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Transforming values into action: Advocacy as a professional imperative

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Key words: occupational justice; occupational therapy; political systems; professional identity; sociopolitical approach.

Abstract

Background. The goal of enabling meaningful occupation for all requires occupational therapy to become a more socially and politically responsible discipline. **Purpose.** This paper argues that occupational therapy's dominant individualist perspective is too narrow to meet this goal. It presents an argument for integrating advocacy into occupational therapy identity and discusses why we should advocate at political and public levels. **Key Issues.** Although the dominant paradigm and political climate pose challenges, there must be a realignment of the balance between helping individuals who are facing disruptions in their occupational lives and addressing systems and structures that prevent them from moving forward. Adopting a broader sociopolitical approach involves engaging in advocacy as a key strategy. Indeed, advocacy is a professional imperative for occupational therapy. **Implications.** Advocacy must become part of the process of professional socialization. A new set of competencies is needed in our educational programs and in our professional development, accompanied by a sense of self-confident idealism.

For some time now, occupational scientists and occupational therapists have been reflecting on how we can become a more socially and politically responsible discipline. Occupational scientists and occupational therapists in Canada and globally have pointed to injustices underlying occupational deprivation that are in need of our attention and action and have called for occupational therapy to take up politically informed transformative approaches (Galheigo, 2011; Pollard, Sakellariou, & Kronenberg, 2009). This year's conference, themed "Occupational Justice: Rising to the Challenge," is a perfect opportunity to reflect on how far we have come, and where we might go, in enacting our collective commitment to furthering social justice, human rights, and occupational opportunities for all. It is a chance to examine systemic advocacy as a way of expressing our moral identity.

I come to this topic after reflecting on my own work in the advocacy and policy arena. For most of my career, I was not particularly active in this area. I simply wanted to help people who were marginalized from mainstream society find their place in the world and flourish through engagement in meaningful occupation. I did not anticipate how this goal would grow into a larger calling. As I witnessed the hardships confronting the people I worked with, the barriers that needed to be overcome, the issues that not only complicated their lives but challenged the work we did together, I started to cast my gaze to the larger system and began stepping into new arenas that could influence how things worked—boards of community mental health programs, government task forces on mental health reform, knowledge translation networks that aimed to move research into practice, and participatory action research. Most recently, my work with the Mental Health Commission of Canada was an opportunity to influence policy and system development on a large scale, culminating in the development of a national standard for psychological safety in the workplace and a desperately needed national strategy for mental health in our country, with Canada being the last of all G8 nations to adopt one.

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My mission as an occupational therapist and occupational scientist, to enable and enhance the occupational lives of people living with illness or disability, did not start out with a social justice and advocacy agenda, not on a system or policy level, at least. I grew into this set of activities rather slowly and quietly, because it was *necessary* to do the things that I set out to do. In my mind, the goal of occupational fulfillment, not only for the group I aimed to help but for my own professional self, could not be met in any other way. I believe now that advocacy is a professional imperative for occupational therapy.

In this paper I present an argument for the need to integrate advocacy and social justice into occupational therapy identity and discuss why we should advocate at political and public levels. I argue that the dominant individualist perspective is just too narrow and inadequate to meet our mission of meaningful occupation for all. I begin by discussing the dilemma regarding occupational therapy's focus on individuals versus the systems and structures that govern their lives, and I then describe the challenges we face in moving beyond an individualist perspective. I discuss reasons for adopting a broader sociopolitical approach, and I examine advocacy as a professional imperative. I provide a framework for advocacy and situate exemplars within it, exemplifying how occupational therapists can contribute to enabling social justice through advocating for occupational rights and opportunities.

Occupational Therapy's Focus: Individuals Versus Systems and Structures

In developing our science, and furthering our evidence-based practices, we have focused primarily on individuals and their occupational performance. Perhaps it is our complete and undying commitment to client-centredness that has anchored us here, at a place where individuals' lives can be made meaningful through attending to their dreams and goals regarding what they do. Our emphasis on the subjective experience of the people we serve allows us to do the important work of finding meaning through doing. But at the same time, in large measure, it maintains our science and our practice at the level of the individual and overshadows the social and structural roots of occupational injustice.

This is not to say that we, in occupational therapy, are not concerned with the social and cultural environments in which occupations are situated. Almost 25 years ago, Law (1991) pointed to the inequities of opportunity posed by environmental barriers and called for occupational therapists to change disabling environments. While occupational therapists have made considerable gains in addressing physical environments, there has been much less attention paid to the social, economic, political, legal, or institutional elements of the environment that afford or prohibit occupational possibilities (Hammell, 2015). Only in the past few years have we started to show our concern for issues of inequitable environmental constraints of this nature. My search of the past 10 years of the *Canadian Journal of Occupational Therapy*, a journal that reflects our country's most salient occupational therapy issues, revealed several articles in recent years that targeted the social and cultural environment: from Polgar's (2011) call for enabling community mobility at a societal level, to Reed's (2012) letter to the editor describing a culture that promotes risk in sport, to Beagan and Etowa's (2009) insights on the impact of racism on the occupations of African Canadian women. These papers and others encourage us to expand our traditional conceptualizations of the environment beyond the physical and beyond the immediate context in which individuals carry out their daily occupations, to address the larger social, institutional, and political ones that determine occupational restrictions and possibilities.

