

Occupational Therapy Now

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Occupational therapy education and intervention in the developing world

Sonia Gulati



A CBR worker works in the classroom with Nandani who has cerebral palsy.

In the summer of 2001, I was selected as a participant by Queen's Project on International Development to work on a project that provided community-based rehabilitation (CBR) services to children and adolescents with disabilities living in rural villages in Southern India. I worked as a student occupational therapist within the Association of People with Disability's CBR program. The international rehabilitation development project took place in July and August 2001.

Rural community-based rehabilitation team in India

India is a developing country that is well known for implementing CBR to reach its disabled population⁷. India houses approximately one-sixth of the world's population⁸. Almost 41% of the population lives in impoverished conditions and approximately 60 million people are disabled^{9,10}. People with disabilities appear to struggle more in rural villages, urban slums and streets.

The rural CBR team included generic CBR workers, physiotherapy aides, social workers, teachers, a Canadian occupational therapist and myself (an occupational therapy student). The CBR team provided rehabilitation services to

children and adolescents with several disabilities and illnesses such as cerebral palsy, polio, visual and hearing impairments, speech impairments, feeding and swallowing difficulties, mobility impairments, severe contractures, problems with posture and positioning, and mental illness. As an occupational therapy student, I was involved in carrying out assessment and treatments within the children's homes and schools, educating team members and developing therapy plans.

Role of occupational therapy in CBR

To promote the role of occupational therapy, the CBR team was encouraged to utilize a client-centred approach, that is, to ensure that the experience and knowledge of children with disabilities and their families were respected while exploring needs and wants and setting goals. CBR workers were encouraged to use occupation in order to guide their interventions. For example, when providing therapy to children where the goal was to increase range of motion, CBR workers were encouraged to use personally meaningful and functional tasks rather than stretching exercises alone to increase range of motion. A significant amount of time was spent educating CBR workers and families regarding quality of life issues

Partner organizations

Queen's Project on International Development, a Queen's University, non-profit, student run, volunteer-based program, partnered with the Association of People with Disability, a non-governmental organization in Bangalore, India. Together these organizations developed an opportunity for Canadian occupational and physical therapy students to become involved in an international rehabilitation initiative that encouraged working collaboratively to improve the quality of CBR services in rural villages in India.

The Association of People with Disability is a reputable organization that was initiated over 40 years ago and over the years has grown to include the following eight programs: Urban Slum Outreach Programme, Home-Based Programme, Orthotic Appliance Centre and Physiotherapy Unit, Industrial Training Centre, Horticulture Training, Shradhanjali Integrated School, Communications and Fundraising Cell, and the Community-Based Rehabilitation Programme¹.

MISSION

*Queen's Project on
International
Development*

To assist developing communities in Canada and abroad in improving their quality of life by partnering student volunteers with locally established development organizations in order to implement and carry out jointly defined projects².

*Association
of People with
Disability*

Working to meet individual needs, create awareness, promote acceptance and integration, instil self-confidence and encourage self-reliance for benefit of persons with disability³.



Teenager in India maneuvers through town on a tri-cycle equipped with hand controls.

The CBR program, which started in 1987, is targeted towards children and adolescents with disabilities and covers over 10 villages in rural areas.

Community-based rehabilitation

The failure to meet the rehabilitation needs of the majority of persons with disabilities (PWD) through traditional health practices resulted in the development of CBR⁴. CBR has been defined as "a strategy within community development for the rehabilitation, equalization of opportunities and social integration of all PWD. CBR is implemented through the combined efforts of PWD themselves, their families and communities, and the appropriate health, education, vocational and social services. CBR empowers PWD to take action to improve their own lives and contribute rather than drain or deplete whatever scarce resources that are available, thereby benefiting all the community⁵." The World Health Organization recognizes "CBR [as] an appropriate, feasible, and economically approach to provide the most essential rehabilitation to the disabled population in developing countries⁶."

especially for children with severe disabilities. As a team, we worked to promote awareness and acceptance of disability, helped to improve the quality of life of children with disabilities and their families, and challenged societal attitudes to support a more inclusive community.

CBR activities that we promoted from an occupational therapy perspective included:

- engaging in activities of daily living assessments and interventions;
- providing physical rehabilitation (e.g., range of motion, strengthening and weight-bearing exercises);
- exploring sensory stimulations activities;
- addressing oral motor dysfunction particularly feeding and swallowing difficulties;
- promoting engagement in meaningful occupation as a means to enhance health (e.g., school-based activities and cooking);
- emphasizing the importance of play in therapy and in daily life for children with disabilities (e.g., with the help

Below a child supports himself with the walker while physiotherapy aides work on his standing position.



Teenager demonstrates a ground-mobility device.

of high school students low-cost toys were developed and incorporated into therapy sessions);

- assessing environmental barriers in the home and school;
- providing consultation on seating and positioning, and basic mobility aids and equipment (e.g., wheelchairs and ground mobility devices);
- making simple modifications and adaptations within the home and school (e.g., adaptive aids for the bathroom for children with poor balance or problems using traditional washroom facilities such as ground toilets);
- increasing community awareness regarding disability issues (e.g., recruited elementary school children to develop a drama that illustrated a day in the life of a mother who has three children with disabilities);
- helping to establish communication networks between CBR workers, families and health-care facilities.teaching simple rehabilitation techniques to CBR workers and families; and
- providing a informational and emotional support to families.

Six formal teaching sessions were developed for the CBR team: (a) sensory stimulation; (b) seating and positioning; (c) feeding; (d) communication; (e) fine motor development; and (f) normal development.

A teaching session on child development was developed for pre-school teachers and a session on pressure sores and seating was developed for urban slums outreach workers.

The CBR team engaged in ongoing discussions with program managers regarding strategies to improve the quality of CBR services.

An unforgettable experience

As a Canadian occupational therapy student working in a developing country, I quickly learned that there was no right or perfect way to provide rehabilitation services to the majority of individuals with disabilities. I developed a greater understanding of what it means to be an occupational therapist and what it means to be creative. I gained a special appreciation of the role of occupational therapy for persons with disabilities living in some of the most isolated and marginal-

As a Canadian occupational therapy student working in a developing country, I quickly learned that there was no right or perfect way to provide rehabilitation services to the majority of individuals with disabilities.

ized places in the world. Despite the numerous barriers (communication, distance and culture) the greatest challenge was coming to terms with being unable to respond to everyone's needs due to limited resources and funding. Upon my return from India, I realized the impact occupational therapy has on someone's life. After all, occupational therapy focuses on something that all community members understand — their daily life.

My international volunteer experience in India as a student occupational therapist furthered my interest to pursue research in the area of CBR in developing countries. Over the past several years, the profession of occupational therapy has grown all over the globe. As a growing profession, it's up to us to promote, market and educate others regarding the role of occupational therapy internationally. Occupational therapy researchers with specialized skills, training and dedication to working collaboratively have both an ethical and social responsibility to help explore and address the rehabilitation needs of persons with disabilities in developing countries.

Acknowledgements

This project was a valuable learning experience for all involved. The significant amount of work completed in India

would have been impossible without the tremendous support from the staff at Queen's Project on International Development and the Association of People with Disability, and the hard work and dedication of the entire rural CBR team. A special thanks to all the families who warmly welcomed us into their homes and lives.

About the author

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References

- ^{1,3}Association of People with Disability. (2001). *Association of people with disability* [Brochure]. Bangalore, India: Author.
- ²Queen's Project on International Development. (2001). *Queen's project on international development* [Brochure]. Kingston, Ontario: Queen's University.
- ^{4,5}International Labour Organization, United Nations Educational, Scientific and Cultural Organization, & World Health Organization. (1994). *Joint position paper on community based rehabilitation for and with people with disabilities*. Geneva: WHO.
- ⁶World Health Organization. (1982). *Community based disability prevention and rehabilitation services* (Report of the proceeding of an Inter-Country Workshop, February 17-28). WHO: Geneva, Switzerland.
- ⁷Crishna, B. (1999). What is community-based rehabilitation? A view from experience. *Child: Care, Health and Development*, 25(1), 27-35.
- ⁸United Nations Children's Fund. *At a glance: India*. Retrieved March 21, 2004, from <http://www.unicef.org/infoby-country/india.html>
- ⁹Dube, S. C. (1994). *Indian society*. New Delhi, India: National Book Trust.
- ¹⁰National Centre for Promotion of Employment for Disabled People, & National Association for the Blind, New Delhi. (1999). *Disability International*, 6(2), 12-13.

