Conceptualizing Occupational Therapists' Change Agent Role To Support Entry-Level Pedagogical Activities: Results From A Scoping Study

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Abstract

Entry-level programs are expected to support occupational therapy students in developing knowledge and skills pertaining to the change agent role. To do so, a detailed, multidimensional conceptualization of this role is necessary. To date, in the occupational therapy profession, there is no such conceptualization, which might impact educators' ability to conduct relevant pedagogical activities. Our study aimed to explore the dimensions of the change agent role for occupational therapy practitioners. We undertook a scoping study of the scientific and grey literature up to August 31, 2018 to "map" what is known about the change agent role. We searched nine databases, including Medline and CINAHL, varying combined keywords according to the database. We also manually searched reference lists and 12 relevant websites. We examined data using thematic charts and analysis. From the 33 documents analyzed, we identified two change agent configurations: social and clinical. The social configuration operates at the macro-level (society) and is aimed at optimizing health and social justice for communities or populations. Actions include lobbying, using media, and assuming a formal duty in an advocacy group. At the micro-level (clinical setting), the intent of the clinical configuration is to inform, sustain and promote individual decision-making and protect civil rights. This involves discussions with clients to understand their values and provide information about rights and options. To play the change agent role, occupational therapy practitioners must acquire a variety of knowledge and skills. To develop their students' ability to take on this important role, educators must tailor their pedagogical activities accordingly.

Keywords

Advocacy, change agency, ethics, professional

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ABSTRACT

Entry-level programs are expected to support occupational therapy students in developing knowledge and skills pertaining to the change agent role. To do so, a detailed, multidimensional conceptualization of this role is necessary. To date, in the occupational therapy profession, there is no such conceptualization, which might impact educators' ability to conduct relevant pedagogical activities. Our study aimed to explore the dimensions of the change agent role for occupational therapy practitioners. We undertook a scoping study of the scientific and grey literature up to August 31, 2018 to "map" what is known about the change agent role. We searched nine databases, including Medline and CINAHL, varying combined keywords according to the database. We also manually searched reference lists and 12 relevant websites. We examined data using thematic charts and analysis. From the 33 documents analyzed, we identified two change agent configurations: social and clinical. The social configuration operates at the macro-level (society) and is aimed at optimizing health and social justice for communities or populations. Actions include lobbying, using media, and assuming a formal duty in an advocacy group. At the micro-level (clinical setting), the intent of the clinical configuration is to inform, sustain and promote individual decision-making and protect civil rights. This involves discussions with clients to understand their values and provide information about rights and options. To play the change agent role, occupational therapy practitioners must acquire a variety of knowledge and skills. To develop their students' ability to take on this important role, educators must tailor their pedagogical activities accordingly.

Practicing occupational therapists are expected to act as change agents (American Occupational Therapy Association [AOTA], 2015; Canadian Association of Occupational Therapists [CAOT], 2012). This expectation is congruent with the World Federation of Occupational Therapists [WFOT] minimum educational standards. These standards state that occupational therapy entry-level programs need to foster their students' skills in awareness and development of "opportunities to act for advocacy and change agency" (WFOT, 2016, p. 40). To be accredited, American and Canadian programs must assist their students in developing the knowledge and skills required to act as a change agent (Accreditation Council of Occupational Therapy Education [ACOTE], 2018; CAOT, 2017). For example, ACOTE expects occupational therapists and occupational therapy assistants to "[b]e prepared to advocate as a professional for access to occupational therapy services offered and for the recipients of those services" (ACOTE, 2018, preamble p. 2-3). Specifically, standard A 5.5.2 stipulates that curriculum design for occupational therapy practitioners should clearly demonstrate the "preparation and application of in-depth knowledge in (…) leadership, (…) advocacy, (…) through a combination of a capstone experience and a capstone project" (ACOTE, 2018, p.19). Curriculum design includes relevant selection of content, teaching and assessment activities (ACOTE, 2018).

Teaching and assessing the change agent role can be influenced by its conceptualization (Puddester et al., 2015; Verma, Flynn, & Séguin, 2005). Specifically, in Canada, the *Profile of Practice of Occupational Therapists* (the *Profile*) defines the change agent role. Occupational therapists acting as change agent use "their expertise and influence responsibly to advance occupation, occupational performance, and occupational engagement" (CAOT, 2012, p. 3). The *Profile* broadly describes the role and defines its key and enabling competencies according to three levels of practice: competent, proficient and advanced. Expectations of occupational therapy assistants are closely linked to occupational therapists' change agent role, albeit adapted to their level of training (CAOT, 2018). Although useful in picturing the progression of expertise, the *Profile* does not clearly distinguish between the different dimensions of the change agent role.

