapy Can Help.* https://www.aota.org.

American Occupational Therapy Association. (2015). *Fact Sheet: The Role of Occupational Therapy with Children and Youth*. Updated by Dottie Handley More, MS, OTR/L, and the Early Intervention & School Special Interest Section Standing Committee for the American Occupational Therapy Association. https://www.aota.org.

Arbesman, M., Bazyk, M., & Nochajski, S. M. (2013). Systematic Review of Occupational Therapy and Mental Health Promotion, Prevention, and Intervention for Children and Youth. *American Journal of Occupational Therapy*, *67*, e120-130. http://dx.doi.org/10.5014/JOR.2013.008359.

Association of Canadian Occupational Therapy Regulatory Organizations. (2012). *Essential Competencies of Practice for Occupational Therapists in Canada, 3rd Ed.* https://www.acotro-acore.org.

Association of Canadian Occupational Therapy Regulatory Organizations. (2019). *ACOTRO Position Statement regarding Utilizing Occupational Therapist Assistants in Occupational Therapy Service Delivery.* https://www.acotro-acore.org.

Association of Canadian Occupational Therapy University Programs. *Members.* Retrieved October 3, 2020, from https://www.acotup-acpue.ca/English/home.

Athabasca Health Authority (AHA). (n.d.). *A Place for Northern People to Heal*. Retrieved January 12, 2021, from https://www.athabascahealth.ca/Pages/default.aspx.

Barthel, K. (2004). *Evidence and Art: Merging Forces in Pediatric Therapy*. Labyrinth Therapies.

Bazyk, S., Demirjian, L., LaGuardia, T., Thompson-Repas, K., Conway, C., & Michaud, P. (2015). Building Capacity of Occupational Therapy Practitioners to Address the Mental Health Needs of Children and Youth: A Mixed-Methods Study of Knowledge Translation. *The American Journal of Occupational Therapy, 60*(1), 1-10. http://dx.doi.org/10.5014/ajot.2015.019182.

Boshoff, K., & Hartshorne, S. (2008). Profile of Occupational Therapy Practice in Rural and Remote South Australia. *Australian Journal of Rural Health, 16,* 255-261. https://dx.doi.org/10.1111/j.1440-1584.2008.00988.x.

Bly, L. (1994). *Motor Skills Acquisition in the First Year: an Illustrated Guide to Normal Development*. Therapy Skill Builders, a division of Communication Skill Builders.

Brunton, L. K. (2017). Clinicians Are Missing Link to Sustainable Community-Based Physical Activity Participation for Children with Disabilities. *Physical & Occupational Therapy in Pediatrics, 37*(4), 359-361. https://10.1080/01942638.2017.1327750.

Canada Government. (n.d.a.). *Crown-Indigenous Relations and Northern Affairs*. Retrieved January 11, 2021, from https://www.rcaanc-cirnac.gc.ca/eng/1450124405592/1529106060525.

Canada Government. (n.d.b.). *Healthy Workplaces.* Retrieved July 5, 2020, from https://www.canada.ca/en/health-canada/services/health-care-system/health-human-resources/strategy/healthy-workplaces.

Canada Government. (n.d.c.). *Indigenous Services - Health*. Retrieved January 11, 2021, from https://www.sac-isc.gc.ca/eng/1569861171996/1569861324236. P 91.

Canada Government. (n.d.d.). *Indigenous Services - Education*. Retrieved January 11, 2021, from https://www.sac-isc.gc.ca/eng/1476967841178/1531399315241.

Canada Government. (n.d.e.). *Indigenous Services – Regional Operations Directors of Education Directory.* Retrieved from Regional Operations ISC on June 26, 2020.

Canada Government. (n.d.f.). *Public Safety of Canada - Cyber Security.* Retrieved January 11, 2021, from https://www.publicsafety.gc.ca/cnt/ntnl-scrt/cbr-scrt/.

Canada Government. (2018). *Autism Spectrum Disorder among Children and Youth in Canada 2018: A Report of the National Autism Spectrum Disorder Surveillance System.* Retrieved December 9, 2020, from https://www.canada.ca/en/public-health/services/publications/diseases-conditions/autism-spectrum-disorder-children-youth-canada-2018.html.

Canadian Association of Occupational Therapy. (n.d.a.). *Advocacy*. Retrieved May 21, 2020, from https://caot.in1touch.org/site/adv/advocacy?nav=sidebar.

