# The Experiences of Occupational Therapists Practicing in Rural and Remote Communities in Northern British Columbia

Prepared by:

Kathryn Fields, Laurel Van De Keere, Neil Hanlon, and Greg Halseth

Community Development Institute
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## Availability

Copies of this report are available from the Community Development Institute website: http://www.unbc.ca/cdi/research.html

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## Introduction

People living in rural and remote communities experience many health disadvantages, not the least of which is poorer access to health services (Hegney & McCarthy, 2000; McMurray, 2004). Unequal access to health services can greatly impact an individual's health, recovery, empowerment, and wellbeing. This unequal access is often due, in large part, to a shortage of health care professionals, which is a common issue in rural areas worldwide (Bushy, 2002).

Research has identified a chronic difficulty in recruiting and retaining health care professionals in northern British Columbia (BC) (Manson & Thornton, 2000). The major issues affecting recruitment and retention include the high workloads of health service providers, inadequate facilities and equipment, and a lack of support networks within and between health care disciplines (Henderson Betkus & MacLeod, 2004).

This study aims to learn from the experiences of occupational therapists practicing in northern BC in order to contribute to the planning and provision of better systems of professional support. The study intends to accomplish this by examining the structure and characteristics of occupational therapy (OT) practice in the region, and various issues around recruitment, retention, and the skills and supports required to practice in rural and remote settings. In this sense, we hope to contribute to a better understanding of the issues affecting the stabilization and improvement of the OT workforce in smaller and remote centres.

# Literature Review

While there is little published information about occupational therapists practicing in rural and remote communities in Canada, there are some experiences to draw from the more prominent, although by no means extensive, literature on physicians and nurses working in smaller centres. What this nursing and physician literature suggests is that lifestyle and personal opportunities are the most important factors in attracting professionals to rural and remote locations, followed by factors such as the level of professional support, working relationships with peers, workload, organizational structure, opportunities for advancement, and access to professional development resources (Leipert, 1999; Millsteed, 2001). The challenges most commonly identified include professional isolation and limited opportunities for continuing education (Francis, 2005). Additionally, literature suggests that professionals practicing in rural areas need to have knowledge in a wider range of practice areas than their counterparts in urban centres (Peterson et al., 2003).

In order to address these challenges, health professionals use telemedicine and other forms of technology to reduce isolation and to enable communication with other professionals. In some cases, governments provide funding for students to complete placements and educational blocks, and for educational facilities to open in these areas, allowing students to experience the lifestyle and practice opportunities available in rural areas (Bushy, 2002; Francis, 2005; Snadden, 2005). Governments have also implemented incentive and remuneration initiatives (Bushy, 2002; Francis, 2005). However, in many instances, these solutions focus on the physician only, to the neglect of nurses, paramedical professionals, and other allied health personnel. In other cases, it has been shown that rural and remote practice is often accompanied by reduced access to newer technology (Wilson et al., 2005), making it more difficult to cope with increased service demands due to processes such as aging population (Campbell, 2000; Hanlon & Halseth, 2005).

There have been a small number of studies of occupational therapists working in small communities, including such countries as Australia (Lannin & Longland, 2003; Millsteed, 2001), the United States (Peterson et al., 2003), and Canada (Solomon et al., 2001). This literature suggests that success in the recruitment and retention of occupational therapists, much like those of nurses and physicians, is closely related to the satisfaction of professional and personal factors (Millsteed, 2001; Solomon et al., 2001). Professional factors include opportunities for professional development and support, feelings of connectedness with peers, appropriate supervision, professional autonomy, appropriate pay, available resources, working conditions, workload, and work-related travel (Denham & Shaddock, 2004; Mitka, 2001; Peterson et al., 2003; Wills & Case-Smith, 1996). Documented personal factors include the influence of a spouse or partner, being from a rural background, friendships, lifestyle choices and preferences, lack of recognition, and homesickness (Millsteed, 2001; Solomon et al., 2001).

As with many other health and care professions, people are being trained to work in increasingly specialized practice areas at a time when rural and remote settings still require the services of a ‘generalist’ practitioner. Such circumstances reinforce the need for a general service model suited to rural and small town places (Northern and Rural Health Task Force, 1995; Struthers, 1994). Occupational therapists practicing in rural areas are often required to have knowledge of a

wide range of diagnoses, as well as expertise in multiple practice areas (Peterson et al., 2003; Wills & Case-Smith, 1996). Many therapists who agree to fill rural positions are new graduates, and their inexperience can compound issues of isolation, lack of professional, technical, and peer support, and extensive job requirements (Lee & Mackenzie, 2003). Research among new graduates demonstrates that a lack of professional supports can result in decreased confidence and decreased job satisfaction, while access to professional supports can assist therapists in building independence and other skills (Steenbergen & Mackenzie, 2004).

The interest in 'social and support networks' for health care providers has been growing given the increasing pressures on health care systems to be more cost-effective (West et al. 1999). A range of research has shown the critical role that support networks and opportunities for interaction with peers and colleagues play in organizational performance, effective delivery of services, efficiency in daily job activities, and overall professional morale, development, and job satisfaction (Hoelscher et al., 2005; Hollins et al., 2000; Joyce et al., 2003; Marshall, 1999)

As of yet, no study has investigated the perceptions of occupational therapists practicing in northern BC to ascertain whether they experience unique recruitment and retention issues, and to identify issues that need to be addressed for rural and remote areas to attract and retain occupational therapists. Similarly, there is a dearth of literature specific to OTs that explores the role of social cohesion, access to professional supports and colleagues, or the importance of obtaining practice training that is relevant to the rural and small town context. By understanding better the factors that lead to successful recruitment and retention, it is hoped that clients throughout northern BC will experience improved access to higher quality OT services.

## Data and Methods

This study used a qualitative case study design to incorporate the contextual component of communities in northern BC with the experiences of occupational therapists. A case study approach was selected as it allows for an in-depth exploration of the multi-faceted characteristics and nuances that shape and influence 'real-life events' (Patton, 1990; Yin, 1994).

To explore the personal experiences of occupational therapists, we undertook interviews with individuals practicing across northern BC. Because this project was carried out by a university based research team, it was bound to standard protocols which identify that all research conducted with people be sent to the university Research Ethics Board for review. Key to ethics review is that participants are advised of the purposes of the study, that their participation is voluntary, and that the research shall protect their confidentiality and anonymity (Dowling, 2005).

Occupational therapists from across the north were contacted and recruited. A total of seventeen interviews were completed in March 2006. Participants were recruited using contact information for hospitals and child development centres accessible on the internet, as well as contact information given by occupational therapists. Once informed consent was obtained, each interview was conducted by telephone by the lead author, following an interview protocol. The interviews lasted between thirty minutes to an hour.

A semi-structured interview guide, comprised mainly of open-ended questions, was used for the project. Semi-structured interviews allow for a predetermined order of topics to be laid out, but there is still flexibility in how the issues are addressed by the respondent (Schoenberger, 1991). The open-ended nature of the questions encouraged participants to express and explain various aspects of their practice environment in their own words (Babbie, 2004). This approach also allows flexibility to explore individual experiences and is open to interviewee's raising issues or topics that were not anticipated in the interview design (Dunn, 2005).

The interview guide (see Appendix 1) covered four main sections. The first asked about the interviewee's occupational therapy practice, including communities served, scope of practice offered, and levels of service demand. The second set of questions focused upon the delivery of OT services, especially their fit with local needs and changes in those needs over time. The third section focused on the practical and personal experiences of working in a rural community in northern BC. In this case, people were asked about why they chose to practice/stay in northern BC, what they see as the benefits or rewards of practicing in the north, and what they consider to be the key challenges for their practice. Finally, the fourth section explored questions about professional supports, including access to continuing education, supervision, other OTs, other professionals, research, workshops, and conferences.

All interviews were audio recorded, from which the lead author prepared summary notes. These notes were distributed to each participant for review, and changes requested by participants were incorporated into the final notes used as the basis of the analysis. From these notes, content analysis was conducted on the data to identify broader themes and concepts around the rewards

and challenges of service delivery in remote locations. Both manifest (overt word/topic appearance) and latent (more general themes) content analysis were employed. The interview data were combined and organized by survey question, then coded and grouped into categories and analysed for both frequency and range of responses (Hycner, 1999; Patton, 1990; Warner and Griffiths, 2006). The construction of the content analysis categories was also compared with findings in the literature (Eisenhardt, 1995).

# Results

## The delivery of occupational therapy in northern British Columbia

Northern BC includes about two-thirds of the landmass of BC, but is home to only eight percent of the province's population (Northern Health Authority, 2006; Statistics Canada, 2005). The growth rate for seniors is the highest in BC, with a projected 48 percent increase by 2010 (Hanlon & Halseth, 2005). Additionally, northern BC has the highest proportion of First Nations people at 13 percent of the population (Northern Health Authority, 2006). The largest city in northern BC is Prince George, which has a population of less than 80,000. Most of the occupational therapists practicing in northern BC are located in urban areas (populations greater than 10,000), but many of these communities are relatively small and all are remote from the nearest metropolitan centre.

In 2006, an estimated 50 occupational therapists were practicing in northern BC, with approximately half of these located in Prince George. Occupational therapists work in a variety of practice settings including hospitals, private practices, complex and extended care facilities, home and community care facilities, schools, and child development centres.