How to use an interpreter effectively

Jose Luis Gonzalez



Achieving appropriate communication between health professionals and clients can be a major challenge especially when cultural and linguistic differences are introduced. Cause, symptoms, risks and treatment of a condition may be appreciated differently by different individuals and cultures¹. Language barriers can also obstruct the occupational therapist's capacity to assess meaning, intention, emotions and reactions. However, working with interpreters, occupational therapists can better assess and treat clients from diverse nationalities and cultures who have varied customs, sanitary habits, beliefs and philosophical concepts.

Each individual tends to perceive and transmit the same information in different ways, causing the message to change in tone and sometimes also in meaning. The information could also be altered when it is transmitted through an intermediary. When this intermediary is not well-trained, the transformation of the message can be even more pronounced. Using a translator can also create a sense of dependence on the interpreter who is then seen by the client as controlling the conversation².

The occupational therapist must be able to detect these types of difficulties and take all necessary measures to transmit the message in the clearest and simplest way possible. Under these circumstances, the therapist must try to verify the client's answers by requesting the same information in different ways. However, posing each question two or more times is time-consuming and may create tension for a time-strapped interviewer. It is important that this tension not be inadvertently transmitted to the client and interpreter, thereby affecting the quality of the interview.

Beware of untrained interpreters

It is often believed that the ability to speak two languages is good enough to appropriately interpret in a professional setting. This error can lead to the use of health professionals from other fields, relatives, friends, or other clients — none of whom are familiar with the terminology and professional interpreting techniques. Furthermore, clients have objected to the breach of confidentiality when friends or relatives have served as interpreters.

Previous studies have revealed the possible distortion of information by the client's relatives, who may exaggerate or understate the client's symptoms³. These and other distortions and omissions result in messages that can be only partially understood or not understood at all⁴.

According to a 2003 research survey conducted in Ontario, 50% of occupational therapists surveyed reported the use of family members or untrained volunteers as interpreters. Furthermore, 29.8% responded that they would do what they could without an interpreter. However, there is mounting evidence that this practice poses risks that potentially expose providers to liability⁵.

Professional interpreters

Professional interpreters know that the occupational therapist is in charge of the interview. They know that they are there to provide essential assistance in translating and, when necessary, in providing specific information about the client's sociocultural characteristics. There should always be open communication between the interpreter and the occupational therapist.

... clients have objected to the breach of confidentiality when friends or relatives have served as interpreters.

Grasska⁶ provides an example in which the interpreter was crucial in revealing symptoms. During a consultation, the doctor did not find anything wrong with the client and was pleased with his good humour. At the end of the session, he announced that the patient was very happy. The interpreter, however, was able to point out that the client only laughed at things that were not funny or humorous. After this observation, the doctor checked the patient's medical records and found a history of mental health problems.

Some occupational therapists, who have used interpreters, have had to endure the frustrating experience of listening to endless exchanges between the client and the interpreter, only to receive the translation of a few ideas. This is often caused by the interpreter's desire to clarify the client's message. This can also be caused by the absence of an equivalent term in the client's language, requiring the interpreter to provide an explanation rather than a simple term. A professional interpreter explains what was happening so the therapist does not feel information is being withheld.

It is seldom that the therapist and the client express themselves in a brief and organized manner, or that they wait courteously for the interpreter to transmit the message. However, if everyone takes note of the process, the interpreter can do his/her job without having to constantly and abruptly interrupt the conversation⁷.

Another problem is the verbose style used by some people. Occasionally, the client's answer to a question turns into a long story, providing anecdotal information that complicates the interpreter's task. What the client finds of great significance may or may not be relevant to the occupational therapist but it is preferable for the interpreter to include the anecdotal information in the translation. If attempts are made to stop the client from producing this information, the client could become inhibited and lose trust.

Methods of interpreting

There are two main methods of interpreting: simultaneous and consecutive. For health assessment purposes, the best method is consecutive interpreting, in which short units of language are translated orally. This method is very accurate but it's slow and requires that the occupational therapist be aware that she/he should stop after one or two sentences to allow the interpreter to transmit the message.

We should keep in mind that note taking is an essential element of consecutive interpreting. It consists of noting on paper figures, names and some other elements to help the

interpreter remember the contents of the speech. The notes should be destroyed once the interpretation is finished to avoid any confidentiality issues with regard to personal information received during the course of the interpreting.

Recommendations

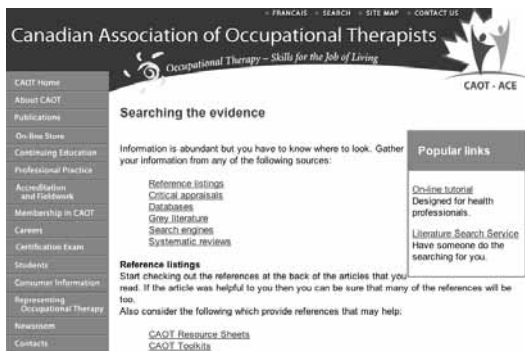
- Use an interpreter if you are not fluent in your client's language.
- Avoid using family members as interpreters.
- Familiarize yourself with the terminology used by your clients. Beliefs, practices and traditions are often alluded to indirectly or through special terms. The moral principles and beliefs can lead to an increase or decrease in the importance of certain symptoms or events.
- Use feedback to establish that the client has understood the message satisfactorily.
- Speak slowly and with an appropriate tone of voice. Remember that the more clearly the interpreter captures the message, the more accurately she/he can then transmit it.
- A good interpretation may require long explanatory phrases; therefore, you must be patient.
- Speak directly to the client, not the interpreter.
- Go over a section more than once if you sense a problem but receive a negative reply. Make sure that the interpreter knows exactly what you want. Use related questions, rephrase the sentences and get to the problem indirectly if necessary.
- Use short sentences. Technical terms and professional jargon should be substituted by plain speech.
- When long explanations are needed, divide them up to make sure that the entire message is translated.
- Avoid ambiguous questions or statements, abstractions, idiomatic expressions, similes and metaphors.
- Mentally organize what you will say to avoid confusing the interpreter with contradictions, conditional ideas or stumbling over words.

Conclusion

Knowledge of a single language imposes a special challenge to occupational therapists working with clients from other cultures. It goes beyond knowing what is involved when dealing with linguistic and cultural barriers to establishing an effective working relationship and good communication between the occupational therapist and the interpreter. Working

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Come visit us!



Both the CAOT and OT Works web sites are full of information to keep you up-to-date. Here are some new and popular destinations to check out.

- 2005 Conference: Pre-conference workshops, early bird registration fees and volunteer information.
- hOT topics – new reference listings on cultural competence and dysphagia.
- Information about the upcoming *CJOT* early electronic edition.
- New “one-stop” resource section with various fact sheets and a PowerPoint™ presentation on Careers in OT.
- Directory of occupational therapists’ Master’s theses and PhD dissertations.
- *CLINICAL REASONING...What is it and why should I care?* Look for it in the members-only area under publications.

Don't forget to visit the on-line store where you can order our latest paediatric publications. Gift certificates are also now available!

And on OT Works...
www.otworks.ca

- Back by popular demand: “Ask an OT” consumer inquiry service.
- Updated book reviews.

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closely together, they can overcome many of the challenges and ensure that the client is understood and can participate actively in his/her assessment and any resulting interventions.