Canadian Association of Occupational Therapy. (n.d.b.). *National Occupational Therapy Certification Examination (NOTCE).* Retrieved January 12, 2021, from *https://caot.ca/site/notce/natotcertexam?nav=sidebar*.

Canadian Association of Occupational Therapy. (n.d.c.). COVID-19 – Occupational Therapists: Essential to Mental Health. Retrieved January 13, 2021, from https://www.caot.ca/site/aboutot/mentalhealthOT?nav=sidebar.

Canadian Association of Occupational Therapists. (n.d.d.). *What is Occupational Therapy*? Retrieved October 3, 2020, from https://caot.ca/site/aboutot/whatisot?nav=sidebar.

Canadian Association of Occupational Therapists. (2009a). *Joint Position Statement on Evidence-based Occupational Therapy.* https://caot.ca.

Canadian Association of Occupational Therapists. (2009b). *Position Statement: Healthy Occupations for Children and Youth*. https://caot.ca.

Canadian Association of Occupational Therapists. (2011). *Position Statement: Occupational therapy and Cultural Safety*. https://caot.ca.

Canadian Association of Occupational Therapists. (2011). *Position Statement: Tele-occupational Therapy and E-occupational Therapy*. https://caot.ca.

Canadian Association of Occupational Therapists. (2012). *Profile of Practice of Occupational Therapists in Canada.* https://www.caot.ca.

Canadian Association of Occupational Therapists. (2018). *Entry Level Education in Occupational Therapy*. https://www.caot.ca.

Canadian Association of Occupational Therapists. (2018). *Position Statement: Occupational Therapy and Indigenous Peoples*. https://www.caot.ca.

Canadian Association of Occupational Therapists. (2019). *Academic Accreditation Standards and Self-Study Guide*. https://caot.ca/accreditation.

Canadian Institute for Health Information. (2017). *Occupational Therapists, 2016: Data Tables*. Retrieved May 25, 2020, from https://OT-2016-data-tables-en—web-4.xisx.

Canadian Institute for Health Information. (2019). *Canada's Health Care Providers, 2014 – 2018 - Data Tables*. Retrieved May 25, 2020, from https://hcp-2017-data-tables-en-web-3.xisx.

Canadian Institute for Health Information. (2020a). *Canada's Health Care Providers: Provincial Profiles, 2008 to 2019 – Data Tables.* Retrieved May 25, 2020, from https://hcp-2017-data-tables-en-web-3.xisx.

Canadian Institute for Health Information. (2020b). *Occupational Therapists in Canada, 2019 – Data Tables.* Ottawa, ON.

CanChild. *Autism Spectrum Disorder.* Retrieved January 11, 2021, from https://www.canchild.ca/en/diagnoses/autism-spectrum-disorder).

Catterall, J. S., Dumais, S. A., & Hampden-Thompson, G. (2012). *The Arts and Achievement in At-Risk Youth: Findings from Four Longitudinal Studies.* National Endowment for the Arts. Research Report #55. www.arts.gov.

Chen, S. W., & Chippendale, T. (2018). Leisure as an End, Not Just a Means, in Occupational Therapy Intervention. *American Journal of Occupational Therapy, 72,* 7204347010. https://doi.org/10.5014/ajot2019.028316.

Clough, C. H. (2017). *What Influences School-Based Occupational Therapists' Decision-making? A Qualitative Study.* Theses and Dissertations. 1598. https://dc.uwm.edu/etd/1598.

Copley, J. A., Turpin, M. J., & King, T. L. (2010). Information used by an Expert Paediatric Occupational Therapist when Making Clinical Decisions. *Canadian Journal of Occupational Therapy, 77,* 240-256. https://doi.org/10.2182/cjot.2010.77.4.7.

Coughlin, K. W. (2018). Position Statement: Medical-Decision Making in Pediatrics – Infancy to Adolescents. *Paediatric Child Health, 2018, 23*(2)*,* 138–146. https://www.cps.ca/en/documents/position/medical-decision-making-in-paediatrics-infancy-to-adolescence.

Craig, J. W., Glick, C., Phillips, R., Hall, S. L., Smith, J., & Browne, J. (2015). Recommendations for Involving the Family in Developmental Care of the NICU Baby. *Journal of Perinatology, 35,* S5-S8. https://www.nature.com/jp/.

Crittendon, P. M. (2015). *Raising Parents: Attachment, Parenting and Child Safety (2nd Ed).* London, UK: Routledye. Willan Publishing.

Cusick, A. & McCluskey, A. (2000). Becoming an Evidence-based Practitioner through Professional Development. *Australian Occupational Therapy Journal, 47,* 159-170.