Seventeen occupational therapists practicing in northern BC participated in this study (Table A1). Three of these participants worked in Prince George, while fourteen worked in smaller communities throughout northern BC. This reflects a purposive sampling bias towards those practicing in smaller and more remote locations. All of the participants were women, although this was not a criterion for participation.

Tables A2, C1, C2a, and C2b describe additional characteristics of the participants. Half of the participants were employed in a single practice area and half were responsible for multiple practice areas. The majority of participants had been practicing in northern BC for more than ten years, although four had been there for less than five years. Seven of the participants were new graduates when they started practicing in northern BC, while the others had practiced previously in the Lower Mainland, in other provinces, or in other countries.

The dispersed pattern of settlement in the region means that travel is a routine feature of practice for many OTs in the region. Six of the participants interviewed stated that they travel regularly as part of their job, mainly to serve clients and visit facilities in nearby communities (Table B4). Ten stated that they travel occasionally (e.g., ranging from biweekly, quad-annually or yearly). Participants who travel regularly make use of cars and air transportation for extended trips to outlying communities or educational consortiums.

Participants came from a wide range of practice locations, and their clients were from across the demographic spectrum (Tables A3a, A3b, A3c, A3d, A3e, and A4). There was fairly even distribution of clients by sex, and most participants perceived that their clients came from a wide variety of income levels. The majority of clients were referred by a doctor, or else self-referred. Likewise, there was a fairly balanced distribution of client diagnoses reported. In short, our sample is not dominated by any type of OT practice.

In general, clinicians felt that the OT services currently provided in northern BC are insufficient (Tables A5a, A5b, A5c, B2). The informants suggested that some clients did not have access to needed services, and that others had to wait for these services. It was also stated that occupational therapists often lack the capacity to deal with clients' issues thoroughly, and that they may not be able to address the needs of certain populations. Many participants made demonstrative statements such as "[t]here are a lot of areas not getting OT service or that could get more OT service" (I3), or "[t]he situation is not sufficient by any means; I'm stretched to the limit here" (I12).

Nine participants had some form of a waitlist in at least one of the communities they were practicing in, and wait times ranged in length up to several-months in duration (Table A5a, A5b). Many of the participants spoke of priority-ranked waitlists, where they may not see clients with fewer or less severe needs, concentrating instead on those clients with higher needs. Participants stated that wait times were influenced by the size of caseloads, the priority or urgency of an issue, and the availability of staff. Of those without a waitlist, two participants felt that they had sufficient time to see all of their clients. Others attributed the lack of a waitlist to reducing services through prioritization, working within a consultation model, or seeing clients less frequently.

Only three participants felt that the frequency with which they were able to see clients was sufficient (Table A5c). One of these participants had the time to provide direct therapy, while the other two worked within a consultation model, but felt that this was efficient and appropriate. Ten participants expressed a desire to see clients more often and described situations in which they were not able to give optimum or adequate treatment. Most of these participants described working in more of a consultation role, rather than providing direct therapy. One participant described it as being in 'triage mode' and having to set priorities. As this participant describes it:

> You are just kind of doing the band-aid thing. You are dealing with crises. You are really not getting into any programs, or anything that would actually really work at improving function if someone had that goal, because there isn't time. (I17)

**Factors that brought therapists to the region**

The factors that led people to northern BC related to lifestyle and practice, as well as to factors such as financial incentives or employment opportunities of a spouse (Table C3). A few participants had received educational funding assistance with the agreement that they would work in an under-serviced area upon graduation. Most participants cited a combination of lifestyle and practice issues as pull factors. Three participants stated that no specific aspects of the job drew them to the north.

Lifestyle factors that led participants to northern BC can be grouped into three categories: a connection to the north; a preference for small town lifestyle; and access to the outdoors and recreational activities. Many of the participants had a connection to the north, either having grown up there, having visited previously, or having family or friends living in northern BC.

Desirable lifestyle factors of a smaller town included the lower costs of housing and living, the perceptions of being a good place to raise children, and the perception of being less congested, cleaner, and quieter than metropolitan areas such as BC's Lower Mainland. Nine of the participants spoke passionately about aspects of the outdoors, citing a variety of recreational activities including skiing, hiking, and camping, as well as the scenery in general.

Practice factors that led participants to northern BC included the availability of jobs, the nature of employment positions, and the quality of employment facilities. The availability of jobs referred both to the availability of jobs in specific practice areas (such as paediatrics, where positions are limited), as well as the general availability of jobs for therapists and their spouses. Desirable factors of positions in the region included a sense of greater responsibility and autonomy in decision-making, the opportunity to be sole charge, financial incentives, and the challenges offered by the job. Desirable aspects of the organizational context of their employment revolved around things such as working within a client-centered ethos, having a supportive inter-professional team, and having a positive and friendly work environment.

**The rewards of practicing in the north**

Participants described both lifestyle and practice factors as being benefits of practicing in the north (Table C4). The practice-related lifestyle factors cited are similar to the issues expressed about what initially drew the participants to the north in the first place. Participants noted access to the outdoors and recreational opportunities once again. In addition, similar concepts regarding the lifestyle of a smaller town were included. Two of the participants specifically stated that there were few practice benefits, and found it difficult to describe any.

One participant felt that the benefits and challenges that she experienced had nothing to do with practicing in a northern community, but were more specific to the location and facility in which she worked. As she stated it, "These are work environment issues, not a northern environment issue" (I4). This participant felt that all of the benefits offered by a rural northern lifestyle could be found in rural areas of Southern BC, and that practice factors could be found in all communities, irrespective of their size. Her reasons for staying in her community related directly to her job and work environment, and she did not feel that there was anything unique about practicing or living in northern BC. As she explained it:

> I have a fabulous job and it happens to be in a great location, but what keeps me here isn't the location, what keeps me here is the job, the autonomy and the team, so it really doesn't have a lot to do with the location. (I4)

This view was certainly not universal, as another participant stated that, "I enjoy the north and that is one major reason I am here" (I11).

Over half of the participants spoke positively about the wide variety of practice roles they encountered, about the opportunity to be a generalist, and about the intimacy of communication with other professionals in a smaller community. Participants spoke of enjoying working with clients with a variety of conditions and being able to implement a variety of interventions. Participants often connected this variety to the idea of being the only therapist in an area. As one participant stated:

> There is such a wide range that you are exposed to. I feel that you're not being very specific in your practice. You are really able to see such a range of things, from feeding, to seating, to the entire range, versus being focused on only one aspect of OT. And because OT is such a wide range, it is nice to really have that perspective. (I6)

Because of this variety, therapists have the opportunity to be generalists. Another participant explained this concept as:

> [Having the opportunity to be] very generalist – you pretty much have to do everything, from splinting, to wheelchairs, to rehab, to cognitive testing, different wards, everything, which you don't do in bigger centres. (I1)

Benefits associated with the intimacy of inter-professional communication included working in a friendly department, drawing connections with familiar community resources, accessing emotional support, and developing close relationships with other team members. One respondent felt that:

> You get to work with such a varied population of professionals. You know what they look like and where they work – you can catch them in the grocery store. So the communication is more intimate here than in a larger setting. (I12)

A third of participants noted the autonomy and freedom of their position as rewarding, and described the benefit of a supportive workplace. One participant described autonomy and freedom as the "autonomy to do things the way you think they should be done" (I5). Another stated that "autonomy [and] flexibility … make practice a little more interesting" (I15). A supportive workplace included having a friendly department, flexible hours, a casual work environment, and educational funding.

Other benefits of practicing in the north included the special 'personality' of clients in the north. One participant described it in these terms:

> I enjoy the northern BC personality of people. They are down to earth, very hardy and put up with a lot of disability, deal with disability well, not everyone, but the majority, because they are used to doing things on their own. (I1)

Others appreciated the opportunity to get to know clients. A few participants discussed the opportunity to learn and to be creative. This included the idea of working "outside the box, because resources are limited, so you have to come up with ways to make things work" (I9), and the idea of broadening personal occupational views.

> [Working as an occupational therapist in northern BC] broadens your view of how people live and what it means to function. You appreciate that people live in many different ways and what it means to function to them, living in a little cabin, is quite different to living downtown somewhere. There is lots of room for creativity – offering recommendations to clients, when services are not readily available (I15).

Another participant felt that practicing in a smaller community provided unique opportunities to expand OT practice and fulfill roles outside of the normal scope of OT. As she stated:

> We get to really know our clients – we hear stories about their kids, we're financial advisors, and we have to do little things that are outside of our normal

> OT area. Just little things – you have the freedom – you're part of the community. You are building trust with your clients. (I18)

The greater familiarity and interaction with clients was seen to be beneficial to some in terms of their own personal development. One participant mentioned learning more about First Nations' cultures through their work with different client groups.