About the author

Jose Luis Gonzalez, B.A. is an account manager for Exacta Interpreting and thanks the staff at Exacta for their support and suggestions in writing this article.

References

- ¹Kleinman, A. (1980). *Patients and Healers in the Context of Culture: An Exploration of the Borderline between Anthropology, Medicine and Psychiatry*. Berkeley, CA: University of California Press.
- ²Putsch, R. W. (1985). Cross-cultural communication. The special case of interpreters in health care. *Journal of the American Medical Association*, 254, 3344-3348.

- ³Marcos, L. R. (1979). Effects of interpreters on the evaluation of psychopathology in non-English speaking patients. *American Journal of Psychiatry*, 136, 171-174.
- ⁴Fredericks, C. (1998). Using non-professional interpreters in a multi-ethnic primary care clinic. *International Conference Critical Link 2*, May 19-23, Vancouver, BC.
- ⁵Lum, J. M., (2004). Meeting the challenge of diversity: Results from the 2003 survey of occupational therapists in Ontario. *Occupational Therapy Now*, 4, 13-17
- ⁶Grasska, M. A., & T. McFarland. (1982). Overcoming the language barrier. Problems and solutions. *American Journal of Nursing*, 82 (9) 1376-1379.
- ⁷Hale, S. (2001). “Excuse me, the interpreter wants to speak” – Interpreters interruptions in the courtroom: Why do interpreters interrupt and what are the consequences? *International Conference Critical Link 3*, May 22-26, Montreal, Quebec.

Employer-sponsored professional insurance: Is it sufficient?

Do you rely on your employer to provide you with professional liability insurance? If so, you may not be as sufficiently covered as you may think and you may want to ask yourself some very important questions.

Do you know the limits provided by their professional liability policy? Does that policy provide legal expense coverage? If so, what is the limit and is there a deductible? Will that policy provide criminal reimbursement defense costs?

In some provinces, professional liability insurance is a requirement for registration with the provincial regulatory authority – does the employer insurance meet the requirements set out by the regulatory organization?

If you have answered no to any of these questions, you may not be properly covered by your employer's policy.

A common misconception amongst occupational therapists employed in hospital settings or similar institutions, is that the professional liability insurance held by their employer is sufficient to cover their practice. They think that they do not need to purchase additional liability coverage through a plan

such as that offered through CAOT. It is true that employer insurance policies are required to cover malpractice insurance claims related to an employee's actions within the scope of their employment, however, members should be aware of the potential limitations within the coverage provided by their employers and the different scenarios in which an employer's policy will not apply.

Limitations on coverage through an employer

There are several scenarios in which your employer's insurance might apply, but there might be varying degrees of limitations on the coverage. For example, are the individual and aggregate limits on the insurance coverage sufficient and comparable to those offered through other plans? If you were named as a defendant, would you be assigned your own legal counsel? Would you be covered for legal representation if you were charged with a criminal act such as assault? Would the policy cover your actions if your employer decided they could not support your actions at the time of the incident? Would the policy cover legal representation for a proceeding before a regulatory College for a complaint or disciplinary hearing? In these situations, individuals without supplementary insurance would need to independently make up for these shortfalls, all of which would be covered by the CAOT Professional Liability Insurance Plan.

In addition to compensating for limitations on employer coverage, additional coverage protects you in situations where coverage through an employer would not apply at all. This includes volunteer work done outside the employment setting (e.g., teaching a course, participating in educational demonstrations), paid work conducted outside your normal employment (e.g., part-time private clients), or by providing professional advice outside of the employment setting.

— Willis Canada

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CAOT innovative practice award winners

What makes an occupational therapist innovative? We interviewed both our 2004 recipients, Susan Duff and Heather Cutcliffe. Here are their thoughts.

Susan Duff

Susan graduated from the occupational therapy program at Dalhousie University in 1988. She is presently the senior occupational therapist at Mill Lane Enterprises in St. John's, Newfoundland. In this position she is responsible for the clinical side of the operation where she matches the consumers' needs and choices with work that is available at Mill Lane. Mill Lane has a woodworking shop, textiles department and runs three recycling depots in the city. There are 150 consumers involved in the program, the majority of whom have a mental illness such as schizophrenia or bi-polar disorder. There are 11 full-time staff and six casual staff, some of whom are responsible for the clinical side and some of whom operate the Foundation which runs the business side.

How has being an innovator helped you in your career and/or helped others?

Being an innovator has helped me to push myself. When I started working in mental health there weren't a lot of opportunities for mental health consumers. This forced me to develop the program. There were no programs outside of acute care so the development of Mill Lane afforded people a workplace and a place to belong.

Who were the people who inspired you and how did they support you (directly or indirectly)?

Obviously the main people are the consumers. They were

coming and saying, "We really want something to do. We can't get jobs." The Health Care Corporation of St. John's has also been very supportive. They gave us a place in the community to operate, helped tremendously with human resources, rent and all the costs entailed in running a program of this size. Coworkers, in both the clinical area and the foundation, were also a support and an inspiration in that they decided we should get involved in recycling. Due to the chronicity of some people's illness, we required work tasks that were more physical. We looked to the community and there was the [recycling] idea that we captured and it fit both the business and the clinical side. [We] started in the 1980s for just the downtown neighbourhood as we thought that recycling would be a good business opportunity. Because we had a foot in the door, we eventually opened three, licensed depots in the city.

What other education/training have you received?

I worked for 10 years before I went to university. I did a BSc in psychology before I went into occupational therapy.

Pierre Trudeau described luck as the time when preparation meets opportunity. Would you agree or disagree with this? Why?

I absolutely agree with this. People say we were lucky but you know, it's because we saw the opportunity in recycling from a business perspective. [We] started working on it when nobody else was doing it and nobody wanted to do it. That put us in a good position and assisted us in setting up three depots. Luck isn't always just luck, that's for sure.

How have your feelings regarding the profession of occupational therapy changed over the years?

I went into occupational therapy because it was so practical — the whole thing was based on activity. However there was a part of me that wanted to go to OT school because I was embarrassed to think of OTs as basket weavers — the old



2004 CAOT innovative practice award winner

Susan Duff, continued

You can't do just what your job description says. I think occupational therapists should advocate for social change and try to push that whole area.

image of occupational therapy. When I went to school you do all the standardized testing, based on the scientific approach and you know what? I am right back to activity again. To me, that is the soul of occupational therapy. The government just did a survey around the province and what consumers were saying was... I want something to do. I want to be active. I want to be involved in something. It's really interesting to come right back to activity. That's how you get to know people. It's from standing beside them while they are mopping the floor, or while they are processing customers in the recycling area that people really talk. It just brings out so much. It's so important to people. It's so simplistic yet it's so complex. Sometimes we get students who say, "This is kind of old fashioned don't you think." By the end of the placement their perspectives have totally changed.

Describe your biggest challenge today?

To solidify the supportive employment part [of Mill Lane]. Not just getting the program up but we have to start meeting with the policy makers. There are so many restrictions, with respect to employment, for people with mental illness. They can only make so much per month or they are off their disability. If they relapse they have no money. We've lobbied for years and we have seen some policy changes. The allotment income has increased from \$20 per month to \$225. Now we have to advocate for policy changes surrounding income and compatible employment.

The other big challenge is to de-stigmatize mental illness in the community. Employers need more education about mental illness and consumers also need to be given assistance and support in meeting the challenges of employment. We just partnered with the Partners for Workplace Inclusion Program (PWIP). They come under the Canadian Council on Rehabilitation and Work. Getting this supportive employment sector in place is a huge development at Mill Lane. People who are coming here I believe work as hard and as efficiently as people who are in competitive employment but

they need support. Right now there are five people [in supportive employment] and we are starting a support group once a month, in the evening, to talk about employment issues, problem solve the best ways to deal with these, and generally create a supportive network for consumers who are in competitive employment.

What advice would you give someone who has reached a plateau in their occupational therapy career?