The heightening sensibility around our commitment to social and occupational justice has fuelled the dilemma of how to balance our work between helping *individuals* who are facing disruptions in their occupational lives and addressing *systems and structures* that prevent them from moving forward. It has highlighted the schism between the theoretical commitment of occupational therapy, which calls for increased work with communities and societies, and its practice, which grapples with how to enable occupation at these levels. Concomitantly, the controversy over individual versus social responsibility for health, productivity, civic engagement, and occupational fulfillment is playing out in our society, and this furthers tensions around how and where to direct our efforts to best meet our goal of enabling occupation and social inclusion for all. Minkler (1999) describes this same dilemma in the area of public health. She refers to this tension as *responsibility versus response-ability*. In other words, she says, the focus on personal behaviour change and individual responsibility is often not accompanied by attention to challenges posed by the larger context that affect the *capacity* of individuals and communities to fulfill their needs and build on strengths. Here, *capacity* refers not to the person's abilities but, rather, to the freedoms, resources, or opportunities to enact those abilities and strengths.

Oftentimes, occupational therapists may feel trapped and helpless in dealing with the larger structural issues that affect the occupational lives of the people they serve. Recently, I spent some time in the United States at a top-tier university occupational therapy program and became familiar with the remarkable work that it does in the area of homelessness. The men's shelter across the street from the occupational therapy school was a much-sought-after student placement, and the important work done within it resulted in some impressive outcomes—an increased sense of community among the residents, a positive and hopeful climate that was almost palpable within the environment, and improvements in social skills, optimism, and self-esteem among the shelter's residents. But the occupational therapists were unable, they told me, to provide what was really needed, and that was an evidence-based "Housing First" approach, shown to be most effective in helping homeless individuals move on with their lives. This recovery-oriented approach quickly moves people experiencing homelessness into independent and permanent housing and then provides

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additional supports so that they can engage and succeed in carrying out their chosen occupational roles. But Housing First relies on the availability of affordable and accessible housing, and more often than not, there is little to none available. So occupational therapists do what they can within these constraints. Faced with the overwhelming and long-term task of advocating for more affordable housing, they work with individuals and groups within the contexts that compose the current reality. Although some wonderful work with Housing First is being done by occupational therapists here in Canada, the fact remains that the number of people on the streets and in shelters keeps growing, and most people experiencing homelessness have no access at all to this housing model.

A recent report, "The State of Homelessness in Canada 2014," written by Gaetz, Gulliver, and Richter (2014), put the problem right in our laps. It said, "In a country as prosperous as Canada, with a broadly shared and strong commitment to social justice, there is no need to accept or tolerate the experiences of poverty, hardship and homelessness" (Gaetz et al., 2014, p. 9). Here, I interpret the meaning of the word *poverty* to be consistent with recent notions of social exclusion that see poverty as not only economic poverty but also poverty of aspiration and poverty of participation, or if you will, poverty of occupation. This quotation causes us to question whether we have accepted the unacceptable, whether we have been swept away by the dominant thinking and economic models of our time. Can we, should we, be doing more to combat such hardship? The obvious answer would be yes, but before we go down that road, I'd like to explore some of the challenges we face with regard to advocacy and action in the realm of social change, so we are aware of what we need to overcome.

Challenges to Moving Beyond an Individualist Perspective

One barrier that impedes our shift from an individual to a societal approach is the enormity of the issues that we must face if we decide to take on this calling. Poverty; discrimination; exploitation; homelessness; abuse; powerlessness; social exclusion; inaccessible, inequitable, or underfunded services—these are indeed daunting problems to address. Australian occupational scientists Wicks and Jamieson (2014) refer to such complex social and environmental problems as "wicked problems" (p. 82) because they defy all the usual attempts to solve them and any seemingly clear solution could create more issues. Many in our field might argue that such wicked problems are beyond our scope of practice, that we do not have the power or political savvy to enact meaningful structural change, that we were not trained to influence policy or politics, that we will lose our focus on occupation and simply blend in with the ranks of others fighting for change, that there is much work to do for individuals with illnesses and disabilities so how can we do it all? In this paper, I make the case that if we *don't* attend to these wicked problems, we really *won't* be able to achieve our goals with the individuals or groups we serve. Furthermore, there is support to go forward with this mission. The policies and position statements we have to guide us as occupational therapists include a focus on social and occupational justice at a high level. Our national Canadian Association of Occupational Therapists' (CAOT) guidelines identify "enabling social change" as a collective form of occupational therapy (Townsend et al., 2013), and the World Federation of Occupational Therapists (WFOT; 2006) Position Statement on Human Rights identifies two of the major tasks to be taken up by occupational therapy as (a) "accepting professional responsibility to identify and address occupational injustices" and (b) "raising collective awareness of occupation and participation in society as a right" (para. 3). We need to decide if we, as occupational therapists, wish to be agents of social transformation by expanding the boundaries of our professional practice in new and challenging areas.