Of the twelve participants who stated that their ability to deliver services within their community had changed over time, the majority felt that these changes were positive (Tables B3a and B3b). Many participants felt that increased staffing, changing roles, structural changes, and increased funding had allowed them to offer more services and to decrease waitlists. Other participants felt that their personal ability to deliver services had improved, or that they were able to make a positive shift from a consultative role to a more intensive one. One participant explained that:

> Moving into a private practice allowed me to do more direct treatment and feel like the clients I am serving are actually getting the service [they require]. In [my previous] position, my caseload was often over 180 – which could only be consultative. Now, doing direct treatment, I have been able to see tremendous progress in clients who weren't progressing through a consultative model. (I7)

**The challenges of northern practice**

Participants identified unique challenges relating to the location of their practice, the size of their community, the complexity of their caseloads, the supports provided through their work environment, their access to allied health professionals and resources, and their own professional expectations and aspirations (Table C5a). Some participants had difficulty identifying challenges or saying whether they felt clients were getting optimal service, because they had no previous experience to compare with. This was especially true for the participants who had worked in northern BC since graduation. Two of these participants stated:

> I am hesitant to say that [the] clients I work with have poor access to rehab or OT services, because I don't really have anything to compare it to. I have been practicing here for [over a decade] now and I don't know what the access is like in the Lower Mainland. (I16)

> It's so hard to say because I don't know what I'm missing. I know I am missing things. I often think to myself, "Am I really doing OT?" (I18)

The challenges identified by over a half of the participants seemed to relate specifically to professional isolation, and included access to colleagues and education opportunities. Participants felt challenged by a lack of contact with fellow therapists in the same practice areas, a lack of contact with colleagues on a daily basis, and a lack of special interest groups. They felt that extra work was required to build support networks as a result. For example:

> We are so well connected with internet, email, phones, [and] faxes. We have the same access to each other as more populated areas. What we don't have are colleagues to run ideas by. We don't have big departmental meetings to brainstorm. We need to organize teleconferences with colleagues elsewhere. You can't just get together at a drop of a hat. (I9)

Challenges relating to education focused on a lack of access to OT-specific courses and local educational opportunities, and included the cost of professional education due to travel expenses.

Other challenges identified by participants included being the sole therapist or sole OT in a region; the lack of access to specialists and specialist knowledge; the variety of caseloads; the small community lifestyle; the barriers to acquiring equipment; the recruitment and retention of therapists; and the lack of mentoring or supervisory support.

Participants characterized the variety of caseloads as a potential challenge if it leads practitioners to overextend themselves. Some participants felt that, because they were expected to know a bit about everything, it had become difficult to specialize or to maintain one's competency in their field.

Regarding small community lifestyle, participants identified issues relating to conflicts of interest and confidentiality. Participants suggested that having personal connections with clients or running into clients within the community was disadvantageous. Moreover, some felt that they were unable to leave their role behind at the end of the working day. Practicing in small and remote communities has other challenges. These include difficulties obtaining equipment that functions in cold temperatures, limited options to acquire funding, and the length of time for equipment to arrive.

The lack of practicing occupational therapists often results in the few therapists available being asked to cover off larger caseloads over wider geographic areas. Participants were also concerned that there were no follow up or outpatient services in some outlying communities. Other concerns presented included having no coverage for holidays or for parental leaves, lack of understanding of the purpose and importance of OT in the community, limited opportunities for career advancement, barriers caused by weather and transportation in accessing services, and difficulties in meeting different cultural expectations. Furthermore, some individuals felt that there was a need to incorporate northern OT practitioners into decision-making processes. Respondents expressed that:

> It feels like our opinion is not always taken seriously, because there are so few of us. We are like the little sister of BC – the north. (I9)

> Related to feeling like the north is behind in some of the recognition of rehab and role of rehab. I think that provides a lot of challenges. [If] you don't have that voice higher up, often policies are made that have a huge impact at the level of the therapists or clients, but they are made by people higher up in administration who really have no concept of how those policies affect people down the way. (I17)

Of the participants who suggested that their ability to deliver services had changed negatively over time, the majority were concerned that their caseload had become heavier (Table B3a and B3b). A lack of staffing, increasing job-related demands, and a lack of administrative support exacerbated this issue. One participant practicing in the education system mentioned that:

> [There] are still many kids that we have to say no to, or if we take on, we really don't get the time to do much with them. So if we take students and don't have time

> to follow them properly, it misrepresents the services. Our ability to deliver a quality service to each client has diminished. (I5)

Half of the four participants who did not think that their ability to deliver services had changed identified this as a concern, since they did not feel that they had been able to increase the scope or quality of the services they provided. As one participant stated:

> Some weeks are harder than others because if someone is off, there is no one to fill that position so other therapists have to cover. I don't think it has changed, I think it has always been this bad. (I8)

**The impacts of these challenges**

Participants described the impacts that these challenges had in terms of their effects on both clients and therapists (Tables C5b and C5c). While these impacts tended to be negative, some positive examples were given.

Impacts on clients included the quality and availability of services, as well as the manner in which challenges affected the lives of clients and caregivers (Table C5b). Regarding the quality of services, some participants felt that clients were not always getting the best service possible. Availability was a concern because some people were not receiving any services at all. Concerns surrounding access to services included people having to travel to, or wait for, available services, as well as the difficulty that clients had in accessing specialist knowledge. Participants felt that clients' and caregivers' lives were impacted when clients were not as independent as they could be, when clients were not receiving the type of care that they needed, or when caregivers became frustrated that the clients' needs were not being met. One participant elaborated on the latter:

> I'm sure it can be frustrating as a … caregiver to see that the needs never seem to really be met; it's always a part, a piece of the pie instead of the whole thing. A little is better than none, but it must be frustrating to just get a little bit. (I6)

For therapists, the negative impacts of the challenges of practicing in the north were to do with issues of competency, additional work and role creation, emotional impacts, limitations on practice, and additional time requirements (Table C5c). In addition, eleven participants mentioned some aspect of professional isolation. This included the difficulty of obtaining new ideas or gaining knowledge, the subsequent limited ability to update practice, and the feelings of incompetence or uncertainty in practice that resulted. Two participants elaborated:

> Rural practice therapists run the risk of incompetence. Because if you are practicing in isolation, how do you know if you are doing it right? There is nobody to check on you. You have to be incredibly motivated to keep checking on yourself. That is not always possible. Because your practice is so general, you have to have a taste of everything. Sometimes you miss those tastes, and you are doing something and then you find out 'I shouldn't be doing that'. How do you maintain your competency if you don't have access to colleagues where you can keep each other informed and up to date? (I12)

> [There is a] downfall of not having another occupational therapist around. Am I doing what I should be doing? Is there something else I should be doing? Am I

> doing what is best for this person? This is kind of nerve-racking at times. I can make phone calls, but it would be nice to have someone there. (I11)

The additional work and roles created because of these hindrances led to a variety of other challenges. Participants felt that they needed to build a support system for themselves, look for other avenues for funding education, do administrative tasks, coordinate with medical suppliers, take more continuing education, advocate for clients, tailor recommendations to the resources available, and provide more and more services. One participant noted that:

> Because we don't have a therapist manager, we do a lot of administration or management things that the manager isn't able to do because he [or] she doesn't have a rehab background. This then takes away from our time for clinical caseload. (I17)

Recalling the earlier reporting of participants who cited independence and autonomy as benefits of practicing in the region, a picture begins to emerge whereby even those predisposed to rural and remote practice recognize the considerable challenges posed by working in greater isolation.

Challenges also involved emotional impacts for therapists, including increased concerns about the safety of clients, frustration regarding the effectiveness of interventions, feeling unsupported, feeling 'spread thin', and becoming burnt out. The following quotes highlight many of these concerns:

> In outlying areas, there is no follow up…. So setting someone up with equipment is horrible, because you're thinking 'will it be set up properly?' There is no one out there to check that. That is a huge barrier and a concern. Sometimes I do worry about people. (I8)

> It's frustrating as a therapist, because you want to give so much more, but you feel that you only have so much. When I talk to other therapists that seems to be the big thing. People allow themselves to get burnt out by that factor, they can't possibly do enough and they wish they could do more. (I6)

The effects of these challenges led to limitations on practice. Common themes here included reduced time with clients, insufficient time to search for information, not being able to be client-centred, running out of materials, and being limited in the OT areas addressed. For example:

> I feel like I am always rushed and clients don't get the best service. I don't think I'm always able to be client-centred. I am always thinking about discharge planning, making sure they have everything they need and then it's done. You don't get to spend time with people finding out what they really want. With regards to self-care, productivity, and leisure, we only get to deal with self-care, even on rehab, which I think is wrong. That's because we're stretched. (I8)

These challenges also posed additional time requirements. This included the time spent educating people about the role and value of OT, the time taken to consult with other therapists when questions arise, the time spent on the internet finding information, and the added thought and time required to practice with limited resources.

On a different note, however, some participants identified positive impacts of the challenges to practicing in the north. The persistence of these practice challenges was seen to make

occupational therapists who remain in the region more self-reliant, creative, and assertive in addressing issues. Additionally, a number of participants felt that these ongoing challenges encouraged greater collaboration with others, the development of areas of specialty, and an appreciation of the value of involving other team members in managing difficult issues. The challenges also shaped how participants utilized telemedicine and other forms of technology to reduce isolation and enable communication with professionals at a distance.

**Skills and characteristics required for northern practice**

Informants felt that the skills most necessary for northern practice were the ability to communicate and collaborate with others, the ability to be resourceful and creative, the willingness to take initiative and problem-solve, and the ability to be flexible (Table C6). Good inter-professional communication skills at a local and provincial level were necessary to address questions, carry out rehabilitation recommendations, and enhance practice. In terms of collaboration, two participants noted that:

> You need to have good ties with the hospital and in- and out-patient programs' therapists so you can meet the needs of your clients. Knowing the therapists and having strong connections between different communities can be helpful. Ultimately this facilitates the care the client receives. (I17)

> [You need to] create teams around yourself in the community, in ways that you may not have to do in a larger community or in a facility where those things are set up for you. You have to do a lot of footwork in terms of developing relationships with people in the community to enhance your practice. (I16)

Participants felt that they needed to be resourceful and creative in order to form resource networks, connect with other occupational therapists, overcome barriers, adapt practice, and work with limited resources. One participant stated that "You need a 'where there's a will, there's a way' attitude" (I7). Willingness to take initiative included being self-directed and a self-learner, and having problem-solving skills. For example:

> [You need to be] self-directed, and problem-based. These are the two biggest issues. You have to be very self-directed. You have to be quite confident and have to know where to go to solve those problems that come up, because chances are you won't have somebody to ask. (I4)

> [You need to be] good at life long learning because you won't be spoon-fed. When you come up against something you don't know about, which happens everyday, you need to know where to look it up. (I9)

Flexibility was also identified by participants, and included things such as scheduling, goal setting, time management, planning, and coping with a lack of services in other areas.

