OCCUPATIONAL THERAPY NOW

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Table of Contents

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Transition and gratitude: A new *OT Now* Managing Editor

Brenda McGibbon Lammi

It is with mixed emotions that I am leaving my role as Managing Editor of *Occupational Therapy Now (OT Now)* to take on a new role at CAOT as the Director of Policy and Professional Affairs. Four years ago, almost to the day, I started my training as the new editor. What was missing in the training was the indescribable benefit of how lucky I was to be in the role, how much my professional development was going to gain from the role, and my inevitable personal development and pride in the role.

As Managing Editor, not only have I been able to keep current in a diverse range of what occupational therapists and occupational therapy students are doing around the world, but have also gained an extensive appreciation for the dedication many of you have for our profession. The dedication is demonstrated in the different levels of contributions made to the publication – there are the members of the Editorial Board, the column editors, the contributors and the readers.

Starting with the Editorial Board, these CAOT members are all volunteers who donate their time (the most valuable commodity most of us can offer) to oversee the direction of the publication, provide support to my proposals and steer me in the right direction for their vision of *OT Now*. In my training, they were described to me by Marcia Finlayson, the then editor of the *Canadian Journal of Occupational Therapy*, as my own personal cheering squad. They did not let me down! Thanks to Emily Etchverry, Tom Grant, Susan Mulholland, Nadia Noble, Aliki Thomas and Sandra Hobson.

Next among those who have contributed are the column editors, the CAOT members with expertise and passion in a specific area of practice. Their responsibility is not small; they recruit and/or review submissions to their columns, attend three meetings a year, work with authors to edit papers, and keep everything on time. A lot to ask of these volunteers who live very full lives outside of their column editor roles. Thanks to Alison Gerlach, Sandra Bressler, Roselle Adler, Josée Séquin, Sue Baptiste, Mary Kita, Jonathan Rivero, Christel Seeberger, Helene Polatajko, Jane Davis, Lili Liu, Masako Miyazaki, Heidi Cramm, Heather Colquhoun, Sandra Hobson, Patricia Dickson, Laura Bradley, Regina Casey, Alison Sisson and Tom Grant.

There are the contributors. The CAOT members, students and working professionals, who submit their work, undergo reviewing and editing, and make additional pressures on their full schedules to share their passion and experience in what it is they are doing so that we can all learn. Thanks to the *OT Now* authors, past, present and future, for making the publication what it is.

And there are the readers, primarily CAOT members, who consistently rank *OT Now* as one of their top three favoured CAOT membership benefits. Evidence-based practice is described by Law and MacDermid (2008) to be composed of three key elements: the research evidence, the clinical experience and the client. *OT Now* contributes to evidence-based practice by sharing clinical experiences amongst the thousands of CAOT members and readers. By reading *OT Now*, you are contributing to your own evidence-based practice and you are supporting the profession by staying current in various practice areas and on the more conceptual aspects of the profession. If the profession of occupational therapy is 'our child', we, the readers of *OT Now*, are part of the village that is raising it, and doing a fantastic job in the process!

My gratitude would not be complete without mentioning those at CAOT who make it possible. Claudia von Zweck and Janet Craik, for providing their expertise and input; Jay Peak, for the design, layout and flexibility when I change my mind; Luce Ouellet, for the excellent and timely translations (I still don't know how you do it!); and Danielle Stevens, for all the finishing touches.

I am slightly envious of Janna MacLachlan, the new Managing Editor of *OT Now*. The rewards of this role, as I said in the beginning, are indescribable. My hope for Janna is that she will gain as much as I have, both professionally and personally. Having spent many hours with Janna as we transitioned roles, I have no concerns that *OT Now* is in good and capable hands.

I am joining the ranks of the *OT Now* reader, and am looking forward to what it will bring.

Reference

Law, M. & MacDermid, J. (2008). *Evidence-Based Rehabilitation: A Guide to Practice*. Thorofare, NJ: Slack Incorporated.

Dear *OT Now* readers,

I am very excited to take on my new role as Managing Editor of *Occupational Therapy Now!* Thank you to Brenda for her hard work and dedication over the last four years! It is clear that she put a lot of tender loving care into making *OT Now* the excellent publication it is today.

To briefly introduce myself, I grew up in Nova Scotia and completed a bachelor of science in biology at Acadia University in 2003. I completed a master of science in occupational therapy in 2006 at The University of Western Ontario. I then went on to spend four incredible years working as a generalist clinician in Iqaluit, Nunavut. I now reside in Ottawa, Ontario where I work part-time in acute care.

I am very much looking forward to hearing from you – whether it be to discuss an idea for an article, or to share your thoughts on what you're reading here. I can be reached at: otnow@caot.ca.

Sincerely,
Janna MacLachlan, Managing Editor, *Occupational Therapy Now*

What's new

Australian Journal of Occupational Therapy

The Canadian Association of Occupational Therapists (CAOT), Occupational Therapy Australia and Blackwell Publishing have signed a reciprocal agreement allowing respective members to receive free full online access to the *Australian Occupational Therapy Journal (AOTJ)* and the *Canadian Journal of Occupational Therapy (CJOT)*. CAOT is pleased to expand the repertoire of occupational therapy journals to its membership and hopes this will help them in their pursuit of evidence informed practice.

The *Australian Occupational Therapy Journal* is the official journal of Occupational Therapy Australia, and welcomes manuscripts relevant to the theory, research, practice and education of occupational therapy. The *Journal* aims to promote research and interdisciplinary communication, and provide a forum for discussion of issues relevant to occupational therapists. The *Journal* is dedicated to promoting occupational therapy internationally. To access the *Australian Journal,* please visit the Members Only section of the CAOT website (www.caot.ca).

Everyday Stories . . . profiles of your CAOT colleagues

Danielle Nason

Education

- BScKin from University of New Brunswick
- MScOT from University of Western Ontario

Career path as an occupational therapist

After graduating from university, my husband and I returned to Inuvik where I had previously worked as a rehabilitation assistant. Familiarity with the department, community and cultural customs eased my transition to working as the only occupational therapist in my department. With referrals from pediatrics to geriatrics and inpatients to home care, I have really used just about all the information I learned in school and then some.

Current role

I currently work for the Beaufort Delta Health and Social Services Authority in Inuvik, NT, as the Supervisor of Rehabilitation Services. As the supervisor of a multidisciplinary department with occupational therapy, physiotherapy, and speech-language pathology that services 13 communities based out of the Inuvik Regional Hospital, my role includes administration and management in addition to clinical work.

Family life

My life is busy with a young family, and maintaining a good life balance can be challenging, but family adventures bundled up outdoors or cozy play in a fort indoors keep me on my toes. Fortunately, we have a great support network here with extended family and friends, so visiting and hosting is part of our routine.

Hobbies/interests

Arctic living implies outdoor activities including cross-country skiing, snowshoeing, skidooing, as well as weekend adventures to our cabin. Nothing compares to the peacefulness of a moonlit ski under the northern lights. During the summer months (yes we do have summer here!), boating, fishing, berry-picking, and hiking keep us outside, though sometimes hidden beneath a bug jacket. Keeping warm and motivated during the long cold dark winters and rested during the 24-hour summer sunshine is all part of the fun. I also enjoy scrapbooking and quilting, as well as learning to bead and to sew mukluks and moccasins.

Greatest tool in my occupational therapy bag of tricks

Resourcefulness! It is an essential tool for serving clients in 13 different communities (most of which are fly-in only). My work involves everything from assessment and treatment to obtaining assistive devices and equipment, not to mention showing clients how to install and use them, and I often have to do this from afar. In the rural setting it is important to understand and utilize all the resources available to you, whether it's the team members within the department or hospital, the staff at the community health centres, or specialists from 'the South'.

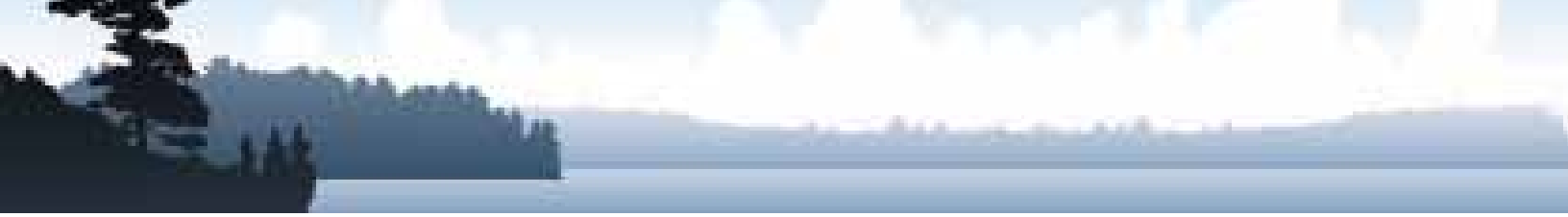
Most important thing I've learned as an occupational therapist

How to hear the clients' stories in order to understand their struggles and challenges, and to use their own words to help them identify their goals have been the most important skills I've learned as an occupational therapist. I attended a workshop once on motivational interviewing which I found very helpful. The Aboriginal population tend to teach and share their knowledge through stories, so I find in my practice that asking the client to "tell me the story of a typical day" is effective.

Greatest influences on my occupational therapy practice

The remoteness of this job has really shaped my practice. It's funny how I can feel self-sufficient yet so connected to a team at the same time. Working as a generalist in the only Canadian hospital north of the Arctic Circle has its unique challenges and benefits. Because of the location, this job includes unusual challenges such as advocating for all-terrain tires for wheelchairs because the roads are unpaved and there are no sidewalks in a client's community, or advocating for home accessibility for above ground houses built on pilings (stilts) due to the permafrost. All of these challenges make my practice here very interesting.

The author (right); Andrea Godfreyson, prenatal nutritionist (centre); and Shona Barbour, early education coordinator (left), traveling to Tuktoyaktuk, Paulatuk, Ulukhaktok and Sachs Harbour.



Canadian Association of Occupational Therapists 2011-2012 Midyear Report

Claudia von Zweck , PhD, OT(C), CAOT Executive Director

As a small organization, CAOT has a broad mandate. We juggle many priorities in order to engage in a large array of diverse activities to effectively address our mission to promote excellence in occupational therapy. It is through the combined efforts of many tireless CAOT volunteers working with our valued staff that we are able to provide a strong voice for over 13,000 occupational therapists in Canada. The summary below outlines the strategic, innovative and proactive initiatives of CAOT in the first half of the 2011-2012 membership year.

Advocacy

A 2011 submission was made to the House of Commons Standing Committee on Finance as part of the pre-budget consultation. CAOT successfully attained government support for our 2010 recommendation to the Standing Committee for the extension of the child tax fitness credit to the adult population. Our 2011 submission advocated for the federal government to promote a continuum of health services that includes injury/disease prevention and health promotion. The creation of a national activity guide was proposed as a key health promotion and injury/disease prevention tool that can promote engagement in meaningful occupations. To support this initiative, CAOT provided funding to occupational therapy researchers Sandra Moll, Rebecca Gewurtz, Terry Krupa and Mary Law for the development of a prototype for the guide. It is planned that the development of this prototype will be followed by a consensus building process both within and outside the profession to position and promote the guide to a national audience. A session will be held by the researchers at the 2012 CAOT conference to obtain member input regarding the activity guide.

