Self-Assessment of Professional Competencies of Occupational Therapists Trained and Working in Kenya

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Abstract

Professional competencies are indicators of standards of practice. There is limited documentation on required occupational therapy (OT) competencies in Kenya. **Objective**: Conduct self-assessment of awareness levels of professional competencies and educational investments of OTs working in Kenya **Method:** Exploratory design with quantitative methods of data collection. The target population comprised, practicing OTs with diploma qualifications (Group 1) and OTs who were studying in or had graduated with upgrade degrees in Kenyan Universities (Group 2). Simple random sample was conducted on 259 OTs to select the two (2) groups. Two separate structured online questionnaires for self-assessment (one for each group) were administered to collect data.

Findings: Significant difference between Group 1 and Group 2 t (23) = -2.769, p = .008 at $p < .05$ in the knowledge and competency levels on twenty-four (24) competency indicators. **Significance:** Educates OTs on the need to update/train/develop professional competencies, especially in emerging practice domains.

Keywords: occupational therapy, self-assessment, professional competencies, lifelong learning

1 Introduction

One of the foundations for any professional practice is the ability to demonstrate and articulate its professional domains through discipline-specific competencies. For occupational therapy (OT), human occupations are the tenet of its professional domain / practice (Rodriguez-Bailon, et, al., 2022). Professional competency refers to the capability of healthcare professionals to effectively serve both individuals and the broader community under expected clinical/professional performance standards (World Federation of Occupational Therapists – WFOT, 2016). The healthcare landscape continues to change rapidly, calling for all healthcare workers, including occupational therapists (OTs), to possess current knowledge and professional competencies for quality service to clients (ACOTRO, et al., 2023). Therefore, every profession should focus on areas of improvement with precision for collective expected performance standards in health care/service delivery.

In addition, OTs need to meet the World Federation of Occupational Therapists (WFOT) minimum standards of entry-level bachelor's degrees to remain relevant and globally competitive (wfot.org, 2023). Competencies in OT encompass a range of interconnected attributes, including knowledge, skills, experiences, and sociocultural factors (Association, 2021). Competency signifies professional standards and set OT apart from related fields like occupational medicine and occupational health & safety. Distinguishing the role of OT through specific competencies can also enhance the profession's recognition and reduce role overlaps/conflicts with other health professions (Avello-Sáez et al., 2022). The World Federation of Occupational Therapists (WFOT) advocates that OTs adapt to evolving environments and emerging demands in both clinical practice and public health settings (Jackson et al., 2019). Thus, OTs should strive to continuously develop or upgrade their competencies with relevance to societal changes in the context of occupations

Entry level health workers including OTs ought to have competencies in research and innovation, administration and management (WHO, 2011). In Kenya, there is no known documentation or research that has been conducted on professional competencies of OTs. Yet, professional competencies are the framework for practice (Association, 2021). OT was established in Kenya in 1968 within the first school at the Medical Training Centre (MTC) attached to the King George

hospital (presently; Kenyatta National Hospital). The first graduates in 1970 obtained certificates. Since then, OT in Kenya has evolved from the highest OT qualification being a certificate in the 1970s, progressing through diploma levels and now includes undergraduate degree programs, introduced by two Kenyan universities in the year 2010. The first-degree cohort graduated in 2013. OTs trained in Kenya, are expected to possess cross-cultural competencies for engagements with diverse socio-cultural settings. They are also are required to demonstrate interpersonal and professional skills, ethical values and professional responsibilities, critical and ethical reasoning, in addition to decision-making and/or problem-solving, flexibility and adaptability (Macharia, 2019) as some of the essential generic skills for OT.

The degree programs in Kenya are offered through two pathways: i) A two-year diploma conversion (upgrade) and ii) A four-year full degree. The introduction of the degree programs created opportunities for the diploma holders to upgrade their qualifications. Continuous education is believed to provide opportunities to learn new skills or reskill previously acquired ones. This study drew its population from two groups of OTs with a diploma background for self-assessment of whether upgrade programs can influence the development of professional competences. Group 1 comprised of diploma holders who were yet to register for degree conversion (upgrade) programs while Group 2 was drawn from OTs who were studying in or had graduated with upgrade degrees in Kenyan Universities. Specific skills and knowledge relevant to the local context, which can guide curriculum development, and support continuous professional development were identified for the self-assessment based on common practice settings in Kenya.

