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## Entry-Level Occupational Therapy Student Volunteer Activities During COVID-19 and Beliefs about Practitioner Roles in Crisis Management

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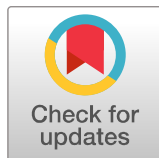
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### Cover Page Footnote

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# Entry-Level Occupational Therapy Student Volunteer Activities During COVID-19 and Beliefs about Practitioner Roles in Crisis Management

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## Abstract

**Background:** Due to the global novel coronavirus disease 2019 (COVID-19) pandemic, many students in entry-level occupational therapy (OT) programs faced changes to their daily roles, habits, and routines. To understand beliefs about OT practitioner roles in a public health crisis, a cross-sectional study was designed to understand occupational therapy students (OTS) and occupational therapy assistant students (OTAS) volunteer activities during the COVID-19 pandemic. **Methods:** A survey was developed and distributed in April 2020, and closed after five weeks. Quantitative data was analyzed in Statistical Package for Social Sciences (Version 27) and open response data was categorized in Microsoft Excel. **Results:** Respondents included students from entry-level OT/OTA accredited programs in the United States such as occupational therapy doctorate, entry level master's, bachelor's to master's and occupational therapy assistant (n=853, 2.8% of OTS/OTAS population). Nearly all respondents endorsed that OT practitioners have at least one role during a crisis (n=851, 99.8%) and after a crisis (n=848, 99.4%) like COVID-19. A minority of students volunteered in response to COVID-19 (n=60, 7.0%). Volunteer activities addressed clinical work, food insecurity, loneliness, social justice, healthcare workers, COVID-19 transmission, and personal protective equipment. Inspirations for volunteering included altruism, justice, personal responsibility, changes to routines, calls to action, and fulfilling obligations. **Discussion:** It is hoped that this study serves as a springboard for future research related to the OTS/OTAS response to COVID-19. Educators can prepare students for future public health emergencies by exposing them to information regarding OT's role in disaster management.

**Keywords:** occupational therapy students, health occupations, volunteer, COVID-19

## **Introduction**

Occupational therapy (OT) practitioners, such as occupational therapists (OTs) and occupational therapy assistants (OTAs), play various roles in crisis management. Roles include rehabilitation of people impacted by the crisis, evacuation planning, and educating first responders (Jeong et al., 2016). The World Federation of Occupational Therapy (WFOT) (2014) reported that OTs create accessible environments for survivors with disabilities, organize daily routines for people in temporary shelters, facilitate access to healthcare, connect people to community organizations, evaluate and treat survivors' mental health, and use occupation to promote recovery. Occupational therapy practitioners may also work to support people who have acquired disabilities as a result of disasters (Parente et al., 2017).

The March 2020 outbreak of the novel coronavirus disease 2019 (COVID-19) pandemic caused a public health crisis, leading 42 states to implement mandatory stay-at-home orders during the first few months of the pandemic (Moreland et al., 2020). Many OTs provided skilled services via telehealth platforms throughout the year 2020 (Tenforde et al., 2020). Acute care OT leaders worked quickly and efficiently to assess and teach personal protective equipment (PPE) compliance to support other healthcare staff (Robinson et al., 2021). Occupational therapists addressed functional impairments, such as limited activity tolerance and intensive care unit-acquired weakness, across the continuum of recovery with COVID-19 patients (Wilcox et al., 2021).

As a dynamic profession, OT practitioners and accredited OT academic programs evolved to meet the needs of individuals, groups, and populations throughout the COVID-19 crisis, including the needs of students who would enter the profession. During COVID-19, the Accreditation Council on Occupational Therapy Education (ACOTE) permitted OT educational programs to temporarily change the delivery of educational coursework from in-person to distance learning without notifying the organization itself (American Council on Occupational Therapy Education [ACOTE],

2021a), or apply for permanent changes under policy IV.B.1 (ACOTE, 2021b). Also, the 2018 ACOTE standards C.1.0-C.1.16 enabled programs to create fieldwork placements in telehealth and non-traditional settings to observe state regulations for COVID-19 safety (ACOTE, 2018). Amid significant transitions in OT education, students faced changes to their daily roles, habits, and routines such as having increased available time in their daily schedules (Werner & Jozkowski, 2022; VanPuymbrouck & Olson, 2022). Students explored new occupations to fill gaps in their typical routines (Werner & Jozkowski, 2022; VanPuymbrouck & Olson, 2022). One new way of occupying time could be volunteering in response to the COVID-19 pandemic.

Volunteering is viewed as a civic duty to support crisis management (Smith et al., 2010). Volunteering motivations include the belief that it is important to help others, the desire to learn more about a cause, and the willingness to work with others to address social problems (Smith et al., 2010). Positive reinforcement from volunteering may promote future participation in volunteer activities (Smith et al., 2010). According to the Occupational Therapy Practice Framework (OTPF), 4th edition, volunteering is an impactful occupation that enables individuals to develop skills, interact meaningfully with others, and form a sense of purpose and identity (American Occupational Therapy Association [AOTA], 2020a).

Occupational therapy students (OTS) and OT assistant students (OTAS) may be ideally positioned to support crisis management via volunteering. Because full-time employment opportunities in their field of study are not yet available, students may be more likely to participate in volunteering to build professional experience (Smith et al., 2010). Facilitators for student volunteering include prior volunteer experience and the desire to work with vulnerable populations (Rogers, 2020). Access to disaster management education and safety materials, like PPE, may also increase the likelihood of volunteering (Patel et al., 2017).

