III. Professional Conceptual Framework

Guiding Principle: The MScOT program’s professional conceptual framework embodies notions of ‘health through occupation’ and scholarly-practitioner’ and is responsive to new and emerging theories in occupational science.

We are committed to advancing knowledge through excellence in research. As scholarly-practitioners, occupational therapists are expected to maintain a practice based on evidence, one aspect of which is current research. “Evidence-based occupational therapy is client-centred enablement of occupation that is based on client information, critical review of relevant research, expert consensus, and past experience” (CAOT, 1999/2009; Law & MacDermid, 2008). “Occupational therapists believe that evidence-based practice is a major element of what is now described as best practice”. (CAOT 1999/2009, para 2). Thus, we aim to graduate students with skills in contributing to programs of research and in the translation and utilization of research, leading to the advancement of knowledge supporting the profession.

Our professional conceptual framework provides the foundational philosophy and values statements of the Program and that inform our curriculum. Each of the values that are part of our professional conceptual framework is rooted in current and emerging occupational theory and practice and is encompassed in our values statements below.

1. Occupation: We believe in the value of occupation and its importance to health and well-being. This Value embraces the ideas that: a) humans are occupational beings; b) engagement in occupation is “a basic human need and right for all”; c) engagement in occupation is “required for survival, health and well-being”; d) occupational disruption can affect health and well-being and generate pathology; e) “occupation has therapeutic value”; f) “occupation brings meaning to life”; g) occupation allows us “to explore and learn from the environment, to master skills, to express our individuality, and to sustain life” (see CAOT, 2002; Christiansen & Townsend, 2010; Townsend & Polatajko, 2013, p. 20-21). Occupation-based practice holds that current and emerging occupational therapy practice must be focused on the enablement of occupational performance and engagement outcomes relative to health and well-being. Thus, occupation is viewed as not only a means of therapy but also an end/outcome of therapy that promotes health and well-being (Townsend & Polatajko, 2013).

We also believe in the importance of the environment as an influence on occupation and quality of life. Humans are “not decontextualized entities”; rather they “act on and interact with a myriad of environments, using occupation” (Townsend & Polatajko, 2013). Further, environments shape who we are as occupational beings and who we will become (Christiansen & Townsend, 2010) and contextual issues, such as physical and social environments, stigma, inequality, accessibility and alienation, influence occupational engagement and quality of life (Christiansen & Townsend, 2010; Townsend & Polatajko, 2013). Thus, understanding and addressing the environment’s role in occupational performance and engagement are crucial for effective occupational enablement and fostering quality of life.

2. Leadership: We value a variety of notions of leadership including the following portrayals:
   - a leader is anyone willing to help, anyone who sees something that needs to change and takes the first steps to influence that situation (Wheatley, 2008);
leadership is a process whereby an individual influences a group of individuals to achieve a common goal (Northouse, 2013);

one can lead from any chair (Zander & Zander, 2000).

We believe that innovation and excellence in research, education and practice arises from a variety of forms of leadership.

3. Interprofessional Collaboration: We are committed to collaborative relationships and partnerships with clients/caregivers and health/social care providers. Collaboration is the KEY enablement skill in the Canadian Model of Client-Centred Engagement (CMCE) (Townsend & Polatajko, 2013). This value of collaboration has been part of our professional values for many years. “Congruent with enabling occupation, the production, retrieval, review, and evaluation of information is viewed as a joint responsibility of the client and therapist working in a collaborative relationship” (CAOT, 1997; CAOT, 1999, para. 4). Additionally, collaboration and communication with other health/social care providers enables a comprehensive client-centred approach.

4. Diversity & Inclusion: We value cultural diversity and individual difference. We view culture as a shared system of values, beliefs, ways of knowing or learned patterns of behaviours which are reflective of one’s intersecting identities as related to ethno-cultural background, gender expression and identity, sexual orientation, socioeconomic status, abilities, race, geographical location, or age. As such, “culture has an essential impact on occupational patterns and occupational choices that are indicative of cultural beliefs” (Townsend & Polatajko, 2013, p. 52). Culture influences our values or ways of engaging in the world. Importantly, “each occupation is uniquely experienced by the individual engaged in it” and “occupations are idiosyncratic” to each specific person (CAOT, 1997; Townsend & Polatajko, 2013, p. 22). The subjective and constructed nature of occupational meaning, purpose and engagement must be understood and appreciated through client-centred or individualized, culturally appropriate assessments and interventions.

We situate discussions of diversity within understandings of social inclusion and occupational justice concomitantly with oppression, privilege, discrimination, exclusion and injustice, all of which impact on occupational performance and engagement. Accordingly, an understanding of diversity must also consider how some forms of difference (i.e., identities or ways of doing, knowing and being) may be privileged (e.g., white, able-bodied, straight) and included while others (e.g., racialized, disabled, LGBT), may be excluded and oppressed (ACOTRO et al., 2014; Beagan, 2015). Awareness of the power inequities across various forms of diversity that play out in the dynamics of the practitioner-client interactions is essential to the value of equity and the maintenance of culturally humble, safe and inclusive approaches to maximizing occupational performance and engagement (CAOT, 2011; Hammel, 2013; Hook, et al., 20013).

5. Client-centredness: We believe that people’s occupational repertoires are idiosyncratic and, as such, clients are the experts regarding their own life experiences and occupations. Therefore, clients must be active partners in occupational therapy process to realize the full potential of occupational engagement. This value is a core component of client-centred enablement as it describes the type of enablement that is necessary to achieve a successful collaborative relationship and positive occupational outcomes. Client-centred enablement is based on the six enablement foundations: (a) choice, risk, and responsibility; (b) client participation; (c) visions of possibilities; (d) change; (e) justice; and (f) power sharing (Townsend, Polatajko, & Craik, 2013, p. 101).

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6. **Professionalism:** *We value professionalism and are committed to fostering its development throughout the MScOT Program.* Occupational therapists are accountable, autonomous practitioners, and are solely accountable for their professional judgment (COTO, 2003, p.4). Students begin their learning about occupational therapists’ accountabilities on the first day of the MScOT program and continue this throughout the two years of academic and fieldwork education. The three Occupational Therapy Practice courses focus explicitly on students’ learning of specific professional accountabilities as well as their socialization into the professional culture of **accountability, integrity, life-long learning, transparency and critical inquiry.** Self, practice and program evaluation are taught as critical elements for the provision of occupational therapy best practices (Law, Baum, & Dunn, 2005).