The demand for OT services in Kenya is steadily increasing (Kenya Gazette, 2022). This is driven by a growing awareness of the benefits of OT in enhancing the quality of life of individuals by managing a wide spectrum of disabilities and more recently, the sequelae of non-communicable diseases (Association, 2021). The recognition of the profession in Kenya led to the establishment of the Occupational Therapy (OT) Regulatory Council in 2022, which is now working to fulfill its mandate of training, registration, and licensing of OTs and its associates. In addition, the Council recognizes international protocols and global education standards which require graduates to adaptively use 21st century skills in working spaces beyond graduate qualifications. Professions are increasingly intertwined with productivity focusing on competencies and skills rather than graduate qualifications (WHO, 2011). Evaluation of competencies and preservation of standards have become increasingly significant topics of discussion and interest in many countries in the 21st Century (Barasa et al., 2018; Mulder, 2014). This is especially important for Kenya; because of its continuous realignment of health care and training programs which contribute to sustainable development goals (SDGs) (Myers et al., 2017).

As the occupational therapy council of Kenya moves forward with its mandate, it is crucial to address issues of professional competencies for the development of a comprehensive policy with standards and practice guidelines. This includes ensuring that the competencies align seamlessly with global standards to facilitate cross-border OT practice. Therefore, assessing the professional competencies of OTs trained and working in Kenya is essential to address unique healthcare needs, enhance educational programs/learning materials, promote evidence-based practice, and maintain global standards. It is imperative for every practicing OT to reflect and be self-aware of changes in the fabric of occupations to acquire competencies relevant to practice. Based on this background, the level of self-awareness of professional competencies of OTs with diploma and post-diploma qualifications will be assessed. This study seeks to assess the competencies of OTs exposed to or interested in further education. The following research questions were informed by the need for OTs

to develop or improve on the identified professional competencies which also informed the data collection tool:

1. What is the awareness level of prevailing competencies of practice for occupational therapists (OTs) working in Kenya?
2. What are the competency levels of occupational therapists (OTs) in selected domains of OT practice in Kenya?
3. To what extent have occupational therapists (OTs) practicing in Kenya invested in knowledge and professional competencies?

The study results will inform policy and regulatory frameworks not only to the Kenya regulatory council but also contribute to global knowledge by providing data on Kenyan OTs' competencies. This would also contribute to international collaborations and the adoption of best practices.

2 Methods

The study utilized an exploratory design with quantitative data collection methods. There are numerous pathways through which professionals can develop competencies including; I) immersive practice within a specialized service and professional environment (Enemark Larsen et al., 2018) ii) pedagogical experience to acquire more knowledge, skills, and attitudes (Shukhratovich, 2022). This study focuses on the pedagogical methods of developing competencies; based on this, the study selected OTs who have recently participated in/or are interested in furthering their education. Thus, the target population comprised of two groups: i) practicing OTs with diploma qualifications who have not registered for an upgrade degree (Group 1) (G1); and ii) OTs who are currently studying in an upgrade degree program and occupational therapists who have graduated with upgrade degrees from Kenyan Universities (Group 2) (G2). Except for a negligible number of OTs who either studied or received further training at universities outside Kenya, the rest of the OTs in the country fall into either Group 1 or Group 2.

Through self-assessment, participants of the two groups were required to respond to questions in two differentiated structured online questionnaires (one for each group respectively). Specific skills and knowledge which build professional competencies relevant to the Kenyan context and which are also common to OT curricula and practice settings in Kenya were identified as indicators and listed in the self-assessment structured questionnaires. These included: Knowledge and skills in conducting standardized assessments, pre-schools & schools practice, workplace and organizational re-design, mental / psychosocial health practice, drugs and substance abuse therapy, handling physical disabling conditions (children & adolescence), physical disabling conditions (adults), hospital (in patient), hospital (outpatient), community based rehabilitation, vocational rehabilitation, telehealth, disaster preparedness, health education / public health, environmental adaptations (buildings, planning), refugees and internally displaced persons, working in industry / manufacturing, working in insurance and indemnity, occupational health and safety, research, education & knowledge sharing, advocacy, marketing and entrepreneurship, inter- and multi-disciplinary teams, and lifelong learning.

This approach gave a comprehensive inquiry into the construct of professional competencies of OTs practicing in Kenya. The main measure was underpinned by the participants' interest in furthering their studies beyond diploma qualifications as an avenue of acquiring new knowledge and skills

(which contribute to competencies). This may also signify the level of self-awareness of the need to improve or acquire new knowledge and skills as the foundation for competencies.

*Sample size***:** For Group 1 (G1), a simple random sampling technique was used on a population of 259 occupational therapists who were members of the Kenya Occupational Therapists' Association (KOTA) WhatsApp forum. Yamane's formula (S= P/1+P(e)^2) was applied to calculate the required sample size, where S represents the sample size, P represents the population of the study (in this case, 259), and *e* represents the margin of error, which was set at 5% (or 0.05) for this study. Using this formula, the sample size was calculated as follows:

S = 259/ (1 + 259 (0.05)^2)

S = 259/1.65

S = 156.9

Rounding up to the nearest whole number, a sample size of 157 was determined for G1. For Group 2 (G2), purposive and census sampling techniques were used to select participants from 108 ongoing and graduated occupational therapists from the databases of two universities. A census sample(Daniel, 2012) targeting a threshold of 30 respondents was set based on the Central Limit Theorem (CLT), which posits that a sample size of 30 or more is sufficient to assume a normal distribution of data (Ganti, 2023). To ensure an adequate response rate, two online questionnaires were administered to as many participants as possible who met the inclusion criteria, to achieve a minimum of 30 respondents. The selection of participants was done purposively based on predetermined criteria to ensure representation. The specific criteria established beforehand were as follows:

- For Group 1, participants must have a diploma qualification, practice in different areas of the country, and be registered members of the Kenya Occupational Therapy Association (KOTA).
- For Group 2, participants were either pursuing their upgrade degree or had already qualified with an upgrade degree in occupational therapy and were registered as KOTA members.