A lobby day on Parliament Hill was held in November 2011. Members of the CAOT Board of Directors and staff met with representatives of the House of Commons finance and health committees to gain support for the CAOT pre-budget consultation recommendations. The meetings led to a number of parliamentarians requesting further information on occupational therapy.

CAOT has been successful in increasing the use of occupational therapists by rehabilitation services of the Canadian Forces. CAOT is working with the Department of National Defence for the hiring of occupational therapists in rehabilitation services across Canada. CAOT has also met with military officials regarding the use of occupational therapists in the delivery of primary care and mental health services. CAOT provided a well-received presentation at the Military and Veterans Health Research Forum regarding driving when transitioning from active deployment based on research conducted by Danielle Booth during her student fieldwork placement at National Office.

A presentation was made to the House of Commons Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities regarding needs of internationally educated occupational therapists (IEOTs) for practice in Canada. CAOT advocated for long term funding to support the participation of IEOTs in bridging programs to facilitate workforce integration.

A presentation was made to the House of Commons Standing Committee on Health in regard to the topic of obesity as part of a health promotion and disease prevention study. Mary Forhan represented CAOT for this presentation that promoted the need for a national active living guide to advance healthy engagement in occupations.

CAOT participated in a round table on elder abuse sponsored by the federal Minister of State (Seniors) Alice Wong. CAOT was asked to present at this round table as a result of our innovative work related to elder abuse prevention and intervention strategies for occupational therapists and other health professionals developed with project funding provided by Human Resources and Skills Development Canada. The Minister of State for Seniors formally introduced the CAOT elder abuse guidelines at a CAOT reception held in Ottawa in November, 2011. The event generated tremendous success and media attention across Canada. Workshops were also held across Canada in late 2011 and early 2012 to inform health professionals regarding the guidelines.

CAOT is working on a variety of initiatives alone and in coalition with other organizations to influence discussions regarding the 2014 health accord among the federal and provincial/territorial governments. CAOT is advocating for strong federal leadership for a continuum of services provided by inter-professional health teams.

CAOT also partners with other organizations in over 20 additional national coalitions to meet mutual advocacy goals. Most recently CAOT became a member of the Canadian Pain Coalition and the Canadian Pain Society to promote the role of occupational therapists in pain management. This involvement follows recommendations of the 2011 professional issue forum

on pain management and occupational therapy. Other follow up initiatives to this forum include a planned special issue of *Occupational Therapy Now* on the topic of pain management in the fall of 2012.

Visibility

CAOT focused recent public promotion activities on our "Ask for it" campaign that was initiated to promote coverage of occupational therapy services by extended health insurance plans. CAOT targeted meetings with representatives of a number of insurance companies across Canada to increase awareness of the benefits of occupational therapy. The findings of our consultations indicate occupational therapy services are valued by insurers as their costs may be reduced through the intervention of occupational therapists. Most insurers use occupational therapists and many cover occupational therapy services in extended health plans. Demand for occupational therapy services however remains low among employer groups and unions that serve as decision-makers regarding the services offered in an extended health plan. CAOT met with the federal Privy Council and Treasury Board, as well as public service unions to promote the use of occupational therapists within the large Canadian public service. CAOT continues to build on the information garnered and the relationships developed to implement a new strategic plan that will target key audiences that can influence what coverage is made available.

As part of the CAOT "Ask for it" campaign, resources were developed for occupational therapists, occupational therapy students and clients to advocate for coverage of occupational therapy services in their extended health care plans. Resources included a calendar provided to all members during Occupational Therapy Month that highlighted the work of occupational therapists in relation to national awareness months for different health conditions. Sample letters to employers and insurers to advocate for extended health insurance coverage are available on the CAOT website. CAOT produced a number of videos, also available on the website, that assist others to understand the work of occupational therapists.

CAOT 85th anniversary events culminated with the hosting of a reception at the World Federation of Occupational Therapists (WFOT) Council meeting in March. The reception in Taipei celebrated the anniversary of CAOT, as well as the 60th year of WFOT.

Other activities of CAOT to promote visibility of the profession include coordination of national projects that highlight the unique role of occupational therapy in significant issues of public concern. In addition to our elder abuse guidelines initiative, such activities include our continuing work towards the goals of the older driver blueprint to promote safe community mobility options for our aging population. We have received strong support for our activities to create awareness of safe driving strategies for older adults in our meetings with parliamentarians and government representatives. Our older driver resource material will soon be distributed by the Public Health Agency of Canada and we are seeking funding for translation of this information into additional languages.

CAOT also partnered with the Rick Hansen Foundation for beta testing of a new Global Accessibility Initiative, an easy-to-use online ratings tool to submit reviews from a mobility, sight or hearing perspective on the accessibility of buildings and public spaces in communities around the world. This initiative aims to provide meaningful information on accessibility for all people to make informed decisions on everyday activities such as where they eat, shop, work and play. With the launch of the tool to the public in the fall of 2011, all CAOT members are now encouraged to contribute towards creating a more accessible and inclusive world by visiting globalaccessibilitymap.com to begin submitting accessibility reviews.

Standards

Preparations are underway by the CAOT Academic Credentialing Council for implementation of a continuous quality improvement approach to academic accreditation. Beginning in 2012, university occupational therapy education programs entering the accreditation process will utilize this revised accreditation process. Pilot-testing of the academic accreditation standards for Occupational Therapist Assistant/Physiotherapist Assistant education programs also commenced in 2012. A six-year schedule has been established to begin the accreditation process for over 18 schools that are expected to meet the eligibility criteria for participation in this program.

Following discussions regarding advanced practice at professional issue forums held in 2009 and 2010, the CAOT Board of Directors approved a discussion paper on advanced competencies that was published in the March 2012 *Occupational Therapy Now*. A revised version of the *Profile of Occupational Therapy Practice in Canada* will be published that includes information from this discussion paper.

An amended agreement with our funder, the Foreign Credential Recognition Program, enables the National Occupational Therapy Examination and Practice Preparation (OTepp) Project to extend to March 2013. The goal of this project is to develop a national curriculum to assist internationally educated occupational therapists prepare for practice in Canada. Additional activities that will be undertaken by the project with this extension include an analysis of issues and barriers to supervised practice opportunities for IEOTs with Canadian employers.

A number of innovative new resources have been developed by the OTepp Project in conjunction with the CAOT Certification Examination Committee to assist with preparation for the national occupational therapy examination. These resources will be available in 2012 for both IEOTs and occupational therapists educated in Canada. The *Trial Occupational Therapy Examination and Manual (TOTEM)* serves as a study guide for the National Occupational Therapy Certification Examination. The *Manual* contains items that reflect the National Occupational Therapy Certification Examination. Answers to the items are provided with explanations to assist the user to understand the rationale for the correct response. This new resource is available in e-book format and includes one-time access to the Trial Occupational

Therapy Examination (TOTE). TOTE is an online exam constructed according to the blueprint categories used for the national occupational therapy certification examination, and uses the same item writing format and guidelines. Candidates receive an immediate confidential online report of their performance after completing the TOTE. Research is currently underway to determine the predictability of performance on TOTE for scores on the national occupational therapy certification examination.

Pilot-testing of the Occupational Therapy Examination Module is currently underway by the OTepp Project. This module provides a structured and facilitated online process to assist candidates to understand the critical reasoning for successfully completing a comprehensive series of sample items that are constructed according to the blueprint categories used for the national occupational therapy certification examination. It is expected that this module will be generally available to Canadian graduates in the fall of 2012. Other successful online course modules developed by the OTepp Project on issues such as mentoring and career planning will also be offered to Canadian educated occupational therapists.

In addition to the development of new exam preparation resources, the CAOT Certification Examination Committee continues with development and review of new items for the national occupational therapy certification examination. A new position of Item Translator Coordinator was created for the committee to assist with enhanced review of translations of examination items.

Practice

CAOT worked in conjunction with the Canadian Physiotherapy Association (CPA) and the Canadian Association of Speech Language Pathologists and Audiologists (CASLPA) to develop a new interdisciplinary caseload management tool. The caseload management tool and instructional webinars explaining use of the resource are available free to CAOT/CPA/CASLPA members on our website.

The second edition of *Enabling Occupation II* is progressing well for introduction in both English and French in 2012. Preconference workshops on *Enabling Occupation II* concepts and tools will be offered in both languages at Conference 2012 in Quebec City. A national consultation is also underway regarding future work of CAOT on such guideline documents. A report on the recommendations of this consultation involving a national survey and interviews will be provided to the CAOT Board of Directors in June 2012.

CAOT is introducing new e-book technology to ease accessibility to our publications, particularly in international markets. International interest in CAOT publications led to the recent translation of *Enabling Occupation II* into Japanese and the *McGill Ingestive Skills Assessment* into Italian. The work of CAOT projects and initiatives has been highlighted in presentations in the last year at the British College of Occupational Therapists, Occupational Therapy Australia, Asia-Pacific and Hong Kong International Conferences.

New CAOT affinity products have been well received by members, including the new Member Assistance Program and access to the HT Health Works database. A recently signed agreement with Occupational Therapy Australia provides members with free online access to the *Australian Journal of Occupational Therapy.* Other journals currently available online free to members include *British Journal of Occupational Therapy* and *New Zealand Journal of Occupational Therapy.*

CAOT welcomed new editors for both the *Canadian Journal of Occupational Therapy (CJOT)* and *Occupational Therapy Now.* CAOT is currently exploring outsourcing of production and distribution of the *CJOT* to promote dissemination of the journal to broader audiences.

CAOT has sponsored a new Leadership Fellowship. The goal of the fellowship is to offer a 12-month work experience to a recent occupational therapy graduate that provides learning opportunities to develop leadership capacity, promote the role of occupational therapists in policy and representation, and address current professional issues influencing occupational therapy through the development and/or application of research in practice. The successful candidate for the Leadership Fellowship will be announced in spring of 2012.

Lunch and Learn and *Water Cooler* webinars continue to be highly successful for presenting professional development opportunities for members and providing support for the work of partner organizations. For example, CAOT partnered with the Alzheimer Society in early 2012 to offer a series of webinars regarding the role of occupational therapy and persons with dementia.

With the closure of the British Columbia Society of Occupational Therapists, CAOT created the British Columbia chapter CAOT-BC. A transition planning team has led to the development of a strategic plan for CAOT-BC, hiring of a managing director and formation of a CAOT-BC Advisory Committee. Priorities identified in the CAOT-BC strategic plan are specific to the needs of British Columbia occupational therapists for a strong voice on provincial professional affairs. In addition to promoting and representing occupational therapy within the province, priorities include building infrastructure and engaging BC therapists in new initiatives to advance practice and influence health policy. For more information, please see the article on CAOT-BC on pages 22-24.