I think what's important is [to ask yourself] who are you working for; what do [these] people say they need; what is the best thing you can do. Advocacy is also a big issue — probably more so in mental health but perhaps it's the same in other areas. There are a lot of issues with long term progressive illnesses, from the quality of life that people enjoy, drugs that are covered, or not covered, programming for employment and things like that. You can't do just what your job description says. I think occupational therapists should advocate for social change and try to push that whole area. Sometimes we don't do it because we don't feel it's our role but if you are looking to improve quality of life then you have to look at all aspects of it.

What is the next step in your career?

I am taking 10 months off and travelling to South East Asia. From my work perspective, the big thing is supportive employment and advocating with government to make policy changes that will impact positively on people transitioning to employment. I think employment is really central to people's lives. It's how we define ourselves in lots of way. I love this work. I absolutely love it!

**For more information write to Susan
c/o Mill Lane Enterprises, 807 Water Street,
St. John's, NF. A1E 1C4 or
telephone: (709) 777-3400.**



2004 CAOT innovative practice award winner

Heather Cutcliffe



Heather (right) receives award
from 2004 CAOT President
Mary Manojlovich

Heather graduated from the University of Manitoba in 1978 and returned home to marry her childhood sweet heart and has practised happily ever after in Prince Edward Island (PEI). In her present position, Heather is the manager for three different departments: Physical Medicine at Queen Elizabeth Hospital (QEH) in Charlottetown, and the psychiatric occupational therapy program at QEH and rehabilitation services at Hillsborough Hospital. She is also the coordinator of the QEH cardiac rehab program and a clinician in the seating clinic. In order to ensure that her plate is completely full, she also works as the PEI fieldwork education coordinator for Dalhousie University. Heather says that she has always put her family first – both her personal and work family. We interviewed Heather to find out the secrets to her success.

How has being an innovator helped you in your career?

Because of my inquiring nature, I've always been someone who has not been afraid to pick up the phone and get information from other people — the who's who. When I look back, I'd say I was a doer and a risk taker. I am someone who likes to do things. I wouldn't necessarily describe myself as an innovator but when I see something that needs doing, I want to pursue it, I want to learn more about it. I've always been willing to work hard. I don't have to wait until things are perfect. Some people, I find, never take action because they are waiting for the all the I's to be dotted and the T's to be crossed. I am not quite that way. People that I work with would tell you that I ascribe to a "quick and dirty approach." This doesn't mean I haven't done my research or looked into things but that I feel comfortable enough to try things out and pilot them without having it to be perfect. I've been like this all my life. I am not afraid to make decisions and I am not afraid to live with those decisions.

I try to facilitate this with the people I work with too. If they come to me with an idea, I will give them the support they need to move forward with it. The same way I was mentored, or coached as I was coming up from being front-line. I don't know that I ever saw myself where I am now. When I came into OT, I really thought that I wanted to be the best clinician I could possibly be. As time went on, I seemed to move in different directions.

Who were the people who inspired you and how did they support you?

I can think of five. Of course my parents who supported me every step of the way including a train trip that brought my seven siblings to my graduation. Alfreda MacDonald, a high-school teacher who had a sister who was a physio. She thought I had a similar personality, liked working with people and might be interested in that as a profession. I went in to spend a day with a physio and lasted 15 minutes. That's when I first met Liz Townsend who has always looked out for me! From grade 10 on, I knew that was what I wanted to be. Everything was focused on becoming an occupational therapist.

When I came back to PEI there were a couple of people who have really influenced me. Margaret Anne Coles, whose clear thinking and logic I always appreciated. We started working here at the same time. She went the way of management much faster than I did but we always kept a good working relationship. She was great to bounce ideas off. My present boss, David White, allows me to be a doer and a risk taker. He welcomes my input and when I have something that I am really fighting for he is there supporting me. It's wonderful to have someone in a senior management position who provides that support and acknowledges your skills.

continued on page 14

I wouldn't necessarily describe myself as an innovator but when I see something that needs doing, I want to pursue it, I want to learn more about it.
I've always been willing to work hard.

What other education/training have you received?

Coming back from Manitoba in 1978 I didn't even have to interview for a job. I chose physical medicine instead of mental health. I went on to marry so returning to the University of Manitoba to do a degree completion was not an option. The school of OT at Dal didn't come into being until 1982. I did take the Canadian Hospital Association's department management program in 1991 and have taken lots of other courses for specific skills — clinical, management, leadership... that kind of thing.

Pierre Trudeau described luck as the time when preparation meets opportunity. Would you agree or disagree with this?

I would definitely agree with this. There have been a few times when the opportunity has appeared before I was prepared. But, for the most part, it seemed like these windows of opportunity opened up just when I was ready for another challenge. I went from a front-line clinician to a supervisor and then to a manager. Before I became manager of Occupational Therapy & Physiotherapy, I was seconded to be the risk manager and admin assistant to our CEO which was an eye-opening experience. I put in a lot of hours as the learning curve was pretty steep. It gave me more contacts within our health system and a bigger picture of the world. Up until that point, I was quite insular and focused on what we were about and not recognizing the importance of being a team member in the biggest sense in a larger health system. I learned a lot about systems and things — like how to do an impact analysis, how to gather information in defence of a complaint or legal suit, and how to start new programs. I realized by the end of the secondment that while I enjoyed the change, I preferred the work in physical medicine. When I finished the secondment, the systems were downsizing so I agreed to take on both OT and physio. Then, within a year and a half, I had OT, physio, orthotics, prosthetics, speech and psychiatry.

How have your feelings regarding the profession of occupational therapy changed over the years?

When I graduated I believed I was very client-centred and an expert. An expert in the sense that I would always know more than the people I was working with. What I've learned about myself, as I have become more experienced, not just as a clinician but in life experiences, is that I have become more

client-centred and much less concerned about who is the expert. When we first graduate we know all the theory but we don't have it well integrated and we haven't practised enough to develop clinical reasoning. I think I am a much better therapist now because I am much more in tune with what the client needs are and I don't have to be right. There is also a much broader focus on occupation today than when I graduated. The pieces of physical medicine were the pieces that launched me and spoke to my heart. I have a soft spot for the clinical piece.

Describe your biggest challenge today.

I tend to overcompensate for my lack of a degree after my name by working harder to prove myself. It certainly does limit my opportunities if I am looking for work outside the province. I have a personal challenge of procrastination. I am not a really bad procrastinator... I just leave it very close to the deadline. I am also guilty of spreading myself too thin. I am not always able to do the quality that I want in my own personal work.

What advice would you give someone who had reached a plateau in their occupational therapy career?

Look around, read journals, chat with colleagues, look at opportunities and have an open mind. Often when I am talking to a colleague who feels they may have reached a plateau we explore the situation and when we finish chatting we end up going away with something new. Networking is invaluable. It can have a ripple effect.

What is your next step?

I'd like to begin to take some courses. I'd like to expand and hone my repertoire of management skills. I think I will be doing something different in six years when I am 55 and for now, I'd like to carve what I do into a more manageable role for whoever comes after. I love what I do and I cannot imagine doing anything else that would have given me the same enthusiasm, satisfaction or opportunities. I have some great stories ... maybe I'll finally put them in writing!

You may reach Heather by e-mail at: hkcutcliffe@ihis.org.



Occupational therapists' roles in intensive care

Jill Foreman

The Intensive Care Unit (ICU) is a unique practice setting for occupational therapists. The acute state of the patients* in this environment not only influences what services an occupational therapist can provide, but also how these services are provided. In taking a position as an ICU occupational therapist, I was excited at the prospect of learning something new and was curious as to how my role in this setting would differ from other practice areas within the hospital. Unfortunately literature describing the role of occupational therapy in the adult ICU setting is both limited and dated^{1,2}. Therefore, I felt it would be beneficial to contact my colleagues with a survey to determine the current role of occupational therapy in the ICU setting.