However, students can face barriers to volunteering. One barrier is time. Students manage multiple responsibilities, such as schoolwork, self-care, and productivity demand such as paid work (Werner & Jozkowski, 2022). First-generation, low-income students might be less likely to volunteer than affluent students due to financial and time constraints (Kawecka Nenga, 2011). Also, students may not volunteer during a respiratory disease outbreak because of the inherent risk that infectious disease poses to health and safety (Patel et al., 2017). National PPE shortages during COVID-19 may have meant that students who chose to volunteer would not have access to PPE (Livingston et al., 2020).

### **Research Aims**

There is limited research on OTS/OTAS time-use and adaptations to changes during COVID-19 (VanPuymbrouck & Olsen, 2022; Werner & Jozkowski, 2022). However, there is a gap in the literature regarding OTS/OTAS volunteer responses to COVID-19, and this study was developed to address this need. The first aim of the study was to identify OTS/OTAS volunteer responses to COVID-19 and what inspired volunteer efforts, including volunteer activities and potential collaborations with other healthcare professional students and community members. A second aim was to explore the roles that OTS/OTAS believed OT practitioners have in crisis management. The alternative hypothesis of this study was that students who believed OT practitioners have more roles in crisis management would be more likely to be involved in COVID-19-related volunteer activities. The null hypothesis was that volunteering respondents and non-volunteers would endorse the same number of OT roles in a public health crisis.

### **Design**

This study had a cross-sectional design and involved a 10-question survey with seven multiple-choice and three open-ended questions (see Appendix A for the full survey). The purpose of the cross-sectional design was to gather information on beliefs and volunteer responses during a historic

moment in the OT profession. The survey included open-ended questions to collect information regarding specific respondent volunteer activities and perspectives related to crisis management. The survey was disseminated online via Qualtrics to OTS/OTAS in the United States.

## **Methodology**

### **Sample**

Purposive sampling was utilized to disseminate the survey to OTS/OTAS. An email was sent to the AOTA Program Director listserv, the academic fieldwork coordinator listserv, and all faculty advisors of Student Occupational Therapy Association (SOTA) chapters in the United States with instructions to share the survey with students. The survey was distributed to student members of AOTA via AOTA's CommunOT listserv and the Assembly of Student Delegate (ASD) leadership. Online communities, such as OT pages and groups on Reddit and Facebook, served as additional sources for sharing the survey. Inclusion criteria required respondents to be enrolled in an entry-level OT/OTA program in the United States. Respondents who indicated that they were not enrolled in an OT/OTA program were prompted to exit the survey. Respondents were also excluded if they did not complete the survey. Participants who completed the survey but did not answer questions nine and ten were included in the analysis because selecting none of the response options was considered a valid response.

### **Instrumentation**

The survey was designed to address research aims and gaps in the literature. Questions one through eight were informed by the literature and included the input of two entry-level OT students, an academic OT program director, and a statistician with expertise in psychometrics. The survey collected demographic data on the type and location of respondent's OT entry-level programs, the number of respondents currently volunteering due to COVID-19, and details about volunteer activities and inspirations. Occupational therapy entry-level programs included entry-level doctorate, master's

degree, bachelor's to master's, and OT assistant. At the time of the survey, a master's degree in OT was required to become a licensed OT (Best Accredited Colleges, n.d.). Four experts in survey design from the authors' affiliated institution reviewed the survey for face validity. Three graduate research assistants then tested the final survey to ensure it functioned properly. Content validity of the survey was supported by a literature review.

Survey questions nine and ten explored OTS/OTAS beliefs about the roles of OT practitioners in crisis management (See Appendix A, Q9 and Q10.) A literature review conducted in March 2020 on PubMed informed the roles of OT practitioners during and after a crisis like COVID-19. Search terms for the literature review included the following keywords and their synonyms combined with appropriate Boolean operators: "occupational therapy," "disaster management," "interprofessional collaboration," and "first responders." Articles were included if they were peer-reviewed and included information about the role of OT, or interprofessional teams including OT, in managing crises such as infectious disease outbreaks and natural disasters. There were no exclusion criteria for publication dates. Full-text sources were screened by two graduate research assistants and reviewed by three study authors. Six articles met the inclusion criteria, and data was extracted regarding the specific roles of OT practitioners in crisis management (Hoying et al., 2017; Jeong et al., 2016; Lee, 2014; Oakley et al., 2008; Parente et al., 2017; Webster & Harrison, 2004). The ninth survey question had six response options from this literature for OT roles during a crisis: mental health and stress management interventions, evacuation planning for people with disabilities, clinical practice with people impacted by the crisis, training and supporting first responders, interprofessional teamwork, and addressing occupational deprivation. For the tenth survey question, respondents could select from the following five roles for OT after a crisis: mental health and stress management interventions, promoting the return to meaningful and purposeful routines, supporting healthcare professionals and first responders, advocating for healthcare policy change, and treating people that acquired conditions, injuries, or disabilities related to the

crisis. Both questions contained an open-response option for respondents to enter additional roles of OT practitioners during or after a crisis.

### **Procedures**

This study received Institutional Review Board exempt status from the university's Office of Human Research on April 17th, 2020. The survey was deployed on April 17th, 2020, and closed after five weeks. Respondent's privacy was maintained by limiting data collection to non-identifiable information. The survey included an introductory statement that completing the survey served as informed consent.