Dahl-Popolizio, S., Muir, S. L., Davis, K., Wade, S., & Voysey, R. (2017). Occupational Therapy in Primary Care: Determining Receptiveness of Occupational Therapists and Primary Care Providers. *The Open Journal of Occupational Therapy, 5*(3). https://doi.org/10.15453/2168-6408.1372.

D'Arrigo, R. G., Copley, J. A, Poulsen, A. A., & Ziviani, J. (2020). The Engaged Child in Occupational Therapy. *Canadian Journal of Occupational Therapy, 87*(2)*,* 127-136. https://doi:10.1177/0008417420905708.

Farre, A., & Rapley, T. (2017). The New Old (and Old New) Medical Model: Four Decades Navigating the Biomedical and Psychosocial Understandings of Health and Illness. *Healthcare*, *5,* 88; doi:10.3390/healthcare5040088. www.mdpi.com/journal/healthcare.

Freda, M. (1992). Retaining Occupational Therapists in Rehabilitation Settings: Influential Factors. *American Journal of Occupational Therapy, 46*(3)*,* 240-245.

Ginsburg, K. R., & the Committee on Communications and the Committee on Psychosocial Aspects of Child and Family Health. (2007). The Importance of Play in Promoting Healthy Child Development and Maintaining Strong Parent-Child Bonds. *American Academy of Pediatrics, 119* (1), 182-191. https://doi.org/10.1542/peds.2006-2697.

Gmitroski T., Bradley, C., Heinemann, L., Liu, G., Blanchard, P., Beck, C., Mathias, S., Leon, A., & Barbic, S. P. (2018). Barriers and Facilitators to Employment for Young Adults with Mental Illness: a Scoping Review. *BMJ Open*, 8:e024487. https://doi.org/10.1136/bmjopen-2018-024487.

Gottschalk, F. (2019). *Impacts of Technology use on Children: Exploring Literature on the Brain, Cognition and Well-being.* Organization for Economic Co-operation and Development OECD Education Working Paper No. 195. https://www.oecd.org/edu/workingpapers.

Grajo, L. C., Candler, C., & Sarafian, A. (2020). Interventions Within the Scope of Occupational Therapy to Improve Children's Academic Participation: A Systematic Review. *American Journal of Occupational Therapy*, *74,* 7402180030. https://doi.org/10.5014/ajot.2020.039016.

Gronski, M. P, Bogan, K. E., Kloeckner, J., Russell-Thomas, D. R., Taff, S. D., Walker, K. A., & Berg, C. (2013). Childhood Toxic Stress: A Community Role in Health Promotion for Occupational Therapist. *American Journal of Occupational Therapy*, 67, e148-e153. https://doi.org/10.5014/ajot.2013.008755.

Hasselbusch, A., & Dancza, K. (2012). Application of the Person-Environment-Occupation (PEO) Model in School-based Occupational Therapy. *Children, Young People & Families Occupational Therapy Journal*, p. 3.

Higa McMillan, C. K., Francis, S. E., Rith-Majarian, L., & Chorpita, B. F. (2016). Evidence Base Update: 50 Years of Research on Treatment for Child and Adolescent Anxiety. *Journal of Clinical Child & Adolescent Psychology*, *45*(2), 91-113. https://doi.org/10.1080/15374416.2015.1046177.

Hill, A. (2017). U of S hopeful it will see OT, Speech Language Pathology Programs within a Decade. *The StarPhoenix.* https://thestarphoenix.com/news/local-news/u-of-s-hopeful-it-will-see-ot-speech-language-pathology-programs-within-a-decade.

Hills, C., Ryan, S., Warren-Forward, H., & Smith, D. R. (2013). Managing 'Generation Y' Occupational Therapists: Optimising their potential. *Australian Occupational Therapy Journal*, 60, 267-275. https://doi.org./10.1111/1440-1630.12043.

Holland, K., Middleton, L., & Uys, L. (2012). Professional confidence: A concept analysis, *Scandinavian Journal of Occupational Therapy, 19*(2), 214-224. https://doi.org/10.3109/11038128.2011.583939.

Kasovac, N., Krupicka, D., Woodworth, K. & Zmuda, M. (2019). Outcomes of School-Delivery Models in School-Based Therapies. *School of Occupational Master's Capstone Projects*, 31. https://soundideas.pugetsound.edu/ot_capstone/31.