Early in 2004, this informal questionnaire was sent to occupational therapists across Alberta and British Columbia in an attempt to define current service provision, frequency, types of referrals, types of equipment used with patients, as well as to describe the unique skill development and challenges in this setting. The information was meant to define a benchmark of current service provision; it is important to note that this data is descriptive information only. This data should be used as a platform from which to discuss "best practice" skills and services for occupational therapists working in an ICU. It should not be assumed to describe evidence-based practice of the occupational therapy role within the ICU.

*The term "patients" is used in this article instead of "clients" because the individuals who receive occupational therapy services within the ICU are typically passive participants in the therapy process.

Survey respondent and work setting description

Hospitals in Alberta and British Columbia were contacted to determine if their facility had an ICU, and if their ICU had access to occupational therapy services. Twenty hospitals met the above criteria: 8 in Alberta and 12 in British Columbia.

Seventy-five percent (15/20) of all surveys were returned (7/8 in Alberta, 8/12 in British Columbia). The majority of respondents (93%) worked in a medical-surgical ICU, with the next most common response being neurological, trauma or cardiac ICUs (67%). Other responses included coronary care ICU (47%), paediatric ICU (20%), and a general ICU (13%). Several respondents indicated more than one category of ICU in their facility. ICU facilities ranged in size from six to 30 beds (median = 10.5 beds) while cardiac care units were from four to 16 beds (median = 10 beds). The overall mean was a 12-bed facility. Most respondents worked in a setting with departmental funding (80%).

The variety in the amount of occupational therapy staffing in the surveyed ICUs was extensive. Some occupational therapists worked in their ICU on a full-time basis (27%), while other units had no assigned occupational therapists at all. In these units, referrals were distributed among multiple therapists depending upon their caseloads (27%).

Service provision and frequency

The majority (93%) of respondents received direct physician referrals (Table 1) and interacted with less than 10% of patients in the ICU at any one time (Table 2). The majority also have a caseload of between one and three ICU patients

Table 1: Referral sources

Referral source	# of responses	Percentage*(%)
Direct physician	14	93
Physiotherapist screens	5	33
OT screens all patients	2	13
Standing order	5	33
Other (nurses screen)	2	13

*Many respondents indicated more than 1 referral source.

Table 2: Percentage of patients seen by an OT

Percentage of patients seen in ICU	# of responses	Percentage (%)
1-10%	9	60
11-30%	5	33
>30%	2	13

Table 3: Caseload averages

Number of Patients	# of responses	Percentage (%)
1-3	9	60
4-6	3	20
7-9	1	7
10-12	1	7
13-15	0	0
Other	1	7

Table 4: Frequency of occupational therapy intervention

How often pt is seen	# of responses	Percentage (%)
Once only	1	7
Daily	4	27
2-3x/week	6	40
Weekly	0	0
PRN	4	27
Other (1-2x/week)	1	7

Table 3). Most occupational therapists provided both consultation and treatment services and saw their patients in the ICU between two and three times per week (Table 4).

Types of services provided

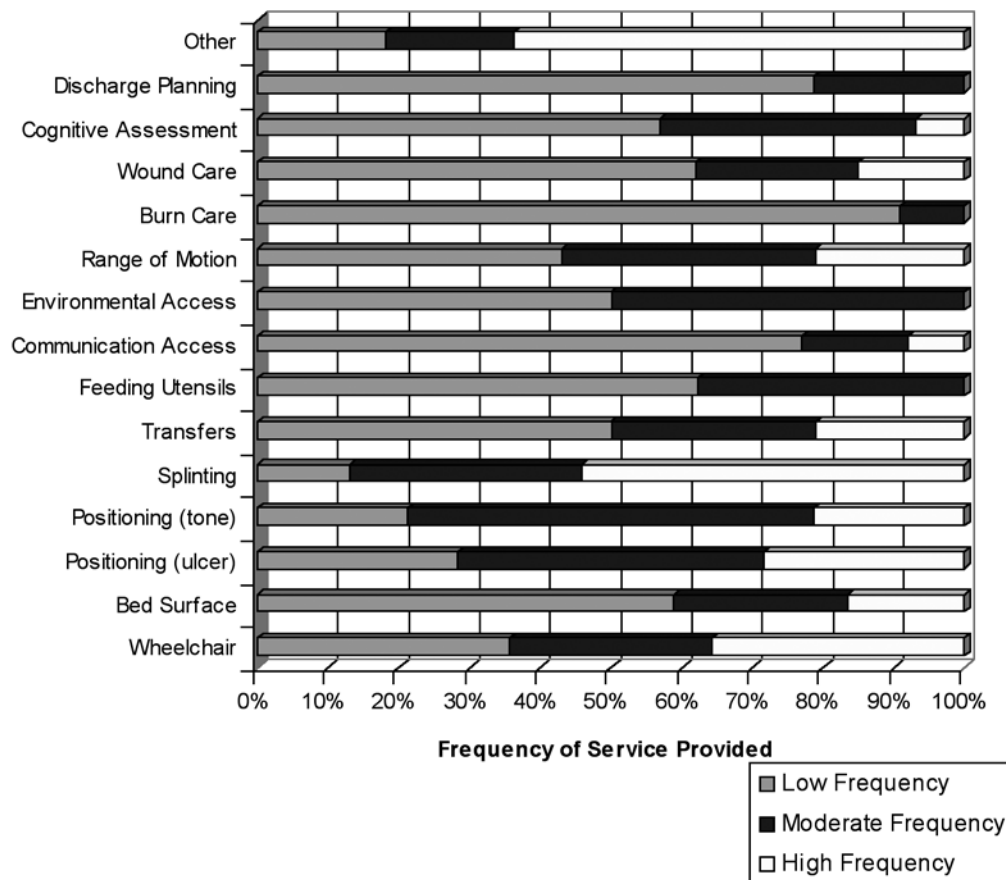
The respondents were asked to indicate how often they provided each of 15 different service types. This list of services was compiled by consulting with colleagues and by reviewing relevant literature. Therapists were asked to circle appropriate numbers corresponding to “never,” “seldom,” “sometimes,” “frequently,” and “always.” The responses were then grouped into high frequency (always, frequently), moderate frequency (sometimes) and low frequency (seldom, never) services (Figure 1). High frequency services included splinting and others such as dysphagia management, Philadelphia collar fitting, swallowing assessment, adapting clothing, relaxation techniques and orientation of occupational therapy role to other health-care professionals. Moderate frequency services included positioning to manage tone, positioning to prevent pressure ulcers, environmental access (e.g., specialized call bell, switches) and wheelchair provision. Low frequency services included burn scar management, discharge planning, communication tool placement/access, adapted feeding utensils, wound management, cognitive assessment/treatment, transfers/mobility, bed surface recommendation and range of motion exercises.

Equipment usage

Seating provision and bed surface recommendations may be a part of the occupational therapy role in the ICU. Recommendations for seating and bed surfaces are dependent on the available equipment and a therapist’s preference for specific products.

The most available type of seating system in the ICU environment was geriatric/cardiac chairs, followed by standard wheelchairs (Table 5). Therapists indicated their favourite seating systems were geriatric chairs and tilt-in-space wheelchairs, whereas their preferred wheelchair cushion types were ROHO and contoured gel (Table 6). The primary influence on the type of bed surface utilized was hospital contracts with mattress suppliers. Respondents often referred to KCI and Hill Rom instead of providing specific mattress choices. The most popular bed style recommended was a bed surface that could be converted to an upright chair configuration (Table 7).

Figure 1 : Frequency of occupational therapy provision in ICU



Unique skill development

According to the survey occupational therapists were effective in the assessment and treatment of patients in an ICU environment if they had developed skills in splinting, wheelchair selection/positioning and skin integrity management. Familiarity with specialized equipment, an ability to prioritize treatment needs and to offer creative and flexible solutions were also skills that were reported to increase effectiveness. Consultation skills identified as an important aspect of the occupational therapist's role included an ability to work within a complex team, to function in a medical environment, to demonstrate a broad base of knowledge and the ability to advocate for patient needs.