A third of participants identified independence, adaptability, the ability to be a generalist, cultural sensitivity, open-mindedness, and confidence. Participants felt that being able to work independently was important, especially with reduced access to colleagues. For example:

> [You] need to be prepared and able to work very independently, because it is rare that you will work with lots of collegial support from other rehab therapists. You are often sole charge. (I16)

Cultural sensitivity and open-mindedness were important for tailoring services to meet the needs of clients. As two participants stated:

> [You need to be] sensitive and aware of different cultures, and take the time to learn what [your clients] believe in and really listen to them and what they want out of OT services, as opposed to what you think they should have. (I10)

> [You need to accept] a wide variety of values and ways of doing things – people from different cultural backgrounds, economic levels, levels of trust in the system that you are working in. [You] need to be sensitive to where [your clients] are coming from, and be client-focused so you are actually being helpful to them. (I5)

Other ideas presented included: the ability to problem-solve; intelligence and knowledge of OT practice; patience and perseverance; friendliness and sense of humour; organization and time management skills; and a desire for, and enjoyment of, living in the north. One participant explained that:

> You have to be willing to expand what OT is a little bit. You can't refer to the social worker so you become the social worker a little bit. You can't refer to the physiotherapist, so you become the physiotherapist a little bit. On those little grey edges where the things overlap and you become a little bit of everything. One of the challenges is to maintain the integrity of what an occupational therapist is. Especially once you start to go over, and then try to pull back, your referral sources will be frustrated. Especially when you don't have those people to refer to, you see the need and you need to be sure that you can define OT. [You] need to be able to think outside the clearly defined areas, and then you need to know what those defined areas are, so you know when you have stepped outside. (I9)

In addition, one participant felt that there were characteristics unique to northern practice. She explained:

> There are intangible things as well. You can always tell when somebody has been working in a big city and comes to a small community. It takes a good year to settle in. There are lots of intangibles such as their expectations and their view of the world. And the same is true if I moved to a big community; it would take me a long time to get used to that. (I16)

**Retaining occupational therapists**

Despite the challenges to practicing in northern BC, three-quarters of participants stated that they were very satisfied with their current position, and the remaining participants stated that they were fairly to somewhat satisfied (Table C7a). The main changes participants felt would improve their level of satisfaction included having more staff (e.g., occupational therapists, administrative positions, and other professionals), more therapy time with clients, and better access to education (Table C7b).

While one might expect to see low retention rates in the rural areas of northern BC, fifteen participants (88%) were planning to continue practicing in the north, thirteen of these for an extended period of time, and two for at least a few years (Table C8a). The other two participants identified that they were either planning to leave, or were unsure of whether they would remain in the north. Reasons for this included a desire to travel and see more places, to specialize and develop skills, to change positions, to move to a warmer climate, and to be closer to family (Table C8b). For example:

> I would like to be able to learn from another OT so I can improve my skills. [Since] you can only learn so much from textbooks, I feel I need hands-on help sometimes, but where am I going to get that?? This may be incentive to leave the north, to improve as an occupational therapist. (I11)

> It would be nice if it were acknowledged that people stay here. We do a lot to get people here, but once we have them we don't do much to keep them here. And I think it is a shortcoming of all the organizations, although I think that there are some health authorities that are better at it. I don't think we show our appreciation enough. (I12)

**Existing professional supports**

Informants described available professional supports in terms of the following: the composition and breadth of their occupational teams; their ability to undertake research and continuing education; and the funding, educational materials, and equipment available to them (Table D2a).

One third of participants identified the composition and breadth of their team as a key component of professional support. Fellow occupational therapists, including those practicing at a distance and locally, provided the highest degree of support, as "peer and case study sharing and ideas for goal setting [are] practical and useful" (I16). Participants maintained connections with colleagues at a distance by phone, by email, or by teleconference.

Participants also described inter-professional teams, management, and administrative workers as supports in that they alleviated therapists' workloads and provided professional guidance. Finally, participants identified non-OT professionals such as equipment distributing companies as supportive.

A third of participants also named research and educational supports. Participants utilized online medical resources made available though the Canadian Association of Occupational Therapists (CAOT), MedLine, the Centre for Childhood Disability Research (CanChild), the Cumulative Index to Nursing & Allied Health Literature (CINAHL), Medscape, and the Provincial Paediatric Therapy Consultant (PPTC) most frequently. Two participants located information utilizing Google or Google Scholar. Participants utilized the CAOT's *Canadian Journal of Occupational Therapy* (CJOT) and other refereed journals available both on and offline.

Given that most provincial education opportunities are located in Prince George or Vancouver, the majority of participants utilized teleconferencing or videoconferencing to further their education. Only two participants, however, felt that there were opportunities to travel to Prince George or Vancouver for educational purposes.

Because of the barriers posed by out-of-town travel, many participants made use of local educational resources in order to further their education. These included the University of Northern BC (UNBC), colleges, community-run educational sessions, committees and conferences. Participants felt that local options tended to be more limited and less OT-specific, however, than non-local options. Two participants described their opinions of educational opportunities in the north:

> [The] education piece is improving. Certainly things happen more in the Lower Mainland and in larger centres, but the north has been becoming better at organizing conferences in this area. This helps because it is local and much more accessible. (I17)

> Now that I've worked for a while, I can take courses in the local area that aren't OT, but can be applied to my practice. This is harder for new grads – they need OT courses and need an employer who can pay to have that happen. (I2)

Participants characterized educational material, funding, and equipment as professional supports. Many participants obtained books, literature reviews, articles, and other resources from libraries. Half of the participants utilized material from the Northern Health Library at the Prince George Regional Hospital, while three others utilized the Ministry of Health's Health and Human Services Library and the Geoffrey R. Weller Library at UNBC. Participants obtained other educational materials directly from professional associations and groups such as the BC Society of Occupational Therapists (BCSOT), CAOT, PPTC, the American Occupational Therapy Association (AOTA), and the Sunny Hill Health Centre for Children.

In order to keep apace with emerging research themes in the realm of OT, participants often shared information from conferences, meetings, and workshops with one another. A number of participants described how "people who go to conferences bring stuff back and make it accessible" (I10) to those who were unable to attend. One participant, who had recently graduated, stated that she continued to draw from the educational materials she had utilized during her schooling.

Participants felt that funding was an important support because it allowed therapists to partake in continuing education, obtain educational materials, conduct research, and communicate with colleagues at a distance. Participants noted that the amounts of funding made available varied from year to year, but generally at levels regarded as insufficient. Participants also deemed access to equipment such as assessment tools and office supplies supportive.

**Barriers to professional support**

When surveyed, only four participants felt that they did not have the resources required to maintain and improve their professional knowledge and skills (Table D2b). The remainder described their access to professional supports as either adequate (8) or moderate (5). Only two participants felt that there were no barriers keeping them from utilizing available supports. This means that a number of barriers were preventing participants from utilizing the full extent of professional supports available to them (Tables D4a and D4b).

Participants described general barriers that affected access to all or most forms of professional support, and specific barriers that pertained only to certain supports (Table D4b). General barriers included inadequate time and funding, the difficulty of obtaining information about available supports, caseload pressures, distance and access issues, and having to leave work or family for extended time periods to avail themselves of support opportunities.

In terms of more specific barriers, many participants stated they were unaware of who to contact when they needed assistance. Many felt unsupported and unable to participate in as many inter-professional meetings as they desired. These barriers inhibited the opportunities for OTs to connect with their peers. The following quotes illustrate some of these frustrations:

> It is up to me to call and connect with people. I expected more of a formal mentoring system or connection, this would have been very helpful in the beginning. (I11)

> [I] feel disorganized here. [I] need a list of who is who, a comprehensive list of what is out there. [I need] access to knowing what is out there, but there doesn't seem to be someone out there who is doing that, it's not updated, and finding information is not easy. When you want to phone someone, you have to spend time trying to figure out where they are. (I8)

Although a number of participants mentioned that the Northern Health Authority's (NHA) Rehab Advisory Committee had the potential to streamline inter-professional communication, there were concerns that the relatively small size of the committee and the physical distance between its members made it difficult to operate effectively. One therapist described this challenge:

> Within the NHA there is a rehab advisory committee that is trying to get off the ground, but most [of its participants] are in PG. It is hard for a limited number of people to carry on. Your resources are limited so there is less you can do. Your ability to maintain an advisory committee is hard when you only have 4 or 5 people, as opposed to 12. They will hopefully look at some direction for us. (I12)

Many participants noted that caseload and time barriers inhibited their ability to participate in office, community, or regional meetings, regardless of whether or not they were aware of contacts and upcoming events. As one participated stated:

