Home Care Occupational Therapists Addressing Leisure Participation for Health and Well-Being

by

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Dalhousie University is located in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq. We are all Treaty people.

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Abstract

While addressing leisure occupations is well within the scope of occupational therapy, limited evidence exists regarding how home care occupational therapists (OTs) address leisure with older adults. The purpose of this study was to explore how OTs practicing in Canadian home care programs address leisure participation challenges among older adult clients in small urban and rural settings. The primary research question was: How do Canadian home care OTs address leisure participation challenges with their small urban and rural-residing older adult clients? The sub-questions ask what are the key factors and challenges, what processes are used and what supports them in this work.

Using Interpretive Description principles (Thorne, 2016), this qualitative study involved two phases: semi-structured interviews with six home care OTs from three provinces followed by a focus group to discuss and expand on initial findings.

The study revealed that OTs engage in two interwoven processes: The system process *Paving the Way for Leisure* and the clinical process *Addressing Leisure*. It identifies two types of practice settings—constrained and comprehensive—in which home care OTs operate. Three unifying themes were identified: valuing leisure, creating opportunities for leisure participation and practicing covertly to navigate systemic constraints.

The results provide novel information about how home care OTs address leisure, underscores its importance for clients' health and well-being and validates the often unseen efforts of OTs who find time to address leisure. It also provides an example of how home care OTs are navigating neoliberal constraints as street-level bureaucrats to address leisure. These findings can offer insights to new practitioners and encourage ongoing dialogue among scholars, clinical, and administrative OTs about integrating leisure interventions in home care.

Keywords: leisure, ontology, covert

List of Abbreviations Used

AusTOMs-OT: Australian Therapy Outcome Measures for Occupational Therapy

CAOT: Canadian Association of Occupational Therapists

CanMOP: Canadian Model of Occupational Participation

CMOP: Canadian Model of Occupational Performance

CMOP-E: Canadian Model of Occupational Performance and Engagement

COPM: Canadian Measure of Occupational Performance

FG: Focus group participants

FTE: Full-time equivalency

MFLPM: Meaning-focused Leisure Practice Model

OT: Occupational therapist

OT1, OT2… OT6: Refers to the OTs who were participants in this study

OTA/PTA/TA: Occupational therapy assistant/physical therapy assistant/therapy assistant

PSW: Personal support worker

SOC: Selective Optimization with Compensation

SOiL: Spirituality and Occupation in Living Model

TCPS 2: CORE: Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans: Course on Research Ethics

Glossary

Occupations: Within the profession of occupational therapy, daily activities, roles, and vocations are known as *occupations*. They are "the things [people] need to do and want to do, with the people and in the places that are important to them" (Egan & Restall, 2022b, p75). Occupational therapists and occupational scientists assert that health and well-being are attainable through occupation, occupation provides meaning, structure, and organization to a person's life and occupations are idiosyncratic. Further, occupations can have health-promoting, therapeutic benefits or may be maladaptive (Law et al., 1996; Moll et al., 2015; Polatajko et al., 2013; Wilcock & Hocking, 2015).

Leisure: For the purpose of this study the term 'leisure' is used, recognizing the dilemmas of categorizing occupation in this manner (Whalley Hammell, 2009). The meanings and experiences of occupations are subjective and something that is experienced as work by one person may be experienced as leisure by another (Weinblatt et al., 2000). The reluctance OTs may feel when considering the use of 'leisure' terminology within the Canadian health care system is also recognized (Turcotte et al., 2019).

A definition from leisure sciences is chosen for this study. It allows for a broad meaning and recognizes that the experience of the activity is what makes it leisure:

> *An experience that results from being intrinsically motivated to participate in what is perceived to be a freely chosen meaningful activity that, when engaged in competently, is a form of self-expression, contributes to a sense of identity and connectedness, and results in positive emotions such as enjoyment. (Dattilo, 2015, p. 14)*

This definition can include social participation and volunteering as forms of leisure, consistent with the leisure research found for the literature review of this study.

Rural: Definitions of "rural" are varied (du Plessis et al., 2002). For this paper, the term "rural" aims to capture OTs whose population base is away from large cities with their primary hospitals, public transit, and wide variety of community resources. A definition was sought that encompassed towns, villages, hamlets, and the countryside between them, which proved surprisingly difficult to find.

Initially, for screening the first participant the following definition was used: Rural communities in Ontario are those with a population of less than 30,000 that are greater than 30 minutes away in travel time from a community with a population of more than 30,000. (Rural and Northern Health Care Panel, 2010).

However, when the study was expanded across Canada, population size definitions from Statistics Canada (2016) were adopted. According to Statistics Canada "A population centre has a population of at least 1,000 and a population density of 400 persons or more per square kilometre… All areas outside population centres are classified as rural areas." When the definition of 'rural' was changed to the Statistics Canada version, the terminology in the study also changed to include 'small population centres'. The intention remained to focus on clients not residing in metropolitan and large urban centres who thus have different access to health and community resources and distinct transportation needs. The following definition of population centres from Statistics Canada (2016) was used to screen participants:

Small population centres: 1,000 to 29,999 people

Medium population centres: 30,000 to 99,999 people

Large urban population centres: 100,000 or more people

For readability, the term ‘small urban’ is occasionally used in this paper to refer to 'small population centres.' Additionally, in keeping with the intended concept, the term ‘rural’ throughout this paper will include ‘small population centres.’

Older adults: Adults aged 65 or older.

Home care OT: Occupational therapists who provide services directly to individual clients in their home settings within the public health system. In the Canadian home care system, these OTs may be employed directly by the home care program or through various contractual or employment arrangements with external agencies that have contracts with home care programs. Home care OTs may be compensated by salary or on a 'paid by the visit' basis, meaning they receive a flat rate for each client visit.

Care managers: Some OTs in this study reported to a health care professional who worked directly in the home care system to coordinate or manage the health care services for clients. They interpret home care policies and procedures regarding service provision. For example, care managers determine if a client qualifies for occupational therapy service and how many visits an OT would be allowed to make. The terms used for this role varied by province, either case manager or care coordinator. To avoid choosing one province’s term over the other a hybrid of both terms is used instead: ‘care managers.’ This term is substituted within direct quotations to strengthen anonymity of the participants.

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Chapter 1: Introduction

It is the work of occupational therapists (OTs) to enable their clients to participate in occupations and roles which promote their health and well-being (Polatajko et al., 2013; Wilcock & Hocking, 2015) and support their needs, values, and aspirations (Egan & Restall, 2022b). Leisure occupations have been a key domain of occupational therapy since its inception (Friedland, 1998). Significant research supports leisure's benefits to health and well-being generally (Canadian Index of Wellbeing & University of Waterloo, 2016; Mannell, 2007; Pressman et al., 2009) and in older adults specifically (Dupuis & Alzheimer, 2008; Menec, 2003; Nilsson et al., 2017; Silverstein & Parker, 2002). However, as stated by Friedland (1998), the profession chose against the arts and crafts movement for a stronger alignment with rehabilitation and biomedical science. While leisure remained a named category of occupations in modern Canadian occupational therapy models along with self-care and productivity until such categorization was recently eliminated in the new Canadian Model of Occupational Participation (CanMOP) (Egan & Restall, 2022b), limited research and my own professional experience suggests that leisure may not be routinely addressed by home care OTs (Turcotte, Larivière, et al., 2015).

Historically, using iterations of the Canadian Model of Occupational Performance and Engagement (CMOP-E), Canadian OTs working in health care systems have addressed their clients' performance, engagement, and participation of self-care, productivity, and leisure occupations within the contexts of their environments (Polatajko et al., 2013). Just as OTs see clients within their environment, home care OTs also

practice occupational therapy within environmental contexts, including rurality and a bio-medical health care system. In Canada, approximately six million people live outside of metropolitan areas (Statistics Canada, 2022a), with rural environments presenting unique barriers to leisure participation for older adults (Meisner et al., 2019) and for the rural-practicing OTs (Lannin & Longland, 2003; Waite, 2015). Canadian home care OTs, including myself, continue to practice in a health care setting based on bio-medical influences and with additional effects of the more recent neoliberal sociopolitical climate (Durocher et al., 2016; Quick et al., 2010). The purpose of this study is to explore how rural and small urban OTs working in Canada's current publicly-funded home care systems are addressing leisure participation challenges experienced by their older adult clients. Further context and rationale are presented in the following sections.

1.1 General Context

As of 2021, almost one in five Canadians were aged 65 years or older. A historically high number of adults will enter this age bracket in the next ten years and the number of older adults living beyond 85 years of age has doubled since 2001 (Statistics Canada, 2022b). Additionally, 93% of older adults are living in private households (Employment and Social Development Canada, 2022). The proportion of older adults tends to be even higher in rural Canada, estimated at 18-25 percent (Channer et al., 2021; Menec et al., 2015), as rural-born younger people move to urban areas for school and work and some retirees migrate from cities to the countryside (Channer et al., 2021; Federal/Provincial/Territorial Ministers Responsible for Seniors, 2008).

Seniors requiring health care support to remain in their homes and communities, transition from hospital, or needing care at end of life may receive in-home occupational

therapy services via Canada's public home care services, which are provided by the provinces and territories (Government of Canada, 2016). Within the realm of publicly-funded home care, the focus of occupational therapy (OT) intervention is optimizing independence in personal care and safe mobility of the older adult (Home and Community Care Support Services, 2024). No literature was found which documented the status of OTs addressing leisure in Canada with the exception of Quebec. One small Quebec study found that older adults had unmet leisure and social needs which were not addressed by their home care OTs (Turcotte, Larivière, et al., 2015).

1.2 The Role of Leisure for the Health and Well-being of Older Adults

Maintaining health and well-being in older adulthood can be positively enhanced through participation in a wide variety of leisure activities and occupations (Betts Adams et al., 2011; Menec, 2003). Benefits can be social, cognitive, spiritual, and physical. Participation can result in community-level as well as individual gains (Burt & Atkinson, 2012; Geda et al., 2011; MacLeod et al., 2016; Schneider & McCoy, 2018; Silverstein & Parker, 2002). Research with older adults shows that engaging in enjoyable leisure activities in general correlate positively with physiological and psychosocial measures related to health and well-being (Pressman et al., 2009). Studies with older adults who participate in specific leisure occupations illustrate how leisure is essential to their well-being. While health benefits of engaging in physical and social leisure activities are well documented and perhaps therefore more anticipated, solitary and sedentary activities also provide benefits. For example, participation in handwork hobbies, music, art, theatre or reading related to higher rated happiness for older adults as compared to those who did not, six years later (Menec, 2003). The wellness benefits of diverse leisure activities are

wide-ranging and include examples such as: improved cognition, social skills, and feelings of pleasure through dance (Marini et al., 2015); skill development and social connections through participation in a knitting guild (Brooks et al., 2019); sense of well-being through quilting (Burt & Atkinson, 2012); reduced anxiety through choir membership (Clements-Cortes, 2013); and biopsychosocial and spiritual benefits through Men's Shed programs (Chippendale & Boltz, 2015; Moylan et al., 2015). While most of the existing research is based on urban populations, several studies were specific to rural communities or included a mix of rural and urban populations (Leipert et al., 2011; Levasseur et al., 2015; Menec, 2003; Vogelsang, 2016).

In addition to leisure being an important occupation for the well-being of older adults, older adults identify leisure as a priority (Warner et al., 2012; Wright-St Clair, 2012). Research also suggests that it represents an unmet need for this population (Turcotte, Larivière, et al., 2015). Difficulties experienced by older adults living in Canadian rural areas include leisure participation challenges (Rozanova et al., 2012). Some older adults have no enjoyable occupations, neither at home nor within their community (Borell et al., 2001), and have difficulty performing their preferred leisure activity (Segev-Jacubovski et al., 2019; Simone & Haas, 2013). Some experience reduced participation as they move from the 65-74 age bracket to the 75 years and older age bracket (Hudon & Milan, 2016).

1.3 Theories of Leisure and Occupation

The importance of leisure within the daily lives of older adults can be understood through the application of both occupational therapy and leisure science theories. Leisure theories help to describe the importance of leisure to well-being, which can then inform

occupational therapy theories that consider the interplay of a person's environments(s) and their personhood, routines, roles and everyday occupations which includes leisure (Law et al., 1996; Polatajko et al., 2013).

One commonly cited leisure theory is the Meaning-focused Leisure Practice Model (MFLPM). The MFLPM describes how the meaning-making components of leisure provide health and life-promotion benefits (Iwasaki, 2017b, 2017a; Iwasaki et al., 2010):

> *The forms that leisure expressions take (e.g. sport, exercise, art, crafts, visits with friends) are secondary to the meanings derived from and associated with the leisure experiences, and it is the outcomes/meanings derived that present the potential contributions to these pathways. (Iwasaki et al., 2010, p. 485)*

From this theory, one can understand that leisure-based activities are idiosyncratic and when meaningful to individuals, they play an important role in their well-being. Specific to older adults, Hutchinson and Nimrod (2012) extended a model of successful aging from life-span psychology, Selective Optimization with Compensation (SOC) (Baltes & Carstensen, 1996), to explain how older adults with chronic health conditions choose and adapt leisure activities to age successfully on their terms.

The CMOP-E (Law et al., 1996; Polatajko et al., 2013) is a commonly used occupational therapy model in Canada that explicates the impact of the environment and the person's abilities on their daily occupations and emphasizes the importance of client-centered approaches. The environment aspect includes physical, social, cultural and institutional influences, and as mentioned earlier, occupations are categorized as having three over-arching purposes: occupations for self-care, productivity, and leisure. Critical theorists have asserted that these three categories of occupations are too limiting and do

not capture the full range of human occupations, perhaps resulting in OTs overlooking important occupational aspects of client's lives (Whalley Hammell, 2009). Recently the CanMOP (Egan & Restall, 2022b) has heeded these criticisms and doesn't include self-care, productivity, and leisure. However, many practicing OTs still refer to these categorizations. OTs can turn to the leisure sciences for both theories and detailed definitions specific to leisure and then can understand leisure within the broader context of other daily activities and the person's broader environment.

Leisure theories introduce an additional layer of challenge for OTs when addressing barriers to leisure participation. Whereas an effective adaptation for showering or meal preparation suggested by an OT might be directing another person to complete the task, the direct participation in many leisure tasks is how the benefit to health and well-being is derived. One cannot effectively engage in leisure by directing another person to listen to their favourite music for them, when they have lost their sense of hearing, for example. Additionally, when an OT's recommended adaptation eliminates the satisfaction derived from the activity, or where no adaptation exists, a new meaningful leisure occupation must be found, thus requiring problem-solving and creativity to tap into the subjective experience and meaning of leisure for each client.

1.4 Home Care Occupational Therapy

Public home care occupational therapy services are part of "Home and Community Health Care" (Government of Canada, 2016) providing services focused on treatment, rehabilitation or palliative care at home rather than hospital, supporting independent living rather than in long-term care facilities and supporting caregivers with family member's care needs. A goal of home and community health care is to "help

people maintain or improve their health status and quality of life" (Government of Canada, 2016). The Canadian Association of Occupational Therapists (CAOT) sees the role of OTs in home care to promote health and prevent injury by reducing barriers and encouraging participation in valued and meaningful occupations or life activities. It reports that "research has shown that home- and community-based occupational therapy services can reduce the need for physician visits and hospital (re)admissions and encourage people to participate in all life roles, thereby decreasing costs and adding immense social value to the health care system" (Canadian Association of Occupational Therapists, 2016). However rural-practicing OTs experience staff-shortages, highly diverse and complex caseloads, lack of networking opportunities, and limited community resources for their clients (Pidgeon, 2015b, 2015a; Roots et al., 2014).

Warner, Doble & Hutchinson (2012) suggested that clients may not be ready to focus on leisure pursuits while in the hospital environment, being more concerned with basic functional skills in the earliest stages of rehabilitation. They suggest that the 'right time' to address leisure occurs once the person is discharged home and the acute care episode is resolving. It was during this sort of transition when their study participants expressed feeling uncertain about their future abilities and unsure if they would be able to engage in activities that were meaningful to them. Additionally, occupations which involve community engagement or resources could be better appraised in the client's home and community setting.

1.5 Problem Statement and Research Objective

Addressing the unmet leisure occupations of older adults is well within the scope of occupational therapy and can enhance health and well-being. However, existing

research suggests that leisure is rarely addressed by Canadian home care OTs (Turcotte, Larivière, et al., 2015). Many older adults live rurally, complicating access to services including leisure options. Moreover, the processes and interventions used by OTs who do address leisure in their practice remain largely unknown.

The purpose of this research was to explore and describe how OTs working in publicly-funded home care in Canada address leisure participation with their rural-residing older adult clients.

Chapter 2: Framing the Issue: Literature Review

2.1 Introduction

This chapter provides an overview of the literature that informed the development of the research purpose, questions, and study design. Key topics explored include leisure's role in aging well in rural areas, Canadian home care occupational therapy and leisure interventions, rural occupational therapy practice and critical perspectives of occupational therapy practice. My positioning as the researcher in relations to these topics is provided at the end of the review. The literature review demonstrates that despite significant evidence indicating the value of leisure for older adults and the potential role of occupational therapy in supporting leisure occupations, little is known about how Canadian home care OTs address this issue in their practice and lesser still about how rural factors may influence their approaches.

2.2 Leisure, Older Adults, and Aging Well in Rural Areas

Participation in leisure activities is crucial for the health and well-being of older adults, who also prioritize these activities. For example, recent studies evidence that seniors are identifying leisure performance problems and goals which are important to them (Lyons et al., 2018; Nielsen, Andersen, et al., 2018). Over a third of the performance problems identified and prioritized as important by 380 85-year-olds in Denmark were related to leisure (Källdalen et al., 2012). Quebec seniors with disabilities who were receiving home care and their family described needs relating to leisure, community life, and social activities that were not being addressed (Turcotte, Larivière, et al., 2015).

Socio-economic, cultural, geographic, and systemic factors contribute to what could be described as occupational deprivation of older rural people, impeding their participation in activities and roles, including leisure (Townsend & Wilcock, 2004). Barriers such as remoteness, dwindling rural economies, poor health, and social isolation hinder social activities for older adults in rural Canadian communities (Rozanova et al., 2012). While the tight-knit character of these communities can promote social connectedness for some established residents, it poses challenges for newcomers to make social connections. Rozanova et al. also found that profound engagement in care work, compulsory altruism, lack of discretionary income, lack of social capital, smaller range of social opportunities result in unequal leisure engagement.

Diversity among older rural adults was explored by Eales, Keefe, and Keating (2008) who identified two groups of seniors: community-active and stoic older adults. Community-active seniors bring to mind images of the ideal active senior, while stoic older adults value self-reliance and privacy, often choosing to go without rather than seeking assistance. This can limit their leisure repertoire, especially when health, income, or driving status are compromised. The impact of driving retirement is particularly significant in rural areas, as highlighted by Marr's study of transportation issues in Huron County, Ontario (2015). Without a personal vehicle, rural residents face a transportation disadvantage, reducing their access to services and community-based activities. Financial barriers and advance booking requirements for the community's transportation service further restrict mobility (Marr, 2015).

Leisure plays an important role in reducing social isolation by providing a venue for social connectedness (Bruggencate et al., 2018). A ten-year survey of older Swedes

found that increased leisure participation improved subjective quality of life, with the greatest benefits seen in widowed individuals, those with functional impairments and those with minimal family contact (Silverstein & Parker, 2002). This has important implications for OTs to consider when providing service to older rural adults, who may be experiencing reduced contact with their families and friends.

These studies show that older adults are recognizing problems with leisure participation and that rural factors can exacerbate these problems, including socio-economic challenges and geographic barriers. Limited research indicates that these issues are not adequately addressed, leaving older adults in rural areas at risk of social isolation and reduced quality of life. Addressing these challenges is crucial, especially given the importance of leisure in fostering social connectedness and well-being among older adults.

2.3 Canadian Home Care Occupational Therapy and Leisure

CAOT recognizes that "residents of Canada have unequal access to occupational therapy services due to a lack of federal/provincial/territorial coordination in both funding and in the development of a pan-Canadian framework for home and community care" (CAOT, 2016). Home care services vary significantly between regions (The Canada Health Act, 1985) as the criteria for Federal funding to Provincial health care Ministries does not require, nor result in, uniformity across provinces and territories.

Due to budgetary constraints in Canadian home care systems, prioritization of treatment goals is based on system mandates in some Canadian provinces rather than individualized, client-centred goals (Freeman & Jauvin, 2018; Freeman et al., 2009). Such constraints can result in "a very limited version of occupational therapy" (Freeman

& Jauvin, 2018, p. 7) . It illustrates the disempowerment of clients and OTs described by critical theorists (Durocher et al., 2016) and the pervasive impact of neoliberal policies on clinical practices. Typical home care occupational therapy interventions in Canada as well as some other countries are often centred on the provision of assistive devices and risk management such as fall-prevention, living independently, and optimizing independence with self-care activities (Arntzen, Sveen, et al., 2019; Bonsaksen et al., 2020; Rahja et al., 2018; Turcotte, Carrier, et al., 2015). Leisure needs are often not addressed. As an example, home care wait-list management policies in Quebec prioritized fall prevention while older adults with disabilities prioritized barriers to community access and social participation (Raymond et al., 2020).

The literature indicates the importance of leisure in promoting health and well-being. Home care OTs can promote health and prevent injury by reducing barriers and encouraging participation in valued and meaningful occupations or life activities. However, OTs may encounter challenges in addressing leisure needs within the context of home care services due to budgetary constraints and regional variations in home care services.