### **Data Analysis**

This study involved both quantitative and qualitative data analysis. Quantitative data analysis included descriptive and inferential statistics using the Statistical Package for Social Sciences (SPSS), Version 27. Counts and frequencies were calculated for all survey items. Chi-square analysis assessed differences in volunteering status and endorsement of OT practitioner roles during/after a crisis between several categorical variables such as the type of entry-level OT program. Independent samples t-tests measured the potential differences between volunteer status and the mean number of roles endorsed for OT practitioners during/after a crisis. Between-groups Analysis of Variance (ANOVA) assessed possible connections between the type of OT entry-level program and the mean number of roles selected for OT practitioners during/after a crisis. The ANOVA tests and t-tests included both the pre-specified OT practitioner roles in the survey (see Appendix A, Q9 and Q10) and the open-ended response options. For statistically significant ANOVAs, effect sizes were calculated with Eta-squared statistics, and post-hoc Bonferroni tests for multiple comparisons determined the specific relationships and directionality of results.

Qualitative data analysis included the organization of open-ended responses from questions five and six into categories and their definitions in Excel (see Appendix A for survey questions). Two authors independently read all open responses to



each question and used keywords and phrases directly from survey responses to create initial categories. The co-authors then met and achieved consensus on initial categories. Foundational OT literature informed definitions for the categories that emerged from open-response data. For example, the AOTA Code of Ethics (AOTA, 2020b) provided standardized definitions for OT-related constructs of altruism and justice described by survey respondents. All study authors individually reviewed initial categories and definitions until they reached a consensus. Two authors collaborated to accept or deny all suggested changes. An audit trail of each round of analysis was maintained. The co-authors calculated counts and frequencies for each of the final open-response categories. Open-response data from questions nine and ten were also summarized in Excel.

## Results

Almost all respondents ( $n = 851$ , 99.8%) believed that OT practitioners have at least one role during a crisis like COVID-19, and only five respondents (0.6%) did not select any roles for OT practitioners after a crisis like COVID-19. The distribution of respondents selecting each OT role during a crisis was relatively even, with approximately a quarter of respondents selecting four, five, or six out of the six pre-specified response options ( $n = 214$ ,  $n = 205$ ,  $n = 217$ , respectively). In contrast, over half of the respondents ( $n = 520$ , 61.0%) selected all five of the pre-specified response options for OT roles after a crisis. On average, participants endorsed 4.44 ( $SD = 1.45$ ) OT roles during a crisis and 4.34 ( $SD = 1.11$ ) roles after a crisis like COVID-19. See Table 1 and Table 2 for a full description of each OT entry-level program and the roles each group endorsed for OT practitioners.

Chi-square test results showed that volunteering respondents ( $n = 29$ , 48.3%) were significantly more likely than non-volunteers ( $n = 277$ , 34.9%) to endorse that OT practitioners have a role in training and supporting first responders during a crisis ( $\chi^2[1, N = 853] = 4.356, p = 0.037$ ), but all other chi-square tests comparing volunteer and non-volunteer endorsement of OT roles were not significant (all  $p > 0.05$ ). Additionally, the t-tests

indicated that volunteers and non-volunteers selected a similar mean number of OT roles during ( $p = 0.11$ ) and after ( $p = 0.87$ ) a crisis. These results failed to reject the null hypothesis for this study.

The between-groups ANOVA showed that the types of entry-level programs differed from each other with regard to the number of roles respondents selected for OT practitioners during a crisis ( $F [3,849] = 10.519, p < 0.001$ ), and this difference had a small-to-medium effect size ( $\eta^2 = 0.036, 95\% CI [0.013, 0.061]$ ). Similarly, respondents in each entry-level program endorsed a different number of OT roles after a crisis like COVID-19 ( $F [3,848] = 3.649, p < .012$ ) with a small effect size ( $\eta^2 = 0.013, 95\% CI [0.001-0.29]$ ). The Bonferroni post-hoc test found that the mean number of roles OTAS selected during a crisis was less than the number of roles selected by MSOT ( $p < .001, 95\% CI [-1.4978, -0.49819]$ ), OTD ( $p < .001, 95\% CI [-1.6099, -0.5557]$ ), and BSMS students ( $p = .042, 95\% CI [-1.4063, -0.0167]$ ). When assessing the number of OT roles selected after a crisis, OTAS selected fewer mean roles than MSOT ( $p = .018, 95\% CI [-0.8311, -0.0494]$ ) and OTD ( $p = .007, 95\% CI [-0.9029, -0.0915]$ ) but not BSMS students ( $p = .602, 95\% CI [-0.8998, 0.2095]$ ). No other differences were identified between entry-level programs. See Table 3 for a full description of the mean number of OT roles during and after a crisis selected by respondents in each entry level program, as well as other descriptive statistics.

Chi-square tests results indicated that during a crisis like COVID-19, OTAS were less likely than MSOT and OTD students to select the following roles for OT practitioners: mental health and stress management interventions, evacuation planning for people with disabilities, clinical practice with people impacted by the crisis, interprofessional teamwork, and addressing occupational deprivation (see Table 1 for specific chi-square statistics comparing each entry-level program). After a crisis, OTAS were less likely than MSOT and OTD students to identify that OT practitioners play a role in advocating for healthcare policy change (see Table 2 for specific chi-square statistics comparing each entry-level program). Results from the chi-

square analyses should be interpreted with caution due to several cells with an expected count of fewer than 5 respondents (see footnotes in Table 1 and Table 2).