Challenges

Survey respondents described several challenges. These included coping with a lack of staffing leading to an inability to attend rounds, the challenge of receiving appropriate and timely referrals, the lack of understanding by other healthcare team members of the role of occupational therapy in the ICU, responding to a lack of compliance with therapist recommendations, working within a very acute medical/technical environment (e.g., lines, monitors), maintaining

Table 5: Types of seating available

Types of seating systems	# of responses	Percentage (%)
Geriatric/cardiac chair	14	93
Standard wheelchair	12	80
Hemi-height wheelchair	7	47
Recliner wheelchair	9	60
Tilt-in-space wheelchair	7	47
Other (total lift chair, neuro chair)	2	13

Table 6: Types of wheelchair cushions available

Types of wheelchair cushions	# of responses	Percentage (%)
ROHO	13	87
Contoured gel	12	80
Contoured foam	11	73
Other – basic foam	5	33
Other – wheelchair seating completed on wards.	1	7

Table 7: Types of beds/bed surfaces available

Types of Bed Surfaces	# of responses	Percentage (%)
Total care/chair beds	7	47
Sport beds	1	7
Magnum beds	1	7
Kinaire	2	13
First Step overlay	2	13

appropriate expectations for acutely ill patients and developing solutions for complex skin integrity challenges.

Future implications

The ICU setting provides a unique practice opportunity for occupational therapists in that it enables therapists to develop skills and provide services to patients who are acutely ill and therefore have complex care needs. The acute state of the patient in the ICU setting challenges therapists to problem-solve and adapt typical intervention strategies to suit the patient and the environment.

Occupational therapists are uniquely suited to participate within the ICU environment because of three key factors. First, our profession believes in providing holistic care to our patients. Therefore we are able to consider the physical, emotional, cognitive and spiritual implications of severe illness on the patient and their family. This framework allows us to provide education and support to both the patient and their family. Second, occupational therapists consider the person-occupation-environment interaction. In this case a very foreign medical environment exists in which the patient's personal control has been replaced by medical technology. The patient's occupation consists of mere survival. Therapeutic goals centre around performance components such as pain relief through joint positioning, passive range of motion and infection prevention through pressure ulcer prevention/management. Third, the skill of task analysis, which the occupational therapist brings to the health-care team, enables creative solutions for complex functional and positional problems for the patient. The occupational therapist is able to impact the patient's future by addressing performance components such as joint positioning, spasticity management and skin integrity through the provision of environmental aids, equipment and splinting. This increases the patient's safety and comfort, which, in turn, influences functional recovery potential for the future.

This survey has helped identify several of the challenges currently facing occupational therapists in the ICU and will hopefully serve as a starting point for further research into this area of practice. For example, what is the best practice method for skin integrity management in the ICU by occupational therapists? A prospective multi-site comparison of pressure reduction product usage and clinical outcomes would provide a foundation for evidence-based practice in this area. Also, how can we best define and promote our specific role within the ICU environment? This survey provides a foundation for occupational therapists to communicate with one another about our current role and the future development of best practice for occupational therapy within the ICU environment.

About the author

Jill Foreman BHScOT is a 2000 graduate of McMaster University. She has worked as an occupational therapist in home care and in the acute care sector. At the time of completing this survey she was working at the Foothills Medical Centre in Alberta. Jill is currently working for Renfrew Educational Services providing school-based occupational therapy. She can be contacted by e-mail at jforeman@renfreweducation.org or (403) 291-5038 ext.1227.

References

- ¹Affleck, A. T., Lieberman, S., Polon, J., & Rohrkemper, K. (1986). Providing occupational therapy in an intensive care unit. *American Journal of Occupational Therapy*, 40, 323-332.
- ²Foisy, C. (1997). Occupational therapy's role in ICU/Emergency. *Perspectives*, May/June, 5.

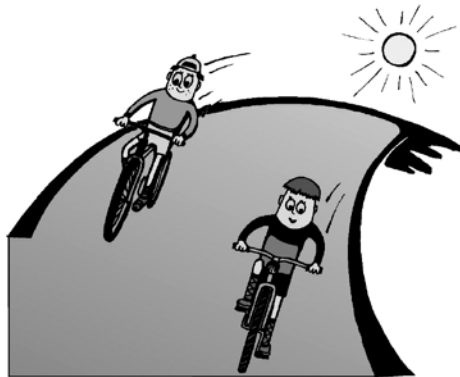


NEW AT WWW.CAOT.CA

Download these reference listings on:
Cultural Competence
Dysphagia

Enabling a sense of doing in children

Ann Zilberbrant & Angela Mandich



Roger, a 10-year-old boy, was referred to the Kid's Skills Clinic at The University of Western Ontario for intervention for his motor problems. He had been receiving therapy that focused on improving his balance and co-ordination for five years, but he still couldn't ride his bike, which is what he really wanted to do. Although Roger still lacked the foundational skills for bike riding, an occupation-based approach* was attempted and after 10 sessions Roger was a competent bike rider! His father recounts:

It was funny, one day he came up and I was walking the dog and Roger was riding ahead of me and we came up our street and there was a group of kids he knew standing there and they all shouted "way to go Roger, good riding, good riding." I thought that was great! He waved as he passed them and nearly fell off his bike because he let the handlebars go, he waved and he knew then he was very very good!


Not only did Roger learn to ride his bike but, as Roger's father explained:

It [learning to ride his bike] has helped his socialization and self-esteem. Just the way it has made him feel good about himself because he was able to do that. He's more adventurous in other aspects of it. I think having learned to ride the bike then he took ownership of it and moved on to trying other things. So that was good too because I see that as part of the independence and growth and you know he is trying to go outside more than he normally used to².

Like Roger, children learn by doing and participating in meaningful activities; it is this "sense of doing" and participa-

tion in daily activities that is crucial to their healthy development. Through participation in the occupations of daily life, children build their occupational repertoire, develop personal independence, become competent and participate in occupational activities. The World Health Organization (WHO) acknowledged the importance of participation within its new International Classification of Functioning, Disability and Health (ICF). The ICF points to the relationship of body function and structure, and activity to participation³. Classic developmental psychologists, such as Maslow and Piaget, have also recognized that participation is a basic human need for persons of all ages.

When working with children, it is especially important to focus on activities that contribute to the child's ability to participate in the typical occupations of childhood. When a mother speaks of her child's accomplishments, she refers to the occupational skills (e.g., riding a bike, tying his/her shoes, etc.) that allow him/her to participate in daily life at home, at school and with his/her friends. Occupational therapists working with children need to have occupational goals in the foreground of their interventional goals. Components such as midline crossing and bilateral coordination can form the background. The occupational goals of the child, whether tying shoes, getting dressed, printing, playing soccer or simply being able to play, must be the ultimate outcome of ther-

CSOS  Canadian Society of Occupational Scientists

Edited by Dr. Helene J. Polatajko, PhD, FCAOT and Jane A. Davis, MSc, OT(C) for CAOT and CSOS. Visit CSOS at www.dal.ca/~csos/index.htm

*The Cognitive Orientation to daily Occupational Performance approach was used⁹.

Occupation is a powerful tool for therapists.

apy, if children are to leave our interventions with a feeling of success. This focus on occupation and enabling occupational performance involves client choice, one of the most important aspects of setting meaningful therapeutic goals⁴. For some children, choosing goals may be an overwhelming task. For this purpose, occupation-based assessment tools are an essential component of the paediatric therapist's tool kit.

Occupation-based assessments

Paralleling the shift to occupation-based practice, a number of assessments have emerged that are focused on occupation. Some of these assessments are designed to elicit the parent's or teacher's perspective. One such assessment is the School Function Assessment (SFA)⁵, which can be used to identify the child's performance at a functional level. The SFA measures a child's performance at school and focuses on functional tasks that support his or her participation in the school setting. Completed by the teacher or professional who knows the student best, the SFA provides an assessment of the child's participation in different school contexts, including the classroom, on the playground and at mealtime or snack time. It also considers the equipment and transportation the child requires and the social relations of the child.