2.3.1 Few Examples of Canadian Home Care OTs Addressing Leisure.

Leisure participation was not identified as a main focus of occupational therapy goals in the community in Canada and internationally, although a few examples of leisure interventions and their benefits are noted. In urban and rural Quebec, a study on addressing health promotion examined barriers, including barriers to leisure participation. It identified that only two of eleven OTs asked about or provided basic information about leisure activities (Turcotte, Carrier, et al., 2015). In another Canadian study, two home

care OTs who conducted an exercise group followed by 'coffee hour' with clients having multiple sclerosis were described as being in "emerging roles." These OTs stated that they avoided using the term 'leisure' when describing their group to health care managers because the intervention would not be viewed as therapeutic (Turcotte et al., 2019), suggesting leisure is a less prioritized focus for these OTs and misunderstood in the healthcare system.

There is some evidence that leisure is being addressed more frequently in other countries. For example, in Sweden, leisure/recreation was the most frequent type of activity addressed using treatment and training methods for 89 older adults. This study focussed on classifying occupational therapy interventions provided by clinicians and did not provide further detail of the interventions used (Lilja & Borell, 2001). In another Swedish study, older adults commented that their OTs had helped with enabling resumption of enjoyed occupations like gardening, taking walks, and shopping with friends (Nielsen, Bjerrum, et al., 2018). Leisure was found to be addressed less frequently in Australia with older adults having dementia (Rahja et al., 2018) where a chart audit of OTs' case notes in four community dementia programs indicated that only 6.9% of the notes documented evidence of "social and leisure" interventions. And in another Australian study, starting a community gardening group was taken on as a project by home care OTs (Quick et al., 2010).

2.3.2 Effectiveness of Home and Community Based Occupational Therapy Leisure Interventions. Two systematic reviews (Berger et al., 2013; Smallfield & Molitor, 2018) support the effectiveness of various leisure interventions for older adults. Additionally, three studies highlighted successful use of outcome measures that included

leisure as well as other occupations (Chen & Eng, 2015; Lyons et al., 2018; Nielsen, Andersen, et al., 2018).

The systematic reviews covered 28 studies conducted in home or community settings with older adults having various medical diagnoses. Another study described an in-home leisure education program after stroke led by a recreational therapist with an OT consulting when adaptations were needed (Desrosiers et al., 2007). These studies found that activity-based and group interventions show promise in helping seniors age successfully by promoting and enabling engagement in leisure occupations either at home or in their community (Chippendale & Boltz, 2015; Clark et al., 2012; Fried, 2004; MacLeod et al., 2016; Moylan et al., 2015). Interventions included leisure appreciation, awareness, and competence, self-determination, recreational activities, role-playing, goal-setting, chronic disease management, and prescription of assistive devices to support leisure participation. Smallfield and Molitor (2018) recommend routine use of nearly all leisure interventions. One exception was prescription of assistive devices to support leisure activities due to limited available research. Berger et al. (2013) developed best practice guidelines for older adults with vision loss, advocating for a problem-solving approach, improved lighting, and a combination of skills training, education, and group and home visits. They emphasize the necessity for OTs to focus on leisure and social participation.

Three additional intervention trials examined client-centred, goal-oriented outcome measures in home visit settings. The outcome measures used were the Canadian Measure of Occupational Performance (COPM) in Denmark (Nielsen, Andersen, et al., 2018), Australian Therapy Outcome Measures for Occupational Therapy (AusTOMs-OT)

in an early discharge stroke program in Singapore (Chen & Eng, 2015), and the Health Through Activity Program (which uses goal setting, problem-solving, and action planning) in a study with older American adults with cancer (Lyons et al., 2018). These studies reported that 24-29% of clients chose leisure-related goals. However, details of the leisure interventions were not included, as the studies focused on the effectiveness of the outcome tools and types of treatment goals.

Despite evidence supporting various leisure interventions, it remains unclear to what extent home care OTs use these evidence-based interventions to address leisure participation with their older adult clients. Most studies involved group formats, while home care occupational therapy services are generally provided individually. Rahja et al. suggest that clinical practice does not reflect the types of interventions shown to be effective in research (2018) and proposes addressing these knowledge gaps. It is notable that in studies where occupation-based outcome measures were used for individual sessions (e.g. goal attainment scaling, AusTOMs, or the COPM), leisure was routinely addressed along with other occupations and a larger number of sessions (range of 5-25 sessions) were provided (Chen & Eng, 2015; Lyons et al., 2018; Nielsen, Andersen, et al., 2018) than what has been my professional experience within Ontario's home care system. This suggests that regular incorporation of these outcome measures could make addressing leisure a standard practice in home care, if sufficient number of visits were possible. Additionally, Turcotte et al.'s community-based participatory research also identified the need for expanding social participation items in clinical data collection forms to support this practice (2019).

2.4 Rural Occupational Therapy Practice

No research articles studying how rural home care OTs address leisure were located. However, several studies discuss the barriers, recruitment, retention, and educational needs of OTs in rural areas across various countries, including Canada. A notable Norwegian study identified four types of practice of rural home care OTs (Arntzen, Sveen, et al., 2019).

Rural OTs face barriers such as heavy caseloads due to staff shortages (Kohler & Mayberry, 1993; Lannin & Longland, 2003; Winn et al., 2015) and cross-cultural practice challenges (Pidgeon, 2015b; Waite, 2015; Watts & Carlson, 2002). Successful rural OTs typically possess extensive generalist knowledge, case management, and administrative skills, compared to their urban counterparts (Roots et al., 2014; Wielandt & Taylor, 2010). They also demonstrate a high degree of flexibility, professional autonomy, resourcefulness, innovation (Arntzen, Sveen, et al., 2019; Roots et al., 2014; Waite, 2015), and engage in community development (Roots et al., 2014). No studies were found to explore how rural practice affects the ability to address leisure, revealing a gap in the literature.

A notable study of rural occupational therapy practice is Arntzen et al's analysis of Norwegian rural community-based OTs, which describes their professional practices, dilemmas, and priorities (2019). From this study, four "ideal types" of community OT were developed: The all-rounder, the provider of assistive devices, the fire extinguisher, and the innovator. The *provider of assistive devices* was considered the traditional community OT role. These OTs felt their role as understood by others was limited to providing assistive devices, often in systems where their practice was highly controlled by external pressures. *Fire extinguishers* were OTs working in very under-resourced

regions struggling to stay on top of their caseloads and waitlists, and feeling that their efforts were too little, too late. OTs who positioned themselves as *all-rounders* felt they had a more generalist role with a diverse client population, more autonomy to determine their role, and more time than the fire-extinguishers. Flexibility and adaptability were characteristics of this group who felt that with generalization came the lack of deep competence possible in more specialized roles. The last type they describe are the *Innovators*, which were OTs working to re-define the community OT role by moving beyond the limits of simply acting on the requests of other health professionals. "The biggest threat to innovators is a lack of opportunity to redefine their own role and limited ability to define themselves as different from being the person who orders assistive devices" (Arntzen et al., 2019, p. 8).

The characteristics of rural OTs described in this section and their practice settings could have potential impacts on addressing leisure. For instance, rural OTs may have the freedom and flexibility to prioritize leisure but may also be constrained by heavy caseloads and staff shortages. The resourcefulness and accountability typical of rural OTs might foster creative solutions for leisure activities, including developing community opportunities (Roots et al., 2014). However limited resources and heavy caseloads may reduce their ability or motivation to address leisure. Further research is required.

2.5 Critical Perspectives in Occupational Therapy and Leisure Sciences

Similar to the MFLPM description of leisure, the CMOP-E describes occupations as idiosyncratic; activities, routines, and roles important and meaningful to one person may not be for another. This assertion emphasizes client-centered practices as central to occupational therapy (World Federation of Occupational Therapists, 2012). However,

critical theorists in occupational therapy have examined the assumption that occupational therapy practice is inherently client-centered (Whalley Hammell, 2015). Others describe the ethical struggles of practicing occupational therapy holistically within the dominant biomedical power structures of the health care system, which are influenced by neoliberal mandates and limited resources (Durocher et al., 2016; Phelan, 2011). They argue that OTs are heavily influenced by the ideologies and constraints of this organizational culture, creating tensions between occupational therapy ideals of client-centered practice which may include addressing leisure goals and practice.

Critical theorists in leisure sciences have explored the tension between the principle of choice and action in leisure. They examine forces which shape, influence, pattern, pre-condition, and constrain supposed choices, values, and meanings of leisure. These many forces include personal health but also geography, culture, political, and economic realities (Rojek et al., 2006). As a result, they conclude that free choice and autonomy in leisure is deceptive. Rojek et al. provide an example of how a confluence of contexts can negatively affect the value, meaning, and choice of leisure practices for home care clients, shedding light on biases relating to leisure:

> *For most people, in most circumstances, leisure is desired; passionately so in the majority of cases. Leisure is usually presented as an unequivocal good. Yet this presupposes a variety of preconditions, among the most important of which are that we possess the health to enjoy leisure and that we have the financial means to access leisure resources. For someone in the advanced stages of multiple sclerosis or Parkinson's disease, limitless leisure may be a dreadful prospect. How are you to fill the minutes and hours pleasantly if your body has ceased to obey your will? ... Leisure is generally desired, but its quality comes with many strings attached. To participate in it with pleasure presupposes that we occupy quite secure status positions that are prior to leisure choice and inform leisure practice.*

> *Health, ownership or use of sufficient capital and paid employment are pivotal. Once these are eliminated, once we become physically ill, homeless, or suffer a significant fall in income, leisure often ceases to be valued as a self-evident good. It may swiftly become our prison. (pp. 10-11)*

This critical perspective highlights the importance of considering the broader socio-economic, cultural, and health contexts that influence individuals' capacity to engage in leisure activities. These perspectives underscore the significant challenges OTs face in maintaining client-centered leisure practices within the constraints of the current health care system.

2.6 Positioning the Researcher Within the Ideas

My professional experiences of addressing leisure with my home care clients provided the motivation for this study. Like many Canadian OTs trained in the 1990s, the Canadian Model of Occupational Performance (CMOP) (Townsend, 1997) and its later iterations (Polatajko et al., 2013; Townsend & Polatajko, 2007) formed the foundation of my understanding of how I, as a clinical OT, should approach the health and well-being of the clients with whom I work. In my work, I endeavoured to employ client-centered practices that address performance issues relating to self-care, productivity, and also leisure. Over time I've observed a narrowing of the expected role of a home care OT. In my current rural Ontario home care program, occupational therapy seems to be about assessing physical and cognitive aspects, addressing safety concerns, and fulfilling equipment needs within a predefined service plan with a dwindling number of visits per client as determined by care managers who are enacting the policies of the home care program. In this context, I have found that it is challenging to address leisure participation and I am interested to learn how other home care OTs are managing it. My

worldview, experiences, biases, and motivation are explained in more detail in the Methodology. When I embarked on this study, I anticipated that few OTs explicitly address leisure due to systemic constraints, yet I hoped to find valuable approaches to share and advocate for the recognition of leisure's role in the health and well-being of occupational therapy clients.

2.7 Summary and Implications for Research

Older adults comprise a large portion of Canada's home care clients and, as noted in Chapter 1, research has established the benefits of leisure for their health and well-being. Occupational therapy theory promotes leisure participation and the home care setting has potential to be the right time and the right place for addressing less-urgent issues of well-being (Warner et al., 2012). While a few home-based occupational therapy leisure interventions have been developed and researched, it is unknown how leisure is addressed in this setting. For example, no studies explored what strategies the OTs who are addressing leisure employed to negotiate system-level barriers. Rather, research-to-date points primarily to system barriers experienced by home care therapists preventing them from addressing health promoting occupations, including leisure (Turcotte, Carrier, et al., 2015). Rurality presents unique barriers and resources for both the older adult and the OT regarding what resources are available to access leisure opportunities. There is a paucity of research on how the unique characteristics of rural practice and environments may impact how OTs address leisure in this setting. Understanding how OTs address leisure in rural home care practices and the challenges they may encounter, will help OTs to better understand how to navigate leisure occupations to promote the health and well-being of their older adult clients.

Chapter 3: Methodology

3.1 Research Objective and Research Questions

The purpose of this research was to explore how OTs working in Canada's publicly-funded home care systems are addressing leisure participation challenges experienced by their small urban and rural-residing older adult clients.

The following research question and sub-questions guided this inquiry:

Research Question: How do Canadian home care OTs address leisure participation challenges with their small urban and rural-residing older adult clients?

Research sub-questions:

1. What are the key factors and tensions encountered when addressing leisure?
2. What processes do home care OTs use to address leisure problems with their older adult clients?
3. What supports these OTs to address leisure?

3.2 Guiding Worldview, Methodology, and Experiences

3.2.1 Worldview. My personal philosophy shares characteristics with critical realism (Maxwell & Mittapalli, 2010) which "retains ontological realism while accepting a form of epistemological relativism or constructivism" (p. 151). I believe that reality exists outside of my knowledge of it and that human knowledge will ever be imperfect and incomplete. Further, it is my belief that reality is made up of both the physical and the experienced worlds. Particularly when considering applied human science, attempting to separate material and experience results in a less complete understanding of reality. I also believe that reality can be perceived differently based on a number of factors including individual motivations, culture, and lived experiences. Epistemologically, I

prefer to explore a problem from multiple directions and perspectives so that any conclusions reached may be based in knowledge that is broad and deep, based in the physical and the experienced. In keeping with critical realism, outcomes of this study will be presented not as 'truth' but rather as warranted assertions (Maxwell & Mittapalli, 2010) and as possibilities for other clinicians to consider when reflecting on their applicability to their own clinical work. These warranted assertions are based in the context of the study participants, their current clients, work culture, and also upon the constructions developed from interactions with myself and each other during the study.

3.2.2 Methodology. Interpretive Description is chosen as the qualitative methodology for this study. It is especially appropriate for the applied sciences when it is difficult or impractical to use the traditional qualitative methodologies rigorously and in their 'pure' form. Interpretive Description was developed to investigate the complex, 'messy' clinical research questions generated within the practices of the applied science disciplines (Thorne, 2016). Initially the traditional approaches were explored for this study and found to be inappropriate. For example, the research questions do not stop at understanding the essence of the OTs' experiences with addressing leisure (phenomenology), nor was there adequate time or potential participants to reach saturation and to create a theory (grounded theory) (Creswell & Poth, 2018), which may not address the clinical nature of the research question. However, methods common to these approaches will be strategically borrowed and used within a research design based in Interpretive Description methodology. The 'description' aspect of this methodology refers to using inductive reasoning to build towards patterns (Thorne, 2016). 'Interpretation' is intended to refer to discovering socially constructed associations,

relationships, and patterns in a focussed way so the findings can be directly applied towards a more optimal clinical response. Interpretive Description is:

> *An approach that requires an integrity of purpose deriving from three sources: (1) an actual real-world question, (2) an understanding of what we do and don't know on the basis of all available empirical evidence, and (3) an appreciation for the conceptual and contextual realm within which a target audience is positioned to receive the answer we generate. (p. 40)*

The outcomes of this kind of methodology generate new insights and provide contextually-based understandings of the everyday practice world to guide future decision-making for improved client care. Interpretive Description fits with the focus of this research, which aims to understand the everyday practices of home care OTs as they address the leisure needs of their clients and generate new insights for consideration by a wider audience of home care OTs.

Methodologies used in the OTs intervention studies described in the literature review focused on the effectiveness of interventions by examining the clinical processes. However, they did not address the critical perspectives of leisure or the practice challenges described within home care systems. There is a disconnect between clinical interventions and the influence of societal and systemic values on leisure for both the OT and client in the practice setting. To better understand clinical processes and their contextual influences it is important to engage a methodology that can explore both aspects. Interpretive Description bridges these two areas. This approach encompasses both the leisure interventions and the broader context in which they are implemented.

3.2.3 Reflexivity Statement. Interpretive Description requires that, in addition to a thorough literature review, the researcher, during the planning stages must also uncover what they are bringing to the study, particularly regarding disciplinary orientation, as it

effects what the researcher decides to observe, how observations are perceived, and how sense is made from those observations (Thorne, 2016). Therefore, a presupposition interview (Spence, 2017) was completed with the thesis supervisor to articulate disciplinary orientation and professional experiences which position the researcher within the ideas for this study. Based on the conversation within this interview, the following Reflexivity Statement is offered to describe what was brought to this topic, what was expected to be found, and what was feared.

In my 15 years practicing as an OT in public home care in Ontario, I have found that the expectations of my occupational therapy role have diminished to assessing part of the person (physical and possibly cognitive components) doing some of their daily occupations (self-care and some productivity) within limited aspects of their physical and social environments (the physical space of their home and caregiving resources). Prior to my receiving a referral a care manager has already completed an assessment of the client, introduced the role of occupational therapy, and determined a service plan including focus of intervention. Within this system, I often begin addressing leisure by providing a more fulsome description of occupational therapy to clients and their caregivers when I introduce myself.

While addressing the issues outlined in the referral I also look for other potential occupational problems, including issues participating in productivity and leisure occupations. Although safety and personal care issues take precedence, I often introduce the idea of following up on leisure issues in future visits. From my experience, older adults who are in a chronic, stable health phase or going through a life-stage transition are more inclined to explore leisure issues. My decision to delve into issues beyond those in

the referral can be influenced by logistics such as fluctuating referral volumes and anticipated reactions from care managers.

When exploring leisure problems with clients, I have noticed two common scenarios. In the first, the client identifies a specific activity they are struggling with, want to resume, or wish to prevent discontinuing. In the second, the client has 'given up' nearly all leisure activities and doesn't know where to begin to rebuild a leisure repertoire. Based on various occupational therapy theories, a few intervention studies including Lyons et al. (2018), and my clinical experience I have developed my own untested approaches for addressing leisure with mixed results. I have found that knowledge of local resources, culture, and leisure opportunities in the client's rural community is important. Clients and caregivers have expressed appreciation to have a health care professional affirm the importance of these activities as meaningful and valuable to their health.

At the onset of this research, I expected to find that few OTs address leisure explicitly. I expected some might note leisure interests to understand more about the person or build rapport, rather than to address engagement issues directly. Some OTs might address leisure indirectly, where interventions for other issues incidentally benefit leisure engagement. For instance, prescribing a mobility device to reduce fall risk may also reduce barriers to engaging in leisure. I also hoped to find OTs who actively addressed leisure and had valuable approaches to share. I expected to encounter frustration due to restrictions within the home care system, such as care managers unable to approve additional visits or areas being so underserviced that OTs must focus solely on safety and self-care independence.

What I feared was that clinical OTs would not see value in studying ways to address leisure in a climate of managed resources. Choosing to use the term ‘leisure’ for this study was challenging. While consistent with the terminology used in the CMOP-E and the literature, within the medical system, 'leisure' may be perceived as a non-essential occupation and dismissed for not aligning with the serious and essential nature of health care.

Having first explored what I brought to this study and my expectations, I was able to observe subtle gaps in participants’ descriptions of their processes during their interviews and knew to probe for more details. This reflexive process to research also helped to avoid making assumptions based on my own experiences, for example there were significant nuances between individual home care systems both in Ontario and other provinces and I caught this a few times, needing to seek clarification.

3.2.4 A Note About the Pandemic. At the time of developing this study and data collection, monumental changes were occurring in health care to contain the global spread of COVID-19. Changes within home care included temporarily restricting occupational therapy practice to essential and urgent care needs, rapid implementation of virtual care, extensive use of personal protective equipment and social distancing precautions (Public Health Ontario, 2020; Williams, 2020). While not the intended focus of this research, a few leisure participation challenges relating to pandemic restrictions are described in the Findings. Also, pandemic events might have played a role in the challenges experienced with recruitment as described below (Section 3.4).

3.3 Overview of Research Design and Rationale

This section provides an overview of the research design and rationale for choice of data collection tools and study size. Interviewing and focus group were the chosen form of data collection as they allowed access to understandings of the therapists' subjective and experiential knowledge, applied practice insights and practice decisions with depth and within context (Thorne, 2016). Individual interviews provided access to individual expressions of variance and the focus group explored shared and socially constructed feedback on the emerging data analysis.

The purpose of the interviews was to obtain first-hand, detailed, contextual descriptions of the OTs' experiences with the study topic (Creswell & Poth, 2018). A semi-structured format was used to structure questions. The questions were worded to elicit contextual data and provided an opportunity for the OTs to elaborate and to share what was relevant when answering the research sub-questions from their own perspective (Charmaz, 2014; Creswell & Poth, 2018; Thorne, 2016). Virtual interviewing was necessary for nation-wide participation and social distancing requirements during the COVID-19 pandemic. Once the preliminary development of themes and practice processes from the initial interviews were completed, the OTs were invited to participate a second time, but in a virtual focus group format.

The purpose of the focus group was to elicit the OTs' reflections on the patterns, themes, and preliminary interpretations that emerged from the initial stages of analysis to further ground and refine the study results (Thorne, 2016). Questions presented to the focus group were designed to encourage sharing of ideas between group members to expand on, clarify, confirm, and elaborate the initial findings, presented as a two-page

written summary in advance of the focus group. The focus group provided an opportunity to fill gaps in the data and draw out more variations and exceptions to the identified patterns of the OTs' practices and experiences addressing leisure. Interaction between therapists with common interest in addressing leisure and variation in experiences yielded more nuanced results than relying on the separate interviews alone, as it added the element of social constructions with a group of like-minded peers (Charmaz, 2014; Thorne, 2016). The data collected from the focus group was used in the later stages of analysis to refine and ground the themes and interpretations in clinical application. This focus on clinical utility is foundational to Interpretive Description (Thorne, 2016).

There were challenges recruiting participants, however the intention was to recruit five to six participants and by amending the inclusion criteria, as described in the next section, six were recruited. This small size is suitable for a qualitative study design and the scale of a Master's-level project relating to time constraints and novice qualitative data analysis abilities. Although qualitative studies can involve much larger numbers, experts such as Creswell and Thorne have suggested that small numbers of carefully selected participants can still result in sufficient data to provide preliminary level results to research questions when extensive detail can be collected from each participant (Creswell & Poth, 2018; Thorne, 2016). Thorne emphasizes that findings from small studies need to be carefully worded to accurately reflect their limitations. This advice was followed when writing the findings and discussion sections of this thesis.