> Through the rehab advisory committee, we were given funds to support rehab initiatives or rehab projects that people wanted to take on. But [the] reality is, that even with a good idea for a project, and funds set aside, there isn't a body to backfill your position so you can be free to do that. (I17)

Although the ability to do research and continue education were seen as important professional supports, they were deemed difficult to access due to a variety of barriers. In terms of attending conferences, symposiums, professional workshops, and continuing education courses, time and funding-related pressures once again limited participants. Participants were also reluctant to leave their practices and families in order to travel. For example:

> Conference access [is] not good, because you need the money (flight and accommodation) and you have to pay up front and then you may get reimbursed. Although I feel that it is my professional responsibility to update my skills, and I am willing to pay part of that cost, you never know if you will get it fully back, because it is quite a lot of money to lay out. (I8)

> UNBC is only starting to get into the field of medicine and look at continuing education. You can do learning from a distance, but you may need to be away for 6 weeks. That is a long time away from family as well as the costs for accommodation. (I12)

> There are courses that I could go on, but choose not to because of leaving my family and work at that time. If I didn't have to travel, that wouldn't be an issue. (I2)

Participants felt that the breadth and nature of courses available to therapists in northern BC further limited access to continuing education. While there was a general feeling that local educational opportunities were expanding, participants were concerned that many of the courses were not relevant to OTs, and that those that were relevant were offered infrequently and at inconvenient times. Others felt that teleconference and videoconference delivery was impeded by a number of technical barriers. Two participants noted that:

> [There] should be more leveling or streaming – a logical flow to how you learn things instead of just this here and this there. Sometimes if a course isn't at the right level for you, you miss things because you aren't at that stage of readiness. (I5)

> There is a pediatric special interest group and a school practice special interest group in the Lower Mainland. I have asked if I could participate and they have said that speaker phones aren't good enough quality and it's just simple things like not having the phones for conferences and not having good enough access to telehealth facilities and not having enough therapists to run the things. Not having the technical support. (I5)

In each of these cases, a lack of organizational leadership and a lack of awareness of contacts and opportunities also created barriers, as the following participants explained:

> Even if funds are approved for education, then we are the ones who have to organize the conference, which is a huge time requirement and would usually all fall under the role of a professional practice leader. (I17)

> We often seem to be out of the loop – we have tried to set up [teleconferences], but people are busy and there isn't an infrastructure of someone who hunts out things. I

> hear about a course and it is too late. I don't know how to get on the mailing list for these things. There is a bit of a disjointed thing going on. (I8)

Barriers to obtaining and utilizing educational materials and equipment also included time and funding issues. Two participants indicated that they were unable to subscribe to BCSOT because of fees, although they felt that it was "a nice newsletter link to the rest of the province" (I18). One participant stated specifically that she felt under-informed of current information and courses because a lack of financial support prevented her from accessing the resource. In terms of time-related barriers, participants felt that "resources are available, but there isn't the time. It isn't made a priority; it isn't scheduled into your week" (I8).

A third of participants indicated that they would like to acquire journals or books, or to gain access to more online resources. Barriers to obtaining new educational materials included the fact these were difficult to identify and locate, and that companies would not ship to certain communities in northern BC.

Three participants stated that, although they did have access to online journal databases, they did not know which journals were the most pertinent, or were unfamiliar with how to utilize these resources. One of these three stated that:

> [I] don't really have access to online resources and don't really know how to access current research. I go into the CAOT website, but they have limited resources. I don't have access through my previous university. If something is on the internet (such as an online journal), I could get it. But I don't know how to access medical journals or databases. (I11)

**Gaps in professional support**

A discrepancy existed between the professional supports that participants identified as needed, and those that they identified as available (Tables D1 and D5). The largest groups of needed but unavailable supports included inter-professional support, continuing education, and professional practice leaders.

The breadth of inter-professional supports identified was significant. General desires included contact with occupational therapists and other professionals locally, regionally, and at a distance. This increased inter-professional contact would enable the exchange of ideas, information, and experiences, and would alleviate caseload pressures and waiting lists. Respondents suggested that this contact could be facilitated by: providing occupational therapists with funding and time allowances earmarked for networking; distributing regional and provincial directories of key contacts; and employing teleconferencing or videoconferencing equipment where required. One participant noted that she required:

> Access to consult with OT's in different specialties – hand splinting, seating, feeding – [in order to] to get support. Because I don't feel that specialized in those areas. I can address the areas, but I would like some OT support. (I14)

For most of the participants, desirable opportunities for continuing education included offering a wider selection of OT-specific courses, special interest groups, and workshops throughout BC, as well as delivering a larger portion of these in northern BC specifically. Two participants felt that available educational opportunities needed to be streamed more logically to make the most of current opportunities, and that more educational opportunities needed to be made available to support staff as well as occupational therapists. Respondents felt that access to each of these supports could be enabled though the provision of funding, time, and infrastructure, as well as research tools such as online journals, books, university library cards, information, and teleconferencing or videoconferencing technology.

Another needed but unavailable continuing education opportunity was peer-to-peer learning, which would encompass information sharing related to courses, case studies, and ideas between occupational therapists. Respondents felt that a number of these activities could be done through the organization of effective local interest groups, or by ensuring participation in special interest groups taking place in the Lower Mainland. In order to take advantage of opportunities at a distance, two participants felt that they needed more technical support and funding.

Five participants expressed a need for variants of professional practice leaders. As the focus of their job, these individuals would offer support to occupational therapists in their area of expertise. Support would be in the form of providing education and training, ensuring regional consistency, overseeing Employment Benefit Plans, and reviewing regional protocol. As one participate put it:

> That's where the professional practice piece comes in. If you had someone in a paid and dedicated position, they could take that on. They would be paid positions of therapists who look at meeting the professional practice needs of the clinicians. We really don't have that in the north. The [current] health service administrator for the … area does some professional practice things for therapists … off the corner of her desk. It is very limited though because it's not her primary position. Having her rehab background helps, but it is much more limited thansomeone who has that as their dedicated position. (I17)

Other needed but unavailable supports identified by participants included orientation, mentoring, and supervisory support. While participants felt that the former would provide needed assistance primarily during the initial stages of training and workplace incorporation, they saw the latter as a support that was necessary throughout therapists' careers. Participants felt that access to each of these supports should be a formal element of OT practice that is actively facilitated.

Participants also expressed a need for additional secretarial support. The Rehab Advisory Committee, for instance, was cited as an instance where this type of support was lacking. As one participant stated:

> In [the] NHA, I expect to be able to access … some support of the rehab advisory committee in terms of administrative support. It is very self-directed and everyone who participates does it off the side of their desk. So there is no time allocated to support that network. It is in place, but there are some improvements that could make that network more effective. (I16)

Finally, seven participants outlined supports that had been promised but were not made available (Tables D6a and D6b). These supports included funding, time for orientation and mentoring, inter-professional support, supervisory support, and support from the Rehab Advisory Committee.

# Discussion

A variety of personal, professional, and environmental factors influence decisions about where occupational therapists decide to practice, and whether they choose to remain in their present location. Many of the factors raised in this study are consistent with findings about OTs and other health professionals in different jurisdictions (e.g., Millsteed 2001, Peterson et al. 2003, and Solomon et al. 2001). As the participants in the study revealed, there are factors unique to professions, organizations, and regional settings that also play important roles in decisions about practice location.

This study adds to a small but growing literature on the factors associated with decisions to enter rural OT practice. Mills and Millsteed (2002) identified partner-related reasons, lifestyle, variety of practice, and having a combined caseload as the main factors influencing the decision to enter rural practice in Western Australia. In their study of recruitment and retention in northern Ontario, Solomon et al. (2001) identified comparable factors, but also suggested that being from a rural background influenced the decision to enter rural practice. Although participants in the present study discussed many of these issues, they were not as inclined to cite partner-related reasons. Instead, practice related factors appeared to play a more significant role in the decision to practice in rural settings. The flexibility, challenge, and opportunity to encounter a wider range of practice activities is attractive to people eager to build their base of experience. The findings of this study also highlight the complex nature of location 'choice'. While the literature tends to treat this issue as one of preferences, there is also an important element of chance and the unanticipated consequences of earlier choices. For instance, some of the OTs mentioned that their main preference was a particular type of position (e.g., pediatrics), and there just happened to be positions available in the region.

The findings of this study also reveal aspects of northern practice that are both beneficial and challenging. For instance, participants felt that the scope of northern practice allowed them to gain a wide range of experience, but felt that this posed challenges to maintaining competency. Similarly, participants felt that small community practice enabled intimate communication, but also noted that it led to issues surrounding confidentiality and conflicts of interest. Generally, participants felt that the OT services in their communities were insufficient, and that they were unable to provide the level of service they would prefer. This concern was exacerbated when they had to rely upon other care providers to follow-up with treatment in places when such follow-up may simply not be available. Participants also described significant practice challenges that have potentially major impacts for both clients and therapists, including decreased quality and access to services, challenges in maintaining competency, limitations on practice, and additional work and time requirements. The main implication of this is that 'one size fits all' recruitment and retention strategies are unlikely to have the desired effect of stabilizing and growing the OT workforce in northern BC.