A second challenge to becoming a more socially and politically engaged profession has been noted by occupational science and occupational therapy scholars who have examined our practice from a critical lens. They have pointed out that the social vision of occupational therapy has been narrowed by the need to comply with particular managerial approaches to the health professions and with medical approaches to health, disability, and well-being in particular. In her text *Good Intentions Overruled*, Townsend (1998) highlighted how we as occupational therapists, on the one hand, promote empowerment for marginalized people and groups and, on the other hand, have those efforts undermined by predominant institutional forces, such as a concern for accountability, budgeting, and hierarchical decision making. External structures can narrow our focus as they overrule both personal and professional values and intentions and stifle advocacy objectives in our field. Power dynamics are organized in such a way that biomedical principles have long been privileged. Although the situation is changing, we have been "colonized by the individualist ethics of medicine and economics" (Lomas, 1998, p. 1181), and this has obstructed social and political change. The restrictive effect of dominant paradigms and politics on the scope of occupational therapy practice is a theme that has echoed through the past several decades across various practice contexts. As far back as the late 1980s, Magalhaes (as cited in Malfitano, Lopes, Magalhaes, & Townsend, 2014) pointed out that conflicting power dynamics may push socially committed occupational therapists to the margins in the same way that the communities within which they work are disenfranchised.

A third force promoting an individualistic approach in our field as opposed to a social or structural one is our current political climate of neoliberalism. Within our neoliberal context, social issues are configured as individual problems and responsibilities, and independence and self-sufficiency are upheld as prime values. The current Canadian government has conveyed the message that problems of oppression and exclusion are not social phenomena but, rather, individual acts. Take, for example, our prime minister's comments in response to the death of

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Tina Fontaine, a First Nations girl whose murder sparked calls for an inquiry into Canada's missing and murdered aboriginal women and girls. Harper argued that an inquiry was not needed because this is not a "sociological phenomenon" but simply a series of individual crimes. In the absence of a broader sociological analysis, structural injustices are not addressed, and governments are allowed to recede from responsibility as problems and solutions are seen to lie outside the state's domain (Prince, 2012).

While the impact of neoliberal values is well explicated in the social policy literature (e.g., Beland, 2007; Finkel, 2006; Navarro, 2007), it has only begun to gain attention in the occupational science and occupational therapy literature. Laliberte Rudman (2013) described the way in which we "individualize the social" (p. 298) and articulated her concerns that this obscures the economic, political, and other social factors that shape inequities in occupational opportunities. Gewurtz, Cott, Rush, and Kirsh (2015) demonstrated how neoliberal principles, which valourize self-sufficiency, become embedded into disability support programs and influence service providers to intervene in ways that place responsibility for work and economic survival on the individual. This neoliberal political frame shapes the institutions in which we practise, the discourse in which we participate, and the priorities we set. Painting social problems as individual ones minimizes our sense of social responsibility that is needed to address structural barriers to occupation.

Reasons for Adopting a Broader Sociopolitical Approach

I argue that the dominant individualist perspective is just too narrow and inadequate to meet our mission of meaningful occupational engagement for all. A broader sociopolitical approach is needed to promote an understanding of institutional and systemic inequality that governs peoples' occupational lives. Specifically, we need to adopt such an approach for at least three reasons.

First, occupation is not an individual issue. As Dickie, Cutchin, and Humphry (2006) state, "occupational science is not served well by definitions of occupation that focus investigation and interpretation almost entirely on individual experience, and indeed, occupation rarely, if ever, is individual in nature" (p. 83). Occupation is not individual because it is situated within communities, institutions, and societies and as such is governed by the policies, systems, and cultures that comprise them.

Our recent research with students experiencing mental health problems in a university setting points to how enmeshed occupation is with prevailing discourses and institutional and social structures (Kirsh et al., in press). Although the students worked hard to manage their mental health using evidence-based techniques, such as mindfulness, medication, physical exercise, and energy conservation, they still faced poor academic outcomes, often sacrificing hopes for their futures, because of the institutional culture and policies that governed their work. Caught within a culture of intense competition, these students, simply by virtue of being university students, were expected to do what they needed to do to succeed. Markoulakis (2014) studied the social relations governing university students with mental health problems and revealed that although accommodations are available, these accommodations are individual arrangements that provide solutions to problems for individual students but do not in and of themselves create an accessible institution. Indeed, she found that the ableist assumptions underlying the complex accommodation system served to weed out the most mentally unwell. The system actually created difficulties for the very students it was meant to assist. This example shows us how vulnerable individuals can be cut off from their desired occupations by policies, processes, and cultures that are embedded in institutions. It highlights that, indeed, occupations are not individual.