3.4 Participant Characteristics and Recruitment Strategies

Study participants were selected based on the following criteria:

• English-speaking, registered OTs practicing in Canadian publicly-funded home care programs and providing direct therapy services to older adults for at least one year, or who have worked in this capacity within the past two years

• Home care OTs whose practice includes at least 50% rural-residing older adults

• Home care OTs with experience addressing leisure participation with their older adult clients and who are interested in sharing their experiences, processes, and strategies

OTs who met these criteria were felt to be in the best position to speak to the phenomenon of interest: addressing leisure interests of older adults in rural areas of Canada.

The initial participant recruitment targeted Ontario rather than Canadian home care OTs. The initial recruitment efforts in the fall of 2020 included an advertisement in the Ontario Society for Occupational Therapists e-newsletter, on the CAOT website for two months and direct emailing to Ontario home care service provider companies, asking if they would share the recruitment posting with their OTs. This resulted in one participant. Because of this low response rate, the inclusion criteria were expanded to include home care OTs across Canada who were working with older adults in either urban and rural areas. As of 2022 there were 11,484 OTs employed in direct client care in Canada (excluding Quebec) with approximately 43% working in community health (Canadian Institute for Health Information, 2023). Community health OTs will include those working in home care, the auto insurance sector, private practice, Veteran's Affairs Canada, primary care, and others.

In the second round of recruitment, study participants were recruited by advertisement through the provincial and national associations. CAOT posted this

research opportunity on their website twice (for 60 days in the fall of 2020 and for 120 days in the summer of 2021), included a link to their research webpage in their regular e-newsletters to members, and on their Facebook page. In Summer 2021, the research advertisement was also sent to ten provincial organizations including the three CAOT provincial/territorial Chapters. Once the research posting was advertised with CAOT, snowball sampling (Creswell & Poth, 2018) was also encouraged, by sharing the advertisement with professors at Canadian occupational therapy schools who arrange student placements or do leisure-related research in Canada and asking respondents to share the posting with colleagues who may be interested. A sample of the wording used in the original research listing is included in Appendix A.

3.5 Data Collection

Data collection included a pre-screening, individual interviews and a focus group. They are described below.

3.5.1 Participant Demographic Characteristics Questionnaire. Upon indicating their interest to participate, respondents received an email or telephone call according to their preference to review the purpose of the study and answered a screening demographic questionnaire to ensure they met the inclusion criteria (Appendix B). Those who met the inclusion criteria received an email including the consent form (Appendix C) and a phone call or email, depending on their preference, to schedule the interview. One respondent did not meet the inclusion criteria as they did not work in a home care program but rather a long term care facility. They received an emailed response explaining they did not meet inclusion criteria at this time, but their contact information would be retained until completion of data collection in the event the inclusion criteria

change. Their contact info was securely destroyed as six other respondents did meet the inclusion criteria. Close to the interview date, participants were sent a pre-interview email to prepare them for the interview and encourage reflection on the research topic. See Appendix D.

3.5.2 Semi-Structured, Individual Interviews. A semi-structured interview guide (Appendix E), consisting of six open-ended questions, was developed based on reflections during development of the literature review and guided by the research questions, qualitative interviewing techniques (Morse, 1994; Spradley, 1979), Interpretive Description methods (Thorne, 2016) and intensive interviewing (Charmaz, 2014). Each of these sources provided slightly different perspectives of general directional advice for qualitative interviewing. Spradley suggests wording for explanations and main interview questions (1979). Thorne (2016) elaborates on strategies when the interviewer has direct experience with the topic and appropriate probes to use for an Interpretive Description study. Charmaz provides a series of reflection questions for revising early drafts of the interview guide (2014). The interview questions and probes were intended as examples of the types of questions to be asked during the interviews, but allowed for flexibility to further explore unexpected but related topics the participants brought forward. Interpretive Description methods utilize concurrent data collection and analysis (Thorne, 2016). As a result interview questions were adjusted slightly over the course of the interviews to confirm patterns and explore variations and gaps emerging from the early stages of analysis. As examples, OT4 was asked, “You mentioned that you can reach out to the other OTs. Do you have conversations regarding addressing leisure with them?”

and OT5 was asked, “How is it different addressing leisure as compared to other types of daily activities?”

3.5.3 Focus Group. The original interview participants were invited to participate in a focus group some months after their initial interview, allowing time to complete the initial data analysis. Completing the initial interviews took longer than the two to three months expected due to recruitment challenges, extending the process to a full year. A semi-structured focus group guide was developed, informed by Interpretive Description Methods (Thorne, 2016), see Appendix F. The questions and probes served as examples, with their exact wording adjusted based on early interview data analysis. The final wording of the primary focus group questions was included in a two-page summary of preliminary findings (Appendix G) and emailed to focus group members a few days before the session. One virtual focus group was arranged, as five of the six interview participants were able to attend on the same date, the sixth preferring to submit brief comments via email.

The interviews and focus group were conducted via videoconferencing using the platform Zoom. Interview and focus group audio data were recorded for later transcription using Voice Memo Application on the researcher’s iphone. A simultaneous, back-up recording was made using an older iphone reserved for this purpose. The interviews were 50 to 85 minutes long and the focus group was 85 minutes long.

3.6 Data Analysis

The recorded interview data was transcribed verbatim and analyzed using several steps consistent with Morse’s four sequential steps of cognitive processing which are: comprehending, synthesizing, theorizing, and recontextualizing (Morse, 1994). This

process of cognitive processing is recommended by Thorne (Thorne, 2016). The data analysis will be described under Morse's four headings. The interviews were spaced apart which allowed for concurrent data collection and analysis.

In keeping with the approved ethics submission, the interviews were transcribed by a professional transcriber, the audio recording and transcripts were stored on the researcher's password-protected computer, and NVivo software (QSR International, 2019) was used. Members of the thesis committee were consulted during the data collection and analysis phase for their expertise in conducting interviews, organizing, coding, and analyzing data. For example, the thesis supervisor read through one transcript and provided feedback on initial codes and strategies. Guidance was also provided as the codes and themes were refined. Efforts to attain a quality and trustworthy analysis are explained in the section following data analysis.

3.6.1 Comprehending. Each transcript was read several times while listening to the recordings to become fully familiar with the content and "developing a relationship with it" (Thorne, 2016, p. 167) similar to Morse's (1994) process of 'comprehending'. During this initial stage, the entire transcript was reflected on, writing early memos (Saldana, 2016), then followed manual 'pre-coding' on a printed copy of the transcripts noting passages that stood out. With repeated readings, broad-based codes or generic group signifiers were manually developed, aiming to be inductive but also guided by the research questions as recommended by Thorne (2016). As recommended by Thorne (2016), the data and initial codes were imported into NVivo (QSR International, 2019) only after becoming fully familiar with the data, developing initial codes, and reviewing them with the thesis supervisor. NVivo is a qualitative data analysis software program

available freely to Dalhousie Graduate students. Once working in NVivo, line-by-line coding was done and increasingly nuanced codes were developed (Charmaz, 2014). Charmaz emphasizes staying close to the data, preserving actions, comparing data with data, and remaining open. Thorne and Saldana also recommend experimenting with more than one coding type "trying different angles of vision" (Thorne, 2016, p. 161). Saldana provides detailed description and excerpts of coding types which I referred to, while generally keeping to types informed by constructivist grounded theory method (Charmaz, 2014). Examples are in vivo coding, coding with gerunds, coding incident with incident, causation coding (Saldana, 2016), and memoing throughout. Thorne recommends creating "analytical memos" (p. 170) to ask increasingly complex questions of the data, record observations of the data and to brainstorm ideas. Charmaz and Thorne both offer questions that were used to guide critical reflections. One of several helpful questions from Charmaz was "What is the process at issue here? How would you define it? To what extent is it explicit or does it remain implicit?" (2014, p. 169). Thorne suggests testing the developing analysis: "How else might I understand this aspect of the data?" (2016, p. 178).

3.6.2 Synthesizing. The synthesis stage refers to identifying patterns and variations in the data and 'sifting' out the non-essential components (Morse, 1994) to begin seeing relationships, keeping mindful of the research questions, and moving towards theorizing. Constant comparative methods (Charmaz, 2014; Thorne, 2016), ongoing use of analytic memos, and reviewing past notes as well as strategies suggested by Saldana (2016) like code mapping, 'coding the codes,' and code charting helped during the synthesis stage.

A draft summary of the initial findings from the individual interviews was presented to the thesis committee before sharing it with the focus group, as a mechanism for checking interpretations. Findings were presented to the thesis supervisor and then the thesis committee again after incorporating the results of the focus group. This provided learning opportunities to improve coding skills and gain deeper insights from the data. As well, the committee's review and auditing of the analysis strengthened trustworthiness and quality of findings (Saldana, 2016).

3.6.3 Theorizing. The next stage of analysis described by Morse moves from synthesis to theorizing (Morse, 1994). Theorizing is described as the process of fitting theories or models to the data and constructing alternate explanations until a best fit is found (Morse, 1994). Theorizing within an Interpretive Description study is intended to interpret the relationship between the data and the research question. Thorne suggests asking, "What pieces of the puzzle am I beginning to see?... What do they tell me about the puzzle as a whole?" (p. 177), and "If I decide to think about it in this way, what possible aspects of an issue might I be missing?" (p. 178). During the initial iteration of the theorizing stage, the focus group was conducted and a summary of the preliminary interpretations presented to them. This strategic use of focus groups allowed for testing the usefulness of the interpretations within the practice context, receiving feedback and provided an opportunity to ask the focus group members questions intended to fill identified gaps in the data (Thorne, 2016). The focus group was recorded, transcribed, and iteratively read several times. The new data compared and contrasted the new with the initial interview data and tentative theoretical findings. The focus group data clarified, elaborated, and filled gaps from the preliminary analysis. At this stage, the tentative

findings were compared with other studies and consideration was given to how the authors of those studies may interpret the findings (Thorne, 2016) before moving on to "recontextualizing" (Morse, 1994). The processes used by the OTs formed the structure from which several conceptual claims were discerned. Determining the final arrangement of the therapists' processes was arrived at by constructing alternate explanations until a best fit was found. Earlier attempts were too fragmented and wordy, they distracted from the primary analytical focus of "illuminating relevant insights" (Thorne, 2016, p. 188).

3.6.4 Recontextualizing. Recontextualization is intended to further develop the theory so that it is applicable in other settings and with other populations. This required going back to the literature including critical theories in occupational science, leisure sciences, and the new version of the CanMOP (Egan & Restall, 2022a) which was published during the writing of the Findings. Going back to the literature is necessary to place the results within the existing body of knowledge and explain its contribution to knowledge and how it has filled the gaps identified during the literature review (Morse, 1994). The original transcripts were reviewed several times for the purpose of testing theories against the full context of the interviews to ensure the analysis was staying true to the data. This was especially important as time wore on to ensure the influence of the researcher's ongoing clinical experiences took a back seat to the data provided by the participants. It was also beneficial to review the presupposition interview to be reminded of personal biases. Numerous memos were made and thesis meetings were audio-recorded for later reflection. Several iterations of the findings were completed, the analysis becoming more interpretive with each refinement.

Thorne suggests a temporal break before undertaking the recontextualization component of analysis to mentally separate summarizing the study findings from the process of reflecting differently on the findings (Thorne, 2016). In the end, due to a pandemic, full time work, and several significant life changes, the analysis and writing of the findings was completed over the course of 18 months. The result was an abundance of time to reflect differently on the findings. The product of the analysis which is hopefully achieved is a conceptual description of "thematic concepts exported from external sources or developed in situ from the data reveal[ing] latent patterns that have been discovered within the data through the application of the interpretive analytic process" (Thorne, 2016, p. 182).

3.7 Quality Considerations

The principles for rigorous and trustworthy Interpretive Description research presented by Thorne (2016) were adhered to. First, Thorne advises that "epistemological integrity" (p. 233) is a key aspect of Interpretive Description studies, where methods are informed by one or a composite of several traditions. The logic was shown to flow coherently from the stated worldview to the research question, interpretation of data and analysis. Section 3.2 described the guiding worldview as being aligned with critical realism. The research question and sub-questions sought to answer both material questions, for example, 'What processes do home care OTs use?' together with OTs' constructed meanings of their experiences with using these processes and supports. Interpretive Description fits logically within this worldview and with the research questions as it is intended to retain the complexity and context of the participants' actions and experiences. From this form of knowledge, home care OTs can identify patterns and

variations in their own experiences with treatment approaches to inform their future decisions in similar, relatable circumstances for improved client care. Research methods were informed by aspects of Constructivist Grounded Theory (Charmaz, 2014; Creswell & Poth, 2018) to generate data which includes intervention strategies used by several therapists, process patterns and variations, and shared cultural influences. Aspects of constructive grounded theory such as the constant comparison method, cross-interview analysis, line-by-line, and focused coding (Charmaz, 2014) were used, driven by the purpose of Interpretive Description to keep the analysis focus on inductive reasoning, patterns, variations, and socially constructed associations. Regarding the purpose of Interpretive Description, "It has more to do with remembering why someone from your applied field would want to be studying the phenomenon" (Thorne, 2016, p. 165) while taking care to be open to new possibilities beyond the assumptions brought to the study. The goal of the analysis in this study is developing thematic patterns and recurring ideas for use in the home care setting rather than a theoretical analysis.

Second, the research needed to show "representative credibility" (Thorne, 2016, p. 234), meaning interpretations were presented in a manner which makes explicit the limitations inherent in the sample size, representation, and level of engagement attained during the data collection. For example, presenting findings as 'warranted assertions' as described in Section 3.2. Additionally, engaging with participants on two occasions, the individual interviews, and the focus group, prolonged engagement as compared to single interviews only, strengthening credibility.

Third "analytic logic" (Thorne, 2016, p. 234) was demonstrated by extensive use of analytical memoing as described in the previous section. The use of NVivo was helpful

to provide evidence of where analytic categories can be traced back to the raw data in the transcripts. An additional unplanned form of analytical memoing emerged from virtual meetings with the thesis supervisor and committee. With their consent, recordings of the meetings using voice memos on a phone were made. Then, while traveling between rural clients or working at a desk, these recordings could be listened to for reflection and more accurately inform revisions to the analysis and writing of the findings.

Fourth and last, an attempt was made to reveal an "interpretive authority" (p. 235) to show interpretations are trustworthy, by subjecting them to the critique and feedback of the focus group and the advisory committee. As an additional step, the presupposition interview conducted by the thesis supervisor prior to data collection included questions intended to bring clarity to assumptions and preconceived ideas. It required the me to reflect upon and further delineate professional experiences and opinions with the research topic. The recording of the presupposition interview, taken together with reflexive journal entries in NVivo, was used to help bring to awareness of what was personal experience and bias of the research topic during data collection. Personal experiences were reintegrated in a conscious manner in the final sections of the Discussion.

3.8 Ethics Considerations

As a separate Ethics proposal was prepared and approved by the Ethics Review Board (see Appendix H), this section is limited to pointing out the more salient issues related to the methods planned for this study. In preparation for undertaking research, the online tutorial for the Tri-Council Policy Statement: Ethical Conduct for Research involving Humans: Course on Research Ethics (TCPS 2: CORE) (Panel on Research

Ethics, 2020) was completed. Supporting ethics documentation and templates from Dalhousie University's websites were reviewed.

Participation was considered to be minimal risk as the participants were speaking about their daily work activities during interviews and commenting on the summary of emerging themes and interpretations in the focus group. Recruitment through CAOT and provincial professional societies avoided any perceptions of feeling required to participate in the study, thus promoting voluntary participation. The study background information was provided to participants via email and they had the opportunity to ask questions prior to the interview. Verbal consent was obtained at the beginning of each interview and again prior to the focus group, ensuring ongoing informed consent. Verbal consent avoided the extra burden (cost, need for technology, or time) of having to sign and scan or mail in paper consent forms.

The key ethical challenges anticipated were the possibility of knowing a participant, implementing appropriate measures for confidential participation in the focus group, protecting identities in the completed transcript, and being respectful of participating therapists' limited time. There were two participants who knew the researcher. In accordance with the plan described in the ethics submission, potential risks were discussed with the participants prior to beginning the interview and they were offered the opportunity to discuss any concerns with the thesis supervisor or ethics review board. Both participants felt comfortable to proceed with participating in the interview and later in the focus group. Focus group participants became aware of each other's' identities and therefore anonymity was not possible. Due to the successful snowball strategy, there were two instances where focus group participants knew one

other participant. To protect each other's privacy, steps were taken to promote confidentiality as part of the informed consent process. It is possible that a participant may be identifiable from a description or quote included in the finished thesis document. To minimize this risk, identifying details within descriptions were cleaned and quotes were carefully considered before including them in the finished product.

The time commitment to participants was minimized by keeping the initial interviews under 90 minutes; interview participants were able to withdraw from the focus group participation and a two-page written summary (Appendix G) was provided to focus group participants in advance of the scheduled group meeting. As per ethical guidelines, all data was securely stored on the researcher's password protected work computer, paper copies of signed consent forms were stored in a locked file cabinet. Only anonymized transcripts were printed, then also stored in the locked file cabinet. Documents shared with the supervisory committee were deidentified and emailed using FileExchange and Dalhousie email addresses.

3.9 Summary

There is a paucity of evidence describing how OTs address leisure with older adults in home care settings. A qualitative study using Interpretive Description methodologies was designed to address this knowledge gap. Throughout planning and conducting this research thoughtful attention was given to methodological, quality, and ethical considerations. Six Canadian home care OTs participated in virtual interviews and a virtual focus group to answer the following research question: How do Canadian home care OTs address leisure participation challenges with their small urban and rural-residing older adult clients?

Chapter 4: Findings

4.1 Introduction to the Findings

The findings are structured into three sections that unpack contextual layers culminating in three conceptual claims explaining how these six OTs working in Canada's publicly-funded home care systems are addressing leisure participation challenges experienced by their small urban and rural-residing older adult clients. The first section describes the OTs and their context, including the general structure of the home care programs in which they worked and the main focus of the referrals to these programs. The next section identifies the key tensions experienced when addressing leisure, namely the valuing and undervaluing of leisure and lack of time. The third section describes the two processes that the participants engage in to address leisure: *Addressing Leisure* which is their clinical process and *Paving the Way for Leisure* which describes the OTs behind-the-scenes process of navigating their home care system to enable their clinical process. Three conceptual claims are unpacked that help to explain how the OTs engage in the two processes: *Holding tight to the value of leisure*, *Creating an opening to explore leisure participation and possibilities*, and *Practicing covertly* as a response to constrained home care culture.

The processes of *Paving the Way for Leisure* and *Addressing Leisure* are interwoven and driven by the OTs being grounded in their valuing of leisure. Addressing Leisure in the clinical setting requires the OTs to create openings to explore leisure participation as they navigate the timing of leisure interventions within the greater context of the client's occupational therapy service and the client's cultural understandings of leisure. OTs were seen to be working in two types of home care

settings, contrasted by the degree of support and resources that either facilitate or hamper Paving the Way for Leisure. Those working in the constrained programs resorted to addressing leisure covertly: addressing it without openly sharing that they were doing so with the program's care managers.

Throughout this chapter, participants' quotes and examples are used to illustrate their processes and insights. Participants are numbered and identifying information has been removed. Quotes were edited for clarity or sometimes paraphrased, making every effort to ensure the meanings of participants' words were not altered.

4.2 Situating Findings: OT Participants and Their Practice Context

This section describes the study participants and their practice context including general structure of the home care programs they work in.

4.2.1 Participant Characteristics. Six home care OTs were interviewed. Of these six participants, five also participated in the focus group (see Section 3.5.3). The home care OTs work in public health care providing occupational therapy service to clients residing in their own homes, including private residences and non-institutional assisted living settings. These OTs travel to their clients' homes and also make virtual visits by video or telephone when appropriate. The home care OTs in this study were all English-speaking. At the time of the study they all practiced within home care systems in Canadian provinces including Alberta (n=1), Newfoundland (n=2), and Ontario (n=3). They worked in urban only (n=1) and combined urban and rural (n=5) practice environments. They ranged from having four to 36 years of home care experience, with an average of 21 years' experience. Five of the six participants had caseloads with at least half of their adult clients being aged 65 years and older. The sixth participant, who

worked in a specialized program with clients having intellectual disabilities, had a smaller amount of older adults on her caseload (approximately 12 percent at the time of determining study eligibility). This participant felt that their younger clients' struggles with leisure were very similar to their older clients struggles and also verified that they had sufficient experience with older adult clients to speak to the research questions. All six participants indicated having experience with addressing leisure with some of the older adults on their caseloads.

4.2.2 Geographical Context. It is notable that this study was expanded from one province (Ontario) to all of Canada (excluding Quebec) in order to attract six participants. In the end, OTs practicing in Ontario, Newfoundland, and Alberta participated in the study. The largest urban areas served by the OTs in this study have populations ranging from 8,500 to 150,000. These urban centres were surrounded by smaller towns, villages, and countryside. All OTs worked in small or medium urban centres and also surrounding rural areas. Their practice regions spanned distances of 20 kms to 100 kms. None worked in remote or northern regions and none worked in metropolitan areas. A few communities had public transit systems and most had some form of accessible transportation service, organized by either local service clubs or the municipality.