The skills necessary for succeeding in rural practice are consistent with those mentioned in the literature (e.g., Mills and Millsteed 2002), including adaptability, resourcefulness, creativity, and well develop management and communication skills. Participants in the present study also described characteristics such as flexibility, problem-solving skills, confidence in clinical skills,

cultural sensitivity, and open-mindedness. As with other studies, we found evidence that OTs who completed student rural placements and educational blocks were better equipped to address the multidimensional care needs common to rural and remote settings (e.g., Lee and Mackenzie 2003). For others, the first year would be telling as to whether they made the transition or not. In such cases, the need for peer and mentoring support is even more critical to retention and successful service delivery. Additionally, participants consistently reiterated the importance of professional cohesion, technological supports, and reliable funding in enhancing the provision of care.

Even though participants described significant challenges, most stated that they were planning to continue practicing in the north. This is potentially due to the 'where there's a will, there's a way' attitude expressed by some participants. Despite the variety of challenges to northern practice, participants chose to problem solve with limited resources rather than leave to practice elsewhere. In addition, many of the participants felt that they were making a difference in people's lives, which may have contributed to high job satisfaction in face of the multiple challenges. Nevertheless, there is a real danger in taking these findings as a cue for complacency on the part of health service administrators and planners. Both the OT workforce and the general population of the region are aging, and it is not difficult to imagine growing demands on these professional services for some time to come. In addition, the apparent stability of the OT workforce is at least partly a product of a lack of new recruits to the region, a situation that does not bode well for the future.

Steenbergen and Mackenzie (2004) argue that access to professional supports assists therapists in building independence and practice skills. Participants in the current study listed the breadth and composition of their occupational teams, access to research and continuing education, and the availability of funding, educational materials, and equipment as desirable professional supports that were currently available. All but two of the participants indicated, however, that there were generalized and specific barriers preventing them from utilizing the full extent of these supports. Generalized barriers hindering access to a variety of professional supports included inadequate time and funding, the difficulty of obtaining information about available supports, caseload pressures, distance and access issues, and leaving work or family. In some cases, participants identified professional supports that were needed, promised, but unavailable. These included such things as inter-professional support, continuing education, peer-to-peer learning initiatives, professional practice leaders, orientation and mentoring, supervisory and administrative support. While such gaps may well be present in many other jurisdictions, the particular challenges of practicing in northern BC warrants attention if there is to be a systematic effort to create a more supportive environment for practice.

# Conclusion

This study examined the experiences of occupational therapists practicing in northern BC in order to contribute to the planning and provision of better systems of professional support. We explored the structure and characteristics of occupational therapy (OT) practice in the region, and various issues around recruitment, retention, and the skills and supports required to practice in rural and remote settings. The results suggest that attention needs to be directed at three broad topic areas. These are: 'opportunities within northern and small town practice' that can support better recruitment and retention efforts; the need for enhanced 'support for the caregiver' in rural and small town locations; and the need to take advantage of some existing opportunities to 'enhance service delivery over time'. Each of these are outlined below.

*Opportunities within Northern and Small Town Practice*

The benefits and the challenges to OT practice in rural and small towns across northern BC speak to two sides of the same coin. Awareness of how these impact individuals needs to be situated closer to the centre of recruitment and retention efforts. The opportunities to engage in multiple areas of practice, to be flexible and responsive to a variety of client needs, to be creative in developing service solutions where resources are otherwise limited, and to have a level of independence unimagined in metropolitan settings, are core attractive features that would be of interest to recruits seeking to develop their skills and make a difference in their service communities. The lack of peer and professional supports reinforces the need for independence and problem solving abilities among recruits. Identifying important factors for recruiting 'successful' applicants is a key contribution of this report. These recruits need to be comfortable in the intimate community and professional environment of northern BC, and they need to be aware that they will be working as a 'local team player' to overcome service limitations in small places.

Rural and small town lifestyles are a second key feature in the recruitment and retention of care professionals. Not all individuals are interested in these features, but for those who are, they provide a tremendous compensation for the other stresses of professional life. Again, recruitment and retention practices need to focus upon the realities of rural and small town environments as a place for 'practice' and lifestyle considerations.

*Support the Caregiver*

A widely acknowledged topic in a variety of health and care literatures speaks to the need to support caregivers. This report identifies three topic areas important in this regard. The first involves facilitating the creation of a sense of 'community' for caregivers, amongst local care teams, and within the broader area within which caregivers provide services. In terms of a community for caregivers, greater attention to peer support, mentoring, and professional practice leaders are needed. In terms of supporting a sense of community amongst local care teams, senior government agencies must work to facilitate local interaction rather than reinforce practice silos at a local level.

The second involves supporting the caregiver through the emotional impacts that can lead to frustration and burnout. Again, facilitating networks of mentors and peers can provide ready supports, which in a metropolitan setting might be found in staffrooms and other informal venues. Key to the way participants understood successful practice was their ability to exercise personal resilience. Senior governments and agencies must support this personal resilience.

A third key support for caregivers is access to ongoing professional development and educational opportunities. Various forms of distance delivery (e.g., teleconferencing, web-based courses) will only address some of the needs identified by our study participants. Organizations such as Northern Health should look to developing a stand alone 'professional development unit' that can deliver routine training and professional upgrading opportunities in a timely, efficient, on-going, and in-community basis. Whenever possible, these must be delivered so that people can learn in a 'hands-on' fashion without OTs having to step away from their practice, clients, community, and family for extended periods of time.

*Enhancing Service Delivery Over Time*

It is clear from this project that occupational therapists in northern BC are motivated and effective. It is also clear that they have many suggestions for improving service delivery. Given the aging of the caregiver workforce, together with the aging of the regional population, finding ways to deliver needed services is going to become even more crucial over time. Support can be extended by developing 'local response teams'. These are already occurring on an informal basis across northern BC, and they are seen to be highly effective. Again, funding and support agencies need to facilitate the efficient dynamics around these local response teams. In addition, future service demands need to be integrated with the professional development mechanisms identified above so that skills develop along with areas of care needs, and both can create a more realistic portrait of northern practice to support future recruitment and retention activity.

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The recruitment and retention issues facing OTs in northern BC are complex and require integrative and innovative responses. The unique set of practice challenges raise concerns about the quality of care that occupational therapists are able to provide now and into the future. In this light, the information provided in this report is intended to serve as a useful guide to efforts aimed at recruitment and retention efforts in the region. Such information should be of use to regional officials and local administrators who are in a position to provide professional support systems and resources to improve conditions for those committed to practice in this region, and to attract those who would like to make northern BC their home and location for practice.

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## Appendix 1:

## Key Informant Interview Guide

## Key Informant Interview Guide

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**Section A: Occupational Therapy Practice**

**The first section of questions asks you about your occupational therapy practice**

A1. In which communities do you currently practice?
A2. What areas of practice do you work in?
A3. How would you describe your clients? Are there gender, age or income patterns? What communities do they come from?
A4. How do people access your services? Do they need a referral from a doctor, can they self-refer?
A5. How accessible are your services in terms of waitlists or the frequency of visits?

**Section B: Delivery of Services**

**In this section, I would like to ask you questions about the delivery of OT services in your community**

B1. Do you consider the community/communities you work in to be rural, remote, or both? Why?
B2. What are your feelings about the comprehensiveness of occupational therapy services in your community? Are the services sufficient? Are there populations that are not being provided with needed OT services?
B3. Has your ability to deliver services within your community changed over time?
    If YES
    B3a. How has this changed?
B4. Are you required to travel extensively as part of your practice?
    If YES
    B4a. Where do you travel?
    B4b. What means of transportation do you use?

**Section C: Experiences of Practicing in a Rural Community**

**In this section I would like to ask you some questions relating to your experience of practicing in a rural community/northern BC.**

C1. How long have you been practicing in northern BC?
C2. Were you a new graduate when you started practicing in northern BC? If not, where did you practice before?
C3. What led you to choose to practice in northern BC? Please elaborate.
    Practice factors
    Lifestyle factors

Other factors

C4. What do you now see as the benefits or rewards of practicing in the north?

Practice factors

Lifestyle factors

C5a. What do you now see as the challenges of practicing in the north?

C5b. What impacts do these challenges have on your practice as a therapist?

C6. What personal skills or characteristics do you feel are necessary for clinicians practicing in the north?

C7. How satisfied are you with your current position and what changes would improve your satisfaction?

C8. Are you planning on continuing to practice in the north and what factors are leading to this decision?

**Section D: Professional Supports**

**In this section, I would like to ask you questions about professional supports and their availability in your current position.** (continuing education, supervision, other OT's, other professionals, access to research, workshops, conferences)

The first two questions ask you to consider what professional supports you expect to receive and what professional supports are currently available to you.

D1. Can you describe the professional supports you **expect** to receive as a therapist?

D2a. What supports are currently **available** to you?

D2b. Occupational therapists are expected to maintain and improve their professional knowledge and skills; do you currently have the resources to accomplish this? (resources such as **continuing education** etc.)

D2c. Occupational therapists are expected to be evidence-based practitioners; do you have access to the **latest research** or **other professionals** in order to accomplish this?

D3. Out of all these supports we've talked about, what would you say are the **most important supports** for occupational therapists in your position?

D4. Are there supports that are available, that you are not using (or not using as much as you'd like to) and why?

D5. What types of support are needed, but are not available? What supports do you wish you had?

D6. Are there any supports that were promised or are supposed to be in place, that are not really available?

**Section E: Concluding Questions**

E1. Is there anything you would like to add that we haven't already touched on?