Killeen, H., Shahin, S., Bedell, G. M., & Anaby, D. R. (2018). Supporting the Participation of Youth with Physical Disabilities: Parents' Strategies. *British Journal of Occupational Therapy, 82*(3), 153- 161. https://doi.org/10.1177/0308022618808735.

Kingsley, K., & Mailloux, Z. (2013). Evidence for the Effectiveness of Different Service Delivery Models in Early Intervention Services. *American Journal of Occupational Therapy, 67*(4), 431-436. http://dx.doi.org/10.5014/ajot.2013.006171.

Lamb, A. J., & Metzler, C. A. (2014). Health Policy Perspectives-Defining the Value of Occupational Therapy: A Health Policy Lens on Research and Practice. *American Journal of Occupational Therapy, 68,* 9-14. http://dx.doi.org/10.5014/ajot.2014.681001.

Larson, R.W., & Suman, V. (1999). How Children and Adolescents Spend Time Across the World: Work, Play and Developmental Opportunities. *American Psychological Association - Psychological Bulletin, 125*(6), 701-736.

Lavoie-Tremblay, M., Paquet, M., Duchesne, M. A., Santo, A., Gavranicic, A., Courcy, F., & Gagnon, S. (2010). Retaining Nurses and Other Hospital Workers: An Intergenerational Perspective of the Work Climate. *Journal of Nursing Scholarship, 42*(4), 414-422.

Lorenzo, T., Mckinney, V., Bam, A., Signeu, V., & Sompeta, S. (2019). Mapping Participation of Disabled Youth in Sport and Other Free-time Activities to Facilitate their Livelihoods Development. *British Journal of Occupational Therapy, 82*(2), 80-89. https://doi.org/10.1177/0308022618817281.

Lynch H., & Moore, A. (2016). Play as an Occupation in Occupational Therapy. *British Journal of Occupational Therapy, 79*(9), 519–520. https://doi:10.1177/0308022616664540.

Mason, V. C., & Hennigan, M. L. (2019). Occupational Therapy Practitioners' Ratings of Job Satisfaction Factors through a Lens of Social Capital. *Occupational Therapy in HealthCare, 33*(1), 88-107. https://doi.org/10.1080/07380577.2018.1543912.

Moore, A., & Lynch, H. (2018). Play and Play Occupation: a Survey of Paediatric Occupational Therapy Practice in Ireland. *Irish Journal of Occupational Therapy, 46*(1), 59-72. https://DOI:10.1108/IJOT-08-2017-0022.

Millar, F., Doherty, M., Forster, G., McFarlane, A., & Ogilvie, P. (2013). Managing Waiting Times and Providing Equitable, Family-centred Care: a Description of Four Key Initiatives from NHS Fife Child Health Occupational Therapy Service (2006–11). *British Journal of Occupational Therapy, 76*(8), 379-383. https://doi.org/10.4276/030802213X13757040168397.

Mills, A., & Millsteed, J. (2002). Retention: An Unresolved Workforce Issue Affecting Rural Occupational Therapy Services. *Australian Occupational Therapy Journal, 49,* 170-181.

Missiuna, C. A., Pollock, N. A., Levac, D. E., Campbell, W. N., Sahagian Whalen, S. D., Bennett, S. M., Hecimovich, C. A., Gaines, B. R., Cairney, J., & Russell, D. J. (2012). Partnering for Change: An Innovative School-based Occupational Therapy Service Delivery Model for Children with Developmental Coordination Disorder. *Canadian Journal of Occupational Therapy, 79,* 41-50. https://doi:10.2182/cjot.2012.79.1.6.

Moore, K., Cruickshank, M., & Haas, M. (2006a). Job Satisfaction in Occupational Therapy: a Qualitative Investigation in Urban Australia. *Australian Occupational Therapy Journal, 53*, 18-26. https://doi.org/10.1111/j.1440-1630.2006.00539.x.

Moore, K., Cruickshank, M., & Haas, M. (2006b). The Influence of Managers on Job Satisfaction in Occupational Therapy. *British Journal of Occupational Therapy, 69*(7), 312-318.

Moore, A., & Lynch, H. (2018). Play and Play Occupation: a Survey of Paediatric Occupational Therapy Practice in Ireland. *Irish Journal of Occupational Therapy*, *46*(1). https://doi.org/10.1108/IJOT-08-2017-0022.

Moose Jaw Autism Spectrum Disorder Program. (2020). *Saskatchewan Agencies and Resources*. Retrieved January 14, 2021, from https://ssot.sk.ca/assets/main/otresources/Saskatchewan-Agencies-and-Resources-list-august-2020.pdf.