A second reason for adopting a more socially focused approach to enabling occupation is the importance it holds for health and occupational well-being. A useful framework to adopt in this regard is Link and Phelan's (1995) fundamental cause theory, which is rooted in the field of public health. Link and Phelan critiqued epidemiological work for focusing too much on individual factors, or what they call "proximate" causes of disease—such as diet, lack of exercise, and other forms of self-care—and not attending enough to social factors, or more "distal" causes. They theorized that it is these distal, social factors that are the fundamental causes of ill health. They come to this conclusion based on the persistent association of such social factors as socioeconomic status with disease and mortality, across time and contexts. Indeed, as pointed out by Phelan, Link, and Tehranifar (2010), socioeconomic inequalities in health and mortality are very large, very robust, and very well documented. Even when mechanisms to reduce health inequities are put into place—universal health care, for example—the relationship between poverty and poor health persists. Link and Phelan were determined to understand why conditions that should eliminate or reduce inequities seemed not to. Their theory of fundamental causes explains that the reason for such persistent associations is that social causes involve access to resources that can be used to avoid risks or to minimize negative consequences with many health conditions or vulnerabilities. These resources include money, knowledge, power, prestige, and interpersonal resources that are embodied in social supports and social networks (Link & Phelan, 1995). These social and economic resources offer advantage to health and well-being and can be used in different ways in different situations; they are *transportable* so the association between a social condition and health will endure.

While the fundamental causes explanation that Link and Phelan (1995) propose has been used primarily to explain health outcomes, it is a useful framework to examine social and occupational processes as well. In my work, I see that

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much of what we do is at what Link and Phelan term the proximate level. In the area of mental health, we have worked hard to improve employment among people with mental illnesses, and we have made progress in some areas. We now think about work as a right and a possibility, and we address it as a central focus of our work with people living with serious mental illness. But unemployment is still dismally high for this group, the highest of any disability group. Even newer, evidence-based models, such as supported employment, which have improved employment rates when and where they are used, rarely pull people out of poverty. Our focus on proximate factors—individual skill building, vocational planning, job training, and connection to mental health treatment—is not going far enough. There are much larger, distal forces at play—fundamental social causes, as Link and Phelan would term them. Research has shown that although there *are* individual-level factors that affect employment, the most pernicious impediments have been found to be rooted in stigma, government policies that disincentivize work, poverty, and other social and economic realities (Baron, Draine, & Salzer, 2013). These are the fundamental social causes that form the bedrock realities that undergird all else. When we create programs that focus on individual capacity factors, without accounting for social disadvantage, social problems become constructed erroneously as individual problems, and what results is "the creation of overly simple interventions and policies to address a complex phenomenon" (Draine, Salzer, Culhane, & Hadley, 2002, p. 565). If we want to succeed at the individual level, we will need to find innovative ways to address these fundamental causes.

A third argument for working at the social, institutional, and political levels is based on rights rather than health. Ignatieff (2000), in his Massey lecture "The Rights Revolution," argues that humans have a longing to live in a fair world and that rights give legal meaning to the values we care about—dignity, equality, and respect. The rights revolution, as he calls it, is about enhancing our right to be equal while protecting our right to be different. The Canadian dream of social decency has positioned our country as one of the most distinctive rights cultures in the world (Ignatieff, 2000), and occupational therapists hold an important place within it. As occupational therapists, we believe in the right of all people to engage in meaningful occupations that contribute positively to their own well-being and the well-being of their communities.

But who benefits in society and who has access to occupations that create the fabric of a good life have much to do with power. Powerful members of society's dominant group take for granted the social policies of which they are beneficiaries, while rights are denied to millions of people who are marginalized based on their ability, health status, race, sexual orientation, age, gender, and other aspects. They experience discrimination on a daily basis with respect to education, housing, employment, transportation, and social participation (Fleming Cottrell, 2005). Engagement in occupation thus becomes a political issue. Occupational scientists—Laliberte Rudman (2013), Perreira (2014), and Whiteford (2000), for example—have implored us to critically interrogate societal influences on occupation and participation to reveal inequities produced through the taken-for-granted ways in which institutions and society as a whole are structured. Scholarship in the field is growing around this issue, but as Fleming Cottrell (2005) states, "occupational therapists have historically shown limited *response* to entrenched societal constraints and discriminatory policies" (p. 566; italics added).

I contend that if occupational justice and social inclusion are our goals, we must not only analyze and *critique* the social, institutional, economic, and political constraints that impede people's ability to participate fully in their communities; we must also take steps to *dismantle* them. For occupational therapy to become a profession committed to attaining occupational rights, we will require political engagement with those issues that limit people's equitable opportunities and resources. We must become more assertive about transforming our values and beliefs into action.

Advocacy as a Professional Imperative

With this mission in mind, advocacy takes centre stage. If we are to adopt a practice grounded in inclusiveness that promotes universal access and equity as a mode of thinking, a therapeutic tool, and an ethical responsibility (Flood, 2014), then advocacy must be a professional imperative. Advocacy has the capacity to bridge the gap between social forces and individual experiences and between the world of policy makers and the lives of our clients (Carlisle, 2000).