Respondents cited additional crisis response roles through open-response text boxes. During a crisis, respondents described professional roles such as creating community outreach programs, designing adaptive equipment, advocating for occupational justice, supporting marginalized groups at-risk for COVID-19, and implementing ergonomic interventions for clients completing school or work from home. After a crisis, respondents suggested that OT practitioners can evaluate environments or implement environmental adaptations to prevent the spread of COVID-19, advocate for the role of OT during future pandemics as well as make remote work and school permanent options.

### **Student Volunteering During COVID-19**

A minority of respondents ( $n = 60, 7.0\%$ ) indicated that they were volunteering in response to COVID-19 in April and May of 2020. In this section and the following results sections, the term “identified volunteers” will refer to this subset of the sample that were volunteering. Identified volunteers (IVs) lived in 22 states, with a range of 1-7 students in each state. Enrollment in each type of entry-level program was not significantly related to volunteer status ( $\chi^2[3, N = 853] = 0.195, p = .978$ ). In regard to question 7, “Who are you currently working with to respond to COVID-19?” IVs most frequently collaborated with community organizations ( $n = 31, 51.7\%$ ) and students from health profession programs ( $n = 26, 43.3\%$ ) (see Table 4 for descriptive statistics for all collaborator categories), while nine IVs (15%) responded that they were not working with anyone.

### **Student Volunteering to Address Health, Social, and Economic Impacts of COVID-19**

Categorizing responses from the question, “what are you doing to respond to the COVID-19 crisis at the individual, group, or population level?” revealed seven types of volunteer activities (See

Table 5 for volunteer activity categories and representative respondent quotes). Three volunteering categories addressed the direct consequences of COVID-19 on health: clinical work, personal actions to reduce COVID-19 transmission, and PPE fabrication. Four volunteering categories targeted the social and economic impacts of COVID-19: addressing food insecurity, combating loneliness, social justice, and supporting healthcare workers and first responders. Some IVs mentioned the specific populations served during volunteering. The most commonly served populations were healthcare workers and first responders, such as EMTs, firefighters, nurses, medical doctors, and OT practitioners ( $n = 11, 18.3\%$ ), older adults ( $n = 11, 18.3\%$ ), and children and families ( $n = 10, 16.7\%$ ). Another population served was people living in institutions such as assisted living, nursing homes, or group homes ( $n = 5, 8.3\%$ ).

Many IVs addressed the consequences of the pandemic on physical health through their volunteer activities (see Table 5 for descriptions of volunteer activities). Most of these respondents did hands-on clinical volunteering in healthcare settings through school or employment ( $n = 12, 20.0\%$ ). Half of these respondents worked directly with people with COVID-19 ( $n = 6, 10.0\%$ ), coordinating respite care, volunteering at COVID-19 testing sites, and supervising staff donning and doffing PPE within COVID-19 units. The other half of respondents volunteering in clinical settings served general populations ( $n = 6, 10.0\%$ ), and fulfilled roles as home health aides, EMTs, or supported the transition to telehealth service delivery.

Other IVs addressed socioeconomic inequalities exacerbated by COVID-19 (see Table 5). Most of these respondents addressed food insecurity ( $n = 17, 28.3\%$ ). They prepared meals, went grocery shopping, and delivered groceries or meals to individuals facing financial insecurity, an inability to order groceries online, or who were homebound due to an immunocompromised status. Some IVs organized new food drives at their church or school, while others participated in existing programs such as “Meals on Wheels” or “Adopt a Senior.”



Approximately a quarter of IVs addressed social isolation ( $n = 16, 26.7\%$ ), and volunteered to reduce loneliness due to the quarantine (see Table 5). They engaged in activities like virtual "social groups," "visits," "calls to neighbors," or activities to increase "social participation." Online group activities consisted of exercise, interactive games, arts and crafts, prayer, and virtual trips to places like museums. Some respondents combated loneliness by sending letters with messages of encouragement or small crafts like origami hearts to isolated individuals. One IV described how maintaining social connections could serve as primary prevention for mental health conditions. They stated, "it is also important to keep people socially engaged because everything is very scary right now and not having something to take your mind off of [COVID-19] affects your mental health, leading to depression, anxiety and stress."

### **Student Inspirations for Volunteering During COVID-19**

Analysis of IV's open responses to the question "what inspired you to get involved in a COVID-19 response activity?" resulted in six categories: altruism, justice, disrupted routines, contracted time, personal responsibility, and calls to action (see Table 6 for inspiration categories and representative respondent quotes). Altruism and justice are directly named as values in the Occupational Therapy Code of Ethics (AOTA, 2020b). Altruism inspired the majority of respondents to volunteer ( $n = 36, 60.0\%$ ). It is demonstrated by showing "unselfish concern for the welfare of others" (AOTA, 2020b). Justice inspired nearly a quarter of respondents ( $n = 14, 23.3\%$ ). It is defined as striving to create a reality where:

"diverse communities are inclusive and are organized and structured so that all members can function, flourish, and live a satisfactory life regardless of age, gender identity, sexual orientation, race, religion, origin, socioeconomic status, degree of ability, or any other status or attributes" (AOTA, 2020b, p. 26).

Another common inspiration for volunteering was "call to action" ( $n = 18, 26.7\%$ ), in which respondents were directly recruited to volunteer by members of their personal network, or indirectly recruited, for example recognizing there was a need for volunteers in the community by seeing posts on social media.