Data Collection Instruments, Procedures, and Analysis: Two (2) structured online questionnaires were designed to test the research questions for both groups concurrently. The questionnaires consisted of three sections; i) demographic information including age, gender, years of experience; ii) specific competencies identified as basic for practice and those required in differentiated practice settings including clinics, schools, and community; and iii) recommended basic skills and training needs based on global practice. Following ethical approvals, email addresses were accessed from the KOTA database and university OT departments for G1 and G2, respectively. The links to the questionnaires, accompanied by request for consent forms were shared on emails inviting participation from the sampled population. Data collection was conducted over three weeks with weekly reminders. Participation was voluntary following informed consent. Analysis was conducted using SPSS (Version 26). Descriptive statistics were calculated, and independent t-tests were conducted to explore relationships between variables in G1 and G2.

Reliability and validity: The questionnaire was developed in consultation with experts in OT and was pilot tested with a small OT group. Feedback from the pilot test was used to revise the questionnaire. The reliability of the questionnaire was assessed using Cronbach's alpha yielding a coefficient score of 0.91 indicative of a reliable and valid instrument**.** A high alpha value (range of 0.7 or higher) indicates that the items are sufficiently consistent to indicate the measure is reliable and measuring a single intended construct; In this case, it was the competency level of selected skills of OTs practicing in Kenya. Cronbach's alpha is also related to validity and can be used as a framework for the same; therefore, a reliable Cronbach's alpha, also means that the questionnaire is measuring what it intends to measure.

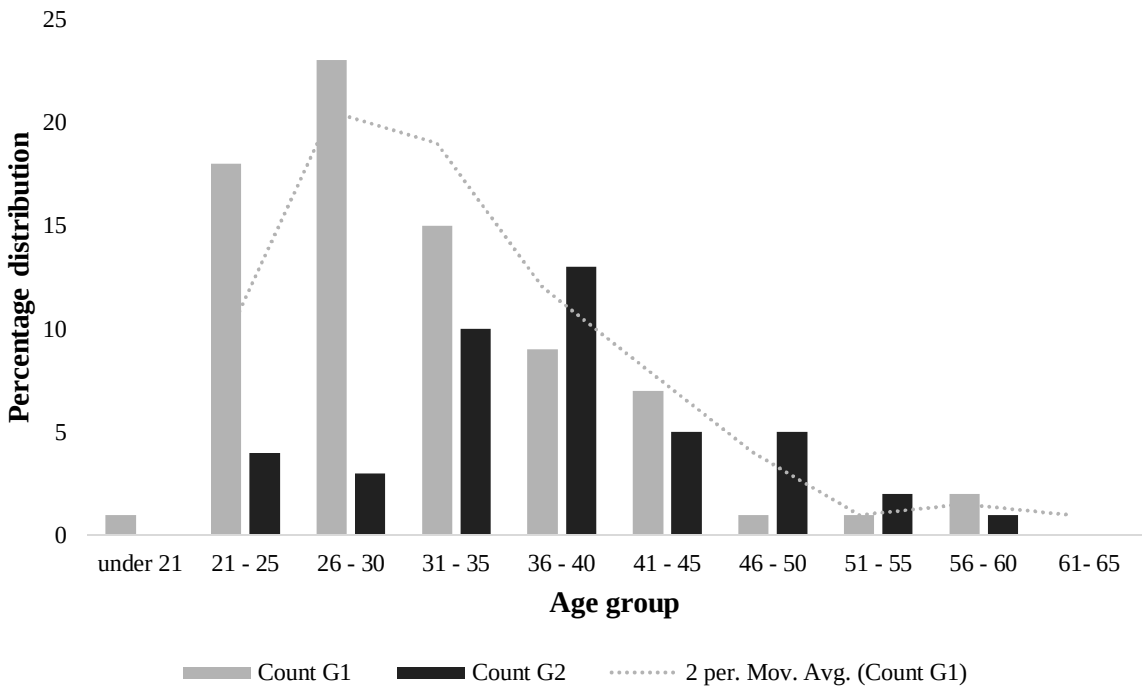
3 Results

For G1,157 questionnaires were sent out; 78 were returned giving a 49.7% response rate. In G2; 108 questionnaires were sent out, 91 were received while 17 emails returned 'wrong address'; Of the 91 questionnaires; 43 responses were received surpassing the expected 30 responses required by the central theorem. The total number of questionnaires analyzed was n (78+43) = (121). Online surveys rarely receive high response rates; 44% to 50% is a practical expectation (Hendra & Hill, 2019; Wu et al., 2022).