For more information on the above activities or regarding other initiatives of CAOT, please contact Claudia von Zweck at: cvonzweck@caot.ca.

Falls prevention: Investigating best practice for community occupational therapists

Anna Tzingounakis

COLUMN EDITOR: SANDRA HOBSON

Falls among the community-dwelling elderly are a serious health concern in Canada (Public Health Agency of Canada [PHAC], 2005). Recognizing the seriousness of this issue, health care authorities in a variety of settings across Canada are developing and implementing falls prevention initiatives. Occupational therapists play an important role on these teams, addressing falls risk through prevention, assessment, and treatment (Peterson & Clemson, 2008). Therefore, it is valuable for us to study best practices, the specific nature of occupational therapy's role on falls teams, and standardized tools that may assist therapists in providing effective care to clients. While on placement in a rural community home care setting in Prince Edward Island, I investigated the available literature addressing best practices for occupational therapists on falls prevention teams, as well as standardized tools to aid in this practice, as part of the development of an interdisciplinary, multifactorial falls prevention program. The results indicated occupational therapists are well positioned to meaningfully contribute to falls prevention initiatives. My suggestions to aid in this practice, based on the literature obtained, are summarized below.

Holistic practice

Environmental assessment and modification are typically emphasized in occupational therapy falls prevention interventions. However, fallers and non-fallers often have similar environmental hazards in the home, indicating the influence of multiple risk factors (Schryburt-Brown, Dixon, Paton, Connolly, & Craik, 2004). The literature emphasizes the importance of taking a comprehensive and holistic approach to falls prevention (Iwarsson, Horstmann, Carlsson, Oswald, & Wahl, 2009). Therapists are encouraged to implement models of practice that evaluate individuals' unique and interacting person, environmental and occupational factors relevant to their falls risks and base interventions accordingly (Federal/Provincial/Territorial Committee, 2001).

Person Factors*

- Ask about recent falls as part of routine care with the 65+ population. Ensure understanding of the client's past falls experiences and any causal beliefs.
- Engage and involve client and caregivers actively during assessment and intervention to ensure client-centeredness, shared responsibility and to maximize behavioural change. Encourage awareness-raising and active problem solving in client. Ensure client understanding of importance and relevance of any recommendations.
- Understand what clients' homes, roles, activities, and sense of control mean to them.
- Limit use of 'scare tactics' to encourage compliance. Address falls prevention in positive and empowering manner.
- Consider each client's physical strength, dynamic balance, steadiness of gait, vision, incontinence, impulsiveness, fear of falling, habits, attention, concentration, memory, comprehension, judgement, reasoning, and medication use.

Environmental Factors*

- Identify the range of environments in which the client performs occupations and the client's ability to meet the functional demands in the environments evaluated.
- Collaboratively assess clients' surroundings both inside and outside the home, emphasizing client or family involvement.
- Minimize hazards and clutter in home and other environments used.
- Note the absence of relevant assistive devices or equipment and prescribe as appropriate.
- Consider cultural and social environments in addition to physical environments. Sensitivity to cultural routines, roles, and the importance placed on items or practices can influence client engagement in interventions and compliance with recommendations.

Occupation Factors*

- Assess performance and functional status of key occupations within the context of home or other relevant environments.
- Consider physical, cognitive and affective resources

during functional task performance. Evaluate the client's ability to utilize these resources to meet occupational demands.
- Ensure understanding of daily activities, routines, schedules and other activities important to the client.
- Focus on the tasks requiring dynamic balance and mobility.

**** Key references:*** Australian Commission on Safety and Quality in Health Care (2009); Federal/Provincial/Territorial Committee (2001); Iwarsson et al. (2009); Peterson & Clemson (2008); and PHAC (2005).

Assessment tools

Community therapists are under significant time constraints due to large client caseloads and the limited number of home visits allotted, making thorough assessment of all relevant factors challenging (Monroe & Rushton, 2008). Although occupational therapy-specific, multifactorial, standardized tools compliant with current best practices for falls prevention are limited, assessment tools appropriate for falls prevention programs that may assist community therapists are available. Measures found that best satisfy the above criteria are summarized below:

TOOL NAME AND AUTHOR(S)	FEATURES	CLINICAL UTILITY
Safety Assessment of Function and the Environment for Rehabilitation - Health Outcome Measurement and Evaluation (SAFER HOME) Chiu, Oliver, Marshall, & Letts (2001)	• 93 items, 10 domains: meal preparation, awareness of safety hazards, mobility and toileting, cognitive impairment, homemaking support, emergency communication, functional communication, personal care, family assistance, medication. • Interview and observation. • 45-90 minutes to complete. • Can be purchased from http://www.vha.ca/pubandmedia/126.html	• Designed to assess the safety of the home and to evaluate the effectiveness of home safety following intervention. • Comprehensive coverage of home safety. • Emphasizes interaction between skills/abilities of person and home environment. • Can be used with individuals with cognitive limitations. • Rigorous testing and development – good content and inter-rater reliability, valid (Chiu & Oliver, 2006).
Home Falls and Accidents Screening Tool (HOME FAST) Mackenzie, Byles, & Higginbotham (2000)	• 25 items looking at environmental hazards throughout the home (indoor and outdoor), including floors, furniture, lighting, bathroom, storage, stairways and mobility. • Assesses functional safety concerns related to environment. • Interview and observation. • 20-30 minutes to complete. • Can be downloaded from http://www.health.vic.gov.au/agedcare/maintaining/falls_dev/Section_b1c1.htm	• Emphasis on functional tasks and movement within home environment and interaction between functional capacity and potential environmental hazards. • Items assessed deemed "highly relevant" to home safety issues (expert review panel). • Quick to administer. • Some predictive validity and is responsive to change. Tool has utility both as falls screen and post-test (Mackenzie, Byles & Higginbotham, 2002). • Community specific. • No cost.

About the author

Anna Tzingounakis, MScOT (Reg BC), is an occupational therapist in acute care at Royal Inland Hospital in Kamloops, B.C. Questions or comments are welcomed and can be forwarded to: anna.tzingounakis@interiorhealth.ca.

TOOL NAME AND AUTHOR(S)	FEATURES	CLINICAL UTILITY
Westmead Home Safety Assessment (WeHSA) Clemson (1997)	• 72 items broken into "hazard categories": internal/ external trafficways, general/ indoors, living area, seating, bedroom, bathroom, kitchen, laundry, footwear, medication management. • Looks at environmental hazards and personal capacities (vision, mobility), fall history, beliefs about causes of falls, patterns of home use and community access. • One home visit or more to complete. • Available for purchase from various vendors.	• Designed to determine how falls history, risky situations, habits, behaviours and personal characteristics affect an individual's safety level within context of their environment. • Considered "gold standard" for falls-related tools in Australian literature (Mackenzie, Byles, & Higginbotham, 2002). • Comprehensive and thorough. • Exclusively focused on falls. • Community specific. • High content validity, inter-rater reliability (Clemson, Fitzgerald & Heard, 1999).
Falls Behavioral Scale (FaB) Clemson, Cumming, & Heard (2003)	• 30 items, looking at 10 behavioural dimensions during occupations: cognitive adaptation, protective mobility, avoidance, awareness, pacing, practical strategies, displacing, being observant, changes in level, getting to phone. • 20-30 minutes to complete. • Can be downloaded from http://sydney.edu.au/health_sciences/staff/docs/lindy_clemson/FaB_manual_2003.pdf	• Designed to evaluate behavioural factors that can potentially protect against (or increase risk for) falling, within context of environment and occupations. • Effective as part of client education: Can help increase client sensitivity to immediate environment, raise awareness of functional abilities and their interaction with the environment. Aids client recognition of everyday habits, adaptive or maladaptive behaviours and how they can contribute to falls risk. • Comprehensive assessment of person factors; includes cognitive elements. • Good goal setting tool, and can measure change (Clemson, Bundy, Cumming, Kay & Luckett, 2008). • No cost.

Additional factors for consideration

In order to maximize the effectiveness of falls prevention interventions, therapists and researchers in falls prevention highlight the importance of considering a client's "readiness for change" when making recommendations. According to the Transtheoretical Model of Change (Prochaska & Velicer, 1997), individuals are presumed to pass through different stages of acceptance when considering change. Tailoring interventions to the client's current stage of change greatly increases the effectiveness of interventions and helps produce a lasting change in behaviour (McNulty, Johnson, Poole, & Winkle, 2003; PHAC, 2005). Occupational therapy intervention goals and strategies to encourage change vary according to the individual's present stage of readiness:
Precontemplation: Increase awareness of client's need to change.
Contemplation: Motivate and increase client's confidence in ability to change.
Preparation: Develop a collaborative plan for change.
Action: Reaffirm commitment to change and follow up.
Maintenance: Problem solve and collaboratively develop plan to ensure continued success.

Further, the effectiveness of falls prevention interventions increases significantly when therapists ensure timely follow up with their clients (Peterson & Clemson, 2008). Clients can be

assisted in making the necessary behavioural changes and home modifications by scheduling follow up telephone calls, extra home visits, or providing general support, as needed (Bleijlevens, Hendricks, Van Haastregt, Crebolder, & Van Eijk, 2010).

Conclusions

Falls in the elderly are a serious health concern, caused by multifaceted, complex and interacting risk factors. Effective falls interventions must consider all relevant influencing factors. Occupational therapists are skilful in holistic client assessment and intervention and can apply this knowledge to falls prevention initiatives, taking person, environment, and occupation factors, as well as a client's readiness for change, into account. The SAFER HOME, HOME FAST, WeHSA and FaB are four examples of occupational therapy-specific tools that may be effectively utilized by community occupational therapists working in falls prevention. Occupational therapy can make a meaningful and valuable contribution to falls prevention programs in the community, supporting the profession's continued involvement in this practice area.

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STUDENT PERSPECTIVES

COLUMN EDITOR: TOM GRANT

gOT Spirit Challenge: Building a bridge for occupational therapy students across Canada

Brianna Boyle, Anita Hamilton and Pamela Armstead

Over the past three years a buzz of excitement has rippled through occupational therapy programs throughout Canada in the fall semester. The excitement was due to the gOT Spirit Challenge, a nation-wide competition designed to showcase the celebrations of Occupational Therapy Month by occupational therapy students across Canada. The gOT Spirit Challenge was created by innovative University of Alberta (U of A) graduate, Pam Armstead in 2009, after she noticed that students in her program had few connections with occupational therapy students in other programs. Pam's vision was to connect occupational therapy students through a meaningful activity that would create a sense of shared identity, and to create a groundswell of excitement among students about the potential of occupational therapy.

Pam's vision was founded on her experience of attending Kin Games as an undergraduate. Kin Games is an annual sports competition between students in Kinesiology programs across Canada. Pam noted that she experienced a profound sense of belonging by participating in Kin Games. As fortune would have it, Pam was able to see a way to enact her vision while participating in a module called "Online technology for Occupational Therapy". The module, developed and taught by assistant professor Anita Hamilton, was designed to enable students to learn about using online technologies for networking and education. Students participating in the module were required to design their own project and this became the ideal platform for Pam to create a students' networking project titled the "gOT Spirit Challenge". As Pam had friends undertaking occupational therapy education in other provinces, she used her existing network to initiate connections with other programs.