This lack of conceptual clarity is not inherent to occupational therapy; it was also identified in physiotherapy (Bessette et al., 2019) and medicine (Verma et al., 2005). Conceptual fuzziness might partly explain why medical residents do not see change agency as part of their daily practice (Verma et al., 2005) as well as educators' discomfort in teaching and assessing change agent skills (Bessette et al., 2019; Puddester et al., 2015; Verma et al., 2005). In occupational therapy, as in medicine (Bhate & Loh, 2015), there is apparent confusion around particular concepts (e.g. political competence vs change agent competence). Also, "our profession, both at the individual and organizational levels, is not universally well equipped to actively promote occupational therapy" (Freeman et al., 2017, p. 23). Confusion and lack of know-how might stem from a lack of conceptual clarity. Furthermore, in practice, few occupational therapists feel competent to act as change agents (Finalyson, 2013; Restall & Ripat, 2008), including recent graduates (Xuan Shi et al., 2017).

Teaching and assessing the change agent role is a challenge that requires strong conceptual grounds (Hubinette et al., 2017). A clear conceptualization of this role would help educators pinpoint which elements are covered in their program and how they are covered and determine which specific topics should be prioritized (Bessette et al., 2019). Educators would also be able to tailor more effective pedagogical activities (Bessette et al., 2019). Describing the conceptual nature of occupational therapists' change agent role more precisely might also have benefits for clinicians and researchers alike. Clinicians might be able to identify which actions they are comfortable with and choose to develop specific knowledge or abilities for actions for which they feel less equipped. For researchers, a clear, detailed description of the change agent role might help to determine which areas of research need to be pursued and how to operationalize relevant variables. To increase conceptual clarity, this study therefore aimed to explore dimensions of occupational therapy practitioners' change agent role.

Methods

A scoping study based on the five stages outlined by Arksey and O'Malley (2005) was undertaken. This method "is a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts" (Colquhoun et al., 2014, pp. 1292-1294). Scoping studies also "provide greater conceptual clarity about a specific topic or field of evidence" (Davis et al., 2009, p. 1386). Our team was comprised of the first and second authors and a research assistant. All three were involved in stages 2 to 5. To determine the research question (stage 1) and explore alternative meanings and obtain feedback on results (stage 5), we consulted three researchers in occupational therapy and one in health law and politics.

Stage 1

The research question was defined as: "What are the dimensions of the change agent role?" As this role is part of occupational therapy practitioners' occupation, we used the six characteristics of human occupations (Who, What, When, Where, How, and Why; Polatajko et al., 2007) as guidance for defining its dimensions.

Stage 2

Relevant studies were identified: First, we searched nine databases in legal, organizational and health sciences (see Table 1) for scientific literature published up to August 2018.

Although change agent is a role that was introduced in the *Profile* in 2007 (CAOT, 2012), it was part of practice prior to its formal introduction (for an example, see O'Sullivan, 2011). In addition, other words are used to represent the same role (e.g. health advocate in medicine). Therefore, to ensure that a wide range of studies was identified, we chose keywords to encompass elements linked to the change agent role (e.g. advocating). Keywords were validated by an information scientist and included Change Agent, Advocacy, Health professionals, Role, Legislation, Policy and Ethics as well as similar concepts (e.g. clinicians). Their exact combination varied with the database. Second, we extended our search strategies to incorporate a manual search of reference lists and websites (e.g. associations of health professionals).

Stage 3

Relevant studies were selected: We included all documents that helped to comprehensively map the dimensions of the change agent role and address at least four of the six characteristics of human occupations (see Table 1). Because of the paucity of documents related specifically to occupational therapists' change agent role, we also included English- and French-language articles that described this role or elements closely related to it in other health professions. We excluded papers if they described a study protocol or involved one of the following: client's advocacy role, health professional's role in the adoption of healthy behaviors by clients, advocacy role for research, court expert or legal counsel. The second author and the research assistant selected the studies and the first author validated their choices.

Table 1

Identification and Selection of Studies (Stages 2 and 3)

Stage 2 Identification	
Databases (n = 9)	Combination of keywords
Academic Search Complete, CINHAL, PsychInfo	advocacy and role and [clinician or health professional or practitioner] and [(law or legislation or legal) OR (policy or policies) OR (ethics or ethic or ethical issues)]
Medline, Mantis, AMED, Cochrane Systematic Reviews, HealthStar	advocacy and role and [clinician or health professional]
LegalTrac	advocacy and health professionals and role

Websites (n = 12)	
Canadian health professional associations and regulatory boards	

Stage 3 Selection	
Inclusion criteria	Exclusion criteria
Articles that:	Articles that:
• comprehensively map the dimensions of occupational therapists' change agent role or elements closely related to it in other health professions and	• describe a study protocol or
• address at least four of the six characteristics of human occupations and	• involved one of the following: client's advocacy role, health professional's role in the adoption of healthy behaviors by clients, advocacy role for research, court expert or legal counsel
• are written in English or French	

Stage 4
Data were charted: We extracted contextual data (e.g. date and country of publication, type of study, health professional(s) involved) into an Excel form. We extracted qualitative data into a chart that included categories related to aspects of the study (e.g. aim, participants, methods) and the six characteristics of human occupations. Specifically, the second author and the research assistant extracted data. To ensure rigor, the first author validated all extractions.