4.2.3 Description of Home Care Programs. Two of the OTs worked in specialized home care programs and five worked in general home care programs (one OT worked in both general and specialized programs). The mission of one specialized program was providing home-based therapy to enhance participation in daily life for clients with intellectual disabilities and the other had an intensive eight-week restorative focus for clients either post-hospitalization or to prevent hospitalization following a visit

to a hospital emergency department. The OTs in the general home care programs saw themselves as "problem solvers" (OT1) toward optimizing safety and independent living. They addressed home safety issues relating to underlying physical, neurological, and cognitive impairments. They prescribed assistive devices and recommended ways to increase independence and safety with basic and instrumental activities of daily living. They provided occupational therapy services to adults and older adults with the purpose of helping clients "make plans about living safely at home" (OT6). Most of the general home care OTs worked within pay structures offering compensation on a per-visit basis and were subject to strict regulations regarding number of visits, sanctioned by the home care managers.

> *We often start with a very minimal number of visits, about two visits and then you can continue to ask for more if you have goals to work on… We need to request visits through the care manager and they need to approve visits and in order to get more visits we need to prove that we're working on things that they interpret as meaningful. (OT3)*

However, one of the general program OTs worked in a salaried position and explained it was left up to her to determine how best to manage direct time with clients based on referral volume.

Four OTs shared access to an Occupational Therapy Assistant/Physical Therapy Assistant (OTA/PTA). The assistants were shared between the OT and physical therapist and in some programs there was one OTA/PTA shared between multiple therapists. Access to the assistants was described as limited and some program mandates prioritized supporting the physiotherapy goals, "because of the high intensity of physio in this program she [the OTA/PTA] does a lot of that program" (OT2). One OT also had access to a volunteer coordinator as well as health care aides. The volunteer coordinator's role

included assisting clients who needed ongoing support for leisure participation after successful occupational therapy intervention.

Table 1: Summarizing the Practice Context of the Study Participants

Participant Attributes	**Study Participants**
Provinces of practice:	
Ontario	3
Newfoundland	2
Alberta	1
Size of the *largest* population area served by each OT:	
Metropolitan area	0
Large urban population centre	2 (pop. 150,000, 114,000)
Medium population centre	3 (pop. 31,500 – 43,000)
Small population centre	1 (pop. 8,500)
Also work with clients who reside in surrounding rural areas	5
Type of home care program:	
General	5
Specialized	2
Amount of home care experience:	
Average	21 years
Range	4-36 years

4.3 Key Factors That Influence Participants' Abilities to Address Leisure

This section explores two key factors that influence home care OTs abilities to address leisure which are: differing views of leisure's value and time as a resource for practice. A tension arises from the diverse values attributed to leisure which can support or hinder the clinical process. The second key tension framing leisure interventions was that OTs recognized the health benefits of addressing leisure, but in a time-pressured context where leisure was often undervalued, it was not prioritized.

4.3.1 Contrasting Values of Leisure. The OTs describe how the concept of leisure holds diverse meanings and significance for their clients, caregivers, society,

home care programs, and the OTs themselves. These diverse perspectives either support or create tension in the OTs clinical process of addressing leisure.

4.3.1.1 Valuing Leisure. All participating OTs valued leisure and cited its benefits. “The value of leisure is something that has always been ingrained in myself and in my life” (OT3). Some acknowledged its historical role in OT: “the roots of OT… we’ve always utilized it as part of our treatment. Be it for the physical, mental, emotional, psychological support…, and the health of the spirit” (FG). They described it as essential to self-identity and expression: “I think you need it [leisure] to be you” (FG), “The ways we socialize and the way we express ourselves are often through hobbies and leisure activities” (OT2). Leisure was also valued for the joy and pleasure it provides: “It’s way more rewarding than having a bath seat to sit on and take a shower” (OT6).

Clients were thought to value leisure as an activity that brings satisfaction, reduces loneliness and creates good memories (OT6): “A reason to get up in the morning” (OT1). Another example emphasizes the productive side of leisure as well as promoting a sense of belonging:

> *And she used her own recipes, so that [client] could take home her own baking for Christmas. So that was very important for her… So it was for [client] to feel, again, she was productive and she was able to give back to these people, to her family [by sharing the cookies] who were so good to her. (OT6)*

Loss of leisure participation was seen as losing a significant source of happiness: “They are losing a big part of what makes them happy” (OT5). Notably, the only leisure referral one OT received was from a client’s daughter who recognized the health benefits of leisure and expected OTs to address a broad range of occupations (OT5).

Several OTs commented on how society became more aware of leisure's importance during the COVID-19 pandemic, with media attention on the negative effects of isolation on older adults and creative community efforts to provide social contact and leisure opportunities.

Half of the OTs felt their program valued leisure or were open to the OT addressing it. For example, leisure fit with a program's restorative mandate and another OT felt it was expected in her role as part of overall participation and inclusion. The third OT felt that management left it up to her to decide what her occupational therapy service should include in order to best meet the client's needs and her colleagues "see great value" in her decision to use home care resources for leisure interventions (OT6).

4.3.1.2 Undervaluing Leisure. However, the deep value OTs placed on leisure contrasted with the varying values clients and caregivers placed on it: "it really depends on the person what value they place on leisure" (FG). Cultural norms, such as stoicism among farming clients, sometimes led to undervaluing leisure (OT1, OT3). OTs suggested that some clients did not prioritize leisure, accepting its loss as a part of aging: "They've just accepted that it's a loss of activity that happens with age" (OT3). Caregivers sometimes gave up on engaging elderly relatives in leisure. At the community level, the OTs described inaccessible venues (i.e., accessibility of stores, restaurants, community pool, and change rooms). They noted that communities often lacked leisure resources to support older adults with impairments, implying communities undervalue leisure participation for its older adults.

While half of the OTs felt their particular program valued leisure and supported their efforts to address it, all acknowledged that within the broader context of Canadian

home care “it’s not really their focus” (OT5). Care managers often did not see addressing leisure as a "meaningful" client goal and would not approve additional visits for it (OT1, 3, 5). “Leisure was not something that was recognized by the community care managers and the [home care] program, because of the waitlists and the extent of clients waiting for services” (FG). Referrals rarely specify the need to address leisure challenges. One OT said “never in my life have I got a referral to address someone’s leisure issues” (OT1).

4.3.2 “Time Crunch.” The dilemma of wanting to address leisure participation problems with clients but having insufficient time represented a dominant tension in the interviews. All participants expressed challenges of working with restricted numbers of visits or limited full-time equivalency (FTE). One OT said “I think my biggest challenge is time. I'm always juggling and prioritizing and half the time frustrated because I just don’t have the time” (OT6). High caseload volumes exacerbated the time challenge.

Some OTs had more time per client than their colleagues, allowing them to address leisure to a greater extent, but this was still affected by fluctuating caseloads. As one OT noted, “It’s a function of the numbers that drives what I’m able to do” (OT4). Another OT describes the tension:

> *I think what happens for a lot of therapists is the time crunch of trying to see as many clients as possible and to deal with the critical crisis issues like wounds, mobility, equipment, independence in bathrooms, and reduced home support hours, that they can’t really address leisure as much (OT2).*

Due to high caseloads and the urgency of addressing critical issues, like mobility and equipment, OTs prioritized these urgent needs but still regarded leisure activities as important. The interviews consistently highlighted the central issue of time-related challenges faced by OTs when addressing leisure issues with clients. Limited FTEs or

visits-per-referral, heavy caseloads, and the urgency of client safety concerns often hindered their ability to allocate adequate time to leisure interventions. The burden of documentation further compounded this issue (OT5), making it a complex juggling act. While some leveraged OTAs and caregiver involvement to mitigate these constraints, they too are bound by time limitations.

This illustrative case encapsulates the intricate interplay of factors such as the appreciation of leisure, the constant time constraints, and the additional constraints inherent in some practice settings:

> *Part of it was that I was working on cognition, but it's also giving her something that she enjoys to do with her time. If I had more visits to go back to follow up on actually playing a game through with her, if I could sit there for an hour or two and actually play a game and do that a couple of times, give that reinforcement, maybe we would have actually got somewhere. But I didn't do it very good justice. I felt guilty doing it [addressing leisure participation] because it didn't feel like it was the goal I'm supposed to be addressing, unfortunately, but I knew that was very important to her, so we still went through it. (OT3)*

This OT provides an example of her inner struggle when choosing to use part of the limited time she is allotted for practicing leisure-related activities with a client. The complex interplay of values and priorities surrounding leisure underscores the challenges and tensions that shape the practical implementation of addressing leisure participation within the home care context. This will be explored in detail in the next section.

4.4 Unpacking the Key Processes

The OTs in this study were seen to be engaging in two key processes: *Addressing Leisure* and *Paving the Way for Leisure. Addressing Leisure* focuses on the clinical aspects of addressing clients' leisure challenges alongside the issues presented on the

referral. To engage in this clinical process effectively, OTs also navigate the home care system in a critical parallel process termed *Paving the Way for Leisure* as some tensions and challenges described in the previous section happened outside the context of client interactions and relate more to the home care system. Thus*, Paving the Way for Leisure* involves navigating their practice setting in order to gain access to the core process of clinically addressing leisure and then maintaining that access throughout treatment. The term 'system' encompasses the policies and culture of the home care programs and also other community agencies outside of home care who provide crucial resources for successful leisure participation.

Paving the Way for Leisure has three components:

1. Choosing to address leisure: Deciding whether to include leisure intervention as part of their role in their practice setting and when time becomes especially tight,
2. Working within the system: Using what leisure supports are available within their system to enact interventions,
3. Working around the system: Finding other ways when they encounter systemic barriers to moving forward and in some situations engaging in community development to change the system.

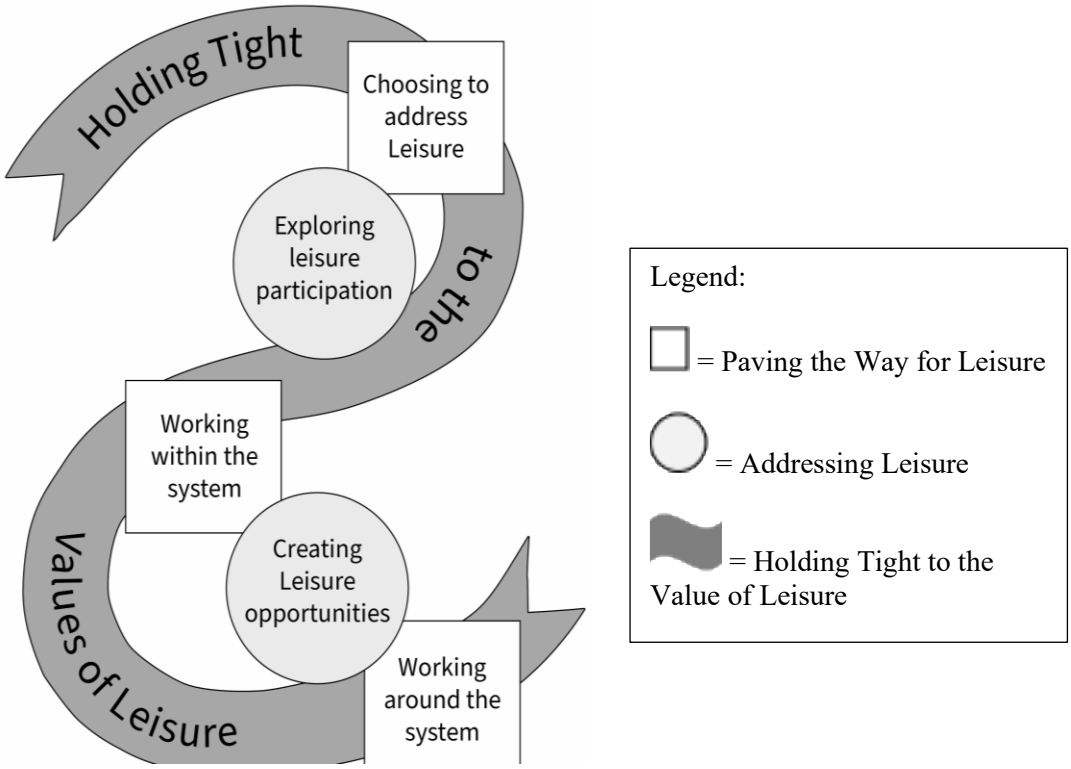
Addressing Leisure pertains to the work OTs do in the home with clients to address their leisure participation challenges. The process is arranged in two general components:

a) Exploring leisure participation: screening leisure participation, identifying leisure barriers and supports

b) Creating leisure opportunities: exploring ways to participate, implementing strategies, and following-up.

Figure 1 below illustrates the relationship between these two processes. They are interconnected, as engaging in *Addressing Leisure* (represented by grey circles in Figure 1) with the client is dependent on navigating the components of *Paving the Way for Leisure* (represented by white squares in Figure 1) which involves behind-the-scenes work relating to the culture specific to the OT's home care program. The two processes are held together and advanced by the OTs' *Holding Tight to the Value of Leisure* (represented by background dark grey ribbon in Figure 1). 'Holding tight to the value of leisure' is the first of three conceptual claims and will be unpacked later in this section. The components are described in more detail below. Although these processes are not necessarily linear, Figure 1 provides the general order that the OTs in the study tended to move through them, starting with Deciding to Address Leisure and ending with Working Around the System, if Creating Leisure Opportunities could not occur when Working Within the System. Although Creating Leisure Opportunities is depicted as occurring before Working Around the System, they often occur simultaneously.

Figure 1: Paving the Way for Leisure and Addressing Leisure Processes



4.4.1 Paving the Way for Leisure: Choosing to Address Leisure. There was considerable dialogue amongst the OT participants defending their choice to address leisure, given their assumption that it is not standard practice in home care. They did not attribute this to a different valuing of leisure by their colleagues; rather, their comments suggested they felt other OTs weren't addressing it due to severe time and program constraints. "I think every OT would agree it's important for mental health to have some leisure… I think it's nice to be able to do it. But I'd be interested in how many OTs actually do it, truly" (FG). "You know, there's no guarantee. It's not consistent, put it that way" (OT1). One OT working in a specialized program said of OTs in her neighbouring general home care program "I don't get the sense it's a major part of their practice because of the time crunch. They have to see as many people as possible as quickly as possible and efficiently as possible" (OT2). Their comments indicated that addressing

leisure is often a choice made by the individual OT rather than a program-level decision. An OT working in a general home care program describes grappling with the question of whether they are supposed to be addressing leisure because "it doesn't always feel like it's the priority, just with some of the pressures, from what I feel like I'm expected to do" (OT3). Another OT commented that when caseloads were particularly heavy, they "might have to pull back a bit" (OT4) in how much they could address leisure. The OTs in this study have made the choice to address leisure despite the obstacles of time and system expectations. This was part of the inclusion criteria:

> *It's easy enough to fit in [addressing leisure], to do a quick phone call or a quick referral, because if clients aren't – they have so much time on their hands regardless – if they're not doing something they enjoy or something functional then we're not accomplishing anything. (FG)*

4.4.2 Addressing Leisure: Exploring Leisure Participation. Once the OT commits to addressing leisure with a client, they engage in several steps to explore leisure participation, including: 1. *Screening for leisure participation* and 2. *Identifying barriers and supports*. They first screen for leisure participation, knowledge, interest, and consider the appropriate timing for addressing it. Basic leisure screening occurs either alongside the stated reason for referral or during subsequent visits. This involves choosing the right time to explore leisure, gauging client interest, beginning to understand the client's beliefs about leisure and providing initial leisure education. When the timing is right, they identify barriers and supports. This stage involves understanding barriers and supports from the client's and caregiver's perspectives, analyzing previous attempts, examining caregiver and community resource availability, and considering transportation barriers particularly in rural and small urban areas where alternatives are limited. OTs

explore driving status, outdoor mobility, and potential caregivers who can facilitate transportation for leisure activities.

4.4.2.1 Screening for Leisure Participation. The OTs described using a general assessment form with their clients which included a section on leisure and prompted them to screen this alongside the stated reason for referral. When asking clients about their leisure occupations, the OTs refrained from using the word "leisure." It was generally felt that their clients didn't use the word 'leisure'. Rather, they used terminology which suited the culture of the client and focussed on the assumed benefit for engaging in leisure occupations including identity, filling time, and enjoyment. Examples of how the OTs ask about leisure are:

> *"Have you any particular interests?"..."What did you like to do when you had all your day's work done?" (OT2),*
> *Usually I just ask them what they do for fun (OT5),*
> *I ask them, "What is it you used to do that you wish you could still do?" and a lot of the time it ends up being more related to leisure than anything else. (OT3)*

In addition to directly asking the client, they also make observations in the home environment to determine a client's leisure interests and potential leisure challenges. They also note impairments that tend to result in leisure barriers like low vision, mobility impairments, impaired hand function, social isolation, cognitive impairment, intellectual delay, mental health challenges, and driving cessation. Contextual data from this step is used later when understanding the barriers and appraising possible ways to address leisure.

If during the screening process the OT sees that leisure participation may need to be addressed, they consider when might be the right time to delve deeper. The 'right time' was usually after the client's main reasons for referral were addressed but with enough

remaining time to address the leisure issue should the client indicate interest. For instance, one OT explained that she usually addressed it toward the latter part of their interactions, as initial sessions tend to focus on the more urgent issues. She said, "in the first session when they're dealing with pain or an acute issue, they're not talking hobbies; they're talking how to get [the acute issue] over with" (OT2). Another OT explained her approach of identifying a connection point early in the process and occasionally this results in addressing leisure during the first session:

> *They feel this disease or whatever's happening to them, their life has been taken from them. You have to find one thing that you can do for them in your first visit… Find one thing where you can make a connection with them about something, that lends itself to the trust and rapport you're building with that client. (OT1)*

OTs found that clients or caregivers sometime benefited from a brief education to help them reconsider including a leisure goal as part of their occupational therapy treatment when their first answer was not to. Other times it served to reinforce and encourage a client's ongoing participation in existing activities when they were managing well. While additional education could be provided at later stages, during this screening stage it was more about helping them understand benefits of leisure they may not have considered before. One OT "tries to point out [to the client] that the therapeutic benefits of these leisure activities are also part of the recovery process" (FG). Clients who strongly emphasize work ethics might resist leisure engagement. An OT described understanding this perspective:

> *They maybe hoed and walked the bean field and the corn field, but they never went to the gym or walked down a road for 20 minutes and back for no reason, you know, other than the benefit of the exercise …So, you coin it as this is how you're going to get stronger. (OT1)*

In such scenarios, providing brief leisure education during the screening stage allows clients to reflect on it until the OT revisits the topic in a future session. When the OT identifies there is a leisure participation problem, they will move on to a more detailed assessment in collaboration with the client and caregivers.

4.4.2.2 Identifying Leisure Barriers and Potential Supports. The OT moves from the gathering of information as part of the general intake to assessing specific leisure issues through observation, discussion, and considering the intake information gathered in relationship to their leisure interests. Sometimes clients articulate their challenges, like "I'm dropping too many stitches [while knitting], I can't quite keep track of it" (OT2). Other times, the barriers become evident through the gradual assembly of information, spanning multiple visits. OTs noted that some clients had complex situations of multiple impairments and contextual barriers that when taken together made it very challenging to tackle, like the following example:

> *I had a fellow this year, he was probably in his eighties, who had lost his wife about a year ago and she was the social planner. So, his impairment was that he still had access to go for coffee with his friends, like he used to, but he didn't really want to go anymore, because he didn't want to talk about his wife. I don't think he was driving anymore, so he felt like it was difficult for him to get there. It was difficult for him to get there transportation-wise and also just difficult emotionally. (OT6)*

This example illustrates the multiple barriers that limit participation in desired leisure pursuits and the OT recognizing both emotional and practical aspects that will need to be addressed.

Participants would check with the clients to learn what they have already tried and reasons for why their attempts were successful or not:

So I look for their solutions first before I come up with solutions because sometimes they have explored things so I don't want to be the expert. I want to say, "Okay what did you come up with, what has worked for you?" (OT2)

When the leisure participation problems were more about trying to find something interesting to do, the OT would find out about previous interests to learn "what they liked about it" (OT4) then explore activities with similar benefits.

OTs also assessed the availability and willingness of caregivers to support leisure engagement. This was a crucial step because they often need to enlist caregivers to facilitate leisure participation. "We may need them in terms of either setting up activities, or actually making the connection out to the community groups and going along with them to get the process going" (FG). Caregivers included family members, friends, and neighbors and when available, more formal supports. "I think about the caregiver or the respite workers' kind of personal style and what they might be willing to participate in themselves, because they have to be game for it" (OT4). Conversely, caregiver burnout can be a part of what their treatment is addressing and in these circumstances "we're not wanting to put a burden on the caregiver to be the main support to help the client re-engage with leisure" (FG). In these situations, engaging the client in leisure can reduce the caregiver's own time crunch. "Leisure is a way to give the caregiver a break" (FG) by meaningfully occupying the client with minimal caregiver involvement.

The OTs inquired about driving status and outdoor mobility as part of their general assessment. However, for leisure purposes, they also explored whether caregivers might drive them to leisure venues in addition to medical appointments and grocery stores. If public transportation systems operated in the area, OTs inquired if the clients were already comfortable with using them and if they had financial means to travel for

non-medical purposes. This initial stage of the clinical process, exploring leisure participation, ends with the identification of leisure issues the client is willing to work on.

In order to move on to the next stage of the clinical process that involves developing interventions, the OTs also need to know who and what is available within their system and community agencies that can support their client's leisure goals. Therefore, next I will describe how the OTs mobilized exploring existing leisure supports at the systems level in order to then move on to interventions.

4.4.3 Paving the Way for Leisure: Working Within the System. Using leisure supports within the home care system helps the OTs find time or minimize time to address leisure by having ready knowledge resources, delegating some aspects to supportive allies and building connections with external agencies such as local senior centres, recreation facilities, libraries, and diagnosis-based organizations e.g. the local chapter of the Parkinson's Society.