The challenge was set: Which occupational therapy program in Canada has "gOT [the most] spirit"? The gOT Spirit Challenge is simple: All events and activities that are included in a school's submission must take place within the month of October of that year (Occupational Therapy Month), each school is responsible for posting their own submission on the gOT Spirit webpage by the deadline, and, most importantly, everyone has to have fun!

The first three years

In 2009, the first year, Pam invited the incumbent president of CAOT, Elizabeth Taylor, to judge the student-driven competition. The inaugural winner was University of Western Ontario, who submitted a multi-faceted and exciting entry that clearly demonstrated that they gOT Spirit! In 2010, the University of Alberta was judged winner by the new CAOT president, Sue Baptiste. Their submission revealed that they were a dynamic student population as they included a flash mob dance, fundraising efforts, volunteer experiences and their organization of, and attendance at conferences designed to further professional development. That year, CAOT initiated the awarding of a prize for the winning team. In 2011 the University of Toronto was recognized as having the most outstanding entry to the gOT Spirit Challenge, with another multi-faceted entry detailing nine wonderful Occupational Therapy Month events hosted by students.

In 2010, the gOT Spirit Challenge was coordinated by University of Alberta student Brianna Boyle. Brianna was excited to assume the role but recognized that she had big shoes to fill when she agreed to organize the second year of the Canada-wide challenge. As challenge organizer, Brianna contacted all the Canadian occupational therapy programs to invite them to be a part of the gOT Spirit Challenge and gave them the link to the website where the previous submissions and competition rules were housed (http://otschools.wetpaint.com/page/The+2009+Challenge).

Brianna doubled her contribution in 2010 by being both the coordinator of the overall competition and the leader of the University of Alberta submission. Brianna undertook to plan, choreograph, and coordinate a flash mob dance, which occurred at the university on October 6, 2010 (http://www.

University of Alberta students hosting an OT Month pancake breakfast for the wider university community.

youtube.com/watch?v=TaHGY0N5b1k). The submission was a program-wide effort with over 160 students taking part in several Occupational Therapy Month events. All schools' submissions for that year can be viewed through this website: http://otschools.wetpaint.com/page/2010+gOT+Spirit.

Why it works

The success of the gOT Spirit Challenge can be explained through the writings of two occupational therapy scholars, Charles Christiansen and Ann Wilcock. Christiansen (1999) states that participation in meaningful activities helps to shape our identity. The gOT Spirit Challenge provided a means by which occupational therapy students in Canada could connect with each other through their shared role and identity of being 'occupational therapy students'. Wilcock's writings (1998; 2006) help us to understand that through positive doing and being we can feel that we are part of something bigger than just the occupational therapy program we are attending. We are starting to belong to the wider profession of occupational therapy.

Through the gOT Spirit Challenge over the past three years, students have participated in a range of activities and events to celebrate Occupational Therapy Month to raise the profile of occupational therapy. Through these 'doings', students were able to explore and express what they knew about occupational therapy, what they were most passionate about, and what they, as fresh-faced recruits, can bring to their new profession.

The activities that students undertook within their communities helped build a sense of connection with each other as occupational therapy students. Wilcock (1998) explains that to "be", we need time to discover who we are as individuals, "to think, to reflect and, to simply exist" (p. 250) within the context and space of occupational therapy. Although there is often a loud groan from students when they are asked to reflect, the gOT Spirit Challenge managed to encourage them to reflect in a fun and non-threatening way. The submissions put forward by each program indicated what students believe about occupational therapy, which is important to understand as they are the future of the profession. The submissions also show the complex roles many of the students maintain in their lives: dancer, singer, videographer, storyteller, volunteer, organizer, and so on. Students demonstrated who they are as individual beings, shaped by past and current experiences, and who they envisage themselves becoming in the future.

A new sense of camaraderie emerged among students from university to university and, despite the long hours spent at university, students found time to share their passion with and commitment to the occupational therapy community. This passion was evident through the increased participation and calibre of submissions across the three years of the competition. In 2011 entries were more creative and more complex than they were when the Challenge started in 2009.

University of Alberta students share information about occupational therapy across campus in OT Month.

Technology plays key role

Online technology played a pivotal role in the success of the event as it provided a platform to share a celebration of occupational therapy. In the first two years of the event the online 'stage' for the challenge was a wiki program called Wet Paint™. A wiki is an interactive website that can have multiple contributors and facilitates collaboration (Hamilton, 2010). The first wiki was titled "mOTion across Canada" (http://otschools.wetpaint.com/). In the third year of the challenge, student organizers Ann Boyd and Laura Mireault decided to host the event through Facebook. Facebook provided a simpler way for the students to upload their submissions, and, with over 500 million users worldwide, Facebook was easier for visitors to find. The gOT Spirit 2011 page can be viewed at: http://www.facebook.com/groups/217078958355077/

About the authors

Brianna Boyle is a University of Alberta graduate and still has a passion for dance. She works as an occupational therapist with OrionHealth Calgary where she enables people with chronic pain and traumatic psychological injuries to discover their own functional independence in productive and meaningful occupations. You can contact her at: bboyle@orionhealth.ca.

Anita Hamilton practiced as an occupational therapist in mental health and vocational rehabilitation for 14 years before becoming an educator nine years ago. Anita is presently undertaking her PhD and is examining the role of online technologies in the advancement of information management and knowledge transfer. She has been teaching at the University of Alberta since October 2007. She can be contacted at: anita.hamilton@ualberta.ca.

Pamela Armstead is a University of Alberta graduate and works as an occupational therapist with Prairie Valley School Division in Saskatchewan where she builds capacity in schools while supporting students to be successful in achieving academic development. Her email is: pamela.armstead@pvsd.ca.

Encouraging students to use online technology through the gOT Spirit Challenge enhances students' readiness to use online technology for professional education, networking, publicity, and client education in preparation for future practice (Hamilton, 2010). Brianna and Pam both noted that as students became more invested in the competition, they began to take ownership of their entries and their technological capacity improved exponentially. As students became more confident in using the technology, their submissions became more creative, which resulted in some impressive marketing outcomes for occupational therapy. As a result, those who participated in the event developed a range of transferable skills that will inform future practice habits.

The gOT Spirit Challenge is quick, competitive and exciting. The success of the competition illustrates how one person's vision can be realized by connecting with the right people and using the right tools. Brianna said that "using online technology well is like putting an idea on steroids". To illustrate the pervasiveness of the concept, Pam recently received an enquiry from a group of occupational therapy students in the United States who had found the wiki. They were interested in how the competition had impacted occupational therapy spirit in Canada, and were planning to run their own version.

Creating strong networks

When Pam Armstead envisioned this friendly competition, she wanted to achieve two key outcomes: To connect occupational therapy students across Canada in a meaningful activity to create a shared identity, and to create a groundswell of excitement about the potential of occupational therapy. Through the use of online technology and the shared goodwill of the occupational therapy community, the gOT Spirit Challenge has facilitated students in Canada to do so that they may become better as individuals and groups to connect and know that they belong to a wider community of occupational therapy students. It is hoped that the gOT Spirit Challenge will be a foundation for strong networks that will carry on as they enter the profession as colleagues.

To participate in gOT Spirit Challenge in October 2012 please contact this year's organizers, U of A students Christine Walker at: cwalker1@ualberta.ca, or Rachel Toppin at: rtoppin@ualberta.ca.

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Understanding the supply of occupational therapists in Canada

Michelle Button

According to the Occupational Therapist Database (OTDB) at the Canadian Institute for Health Information (CIHI), there were 13,040 occupational therapists in Canada in 2010, a 10.7% increase from 2006. The ratio of occupational therapists per 100,000 population in Canada grew from 36.0 per 100,000 population in 2006 to 38.1 per 100,000 population in 2010.

These supply or head counts are comparable across jurisdictions and occupations and are therefore commonly used to estimate the number of health care providers in Canada. This approach continues to be the most prevalent even though most will recognize it as a relatively rudimentary way of measuring the number of health care providers for a given profession. While this approach may be the most customary, it may not provide the complete picture of the actual supply of occupational therapists in Canada.

The reason for this discrepancy may be due to the assumption that each individual works on a full-time basis, which does not appear to be true for the occupational therapy profession. To demonstrate this point, Figure 1 provides a snapshot of weekly hours worked (based on self-reported estimates of total hours per week worked) by occupational therapists.

Two out of five occupational therapists (44.0%) in selected provinces worked less than 36 hours per week in 2010. There is a variation in the total hours worked across provinces. Almost half (47.0%) of the occupational therapists in Manitoba worked less than 36 hours per week whereas a little over a quarter (26.7%) of the occupational therapists in PEI worked less than 36 hours per week.

Based on head counts and hours worked by occupational therapists in the specified provinces, the full-time equivalent (FTE) can be calculated by converting the number of hours worked into a standard work week.

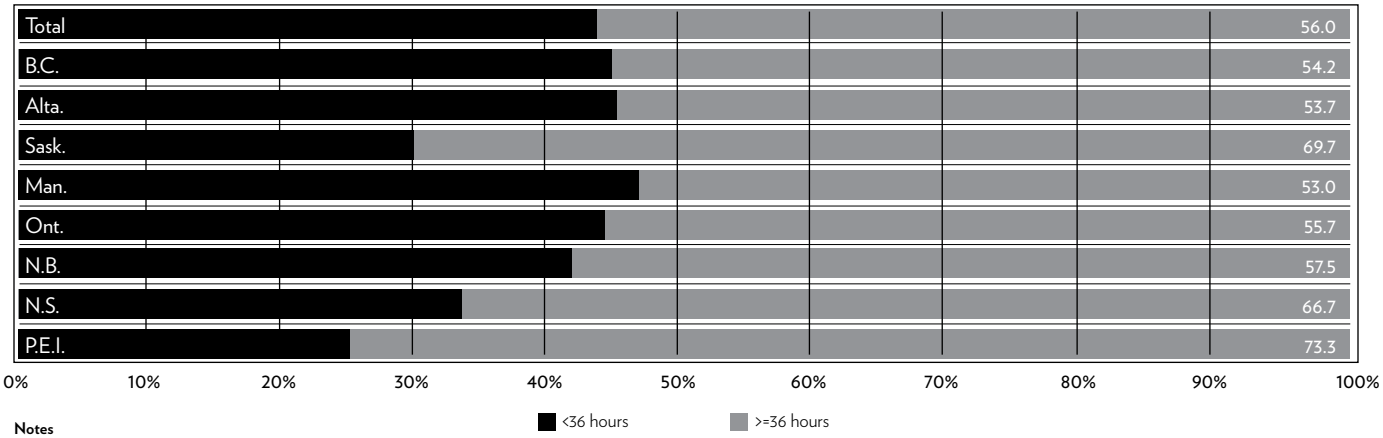
Calculating the full-time equivalent supply of occupational therapists

Based on the Australian Institute of Health and Welfare method, the FTE is calculated by using the average weekly hours worked by a health care provider and the standard work week for the occupation, which, while debatable and likely to vary across occupations, was set at 36 hours per week for this analysis. The FTE is then averaged across the sample to provide an overall provincial and territorial estimate.

$$\text{FTE} = \frac{\text{Total Usual Weekly Hours}}{36}$$

When looking at the adjusted head count based on the above FTE calculation, the overall supply of the occupational therapist workforce in 2010 is profiled in Table 1.