Others are questionnaires or checklists that require the child to be able to read and write or hold a pencil or pen, such as the Activities Scales for Kids (ASK)⁶. The ASK is a child self-report measure for children five to 15. It contains 30 items that are compiled into one overall summary score. There are nine sub-domains. The ASK inquires about the child's activities that happen at home, at school and on the playground. It has excellent reliability and validity and is a valuable tool for therapists.

Some, such as the Canadian Occupation Performance Measure (COPM)⁷, are based on interviews with the child. In the COPM, the child and/or the parents (if the child is quite young) are asked to identify occupational tasks to be worked on during therapy. Using a 10-point scale, the child rates the tasks on perceived importance, performance and satisfaction. The COPM can be repeated after treatment to evaluate perceived change in performance and satisfaction.

Others, such as the Paediatric Activity Card Sort (PACS)⁸, are based on pictorial representations. The PACS, designed to

be used alone or in combination with the COPM, provides the therapist with the current occupational repertoire of the child along with activities the child would like to do in the future. The PACS is designed to allow the child to pick activities, in which they participate, by looking through photographs while the therapist can elaborate and acquire more detailed information throughout the assessment and goal setting process. The PACS is comprised of photographs of typical children engaging in typical childhood occupations. These pictures assist the therapist in determining the child's level of occupational engagement and can be used for goal setting and intervention planning by paediatric therapists.

The importance of using occupation as the foreground and the components as the background is not only more motivating for children but is more effective in producing generalization, transfer and retention of desired activities⁹. There are many opinions, arguments and research that exist in the practice of occupational therapy. As evidence-based practitioners we need to evaluate the level of evidence presented as producing occupational outcomes. As professionals, we need to critically evaluate the evidence that we use to support our intervention strategies but also its effectiveness on occupation-based performance outcomes.

There is no doubt about it, that for Roger, bike riding has been a lifeline, a lifeline into the social community, and a lifeline so far as his self-esteem it has definitely grown. It sort of was a rite of passage, a real marker for him. It has built his confidence to do other things and to keep trying¹⁰.

This parent describes his child's learning to ride a bicycle as a transforming experience; not only did his child improve his motor skills but also his confidence, self-esteem, increased independence and opportunity to socialize with friends. Occupation is a powerful tool for therapists.

As occupational therapists we need to embrace the concepts of client-centred, occupation-focused and evidence-based practice. This is an exciting time in the growth of occupational therapy. By enabling the children we work with every day to reach their full potential through the use of occupation-based assessments and occupation-based enabling strategies, we help children like Roger develop occupational competence and participate fully in day-to-day life.

About the authors

Ann Zilberbrant, MScOT is an occupational therapist at the Yaldei Developmental Centre in Montreal.

Angela Mandich, PhD is an assistant professor, Director Kids Skills Clinical Research Lab, School of Occupational Therapy, The University of Western Ontario, in London, Ontario.

References

- ^{1,2, 10}Mandich, A., Polatajko, H., & Rodger S. (2003). Rites of passage: Understanding participation of children with developmental coordination disorder. *Human Movement Science, 22*, 583-595.
- ³World Health Organization. (2001). *ICF: International Classification of Functioning, Disability and Health*. Geneva, Switzerland: Author.
- ⁴Canadian Association of Occupational Therapists. (1997). *Enabling occupation: An occupational therapy perspective*. Ottawa, ON: CAOT Publications ACE.
- ⁵Coster, W. J., Deeney, T., Haltiwanger, J., & Haley, S. M. (1998). *School Function Assessment*. San Antonio, TX: The Psychological Corporation.
- ⁶Young, N. L., Williams, J. I, Yoshida, K. K., & Wright, J. G. (2000). Measurement properties of the Activities Scale for Kids. *Journal of Clinical Epidemiology, 53*, 125-137.
- ⁷Law, M., Baptiste, S., Carswell, A., McColl, M. A., Polatajko, H., & Pollock, N. (1998). *Canadian Occupational Performance Measure* (3rd ed.). Ottawa, ON: CAOT Publications ACE.
- ⁸Mandich, A., Polatajko, H., Miller, L. T., & Baum, C. (2004). *The Paediatric Activity Card Sort (PACS)*. Ottawa, ON: CAOT Publications ACE.
- ⁹Polatajko, H., & Mandich A. (2004). *Enabling occupation in children: The Cognitive Orientation to daily Occupational Performance approach (CO-OP)*. Ottawa, ON: CAOT Publications ACE.



Occupational Therapy — Building the skills for the job of living

National Occupational Therapy Month

Lauren Klump, CAOT Communications Coordinator

October 2004 marked our first National Occupational Therapy Month, a time to celebrate the profession's role in maintaining the health of Canadians. CAOT provided members with resources to help plan and promote OT Month — these included the perennial favourite O'Tea as well as fact sheets on workplace mental health, an on-line mental health quiz and a special issue of *Occupational Therapy Now*.

Using the theme of Mental Health in the Workplace, CAOT promoted Occupational Therapy Month to local media. CAOT member Adeena Wisenthal, a workplace mental health expert who contributed to the September special issue of *OT Now*, appeared on the Ottawa morning show "Breakfast @ the New RO," to promote workplace mental health. Members Bonnie Kirsh and Lynn Cockburn also co-authored an article that appeared on *Workplace Today*, an informational web site catering to human resource professionals.

CAOT would like to thank its members for their efforts in helping make our first OT Month a success. Based on upon our survey results, here is a small sampling of your OT Month activities that we hope will help spark ideas for next year!

- Corporate breakfasts and luncheons with educational components
- Displays in high-traffic areas
- Guest speakers
- Handouts
- Interactive games such as "Wellness Plinko" to raise awareness of occupational therapy
- Articles in local newspapers
- Open houses

CAOT member Siobhan Donaghy describes her OT Month experience in the next column. If you have any ideas or questions for next year, please don't hesitate to contact me at: lklump@caot.ca.

A month of success

With the opportunity to expand national occupational therapy celebrations from a week to an entire month, some creative thinking brought even more opportunities to provide education, celebration and fundraising for charity. With this year's theme of balance and leisure, occupational therapy staff at St. John's Rehab Hospital in Toronto promoted enjoyable wellness activities for hospital staff.

The month kicked off with a leisure walk that encouraged staff to take part in a free stroll around the picturesque gardens of St. John's and enjoy freshly harvested apples. Following the wellness theme, the occupational therapy staff gathered pledges and met for a six-kilometre walk on a nearby trail. Money raised supported the Canadian Occupational Therapy Foundation and Doctors Without Borders.

... occupational therapy staff at St. John's Rehab Hospital in Toronto promoted enjoyable wellness activities for hospital staff.

The educational component included weekly e-mails to staff with links to occupational therapy web sites and information on stress management, relaxation and life balance. The grande finale of the month was an overwhelmingly popular Halloween-themed pumpkin carving event. During their lunch hour, teams of staff competed enthusiastically to create the best work of art. The unique creations were judged by a panel of expert clients and then auctioned, bringing the fundraising total to \$1450!

With the support of colleagues, families, friends and commercial sponsors, St. John's was successful in promoting the values of occupational therapy and the importance of leisure and wellness while at the same time supporting two worthwhile charities.





News from the Foundation

Upcoming competitions

March 1

- OSOT Presentation Award (\$1,000)
- OSOT Multi-Disciplinary Presentation Award (\$1,000)

March 31

- Marita Dyrbye Mental Health Award (\$500)

April 1

- AAROT Research Award
- AAROT Research Education Award
- AAROT Research Presentation Award

For details and application forms, see the Grants section at www.cotfcanada.org.

Congratulations to the 2004 scholarship winners!