Stage 5
Data were collated and summarized: We analyzed contextual data using descriptive statistics (frequency and percentage) and qualitative data with thematic analysis (Braun & Clarke, 2006). Thematic analysis led to the identification of emerging themes. Specifically, for each characteristic of human occupations, the extracts were coded by unit of meaning. Each code was described. Its description included which article(s) addressed it (number and page) and which codes from other characteristics of human occupations were explicitly linked to it. The codes were then grouped into sub-themes and themes. For example, for the characteristic How, a sub-theme identified was "Endorsing others' initiatives", which was grouped under the theme "Identify potential partners, develop relationships and collaborate". As the analysis progressed, the links between themes were scrutinized. For example, we realized that the Why "Improve health" was linked to the Where "Macrosystem", the Who "Community" and the How "Assume a formal duty in an advocacy association". It became apparent that themes could be divided up into two broad categories, called "configurations" below. The first author analyzed the data. Through discussions, alternative meanings were explored with the second author and the research assistant.

Results
From the 1298 documents initially identified, 1125 were excluded after reading title and/or abstract based on the eligibility criteria (see Figure 1). The remaining 173 documents were retrieved for further investigation and 145 were excluded based on the same criteria. Extended strategies identified five additional papers. Final analysis was done on 33 documents, most of which were theoretical articles ($n = 23$; 69.7%) published in the last 10 years ($n = 18$; 54.5%) in the United States ($n = 20$; 60.1%); some were related to the nursing ($n = 9$; 27.3%) and medical ($n = 6$; 18.2%) professions.
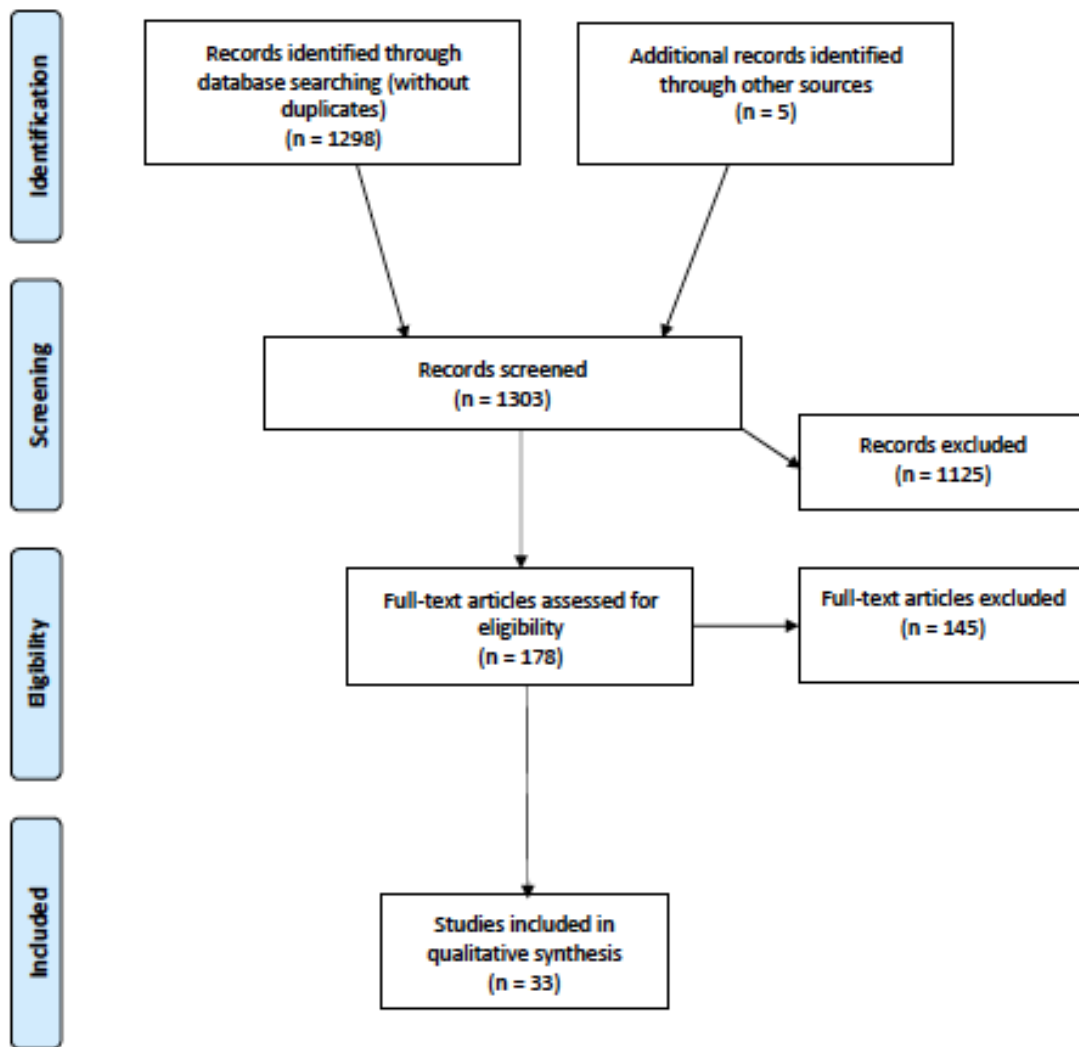
Figure 1. Flow chart.