Muhajarine, N., Green, K., Sivajohanathan, D., Chellandurai, S., & Todd, T. (2014). *Evaluation of the Government of Saskatchewan's FASD-Related Services: Cognitive Disabilities Consultants and Community-Based Support Programs.* University of Saskatchewan, Saskatchewan Population Health and Evaluation Research Unit.

Murray, C., & Lawry, J. (2011). Maintenance of Professional Currency: Perceptions of Occupational Therapist. *Australian Occupational Therapy Journal, 58,* 261-269. http://doi.org/10.1111/j.1440-1630.2011.00927.x.

Nelson, D. (1997). Why the Profession of Occupational Therapy Will Flourish in the 21st Century. *American Journal of Occupational Therapy, 51.*

Newman, L., Sivaratnam, C., & Komiti, A. (2015). Attachment and Early Brain Development-neuroprotective Interventions in Infant-caregiver Therapy. *Translational Developmental Psychiatry, 3,* 28647. https://dx.doi.org/10.3402/tdp.v3.28647.

Newton-Scanlan, J., Still, M. Stewart, K., & Croaker, J. (2010). Recruitment and Retention Issues of Occupational Therapists in Mental Health: Balancing the Pull and Push. *Australian Occupational Therapy Journal, 57,* 102-110. https://doi.org/10.1111/j.1440-1630.2009.00814x.

Novak, I., & Honan, I. (2019). Effectiveness of Paediatric Occupational Therapy for Children with Disabilities: A Systematic Review. *Australian Occupational Therapy Journal, 66,* 258-273. https://doi.org./10.1111/1440-1630.125733.

Parks, S. (1992). *Inside HELP Administration and Reference Manual for using the Hawaii Early Learning Profile as a Birth to Three, Curriculum-Based Assessment*. Vort Corporation.

Pereira, R. B. (2017). Towards Inclusive Occupational Therapy: Introducing the CORE Approach for Inclusive and Occupation Focused Practice. *Australian Occupational Therapy Journal, 64,* 429-435. https://doi.org/10.1111/1440-1630.12394.

Pihlar, Z. (2012). From Activity to Participation – Occupational Therapy Intervention for CP Children. *Eastern Journal of Medicine, 17,* 199-201.

Polatajko, H. J., & Mandich, A. (2004). *Enabling Occupation in Children: the Cognitive Orientation to Daily Occupational Performance (CO-OP) Approach.* CAOT Publication ACE.

Powrie, B., Copley, J., Turpin, M., Ziviani, J., & Kolehmainen, N. (2020). The Meaning of Leisure to Children and Young People with Significant Disabilities: Implications for Optimising Participation. *British Journal of Occupational Therapy, 83*(2), 67-77. http://doi.org/10.1177/0308022619879077.

QED Information Systems Inc. (2016). *The Labour Market for Occupational Therapists in Saskatchewan: A report prepared for Saskatchewan government Ministry of Advanced Education*. Regina.

Reason, D. (2012). *A Clinical Reasoning Framework for Community Occupational Therapists – a Formative Evaluation Study.* Research Project. Otago Polytechnic, Dunedin, New Zealand.

Re-Imagine Education. (2019). *Education Re-Imagined: 12 Actions for Education*. https://www.reimagineeducation.ca.

Reupert, A., Maybery, D., & Morgan, B. (2015). The Family-focused Practice of Primary Care Clinicians: a Case of Missed Opportunities. *Journal of Mental Health, 24*(6), 357-362. https://doi.org/10.3109/09638237.2014.998803.

Rexe, K., McGibbon-Lammi, B., & von Zweck, C. (2013). Occupational Therapy: Cost-Effective Solutions for Changing Health System Needs. *Healthcare Quarterly, 16*(1), 69-75.

Richards, L. G., & Vallée, C. (2020). Not just Mortality and Morbidity, but also Functioning: Opportunities and Challenges for Occupational Therapy in the World Health Organization's Rehabilitation 2030. *Canadian Journal of Occupational Therapy*, *87*(2), 91-99. https:// DOI: 10.1177/0008417420910327.

Robinson, L. R., Htisko, R. H., Thompson, R.A., Dworkn, P. H., McCabe, M. A., Peacock, G., & Thorpe, P. G. (2017). CDC Grand Rounds: Addressing Health Disparities in Early Childhood. *Morbidity and Mortality Weekly Report - Centers for Disease Control and Prevention, 66,* 29.