Advocacy work can take place at the level of "cases" or "causes" (Carlisle, 2000). Case advocacy involves representing vulnerable individuals or groups with the aim of promoting their rights and opportunities. Cause advocacy acknowledges that structural factors need to be addressed to create occupational opportunities for all. In the occupational therapy profession, we most often operationalize advocacy at the level of cases. Dhillon and colleagues studied how and why occupational therapists are involved in advocacy and found that, most often, occupational therapists advocate for individual clients on a case-by-case basis as a part of their client-centred practice, rather than creating change at the level of social policy and political action (Dhillon, Wilkins, Tremblay, Law, & Stewart, 2014). However, the CAOT's (n.d.) definition of advocacy moves us toward levels of causes. It states that advocacy is "a political process performed by an individual or group that aims to influence public-policy and resource allocation decisions within political, economic, social systems and institutions" (CAOT, n.d., para. 1). The very existence of a definition of this nature suggests that we are well positioned to be facilitating change at the level of organizations, systems, and society. Moving into the realm of

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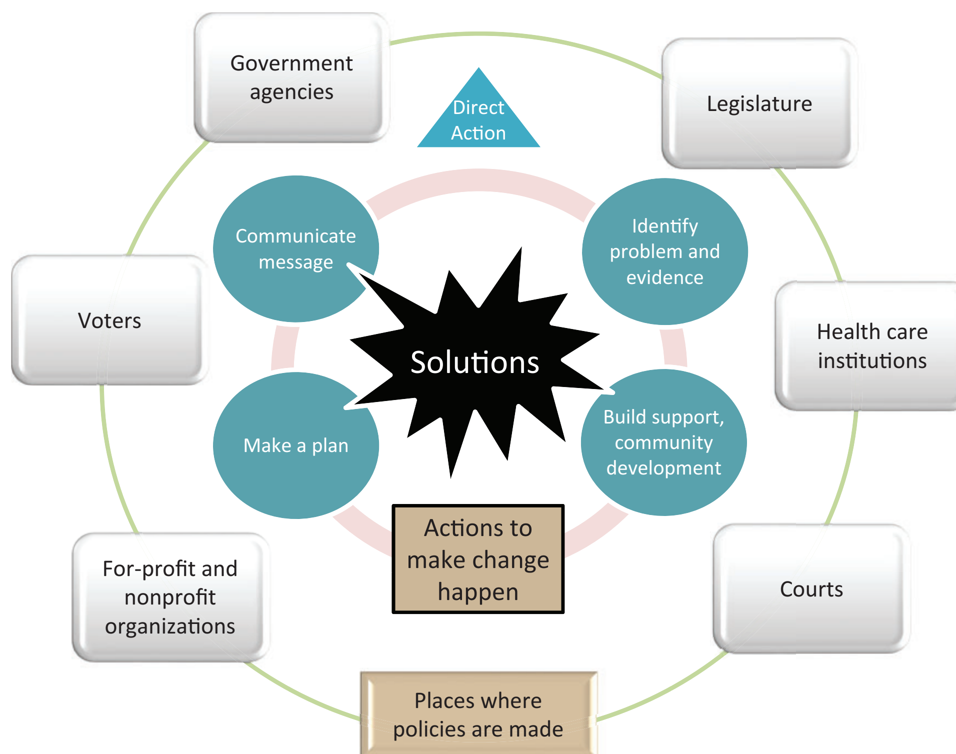

Figure 1. Advocacy world. This figure has been adapted slightly from the original, which was developed by Harry Snyder for *Working Upstream: Skills for Social Change* (p. 96), by Lori Dorfman, Susan Sorenson, and Lawrence Wallack, 2009, Berkeley, CA: Berkeley Media Studies Group. Copyright 2009 by Berkeley Media Studies Group. Adapted with permission.

advocacy in this larger sense involves speaking out against inequity and inequality, mobilizing evidence to influence policy and practice, and participating directly and indirectly in political and institutional processes.

Historically, there are some fine examples of occupational therapy advocacy as a means of translating our core values into sociopolitical action. In the United States, occupational therapist Beatrice Wade worked with veterans groups to amend the 1920 Vocational Rehabilitation Act because it excluded persons with mental illnesses (Bing, 1981). Their efforts were finally successful over a decade later when president Franklin D. Roosevelt signed an amendment to Public Law 113 extending vocational rehabilitation benefits to veterans with mental illness (Bing, 1981). American occupational therapist Fleming Cottrell (2005) writes about Wade, describing her as a classic example of an occupational therapist dedicated to our profession's holistic roots and involved in social change. However, Fleming Cottrell goes on to lament that "few in the profession have followed in her footsteps" (Fleming Cottrell, 2005, p. 567).

Occupational therapists have the capacity to influence political and institutional agendas and chip away at the fundamental social causes of occupational deprivation. But to do so, we need to build our capacity to effectively navigate the challenging terrain of advocacy.

A Framework for Advocacy

For advocacy to be effective, there must be a foundation upon which to build coordinated, collaborative action as well as overarching strategies to draw on. A guiding framework, developed by Dorfman, Sorenson, and Wallack (2009), is useful in this regard (see Figure 1). The framework, developed as part of an advocacy training program to help health practitioners and community leaders become active in local, state, and national policy, provides a way to visualize and understand the components of advocacy and how they work together. It shows us that there are many steps and strategies that can promote change as well as a variety of places where advocacy decisions are made. Occupational therapists wishing to take up the role of advocate may employ some or all of the elements of the framework.