Two distinct configurations of the change agent role emerged, each with four dimensions: aim of change agent actions (Why), context in which these actions take place (Where), actors involved (Who) and the actions themselves (How).

Two Configurations: Social and Clinical
The change agent role has two configurations: social and clinical (see Figure 2). On a continuum with each other, both these configurations are closely linked to promoting the profession (CAOT, 2012; Frank et al., 2015; Hall-Long, 2010; National Physiotherapy Advisory Group [NPAG], 2017; Roysircar et al., 2018) and to professional autonomy (Bernal, 1992). The need to act as a change agent is explicitly linked to ethical issues faced by health professionals, be they resolving social injustice (e.g. Ely & Dumulus, 2010) or child abuse (e.g. Hyman & Schreiber, 1975).To achieve the desired objectives, change agents use their expertise and professional power and work collaboratively with other professionals (CAOT, 2012; Frank et al., 2015; NPAG, 2017). In the literature, the

social configuration is seen as an opportunity to be seized, not an obligation to act (Barber, 2008; Ely & Dumulus, 2010; Gruen et al., 2004), while the clinical configuration is explicitly identified as an obligation inherent to professional status (Bernal, 1992; Park, 2009; Wakefield, 2001). The social and clinical configurations also differ when it comes to aims, contexts, actors and actions.
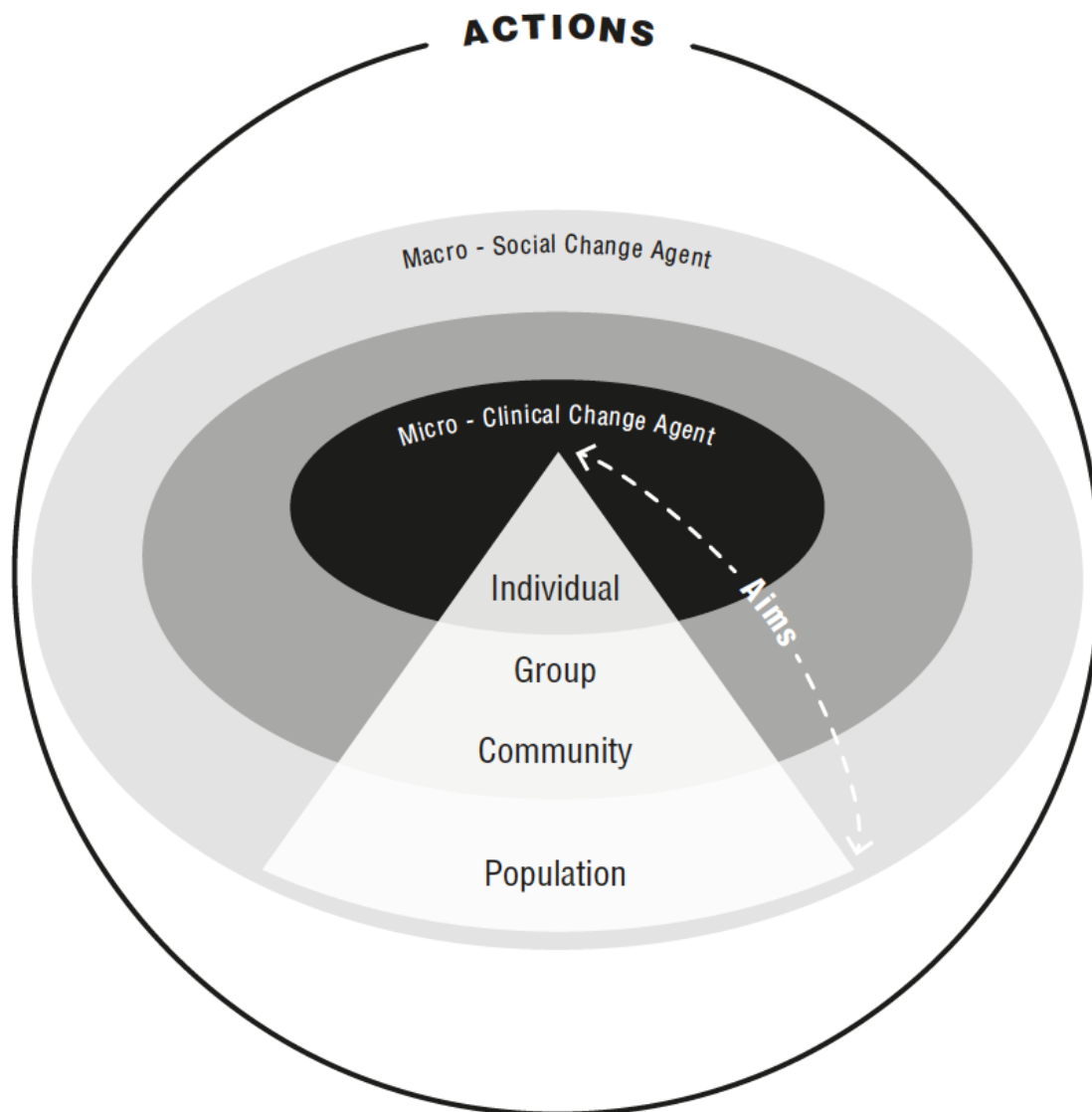
Figure 2. Social and clinical configurations of the change agent role. The gray gradient shows that the two configurations are on a continuum with each other from the micro to the macrosystem. The clinical configuration is shown in a darker shade of gray because it is inherent to professional status and therapeutic relationships while the social configuration is shown in a lighter shade because it is an opportunity to be seized. The triangle represents the pillar of change agent actions: actors concerned by the sought-after change. The arrow indicates that the aims of actions are closely linked to the actors. The circle shows that the actions encompass all configurations, are determined by the aims and cover a wide range of knowledge and skills.