Rodger, S., & Kennedy-Behr, A. (2017). *Occupation-centred Practice with Children: a Practical Guide for Occupational Therapists.* Wiley Blackwell.

Rogers, A. T., Bai, G., Lavin, R. A., & Anderson, G. F. (2017). Higher Hospital Spending on Occupational Therapy is Associated with Lower Readmission Rates. *Medical Care Research and Review, 74*(6), 668-686. https://doi.org./10.1177/1077558716666981.

Roots, R. K., Brown, H., Bainbridge, L., & Li, L. C. (2014). Rural Rehabilitation Practice: Perspectives of Occupational Therapists and Physical Therapists in British Columbia, Canada. *Rural and Remote Health, 14,* 2506. http://www.rrh.org.au.

Rourk, J. D. (1996). Roles for School-Based Occupational Therapists: Past, Present, and Future. *The American Journal of Occupational Therapy, 50*(9), 698-700.

SaskAbilities. (n.d.). *Special Needs Equipment*. Retrieved January 12, 2021, from https://www.saskabilities.ca/programs-services/daily-living-rehabilitation-services/special-needs-equipment.

Saskatchewan Advocate for Children & Youth. (2019). *Annual Report 2019*. https://www.saskadvocate.ca.

Saskatchewan Government. (n.d.a.). *Acquired Brain Injury Services*. Retrieved January 12, 2021, from https://www.saskatchewan.ca/residents/health/accessing-health-care-services/health-services-for-people-with-disabilities/acquired-brain-injury-services#access-abi-services.

Saskatchewan Government. (n.d.b.). *Autism Services*. Retrieved January 12, 2021, from https://www.saskatchewan.ca/autism#utm_campaign=q2_2015&utm_medium=short&utm_source=%2Fautism.

Saskatchewan Government. (n.d.c.). *Bureau of Statistics*. Retrieved August 9, 2020, from https://www.saskatchewan.ca/government/government-data/bureau-of-statistics.

Saskatchewan Government. (n.d.d.). *Children's Therapy Services – Service Delivery Model.* Retrieved November 30, 2020, from https://publications.saskatchewan.ca/#/products/84034.

Saskatchewan Government. (n.d.e.). *Demography and Census Reports and Statistics*. Retrieved January 12, 2021, from https://www.saskatchewan.ca/government/government-data/bureau-of-statistics/population-and-census.

Saskatchewan Government. (n.d.f.). *Group Home Listing*. Retrieved January 14, 2021, from https://www.saskatchewan.ca/search#q=Group%20home%20listing&sort=relevancy.

Saskatchewan Government. (n.d.g.). *Health.* Retrieved January 12, 2021 from https://www.saskatchewan.ca/government/government-structure/ministries/health#annual-reports.

Saskatchewan Government. (n.d.h.). *Housing and Support for People with Disabilities*. Retrieved January 12, 2020 from https://www.saskatchewan.ca/residents/family-and-social-support/people-with-disabilities/housing-and-support-for-people-with-intellectual-disabilities.

Saskatchewan Government. (n.d.i.). *K-12 School Divisions in Saskatchewan.* Retrieved January 12, 2021, from https://www.saskatchewan.ca/residents/education-and-learning/prek-12-education-early-learning-and-schools/k-12-school-divisions-in-saskatchewan.

Saskatchewan Government. (n.d.j.). *Literacy in Saskatchewan*. Retrieved January 12, 2021, from https://www.saskatchewan.ca/residents/education-and-learning/literacy-in-saskatchewan.

Saskatchewan Government. (n.d.k.). *Saskatchewan Aids to Independent Living.* Retrieved January 12, 2021, from https://www.saskatchewan.ca/residents/health/accessing-health-care-services/health-services-for-people-with-disabilities/sail.

Saskatchewan Government. (n.d.l.). *Social Services*. Retrieved January 12, 2021, from https://www.saskatchewan.ca/government/government-structure/ministries/social-services.

Saskatchewan Government. (n.d.j.). Zones in Saskatchewan. Retrieved April 10, 2021, from https://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/treatment-procedures-and-guidelines/emerging-public-health-issues/2019-novel-coronavirus/cases-and-risk-of-covid-19-in-saskatchewan/index-of-communities.

Saskatchewan Government. (2010). *Guide for Children Exposed to Violence Programs in Saskatchewan*. https://publications.saskatchewan.ca/#/products/84472.

Saskatchewan Government. (2015a). *Actualizing a Needs-Based Model*. https://publications.saskatchewan.ca/#/products/33546.