Figure 1 Percentage distribution by gender (G1 n=78), (G2 n=43)

Figure 1 depicts the demographic distribution of participants: in G1 (n=78), there were more male participants at 56% (n=78) than females at 42% (n=78) while in G2 (n=43), there were more female participants at 58% (n=43) compared to males at 44% (n=43).

Figure 2 Percentage representation by age group (G1 n=78), (G2 n=43)



In Figure 2 illustrates the percentage distribution of OTs who were interested in upgrade degree as contribution to developing competencies through education: the highest percentage of therapists who were interested in registering for upgrade programs (G1, n=78) were in the age group of 26-30 years at 29% while the same for the registered or graduated (G2, n=43) were in age groups of 36-40 years at 30%.

Table 1 Self-assessed Twenty-four (24) skills (competency indicators) in OT practice in Kenya

	Means of Indicators of Competencies (skills, knowledge and competency levels)	G1	G2
1.	Skills standardized assessments	4	4
2.	Skills Pre-schools & Schools	3	3
3.	Skills Workplace and organisational re-design	4	4
4.	Skills Mental / psychosocial health	3	4
5.	Skills Drugs and substance abuse	3	4
6.	Skills Physical disabling conditions (children & adolescence)	4	4
7.	Skills Physical disabling conditions	4	4
8.	Skills Hospital (in patient)	4	4
9.	Skills Hospital (outpatient)	4	4
10.	Skills Community based rehabilitation	4	4
11.	Skills Vocational rehabilitation	3	4
12.	Skills Telehealth	3	3
13.	Skills Disaster preparedness	3	3
14.	Skills Health education / Public health	3	4
15.	Skills Environmental adaptations (buildings, planning)	3	4
16.	Skills Refugees and internally displaced persons	3	3

17.	Skills Working in industry / manufacturing	3	3
18.	Skills Working in Insurance and indemnity	3	3
19.	Skills Occupational health and safety	3	4
20.	Skills Research, education & knowledge sharing	3	4
21.	Skills Advocacy	3	4
22.	Skills Marketing and entrepreneurship	3	4
23.	Skills Inter- and multi-disciplinary teams	4	4
24.	Skills Lifelong learning	4	4

Key	Blank	Least competent	Somewhat competent	Averagely competent	Competent	Most competent
	0	1	2	3	4	5

From Table 1 illustrates select skills of practice through which participants can assess their competencies. Here, the independent *t-test* returned*;* G1, n=78 (SM = 3.375, SD = 0.495) paired with G2, n=43 (SM = 3.750, SD = 0.442) demonstrated a significant difference t (23) = -2.769, p = .008 at $p < .05$ in competency levels of both groups. G2 (n=43) indicated a higher sample mean (SM).