Social change agents (see Table 2) operate in the macrosystemic context and target group, community and population. Typically, their purpose is to improve health and social justice, including access to services. Therefore, their actions are aimed at changing health policy (Hall-Long, 2010; Wise, 2001) or impacting laws that affect health, development, and well-being (Evans et al., 2008). Targeted laws may vary in nature: public administrative (e.g. access to services for the elderly; Greene & Knee, 1996), criminal (e.g. juvenile sentencing; Madden & Wade, 2003) or private (e.g. childcare; Madden & Wade, 2003). The role of social change agent is thus a tool for creating, modifying, and enforcing laws in a therapeutic way, such as to support and promote individual health and well-being (Madden & Wade, 2003). For its part, the role of clinical change agent (see Table 3) is employed more in the microsystemic context, in the clinical setting, for a client or group of clients. Clinical change agents primarily seek to resolve ethical dilemmas of varying nature (e.g. protecting confidentiality vs. protecting the client against abuse; paternalism of healthcare team vs. autonomy of the client). Other aims are to inform, sustain and promote decision-making as well as protect civil rights. For example, professionals might be speaking up for dying clients, so their choices are respected by the healthcare team (McSteen & Peden-McAlpine, 2006) or helping transgender people to legally change their name (Collazo et al., 2013).

In pursuing their primary purpose, change agents, be they social or clinical, might aspire to change public and organizational policies. Policies are defined as the way in which organizations, via their decision-makers, implement laws (Rappaport & Yarbrough, 2006). In pursuing this objective, change agents target different people depending on their context of action: i.e. microsystem (e.g. decision-makers in clinical settings) or macrosystem (e.g. decision-makers in government circles). For example, in ensuring that choices of dying clients are respected, the professional targets his/her colleagues in the healthcare team. In assisting transgender persons changing their legal name, the professional might need to convince government officials (if the law does not permit name changing) or talk with civil servants (if the law permits it).

The actions taken by social and clinical change agents usually differ. Social change agents might assume a formal duty in an advocacy organization, lobby politicians, give or collect funds, ask questions, speak publicly, make phone calls, disseminate research results, use media and write (see Table 2). Clinical change agents talk with clients to understand their values and provide information about rights and options, discuss with and make demands on other professionals or managers, whistleblow, and write reports and charts systematically and accurately (see Table 3). Other actions shared by both configurations (not shown in Tables 2 and 3) include but are not limited to: 1) identifying health needs and determinants, barriers to accessing services and resources (CAOT, 2012; Frank et al., 2015; NPAG, 2017); 2) supporting (Frank et al., 2015), assisting (CAOT, 2012), and fostering client empowerment (CAOT, 2012; NPAG, 2017); and 3) identifying vulnerable or marginalized populations and advocating with them and on their behalf (CAOT, 2012; Frank et al., 2015).

Table 2

Themes According to Change Agent Social Configuration

Aims: Why act
▪ Improve health[2,6,10,12,13,19,21,22,24,26,27,30] and well-being[7,9,15,19,21,24]
▪ Improve social justice[1,5] and equity[1,8,10], including access to services[5,9-11,20,21]
Context: Where actions take place
Macrosystemic (organizational or societal setting)[1,2,5-13,15,19-22,24,26-28,30-33]
Actors: Who is concerned by the sought-after change
▪ Group[5,20,26,28,31-33]
▪ Community[1,2,6-8,10,13,20,21,24,26,30-33]
▪ General population[2,6-10,12,13,15,20,21,22,24,26,27,30-33]
Actions: How aims are pursued
▪ Assess / reassess current social and political context[21] and impact on health issues[1,32]
▪ Belong to[10,11] or assume a formal duty in[2,5,11,12,20,24,26] an advocacy association or political group, including getting involved in a candidate's campaign[10]
▪ Communicate[1,8,12,13,19,21,24], tailoring message to audience[8,13]:   o Ask questions[10]   o Make phone calls (e.g. to stimulate buy-in to the change)[5,11]   o Speak publicly[2,11,20,26,33]   o Write (e.g. email, letter, one-page policy brief)[2,5,8,10,11,12,20]
▪ Compromise[6]