Saskatchewan Government. (2015b). *People Before Systems: Transforming the Experience of Disability in Saskatchewan: The Saskatchewan Disability Strategy*. https://www.saskatchewan.ca/disabilitystrategy#utm_campaign=q2_2015&utm_medium=short&utm_source=%2Fdisabilitystrategy.

Saskatchewan Government. (2016). *Saskatchewan's Early Years Plan 2016-2020*. https://www.saskatchewan.ca/residents/family-and-social-support/child-care/saskatchewans-early-years-plan.

Saskatchewan Government. (2017). *Inclusive Education Plan – Saskatchewan Ministry of Education*. https://publications.saskatchewan.ca/#/products/85573.

Saskatchewan Government. (2019). *Framework for a Provincial Education Plan 2020-2030*. https://publications.saskatchewan.ca/#/products/103407.

Saskatchewan Government. (2020a). *Saskatchewan Ministry of Health Plan 2020-21*. https://www.saskatchewan.ca/government/government-structure/ministries/health#annual-reports.

Saskatchewan Government. (2020b). *Saskatchewan Ministry of Social Services Plan for 2020-21*. https://www.saskatchewan.ca/government/government-structure/ministries/social-services#annual-reports.

Saskatchewan Health Authority. (n.d.a.). *Healthy People, Healthy Saskatchewan.* Retrieved January 12, 2021, from https://www.saskhealthauthority.ca/Pages/Home.aspx.

Saskatchewan Health Authority. (n.d.b.). *Mom & Kids Health Saskatchewan*. Retrieved January 12, 2021, from https://momsandkidssask.saskhealthauthority.ca/about-us/moms-kids-programs-and-services.

Saskatchewan Society of Occupational Therapists. (n.d.a.). *Continuing Competency Program*. Retrieved January 12, 2021, from https://ssot.sk.ca/standards-of-practice/continuing-competency-program.

Saskatchewan Society of Occupational Therapists. (1997). *The Occupational Therapists Act, 1997.* https://www.ssot.sk.ca.

Saskatchewan Society of Occupational Therapists. (2006). *Practice Guidelines: Assignment of Service Components to Unregulated Support Personnel*. https://www.ssot.sk.ca.

Saskatchewan Society of Occupational Therapists. (2010). *Occupational Therapy for Children: Services in Saskatchewan.* https://www.ssot.sk.ca.

Saskatchewan Society of Occupational Therapists. (2018). *Saskatchewan Society of Occupational Therapists – Bylaws under The Occupational Therapists Act, 1997.* https://www.ssot.sk.ca.

Saskatchewan Society of Occupational Therapists & Saskatchewan Pediatric Occupational Therapy Practice Network. (2019). [Unpublished results from the Occupational Therapy for Children in Saskatchewan Questionnaire and data retrieved from 2020].

Saskatchewan Society of Occupational Therapists. (2020). *Occupational Therapy Telepractice Guidelines.* https://www.ssot.sk.ca.

Schell, B. A., & Cervero, R. M. (1993). Clinical Reasoning in Occupational Therapy: An Integrative Review. *American Journal of Occupational Therapy*, *47*(7), 605-610.

Shepherd, A., Stewart, H., & Murchland, S. (2007). Mothers' Perceptions of the Introduction of a Hoist into the Family Home of Children with Physical Disabilities. *Disability and Rehabilitation: Assistive Technology. 2*(2), 117-125.

Spencer, J. E., Emery, L. J., & Schneck, C. M. (2003). Occupational Therapy in Transitioning Adolescents to Post-Secondary Activities. *American Journal of Occupational Therapy, 57,* 435-441.

StarPhoenix. (2012). *Editorial – Sask. Should Train own OTs.* The Star-Phoenix – June 7, 2012 p. 47.

Stockdale Winder, F. (2014). *Working Together for Change: A 10 Year Mental Health and Addictions Action Plan for Saskatchewan*. https://www.saskatchewan.ca.

Teeters Myers, C., Schneck, C. M., Effgen, S. K., McCormick, K. M., & Brandenburger Shasby, S. (2011). Factors Associated with Therapists' Involvement in Children's Transitions to Preschool. *American Journal of Occupational Therapy, 65,* 86-94. https://doi:10.5014/ajot.2011.09060.

Townsend, E. A., & Polatajko, H. J. (2013). *Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-being & Justice through Occupation (2nd Ed.)* Ottawa, On: CAOT-ACE.