Figure 3 Self-awareness of professional competencies / skills for OT G1 n=78

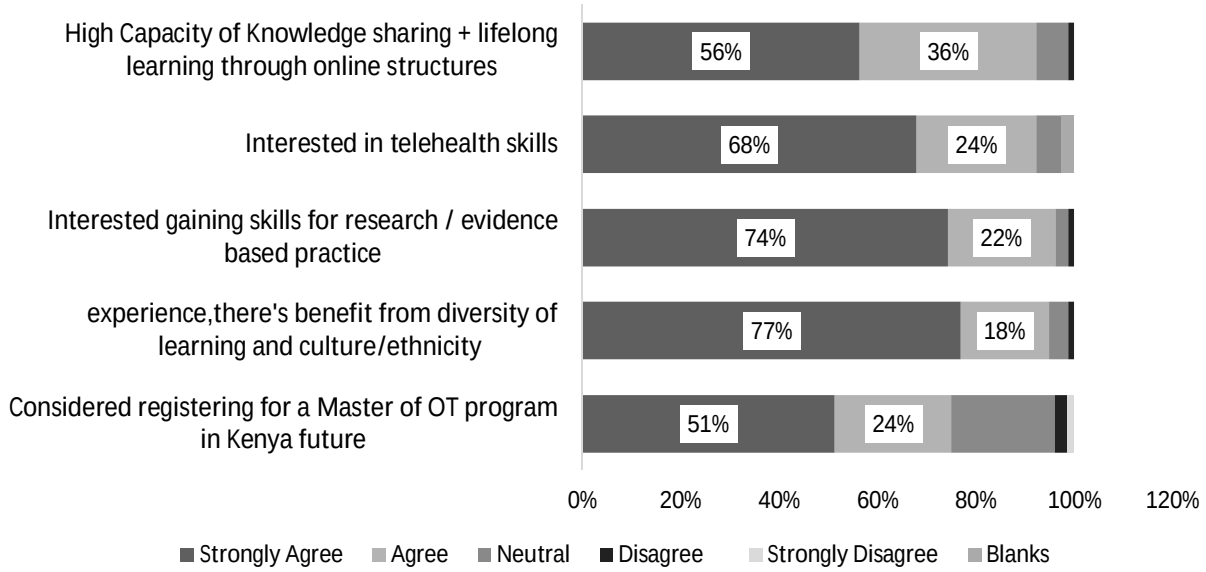


Figure 3 illustrates a selection of practice areas to test for professional competencies: specific competencies that are considered important for diploma holders to have or form a basis to seek further studies were explored (G1 n=78). These factors included building capacity in knowledge sharing and lifelong learning skills, telehealth, and evidence-based practice skills among five competency skills. Skills needed for working in multicultural and diverse settings scored the highest motivation factor for enrolling for further studies (upgrade degree program) at 77% (n=8) indicating that 77% (n=78) of respondents lacked such skills. Generally, all the factors scored over 50% (n=78) indicating that though the therapists had some of the skills, they believed that they could develop more of these skills by going back to school.

Figure 4 Investment in emerging OT practice domains competency levels (G1 N=78), (G2 N=43)

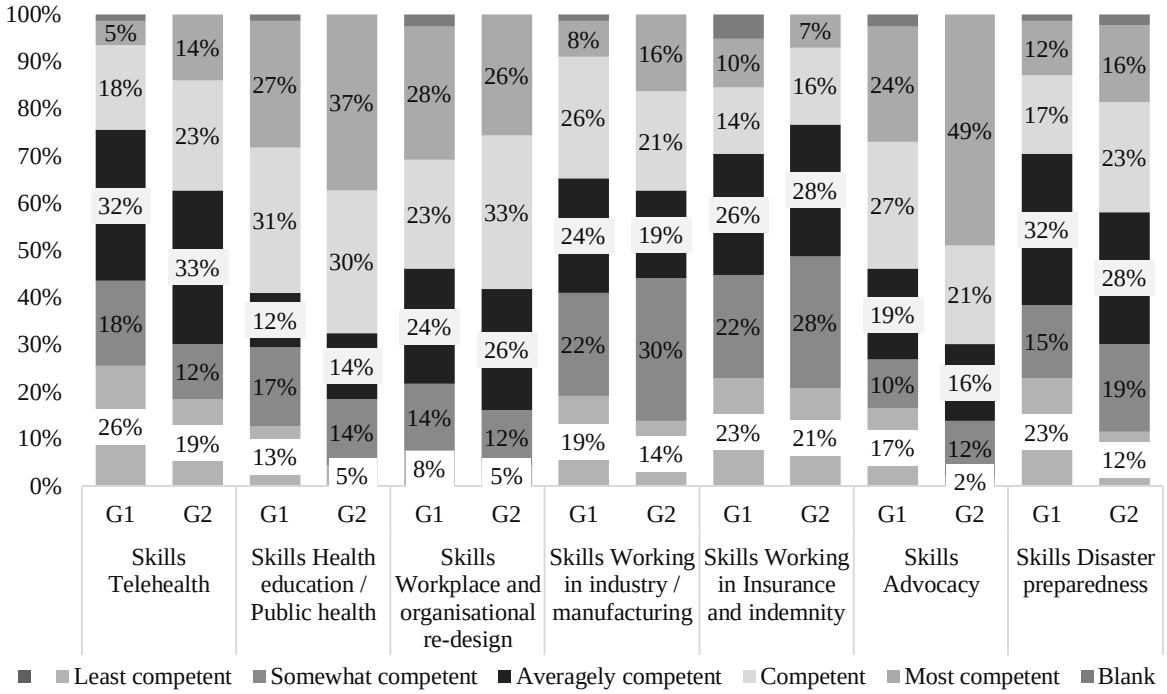


Figure 4 indicates self-assessment on competencies for emerging practice domains including OT in Public health and OT in industry. Here, skills for telehealth scored 76% (n=78) and 64% (n=43) combined from the scale; least competent, somewhat competent, and averagely competent for G1 and G2 respectively. Overall, skills for emerging frontiers scored means of 3 and 4 for all the skills of new frontiers for both G1 and G2 (Table 1). Independent *t-test* returned G1, n=78 (SM = 1.873, SD = 0.309) compared G2, n=43 (SM = 1.787, SD = 0.565) and $t(6) = -0.328$, $p = .748$ at $p < .05$. There was no significant difference in the means indicating that both groups need to invest more on skills which develop competencies to practice in emerging frontiers of OT.