- Identify potential partners[13,21], develop relationships[7,12,19,21] and collaborate[5,6,10,13,20,21,22,26,33] within multidisciplinary / multisectoral partnerships, including:
  - endorsing others' initiatives ("lending one's voice")[13,20]
  - leveraging others' strengths[13]
  - knowing when to disengage[13]

- Get / keep informed about
  - policy processes[7,19]
  - what the government has committed to (take advantage)[24]

- Get involved in law and policy processes[7,20,21,22,27,30]

- Give[11] or collect funds[2,12,20,21,26]

- Identify[21,32], develop relationships with[21] and lobby Members of Parliament[2,7,8,12,13,20] or individuals in a position of power[8,24]

- Reflect critically on actions[1,13]

- Share research results[8,11,24]
  - Use jigsaw evidence (many pieces of evidence of varying quality creatively pieced together)[8]

- Use various media[8,12,11,24,26]

- Use activist strategies[10] (e.g. boycotts, protests)

References associated with each number can be found below Table 3.

Table 3

Themes According to Change Agent Clinical Configuration

Aims: Why act
▪ Resolve ethical dilemmas[3,14,16,17,23,28]
▪ Inform[4,12,13,16-18,23,31-33], sustain[16,17] and promote decision-making[4,16-18,23,31-33]
▪ Protect rights (e.g. civil rights, access to services)[3,4,7,14,15,18,19,25,28,29]
Context: Where actions take place
Microsystemic (clinical setting)[3,4,7,9,10,12,13,14-21,23,25,26,28,29,31-33]
Actors: Who is concerned by the sought-after change
▪ Individual client[3,4,7,9,12,13,15-18,20,23,25,26,28,29,31-33]
▪ Group of clients[4,7,10,12,16,20,21,26,28,31-33]
Actions: How aims are pursued
▪ Assist and encourage clients and families to advocate for themselves[12,21,23,25,31,33]
▪ Determine level of readiness for change[4] and potential safety risks[4]
▪ Develop therapeutic relationships[23]
▪ Discuss with clients and families to understand their values and inform them of their rights and options[12,15-18,33]
▪ Discuss with and advocate to other professionals and managers in the organization in the name of the client(s)[4,7,10,12,15,17,18,23,31-33]

- Get / keep informed about
  - attitudinal barriers[28]
  - laws and systems[28]
  - local and national resources[4]
  - programs[21,28] and processes[4]
  - related costs[4,21] and effectiveness[21]
  - role and actions of institutional actors[28]

- Offer free care[10]

- Speak up[16,17] and / or whistleblow[3]

- Write complete and systematic notes in clients' files[29]

1. Bakshi, James, Hennelly, Karani, Palermo, … Atkinson, 2015; 2. Barber, 2008; 3. Bernal, 1992; 4. Collazo, Austin, & Craig, 2013; 5. Ely & Dumulus, 2010; 6. Evans, Williams, & Perko, 2008; 7. Falk, Baigis, & Kopac, 2012; 8. Farrer, Marinetti, Cavaco, & Costongs, 2015; 9. Greene & Knee, 1996; 10. Gruen, Pearson, & Brennan, 2004; 11. Hall-Long, 2010; 12. Hilliard, Oser, Close, Liu, Hood, & Anderson, 2015; 13. Hubinette, Regehr, & Cristancho, 2016; 14. Hyman & Schreiber, 1975; 15. Madden & Wade, 2003; 16. McBride Robichaux, 2006; 17. McSteen & Peden-McAlpine, 2006; 18. Park, 2009; 19. Rappaport & Yarbrough, 2006; 20. Restall, Ripat, & Stern, 2003; 21. Roysircar, Studeny, Rodgers, & Lee-Barber, 2018; 22. Sanghavi & Siddiqui, 2017; 23. Seal, 2007; 24. Shaw, 2014; 25. Sullivan & Main, 2007; 26. Vine, Hargreaves, Briefel, & Orfield, 2013; 27. Wakefield, 2001; 28. Waldmann & Blackwell, 2010; 29. Winters, 2010; 30. Wise, 2001; 31. CAOT, 2012; 32. Frank, Snell, & Sherbino, 2015; 33. National Physiotherapy Advisory Group, 2017.

Discussion

This scoping study aimed to explore the dimensions of occupational therapy practitioners' change agent role. Results show that the change agent role is multifaceted and varies according to aim pursued, clients involved, context of achievement, and actions taken. Therefore, acting as a competent or proficient change agent requires familiarization with and mastery of a variety of actions, some of which are not always aligned with day-to-day clinical tasks (Drolet et al., in press). For example, although they are well equipped to analyze their client's personal context and its impact on his/her occupations, occupational therapists might lack the knowledge and skills to assess the political context and its impact on social change agency initiatives. Also, occupational therapists are generally able to navigate healthcare processes, but might experience difficulty getting involved in policy processes, as is often required by the social configuration. Even the clinical configuration entails advocacy actions that differ from clinical tasks per se. This variety and misalignment of some dimensions of the change agent role with clinical tasks might explain occupational therapists' discomfort with acting as change agents, as reported by various authors (e.g. Finlayson, 2013; Restall & Ripat, 2008; Xuan Shi et al., 2017). Our results therefore point to the potential need to review the initial training of occupational therapists.