Figure 1: Percentage of occupational therapist workforce by total usual weekly hours worked, 2010



Notes
Quebec data was not available.
Findings do not include data for Newfoundland and Labrador, as Total Usual Weekly Hours Worked data was not provided to CIHI.
Data for the territories was not included due to a high proportion of missing values for Total Usual Weekly Hours of Work.
The results do not include data for which responses were unknown.
Total Usual Weekly Hours Worked refers to self-reported usual weekly hours across all employments (if applicable).
CIHI data will differ from provincial and territorial statistics due to CIHI's collection, processing and reporting methodology.
The Methodological Notes provide more comprehensive information regarding the collection and comparability of OTDB data.
Source: Occupational Therapist Database, Canadian Institute for Health Information.

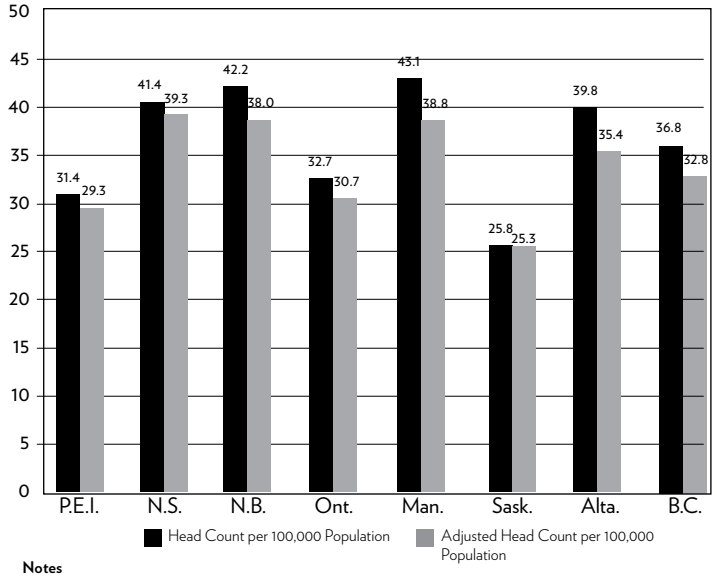
Table 1: Full-Time equivalent estimates based on total usual weekly hours worked, selected provinces of registration, 2010

	Head Count	FTE	Adjusted Head Count	% Difference
P.E.I.	45	0.94	42	-6.7
N.S.	391	0.95	371	-5.1
N.B.	318	0.9	286	-10.1
Ont.	4337	0.94	4077	-6.0
Man.	534	0.9	481	-9.9
Sask.	271	0.98	266	-1.8
Alta.	1485	0.89	1322	-11.0
B.C.	1676	0.89	1492	-11.0

Notes
Head count: number of occupational therapists.
FTE: full-time equivalent.
FTE = total usual weekly hours/standard work week (in hours)
Standard work week: 36 hours.
Adjusted head count: number of occupational therapists adjusted based on their hours worked.
Quebec data was not available.
Findings do not include Newfoundland and Labrador, as Total Usual Weekly Hours Worked data was not provided to CIHI.
Data for the territories was not included due to a high proportion of missing values for Total Usual Weekly Hours of Work.
CIHI data will differ from provincial and territorial statistics due to CIHI's collection, processing and reporting methodology.
The Methodological Notes provide more comprehensive information regarding the collection and comparability of OTDB data.
Sources: Occupational Therapist Database, Canadian Institute for Health Information.

This adjustment to the supply of occupational therapists using the FTE methodology also has an influence on the number of occupational therapists per 100,000 population. The number of occupational therapists per 100,000 population based on the overall supply of occupational therapists provides a basic ratio within the specific jurisdiction. When taking into account the hours worked by an occupational therapist, calculating the FTE and then calculating the ratio of adjusted number of occupational therapists per 100,000 population helps take into account the availability of occupational therapists to provide their services in those jurisdictions.

Figure 2: Number of occupational therapists per 100,000 population using head counts and FTE-adjusted head counts, selected provinces of registration, 2010



Notes
Head count: number of occupational therapists.
FTE: full-time equivalent.
FTE = total usual weekly hours/standard work week (in hours)
Standard work week: 36 hours.
Adjusted head count: number of occupational therapists adjusted based on their hours worked.
Quebec data was not available.
Findings do not include Newfoundland and Labrador, as Total Usual Weekly Hours Worked data was not provided to CIHI.
Data for the territories was not included due to a high proportion of missing values for Total Usual Weekly Hours of Work.
Population statistics are based on data from Statistics Canada.
CIHI data will differ from provincial and territorial statistics due to the CIHI collection, processing and reporting methodology.
The Methodological Notes provide more comprehensive information regarding the collection and comparability of OTDB data.
Sources: Occupational Therapist Database, Canadian Institute for Health Information; Statistics Canada.

All jurisdictions examined in this analysis showed a decline in the per population estimate when FTE was taken into account. For example, in Manitoba the ratio went from 43.1 occupational therapists per 100,000 population to 38.8 occupational therapists per 100,000 population.

Other factors that drive FTE estimates

There are other factors that could potentially influence these estimates. For example, in 2010, the majority of occupational therapists in Canada were female (91.8%). Of the female occupational therapist population, almost half (46.0%) were working fewer than 36 hours per week as compared to 21.7% of the male population.

Occupational therapy is a fairly young profession; however, when looking at the average age of occupational therapists over time, we find that the age of therapists has increased from 38.6 in 2006 to 39.1 in 2010. When taking into account the weekly hours worked by different age groups, we found that one-fifth (20.1%) of the occupational therapist workforce was between the ages of 20-29 and of these, 74.4% worked more than 36 hours per week. In contrast, less than half (45.5%) of the occupational therapists between the ages of 40-49 worked 36 hours or more per week. The latter age group makes up 26.5% of the occupational therapist workforce.

Conclusion

Accurately estimating the supply of the occupational therapist workforce in Canada is a multifaceted but essential task

requiring an understanding of the availability and accessibility of the occupational therapist workforce to provide ongoing services. Using simple head counts might not be the most effective method to estimate the supply of occupational therapists. Many factors influence the supply and availability of the occupational therapist workforce and it is important to take these factors into account when estimating the actual supply of occupational therapists.

About the Occupational Therapist Database (OTDB)

OTDB has been a source of timely, quality information for the occupational therapist workforce in Canada since 2006. The OTDB aims to provide standardized comparative pan-Canadian data and analysis on this healthcare provider group in Canada. More information about the OTDB and the *Occupational Therapists in Canada* reports can be found at: www.cihi.ca

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The occupational therapist's role in lymphedema self-management

Byron Shier

COLUMN EDITOR: PATRICIA DICKSON

Lymphedema is a chronic medical condition caused by an abnormal accumulation of protein-rich lymphatic fluid in the extra-vascular (interstitial) space, causing recurrent or progressive swelling associated with physical, psychosocial, and occupational performance complaints (Ramos, O'Donnell, & Knight, 1999; Woods, Tobin, & Mortimer, 1995). Lymphedema onset is associated with a variety of medical diagnoses including venous disease, infection, and oncological, orthopedic and congenital issues. Occupational therapy services are indicated to assist clients to concurrently address integration of lymphedema self-management techniques into daily living and any occupational performance complaints associated with lymphedema onset. Occupational therapists can enhance their professional practice by pursuing continuing education opportunities to develop specialized clinical skills in lymphedema assessment and treatment.

This article will discuss various issues facing the client with lymphedema, and the role of the occupational therapist in dealing with those issues. It will also briefly describe complete decongestive therapy (CDT), a widely accepted treatment protocol, which integrates client self-management as a key component of treatment interventions (Executive Committee of International Society of Lymphology, 2009).

Reduced independence

Chronic lymphedema may contribute to clients developing physical impairments including mobility restrictions and orthopedic or soft tissue issues. Impaired client strength, endurance, dexterity, and mobility may contribute to functional performance complaints (Crane, 2009; Helms, Kuhn, Moser, Remmel, & Kreienberg, 2009). Physical complaints may impede our clients' ability to complete lymphedema self-management strategies including: ability to don and doff graduated compression garments, routine self-bandaging, and skin care. The occupational therapist's skill in activity analysis will facilitate addressing these challenges by introducing adaptive strategies, equipment and biomechanical education to promote client independence. The occupational therapist's ability to successfully address these functional issues may be the difference between our clients' success in managing their lymphedema independently versus having to rely on daily caregiver assistance.

Clients' effective self-management may contribute to a reduction in secondary complications including the risk of serious infection requiring emergency department visits or hospitalization (Williams, Franks, & Moffatt, 2005). Ko, Lerner, Klose, and Kosimi (1998) found that incidence of infections decreased from 1.10 infections per patient per year to 0.65 infections per patient per year after a course of intensive therapy followed by consistent client self-management. The occupational therapist needs to consider assessing clients' abilities with bathing, skin care, wound care, and appropriately donning and doffing fitted graduated compression garments. The occupational therapist may provide client and caregiver education on the signs and symptoms of infection and the importance of immediate medical follow-up. Furthermore, occupational therapists may incorporate client-appropriate adapted strategies to enable improved occupational performance. Occupational therapists may also be involved in homecare coordination, including assessing a client's caregiver needs.

Psychological issues

Research suggests lymphedema onset poses a significant risk of psychological morbidity with clients' ability to engage in meaningful, purposeful, activities of daily living. McWayne and Heiney (2005) report onset of lymphedema contributes to frustration, distress, depression and anxiety, subsequently contributing to impaired occupational performance. This study notes clients also report becoming angry with perceived loss of independence with leisure and vocational pursuits. Occupational therapists have a role to provide education and intervention, and coordinate appropriate referrals to other health disciplines in order to improve clients' psychosocial status and support improved functional performance.

Occupational performance barriers

The focus of occupational therapy is to enable occupation by holistically addressing occupational performance barriers. Evidence suggests clients with lymphedema often report declines in at least one area of occupational performance. McWayne and Heiney (2005) report some clients with lymphedema have noted difficulties in performance of basic self-care activities including dressing and bathing. In clinical

Client with lymphedema prior to complete decongestive therapy.

Client with lymphedema after complete decongestive therapy.

practice, clients often report difficulty fitting clothes due to volume changes of their affected limbs. This was one concern reported by a secondary lymphedema breast cancer survivor as seen in the pre and post treatment photographs (see above).