4.4.3.1 Cultivating a Leisure Database. As the home care systems don't have existing leisure databases and as leisure and community supports are disjointed, the OTs develop and maintain their own leisure database. They are a collection of contacts, programs, and intervention ideas collected over time and stored together in a paper file or electronically. One participant describes it as "a wonderful resource base that I've built up over the years" (OT1). Most of the OTs in this study had worked in the same position for years. They were able to speak at length and in detail about what leisure resources were in their community. Clients shared details about resources in the community which the OTs add to their personal database of leisure resources for future clients:

> *If you asked every client what they're doing for leisure, someone's going to tell you something that's pretty cool, like wheelchair curling and where do you get to*

do that around here? Then you keep it in your back pocket for the next person. (FG)

They also collect resources from their network of community contacts. All OTs made reference to having a database and referring to it frequently when considering possibilities for leisure participation; it is a vital resource. However, they did not mention their home care system providing them with material for their database. It seems to be gathered and kept up-to-date by the individual therapists. This is in contrast to self-care supports organized and provided by home care systems; for example, a catalogue of assistive devices available through a home care program for trial. Particularly for those OTs who are paid only for client visits, the collecting, organizing, and maintaining of their leisure resources is done on their own time. OTs mentioned that it is challenging to keep abreast of what leisure resources are available in the community.

4.4.3.2 Delegating to Supportive Allies: Allies can be team members and caregivers who support the concept of OTs addressing leisure. Supportive teams, personal support workers (PSWs) and OTAs work with the OTs to help their clients achieve leisure-related goals. In one example, the client's caregiver was the greatest ally: "Her daughter actually was the one that pushed it, because she would have called the care manager to say we need an OT back in" (OT5). Another OT noted that social workers have a practice paradigm more closely linked with the social support model than the medical model, resulting in natural allies (OT4). Having access to support personnel to implement a therapy program for leisure was available to one of the OTs. She described how she uses this system support:

So, then I just say, "Can I bring my OTA to meet you?" Then usually we would go together and we would talk again about what it is that they would like to do in

> *their community or for a leisure project and what we are able to help them with. From there, I write a therapy program, put it in the OTA's hands, and she is the one who carries it out. (OT6)*

This OT also had access to a volunteer network and PSWs to continue the activity with the client once they had worked through the challenges in their occupational therapy and OTA sessions. Another option especially in less resourced systems was reporting the need to the client's home care manager and asking them to arrange referrals. OTs provided examples of asking the care manager to arrange referrals to Seniors' Day Programs or to a social worker to address isolation, mental health, and funding barriers (OT1, OT5).

As described in the practice context section of the findings, most of the participants worked in small urban and rural areas, where transportation options were limited or not appropriate for clients' needs. It was important for these OTs to have this local knowledge and be aware of the limitations of the transportation systems in the community that would impact social and community-based activities.

4.4.3.3. Building Connections with External Agencies. Establishing connections with other agencies provides a deeper and more confident knowledge about their resources and knowing how well they fit the client's needs. One OT calls the local library to keep up-to-date on the programs and groups running there (OT2). Another had a detailed understanding of the local accessible bus system and how it impacted her client's use of the system:

> *With the [accessible] bus there's also a lot of challenges because there's a window of half an hour or 15 minutes before or after pick up times. So it can be difficult for some of my clientele to wait - to be ready but then wait - kind of a difficult state to be in. I had one person who really loved to go swimming, and because of*

> *the way the [accessible] bus timing would work she quite often would be picked up too late to be able to do the swimming activity. (OT4)*

This OT also described understanding the policies of the accessible bus system and was planning to connect with them to discuss concerns.

Engagement with local community agencies provided OTs with valuable knowledge of available resources and expanded their professional networks related to leisure. Examples of this involvement include activities outside of work hours, such as riding the community bus to understand the client experience (OT1), and volunteering to give fall prevention talks at local senior centres. One participant noted, "I got to know all the senior centres and often referred clients to their visiting service and exercise classes" (OT1). Building connections with community resources equips OTs with a more nuanced understanding enabling more personalized solutions for clients.

4.4.4 Addressing Leisure: Creating Leisure Opportunities. In this second part of the clinical process, the OTs pull together what they have learned about the person, their leisure activity, environment, and what they have already tried. They begin to offer suggestions and when there is time and resources, to implement them. They draw on their leisure database and knowledge of system supports for potential ideas and consider their understandings of the client's culture, personality, and personal meanings of leisure when choosing how to share their information. A nuanced understanding of their resource base included knowing the physical accessibility as well as cultural aspects of programs and groups to help the client decide if they might fit in socially, "Being able to regulate emotions and behaviours to fit social norms can mean that certain settings would be difficult to manage" (OT4). One example during COVID-19 highlighted an awareness of

logistical challenges that informed her decisions about whether a community resource would be suitable for a client who used public transportation:

> *With COVID-19 and the fact that people are not allowed to wait in the setting of the pool for the GO bus ride, it's meant that lots of people who were going swimming can't go swimming now, because now they're not allowed to wait for their ride. (OT4)*

Being considerate of the client's point of view and their culture enabled the OTs to provide suggestions in a sensitive manner, "But again, you're careful to use their language, their culture, their ways of thinking to increase the possibility that they will accept your suggestions" (FG). The provision of strategies tended to be done in a gentle 'ideas' manner rather than providing the client with prescriptive recommendations:

> *"Did you know just down the road from you this club offers this?" or "Within your building are you aware that there's a library on the next floor that you could go up to and join the book group up there?" (OT2)*

When exploring ideas with the client, the OTs were also considering which interventions they could support and how in-depth they could go based on their navigation of the system. When the OT had the necessary system supports, or found a way to work around their system, they went the next step in the clinical process. They either followed up on what was discussed at a previous visit, or provided more in-depth intervention over one or more additional visits. What follows are the types of interventions used by OTs with their clients: 1. *Linking to leisure resources*, 2. *Adapting, re-learning, and finding new leisure interests*, and 3. *Getting them there*. Some interventions will be quite familiar to OTs and so descriptions are limited to the more unique aspects of how these OTs applied the interventions to leisure.

4.4.4.1 Linking to Leisure Resources. The most commonly discussed intervention was linking their clients with appropriate leisure opportunities and supports. These links were to direct sources of leisure activities like local clubs, building informal social networks, referrals to help overcome impairment barriers (e.g. Social worker, Arthritis Society, low vision specialists) or arranging a means of transportation.

Therapists helped clients use their own social network for engaging in mutual interests, navigating and sourcing resources, and providing encouragement. This therapist illustrated how she helped her client talk to a neighbor about moving beyond her usual brief check-ins to enjoying mutually beneficial leisure activities:

> *I had a 103 year old recently and she had a neighbour who used to check in, and her neighbour said, "I want to be upfront. I'm 87, okay, so I'm not taking on too much." I said, "I get it, but if you both watch the same show could you watch it together, or you seem to like to – you run an errand for her – could you stay and share that activity?" (OT2)*

Social workers were sometimes used as a resource when there was a significant mental or emotional health barrier: "There is a definite need here. I'm not here to manage this and so I need a social worker" (OT1). Additionally, social workers helped obtain funding for leisure-related activities and equipment and shared their knowledge of community leisure resources (OT4).

Linking the client to another person, group or agency was a common leisure intervention, and it utilized their leisure database of resources. This strategy was also perceived as requiring less therapist time as compared to more direct interventions. Sometimes they provided contact information about community resources and the client or family investigated it further on their own. However, the OTs emphasized the importance of ensuring time to follow up on their initial suggestions or referrals. They

followed up with clients to help work through obstacles and to ensure that the connection was successful: “I think giving yourself enough time to link them with the community services and getting the feedback of a follow-up from community services ... The families and client very much appreciated that” (FG). When the OT lacks the time to address it themselves, they may report the need to the client's home care manager, recommending referral to a service like a Day Program.

4.4.4.2 Adapting, Re-learning, and Finding New Leisure Interests. Participants described adapting or modifying the leisure activity using traditional occupational therapy strategies like using assistive devices and modifications, scaling down or grading up the activity, and pacing. Examples for managing activity tolerance during leisure activities include spreading a project over a longer timeframe, positioning chairs throughout a garden for rest spots and planning ahead to allow for an enjoyable but tiring activity, as well as taking on smaller projects such as moving from knitting dishcloths rather than Afghans. Reduced hand function, vision, and sometimes cognition can be addressed by moving to less dexterous versions: “You can do a much chunkier kind of rug hooking” (OT2). When a client is no longer able to engage in solitary leisure activities, OTs suggested they do it with another person, like a friend or caregiver. In the following example, the participant is encouraging the client to participate in leisure by joining her daughter in a shared interest.

> *“…Oh my daughter makes that stuff,” she said. I said, “Okay, can you help her lay out the squares for a quilt? Show her how to do a pattern with the colours… so that you have participation in the activity even if it’s not your hands shoving it through the sewing machine” (OT2)*

This collaborative approach allows for shared leisure experiences and enabling clients to continue participating in activities they enjoy.

Another common intervention was stepping back with the client to examine how the activity provides them enjoyment or identity, then "changing up the scenario" (OT2). In the examples provided by participants, clients were able to overcome barriers related to reduced activity tolerance, mobility, cognitive decline, and vision loss by changing the scenario while holding to the valued aspect of the leisure activity (OT1, OT3, OT5). Here is one such example:

> *I know a client at the moment who has sudden visual loss. [Before experiencing the vision loss] she started a girl's card night and they used to play board games. This group of girlfriends used to get together, and the client said, "What the hell are we going to do now?" I'm having to help her say, "Well there are ways to play some games…" The client said, "but I'm not very good at technology," and I said, "but maybe the group needs to think of other activities, so they might go to a concert or they might go for walks together and finding ways to do some social things like board games that are more audio..." OT2*

This flexible approach preserves the valued aspects of leisure activities. It helps clients shift their perspective and find alternative ways to engage in meaningful activities despite challenges related to health or abilities.

Conversations extending across several visits may be needed to explore new ways of participating in leisure activities. Continuing from the Girl's Night example above:

> *…But that's a lot of digging to let them know that there are ways to do things. I told her "I know it's a huge loss for you but maybe we could figure out with your girlfriends other ways to do things so you have your socialization together without losing it all" (OT2)*

Some trial and error, and time to reflect and talk with the others involved in the leisure activities is needed to find a workable solution. Some types of interventions, like the one above, extend over several sessions. Teaching or re-teaching the client a leisure activity or new task to facilitate leisure, like learning Zoom or how to use the accessible bus also took additional time for the client to build skill and confidence. In the following example, an OT describes helping a client to re-learn a favourite pastime with the new barrier of a cognitive impairment:

> *I had a client one time who used to play cribbage. It was a game that she used to very, very much enjoy playing. So I actually booked a visit to specifically go through the rules of this game. She was very interested in starting to play again and practice again. So we met up and went through it. She seemed to catch on to the rules, but it's really hard to get somebody comfortable with a game again in one visit. (OT3)*

When time was especially restricted the OTs were limited to a brief collaboration on potential strategies, leaving the client and their caregiver to work it out on their own. With a bit more time they would trial the suggestions with the client, then perhaps teach the caregiver so the caregiver can continue to work on it with the client. Others have access to OTAs and will utilize them to teach the client skills. One OT (OT6) had access to a volunteer network and PSWs to sustain the activity with the client after the occupational therapy service ended.

4.4.4.3 Getting Them There. As described earlier, the OTs often helped link the clients to overcome mobility and transportation limitations in order to access leisure venues. Rural terrain presented mobility challenges:

> *They like to spend a lot of time outside, going next to a river and having a boil-up or a mug-up or a meal. [The caregivers] also have fields where they take care of*

their vegetables and they like to have [the client] come along. But when he could no longer walk they found it really difficult to get him close to those activities. (OT4)

Heightened reliance on personal transportation in rural areas amplified issues around access to leisure; how to get there and who was going to get them there:

When they live in the rural areas their whole life is bound around the fact you can drive...
...and if you can't drive you're done ....
...And when their friends can't drive they're all in more trouble
(2 FG members in dialogue).

Sometimes, linking a client with either public or informal transportation options was insufficient to overcome this barrier. For example, the OTs explained that clients accustomed to using personal vehicles were often unfamiliar with public transit and accessible van services. One OT described making use of their OTA for teaching clients to use the accessible bus service so they could become confident and familiar with it:

We worked with her with being able to access that little pharmacy's coffee shop just by walking out her apartment door and walking for fifteen minutes to get there. Accomplished that. Taught her how to use the Handy bus to get to further away places to go for coffee or for lunch, accomplished that. (OT6)

Participants also recognized that prescribing mobility devices and facilitating funding for barrier-free modifications also remove barriers to leisure:

"Is there anything else he wants to do when he's in his chair?" I always ask that question, because that matters… Well, as an OT you always assess that part. It may not be coined 'leisure' though, but it is. This fellow wants to be able to get outside on his own and go somewhere on his own and he should be able to. If function is not great in the manual chair they need an alternative... But I don't think if I had pursued that he would have ended up with [a power] chair, because no one would know. (OT1)

In these instances, OTs aimed to not only identify transportation solutions for clients, but also explored opportunities for addressing mobility limitations and recommended equipment that could enhance independence, ultimately opening doors to more leisure participation. Another OT (OT4) used additional time to configure wheelchairs to go places for leisure instead of just homes and stores, and helped to acquire a second device more suitable for the physical environments where the client's leisure activity takes place.

At times the intervention ended after exploring potential solutions, or after leaving messages with community agencies: "You link them with those programs and hopefully somebody follows up. And, that's what you say in your report [to the care manager]. You're done, you can't go back. You don't have visits." (OT1). However, when they were able to squeeze in a follow up, or had "the luxury" (OT2) of time and supports to address leisure in more depth, there was more confidence that the client's leisure goals were met.

4.4.5 Paving the Way for Leisure: Working Around the System. When the home care system lacks explicit support for addressing leisure, the OTs in this study find alternative ways to incorporate leisure interventions within the system constraints by *working around the system*. To navigate these obstacles, they 1. *Exploit system ambiguities and*, 2. *Anchor leisure interventions to the primary referral goals*. Finally, a few OTs in this study actively seek to 3. *Change the system* by utilizing community development techniques to create new leisure opportunities for their clients. In this part of Paving the Way for Leisure, the third conceptual claim emerges: *Proceeding covertly as a response to constrained system culture*. It will be discussed in detail later in this chapter.

4.4.5.1 Exploiting System Ambiguities. OTs working in constrained home care systems exploited ambiguities in their system as a strategy to help them with Paving the

Way for Leisure. They did this by justifying the inclusion of leisure when it was not in the referral, using their time flexibly, and considering the likelihood of informal support by that client's home care manager for going this extra step. Not receiving specific referrals for addressing leisure problems could easily prevent starting the whole process. For some of these therapists this wording was a stumbling block because it emphasized with every incoming referral that the primary role of occupational therapy in home care doesn't include leisure. A lot of the decision-making regarding choosing to address leisure and exploiting system ambiguities came from needing to work around the referral wording or justify including leisure when it not the focus of the referral. One strategy used by participant OTs was to interpret referral requests broadly. For example, one participant stated, "I feel like I need to interpret it as 'How can I also address leisure when I'm looking at this'" (OT3). During the focus group one OT explained that she interpreted the stated referral reason broadly not only because she considers it to be part of her role, but also because she didn't expect the referral sources to understand the full range of occupational therapy service:

> *I think it's easier to just get those referrals based on what people know OTs do. Because some care managers still don't really know what OTs do and the referrals aren't appropriate. So, I'm not so worried that leisure doesn't show up on the referrals. It's just part of our full scope of practice that you would ask it all anyways. (FG)*

Although the OTs did not receive referrals specifically for addressing leisure, they stayed on track with addressing leisure by habitually completing a full occupational therapy assessment including asking about leisure.

The participants described their understandings of their program limitations regarding addressing leisure and the best way to squeeze it in. They made use of a

leftover visit to address leisure e.g., the referral came with three authorized visits, but only two were needed to address the non-leisure goals. They also worked on the leisure goal using time left over in a visit when the other goals were accomplished quickly, or stayed longer; voluntarily lengthening their work day. Some felt they were free to address leisure within the visits granted by the care manager but fully expected they would be unsuccessful with getting additional time. They would need to work within the bounds of the authorized visits, "I couldn't ask for an extra visit from the care manager because I wanted to assess and make sure the leisure needs were met. Are you kidding me?... It's just no" (OT1). However, they conceded there may be rare occasions when a care manager, open to interpreting the system's boundaries more flexibly, may grant an extra visit: "If you have a care manager who understands that and they have a supervisor who allows it, good. I'll advocate" (OT1).

In one home care program, clients were assigned to different types of caseloads--either acute, chronic or palliative/complex. The boundary for addressing leisure was perceived as being different depending on which caseload the client was assigned to:

> *I think that with the acute caseloads the care managers are a little bit more stringent with how many visits you can ask for and the length of time that you have to work with people. I think that it needs to be a lot more focused on general safety, is what I feel with a lot of that population. (OT3)*

Likewise, there was more leniency to address leisure issues in the specialized programs versus standard home care program.

4.4.5.2 Anchoring Leisure to the Primary Referral Goals. Some OTs needed to make sure they were reporting other goals in addition to the leisure goal for the occupational therapy service to be legitimate in the eyes of the care manager, "If the only

goal on my report was that I was working on leisure, they would shut me down" (OT5). "I think if I asked for a visit just to work on returning to leisure activities they would probably ask for more justification of "what else are you working on" from other goals more related to home safety" (OT3). Therefore, wording their goals and treatment plans in a way that linked the leisure participation to the reason for referral was a way of anchoring leisure to other goals. It was a way to effectively work around a system that does not value leisure: "I would use whatever I'm working on in leisure, if it was visual issues, or memory for example, and I would tie it back somehow to home safety or something and work it that way" (OT1).

4.4.5.3 Changing the System. A few of the OTs in this study described creating new leisure opportunities for their clients using community development techniques either as part of their home care role or outside of it. Community development was not an accessible option for all OTs as it was too far removed from their home care role, and some lacked time or know-how for this process: "There's no time to fit that in, and I wouldn't actually know where to start, oh my gosh" (FG).

OTs described engaging in a variety of strategies to increase the accessibility of leisure within their communities. For example, one of the participants was able to dedicate work time to have discussions with the community's accessible bus agency regarding the issues her clients were having with specific barriers within that transportation system (OT4). This participant also described how she persisted in working with a city to make a community pool accessible over multiple years and through several set-backs. Another participant also spoke of engaging with 'the city' to avoid having a public swimming pool renovated in a way that would render it less

accessible for older adults (OT2). A third OT shared that she used her role in municipal politics, outside of her occupational therapy position, to help improve the public transportation system in her community to benefit the older adults in the community as well as her clients (OT1).

While techniques for creating new leisure opportunities at a community-level are not readily available to all OTs in the study due to system constraints, some participants used this approach to advocate for their clients' opportunities for leisure participation. These efforts reflect the commitment of OTs to enrich the leisure options available to their clients and the broader community.

4.4.6 Summarizing the Two Processes. The OTs in this study engaged in two key processes: Addressing Leisure and Paving the Way for Leisure. Paving the Way for Leisure requires OTs to decide to include leisure interventions, utilize available supports, and find alternatives when faced with systemic barriers, sometimes engaging in community development. Addressing Leisure itself involves screening and identifying leisure barriers and supports, then implementing strategies, and following up. These processes are interconnected, as successfully addressing leisure depends on effectively navigating the home care system. The OTs' strong value of leisure holds the processes together and transitions into the next section, 'Unpacking the Conceptual Claims.'

4.5 Unpacking the Conceptual Claims

Throughout the representations of the two processes, several conceptual claims are noted as additional, more interpretive findings. These claims reveal latent patterns that have been discovered within the data through the application of the interpretive

analytic process. There were three claims: Holding tight to the value of leisure; Creating an opening to explore leisure participation and possibilities; and, Practicing covertly.

4.5.1 Conceptual Claim #1: Holding Tight to the Value of Leisure. The valuing of leisure by the OTs was the driving force motivating them through the complex processes of addressing leisure and navigating the system so they were able to address leisure. Throughout their descriptions of their processes, the OTs shared explanations of why they are committed to leisure despite the tensions and challenges, such as this example:

> *Part of it is trying to encourage people to be active and to be social because it's good for your mental and physical health. It's all very connected. Leisure is so connected, even to self-care. People are going to shower because they know they're going out to their card game. People are going to want to stay active so that they can still participate in their lawn bowling league. It's a motivator and it is activity that keeps people healthy, gives them reasons to get out of bed, and leave the house. I think it is really good for people. (OT3)*

These OTs observed their clients benefitting in the form of enhanced leisure participation, whether it's the resumption of activities, the adoption of alternative activities, or the pursuit of entirely new ones. The benefits included physical aspects encompassing mobility, activity tolerance, and hand use. Better emotional regulation ("the client's face would light up and he was less engaged in another sort of behaviour" (OT4)), reduced stress, increased joy, and personal fulfillment ("life is brighter for them" (FG)) were also described as outcomes for engaging in leisure. They commented on it being a high value occupation for older adults as "working people have productivity to fill their times, but as people get older, a bigger portion of their time is spent doing leisure activities" (OT3), "well, leisure is probably your day" (OT5). Anticipating these outcomes supported the

therapists' valuing of leisure and their motivation to address it even though it is difficult to do within home care systems. Holding tight to the value of leisure serves as a foundational thread woven through the two processes. The significance attributed to leisure by these OTs is a driving force, motivating them through the process, serving as a guiding principle and recognizing its direct impact on health and well-being. Grounded in the potential benefits of leisure for their clients, the OTs worked their way through the two processes.

4.5.2 Conceptual Claim #2: Creating an Opening to Explore Leisure Participation and Possibilities.

The second conceptual claim emerges during the clinical process; the OTs were *creating an opening to explore leisure participation and possibilities*. They did this by illuminating the values of leisure for clients and caregivers who have not thought much about it. They used nuanced approaches when inquiring about leisure participation, sharing the occupational therapy perspective of its values and alternative ways of doing, while also learning about and holding the client's meanings and values of leisure participation. They used a collaborative approach of exploring leisure ideas and options rather than making prescriptive recommendations. They strived to have a deeper understanding of the leisure resources in the area to facilitate careful consideration of which resources have more potential for success with each client. Even time plays a role in how the OT guided the client toward a place where they were open to working on it, by carefully choosing the right time to bring it up within the context of other health priorities and more urgent occupation goals, or circling back to it later if the client was not ready.