Other reasons for volunteering were described by less than a quarter of IVs (see Table 6 for frequencies). Disrupted routines indicated a major change in daily routines that created "boredom" and made time available for volunteering. Personal responsibility refers to an individual's belief in the ability to control their own health behaviors and influence the overall health of their community. It is similar to the "internal locus of control" (Rotter, 1966) which states that personal behaviors, rather than external forces, impact the outcomes of events in one's own life. Contracted time was the least common inspiration for volunteering, and it is defined by Ås (1978) as fulfilling a commitment to existing employment, school, or volunteer obligations.

### **Discussion**

Almost all respondents believed that OT practitioners had at least one role during and after a crisis, indicating that OTS/OTAS saw the value of OT in the COVID-19 response. However, OTAS were more likely to believe OT practitioners had fewer roles to serve, especially during a crisis like COVID-19. This difference in OTAS perception of OT practitioner's scope of practice indicates that OTA curricula may benefit from coursework on healthcare provision during a pandemic. This curricular approach is supported by ACOTE standard B.7.5, which reveals the "personal and professional responsibilities" that all OT practitioners should consider, specifically recognition of "varied roles of the OT/OTA providing service on a contractual basis" (ACOTE, 2018, p. 38). Adding a new accreditation standard for crisis management education may facilitate the implementation of such content in OT/OTA curricula (ACOTE, 2018). All entry-level OT programs could likely benefit from such

coursework; prior research indicates healthcare students feel unprepared to handle public health emergencies (Patel et al., 2017; Yonge et al., 2010).

Identified volunteers were more likely than non-volunteers to endorse that OT practitioners had a role in training or supporting first responders during a crisis like COVID-19. The qualitative analysis also showed that IVs performed activities that served healthcare practitioners or first responders ( $n = 11, 18.3\%$ ), and engaged in clinical work ( $n = 12, 20.0\%$ ). These findings suggest that being involved in a crisis response activity may have exposed OTS/OTAS to the possibility of collaborating with professionals across the healthcare continuum during a public health emergency, such as first responders. In comparison, respondents who were not volunteering may not have had as much exposure to frontline healthcare workers during COVID-19.

### **Students Were Unlikely to be Volunteering at the Start of the Pandemic**

Although most respondents believed OT professionals have a role during a crisis, few respondents ( $n = 60, 7.0\%$ ) were currently volunteering to fulfill those roles. For context, an estimated 23.2% of people in America formally volunteered with an organization, and 51% informally helped others in their own community during COVID-19 (Americorps, 2021). A potential reason for low volunteering rates in this survey may be that OTS/OTAS faced difficulty adjusting to virtual learning and changes to fieldwork. A study on OTS time use during the initial phase of COVID-19 found that students experienced occupational disruption, and none of the participants reported volunteering (Werner & Jozkowski, 2022). Another study reported that OTS faced difficulties adapting to changes in their habits and routines during COVID-19 and expressed a loss of motivation as well as volition to engage in valued or new occupations (VanPuymbrouck & Olsen, 2022). Time constraints, limited financial resources, lack of education on proper PPE and a respiratory outbreak are additional factors that were previously shown to negatively impact healthcare student volunteering (Kawecka Nenga, 2011; Patel

et al., 2017; Rogers, 2020; Yonge et al., 2010). Many non-profit organizations were not accepting volunteers due to pandemic restrictions, and economic pressures made one in three non-profits at risk for closure during COVID-19 (Candid & Center for Disaster Philanthropy, 2021).

### **Volunteer Responses and the Unique OT Perspective**

Survey responses revealed that IVs were involved in activities consistent with OT roles identified in the literature (see Appendix A response-options for Q9 and Q10), as well as volunteer activities that were not identified in the literature review. Occupational therapy roles identified in the literature review that were reflected among respondent volunteer activities included: implementing mental health and stress management interventions (Jeong et al., 2016; Oakley et al., 2008; Webster & Harrison, 2004), treating individuals with conditions acquired due to a crisis (Jeong et al., 2016; Lee, 2014; Parente et al., 2017), and collaborating with interprofessional teams including first responders (Hoying et al., 2017; Jeong et al., 2016). Respondent volunteer activities that were novel included social justice and addressing food insecurity. These activities reflected a concern with the equitable distribution of vital resources to individuals, groups, and communities at risk for severe social and economic deprivation due to COVID-19 (World Health Organization, 2021). This concern is further reflected through AOTA's Vision 2025, in which the profession is committed to addressing "health, well-being, and quality of life for all people, populations, and communities" (AOTA, 2019).

The analysis of student inspirations for volunteering and volunteer activities demonstrates OT's unique and holistic perspective. Respondents' intention to target quality of life, physical and mental health, and participation in meaningful everyday activities speak to the unique scope of OT as defined by the OTPF (AOTA, 2020a). Another consistency with the OTPF is the service of individuals, groups, and populations, corresponding to the categories of clients within OT scope of practice (AOTA, 2020a). References to

“justice” and “altruism” in the open-ended responses align with the OT Code of Ethics (AOTA, 2020b), implying that OTS/OTAS have already begun applying the terminology and mindset outlined in the Code of Ethics to real-time crises.

### **Strengths and Limitations**

Many respondents endorsed all possible roles of OT practitioners after a crisis that were included in the survey (see Appendix Q10), which may mean that respondents had additional beliefs about roles that existed outside of the survey. This may indicate a ceiling effect for question ten, showing that our survey did not capture all possible OT roles in a crisis response. The ceiling effect may have obscured or downplayed the potential differences between groups in terms of the number of roles each group believed OT had after a crisis like COVID-19. However, the ceiling effect does not apply to the qualitative analysis of question ten, because participants were able to write an open-response not captured by the provided options.