Radina and Armer (2001) report clients have modified routine home management tasks to reduce noticeable flare-up of symptoms, while Ridner (2009) reports clients with lymphedema may reduce their social and leisure activities. In clinical practice, clients have reported flare-up of symptoms after homemaking, cleaning and vacuuming tasks, and leisure and social activities including golfing, playing with children/grandchildren, knitting, or utilizing a home computer. Lymphedema clients may experience a negative impact on their vocational pursuits as well. Soran and colleagues (2006) found that the level of hand use based on vocational requirements was a statistically significant risk factor in lymphedema onset. Return to work concerns cited by clients in clinical practice include decreased workplace durability, an increase in lymphedema-related pain symptoms, and perceived limb volume increases while at work. Completion of a worksite ergonomic and job demands analysis provides opportunity to address workplace set-up, work conditioning, and work behaviors to support a durable return to work. A review of this author's clinical practice outcomes in 2008 suggests 60% of clients assessed by the occupational therapist identified at least one occupational performance complaint associated with lymphedema onset. As research and clinical evidence suggests lymphedema clients routinely experience occupational performance deficits, occupational therapists have a role to help clients meet these challenges.

Complete decongestive therapy (CDT)

Complete decongestive therapy (CDT) is a widely accepted treatment protocol, which integrates client self-management as a key component of treatment interventions (Executive Committee of International Society of Lymphology, 2009). Lymphedema clients may present with absolute and relative medical contraindications that must be recognized by the assessing clinician. Training to learn CDT techniques will provide occupational therapists with an opportunity to acquire condition-specific assessment and treatment skills that are fundamentally important to guiding appropriate clinical care, judgment, and decision-making. By enhancing their practice knowledge and skills in this area, occupational therapists will be able to provide more effective treatment services for clients.

One important component of CDT is integrating client self-management education into treatment sessions. Vignes, Porcher, Arrault, and Dupuy (2007) comment on the importance of effective client self-management, finding clients' compliance with routine use of graduated compression garments and low stretch self-bandaging of the affected limb is crucial to stabilize lymphedema volume over time. Lymphedema clients report challenges implementing these required self-care management strategies including mobility restrictions, location of lymphedema, and the daily time required to complete care (Mayrovitz, 2009). Clients who effectively integrate self-management strategies may help expedite the rehabilitative process, improve clinical outcomes, and reduce the frequency of required follow-up services with a health care professional to address lymphedema-related concerns. Cheville, McGarvey, Petrek, Russo, Taylor, and Thiadens (2003) provide an outline of conventional CDT treatment: a multi-modal, two-phase approach to lymphedema management. The first phase includes up to daily treatment sessions involving a combination of manual lymphatic drainage techniques, multi-layered graduated compression bandaging, skin care, and a remedial exercise

program. Clients may be expected to wear graduated compression bandages for up to 20-22 hours daily between sessions. This intensive phase of treatment typically continues until the affected extremities are decongested and volume is stabilized. Phase two of treatment focuses on long-term lymphedema self-management through daytime graduated compression garment use, night time use of short stretch compression bandaging, remedial exercises with graduated compression bandages or garments, daily skin care, and manual lymphatic drainage as required. Further information about treatment, management, and on-line resource links are available at Canadian Lymphedema & Rehabilitation Services, Inc. (www.canadianlymphedema.com).

There are a variety of training programs available for occupational therapists' consideration. The National Lymphedema Network offers a list of training programs that meet the established training standards to apply to sit the Lymphology Association of North America (LANA) certification exam. LANA requires the clinician to complete a minimum of 135 hours of academic training consisting of one third theoretical instruction and two thirds practical lab work, a minimum of one year of lymphedema clinical experience using CDT, followed by successful completion of the LANA exam.

Conclusion

In summary, as lymphedema is a chronic condition, all clients have to be expected to integrate self-management strategies into daily living activities. As clients with lymphedema also often report occupational performance complaints, occupational therapists have a crucial role in providing assessment and treatment services to meet the needs of this under-served Canadian population. CDT is a key component of treatment interventions for clients with lymphedema, and a variety of training opportunities are available to enable occupational therapists to incorporate this protocol into their practice.

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CAOT-BC: A new model of provincial occupational therapy representation for British Columbia

Claudia von Zweck, PhD, OT(C), CAOT Executive Director and Sue Baptiste , MHSc, OT Reg. (Ont.), CAOT President

In the fall of 2011, the creation of the Canadian Association of Occupational Therapists - British Columbia (CAOT-BC) was announced as a new provincial chapter of CAOT to represent the occupational therapists in the province of British Columbia. This report provides an overview of the events leading to this historic new arrangement and outlines some of the exciting new plans for CAOT-BC.

Occupational therapy professional associations in Canada

While CAOT works at a national level on a broad range of issues to promote excellence in occupational therapy, professional associations or societies with independent governance are also established in most provinces and territories of Canada to address provincial and local needs of occupational therapists. The mandates of such provincial/territorial organizations vary in different jurisdictions, with some assuming regulatory functions in addition to providing professional services and representation for occupational therapists.

Discussions regarding the relationship between CAOT and provincial/territorial professional associations for serving the occupational therapy community have been held at many times during the history of the profession in Canada. CAOT seeks opportunities to promote collaboration and reduce competition among voluntary membership organizations that represent occupational therapists. Actions that serve to fragment and divide loyalties of occupational therapists among different organizations weaken the ability of our small profession to develop and grow. CAOT encourages initiatives that allow organizations to actively work together and coordinate services to optimally meet the needs of occupational therapists in Canada.

CAOT and the British Columbia Society of Occupational Therapists

In recognition of the need for strong and viable organizations to address professional issues for occupational therapists living in British Columbia, CAOT worked with the British Columbia Society of Occupational Therapists (BCSOT) between 2007 and 2009 to explore a partnership that would require joint membership in both associations. The goal of the joint membership initiative was to promote coordinated action at local, provincial and national levels to proactively and effectively address complimentary factors influencing the profession. While feedback from CAOT members lauded our efforts to create a stronger voice for occupational therapists and reduce divisiveness among organizations, support for a joint membership model was weak. Ultimately discussions regarding a joint membership model between BCSOT and CAOT failed in 2009, although collaborative work continued among the two organizations on a number of initiatives.

In July of 2011, the BCSOT Board approved a motion to work with CAOT to develop a new model of provincial representation. BCSOT was in a position of needing to close as the number of members enrolled in the organization did not generate sufficient revenue to cover ongoing operational expenses. An independent consultant working with BCSOT and CAOT suggested that given the small size of the profession, the current provincial association structure was not viable. An integrated national and provincial model was recommended that maximizes available resources and eliminates duplication of services. To promote continuity of service for products such as professional liability insurance and advocacy activities, and to prevent an appearance of apathy within the profession regarding the closure of BCSOT, it was decided among the two organizations that the transition to a new model for provincial representation should occur as soon as possible.

With BCSOT ceasing operations in late 2011, responsibility for provincial representation of occupational therapy in British Columbia shifted to CAOT. A transition planning team was initiated to lead the creation of CAOT-BC, the new provincial chapter in British Columbia

CAOT-BC Transition Planning Task Force

- Lori Cyr, BC representative of the CAOT Board of Directors
- Les Smith, Past BCSOT President
- Mary Wallace Poole, BCSOT Executive Director
- Mary Glasgow Brown, Past BCSOT Board Director
- Catherine Backman, Director, University of British Columbia Occupational Therapy and Occupational Science Department
- Sue Baptiste, CAOT President
- Claudia von Zweck, CAOT Executive Director

CAOT-BC strategic planning

To guide the work of CAOT-BC, a strategic planning day was held in September 2011 with members of the boards of directors of BCSOT and CAOT, as well as other occupational therapy

Giovanna Boniface, a resident of North Vancouver, B.C., joins the CAOT team as the managing director of CAOT-BC. Giovanna graduated from the University of British Columbia (UBC) Faculty of Science in 1992 with a degree in animal biology followed by a degree in occupational therapy from the UBC School of Rehabilitation Science in 1997.

Giovanna owns and operates Boniface Consulting, a private practice which focuses on providing expert medical-legal opinion in cost of future care/life care planning, community brain injury and complex orthopaedic work. Outside of her work, Giovanna has a strong history with BCSOT, which includes volunteer positions such as co-president, treasurer, regional representative, and private practice special interest group chair, to name only a few.

We look forward to working with Giovanna and continuing her interest in professional issues through new endeavors with CAOT-BC.

leaders from British Columbia. The meeting opened with a statement from CAOT President Sue Baptiste that expressed admiration for the strong practice culture and occupational therapy accomplishments in the province. She acknowledged her sadness regarding the closure of BCSOT and the courage of the BCSOT Board to make the decision to cease operations, noting that a provincial voice for occupational therapy was essential. Her hope was expressed that the day's discussion would result in a clear statement of provincial and national collaboration for best serving the profession in British Columbia.

Participants of the strategic planning day clearly identified representation of the profession as the focus for the work of CAOT-BC. A list of activities best left at national level was generated, recognizing that this work should not be duplicated, but may be shaped or emphasized within CAOT-BC to meet specific needs of British Columbia members.

Participants recognized that a key benefit of the provincial chapter model of professional representation for occupational therapy in British Columbia was that the existing infrastructure of CAOT would not need to be duplicated to provide services to CAOT-BC members. Freedom from the need to undertake operational activities already assumed at the national level, such as enrolling/renewing memberships, will allow provincial efforts to concentrate on important strategic priorities to represent, promote, and engage occupational therapists in British Columbia.

Moving forward with CAOT-BC

In November 2011, the CAOT Board approved new structures to guide the future development and work of the provincial chapter, including the ends policies that define outcomes for the work of CAOT-BC. A second approved policy identifies the membership of CAOT-BC as all members of the association living within the province of British Columbia. Lastly, a policy was approved that indicates services and benefits offered by CAOT-BC:

1. will be directed towards meeting the specific needs of members living or working in the province;
2. will be available to any CAOT member where appropriate and feasible; and
3. will not duplicate services and benefits available nationally from CAOT.

It is an expectation that revenues generated in the province of British Columbia will cover the cost of services that are uniquely provided to members of CAOT-BC. In the 2011-2012 transition year remaining funds from BCSOT will assist with these costs. In future years, the work of CAOT-BC will be funded by a modest fee increase for British Columbia members. As a result of setting clear priorities for the work of CAOT-BC and reducing duplication of services, it is proposed that CAOT-BC member fees rise by only $75 (less than 30% of the annual BCSOT dues).

Operational costs for CAOT-BC include the recent hiring of a managing director for CAOT-BC. The CAOT-BC managing director position was established as a local contact to address provincial practice and advocacy issues. We welcome Giovanna Boniface in this new role.

Intensive work towards the CAOT-BC strategic priorities has now commenced. The transition planning team has completed a review of all services and products formerly offered by BCSOT to determine if and how such services will be offered by CAOT-BC. For example, BCSOT local special interest groups will continue operation with the support of CAOT-BC as required and will complement the existing communities of practice offered at the national level. A logo has been established for CAOT-BC for use in all communications and a new section for CAOT-BC has been created on the CAOT web site. Frequent communiques have been sent to occupational therapists in British Columbia to inform them of the development of CAOT-BC. In addition, CAOT-BC volunteers headed by conveners Caroline Ehmann and Susan Gmitroski have begun planning for Conference 2013 which will be held in Victoria in June 2013.