Figure 5 Investment in community-based OT practice areas competency levels (G1 n=78), (G2 n=43)

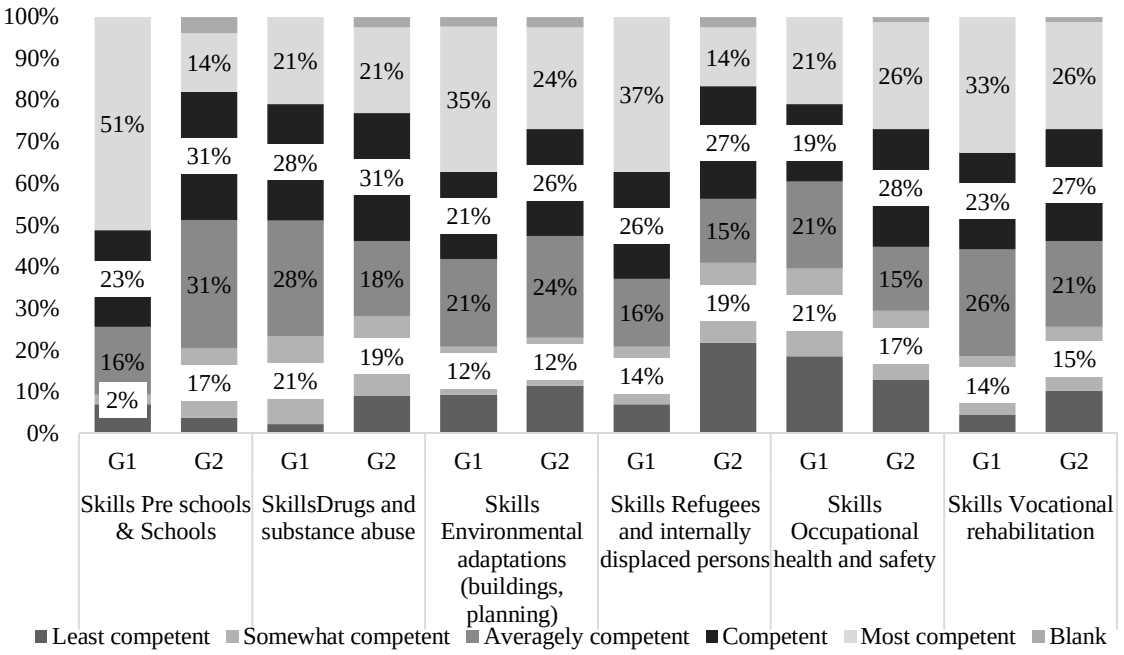
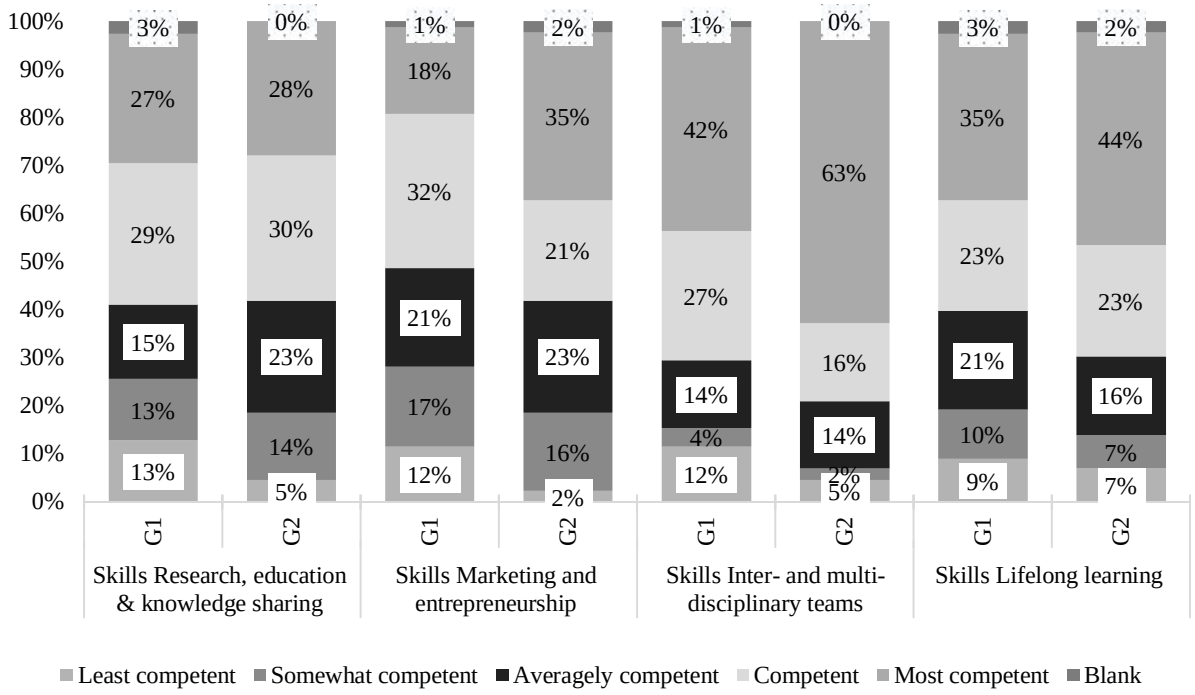