Choosing the right time was considered to be a unique aspect of screening leisure as compared to other occupations and required experience to discern when the optimal time might be and considering the interplay of other occupational goals. One OT expressed “as you get more experience you might be more savvy with recognizing when to introduce or explore certain things” (FG). In cases where the initial offer to address leisure was declined by the client, some OTs mentioned revisiting the topic later, once they had gathered enough contextual information to also offer tentative suggestions. This approach was seen as a means of ensuring the client could make an informed decision. An OT described her approach as sowing the initial idea seed during early visits, then patiently waiting for a more suitable moment to revisit it with a potential solution in mind, as she explained:

> *If they play it down, I tend to say, 'Oh, okay.' Then on my next visit, I would say, “You mentioned this and I know you don't want to spend a whole lot of time on it, but I just found this, or this might be an idea” (OT2)*

These approaches revealed a nuanced grasp of timing and respectful persistence, as elaborated upon by a Focus Group participant:

> *You go back, right. You back off and go through another route, and then we come back. But again, you’re careful to use their language, their culture, their ways of thinking to increase the possibility that they will accept your suggestions.*

The heightened awareness of the necessity of selecting the right moment and returning to the leisure issue with potential solutions was acknowledged as a valuable strategy when discussed in the focus group.

4.5.3 Conceptual Claim #3: Addressing Leisure Covertly. In this study, OTs demonstrated varying degrees of flexibility in addressing leisure, which seemed to be largely influenced by the focus of their respective home care programs. Some programs

focussed on comprehensively enhancing participation and reducing re-hospitalization, which fostered an environment supportive of addressing leisure. In contrast, other programs were perceived as being more constrained to basic health service provision, which reduced the scope of occupational therapy and limited opportunities for addressing leisure needs. OTs working in the more constrained practice settings sometimes addressed leisure covertly as it seemed incongruent with the program's focus for service.

In programs whose mission had a broader focus, for example improving client participation, addressing leisure participation was "supported by the program having that vision and goal" (OT2). These OTs had support from their colleagues (OT6) when addressing leisure participation. They spoke of having autonomy to determine their home care OT role: "I do have a lot of leeway to determine myself how I do things" (OT4), "I have flexibility in how I use my time. I can use my time and the TA's time to do some leisure projects with the client" (OT6).

The programs with broader missions also tended to have more opportunity for professional collaboration. This led to opportunities for explaining leisure goals with their colleagues (OT4). This regular collaboration provided opportunity for the OT to explain the value of incorporating leisure into client's program, and engage the OTA and other support personnel with directly working on the leisure goals with clients.

One OT worked in both general and specialized programs, and noted there was more time for addressing leisure issues in the specialized program:

> *But generally we're not 'the person's had ten sessions that's it.' We don't have that kind of limitation put on us… I'm just lucky, you know, because then especially if you're looking at leisure these are often issues you start addressing towards the end of your treatment. (OT2)*

Having been allotted more visits per client and an extended period of time as well as a broader, more flexible program mission as compared to the general home care program in her area, she was able to explore and address the client's leisure participation needs more thoroughly.

OTs working within more comprehensive programs reported greater autonomy and flexibility in defining their services, and comparatively more time per client. This autonomy and time allowed for more comprehensive assessments and interventions including addressing leisure participation. They were able to address leisure overtly, and in collaboration with colleagues who supported the integration of leisure into their practice.

In contrast, the OTs working in constrained home care systems described limited autonomy, less internal resources, and less time per client. Referrals often focused narrowly on home safety and self-care independence, reflecting the expectation of basic health service provision, and leaving little leeway for addressing leisure. The OTs working in more constrained settings also seemed to work in relative professional isolation. In these interviews, there was an absence of practice examples which included collaboration with the other members of client's home care team. In comprehensive programs, OTs could discuss client leisure goals with colleagues, but in constrained settings, siloed organization limited OTs' ability to advocate for incorporating leisure into client programs. One OT with many years' experience working within the same home care program described having much less "latitude" in recent years, "it's really tightened up now, really, really tightened up" (OT1). Because of their firm beliefs in the value of

leisure for their clients, these OTs were still fitting it in on a smaller scale and by addressing leisure covertly.

As described in a previous section, the participants rarely receive referrals specifically to address leisure issues. In comprehensive settings, the OTs did not express feeling limited to specific referral wording. However, tensions arose for some OTs working in the constrained settings, around whether or not to move beyond perceived boundaries imposed by the specific wording of the referral. The specific nature of referral wording can result in home care OTs responding only to the specified issue rather than "asking it all" (FG).

Some OTs avoided including their leisure interventions in their home care reports for fear of negative feedback, or used alternate wording in their goals to mask the leisure aspect. When this was raised in the focus group there was consensus among those working in the narrower systems that they used covert strategies at times:

> *Because I have asked for more visits from the care manager where I know mostly what I'm working on is going to be a leisure goal but still trying to work it together with what the referral is for or what typically is seen as an approved goal; like more of the home safety - fall prevention - cognitive function. So, I may be working on, "Hey, let's find some apps or card games or a music program or something that you enjoy." But in my goals it ends up being a little bit more covert, because I'm talking about it more like I'm addressing cognition, right? Rather than specifically leisure when really that is more of my goal. So, I find that especially with asking for more visits it sometimes ends up being tied in a little bit to other things, and being a little bit more covert. (FG)*

This interpretation of addressing leisure covertly resonated with the Focus Group. They quickly adopted the phrase into the conversations and expanded on how this explained the way they addressed leisure:

I like the covert thing; you're in officially for one reason and then because it's important to you as an OT, you're then fitting it in under the heading of something else just to make sure something is done to address people's leisure needs. (FG)

OTs justified their need for covert strategies by explaining that the client had identified leisure as one of their goals and they didn't want to risk being told by the care manager than they couldn't work on it, especially if an additional visit was needed, "They would never give it to us." (OT1). They felt the care manager wouldn't understand that addressing leisure really is part of occupational therapy scope of practice, "The [home care system] is a bit of an obstacle, because that's not really their focus, so you don't put it on your paperwork. You just kind of do the other stuff and throw it in there" (FG).

For these OTs, the constrained practice setting fostered a need for covert strategies as they work within perceived boundaries imposed by referral wording, fearing negative feedback for advocating leisure interventions openly. They face limited autonomy and professional isolation as compared to comprehensive home care programs where OTs have more autonomy, resources, and collaborative opportunities. Their covert approach, resonating with the OTs, reflects their response to a culture that undervalues leisure within the home care system.

4.5.4 Summarizing the Conceptual Claims. In summary, the exploration of addressing leisure revealed three conceptual claims which are like an undercurrent of the OTs' practices in home care settings. The first claim, Holding Tight to the Value of Leisure, underscores how OTs are driven by their belief in the profound benefits of leisure for client health and well-being, despite systemic challenges. This commitment serves as a guiding principle throughout their clinical interventions and system navigation efforts. The second claim, Creating an Opening to Explore Leisure Participation and

Possibilities, highlights OTs' nuanced approaches to introducing leisure interventions emphasizing collaboration and timing to foster client acceptance and engagement. Finally, Addressing Leisure Covertly emerges as the third claim, reflecting OTs' adaptive strategies in constrained settings where overt leisure interventions might not align with program priorities or referral expectations. These claims illuminate the complex landscape within which OTs operate, balancing their professional values with the practical realities of home care systems.

In the final chapter, the research questions are answered based on these findings, and the processes of addressing leisure are examined alongside the conceptual claims in relation to the current literature.

Chapter 5: Discussion

This study set out to answer the research question: *How do Canadian Home Care OTs address leisure participation challenges with their small urban and rural-residing older adult clients?* This chapter revisits the research sub-questions to synthesize the key findings and to explore them in light of extant literature. Following this, the three conceptual claims introduced in the Findings are further discussed to explain what is happening in practice. Again, the conceptual claims are: 1. Holding tight to the value of leisure, 2. Creating an opening to explore leisure participation and possibilities, and 3. Practicing covertly as a response to constrained system. It is suggested how creating an opening with clients to explore leisure aligns with using an ontological lens (Reed, 2008; Reed et al., 2010; Reid et al., 2024). Additionally, covert practices are examined through the lens of street-level bureaucracy (Aldrich & Laliberte Rudman, 2020a) and Gary's (2013) concept of positive deviance. An exploration of the practice implication of these findings follows. The chapter concludes with a discussion of the study's limitations and recommendations for further study.

5.1 Revisiting the Research Questions

To review, three sub-questions guided the research in this study:

1. What are the key factors and tensions encountered when addressing leisure participation?
2. What processes do Home Care OTs use to address leisure issues with their older adult clients? and
3. What supports these OTs to address leisure?

A summary of the findings in answer to the above questions is provided below.

5.1.1. What are the Key Factors and Tensions Encountered When Addressing Leisure Participation?

A major tension for these OTs was balancing addressing leisure with its' known health benefits in time-pressured settings that prioritized other treatment areas. Reflecting on Arntzen et al's (2019) work, the OTs in this current study aimed to practice holistically and with autonomy. However, time constraints could result in reverting to the traditional, or expected home care OT role. This 'time crunch' limited comprehensive service provision, highlighting how leisure is often seen as least important especially in resource-limited rural areas, where staff shortages further restrict treatment goals to more urgent issues (Arntzen, Sveen, et al., 2019; Roots et al., 2014). Findings align with existing literature that home care OTs often operate within a limited scope (Arntzen, Moe, et al., 2019; Freeman & Jauvin, 2018; Rahja et al., 2018; Turcotte, Carrier, et al., 2015), with leisure not prioritized in Canadian home care (Raymond et al., 2020). Even specialized programs with more freedom faced time constraints.

The valuing or devaluing of leisure is a factor impacting much of what the OTs in this study did. The value of leisure is a factor for the OT, system, client, and community. It is reflected in the therapist's willingness to introduce leisure with the client, time, resources, and mandates to address leisure within each home care system, the client's history with leisure and interest in exploring current leisure participation, and availability of community leisure resources. Previous research indicates that older adults value leisure, and some have unmet leisure participation needs that home care OTs could address (Källdalen et al., 2012; Lyons et al., 2018; Nielsen et al., 2018; Turcotte, Larivière, et al., 2015). This study identifies a subgroup of clients who initially devalue leisure, due to cultural and contextual factors, emphasizing the need for strategies to

encourage leisure engagement. It also emphasizes the importance of OTs strongly valuing leisure to engage in the processes to address it with their clients.

Additionally, rural OTs noted transportation and mobility barriers, compounded by cultural factors, as significant challenges. This is confirmed in previous work by Marr, (Marr, 2015) regarding rural transportation barriers, and Rozanova et al. (2012) regarding rural barriers to social engagement and well-being in later life. This study adds nuance to the rural transportation challenges described by the geographer Marr (2015), who focused on the reliance on personal vehicles and lack of public transportation systems in rural areas. While Marr's recommendations include alternative options like inter-community buses, the OTs in this study highlighted the need to address clients' unfamiliarity and fear of using new transportation systems. The current study adds rural mobility challenges in addition to the transportation challenges. Rural mobility issues include accessing rural leisure activities such as using personal mobility devices over rural terrain requiring adaptations to equipment designed for urban environments. These barriers, including cultural influences in farming communities, require careful consideration in addressing leisure participation.

5.1.2. What Processes do Home Care OTs Use to Address Leisure Problems With Their Older Adult Clients? To address leisure participation problems, OTs in this study engaged in two processes: the clinical process of *Addressing Leisure and* the system process of *Paving the Way for Leisure*. As no previous studies have detailed how home care OTs address leisure participation challenges, these findings offer novel insights useful for practitioners and provide a foundation for future research.

Paving the Way for Leisure involves critical decisions about whether to address leisure, utilizing available resources, and working around system constraints. This critical reasoning includes covert strategies, which are not considered in occupational therapy practice models that emphasize advocacy (Townsend et al., 2011). While Canadian practice models do acknowledge the challenges of working with limited resources and conflicting power structures, they suggest professional accountability strategies geared more towards OTs in management and leadership roles (Townsend et al., 2013) and direct advocacy by individual clinicians (Restall et al., 2022). However, studies of other front-line health and social service professionals reveal the use of covert strategies similar to those employed by OTs in this study rather than attempting more direct forms of advocacy. Examples are nurses and other home health care professionals not documenting deviations from protocols (Ethier et al., 2024; Gary, 2013) and social workers camouflaging decisions to support clients outside of service rules (Theriault et al., 2014). This indicates that working covertly may be a strategy that is relevant but not well understood, acknowledged, or explicitly named by OTs working in home care settings.

To explore leisure possibilities with clients, OTs created and maintained a detailed leisure database of local resources. This system-level task was not supported by the home care system, so OTs gathered information from community knowledge and clients, akin to community development approaches (Lauckner et al., 2019).

Addressing Leisure was organized into two sub-processes: Exploring Leisure Participation and Creating Leisure Opportunities. OTs used data collection forms that included sections on leisure to ensure it was regularly addressed, supporting literature

that advocates for this strategy (Turcotte et al., 2019). Interventions included leisure education, problem-solving, and prescribing assistive devices, similar to successful leisure intervention studies (Berger et al., 2013; Clark et al., 2012). However, a number of studies on leisure interventions use group formats with developed protocols (Chippendale & Boltz, 2015; Levasseur et al., 2019). OTs in the current study did not adhere to specific protocols, their practice settings allowed only for individual sessions, and needing to squeeze leisure interventions in with other goals.

Addressing leisure participation challenges requires strong relational skills, particularly in understanding clients' cultural and socioeconomic contexts to provide thoughtful and sensitive leisure education. OTs valued circling back to leisure later if clients were not initially ready, allowing time to explore appealing strategies while addressing other needs. These techniques could be viewed as examples of going beyond client-centred practice to a more collaborative relationship-focused practice (Egan & Restall, 2022a) and using an ontological lens (Reid et al., 2024) emphasizing a deeper understanding of the client's identity and the role of leisure. An ontological lens goes beyond a clinical focus to understand the person as a whole, occupational being, in a unique context. These aspects will be further examined under the heading *Creating an opening to explore leisure participation*.

5.1.3. What Supports These OTs to Address Leisure? The OTs in this study were supported to address leisure participation when it was valued by the community, client culture, Home Care system and themselves. Their personal and professional beliefs in the value of leisure and positive client outcomes motivated them to make the extra effort, even in systems lacking financial incentives or recognition. They were further

supported in home care systems that prioritized leisure by incorporating terms like 'participation' or 'health and well-being' into the organization's mission, allowing therapist autonomy and providing time and resources such as OTAs. Community supports included accessible transportation, funding for leisure activities and available community venues. Practical methods developed by the OTs also supported their efforts. These included using data collection forms that include leisure, maintaining a leisure database, and incorporating specific techniques in the *Addressing Leisure* clinical process.

Collectively, the OTs in this study who work in small urban and rural areas demonstrate professional traits of all-rounders and innovators (Arntzen et al., 2019), which may support them to address leisure. These traits include generalist knowledge, strong case management and administrative skills (Roots, Smith, Brown, Bainbridge, & Li, 2014; Wielandt & Taylor, 2010), flexibility, professional autonomy (Arntzen et al., 2019), resourcefulness (Roots et al., 2014; Waite, 2015), innovation (Arntzen et al., 2019), and community development (Roots et al., 2014).

5.2 Conceptual Claims

One of the purposes of Interpretive Description studies is to suggest more optimal clinical responses to clinical problems (Thorne, 2016). Understanding the challenges, tensions, processes, and supportive factors that enable this group of home care OTs to address leisure is the first step toward this goal. This discussion builds on that foundation by further exploring the three conceptual claims described in the Findings, in light of the existing literature.

5.2.1 Holding Tight to the Value of Leisure in a Bio-medical, Neoliberal Environment.

Holding tight to the value of leisure was identified as a core element and

impetus woven through both processes, recognized for its potential influence on health and well-being, and professionally fulfilling when their clients were successful. However, choosing to address leisure and remaining committed to doing so was described as a constant challenge for all OTs in the current study due to time constraints, and even more difficult for those who work in more constrained home care systems. To understand factors that may be influencing the constraints of the home care system, an understanding of bio-medical systems and neoliberalism may be helpful. In the next paragraphs I will explore the tensions of holding tight to the value of leisure and addressing it with home care clients in light of neoliberalism effects and the bio-medical orientation of the constrained home care systems.

5.2.1.1 Biomedical influences. OT has been long influenced by biomedical systems which encouraged the profession to focus on rehabilitation and move away from its social reform roots (Friedland, 1998). The "paradigmatic conflict that arises between a profession informed by occupation and a predominantly biomedical setting" (Wilding & Whiteford, 2007, p. 185) has affected the profession's attention towards leisure occupations. Leisure does not receive much attention from OTs as a goal for intervention, nor for using leisure activities as a tool in practice (Chen & Chippendale, 2018; Turcotte & Holmes, 2021a). There is also a reluctance to use the word "leisure" in health care systems (Turcotte et al., 2019). The scarcity of papers, workshops, webinars, and book chapters found on the topic of OTs addressing leisure illustrates that the profession, uneasily engulfed in biomedical systems, may be reluctant about overtly valuing and prioritizing leisure occupations. This results in limited resources for those who choose to address it. Despite attempts to remain client-centered and recent calls to move toward

collaborative relationship-focused occupational therapy (Restall & Egan, 2021), the biomedical model, along with the recent effects of neoliberalism seem to remain the dominant influence in the home care programs for most OTs.

5.2.1.2 Effects of Neoliberalism. Critical theorists in occupational therapy and occupational science have described the effects of neoliberalism on occupational therapy practices (Rudman, 2021; Turcotte & Holmes, 2021a; Whalley Hammell, 2013) including scarcity of time (Park & Rouleau, 2022; Turcotte, Larivière, et al., 2015), which was repeatedly noted by all OTs in this study. Critical theorists in leisure sciences have explored neoliberalism's impact on the valuation of leisure in society, offering insights into how these influences affect both clients and the profession's perception of leisure. The OTs in this study link leisure activities to other therapeutic goals, strategically manipulating the biomedical and neoliberal ideologies of the health care system to benefit their clients. However, in doing so, they risk absorbing some neoliberal ideology, such as emphasizing leisure primarily for maintaining health and neglecting its role in affirming identity and providing pleasure. Leisure science scholars such as Rose (2022) have noted that leisure and recreational choices are increasingly entangled in neoliberal processes and outcomes. Neoliberalism emphasizes privatization, commodification, and the reinforcement of class power, leading to an inequitable distribution of funding for leisure venues and programs. This perpetuates an ideology that seldom views leisure as a broadly accessible right.

5.2.1.3 A Discretionary Decision? Considering the broader political and societal context, it becomes evident that there are several challenges working against the OTs in this current study. Why, then, do they persist in addressing leisure when others do not?

Most of the OTs in this study were veterans in the profession. One had an undergraduate degree in leisure studies and the more novice participant held a strong personal belief in the health and wellness benefits of leisure. They attributed their choice to address leisure to a strong belief in its benefits for their clients. They cited their colleagues' lack of addressing leisure as due to lack of time, although the OTs in this study also faced time constraints. A study by Freeman et al. (2009) describes the struggle of OTs in determining where to draw the line between non-discretionary and discretionary interventions. For all practitioners, meeting essential requirements was non-negotiable, but discretionary decision-making beyond these varied. Different therapists positioned this boundary based on contextual factors such as external regulations and their own interpretations of fulfilling expectations. Some OTs expressed concerns about their colleagues spending time on discretionary interventions, arguing that this time would be better spent reducing their collective waitlist. Freeman et al. observed that this resulted in an inconsistent and variable scope of occupational therapy practice offered to clients. While specific examples of what one therapist considered discretionary versus non-discretionary were not described, the need for the OTs in the current study to defend addressing leisure and their comments that other home care OTs do not address leisure due to lack of time suggest that leisure could be viewed by some as discretionary. This perspective is also identified in leisure science literature (Mannell, 2007).

The OTs in the current study, who hold firmly to the value of leisure participation and endeavor to practice holistically, do not consider leisure to be discretionary. Their efforts to address leisure push back against systemic biomedical and neoliberal tendencies.

5.2.2 Creating Openings to Explore Leisure Participation and Possibilities Using an Ontological Lens.

Among the strategies brought together in this theme are those that require a deeper knowing of the client in order to introduce leisure in a way that that aligns with their values and needs, thereby retaining the occupation's meanings for the client. Strategies include having a nuanced grasp not only of the culture of the person, but also a heightened awareness of timing for each individual and recognizing the role leisure can play within the broader context of the person's life. This section explores how these strategies align with an ontological approach (Reed, 2008, Reid, 2024), focusing on the holistic understanding and genuine care required to support the client's unique occupational needs. This perspective emphasizes the importance of seeing the client as a whole person within their life context, beyond mere clinical interactions.

The timing of when OTs share certain education (Cameron et al., 2015; Danzl et al., 2016; Van de Velde et al., 2016) and using different approaches (Van de Velde et al., 2016) are part of managing the interplay of multiple goals during visits (Restall & Egan, 2021). Persistently 'circling back' once the OT and client have worked together on other issues, waiting to address leisure until the OT has gleaned a more nuanced understanding of who the client is, could be considered an ontological approach. Reid et al. (2024) describe an ontological way of being a therapist which focuses on the person as a whole, occupational being. It involves a genuine care or concern for the client that goes beyond clinical agendas and focuses on understanding the uniqueness of the person in their context. This requires setting aside the therapist's own preconceptions and being fully present to listen and understand the deeper meanings behind the client's words and actions.