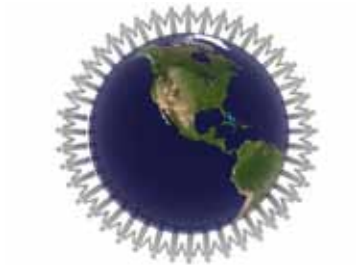
The Board also approved in November 2011 the establishment of the CAOT-BC Advisory Committee that will replace the

transition planning committee. This committee will be composed of a minimum of six members, each representing geographic and major practice areas in British Columbia. The CAOT British Columbia Board director shall act as chair.

In closing, it is recognized that the work completed for CAOT-BC may serve as a model for potential collaboration in other provinces. Consideration has therefore been given to the establishment of structures and processes that have the potential to be replicated in other areas as needed or desired. CAOT does not suggest that the 'British Columbia way' is optimal for other jurisdictions, but understands the need for coordinated representation of the profession at all levels and remains committed to development of strong organizations that can effectively serve occupational therapists in Canada.

Occupational therapists in British Columbia have a great new opportunity. For years it was a struggle to entice occupational therapists to belong to both a provincial professional society and a national one. Now a new chapter has begun – CAOT-BC. This venture provides occupational therapists in BC the combined power and resources of both provincial and national advocacy efforts through joining one association. CAOT-BC will be the voice of occupational therapists in BC, ensuring provincial advocacy efforts progress and the influence of occupational therapy in BC continues to grow. As the British Columbia based members of the Transition Planning Team, we are excited to be developing the new chapter and eagerly look forward to the future of occupational therapy in BC.

- Les Smith, BCSOT President, Lori Cyr, CAOT Board member, Mary Glasgow Brown, BCSOT Board member
Catherine Backman, UBC, Mary Wallace Poole, BCSOT Executive Director.



COLUMN EDITOR: SANDRA BRESSLER

The impact of international fieldwork in developing nations

Haley Augustine

International fieldwork (IFW) opportunities are gaining more attention and are highly sought after by occupational therapy students. IFW provides unique opportunities to enhance one's education and future practice which can, in turn, benefit the profession as a whole by educating therapists who have experienced working in different settings, cultures and languages (Van Iterson, 2009). The valuable learning occurring during IFW teaches students to be creative in resource-limited settings while developing skills in problem-solving and cultural awareness (Horton, 2009). While reflecting on these benefits enjoyed by students, it is also important to consider the impact international students have on the provision of local occupational therapy services. During my own experience in IFW, I found myself wondering: what cultural and ethical concerns are associated with IFW, particularly in developing countries, and how can these be negotiated? In this reflection piece, I will explore these questions by reflecting on my personal experiences in Tanzania, Africa as a final-year MScOT student.

Concerns with IFW

IFW is an excellent chance for students to explore basic occupational therapy principles applied in different locations around the world. It is an opportunity to adapt these principles to fit different social and cultural situations, develop skills in problem solving, and become more resourceful. These placements train students to be global citizens and help them to gain cultural competence, which are necessary skills for working with culturally diverse groups in practice (Horton, 2009). For these many reasons, I elected to complete one of my fieldwork placements in Tanzania, Africa. Two months later, I returned to Canada inspired, humbled, and curious about all I had learned about the culture and health practices in Tanzania. Until most recently, I have found it easy to assume my actions were good as they arose out of good intentions; now I would like to address some of the concerns associated with IFW.

While completing IFW there are competencies and objectives a student must fulfill based on program requirements. In meeting these requirements the student may require input and resources from the host site, such as training from the preceptor. This use of local human resources therefore raises concern about the reciprocity between the students who are learning and the host site's human resources. Conversely, the student-preceptor relationship may also be described as a mutual exchange, as students tend to challenge their preceptors at the host site by bringing a fresh perspective and asking questions. In settings where there are limited resources, students can also assist in extending services by providing additional person power once they have developed the necessary skills.

Another concern I considered is the potential burden students may place on their preceptors as a result of communication barriers and unfamiliarity with cultural practice (DeCamp, 2007). Communication is a key component in the foundation of occupational therapy that enables client-centred, empathetic and productive interactions with clients. Different local customs and norms may limit a foreign student's ability to communicate through body language and verbal communication (Horton, 2009). One custom I noticed in Tanzania was that looking someone directly in the eyes was intimidating and made them shy away from communicating with me. During my time in Tanzania, I quickly became aware of the need for demonstration through hand gestures and imitation as a means of communicating, as well as the value of learning basic words related to daily activities.

Education and fieldwork are investments in human capital; however, it is important to consider the sustainability for host countries once international students have completed their placement (DeCamp, 2007). Additionally, there is the question as to whether IFW limits placements for local students who would eventually work locally as occupational therapists. This is something that should be discussed with the host country prior to sending students, ensuring local occupational therapy programs are not negatively impacted because of fewer available placements. I was fortunate to be placed in a setting where I could collaborate with local occupational therapy students for translation and knowledge sharing.

Bringing ethical issues to the forefront

Despite the above-mentioned ethical questions and cultural

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concerns, there are profound benefits with IFW experienced by occupational therapy students and the profession as a whole (Ethics of International Engagement and Service-Learning Project [EIESL], 2011; Horton, 2009). For me, the question remains: how can we engage students in IFW in a way that brings these ethical issues to the forefront while engaging in a respectful cultural exchange? Reflecting on the current literature and my personal experiences, there are three main strategies to promote international placements which recognize and address potential cultural and ethical issues: preparing the students, developing long-term partnerships through the university and host facility, and linking with local students to facilitate knowledge exchange.

1. **Preparing the students:** The first important step to developing good and mutually respectful relationships with host countries is preparing the students interested in IFW (DeCamp, 2007; EIESL, 2011). Students are ambassadors who represent their educational institution, their profession and their country of origin. Preparation can begin through the application process by challenging students to reflect on their motives for doing IFW and their preparedness for this type of setting. Additionally, students may benefit from attending training and education sessions on the local language of the host country, cultural differences, and common challenges associated with IFW. From my experiences, connecting with previous students and faculty who had traveled to my placement site helped me prepare for cultural challenges and enhanced my awareness of local customs and occupational therapy practice. Discussion of ethical issues helped me prepare for some of the challenges I faced, such as colleagues requesting money, encountering practices that would not be acceptable in Canada, and issues around resource allocation. Comprehensive preparation equips students to make ethically and culturally sound decisions while on placement (DeCamp, 2007).

2. **Developing long-term partnerships:** Developing a reciprocal partnership between the university and international setting is integral to promoting sustainability. While students continue to be an essential liaison with partner countries, their IFW is a short-term placement (DeCamp, 2007; EIESL, 2011). Therefore it is important to engage faculty to facilitate long-standing and reciprocal relationships. This partnership may include faculty and students collaborating with international partners to address research questions or training needs. From my experience, it is not the donations that provide sustainable growth for local clinics; it is the investment in human capital that has the greatest impact. Therefore specific attention must be paid to ways to support training through long-term partnerships.

3. **Knowledge exchange:** Linking with local students in developing countries is a good way of investing in human capital for local occupational therapy students and enhancing cultural knowledge with respect to practice for the international student. Canadian students are learning from their preceptors and local students; therefore, we can empower these local communities and occupational therapy programs by asking questions, working alongside them and demonstrating that their knowledge is valuable to Canadian students (EIESL, 2011). This may include offering learning opportunities to local students first, as well as taking time to learn from local students and share knowledge on occupational therapy. While completing my IFW in Tanzania, it was an incredible experience to work closely with local occupational therapy students comparing and contrasting our theoretical approaches to occupation and learning about each other's culture. Working together in a mutually respectful learning environment, students can learn from each other while strengthening international collaboration with host countries, and thus work to minimize power imbalances, or excess burden they may impose (EIESL, 2011).

Haley worked with the wheelchair technician to adjust a girl's wheelchair during a home visit. Home visits were a critical component of care in Tanzania, as traveling with a wheelchair and child on public transport was a major barrier.

Conclusion

IFW in occupational therapy is a unique, rewarding, and challenging experience that some students are privileged to be a part of. It is my hope that our profession continues to foster these partnerships with developing countries to facilitate international learning. Through this paper I hoped to raise important ethical and cultural questions and propose suggestions to students, practitioners, researchers and institutions on ways to engage in a socially responsible manner with respect to international work. I encourage people to critically reflect on their motives for choosing to participate in IFW, their experiences while abroad and ways to apply their learning from IFW locally . My experiences in Tanzania have left me with valuable skills in occupational therapy that will last a

me with valuable skills in occupational therapy that will last a lifetime. I am less certain that my colleagues in Tanzania benefitted as much from the experiences as I did. In writing this article I have come to realize that immediate solutions to some of these ethical and cultural questions may not be forthcoming, but the first step to examining them is to ask the questions in the first place.

Acknowledgements

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Did you know...

Cheryl Evans-Crowell, CAOT Communications Coordinator

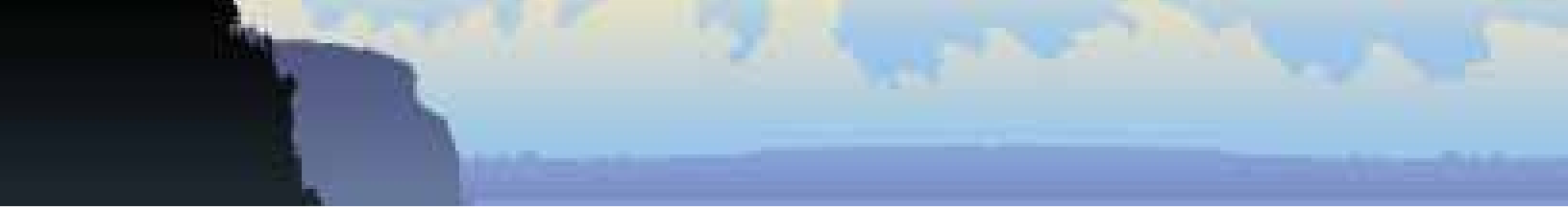
Did you know that Sharon Johnston, who is married to the Governor General of Canada, David Johnston, is a physiotherapy and occupational therapy alumna?

Mrs. Johnston graduated as a physical and occupational therapist in 1966, from the University of Toronto. She worked in the area of child psychiatry. When the Johnston family moved to Montréal, she completed a master's and doctorate in rehabilitation science, all while raising her five daughters. At the master's level, she studied a more effective way of clearing the small airways of cystic fibrosis sufferers. Her doctoral thesis examined the coordination of respiratory muscles during normal speech, stuttered speech and singing. Her thesis resulted in the publication of scientific articles on respiratory mechanics.

As the spouse of the governor general, Mrs. Johnston plays a tangible role in fulfilling the governor general's mandate by taking part in official ceremonies and national celebrations, such as the opening of Parliament, Order of Canada investiture ceremonies, Canada Day events, the reception of foreign dignitaries and the governor general's visits at home and abroad. The spouse of the governor general is designated His or Her Excellency while in office. In addition, the spouse is granted membership in the Order of Canada at the level of Companion, and is designated a knight or dame of the Most Venerable Order of the Hospital of St. John of Jerusalem.