The small effect sizes of the between groups ANOVA tests call into question the meaningful differences between OTAS, MSOT, and OTD students in relation to the number of roles each group endorsed for OT practitioners during or after a crisis. However, OTAS endorsed a statistically significant fewer number of OT roles during and after a crisis than MSOT and OTD students, on average selecting at least one less role. Other limitations include study design, sampling method, and a small sample of IVs. The cross-sectional design provided data from one point in time and did not capture how volunteering may have changed during the COVID-19 pandemic. Because of purposive sampling, respondents may have been more likely to participate in the study if they were members of certain online OT networks where the questionnaire was disseminated. Although our overall sample size was large ( $N = 853$ ), the number of volunteers was much smaller ( $n = 60, 7.0\%$ ), which provided a less robust sample size for statistical analyses.

Conducting this study at the beginning of the pandemic is a unique and important strength. At the time of the survey development, there was a gap in the literature regarding OTS/OTAS time use, volunteer activities in response to COVID-19, and beliefs regarding OT practitioner roles in crisis. The novelty of this study can potentially serve as an inspiration for future studies that involve OTS/OTAS volunteering, crisis response, and the profession’s ability to adapt to the needs of real-time crises. Another strength of this study is the large overall sample size, which provided adequate power for analysis with inferential statistics. Additionally, the authors completed a thorough process for categorizing open-response questions to limit bias, with all co-authors coming to a consensus on the categories and their definitions.

### **Future Directions for Research**

The study can be used to support several related research endeavors. The findings of this study failed to reject the null hypothesis since IV’s and non-volunteers believed OT had a similar number of roles to serve in a public health crisis like COVID-19. Future studies can explore the association between the likelihood of OTS/OTAS volunteering and other factors including demographic variables and previous volunteer experiences. Given that justice and altruism were the most cited reasons for volunteering, future studies can address the potential link between service learning in OTS/OTAS and the cultivation of ethical values.

Future research can also investigate the connections between the most common OTS/OTAS volunteer activities and collaborators identified in this survey, such as volunteering to address social isolation and collaborating with other students or community organizations. The most common activities and collaborators can also inform program development for student service learning. Activities with higher-response rates, such as addressing food insecurity, can indicate opportunities that might be of greater interest to entry-level students. Due to a higher number of volunteer activities that addressed the socioeconomic impacts of COVID-19, future research can explore the connection between

student volunteering and social justice. Similarly, OT roles that respondents submitted through the open-response options can inform future questionnaires about OT in crisis response, for example, implementing ergonomic interventions for clients working from home.

## **Conclusion**

This study identified OTS/OTAS volunteer activities and beliefs about the role of OT professionals in a public health crisis. One of the main findings was that most respondents were not volunteering in response to COVID-19, and the number of IVs was less than the national average in the United States. This finding may be reflective of the occupational role change that OTS/OTAS faced at the start of the pandemic, or educational curriculum gaps, as OTS/OTAS may not have been exposed to possible opportunities to support crisis management as student practitioners.

Educational OT/OTA curriculum design can be adapted to expose students to the profession's unique roles and responsibilities during a public health emergency. These may include consultation skills, prevention and intervention. Educating OTS/OTAS on service delivery during pandemics can also prepare students to provide a high standard of care for all patients with infectious diseases. Although the majority of respondents were not volunteering, almost all respondents endorsed that OT practitioners have roles in crisis response, indicating that OTS/OTAS were aware of the importance of their profession in public health emergencies.

Another main finding of this study was that respondents who did volunteer were involved in a variety of activities that addressed the health, social, and economic impacts of COVID-19. This suggests that students reflected the profession's wide-ranging scope of practice in student activities. Participation in volunteer activities can potentially bolster the ethical and professional development of student practitioners.



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**Table 1**

*Type of Respondent Entry-Level Program and Beliefs about Occupational Therapy (OT) Practitioner Roles During a Crisis like COVID-19*

Role of OT practitioners during a crisis like COVID-19	Entry-level OT program <i>n</i> (% of category)				Chi-square statistic
	OTA	BSMS	MSOT	OTD	
Mental health and stress management interventions	55 (87.3)	43 (87.8)	436 (94.8)	265 (94.3)	$\chi^2(3, N = 853) = 8.352$ $p = .039^{*a}$
Evacuation planning for people with disabilities	24 (38.1)	26 (53.1)	257 (55.9)	182 (64.8)	$\chi^2(3, N = 853) = 16.650$ $p = .001^*$
Clinical practice with people impacted by the crisis	34 (54.0)	38 (77.6)	380 (82.6)	226 (80.4)	$\chi^2(3, N = 853) = 28.173$ $p < .001^*$
Training and supporting first responders	19 (30.2)	18 (36.7)	171 (37.2)	98 (34.9)	$\chi^2(3, N = 853) = 1.370$ $p = .713$
Interprofessional teamwork	39 (61.9)	37 (75.5)	390 (84.8)	241 (85.8)	$\chi^2(3, N = 853) = 24.237$ $p < .001^*$
Addressing occupational deprivation	46 (73.0)	42 (85.7)	400 (87.0)	259 (92.2)	$\chi^2(3, N = 853) = 18.043$ $p < .001^*$

*Note.* OTA = Occupational Therapy Assistant; BSMS = Bachelor’s to Master’s; MSOT = Master’s of Occupational Therapy; OTD =

Doctorate of Occupational Therapy; asterisks (\*) = significant result

<sup>a</sup> Chi-square analysis had 1 or more cells with an expected count of less than 5 respondents