While specific tasks like assessing shower transfers might not need an ontological lens, the experiences shared by OTs in this study suggest that an ontological approach is beneficial for addressing leisure participation. For example, understanding the significance of baking cookies for a client helped the OT plan the activity in a way that retained its meaning for her, even with physical assistance from an OTA (OT6). Tools like the Spirituality and Occupation in Living (SOiL) model (Heard, 2023) could help OTs practice more ontologically, but time constraints and juggling multiple goals at once in Home Care settings often prevent a separate approach for leisure. Thus, OTs often gather insights about the client's "being" through observations and listening while working on other treatment goals. This helps them understand the nuances of their client's occupational being and how to address leisure pursuits in a way that will retain its meanings for them.

An ontological approach to successfully addressing leisure may help explain why the OTs who could articulate this approach were among the more veteran OTs, as their confidence stemmed from experience and working in the same practice setting for a longer time. It is more complex and subtle, and hard to fit in with the ‘time crunch’ they are experiencing. Further, perhaps it requires the assurance that comes from experience to let go of the tick boxes, categories, and quick scientific documentation, however briefly.

Reed explored the meanings of occupations in their dissertation (2008) and subsequent article (Reed et al., 2010), drawing on the philosophies of Heidigger and Gadamar. Reed identified three interconnected facets of meaning: The call (what motivates a person to choose certain occupations), Being-with (the sense of connection from engaging in occupations), and Possibilities (connecting the person with their past,

present, and future 'Becoming'). Reed noted that addressing occupational disruptions without understanding their meanings for the client seemed simple at first. However, uncovering the meaning of an occupation for a specific client might get to the heart of the occupation, uncover the specific benefits of engaging in it, give the client insights into his 'Being,' enable more authentic support and add depth to occupational therapy practice. This is reflected in a comment by an OT in this current study "I don't think sometimes they've reflected on it at all, they just assume you're getting older you can't do stuff anymore" (OT2). It's also reflected in a focus group comment regarding leisure's role in forming spirituality:

> *I keep wondering about how spirituality fits with occupational therapy. Sometimes I think it needs to be a broader idea of what spirit or spirituality might be… so I wonder if having leisure occupations is part of having that balanced palate of things that you do and the things that bring you a little bit of extra joy, or also help with creating your identity. (FG)*

In exploring the meaning of occupations with clients, Reed suggested asking about the importance, goals, and social connections related to occupations. While OTs in the present study sometimes asked these questions, they often gathered insights through observations and conversations. In addition to asking "how do you pass the time and what do you like to do?" (OT6), adding questions about why leisure interests are important or how clients maintain their social connections could enhance understanding of their occupational engagement.

5.2.3 Addressing Leisure Covertly as a Response to Constraining Systems.

The final claim from the findings of this study is that some OTs working in constrained systems covertly address leisure with their clients but avoid sharing this aspect of their interventions with home care system's care managers. Practicing holistically in home care

by also addressing leisure could be viewed as a political situation and choosing to do so covertly, another political choice made by the OT. It may be viewed as an act of disobedience as they navigate conflicting interests of the client, profession and system and the limitations of what they felt was within their power as front-line health care worker rather than policy-maker (Turcotte & Holmes, 2021b). The OTs in the current study were trying to reconcile the gap between professional accountability and home care's resource-strapped, narrower focus.

5.2.3.1 Politics. Pollard, Kronenberg and Sakellariou (2009) describe politics in this context as driven by local conditions, accountability, interprofessional relationships, user and carer needs, and individual motivations. This perspective emphasizes the everyday politics front-line OTs engage in as they operate within their local sphere, rather than the kind of politics that happens "at a macro level which is far removed from practice and about which we can do little" (Rebeiro Gruhl, 2009, p. 20). While the OTs in this study did not speak in terms of their decisions being political ones, their actions reflected an implicit engagement with the politics of their practice, as they navigated and negotiated the constraints imposed by the home care system to better serve their clients' needs.

Other professions struggling with similar conflicts have also chosen to act in covert ways. Social workers acting as care managers in New Brunswick struggled with a lack of autonomy and power to provide the services needed by their clients in a 'menu-driven' system. This put them in conflict with ideal professional social work norms and required them to work around the system (Theriault et al., 2014). Nurses have used

discretion (Byers, 2017) or ‘responsible subversion,’ at times bending the rules or finding workarounds for the best interests of the client (Gary, 2013).

5.2.3.2 Clinical Decision-Making. Carrier, Freeman, Desrosiers and Levasseur (2020) studied how community OTs make decisions about client care and found that long wait times, limited mandates, restrictive institutional procedures, and a limited basket of services primarily guide their clinical decision-making. Further, they emphasized that professional practice is ideally determined by the professionals themselves, guided by laws and regulations from regulatory colleges and associations. When OTs limit their clinical reasoning to institutional imperatives, they do not consider other potentially appropriate interventions. Consequently, clients and their caregivers are deprived of their power, unable to advocate for necessary services and are left with unmet needs. OTs in the current study considered more than just the institutional elements when their decision to address leisure runs counter to the institution's primary mandates. The OTs in the current study appear to support the understanding that leaving clients with unmet needs (including leisure needs) can result in hospitalization, institutionalization, and increased caregiver burden, which is counterproductive to the general mandates of home care (Tousignant et al., 2006).

5.2.3.3 Street-Level Bureaucracy. Lipsky’s concept of street-level bureaucrats (2010) (Aldrich & Laliberte Rudman, 2020) aimed to “open new spaces for future studies of occupation-focused and emancipatory therapeutic practices” (p. 138) and is applicable to front line OTs. The work of the OTs in the current study may shed light on how some are enacting street-level bureaucracy. Street-level bureaucrats use their discretion to determine how to provide service within the rules set by the system (Aldrich & Laliberte

Rudman, 2020), sometimes bending the rules to better align with professional values (Theriault et al., 2014).

The sub-group of OTs in this study who employed covert strategies when addressing leisure were accountable to care managers. These care managers were responsible for determining eligibility for occupational therapy services and the number of visits granted, based on home care policies. Consequently, the care managers fit the role of street-level bureaucrats more so than the front-line OTs. However, the OTs also demonstrated a degree of discretion in providing services within the constraints of the home care system. Exercising discretion to address leisure, even covertly, can increase job satisfaction and lead to meaningful client outcomes but also exposes OTs to risks including fear of reprisal (Carrier et al., 2021), necessitating that these actions remain hidden (Aldrich & Laliberte Rudman, 2020). In the current study, OTs were motivated by professional satisfaction and client outcomes, and their covert actions shielded care managers from having to approve these deviations.

Lipsky (2010) stated that through negotiating the conditions of bureaucracy, the decisions and processes of street-level bureaucrats become public policy. For these OTs, addressing leisure was not an occasional deviation from standard policy but had become routine practice. By routinely addressing leisure, these OTs are transforming a small part of the system in which they and their clients are embedded. Had these clients been seen by a different OT, they likely would have experienced a different version of home care OT.

Aldrich and Laliberte Rudman conclude that, “It is crucial that OTs become critically aware of their own situatedness within political systems and structures and be

reflexive about how their practices can perpetuate or transform power relations" (2020, p. 143). In the newest Canadian occupational therapy practice model, front-line OTs are encouraged to work at the level of policies and system processes (Park & Rouleau, 2022; Restall et al., 2022). Yet when front-line OTs consider their political landscape (Pollard et al., 2009), they might see that their circle of influence is quite limited. The OTs in this study mentioned only their direct manager (who may work for a separate agency under contract to home care, may not be an OT, and may be dealing with different political issues that push advocating for leisure to the back burner), the care managers, and a handful of front-line colleagues. It's no wonder that covert practices seem more within their political power to enact.

5.2.3.4 Positive Deviance. Gary (2013) explored a related concept coined "positive deviance," defined as intentional, honorable behavior that deviates from established norms through innovation, creativity, and adaptability. Positive deviance involved risk for the health care worker and it was usually not documented. Gary (2013) highlighted that failing to document such practices falsely supported ineffective protocols. In the current study, covert OTs documented their leisure interventions in their assessment forms and progress notes but camouflaged or omitted these details in reports to care managers. This omission limits the care managers' ability to expand occupational therapy referrals to include leisure participation, keeping the potential expanded role of occupational therapy invisible.

Social change literature emphasizes that change does not always start at the top and trickle down, it can also originate from the grassroots, driving transformation from within the system. Aldrich and Laliberte Rudman (2020) propose that front-line OTs

consider their power to effect change within their roles. Examples from the current study highlighting how some OTs address leisure in constrained home care settings can inspire and support collective risk-taking among their peers. By covertly dividing their visits to cover leisure and other tasks, OTs manipulate the bio-medical and neoliberal health care system ideology to benefit the client. However, this covert work can be professionally alienating and keeps the broader role of occupational therapy invisible to care managers and policy-makers. Perhaps an alternative is to initiate conversations with managers who might be open to advocate for re-wording the menu of occupational therapy services to include 'addressing daily occupations,' allowing leisure and other occupations beyond self-care and fall prevention to be explored for the benefit of the client's health and well-being. Carrier et al (2021) propose change agency training would also be beneficial.

5.4 Limitations of this Research

The primary limitation of this research is the small sample size. The participants were mostly veteran OTs and one a recent graduate. Additionally, the sample did not include any male participants. Another limitation is that participants were drawn only from small and middle-sized urban and rural geographies, as I was unable to recruit OTs working in northern and remote regions, and the intent was to focus on rural rather than metropolitan areas. The findings are not transferrable to all home care OTs in Canada. These findings are interpretive descriptions and might have been interpreted differently by a different researcher with a different practice lens. Therefore, the results, practice suggestions and recommendations should be interpreted by the reader with caution.

5.5 Implications: Main Messages for the Practice Field and Recommendations for Further Study

In light of the research results and the discussion presented above, this study has several implications for home care occupational therapy practitioners, provincial occupational therapy advocacy groups, care managers, home care administrators, policy-makers, and scholars.

For practitioners, this research highlights and validates the hidden work of OTs who are addressing leisure. It names strategies used by OTs, facilitating more informed conversations amongst practitioners and with managers about the importance of addressing leisure. This research suggests that it is possible for home care OTs to address leisure and reminds others of its value for home care clients.

The literature has provided a starting place for considering how OTs' navigation of the home care system is an example of street-level bureaucracy. In this context, the findings of this study suggest how front-line clinicians could engage in more informed conversations and more openly report on their leisure interventions to care managers. The findings highlight the need to consider collective professional power within political landscapes to educate care managers and administrators, influencing the system from the bottom-up towards a more fulsome understanding of the OT role, one that includes addressing client's leisure occupations.

For new practitioners, this research offers insights into how some experienced OTs navigate the complexities of addressing leisure in clinical practice and across various systems. It highlights additional skills required, such as circling back, being in tune with the client, and weaving in leisure at different times.

Given the highlighted tension between the holistic nature of occupational therapy practice and the constraints imposed by neoliberal policies emphasizing efficiency, cost-cutting, and standardized care, it would be beneficial for provincial and national associations to continue advocating on this issue. Professional associations may also encourage their OT members to critically examine and challenge their own perceptions of leisure, recognizing how they may be influenced by neoliberal ideologies. By addressing these internal and external presses, OTs and their associations can work towards a more supportive and comprehensive framework that acknowledges and facilitates a fuller scope of occupational therapy practice.

One of the main purposes of using an Interpretive Description approach in qualitative research is to develop more effective clinical responses. This methodology aligns with my passion for the topic and my desire to understand and improve my practice. I aimed to explore new strategies to navigate the challenges, which this approach facilitated. It was encouraging to discover other OTs routinely addressing leisure in home care. Personally, this research has validated my efforts, both affirming the complexity of the work and highlighting areas for improvement. As one example, I now make a point of briefly mentioning leisure interventions in my home care reports, and so far I have not been sanctioned. My hope is that by doing so, the care managers are able to understand the broader role of OT. This research has also underscored for me the need to collaborate more with care managers, who, like myself, function as street-level bureaucrats, navigating the constraints of neoliberal systems. Recognizing the shared struggles of care managers can inform my approach to advocating for a broader scope of occupational therapy services. Another strategy that came from this research was opening

a dialogue with an open-minded manager about the 'basket of services.' I learned that questioning and potentially influencing service lists was simpler than anticipated. However, due to management changes and infrequent meetings with home care about this, progress has been slow. Addressing leisure is not just about employing certain clinical skills, significant system barriers are encountered with important implications.

For care managers, OT managers, home care administrators, and policy makers the results of this research identify OTs who may be considered outliers within the system. This study offers an example of how street-level bureaucracy and positive deviance apply to front-line home care OTs using discretion within constrained systems. This study illustrates the considerable and invisible time and energy required to navigate the system and to provide a more holistic version of OT; one that more fully addresses client needs, including leisure, promotes health and well-being and supports aging in place. These findings may begin to address these issues in the wider context of home care policy.

The implications of this study suggest several avenues for further research. First, surveying home care OTs to identify how many address leisure, the frequency, extent, and type of these interventions (individual, group, community development) and their perceived agency in doing so would be valuable. This information would help others to understand the breadth of leisure-related interventions used by home care OTs across provinces and Canada. It would also cast light on why some OTs address leisure while others do not, despite the profession valuing leisure participation as a meaningful occupation.

It would also be helpful to examine administrators' and home care managers' understanding of the role of OT, as a way to better understand current practices and scope limitations within home care, as well as to explore and suggest ways to bridge these gaps.

Additional research could address some of the limitations of this study, such as exploring differences between new graduates and seasoned OTs addressing leisure and identifying supports needed for new graduates. Since leisure is culturally bound, it would be valuable to ask similar questions of OTs working with more diverse client populations and geographies. This study focused on the OTs providing interventions, further studies could focus on clients' experiences of interventions. Additionally, there was an emphasis on the benefits of leisure, further studies could explore the negative outcomes of leisure.

Finally, current occupational therapy models focus primarily on the OT and client with much less attention to the OT interacting with the institutional system they work in and yet for these OTs, that aspect was just as important. Future occupational therapy models could address these aspects more explicitly as well as less visible, more tacit clinical skills such as the ones highlighted in this study.

5.6 Conclusion

This research has revealed the often-hidden work of Canadian home care OTs' addressing leisure participation. Although participants worked in different home care settings, commonalities among their challenges, supports, and processes are evident as they navigate system barriers while also collaborating with the client on solutions. Three conceptual claims were made regarding how home care OTs are addressing leisure: 1) They hold tight to the value of leisure, which provides the impetus to work through system barriers as well as client's challenges, 2) They create openings to explore leisure

participation and opportunities using an ontological lens, and 3) some practice covertly, in response to constraining system cultures.

The results highlight the impact of biomedical and neoliberal effects on OTs' interventions within home care services. Guided by their value of leisure, OTs subvert biomedical beliefs and neoliberal assumptions by adopting an ontological approach and, when necessary, practicing covertly. This approach rebalances the focus from merely parts or productivity of the person to the holistic being of the person.

This study underscores the need for more informed conversations about the importance of leisure. The findings highlight how OTs navigate the home care system as street-level bureaucrats, emphasizing the importance of collective professional power and the need for policy advocacy to challenge constraints imposed by neoliberal policies. While covertly addressing leisure demonstrates OTs' innovation in meeting clients' needs, a more optimal clinical response would involve fostering open dialogues with management and advocating for policy changes that explicitly include daily occupations or leisure as core components of occupational therapy services. This approach would not only legitimize the essential role of leisure in client health and well-being, but also, align professional practices with the broader mandates of home care, ultimately leading to more comprehensive and effective client care.

Addressing leisure in home care is relatively unexplored research territory and this study offers a beginning. The experiences of the participants in this research have provided new information and raised questions to encourage ongoing dialogue among scholars, clinicians and administrative OTs about integrating leisure interventions in home care. In a small, quiet way, they are creating social change.

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Appendix A: Invitation to Participate in Research Opportunity

Invitation to participate in this research will be via CAOT and OSOT Research listings. The following is the proposed 50-word descriptor of the project for the online Research listing:

Are you an OT working in the Ontario Home and Community Care sector with rural-residing older adults? Have you addressed older adults' participation in their favourite activities? You are invited to participate in a 60-minute virtual interview and virtual focus group exploring how OTs address leisure needs in rural settings.

Appendix B: Demographic Screening Questionnaire

1. Are you an English-speaking occupational therapist registered to practice in Ontario?

2. Are you presently working the Ontario Home and Community Care system providing direct service to older adults? Or have you worked in this capacity within the past two years?

3. Do you have at least one year of experience working in the home care system?

4. Does your caseload include at least 50% adults aged 65 and older?

5. Do the older adults on your caseload primarily reside in long-term care facilities?

5. Do at least 50% of the older adults on your caseload reside in rural areas?

6. Do you have experience addressing leisure participation with some of the older adults on your caseload?

7. How many years of home care experience do you have?

8. What area of Ontario do you work in?

9. Do your clients live in rural communities? Northern communities? Remote communities? Here are the definitions of each:

Rural: Rural communities in Ontario are those with a population of less than 30,000 that are greater than 30 minutes away in travel time from a community with a population of more than 30,000.

Northern: Northern Ontario is comprised of 10 territorial districts (145 municipalities): Kenora, Rainy River , Thunder Bay, Cochrane, Algoma, Sudbury, Timiskaming, Nipissing, Manitoulin and Parry Sound… It extends… from the southern boundary of the District of Parry Sound, north to Hudson Bay and James Bay and westerly from Quebec to the Manitoba border"

Remote: Remote communities are those without year-round road access, or which rely on a third party (e.g. train, airplane, ferry) for transportation to a larger centre.

Appendix C: Consent Form for Interview Participation

DALHOUSIE UNIVERSITY

CONSENT FORM

Project title: Addressing leisure with older adults in home care OT

Lead researcher: Tressa Ducharme, BScOT, OT Reg. (Ont), Post-professional Masters student, School of Occupational Therapy, Dalhousie University. Tressa.ducharme@dal.ca

Other researchers

Dr. Heidi Lauckner, Assistant Professor, thesis supervisor, Dalhousie University School of Occupational Therapy, Heidi.lauckner@dal.ca, Dr. Grace Warner, Associate Professor, Dalhousie University School of Occupational Therapy, grace.warner@dal.ca, Dr. Karen Rebeiro-Gruhl, Adjunct Faculty, Dalhousie University School of Occupational Therapy, Dalhousie University, kl_rebeirogruhl@dal.ca

Funding provided by: No funding was received for this study.

Introduction

We invite you to take part in a research study being conducted by Tressa Ducharme, who is a Post-Professional Master's student at Dalhousie University. Choosing whether or not to take part in this research is entirely your choice. The information below tells you about what is involved in the research, what you will be asked to do and about any benefit, risk, inconvenience or discomfort that you might experience.

You should discuss any questions you have about this study with Tressa Ducharme. Please ask as many questions as you like. If you have questions later, please contact Tressa Ducharme.

Purpose and Outline of the Research Study

The purpose of this study is to explore how occupational therapists in the Ontario public Home and Community Care system are addressing the leisure participation challenges experienced by their older adult clients, with a particular interest in rural practices. In this study, the lead researcher intends to speak with approximately 6 OTs who work with older adults to learn about how they identify and address leisure issues. She plans to offer the choice of either telephone call or Zoom, an online video conferencing platform for the interview. She will transcribe the audio recordings of these interviews and look for common and unique themes to summarize and share back with the OTs. You will be invited back for a focus group using Zoom conference call to discuss the summary of themes. During the group call, you can

provide feedback and clarify information. The purpose of this research is to identify strategies for working with older adults in rural settings to address their leisure needs in order to ultimately improve client care.

Who Can Take Part in the Research Study

You may participate in this study if you are an occupational therapist registered to practice in Ontario and currently providing direct occupational therapy services to older adults within the Ontario Home and Community Care system. More specifically, you may participate in this study if you have worked in this capacity for at least two years, are English-speaking, your caseload includes at least 50% rural-residing older adults (65 years +) and you have experience addressing older adult's leisure participation problems. "Rural-residing" refers to people living in communities with a population of less than 30,000 that are greater than 30 minutes away in travel time from a community with a population of more than 30,000. 'Rural' includes northern and remote communities.

You will receive an email with screening demographic questions to ensure you meet the criteria required to participate in this study.

What You Will Be Asked to Do

If you decide to participate in this research you will be asked to participate in one virtual interview followed by one virtual focus group scheduled 2-3 months after the interview. The interview will be conducted by either telephone or Zoom, depending on your preference and arranged at a time convenient to you. The virtual focus group will be conducted using the Zoom videoconferencing platform. The video feature will be optional and you are encouraged to use just your first name, or a name of your choice if you prefer to remain anonymous.

Several days in advance of the interview, the lead researcher will send you an email with four general questions to think about in preparation for the interview. The interview will take up to 60 minutes and will be audio recorded. You will be asked to respond to six open-ended questions related to the research purpose as described above.

Several days in advance of the focus group, the lead researcher will send you a link to join the videoconference and a 1-2 page written summary of the common themes and variations which emerged from the interviews and the researcher's tentative interpretations of these. During the virtual focus group you will discuss these preliminary findings with the 3-5 other focus group participants and respond to questions intended to fill information gaps. The focus group will be no longer than 90 minutes and will be audio recorded.

Possible Benefits, Risks and Discomforts

Benefits: There will be no direct benefit to you for participating in this research. However, by participating in the study you might contribute to new knowledge that will benefit others. Results may inform further research, education and practice to address identified gaps and priorities. You may derive benefits from conversing with other home

care OTs during the focus group.