There has been a long-standing relationship between the governors general of Canada and/or their wives, and the Canadian Association of Occupational Therapists (CAOT).

The first patron of CAOT, Her Excellency Lady Willingdon, wife to Governor General Lord Willingdon, dates back to 1930. Today, we are pleased to have His Excellency the Right Honourable David Johnston who was sworn in on October 1, 2010, and is the 28th governor general since Confederation.



Occupational therapy and health care: An interview with Her Excellency, Mrs. Sharon Johnston

Conducted by Brittney Wiley and Alison Hogg

On October 19th, 2011, two University of Toronto occupational therapy students travelled to Ottawa to meet with Her Excellency, Mrs. Sharon Johnston. To celebrate and promote Occupational Therapy Month, they sat down together to discuss occupational therapy, its development and its role in modern day health care. The following is a transcription of that meeting.

B: Your biography on the Governor General's website mentioned that you used to practice in child psychiatry and also did some research with clients with cystic fibrosis. Could you tell us a bit more about what those roles entailed or if you have had experience in other areas as an occupational therapist?

SJ: The first thing to say is that my working life was quite short due to frequent moves and starting my family early. By 34, I had five children less than seven years of age. I began working as an occupational therapist in 1966 at the Beechgrove Children's Psychiatric Unit in Kingston. With a move to Toronto I worked at the Crippled Children's Centre — the precursor to Holland Bloorview. I'd like to talk about working at the Crippled Children's Centre as a combined physical and occupational therapist.

" The emphasis was on physical rehabilitation. But I put more emphasis on the adolescents being properly socialized. This was considered, in some people's minds, not good physio and occupational therapy ."

At the Crippled Children's Centre, I was part of what they called the "Apartment Program" and this was notable because they were moving handicapped children into regular schools. In the Apartment Program, physical and occupational therapists concentrated on transfers - wheelchair to bed or toilet. The emphasis was on physical rehabilitation. But I put more emphasis on the adolescents being properly socialized. This was considered, in some people's minds, not good physio and occupational therapy . I wanted these kids to learn about proper hygiene, fashion, cooking, having friends and understanding the basics of sexuality so they would be confident and not embarrassed when they entered a regular school. I almost lost my job over that but it was so much fun.

I just want to excite you about the 60's — the era of the Civil Rights Movement. People advocated for rights for blacks and the handicapped. They really wanted better lives for everybody. At Beechgrove I was working with children who were difficult or badly behaved. The flu pandemic that followed World War I saw many children with hyper active behavior. This was attributed to the meningitis that accompanied the flu. But for the first time since the pandemic, hyperactive behaviour was not thought to be due to a brain infection. Hyperactivity had a genetic or environmental component.

It took many decades to see this — that kids were not just badly behaved but had a learning disorder. For physical and occupational therapists, this was an opening to look at motor movement programs, learning and attention techniques that could make it easier for these hyperactive children to learn. Attention deficit hyperactivity disorder is well recognized today. It was a very exciting time back in the 60's. The social pressure to do the right thing was really there and there were huge, huge changes happening. I think physical and occupational therapists were a part of that. At the Crippled Children's Centre, some mothers were taking the drug 'thalidomide' for nausea. However, some of the children, as a result of their mothers taking the drug, were born with missing limbs. Therefore, occupational therapists in particular began working with the engineers to develop prosthetics. In the 70's physical and occupational therapy were taught as separate courses reflecting the growth in both professions.

B: To go along with that, our next question, a lot has changed within the Canadian health care system since the 60's, 70's. What changes have you seen in the profession from then until now and does occupational therapy still have a spot in today's health care system?

SJ: Many old style institutions such as 999 Queen Street in Toronto closed in the 70's and 80's. Occupational therapists had only limited working surroundings in these institutions. Health care is moving towards community and home based medicine. This is a great opportunity for occupational therapy to be covered under the Canada Health Act.

Health care has moved toward best practices in community

settings because institutional care can be very costly. As the Health Act includes new services such as home care or community resources it's important that occupational therapy is also funded under the Act. If the elderly and sick in the community have to pay for occupational therapy through private insurance or cash they may not ask for those services. Occupational therapists must put them in the mainstream of medical care. So, that's what occupational therapists have to do.

B: So, that's what we have to work on, getting funded.

SJ: Yes.

A: Going back, you said in the 70's, our profession made a drastic change. I wasn't around in the 70's so I was wondering if you could explain a little more how between the 60's and the 70's there was such a huge change in our profession?

SJ: I'm going to read you comments made by Dr. John Bockoven in 1970 in an address to occupational therapists. I was stunned when I read it. He was trying to move occupational therapists away from just teaching arts and crafts and broadening the treatment mandate.

"It would be most unfortunate if occupational therapy were to limit itself by continuing to be satisfied with running dinky little sideshows in large mental institutions. It is time for occupational therapists to listen to the idea that their profession has been the child of medicine long enough, to consider that it is ready to go off on its own as the next step towards full maturity and full social effectiveness."

Is that not a challenge? That's a verification of what I'm saying in the 70's.

B: What message would you like to send the general public who don't know about occupational therapy services? What do you want to tell them about occupational therapy?

SJ: Last year David and I skied at Owl's Head in the Soldier On program. There was a military woman, double amputee, and she, of course, could get on this bobsled and she was very independent. From this point of view, you could see that she had been through physiotherapy. But when I spoke to her, she explained how she was going back to Valcartier alone in her home. She said she felt very lonely, that no one comes to visit and that she didn't go out. And I thought she should be able to call and request an occupational therapist to visit her because she needs help in her home. So, that's what I would say, for people who don't know about occupational therapy. It's a tremendous service to re-orient your living space and your means of communication.

A: Where do you think you'd see occupational therapy going in the future and what kind of role do you see it playing in health care?

SJ: The boomer population has high expectations of life expectancy and life style. In considering community and home based medicine it is more beneficial to work upstream by promoting good health rather than working after the fact to treat disease. This is a great opportunity for occupational therapists. So, promoting wellness in communities, going into homes, making those homes something that can maximize the way a person lives is vital for an older population. This approach keeps people out of institutions. We just closed many institutions, let's not open them again.

A: So prevention approaches...

SJ: Yes, prevention and promotion of the community concept of medicine. Again one needs funding. You need to be in the mainstream of medicine where occupational therapists make the difference between a person coming into the health care system and being expensive or being able to stay out of the health care system and not be so costly. We've been studying the health care system extensively, so let's get on with it. And the occupational therapists will do it.

" It was a very exciting time back in the 60's. The social pressure to do the right thing was really there and there were huge, huge changes happening. I think physical and occupational therapists were a part of that."

[Prompted by staff to speak about work with First Nations]

Aboriginal people are very sensitive about their own knowledge of how to be well. And certainly we know there are problems. But as we've travelled from one end of the country to the other, we've found that there have been some great initiatives in the community for health that really are working.

These are initiatives I'd like to see replicated across the country. People from the south look at our average Aboriginal, Inuit, Métis population and say "Oh they are struggling." Some places have their challenges — but in many instances, some good initiatives are emerging. That's where occupational therapists could be involved and share information. Dr. Malcolm King who co-supervised my master's degree is now in Edmonton and is the clinical director of the Aboriginal Health

About the interviewers

Brittney Wiley (Mississauga, Ontario) is a second year occupational therapy student at the University of Toronto. She hopes to work in paediatrics upon graduation. Brittney can be contacted at: wiley.britt@gmail.com.

Alison Hogg (Port Colborne, Ontario) is a second year occupational therapy student at the University of Toronto. She has enjoyed placements in musculoskeletal and geriatric rehabilitation programs thus far. Alison can be contacted at: alison.hogg@mail.utoronto.ca.

Initiative. His research is oriented towards Aboriginal health. I'd like to think that occupational therapists with their practical skills and their ability to share their human realization of what Aboriginals are dealing with could get involved with First Nations communities. That would really please me.

A: Lastly, do you have any words of advice for students in OT programs or people who are considering occupational therapy as a career?

SJ: Accountability is really important in everything. Within your curriculum, you want to know you're producing the best occupational therapists possible and you need to have consistency from one place to another. Continuing education, post graduate courses and short courses are vital to improving science based and best practices medicine. The best curriculum turns out the best therapists. Also, do research and publish your findings.

Let me end with a story. I remember thinking what does an occupational therapist have to write about? What journal would want to publish the findings? There were not very well known journals and occupational therapists felt shy about getting right out there and giving their message.

In 1975 when David went to Western University as the Dean of Law he encountered the same reticence to publish in his young colleagues. Many of them did outside work such as arbitration, rather than writing about the law. They didn't believe they had the ability to write articles worth publishing; and these were law professors! David brought Supreme Court Justices down to talk to them about the need for research in law, family law and other subjects. He also brought publishers in so they could talk with them personally. We used to go running around the campus and look up at all the windows that were unlit on a Friday. Within two or three years, we'd go running and all those windows in the professors' offices were open, and there were lights on. It was winter time and the lights were on and they were up there working. That's because they believed in themselves, that they could actually study parts of the law and then publish and present it and people would be interested. It was just an incredible moment.

Occupational therapists need to do the same, to not be shy, know that they've got something to say and say it. So whoever's dealing with the occupational therapists should be there with their publishers and people who represent journals and get their message out there. There's a big difference in journals and you want to get into the best journals you can and keep on moving up to peer reviewed journals. You're in a great profession.

Update from the COTF

Why it is important to donate to COTF

Individuals are regularly asked to donate to a variety of causes. Some of the causes are linked to family and friends, and those are the ones that pull at the heart strings.

In this busy world, it is easy to forget that there are other causes that merit donations. One of those causes is COTF. Why, you ask? To begin with, did you know that COTF is the only funding agency in Canada that exclusively supports research and scholarship for occupational therapists? That means COTF is the only funding agency that supports your profession – occupational therapy!

Without COTF, many occupational therapists would not have been able to enter the profession. Some of them would not have been able to complete master's and PhD degrees. Those who entered the world of research in occupational therapy would not have received that first grant that literally opened up the door to a career in research. In essence, COTF provides experience to occupational therapy researchers to secure grants from within their foundation before applying to larger ones.

Research ultimately benefits everyone. Who is everyone? Everyone includes each and every occupational therapist in Canada, and in the world, for that matter (clinician, researcher, student, manager, and the list goes on). Professionals in other disciplines can draw from the great work produced by these occupational therapists. And finally, each person is also impacted in a positive way, directly or indirectly, by the research that COTF funds. It improves daily living for everyone.

So, the next time you are thinking about making a donation, choose COTF! Support YOUR foundation!

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Please inform COTF of any contact information changes. In particular, if you have an e-mail address, please share it with COTF. COTF is using e-mail when possible to communicate with donors in order to be respectful of the environment. Updates can be made by contacting: amcdonald@cotfcanada.org or 1-800-434-2268 x226.