Some authors have previously underlined the necessity to modify healthcare professions curricula to better support the development of the change agent role (e.g. Bhate & Loh, 2015; Kirsh, 2015). However, their recommendations focused mainly on general strategies to follow without identifying specific elements to be addressed in healthcare programs (e.g. topics to be covered, skills to be practiced). Our results describe the dimensions of each configuration. As such, they provide more specific information on the knowledge and skills that could be integrated into occupational therapy university programs. Table 4 provides examples of possible educational content and activities based on the knowledge and skills to be developed. For example, elements essential for advocacy efforts appear to be strategic communication skills, initiation of strategic partnerships, analysis of organizational and political contexts as well as planning and assessing change agent actions. This is in line with Rahimaly and colleagues' (2019) suggestions about topics to be addressed through knowledge acquisition and skill honing activities. Developing such knowledge and skills could be helpful for taking actions related to both configurations of the change agent role, whether in the microsystemic or the macrosystemic context.

Table 4

Skills Required According to Our Conceptualization of the Change Agent Role and Implications for Occupational Therapy Entry-Level Education Programs

A Change agent should know how to*…	Clinical	Social	We could teach	Building on acquired knowledge/skills about	Using
Identify need(s) that require change agent action	Individual and group	Group, community, and population	Ethical and cultural sensitivity Critical analysis model[1] Critical reflection guide[2]	Ethics (ex.: sensitivity, framing the problem, etc.) Occupational injustice, deprivation, alienation	Activities such as Lecture Guided reading Case study Role play Simulated situation with standardized actors Project Service learning
Analyze contexts	Clinical and Organizational	Organizational, Political and Societal	Context analysis matrix[3] Pestle analysis[4]	Environmental analysis	
Determine objectives	Specific, measurable, assignable, realistic, time-related		Formulation of objectives (e.g. SMART[5])	Formulation of therapeutic objectives	Strategies such as Experiencing Modeling Reflecting Scaffolding
Communicate strategically	Adapt language to clients, colleagues, decision makers in the organizational arena	Adapt language to decision makers in the political arena	Olson narrative strategies[6] Rhetoric and argumentative strategies[7] SUCCESS model[8]	Communication with clients, their families and colleagues	

Initiate partnership and collaborate	Mainly within the clinical setting	Mainly outside of the clinical setting	Potential micro and macrolevel partners (ex.: unions, committees, users' associations, etc.) Official and non-official channels and groups within the organization, the political arena and elsewhere Co-construction strategies[9]	Interprofessional collaboration	<u>Theoretical underpinnings such as</u> Competence-based curricula Critical consciousness Programmatic assessment Transformative learning
Determine plan of action and plan of assessment	What? Who? When? Where? How? Why? (objectives)		Planning change action models[10] Program evaluation models[11]	Planning an intervention process and outcomes assessment	
Assess results	Iteratively and over the course of the action plan		Program evaluation models[11]	Outcomes assessment	

*Adapted from Rahimaly et al., 2019; 1. Nixon, Yeung, Shaw, Kuper, & Gibson, 2017; 2. Carrier & Prodinger, 2014; 3. Contandriopoulos, 2012; 4. Stokes, Kruger, Harwood, Dantile, & Warren, 2015; 5. Doran, 1981; 6. Olson, 2015; 7. Drolet, Lalancette, & Caty, 2015; 8. Heath & Heath, 2010; 9. Freeman, Churchill, Douglas, Just, Paterson, & Pilger, 2020; 10. Carrier & Contandriopoulos, 2016 in Rahimaly et al., 2019; 11. Brousselle, Champagne, Contandriopoulos, & Hartz, 2009.

Bessette and colleagues (2019) have suggested that physiotherapy entry-level pedagogical activities should focus first on individual-level change agent initiatives (akin to the clinical configuration), then on system-level ones (akin to the social configuration). They contend that doing so would allow for a gradual increase in the complexity of actions required to act as a change agent in each type of initiative. Although our study did not aim to determine the complexity of change agent actions, our results do point to a similarity between some individual clinical tasks (e.g. discussions with client and family to know their meaningful occupations and inform them of their options) and actions pertaining to the clinical configuration in the microsystemic context (e.g. discussions with client and family to know their values and inform them of their rights and options). Since occupational therapy curricula mainly support the development of clinical expertise (Townsend & Polatajko, 2007), it is possible that pedagogical activities involving individual-level initiatives would be a more efficient way of learning the change agent role in entry-level programs. Among other things, focusing at first on individual-level actions might allow for easier knowledge anchoring. Also, since the clinical configuration is more in line with clinical tasks and ethical reasoning, it could be easier to integrate clinical change agency in existing occupational therapy curricula. A starting point for teaching about change agency could be through professional ethics activities (see Table 4). Elements related to the social configuration could then be integrated as more complex pedagogical activities, as suggested by Bessette and colleagues (2019). In line with this suggestion, other authors have stated that the acquisition of complex skills is fostered by a longitudinal, gradual and explicit deployment of activities. Such activities could be professional situations with high ecological validity inspired by transformational learning (Liotta-Kleinfeld et al., 2018) and critical consciousness (Halman et al., 2017) combined with the evaluation of skills using programmatic or longitudinal approaches (Marceau, 2019).