**Table 2**

*Type of Respondent Entry-Level Program and Beliefs about Occupational Therapy (OT) Practitioner Roles After a Crisis like COVID-19*

Role of OT practitioners after a crisis like COVID-19	Entry-level OT program <i>n</i> (% of category)				Chi-square statistic
	OTA	BSMS	MSOT	OTD	
Mental Health and stress management interventions	55 (87.3)	44 (89.8)	422 (91.7)	261 (93.2)	$\chi^2(3, N = 852) = 2.696$ $p = .496^a$
Promoting return to meaningful and purposeful routines	58 (92.1)	47 (95.9)	450 (97.8)	272 (97.1)	$\chi^2(3, N = 852) = 4.794$ $p = .082^a$
Supporting healthcare professionals and first responders	36 (57.1)	32 (65.3)	313 (68.0)	199 (71.1)	$\chi^2(3, N = 852) = 4.488$ $p = .213$
Advocating for healthcare policy change	42 (66.7)	40 (81.6)	372 (80.9)	230 (82.1)	$\chi^2(3, N = 852) = 8.147$ $p = .043^*$
Treating people that acquired conditions, injuries, or disabilities related to the crisis	54 (85.7)	46 (93.9)	435 (94.6)	264 (94.3)	$\chi^2(3, N = 852) = 7.635$ $p = .054^a$

*Note.* OTA = Occupational Therapy Assistant; BSMS = Bachelor’s to Master’s; MSOT = Master’s of Occupational Therapy; OTD = Doctorate of Occupational Therapy; asterisks (\*) = significant result

<sup>a</sup> Chi-square analysis had 1 or more cells with an expected count of less than 5 respondents.

**Table 3**

*Descriptive Statistics for Respondent Entry-Level Program and Occupational Therapy (OT) Practitioner Roles During and After a Crisis like COVID-19*

Entry-Level OT program	n	Mean	SD	95% confidence interval for mean	
				Lower bound	Upper bound
Number of OT practitioner roles during a crisis <sup>a</sup>					
OTA	63	3.51	1.70	3.079	3.937
BSMS	49	4.24	1.71	3.753	4.737
MSOT	460	4.50	1.43	4.367	4.629
OTD	281	4.59	1.31	4.437	4.744
Number of OT practitioner roles after a crisis <sup>b</sup>					
OTA	63	3.92	1.38	3.572	4.269
BSMS	49	4.27	1.19	3.925	4.606
MSOT	460	4.36	1.11	4.259	4.462
OTD	280	4.42	0.99	4.301	4.535

*Note.* SD = Standard Deviation; OTA = Occupational Therapy Assistant; BSMS = Bachelor’s to Master’s; MSOT = Master’s of Occupational Therapy; OTD = Doctorate of Occupational Therapy.

<sup>a</sup> There was a total of 7 possible roles respondents could have selected for this question

<sup>b</sup> There was a total of 6 possible roles respondents could have selected for this question



**Table 4**

*Descriptive Statistics for Collaborators in Entry-Level Occupational Therapy Student’s Volunteer Activities During COVID-19*

Collaborator categories	n (%) <sup>a</sup>
Community organizations	31 (51.7%)
Students from health profession programs <sup>b</sup>	26 (43.3%)
Friends and family	15 (25%)
Healthcare practitioners	15 (25%)
Faculty members	9 (15%)
Churches <sup>c</sup>	1 (1.7%)
EMT squads <sup>c</sup>	1 (1.7%)
Grocery stores <sup>c</sup>	1 (1.7%)
Home health operations <sup>c</sup>	1 (1.7%)
Military organizations <sup>c</sup>	1 (1.7%)

*Note.* EMT = Emergency Medical Technician. This data is from a subset of survey respondents ( $n = 60$ ) who were volunteering in response to the first wave of COVID-19 during April and May of 2020.

<sup>a</sup> Some survey respondents described multiple collaborators.

<sup>b</sup> Health profession programs included occupational therapy/occupational therapy assistant ( $n=17, 28.3%$ ), medical ( $n=4, 6.67%$ ), nursing ( $n=2, 3.33%$ ), physician assistant ( $n=2, 3.33%$ ), and physical therapy ( $n=1, 1.7%$ ).

<sup>c</sup> Submitted by respondents via the open-response option for the survey question

**Table 5**

*Entry-Level Occupational Therapy Student Volunteer Activities During COVID-19*

Volunteer activity category	Definition	Perspectives	<i>n</i> (%) <sup>a</sup>
Volunteer activities addressing health impacts of COVID-19			
Clinical work	Hands-on activities in healthcare settings through school, employment, or volunteering	<i>“I am volunteering for the local county health district in completing daily monitoring calls for COVID-19 positive patients.”</i>	12 (20.0)
Personal actions to reduce transmission of COVID-19	Preventing transmission of disease in households and communities via activities such as promoting social distancing	<i>“Keeping surfaces sanitized in high foot traffic areas”</i>	9 (15.0)
Personal protective equipment (PPE) fabrication	Fabricating PPE such as facemasks and hazmat suits due to national shortages and national mask mandate	<i>“Making facemasks with my church for the local hospital systems”</i>	8 (13.3)
Volunteer activities addressing social and economic impacts of COVID-19			
Addressing food insecurity	Providing groceries or meals to those unable to afford food or those unable to grocery shop (e.g., due to being immunocompromised)	<i>“I am volunteering with my church to deliver food pantry items to people who are unable to go to the grocery store or who are having financial difficulties.”</i>	17 (28.3)
Combating loneliness	Facilitating connection and social participation despite isolation and quarantine	<i>“We are doing virtual visits for people with Intellectual and Developmental disabilities who are (no) longer receiving day services or living in their group homes in order to increase social participation.”</i>	16 (26.7)