The place to begin is to identify the problem and provide evidence of it. This is what will establish its importance in the minds of the public and policy makers. It is important to become well versed in viewpoints on all sides of the issue to provide a complete and accurate picture. Research, stories, and voices of those impacted by the problem are needed to substantiate it. However, experts in designing healthy public policy point out that while necessary, evidence alone is rarely sufficient for influencing policy processes (Johnson, 2009), as policy decisions are often not based on research (DeLeon, Loftis, Ball, & Sullivan, 2006).

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An important component of the advocacy process is building support through community development and coalition building. Our discipline has cultivated a strong practice and research base in community development. There are many principles and examples that focus on how occupational therapists can and do partner with and support communities in identifying and addressing their needs. Lauckner, Pentland, and Paterson (2007) describe community development as "a multilayered, community-driven process in which relationships are developed and the community's capacity is strengthened, in order to affect social change" (p. 6). In community development, power relations are closely attended to, so there is shared accountability and responsibility. This approach is consistent with occupational therapists' belief in participation and power sharing.

An essential component involves developing a plan, with goals and strategies. This plan will be the road map of the steps to be taken along the way. The plan will need to support the development of a clear strategy based on the chosen forum and needs to consider the resources available. The plan will inevitably change along the way.

Another important component of advocacy is communicating the message well to inform the public and decision makers. This message needs to convey the importance of the issue based on accurate information and a well-reasoned analysis. It needs to reach the right audience, tell a simple and compelling story, and connect to the well-being of communities or society.

Sometimes, direct group action—for example, protest—can focus public attention on an issue. In addition to deciding on these actions for change, the place where change is to be made must be targeted, such as government agencies or the legislature, health care institutions, the courts, profit or not-for-profit organizations, a voting constituency, or a combination of several. These components, considered carefully, can lead to solutions for change.

Advocacy in Action

For some time, injured workers in Ontario, Canada, had been struggling to have their voices heard; they felt they were treated unjustly by the workers' compensation system and by society at large. They not only found themselves struggling with an injury that rendered them unemployed but also found themselves facing poverty, poor physical and mental health, and negative attitudes from others (Beardwood, Kirsh, & Clark, 2005). Several years ago, a group of injured-worker representatives and researchers came together to explore the plight of injured workers in Ontario with the aim of creating some real change in the system.

We began by identifying the problem and gathering evidence. The problem, as told to us by injured workers, was that widespread suspicion and stigma were embedded in workplaces, the health care system, and the workers' compensation system. This suspicion and stigma created anger, a diminished sense of social status, and barriers to health recovery and return to work (Kirsh, Slack, & King, 2012). One injured worker put it,

> They know how to instil fear in the person that's injured. You're already injured so your defenses are down. You're now backed into a corner . . . you feel like you're alone and you have no recourse. And it's a rotten position to be in.

International research on the topic was consistent with these reports. It pointed to the stereotypes that painted all injured workers as "fraud artists abusing the system" (Lippel, 2007, p. 433) as well as institutionally embedded expectations that injured workers will violate or abuse entitlements (Eakin, 2005).

We went on to building support through community development and forming coalitions. We were fortunate to receive substantial funding that enabled us to develop an infrastructure for research and action. We called ourselves RAACWI—Research Action Alliance on the Consequences of Work Injury. Coleading the project were an academic and a community member who was active in the injured-worker community. We recruited injured workers to become researchers on the project, we partnered with injured-worker organizations, and we engaged other stakeholders. People heard about RAACWI and came with their stories, their energy, and their readiness to work hard on the cause.

As our work developed, we communicated our messages to multiple audiences. Of course, there were the usual academic articles and conference presentations (see, for example, Cacciacarro & Kirsh, 2006; Franche et al., 2009; MacEachen, Kosny, Ferrier, & Chambers, 2010), but there was so much more. An injured workers "Speakers School" was started where injured workers learned to convey their messages to the public, or in the words of one of the organizers, injured workers practised moving "from venting to convincing." They not only told their personal stories but learned to frame them in a larger political context from which they were able to express and defend their rights. Another way of communicating the message was a play, titled "Easy Money," that was based on research by some of our team members (see Eakin & Endicott, 2006). As the title suggests, the play took a satirical look at the misperception that injured workers prefer to rely on workers' compensation as a source of "easy money" rather than to work for a living. Written and directed by Kate Lushington, actors portrayed the frustration that many injured workers experience. We also included policy makers in both receiving and delivering the message that justice for injured workers was much needed. We held a symposium (Kirsh, Eakin, & Mantis, 2010) and invited the then minister of labour, the Honourable Linda Jeffrey, to deliver closing remarks. At the same time, there was direct action. For years, there has been an annual injured workers' day during which there is always a rally at Queen's Park. Injured workers and others from our group attended.

We targeted the Workers' Safety and Insurance Board (WSIB) as the specific place to make change. The WSIB administers the province's no-fault workplace insurance for employers and their workers, providing disability benefits for workers injured or made ill on the job. Many of our participants and research partners had shared stories about the systemic

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discrimination they encountered there and the barriers they experienced in trying to return to work. Eakin (2005) described the "discourse of abuse" (p. 159) that pervaded the system, and we had a pretty clear picture that this was, in the words of Link and Phelan (1995), a fundamental social cause of occupational deprivation and ill health. Many of us met with the president and senior managers at the WSIB to share our concerns and our findings about stigma and to talk about how we could work together. The president picked 10 people from her management team to explore the issue, and we chose six, comprising researchers, injured workers, and injured-worker advocates. Together, we embarked on a set of sessions that were dubbed "blue sky discussions." The approach was respectful, open, democratic, and honest. We developed a framework describing how stigma becomes embedded into institutions and what changes were needed to address it (WSIB, 2010). We then developed an action plan with clear objectives and a set of deliverables.