The specific deployment of teaching activities must be adapted to the contexts of each program and each country. For example, occupational therapy assistants are expected to support occupational therapists' actions as change agents (CAOT, 2018). Since they are not expected to determine the actions to be taken, analysis of contexts and planning of actions (see Table 4) might not need to be addressed in depth in their program. Another example is the entry-level diploma required for occupational therapists according to their country (WFOT, w.d.). In the United States, the doctorate degree is required. Doctorate programs may have more opportunity to help their students develop advanced change agent skills. In most other countries, such as Canada, the entry-level degree is a masters. It may be more appropriate for these programs to focus on achieving a competent level among their students, rather than a proficient or an advanced level. Thus, for these countries, continuing education is an essential avenue to consider, as illustrated by Rahimaly and colleagues (2019).

Finally, although the reviewed literature suggests that only the clinical configuration is a professional obligation, in light of professional organizations' expectations (e.g.: ACOTE, 2018; CAOT, 2017; WFOT, 2016), it could be argued that the social configuration is also an obligation. In fact, Drolet and Hudon (2014) have demonstrated that both configurations are ethically linked to the occupational therapy profession.

Therefore, both configurations should be acted upon by occupational therapists in practice. However, in light of the role complexity that emerged in this study, our main ascertainment is that it is not enough to simply call upon occupational therapists to embrace change agency (e.g. Finlayson, 2013; Kirsch, 2015; Pattison, 2015). Concrete, systematic and concerted actions on all professional fronts might be needed to further conceptualize, operationalize and teach the change agent role.

Implications for Occupational Therapy Education and Future Research
Although our conceptualization of the change agent role might be further refined, this first effort to add conceptual clarity to this important role might still be useful for clinicians. For example, clinicians might realize that they already act as change agents in their day-to-day practice according to a clinical configuration. This realization might help them develop the assurance and motivation to increase their change agent actions. Also, clinicians could identify actions according to each configuration and determine the ones they are already comfortable with and master those that require further training. This identification could also lead to developing partnerships with others (professionals or not) according to each other's strengths and limitations. Likewise, the results could help educators to map which configuration is addressed in their curricular activities (including fieldwork), when and how it is addressed, and evaluate if this is sufficient to attain a competent level. Continuing education could also be scrutinized in that regard.

Results from this study could be built upon to further detail the configuration continuum. Aims, actions, and required knowledge, skills and strategies could also be identified and described, for example, by empirical research that involves occupational therapists successfully acting as change agents. Such studies could inform university and continuing education programs about the specific elements to include. Elements of both configurations must also be operationalized in pedagogical activities and assessments and variables that can be used for evaluation. Finally, acting as a change agent may trigger potential ethical and legal conflicts, some of which are explicitly mentioned in the *Profile* (e.g. occupational therapists must manage any conflicts that may arise between their role as change agent and the resource regulator's role) or have been explored (e.g. Drolet & Hudon, 2014). Researchers need to develop tools to support occupational therapists' analysis, decision-making and actions taken in such situations.

Strengths and Limitations
Using the rigorous methodological framework for scoping studies and after searching in numerous databases and websites, this study provides an accurate, up-to-date synthesis of knowledge about the dimensions of the occupational therapists' change agent role. However, as is usually the case with scoping studies (Arksey & O'Malley, 2005), this study did not assess the quality of the documents examined. Furthermore, publication bias might have affected the results. To add depth in our research, we also could have added business industry databases such as Business Source Primer, ProQuest Business Premium Collection or ProQuest Research Library Business. Finally, experts could have been consulted as recommended by Levac and colleagues (2010). This analysis is thus a first step, which could lead to more in-depth studies.

Conclusion

Occupational therapists' change agent role encompasses two configurations, social and clinical, each operating in a different context, with different aims and clients, leading to distinct actions. It is important to have a better understanding of these configurations in order to inform occupational therapy practitioners about possible ways to optimize their change agent role. Knowing more about the dimensions of the change agent role may inform content and activities to be included in occupational therapy entry-level curricula as well as continuing education. Educators could also tailor their pedagogical activities based on these dimensions. Although this scoping study provides a first step in exploring the change agent role of occupational therapy practitioners, further efforts are needed on all professional fronts to further conceptualize, operationalize and teach this essential role. Simply calling upon occupational therapists to fully embrace the change agent role is not enough.

Key Messages

- For occupational therapy educators and practitioners to learn and embrace their role as change agents, conceptual clarity of this role is needed
- This scoping study provides a starting point for a clearer conceptualization and subsequent operationalization in pedagogical activities and assessments
- Concrete, systematic and concerted actions on all professional fronts are needed to further conceptualize, operationalize and teach about occupational therapists' change agent role

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