United Nations Children's Fund. (2006). *A World Fit for Children*. https://www.unicef.org/publications/.

United Nations. (1989). *Convention on the Rights of the Child. Retrieved January 12, 2021, from https://www.unhcr.org/uk/4aa76b319.pdf.*

Waclawik, K., Jones, A. A., Gicas, K. M., O'Connor, T. A., Smith, G. N., Leonova, O., Mathias, S., Barr, A. M., Procyshyn, R. M., Lang, D. J., Woodward, M. L., MacEwan, G. W., Panenka, W. J., Yamamoto, A., Honer, W. G., & Thornton, A. E. (2019). Cognitive Impairment in Marginally Housed Youth: Prevalence and Risk Factors. *Frontiers in Public Health, 7*:270. https://10.3389/fpubh.2019.00270.

Whalley-Hammell, K. R. (2014). Belonging, Occupation and Human Well-Being: An Exploration. *Canadian Journal of Occupational Therapy, 81*(1), 39-50. https://doi.org/10.1177/0008417413520489.

Whalley-Hammell, K. R. (2018). Opportunities for Well-being: The Right to Occupational Engagement. *Canadian Journal of Occupational Therapy*, *84*(4-5), 209-222. https://doi.org/10.1177/0008417417734831.

Wielandt, P. M., & Taylor, E. (2010). Understanding Rural Practice: Implications for Occupational Therapy in Canada. *Rural and Remote Health, 10*:1488. http://www.rrh.org.au.

Wilson, A. L., & Harris, S. R. (2018). Collaborative Occupational Therapy: Teachers' Impressions of the Partnering for Change (P4C) Model. *Physical & Occupational Therapy in Pediatrics*, *38*(2), 130-142. https://doi.org/10.1080/01942638.2017.1297988.

Winn, C. S., Chisholm, B. A., Hummelbrunner, J. A., Tryssenaar, J., & Kandler, L. S. (2015). Impact of the Northern Studies Stream and Rehabilitation Studies Programs on Recruitment and Retention to Rural and Remote Practice: 2002-2010. *Rural and Remote Health, 15*:3126. http://www.rrh.org.au.

World Federation of Occupational Therapists. (2016). *Minimum Standards for the Education of Occupational Therapists.* https://www.wfot.org.

World Federation of Occupational Therapists. (2014). *Position Statement: Telehealth.* Retrieved January 13, 2021, from https://www.wfot.org/resources/telehealth.

World Federation of Occupational Therapists. (2019). *Position Statement: Occupational Therapy and Mental Health.* https://www.wfot.org/resources/occupational-therapy-and-mental-health.

World Federation of Occupational Therapists. (2020). *Quality Evaluation Strategy Tool: An Essential Guide for using Quality Indicators in Occupational Therapy.* Geneva, Switzerland: Author.

World Health Organization. (2007a). *Early Child Development*. https://who.com.

World Health Organization. (2007b). *International Classification of Functioning, Disability and Health Children and Youth Version.* https://who.com.

Acknowledgements

The Saskatchewan Society of Occupational Therapists (SSOT) and the Saskatchewan Pediatric Occupational Therapy Practice Network (SPOT) wish to thank the following individuals and groups for their contribution to the research, writing, review, and compilation of this resource document:

- the members of the Pediatric Paper Working Group (PPWG) - struck as a group of volunteers in May 2019 from SPOT members; chaired by Maureen Blight,
- Havelin Anand, Director of Government Affairs and Policy, CAOT, who provided initial expert advice suggesting short, targeted documents with high visual appeal were most effective for advocacy, and thus indirectly catalyzed the idea of creating a resource document that would support many potential advocacy and informational efforts,
- SSOT council and staff, from May 2019 through to May 2021, who contributed support with the technical aspects of surveying the SSOT membership, and who acted as links and liaisons as the PPWG navigated the larger occupational therapy community of Saskatchewan, relative to professional and regulatory interests,
- the many SSOT members who provided feedback and firsthand information via the Survey,
- SPOT leadership and members who supported the ongoing work of the PPWG,
- members of SSOT and SPOT who agreed to collect and verify information, critical to providing this highly specific collection of resource data,
- SSOT and SPOT reviewers, who provided perspectives on style, content, presentation, and potential perception, as well as guidance relating to target audiences, possible uses of the document, and further sources of information,
- the original writers of *Occupational Therapy for Children: Services in Saskatchewan - 2010,* whose work served as a catalyst, foundation, and historical reference throughout the development of the 2020 document.