Very soon, stigma was being discussed everywhere within the organization as managers took the messages back to their departments and senior executives conveyed that the problem was real. We knew we were making an impact on raising awareness, but we wanted to ensure that some changes were made in policies and procedures as well. And to the credit of the organization and its leadership, we managed to see some concrete results. The organization implemented a draft recruitment screen to identify negative attitudes toward workers with disabilities when recruiting internally and externally. It also implemented a worker sensitivity check tool used during the development or updating of new or existing written communication to help identify if the communication might promote stigma. A brochure that pointed out and corrected some of the myths about injured workers was disseminated widely (WSIB, 2010). In that brochure, the president of WSIB took a stand:

> When someone is injured on the job, they need our help—not snap judgments about who they are just because they got hurt on the job. We have to do everything we can to help them recover their lives, dignity, and health.

Finally, an e-learning course on stigma aimed at reducing negative attitudes and behaviours toward injured workers was embedded into the competency training that all WSIB staff complete as part of their performance evaluations (WSIB, 2010).

These changes—new policies on recruitment, orientation and training of staff, new systems for corporate communication within the organization, and new tools and procedures for the creation and approval of documents—were all put into place to shift the culture and social relations that governed how injured workers were treated by the system. We knew that these changes had to go further, that governments needed a heightened consciousness for changes to infiltrate the public domain. We were delighted that the message was carried forward by incoming WSIB president David Marshall and deputy minister of labour Cynthia Morton as they discussed stigma when they appeared before the Standing Committee on Public Accounts.

We were very proud of the changes and the impacts of our advocacy work. We engaged injured workers and other key stakeholders in a participatory process and then targeted institutions and systems to create change. It resulted in new policies and procedures within the organization and reached the government level as well. It was the beginning of some real social change. We knew that it was *just* the beginning, that advocating for social and occupational justice demands continued attention to ensure change is sustained over time and not undermined by shifting social and political trends (Jason, Beasley, & Hunter, 2014). In the words of Ignatieff (2000), "the price of freedom is eternal vigilance" (p. 5).

There are many other occupational therapy exemplars to draw on as well, from researchers and clinicians alike. Barry Trentham has been working with Care Watch, a senior citizen–led group advocating for adequate funding for supportive home care by working with policy makers and those who influence policy. His interest in how social attitudes influence occupations of senior citizens has led him to examine the intersection of ageism and senior citizenship advocacy (Trentham, Sokoloff, Tsang, & Neysmith, 2015). Together, Trentham and the senior citizens of Care Watch have shaped policy discourse on ageism and senior citizenship. Karen Rebeiro Gruhl in northeastern (NE) Ontario recognized that policies and programs that are meant to help people with mental illnesses be successful in their employment goals are actually barriers to those individuals most needing the support (Rebeiro Gruhl, Kauppi, Montgomery, & James, 2012). She created a groundswell of interest in the vocational service provider community throughout NE Ontario and brought together important decision makers from the Ministry of Community and Social Services, the Local Health Integration Network, and the Ontario Disability Support Program to review employment issues of people with mental illnesses in NE Ontario. As a result, the focus on employment for people with serious mental illness within NE Ontario has elevated in importance. Rebeiro Gruhl has said that her organization has seen a significant increase in the numbers of individuals who seek work and who transition off social assistance (Rebeiro Gruhl, personal correspondence, January 31, 2015). Robin Mazumder, an occupational therapist working in Edmonton, uses social media to mobilize occupational therapists and others to apply pressure on governments about issues of social justice. For example, his occupational therapy blog calls on the people of Edmonton to increase bike lanes for the health and well-being of the city and its people as well as for people living in poverty struggling with the costs of transportation. Mazumder also tweeted about Bill 10, which, if passed in its original form, would have allowed the province's school boards to reject students' requests to create a gay–straight alliance. The bill was amended to protect gay youth and enable these peer support groups to form. These occupational therapy exemplars, and the many others that exist nationally and globally, inspire us to move forward with our collective responsibility of advocating for social and structural change.

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Conclusion

In this paper, I have argued and demonstrated possibilities for increased involvement in political and systemic advocacy on the part of occupational therapists. Promoting social change through advocacy is a professional imperative and one that can—and must—be taken up by occupational therapists in any research or practice role or capacity. The time is ripe, and the opportunities are many for expansion of our efforts in this realm.