Figure 5 illustrates some of the skills required of an OT practicing community-based occupational therapy. Most participants indicated high competency levels in the tested areas (Figure 5). Independent *t-test* returned*;* G1, n=78 (SM = 3, SD = 0) compared to G2, n=43 (M = 3.671, SD = 0.471) demonstrated a significant difference *t* (5), p = .010 at p < .05. G2 (n=43) returned a higher sample mean. The highest competency was in working in pre-schools and schools at 51% (n=78) in G1 while G2 scored this as one of the areas of the least competency at 14% (n=43). G2 also scored low for 'most competent' in skills for working with refugees and displaced persons at 14% (n=43) most competent scale. Independent t-test returned; G1, n=78 (SM = 3, SD = 0) compared to G2, n=43 (M = 3.671, SD = 0.471) demonstrated a significant difference t (5), p = .010 at p < 05. G2 (n=43) returned a higher sample mean.

Figure 6 Investment in managerial skills OT competency levels (G1 n=78), (G2 n=43)



Often, OTS are required to step up to administration or management of departments or institutions. Figure 6 depicts some of the common interdisciplinary and multidisciplinary skills adept to management. Skills for leading interdisciplinary and multidisciplinary teams scored highest at 42% (n=78) and 63% (n=43) for most competent while investment in life-long learning skills scored 35% (n=78) and 44% (n=43) for G1 and G2 respectively. 26% (G1, n=78) indicated that they needed to develop research/education/knowledge sharing skills in addition to 27% (G1, n=78) who needed more competencies in marketing and entrepreneurial skills. Independent *t-test* returned*;* G1, n=78 (SM = 3.5, SD = 0.577) compared to G2, n=43 (M = 4, SD = 0) demonstrating no significant difference t (3) = -1.732, p = .134 at $p < .05$. Both groups thus require training in the administrative/managerial domain of competencies. Interdisciplinary and multidisciplinary skills

4 Discussion

4.1 Awareness level of prevailing competencies of practice in occupational therapy

To test if age and gender are factors in the awareness of prevailing competencies of practice in occupational therapy, the study results indicate a notable difference in the gender distribution of participants between the two groups, with G1 having a higher number of male participants and G2 having more female participants. This gender disparity might reflect underlying societal trends in education. Reviewed data on tertiary education enrollment in Kenya from 1985 to 2017 indicate lower enrollment rates compared to women (Stoet & Geary, 2020). In this study, the age group of 26-30 years had the highest proportion of occupational therapists (OTs) at 29% interested in registering for upgrade degree programs. However, the majority of those who had registered or graduated (30%) were in the 36-40 years age group.

This suggests that although younger OTs recognize deficiencies in their knowledge and skills and are eager to enhance their competencies through further education, there are barriers preventing them from promptly actualizing these intentions. These barriers need to be identified and addressed. Another possible explanation for this discrepancy is the ambition and aspirations of younger therapists. Younger people in general, are often more motivated towards higher career goals and are eager to advance professionally. Despite this eagerness, they may face significant challenges including insufficient savings for tuition fees and associated expenses in acquiring higher education. The rising cost of higher education continues to be a major obstacle, limiting access and participation for many potential students (Boneva et al., 2022; Vincent & Chiwandire, 2019). An associated systematic review of literature indicated that time, competing clinical and educational demands, lack of support in the clinical and educational environment, a lack of opportunities to practice the skills due to types and duration of clinical rotations, and lack of reliable assessment methods in this domain contributed to inadequate development of competencies (Gibson & Molloy, 2012).

4.2 Competency levels and knowledge investments of occupational therapists (OTs) in selected domains of practice in Kenya

The independent t-test results indicate that there is a statistically significant difference in competency levels between Group G1 and Group G29 (p-value = 0.008). Specifically, participants in G2 demonstrate significantly higher competency levels compared to those in G1. The higher competency levels in G2 suggest that the training or educational interventions applied during the upgrade training are effective. Additionally, one study found that upgrading entry-level professional credentials can lead to new generations of OTs having more positive attitudes towards, better knowledge of, and greater confidence in using evidence-based practice (EBP) compared to previous generations (Thomas & Law, 2013). The study further stated that clinicians who have not received explicit instruction in EBP can benefit from enhancing their education through post-professional training and continuing professional development (CPD). The ability to use EBP enhances competence, and there is a relationship between the performance and competency of employees (Kolibáčová, 2014).