Risks: The risks associated with participating in this study are minimal. Given that the interview includes questions about challenges OTs may encounter regarding addressing leisure, some people may experience emotional discomfort; you are encouraged to engage in self-care and contact your professional practice leaders or peers for debriefing if needed. There is a risk that other focus group participants may not respect your privacy. To minimize this risk, confidentiality expectations are clearly explained in this consent form and will be reviewed at the outset of the focus group. You will also be reminded to only answer the questions and share information you feel comfortable sharing.

Compensation / Reimbursement
Although your time is highly valued, no compensation is available for those who participate in this study.

How your information will be protected:
Privacy: The researcher will take all reasonable measures to ensure the virtual interview and focus group will be conducted in a private setting and not overheard by others. You will be required to do the same, particularly during the focus group to protect not only your own privacy, but also the privacy of the other group members. Your full name and contact information will be known only to the lead researcher. Email subject lines will not disclose study participation. Your physical identity and first name will be known to the other focus group participants unless you decide a) to join with audio only and using a pseudonym or b) to withdraw from the study before the focus group begins. Due to occupational therapy being a relatively small professional community, it is possible that you may be recognized by, or recognize, another participant in the focus group. Before the focus group we will remind people to keep the information discussed private and remind people not to share anything they don't feel comfortable sharing.

Confidentiality: The information that you provide to us will be kept confidential. Only the research team at Dalhousie University will have access to this information. The people who work with us have an obligation to keep all research information confidential. All your identifying information (such as your name and contact information) will be securely stored separately from your research information. We will use a participant number (not your name) in our written and computer records so that the research information we have about you contains no names. During the study, all electronic records will be kept secure in an encrypted file on the researchers' password-protected computers. All paper records will be kept secure in a locked filing cabinet located in the lead researcher's office.

Study results will be contained in a Master's thesis and possibly in a journal article and conference presentations. You will be identified with a pseudonym in the study results. Comments including demographics which could identify you or your workplace will be

anonymized.

Limits to confidentiality: There is no guarantee that focus group participants will maintain confidentiality. We will not disclose any information about your participation except as required by law or our professional obligations. If you inform us about abuse or neglect of a child or an adult in need of protection we are required by law to contact authorities. If we notice that you are at an immediate risk of harming yourself or other people we are required by our professional code of ethics as occupational therapists to seek assistance.

Data retention: Once the study is over identifying information will be removed and your anonymous data will be retained for 5 years following thesis defense or publication, then destroyed. Anonymized data may be used for secondary data analysis.

If You Decide to Stop Participating

You are free to leave the study at any time. If you decide to stop participating during the study, you can decide whether you want any of the information that you have provided during the interview to be removed or if you will allow us to use that information. After participating in the interview, you can let us know within 1 week if you want us to remove your data. After that time, it will become impossible for us to remove it because it will already become part of the analysis process. If you decide to stop participating during or after the focus group, it will not be possible to remove your focus group data after it is collected.

How to Obtain Results

We will provide you with a short description of group results when the study is finished. No individual results will be provided. You can obtain these results by emailing Tressa Ducharme or visiting her ResearchGate webpage in approximately 6 months.

Questions

If you have any questions, comments or concerns about your participation in this research study please contact Tressa Ducharme at 519-870-2269 or Tressa.Ducharme@dal.ca (if you are calling long distance, please call collect). If you have any ethical concerns about your participation in this research, you may also contact Research Ethics, Dalhousie University at (902) 494-3423, or email: ethics@dal.ca (and reference REB file # 20XX-XXXX)."

Consent

Your consent will be orally confirmed and recorded at the beginning of the interview and reconfirmed at the beginning of the focus group.

The following statement will be read to the participant at the beginning of the interview:

Please indicate your agreement by responding ‘yes’ or ‘no’ to each of the following consent statements:

“I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that I have been asked to take part in this interview and consent to this interview being audio-recorded.”

“I understand direct quotes of things I say may be used without identifying me.”

“I agree to take part in this study. My participation is voluntary and I understand that I am free to withdraw from the interview portion of the study at any time, until 1 week after my interview is completed.”

“I understand that after the interview I am free to withdraw from participation in the focus group at any time, until the focus group session is completed.”

The following statement will be read to the participants at the beginning of the focus group:

Please indicate your agreement by responding ‘yes’ or ‘no’ to each of the following consent statements:

“I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that I have been asked to take part in this focus group and that this focus group is being audio-recorded.”

“I understand that my first name and physical identity will be known to the other focus group participants unless I choose to use a pseudonym and participate without video, using audio only.”

“I am participating in this focus group in a private setting and will keep private the identities and information shared by the focus group participants.”

“I understand direct quotes of things I say may be used without identifying me.

“I agree to take part in this study. My participation is voluntary and I understand that I am free to withdraw from the study at any time, until the focus group session is completed.”

Appendix D: Pre-Interview Preparation

Thank you for agreeing to share your experiences with me for my research project. I look forward to our upcoming interview. To prepare for our conversation, it might be helpful if you could look at a few client files, or just reflect on recent experiences with clients, relating to the research topic. Here are a few questions to reflect on prior to the interview:

1. What has been your experience of addressing leisure with older adults in your home care practice?
2. What assessments, interventions, resources or strategies related to leisure do you use?
3. How does your clients' rural environment impact their leisure and how you address it?
4. What systemic or workplace challenges or tensions relating to your ability to address client leisure problems have you encountered and how have you overcome them?

Appendix E: Semi-Structured Interview Guide

Project explanation: As you might imagine, some OTs address leisure and others do not. I am particularly interested to learn more from the OTs, such as yourself, who are addressing leisure.
I'd like to ask you questions about how you address leisure occupations with your clients. I'm interested in your process. What steps you take, what kinds of tools you use and how you manage the challenges you encounter. I am expecting the interview will take approximately 60 minutes of your time to complete. As stated in the consent form, you are welcome to not answer any questions you don't feel comfortable answering. You are welcome to stop the interview at any time. If you are okay with it taking a bit longer, that is also fine.

(Note to reader: the main questions and sub-questions are numbered and lettered in order of priority in the event not all questions can be asked within the timeframe. Possible probes are included below sub-questions)

Context

I'd like to spend just a few minutes understanding the context of your practice.

1. a. Briefly describe the geographic area and population where you work.

- How much of your geography is rural/remote/northern?

b. Can you tell me, briefly, about the demographics of your caseload and key reasons for referral?

- Probe for older adult mix, rural-urban mix, rural features, culture/ethnic diversity
- Reasons for referral

Leisure General

I'd like to get a general sense of how often and in what ways you address leisure, before asking about some specific examples**.**

2. How often do clients bring forward leisure issues and what are examples of leisure issues they identify?

- What other leisure issues or activities have clients had trouble with?
- Probe for diversity – active/physical, social/solitary, indoor/outdoor/community, creative/sport/club/hobby/volunteer

Leisure examples

Now, I'd like to hear more detail about your experiences of addressing leisure.

3. a. Can you share a story when you were successful with resolving a client's leisure problem?

- Can you talk me through the steps you used?
- What guided your reasoning as you worked through the problem?
- What was the client/caregivers response?

b. What kinds of assessments, tools and interventions did you use?

- What guided your choice to use those tools?
- What are some other resources or processes you've used other times?

c. Can you share a story where addressing leisure didn't go so well?
- Looking back on that episode, what was the primary challenge or tension there?

Rural/remote Context

A rural/remote/northern environment can present unique challenges and unique opportunities. I'm wondering how your rural context impacts your client's leisure problems and your ability to help solve them.

4. a. Can you share an example where the rural environment contributed to the leisure challenge a client was experiencing?
- How did you overcome this?

b. Can you tell me about an example when something unique about 'being rural' was part of the solution?
- How did you leverage this?

Other factors

5. a. Outside of the rural context, what are some obstacles or tensions you have run into that made it more challenging to address leisure?
- Probe for barriers on a system level, client level, personal/professional level
- How do you navigate that?
- What strategies have you used to work around that challenge?

b. What are some of the factors that support you with addressing leisure?
- Probe for facilitators on a system level, client level, personal/professional level
- Tell me more about that

We have come to the end of my questions.

6. **Is there anything you wished I had asked you? Or anything more you think is important for me to know?**

Appendix F: Guide for Focus Group Questions

Group Introduction: Thank you for joining this focus group, where I get to share what I have learned so far from you and we can speak with each other about how see yourselves in these themes, what you think about them and what I might be missing yet. I hope you have all had a chance to read through the summary and have it available to refer to during our group today. I am expecting this focus group will take approximately 90 minutes to allow everyone the opportunity to share their thoughts. This virtual format works best when one person talks at a time. I will be facilitating the conversation by introducing some questions, making sure everyone has a chance to share their thoughts and bringing us back to the topic when we get side-tracked.
Just a reminder about confidentiality before we begin. What others share in the focus group is confidential and not discussed with others outside of this group. Information from this group as well as the interviews will be anonymized. You are welcome to not answer any questions you don't feel comfortable answering. You are welcome to leave the focus group at any time. If the group runs a bit longer, that is also fine, but I will wrap it up in 2 hours if we haven't finished before then.

(Note to reader: the main questions and sub-questions are numbered and lettered in order of priority in the event not all questions can be asked within the timeframe. Possible probes are included below sub-questions)

1. Can you see yourself in these interpretations?

2. How do these themes relate to your processes?

3. What aspects of your practice/experience are missing in these interpretations?

4. What am I not seeing? What else do you want me to know? What is missing?

5. What does this data tell you? How does it inform your practice?

6. How could these interpretations have influenced or added to your intervention with a

past client?

7. What more do you want to know?

Probes:

What are your thoughts (encouraging group members to respond to each other's

comments)

How else do you understand this issue?

What can you add to clarify or elaborate on these ideas?

Have you had similar thoughts?

Have you had opposing experiences?

Appendix G: Summary on Leisure in Home Care for Focus Group

Summary on Leisure in Homecare for Focus Group

Your practice contexts:
A total of 6 Home Care OTs participated in the interviews. OTs are from Alberta, Newfoundland and Ontario with rural, urban or mixed practice environments and ranging from 4 to 31 years' experience. Two work in specialized homecare programs. Some have OTA/PTA support and a few work in other settings in addition to home care.
Many years' experience in same location related to deep knowledge of community resources, familiarity with clients and their contexts and efficient time use. Some described having professional autonomy or a program mandate/team which valued client participation. This 'system-freedom' as well as access to support personnel and more time with clients supported addressing leisure. Others are still fitting it in by doing it on a smaller scale and perhaps more "covertly" when there is not freedom in the system to support explicitly addressing leisure.
Question: In what ways does this idea of "covertly" addressing leisure resonate or not with you?

Leisure participation challenges of your older adult clients:
You described addressing leisure with clients having impairments in cognition, mobility, hand function, activity tolerance, vision, mental health and emotion/behaviour regulation. Contextual factors compounded the challenge and complexity; particularly isolation, transportation and accessibility barriers, financial and technology barriers and limited leisure repertoire. Clients with multiple, progressive or palliative conditions were described to have changing leisure challenges. Complex attitudes and beliefs around receiving assistance related to leisure, and around valuing leisure also affected receptivity to addressing leisure challenges. Caregivers and social networks are a valuable resource and sometimes a barrier. You describe gauging caregiver abilities, limits and leisure beliefs to direct your approach when involving caregivers to support the client's leisure participation. Handcrafts, baking, carpentry, socializing, music, enjoying nature, exercise, gardening, TV, art and reading show the diversity of leisure activities addressed.
Question: What insights, if any, does this summary of your collective clients and context provide?

Getting a handle on how you view leisure and how you see your clients view leisure:
I saw five different leisure purposes from your descriptions:
1. Leisure as therapeutic exercise eg. Introducing leisure as a tool for improving hand function after an acute illness
2. Leisure as the main occupational goal eg. Client presents goal to resume knitting
3. Leisure as a gateway to promote health and wellbeing eg. Educating client/caregiver on health benefits of leisure
4. Leisure as a time-filling activity eg. To provide respite for a caregiver or ease boredom
5. Leisure as an entry point eg. Building rapport with client, which then opened the door with a client reluctant to address the reason for referral

The purpose for addressing leisure resulted in variations in your process, described on page 2.

I heard conflicting views on the value of leisure throughout the interviews. As a group, your experiences and your descriptions of clients and others span this spectrum.

'Extra', superfluous, dismissive, frowned upon: ---------- Important, beneficial and valuable:
Participant OT: *"because leisure is often the icing"* ---------- *"To me it's important for their health"*

Your perspectives of how others value leisure:

Client: *"But they don't think it's important"* ---------- *"Awfully important"*
Caregiver: *"Well, like she can't do that anymore"* ---------- ***"and her daughter actually was the one that pushed it"***
Gatekeeper: *"It's not recognized."* ---------- ***"supported by*** *the program having that vision and goal"*
Society: *"especially not for people with disabilities, it's just not the same level of access"* ---------- *"[COVID-19] shows us the importance of leisure on mental health and day-to-day life"*

Question: What helps you shift people toward the 'important, beneficial and valuable' end of the spectrum?

Rural challenges and what supports you addressing leisure in rural environments:
Distance, transportation, graveled surfaces, weather, less internet and fewer activity options were felt to be greater challenges in rural areas. One OT was careful how she talked to farmers about leisure, 'coining' it in a way that tapped into their strong work ethic. By leveraging client's familiarity in tight-knit rural areas, the grocery bus can be a social outing, knowing their cousin's wife will be there can persuade a client to join a new activity. One OT felt her rural practice offered greater professional autonomy. She capitalized on the resulting flexibility to include leisure in her role.

How you address leisure participation and what supports you to do this:
This diagram is a work in progress to show the processes I heard being used, which is a blending of your different descriptions. You begin with addressing the reasons for referral, noting referrals to Home Care OT are not (or very rarely) for leisure-related problems. However during your initial assessment, you also screen for leisure challenges. The diagram below roughly shows what happens next using a train analogy. I found there are 3 general stages to addressing leisure, and have linked this with potential barricades at each stage. The diagram shows how you overcome these challenges to stay on track with addressing leisure. ***Questions:*** Do you see yourself in here? Is anything missing?

	Potential barricades at each stage:	Staying 'on track':
Stage 1: Exploring Leisure Participation Basic leisure screening Looking for clues and red flags Choosing the right time Confirming client interest	Not reason for referral Limited time System restrictions Client not 'on board'	Screening considered part of general assessment Leveraging experience and efficiency Advocating Coming back to it later with potential solutions *"Opening their minds"* to leisure benefits
Stage 2: Identifying leisure barriers Client and caregiver describe barriers Learn what client tried already Activity analysis	Limited time Not reason for referral System restrictions	Using info from addressing referral reason Longer visit, additional visit Justify by connecting to reason for referral Proceeding covertly
Stage 3: Exploring ways to participate Bring together info about client, activity, barriers, context and resources to suggest possible solutions Consult mental database of resources, past solutions, other clients' ideas Strategies: - Link to person, group or agency - Adapt, modify, grading, pacing - *"Getting them there"* - *"Change the scenario"* - Finding new leisure activities - Teaching client new task or caregiver how to support - Advocating - Community-level work	Limited time Limited ideas Complexity of impairment + client's contextual barriers Client not 'on board' with suggestions Not reason for referral System restrictions	Developing a solid mental database Heavy reliance on 'linking' strategy Asking care coordinator to refer on Using OTA or other support personnel (PSW/HCA) Expand mental database: consulting network, asking Google Prepared with multiple ideas Re-assessing and trying again Revisiting it another time Community-level work to address systemic barrier 'Opening their mind' to benefits of leisure Offering a variety of strategies, Revisiting it later Respect client choice Justify by connecting to reason for referral Proceeding covertly

Questions: When you get to the end of your leisure intervention, can you describe what is achieved?
What could be added, changed or emphasized in the diagram to better reflect your *rural* experiences?

COVID-19
I heard how the pandemic impacted your clients' leisure participation by reducing the available supports and opportunities. It was also noted that the increased use of virtual communication is a silver lining for those with internet but limited transportation options. You saw that COVID-19 put a spotlight on the value of leisure for your client population. The sudden increased isolation provided a need and justified addressing leisure more frequently.

*** ***"Changing up the scenario"***

A commonly described intervention is using a different lens to see the leisure activity. Often this is done by stepping back with the client to examine how the activity provides them enjoyment or identity. In the examples provided by participants, clients were able to overcome barriers related to reduced activity tolerance, mobility, cognitive decline, and vision loss by "*changing up the scenario*" while holding to the valued aspect of the leisure activity. In this example, 'belonging' is the important aspect. *"I know a client at the moment who has sudden visual loss and she started like a girl's night card night, and they used to play board games. This group of girlfriends used to get together, and she said like, "What the hell are we going to do now?" you know, and so I'm having to help her say, "Well there are ways to play some games – "but I'm not very good at technology", but maybe the group needs to think of other activities so they might go to a concert or they might go for walks together, and finding ways to do some social things like board games that are more audio. But that's a lot of digging to let them know that there are ways to do things. "I know it's a huge loss for you but maybe we could figure out with your girlfriends of ways to do things so you have your socialization together without losing it all." P2*

Appendix H: Ethics Approval Letter

DALHOUSIE UNIVERSITY
Research Services

Health Sciences Research Ethics Board
Letter of Approval

September 09, 2020

Tressa Ducharme
Health\School of Occupational Therapy

Dear Tressa,

REB #: 2020-5275
Project Title: Promoting leisure participation of older adults in homecare occupational therapy

Effective Date: September 09, 2020
Expiry Date: September 09, 2021

The Health Sciences Research Ethics Board has reviewed your application for research involving humans and found the proposed research to be in accordance with the Tri-Council Policy Statement on *Ethical Conduct for Research Involving Humans.* This approval will be in effect for 12 months as indicated above. This approval is subject to the conditions listed below which constitute your on-going responsibilities with respect to the ethical conduct of this research.

Effective March 16, 2020: Notwithstanding this approval, any research conducted during the COVID-19 public health emergency must comply with federal and provincial public health advice as well as directives issued by Dalhousie University (or other facilities where the research will occur) regarding preventing the spread of COVID-19.

Sincerely,

Dr. Lori Weeks, Chair

Post REB Approval: On-going Responsibilities of Researchers

After receiving ethical approval for the conduct of research involving humans, there are several ongoing responsibilities that researchers must meet to remain in compliance with University and Tri-Council policies.

1. Additional Research Ethics approval

Prior to conducting any research, researchers must ensure that all required research ethics approvals are secured (in addition to Dalhousie approval). This includes, but is not limited to, securing appropriate research ethics approvals from: other institutions with whom the PI is affiliated; the institutions of research team members; the institution at which participants may be recruited or from which data may be collected; organizations or groups (e.g. school boards, Indigenous communities, correctional services, long-term care facilities, service agencies and community groups) and from any other responsible review body or bodies at the research site.

2. Reporting adverse events

Any significant adverse events experienced by research participants must be reported **in writing** to Research Ethics **within 24 hours** of their occurrence. Examples of what might be considered "significant" include: a negative physical reaction by a participant (e.g. fainting, nausea, unexpected pain, allergic reaction), an emotional breakdown of a participant during an interview, report by a participant of some sort of negative repercussion from their participation (e.g. reaction of spouse or employer) or complaint by a participant with respect to their participation, report of neglect or abuse of a child or adult in need of protection, or a privacy breach. The above list is indicative but not all-inclusive. The written report must include details of the situation and actions taken (or proposed) by the researcher in response to the incident.

3. Seeking approval for changes to research

Prior to implementing any changes to your research plan, whether to the risk assessment, methods, analysis, study instruments or recruitment/consent material, researchers must submit them to the Research Ethics Board for review and approval. This is done by completing the amendment request process (described on the website) and submitting an updated ethics submission that includes and explains the proposed changes. Please note that reviews are not conducted in August.

4. Continuing ethical review - annual reports

Research involving humans is subject to continuing REB review and oversight. REB approvals are valid for up to 12 months at a time (per the Tri-Council Policy Statement (TCPS) article 6.14). Prior to the REB approval expiry date, researchers may apply to extend REB approval by completing an Annual Report (available on the website). The report should be submitted 3 weeks in advance of the REB approval expiry date to allow time for REB review and to prevent a lapse of ethics approval for the research. Researchers should note that no research involving humans may be conducted in the absence of a valid ethical approval and that allowing REB approval to lapse is a violation of the University Scholarly Misconduct Policy, inconsistent with the TCPS and may result in the suspension of research and research funding, as required by the funding agency.

5. Final review - final reports

When the researcher is confident that all research-related interventions or interactions with participants have been completed (for prospective research) and/or that all data acquisition is complete, there will be no further access to participant records or collection of biological materials (for secondary use of information research), a Final Report (available on the website) must be submitted to Research Ethics. After review and acknowledgement of the Final Report, the Research Ethics file will be closed.

6. Retaining records in a secure manner

Researchers must ensure that records and data associated with their research are managed consistent with their approved research plans both during and after the project. Research information must be confidentially and securely retained and/or disposed of in such a manner as to comply with confidentiality provisions specified in the protocol and consent forms. This may involve destruction of the records, or continued arrangements for secure storage.

It is the researcher's responsibility to keep a copy of the REB approval letters. This can be important to demonstrate that research was undertaken with Board approval. Please note that the University will securely store your REB project file for 5 years after the REB approval end date at which point the file records may be permanently destroyed.

7. Current contact information and university affiliation

The lead researchers must inform the Research Ethics office of any changes to contact information for the PI (and supervisor, if appropriate), especially the electronic mail address, for the duration of the REB approval. The PI must inform Research Ethics if there is a termination or interruption of his or her affiliation with Dalhousie University.

8. Legal Counsel

The Principal Investigator agrees to comply with all legislative and regulatory requirements that apply to the project. The Principal Investigator agrees to notify the University Legal Counsel office in the event that he or she receives a notice of non-compliance, complaint or other proceeding relating to such requirements.

9. Supervision of students

Faculty must ensure that students conducting research under their supervision are aware of their responsibilities as described above and have adequate support to conduct their research in a safe and ethical manner.