Enhancing our commitment to social change through advocacy must become part of the process of professional socialization—a professional imperative—which we undertake by equipping ourselves with the analytic and practical tools necessary to undertake this calling. We need to address and develop a new set of competencies in our educational programs and in our professional development. We need to become knowledgeable in community development and coalition building, the structure and function of political systems, policy analysis, conflict resolution, and systems change principles, including how power distribution and decision-making processes unfold. We need new platforms for communication. We should become more astute in using media, especially social media, for advocacy purposes. We need to hold conferences, publish newsletters, organize task forces, and create awards for work in the advocacy arena. Most of all, we need to embrace a sense of self-confident idealism reflected in a strong belief that our investment in advocacy will make the world a better place. Occupational therapy is a visionary discipline. Occupational justice is our most ambitious enterprise, and advocacy is one of its key strategies.

In closing, I return to a question I asked earlier in this paper: "Have we accepted the unacceptable?" I propose our collective response should be a quotation from political activist Angela Davis: "I am no longer accepting things I cannot change. I'm changing things I cannot accept."

Key Messages

- Occupational therapy must broaden its current individualist perspective and adopt a sociopolitical approach to address issues that limit people's equitable opportunities and resources. Advocacy is a professional imperative.
- The profession will face challenges in becoming more socially and politically active: daunting, "wicked" problems; paradigm dominance and power relations; and a climate of neoliberalism.
- Advocacy must be embraced in our educational programs and in our professional development. There are useful frameworks and exemplars in the field to draw on.

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Supplemental Material

A video of this lecture can be viewed at https://www.youtube.com/watch?v=KoI4pO0bm8U. The full French translation of this paper is available at http://www.cjotrce.com/content/82/4/E1.

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Précis – Discours commémoratif Muriel Driver 2015

Transformer les valeurs en action : La défense des intérêts en tant qu'impératif professionnel

Bonnie H. Kirsh

Cet article soutient que la perspective individualiste dominante en ergothérapie est trop étroite pour atteindre notre mission visant à favoriser la réalisation d'occupations significatives pour tous. Une approche sociopolitique plus large est requise pour mieux comprendre les inégalités institutionnelles et systémiques qui gouvernent la vie occupationnelle des gens. On constate plus particulièrement le besoin d'intégrer la défense des intérêts à même l'identité de l'ergothérapie.

Au moins trois raisons nous incitent à adopter une approche sociopolitique. La première raison est que les occupations ne sont pas un enjeu individuel; elles sont situées au sein des communautés, des institutions et des sociétés, et donc, elles sont régies par les politiques, les systèmes et les cultures qui les comprennent. La deuxième raison d'adopter une approche plus sociale de l'habilitation de l'occupation est l'importance des occupations pour la santé et le bien-être occupationnel. La théorie des causes sociales fondamentales de Link et Phelan (1995) soutient que des facteurs distaux et sociaux sont les causes fondamentales d'une mauvaise santé, plutôt que des facteurs plus proximaux (comme le fait de prendre soin de soi). Cette théorie nous aide à comprendre que si nous voulons réussir à l'échelle de l'individu, nous devons aborder ces causes fondamentales en adoptant des approches novatrices.

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Lorsque nous créons des programmes axés sur des facteurs liés aux capacités individuelles, qui ne tiennent pas compte des désavantages sociaux, alors les problèmes sociaux sont faussement perçus comme des problèmes individuels.

La troisième raison de travailler à l'échelle sociale, institutionnelle et politique est fondée sur les droits plutôt que sur la santé. En tant qu'ergothérapeutes, nous croyons au droit de toutes les personnes de participer à des occupations significatives qui contribuent positivement à leur bien-être personnel et au bien-être de leurs communautés. Nous devons nous engager fermement à transformer nos valeurs et nos croyances en action.

Dans cette optique, la défense des droits occupe le devant de la scène. La promotion du changement social par la défense des intérêts est un impératif professionnel qui peut être entrepris par tous les ergothérapeutes, par l'intermédiaire de leurs activités de recherche ou de leur rôle de praticien. La défense des intérêts peut permettre de combler le fossé entre les forces sociales et les expériences individuelles et entre le monde des décideurs et la vie de nos clients (Carlisle, 2000). Pour que la défense des intérêts soit efficace, il faut établir des bases solides permettant de coordonner des actions concertées, de même que des stratégies d'ensemble. Le cadre d'orientation élaboré par Dorfman, Sorenson et Wallack (2009) est utile à cet égard. Ce cadre propose une façon de comprendre les éléments de la défense des intérêts et la manière dont ils s'organisent ensemble. Il nous montre aussi que de nombreuses étapes et stratégies peuvent favoriser le changement, et qu'il y a de nombreux endroits où des décisions sont prises en matière de défense des intérêts.

Le renforcement de notre engagement au changement social par la défense des intérêts doit faire partie intégrante de notre processus de socialisation professionnelle. Nous avons besoin d'un nouvel ensemble de compétences dans nos programmes de formation et dans nos activités de développement professionnel; de nouvelles plateformes de communication, notamment les médias traditionnels et les médias sociaux; et d'un sentiment d'idéalisme confiant se traduisant par la ferme conviction que notre investissement dans la défense des intérêts permettra de bâtir un monde meilleur. L'ergothérapie est une discipline visionnaire. La justice occupationnelle est notre entreprise la plus ambitieuse, et la défense des intérêts est l'une des stratégies clés dans ce domaine.

Le moment est propice, et les possibilités de déployer nos efforts dans ce domaine sont innombrables.

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