## Appendix 2:

## Data from Key Informant Interviews

## Section A: Occupational Therapy Practice

### A1 In which communities do you currently practice?

| Location | Number of Responses | % |
|---|---|---|
| Bulkley-Nechako | 10 | 23.8 |
| Kitimat-Stikine | 10 | 23.8 |
| Cariboo | 9 | 21.4 |
| Fraser-Fort George | 4 | 9.5 |
| Skeena-Queen Charlotte | 4 | 9.5 |
| Peace River | 2 | 4.8 |
| Other | 3 | 7.1 |
| Total | n=42[1] | 100% |

### A2 Organizational setting of practice

| Area of Practice | Number of Responses | % |
|---|---|---|
| Hospital | 7 | 41.2 |
| Pediatrics | 5 | 29.4 |
| Community | 3 | 17.6 |
| Long-term care | 1 | 5.9 |
| Private practice | 1 | 5.9 |
| Total | n=17 | 100% |

[1] For a number of questions in this interview, participants were able to give multiple answers. As a result, the total number of answers represented by *n* may not be limited to 17.

**A3a Age structure of clients served**

| Age | Number of Responses | % |
|---|---|---|
| 0-5 | 4 | 7.5 |
| 6-9 | 6 | 11.3 |
| 10-18 | 6 | 11.3 |
| 19-29 | 5 | 9.4 |
| 30-39 | 5 | 9.4 |
| 40-49 | 5 | 9.4 |
| 50-65 | 6 | 11.3 |
| 65+ | 9 | 17.0 |
| All ages | 7 | 13.2 |
| Total | n=53 | 100% |

**A3b Sex distribution of clients served**

| Sex | Number of Responses | % |
|---|---|---|
| More females than males | 1 | 10.0 |
| More males than females | 1 | 10.0 |
| Equal males and females | 8 | 80.0 |
| Total | n=10 | 100% |

**A3c Income characteristics of clients served**

| Income | Number of Responses | % |
|---|---|---|
| Low income | 3 | 30.0 |
| Low to middle income | 2 | 20.0 |
| All income levels | 5 | 50.0 |
| Total | n=10 | 100% |

**A3d Residing communities of clients served**

| Community | Number of Responses | % |
|---|---|---|
| Terrace | 6 | 9.7 |
| Kitimat | 5 | 8.1 |
| Prince George | 4 | 6.5 |
| Smithers | 3 | 4.8 |
| Williams Lake | 3 | 4.8 |
| Burns Lake | 2 | 3.2 |
| Dease Lake | 2 | 3.2 |
| Prince Rupert | 2 | 3.2 |
| Other | 35 | 56.5 |
| Total | n=62 | 100% |

**A3e Nature of care needs provided**

| Diagnoses/Issues | Number of Responses | % |
|---|---|---|
| Activities of daily living | 5 | 10.4 |
| Orthopedic | 5 | 10.4 |
| Cardiovascular | 3 | 6.3 |
| Mental health | 3 | 6.3 |
| Mobility and transfers | 3 | 6.3 |
| Developmental | 2 | 4.2 |
| Neurological disorders | 2 | 4.2 |
| Range of diagnoses | 11 | 23.0 |
| Other | 14 | 29.2 |
| Total | n=48 | 100% |

**A4 Source of referral**

| Referred by | Number of Responses | % |
|---|---|---|
| Doctor | 14 | 23.3 |
| Self | 11 | 18.3 |
| Family | 6 | 10.0 |
| Nurse | 6 | 10.0 |
| School-based team | 6 | 10.0 |
| Other therapist | 5 | 8.6 |
| Clinic | 3 | 5.0 |
| Hospital | 2 | 3.3 |
| Anyone | 4 | 6.7 |
| Other | 3 | 5.0 |
| Total | n=60 | 100% |

**A5a Do you have a waitlist?**

| Waitlist prevalence | Number of Responses | % |
|---|---|---|
| Yes | 9 | 52.9 |
| No | 8 | 47.1 |
| Total | n=17 | 100% |

**A5b Waitlist duration**

| Waitlist duration | Number of Responses | % |
|---|---|---|
| < 1 week | 3 | 12.5 |
| < 1 month | 5 | 20.8 |
| < 3 months | 4 | 16.7 |
| > 3 months | 3 | 12.5 |
| Total | n=15 | 100% |

**A5c Frequency of visits**

| Frequency of visits | Number of Responses | % |
|---|---|---|
| Sufficient | 3 | 15.8 |
| Somewhat sufficient | 6 | 31.6 |
| Insufficient | 10 | 52.6 |
| Total | n=19 | 100% |

## Section B: Delivery of Services

### B2 Are the occupational therapy services in your community comprehensive?

| | Number of Responses | % |
|---|---|---|
| Not comprehensive | 14 | 82.4 |
| Moderate | 2 | 11.8 |
| Comprehensive | 1 | 5.9 |
| Total | n=17 | 100% |

### B3a Has your ability to deliver services within your community changed over time?

| | Number of Responses | % |
|---|---|---|
| Yes | 12 | 70.6 |
| No | 4 | 23.5 |
| Unsure | 1 | 5.9 |
| Total | n=17 | 100% |

### B3b Reasons given for a change in service delivery

| | Number of Responses | % |
|---|---|---|
| Increased staffing | 6 | 15.8 |
| Offering more services | 6 | 15.8 |
| Changed roles | 5 | 13.2 |
| Policy/structural changes | 4 | 10.5 |
| Heavier caseload | 3 | 7.9 |
| Increased funding | 2 | 5.3 |
| Personal improvement | 2 | 5.3 |
| Shift from consultative to intensive role | 2 | 5.3 |
| Shorter waitlists | 2 | 5.3 |
| Other | 6 | 15.8 |
| Total | n=38 | 100% |

**B4 Are you required to travel extensively as part of your practice?**

| Travel | | Number of Responses | % |
|---|---|---|---|
| Yes | | *7* | 41.2 |
| | Up to 2 hours by car | 6 | |
| | Requiring air travel | 2 | |
| No | | 10 | 58.8 |
| Total | | n=17 | 100% |

## Section C: Experiences of Practicing in a Rural Community

### C1 How long have your been practicing in northern British Columbia?

| Length in north | Number of Responses | % |
|---|---|---|
| 0 - 4 years | 4 | 23.5 |
| 5 - 9 years | 2 | 11.8 |
| 10 - 14 years | 7 | 41.2 |
| 15 - 19 years | 3 | 17.6 |
| 20+ years | 1 | 5.9 |
| Total | n=17 | 100% |

### C2a Were you a new graduate when you started practicing in northern British Columbia?

| New graduate | Number of Responses | % |
|---|---|---|
| Yes | 7 | 41.2 |
| No | 10 | 58.8 |
| Total | n=17 | 100% |

### C2b If you were not a new graduate when you started practicing in northern British Columbia, where did you practice before?

| Location | Number of Responses | % |
|---|---|---|
| Lower Mainland | 5 | 41.7 |
| Other province | 4 | 33.3 |
| Other country | 3 | 25.0 |
| Total | n=12 | 100% |

**C3 What led you to choose to practice in northern British Columbia?**

| Pull factors | Number of Responses | % |
|---|---|---|
| Lifestyle factors | | |
| Small community lifestyle | 18 | 20.2 |
| Connection to the north | 14 | 15.7 |
| Outdoor activities/scenery | 9 | 10.1 |
| Other | 6 | 6.7 |
| Practice factors | | |
| Nature/scope of job | 28 | 31.5 |
| Availability of employment | 8 | 9.0 |
| Quality of employment facility | 3 | 3.4 |
| No aspects of job | 3 | 3.4 |
| Total | n=89 | 100% |

**C4 What do you now see as the benefits or rewards of practicing in the north?**

| Benefits | Number of Responses | % |
|---|---|---|
| Lifestyle factors | | |
| Access to outdoors | 6 | 7.4 |
| Minimal traffic | 5 | 6.2 |
| Friendly community | 4 | 4.9 |
| Size of community | 4 | 4.9 |
| Cost of housing/living | 3 | 3.7 |
| Raising children | 3 | 3.7 |
| Clean air/climate | 2 | 2.5 |
| Other | 3 | 3.7 |
| Practice factors | | |
| Opportunity for intimate inter-professional communication | 10 | 12.3 |
| Nature/scope of job | 6 | 7.4 |
| Level of autonomy/freedom | 5 | 6.2 |
| Opportunity to be a generalist | 5 | 6.2 |
| Opportunity for advancement | 4 | 4.9 |
| Supportive workplace | 4 | 4.9 |
| Opportunity for creativity/flexibility | 3 | 3.7 |
| Opportunity to specialize | 3 | 3.7 |
| Opportunity to develop relationships with clients | 2 | 2.5 |
| Opportunity to travel/further education | 2 | 2.5 |
| Working with a variety of professionals | 2 | 2.5 |
| Other | 3 | 3.7 |
| There are few benefits to northern practice | 2 | 2.5 |
| Total | n=81 | 100% |

**C5a What do you now see as the challenges of practicing in the north?**

| Challenges | Number of Responses | % |
|---|---|---|
| Access to education | 13 | 14.6 |
| Degree of inter-professional contact/support | 11 | 12.4 |
| Access to specialist knowledge | 10 | 11.2 |
| Recruitment and retention | 8 | 9.0 |
| Weather/transportation barriers | 6 | 6.7 |
| Variety of caseload | 6 | 6.7 |
| Access to equipment | 5 | 5.6 |
| Communication barriers | 5 | 5.6 |
| Professional isolation | 5 | 5.6 |
| Access to professional resources | 4 | 4.5 |
| Access to supervisory support | 4 | 4.5 |
| Small community life | 4 | 4.5 |
| Lack of outpatient support services | 2 | 2.2 |
| Opportunity for career advancement | 2 | 2.2 |
| Other | 4 | 4.5 |
| Total | n=89 | 100% |