The study findings further reveal that a significant majority of respondents, especially in group 1 (77%) identified working in multicultural and diverse settings as their primary motivation for enrolling in upgrade programs. This indicates a self-recognized deficiency in these skills among current diploma holders. In addition, several specific competencies were identified as important for diploma holders to either possess or develop through further education. These include i) knowledge sharing and lifelong learning skills, ii) telehealth, iii) evidence-based practice (EBP) and iv) working in multicultural and diverse settings. All identified factors scored over 50%, suggesting that while OTs may possess some level of these skills, they believe there is substantial room for development. This belief drives their interest in further education to enhance their professional competencies. The most recent development, resulting from the COVID-19 pandemic shutdowns, is the provision of telehealth and health education from any global location (Alvi, 2023; van der Stap et al., 2023). The study indicates that differences in the competencies of telehealth in groups 1 and 2 were not significant, indicating that both groups need to invest more in skills that develop competencies to practice in emerging frontiers of OT.

Competencies for community-based rehabilitation (CBR), including working in schools and with refugees and displaced persons, showed a significant difference between the two groups, with G1

having a higher competency level. This indicates that further education programs should focus on training or improving CBR practice competencies. Key components of sustainable development goals (SDGs) (Abualghaib et al., 2019; Barasa et al., 2018; Macharia, 2019), coupled with the rising prevalence of non-communicable diseases (NCDs), which are strongly associated with occupations and environmental adaptations, highlight the need for effective community-based rehabilitation (CBR) (Avello-Sáez et al., 2022; Kok et al., 2023). CBR encompasses various contexts, including community organizations, schools, spiritual centers, hospitals, and refugee environments, which often present barriers to optimal occupational performance for persons with disabilities (PWDs). Occupational therapists (OTs) need to acquire these skills during basic training and continue to refine them through lifelong learning opportunities including upgrade degree programs. Disability mainstreaming and inclusion initiatives are also crucial components of SDGs.

Skills for leading interdisciplinary and multidisciplinary teams scored highest for most competent in both groups while investment in life-long learning skills scored 35% and 44% for G1 and G2 respectively. In both G1 and G2, there was no significant difference among those who indicated a need to develop research, education, and knowledge-sharing skills, as well as those who needed more competencies in marketing and entrepreneurial skills (t (3) = -1.732, p = .134 at p < .05). OT education standards and guidelines (World Federation of Occupational Therapists – WFOT, 2016) prioritize leading multidisciplinary teams, administrative and managerial skills as some of the important generic competencies. Therefore, it is important to gauge the competencies/knowledge and individual's investment to develop the same. Both groups thus require training in the administrative/managerial domain of competencies. The low sample means for both groups indicated that they did not have student-centered learning skills. A cross-sectional study design provides a snapshot at one point in time, making it difficult to assess changes in the competencies of the OTs over time. In addition, relying on self-reported data from participants may introduce bias, as individuals may overestimate or underestimate their competencies and motivations for further education.

4.3 Limitations

A cross-sectional study design provides a snapshot at one point in time, making it difficult to assess changes in the competencies of the OTs over time. In addition, relying on self-reported data from participants may introduce bias, as individuals may overestimate or underestimate their competencies and motivations for further education.

5 Conclusions

This study provided an opportunity for practicing OTs to participate in self-assessment of selected skills that build the framework for professional competencies. The focus was on OTs trained and working in Kenya. However, it should inform other OT professional communities on the role of education and lifelong learning in developing skills which contribute to professional competencies. There is now positive awareness of expected professional competencies and a recognition of the need to invest in further education as an opportunity for knowledge-based competencies among representative groups of occupational therapists in Kenya. Once in practice, knowledge-based skills translate into professional competencies. The study reveals notable differences in gender distribution, with more males in Group G1 and more females in Group G2 but not necessarily a factor in the development or acquisition of professional competencies. The statistically significant differences in competency levels between Group G1 and Group G2 suggest the effectiveness of

upgrading through education and highlight disparities that need to be addressed. The need for skills in multicultural settings, evidence-based practice (EBP), telehealth, and community-based rehabilitation (CBR) highlights the areas where diploma holders feel they need further development. The study underscores the importance of lifelong learning, especially in emerging areas like telehealth, and the need for OTs to develop competencies in administrative and managerial domains.

6 Recommendations

Policymakers including regulatory bodies should consider developing policies that ensure equitable access to resources and training programs, especially for groups that are currently underperforming (G1 in this case). The OT educational programs should update curricula to include more comprehensive training in multicultural competencies, telehealth, EBP, and CBR. Regulatory bodies should encourage ongoing professional development through accessible continuing education opportunities, both synchronous and asynchronous, to accommodate diverse schedules and responsibilities. There is a need for more research on the development of skills necessary for working in diverse and multicultural settings to ensure inclusive and culturally sensitive care. There is also need for further research to investigate the specific barriers preventing younger OTs from pursuing further education (as a means for developing knowledge-based competencies) and develop targeted strategies to overcome these challenges.

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