Volunteer activity category	Definition	Perspectives	<i>n</i> (%) <sup>a</sup>
Volunteer activities addressing social and economic impacts of COVID-19			
Social justice	Fostering the equitable distribution of essential resources and access to basic human rights	<i>“Calling older adults with chronic conditions living alone, communicating needs to local community resources”</i>	9 (15.0)
Supporting healthcare workers and first responders	Showing gratitude for or easing the workload of healthcare workers and first responders	<i>“Helping with childcare for children whose parents are healthcare workers.”</i>	5 (8.3)

*Note.* This data is from a subset of survey respondents (*n* = 60) who were volunteering in response to the first wave of COVID-19 during April and May of 2020.

<sup>a</sup> Some survey respondents described multiple volunteer activities.

**Table 6**

*Entry-Level Occupational Therapy Student Inspirations for Volunteering During COVID-19*

Inspiration category	Definition	Perspectives	<i>n</i> (%) <sup>a</sup>
Altruism	As per AOTA's Code of Ethics (2020), "altruism involves demonstrating concern for the welfare of others."	<i>"I think I am fortunate to be in a situation that is very stable during this time, so I want to help those who are experiencing difficulty because I can. I hope to be a positive beacon during this challenging time."</i>	36 (60.0)
Call to action	Inspired by or directly asked to volunteer through an affiliated network, including school, neighbors, previous volunteer organizations or religious communities.	<i>"I was asked to volunteer by the parish nurse."</i>  <i>"I saw posts on social media."</i>	16 (26.7)
Justice	As per AOTA's Code of Ethics (2020), justice describes the promotion of a society in which diverse communities are structured such that all members experience equity and inclusion, so that they can function, flourish, and live a satisfactory life.	<i>"I ... feel passionate about older adults aging in place and want to ensure their safety during this time of crisis."</i>	14 (23.3)
Disrupted routines	Major changes to daily routines made time available for volunteering. These changes may have caused boredom and inspired individuals to fill gaps in their schedule.	<i>"Lack of fieldwork opportunities at the time"</i>  <i>"Losing my job afforded me more time to explore other opportunities"</i>	12 (20.0)
Personal responsibility	Volunteering due to personal skills, roles, privileges, or capacities. Personal responsibility can also refer to taking care of matters within one's personal life or locus of control.	<i>"Those who are at a lower risk have a responsibility to assist others. It helps to provide a role for myself and reduces the anxiety of the individuals assisted."</i>	11 (18.3)

Inspiration Category	Definition	Perspectives	<i>n</i> (%) <sup>a</sup>
Contracted time	Fulfilling a commitment to an existing employment, student, or volunteer role.	<i>“My per-diem job (hospital) needed volunteers”</i>	3 (5.0)

*Note.* This data is from a subset of survey respondents (*n* = 60) who were volunteering in response to the first wave of COVID-19 during April and May of 2020.

<sup>a</sup> Some survey respondents described multiple inspirations for volunteering.



## Appendix A

### OTS/OTAS COVID-19 Survey Questions

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**Q1.** What type of entry-level Occupational Therapy program are you currently enrolled in?

- Occupational Therapy Assistant
- Bachelor's to Master's
- Master's Degree
- Entry Level Doctorate
- I am not currently enrolled in an entry-level Occupational Therapy program

Skip to: End of survey if response to Q1 = "I am not currently enrolled in an entry-level Occupational Therapy program" <sup>a</sup>

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**Q2.** What state is your OT program in?

- (Open response)

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**Q3.** Are you currently volunteering in response to COVID-19?

- Yes
- No

Skip to: Q9 if response to Q3 = "No" <sup>a</sup>

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**Q4.** Which state are you currently volunteering in response to COVID-19?

- (Open response)

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**Q5.** What are you doing to respond to the COVID-19 crisis at the individual, group, or population level?

- (Open response)

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**Q6.** What inspired you to get involved in a COVID-19 response activity?

- (Open response)

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**Q7.** Who are you currently working with to respond to COVID-19? (Select all that apply)

- I am not working with anyone
- Other OT/OTA students from my school
- OT/OTA students from schools different from my own
- Faculty members
- Health practitioners
- Medical students
- Nursing students
- Physician Assistant students
- Physical Therapy/Physical Therapy Assistant students
- Social work studies
- Speech Language Pathology students
- Dental students

- 
- Friends and family
  - Community organizations
  - Other (Open response)

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**Q8.** If you indicated that you are working in an interprofessional group, what is your role in the group?

- (Open response)

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**Q9.** What role(s) do you believe OT has during a crisis like COVID-19? (Select all that apply)

- Mental health and stress management interventions
- Evacuation planning for people with disabilities
- Clinical practice with people impacted by the crisis
- Training and supporting first responders
- Interprofessional teamwork
- Addressing occupational deprivation
- Other (Open response)

---

**Q10.** What role(s) do you believe OT has after a crisis like COVID-19?

- Mental health and stress management interventions
- Promoting return to meaningful and purposeful routines
- Supporting healthcare professionals and first responders
- Advocating for healthcare policy change
- Treating people that acquired conditions, injuries, or disabilities related to the crisis
- Other (Open response)

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<sup>a</sup> This text indicates the survey logic and was not part of the survey text that was displayed to respondents.