**C5b What impacts do these challenges have on your clients?**

| Impacts for clients | Number of Responses | % |
|---|---|---|
| Access to services | 6 | 33.3 |
| Quality of care | 4 | 22.2 |
| Impact on clients' lives | 4 | 22.2 |
| Availability of services | 3 | 16.7 |
| Impact on caregivers' lives | 1 | 5.6 |
| Total | n=18 | 100% |

**C5c What impacts do these challenges have on your practice as a therapist?**

| Impacts for clinicians | Number of Responses | % |
|---|---|---|
| Reduces professional competency | 11 | 30.6 |
| Creates additional work/roles | 6 | 16.7 |
| Emotional impacts | 5 | 13.9 |
| Limits practice | 5 | 13.9 |
| Additional time requirements | 4 | 11.1 |
| Shapes practice and clinician | 3 | 8.3 |
| Other | 2 | 5.6 |
| Total | n=36 | 100% |

**C6 What personal skills or characteristics do you feel are necessary for clinicians practicing in the north?**

| Necessary skills | Number of Responses | % |
|---|---|---|
| Ability to communicate/collaborate with inter-professional team | 13 | 14.9 |
| Resourcefulness/creativity | 9 | 10.3 |
| Flexibility | 8 | 9.2 |
| Initiative | 8 | 9.2 |
| Ability to be a generalist | 7 | 8.0 |
| Independence | 7 | 8.0 |
| Adaptability | 6 | 6.9 |
| Ability to solve problems | 4 | 4.6 |
| Confidence | 4 | 4.6 |
| Cultural sensitivity/open-mindedness | 4 | 4.6 |
| Intelligence/knowledge of OT practice | 4 | 4.6 |
| Patience/perseverance | 4 | 4.6 |
| Friendliness/sense of humour | 3 | 3.4 |
| Ability to manage time | 2 | 2.3 |
| Other | 4 | 4.6 |
| Total | n=87 | 100% |

**C7a How satisfied are you with your current position?**

| Level of satisfaction | Number of Responses | % |
|---|---|---|
| Very satisfied | 13 | 76.5 |
| Fairly/somewhat satisfied | 3 | 17.6 |
| Very satisfied with one job, less satisfied with other job | 1 | 5.9 |
| Total | n=17 | 100% |

**C7b What changes would improve your satisfaction?**

| Changes | Number of Responses | % |
|---|---|---|
| More staffing | 10 | 31.3 |
| More therapy time | 5 | 15.6 |
| More educational opportunities | 4 | 12.5 |
| Improved facilities | 2 | 6.3 |
| More administrative help | 2 | 6.3 |
| More inter-professional communication | 2 | 6.3 |
| Departmental changes | 1 | 3.1 |
| Improved continuum of care from hospital to community | 1 | 3.1 |
| More opportunities for career advancement | 1 | 3.1 |
| More equipment | 1 | 3.1 |
| No changes | 3 | 9.4 |
| Total | n=32 | 100% |

**C8a Are you planning on continuing to practice in the north?**

| | Number of Responses | % |
|---|---|---|
| Yes | | |
| Indefinitely | 13 | 76.5 |
| Temporarily | 2 | 11.8 |
| No | 1 | 5.9 |
| Unsure | 1 | 5.9 |
| Total | n=17 | 100% |

**C8b What factors are leading to this decision?**

| Incentives to leave | Number of Responses | % |
|---|---|---|
| Lifestyle factors | | |
| To live in another place | 4 | 26.7 |
| To be closer to family | 2 | 13.3 |
| To travel | 2 | 13.3 |
| Family reasons | 1 | 6.7 |
| Practice factors | | |
| To change positions | 3 | 20.0 |
| To receive professional mentoring/to specialize | 2 | 13.3 |
| Lack of staffing | 1 | 6.7 |
| Total | n=15 | 100% |

## Section D: Professional Supports

### D1 Can you describe the professional supports you expect to receive as a therapist?

| Expected supports | Number of Responses | % |
|---|---|---|
| Inter-professional support | 12 | 21.1 |
| Continuing education | 11 | 19.3 |
| Support from college | 7 | 12.3 |
| Orientation/mentoring | 5 | 8.8 |
| Managerial support | 4 | 7.0 |
| BCSOT | 3 | 5.3 |
| Supervisory support | 3 | 5.3 |
| Administrative support | 2 | 3.5 |
| CAOT | 2 | 3.5 |
| Equipment | 2 | 3.5 |
| Support from hospitals/health authority | 2 | 3.5 |
| Time | 2 | 3.5 |
| Freedom/autonomy | 1 | 1.8 |
| Research tools | 1 | 1.8 |
| Total | n=57 | 100% |

**D2a What supports are currently available to you?**

| Available supports | Number of Responses | % |
|---|---|---|
| Team | *46* | 29.9 |
| Inter-professional team | 14 | |
| Other OTs | | |
| Distance | 11 | |
| Local | 8 | |
| Non-OT professionals | 7 | |
| Management/administrative support | 6 | |
| Educational materials | *31* | 20.1 |
| Libraries | 12 | |
| Material from professional associations/groups | 12 | |
| Material from workshops/conferences | 6 | |
| Material from schooling | 1 | |
| Research tools | *28* | 18.2 |
| Online medical resources | 11 | |
| CJOT (CAOT) | 6 | |
| Online journals | 5 | |
| Journals | 4 | |
| Google/Google Scholar | 2 | |
| Funding | *22* | 14.3 |
| Continuing education | 13 | |
| Education/research time | 4 | |
| Educational materials | 4 | |
| Communication | 1 | |
| Continuing education | *21* | 13.6 |
| Local education | 15 | |
| Distance education | 6 | |
| Equipment | *2* | 1.3 |
| Other | *4* | 2.6 |
| Total | n=154 | 100% |

**D2b Occupational therapists are expected to maintain and improve their professional knowledge and skills; do you currently have the resources to accomplish this?**

| Level of support | Number of Responses | % |
|---|---|---|
| Adequate | 8 | 47.1 |
| Moderate | 5 | 29.4 |
| Inadequate | 4 | 23.5 |
| Total | n=17 | 100% |

**D3 Out of all these supports, what would you say are the most important supports for occupational therapists in your positions?**

| Important supports | Number of Responses | % |
|---|---|---|
| Inter-professional support | 15 | 41.7 |
| Supervisory support | 5 | 13.9 |
| Continuing education | 4 | 11.1 |
| Orientation/mentoring | 3 | 8.3 |
| Research tools | 3 | 8.3 |
| Special interest groups | 3 | 8.3 |
| Administrative support | 2 | 5.6 |
| Freedom/autonomy | 1 | 2.8 |
| Total | n=36 | 100% |

**D4a Are there supports that are available that you are not using?**

| Unused supports | Number of Responses | % |
|---|---|---|
| Continuing education | 10 | 32.3 |
| Internet and journals | 7 | 22.6 |
| Books and library | 4 | 12.9 |
| Other therapists | 3 | 9.7 |
| Special interest groups | 2 | 6.5 |
| Staff meetings | 2 | 6.5 |
| Available funding | 1 | 3.2 |
| Job shadowing opportunities | 1 | 3.2 |
| Networking opportunities | 1 | 3.2 |
| Total | n=31 | 100% |

**D4b What barriers are preventing you from using available supports?**

| Barriers to use | Number of Responses | % |
|---|---|---|
| Time | 17 | 39.5 |
| Funding | 8 | 18.6 |
| Difficulty obtaining information | 4 | 9.3 |
| Caseload pressures | 3 | 7.0 |
| Distance/access | 3 | 7.0 |
| Leaving family | 2 | 4.7 |
| Leaving work | 2 | 4.7 |
| No desire to utilize supports | 2 | 4.7 |
| No barriers exist | 2 | 4.7 |
| Total | n=43 | 100% |

**D5 What types of supports are needed, but not available?**

| Needed supports | Number of Responses | % |
|---|---|---|
| Inter-professional support | 15 | 24.2 |
| Continuing education | 11 | 17.7 |
| Research tools | 7 | 11.3 |
| Professional practice leaders | 5 | 8.1 |
| Access to clients and inter-professional support | 4 | 6.5 |
| Supervisory support | 4 | 6.5 |
| Peer-to-peer learning | 3 | 4.8 |
| Administrative support | 2 | 3.2 |
| Orientation/mentoring | 2 | 3.2 |
| Special interest groups | 2 | 3.2 |
| Funding | 1 | 1.6 |
| Technological support | 1 | 1.6 |
| Other | 5 | 8.1 |
| Total | n=62 | 100% |

**D6a Are there any supports that were promised, but are not available?**

| Unavailable supports | Number of Responses | % |
|---|---|---|
| No | 10 | 58.8 |
| Yes | 7 | 41.2 |
| Total | n=17 | 100% |

**D6b Which promised supports are unavailable?**

| Unavailable supports | Number of Responses | % |
|---|---|---|
| Funding | 2 | 28.6 |
| Orientation/mentoring | 2 | 28.6 |
| Inter-professional support | 1 | 14.3 |
| Rehab Advisory Committee | 1 | 14.3 |
| Supervisory support | 1 | 14.3 |
| Total | n=7 | 100% |