Mélanie Levasseur	Goldwin W. Howland Award (\$1,000)
Alison Douglas	Thelma Cardwell Scholarship (\$1,000)
Jane Davis & Sonia Gulati	Doctoral Scholarships (\$2,000 each)
Susan Nelson & Mari Basiletti	Master's Scholarships (\$1,000 each)

November 2004 COTF Board meeting

The COTF Board of Directors met in Ottawa on November 24. The following three significant changes were made to the Grants Program.

- Effective in 2005, COTF will no longer be offering Publications Grants because the Foundation's focus is research and scholarship.
- COTF will be channeling more funding towards scholarship and research, with more of an even distribution between the two.
- COTF will be increasing the total amount of funding for awards.

For more information, please contact Sangita Kamblé at skamble@cotfcanada.org or visit the COTF web site at www.cotfcanada.org.



From left to right: Bradley Roulston (Governor), Deb Cameron (Governor), Karen Yip (Treasurer), Sangita Kamblé (Executive Director), Sandra Bressler (President), Tamra Ellis (Vice President), Diane Méthot (CAOT President), Sandra Wittenberg (Executive Assistant) and Paul McFarlane (Governor).

Your support counts!

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OT Now – September 2005 Consumer Issue Call for articles

The Council of Canadians with Disabilities and other advocacy groups consider that their first priority is to provide resources and supports directly to people with disabilities to maximize independence and autonomy.

How, as occupational therapists, do we enable this? How do we support and advocate for inclusive occupations and occupational environments? What can we do to address the poverty that too many people with disabilities face?

We are looking for the following articles/stories for our consumer issue.

Overview of our role in enabling independence and autonomy.
This overview should include best practices and relevant research.

Success stories that demonstrate best practices.

Reflection/opinion pieces.

Please help to promote occupational therapy's role in creating a better world for people with disabilities by sending your story proposal(s) to the managing editor at: otnow@caot.ca.

The deadline for submissions of accepted articles is June 1 with final copy due July 1, 2005.

CAOT thesis directory

A wealth of information lies in master's theses and doctoral dissertations that may or may not be easily accessible. CAOT has begun to gather information regarding theses/dissertations that have been successfully defended by

occupational therapists within the past fifteen years. Please visit the CAOT web site to post your information and/or to access the most recent listings. If you have any questions, please e-mail otnow@caot.ca.

A kinematic and electromyographic comparison of two computer pointing devices

Leann Merla (leann.merla@lhsc.on.ca)

1998

MSc – University of Western Ontario

L'identification des facteurs qui vont favoriser la participation sociale des adultes présentant des séquelles de traumatisme cranio-cérébral

Claire Dumont (Claire.Dumont@rea.ulaval.ca)

2003

PhD – Université Laval

Dumont, C., Bertrand, R., Fougeryollas, P., & Gervais, M. (2003). Rasch modeling and the measurement of social participation. *Journal of Applied Measurement, 4*(4), 309-325.

Dumont, C., Gervais, M., Fougeryollas, P., & Bertrand, R. (2004). Toward an Exploratory model of social participation for adults with traumatic brain injury. *The Journal of Head Trauma Rehabilitation, 19*(6), 431-444.

Enhancing research utilization capacity in occupational therapy

Janet Craik (jcraik@nb.sympatico.ca)

2003

MSc Rehabilitation Sciences - University of Toronto

Craik, J., & Rappolt, S. (2003). Theory of research utilization enhancement: A model of occupational therapy. *Canadian Journal of Occupational Therapy, 70*(5), 266-275.

The technology-related recommendations of occupational therapists for students with handwriting problems: What they are and how they are made

Andrew R. Freeman (freebret@sprint.ca)

2001

MSc – University of Western Ontario

Freeman, A. R., MacKinnon, J. R., & Miller, L. T. (2004). Assistive technology and handwriting problems: What do occupational therapists recommend? *Canadian Journal of Occupational Therapy, 71*(3), 150-160.

Cultural issues & Canadian First Nations families: Implications for collaboration

Alison Gerlach (skillsforkids@shaw.ca)

2003

MScOT – San Jose State University, California, USA

Influence of parenting style on cognitive strategies Used by Preschoolers

Debra Linda Cameron (deb.cameron@sympatico.ca)

2003

PhD – University of Toronto (Ontario Institute for Studies in Education)

The relationship between hand strength and hand function

Jane Cox (jane.cox@lhsc.on.ca)

2004

MSc – The University of Western Ontario

Perception of experts on criteria for the assessment of the "dysexecutive syndrome" in everyday activities

Carolina Bottari (carolina.bottari@umontreal.ca)

2001

MSc Biomedical Science (rehabilitation option) – Université de Montréal

The measurement of function and social function in a community sample of persons with Alzheimer's disease

Anne Carswell-Opzoomer (anne.carswell@utoronto.ca)

1990

PhD – University of Toronto

Carswell, M. A., & Eastwood, R. (1993). Activities of daily living, cognition and social function in community residents with Alzheimer's disease. *Canadian Journal of Occupational Therapy, 60*(3), 130-136.

Spirituality and loss of functional autonomy in aging: Meaning given to occupation

Jennifer Griffith (jennifer.griffith@usherbrooke.ca)

2003

MA Gerontology – Université de Sherbrooke

Developmental Coordination Disorder: Exploration of a cerebellar hypothesis

Noemi Cantin (noemi.cantin@utoronto.ca)

2004

MSc – University of Toronto

continued on page 26

From the neck up: Quality in life following high spinal cord injury

Karen Whalley Hammell (ik.hammell@sasktel.net)
1999

PhD (Interdisciplinary Studies: Rehabilitation Sciences, Anthropology, Sociology) – University of British Columbia

Hammell, K. W. (2004). Quality of life among people with high spinal cord injury living in the community. *Spinal Cord*, 42(11), 607-620.

Hammell, K. W. (2004). Exploring quality of life following high spinal cord injury: a review and critique. *Spinal Cord*, 42(9), 491-502.

Resident-centred care and the quality of life of long-term care facility residents

Margot L. McWhirter (margotmcw@sympatico.ca)
2002

MA (Gerontology) – Simon Fraser University, Vancouver, BC

Impact of a participatory ergonomics education programme on work posture and general health status of heavy video display terminal users

Susan L. Street (slstreet@ca.inter.net)
2000

MScOT – University of Western Ontario

Street, S.L., Kramer, J.F., Harburn, K.L., Hansen, R., & MacDermid, J. (2003). Changes in postural risk and general health associated with a participatory ergonomics education program used by heavy video display terminal users: A pilot study. *Journal of Hand Therapy*, 16(1), 29-35.

Walking the labyrinth: Its impact on healthcare professionals in a hospital setting

Lorraine Fairbloom (lfairbloom@hotmail.com or lorraine.fairbloom@sw.ca)
2002

MA – University of Toronto (Ontario Institute for Studies in Education)

How consumers of community mental health services come to understand their potential for work: A grounded theory study

Rebecca Gewurtz (rebecca.gewurtz@utoronto.ca)
2004

MSc – University of Toronto

The test retest reliability of the Allen's Cognitive Level test

Andrea M. Brookson (andrea.brookson@sympatico.ca)
1997

MScOT – D'Youville College, N.Y.

A social perspective on the construction of occupational therapy in Japan

Michael K. Iwama (iwama@sent.com)
2001

Doctor of Philosophy (Sociology) Kibi International University, Japan Institute of Sociology, Graduate School of International Comparative Sociology

Iwama M. (2003). The issue is toward culturally relevant epistemologies in occupational therapy. *American Journal of Occupational Therapy*, 57(5), 582-588.

Iwama, M. (2004a). Occupation as a cross-cultural construct. In: Whiteford G., Wright-St. Clair (eds), *Occupation and Practice in Context*. Sydney: Churchill Livingstone, Elsevier.

Iwama, M., (2004b). Situated meaning: an issue of culture, inclusion and occupational therapy. In: Kronenberg F., Algado S.A., Pollard n. (eds), *Occupational Therapy Without Borders — Learning from the Spirit of Survivors*. Edinburgh: Churchill Livingstone, Elsevier.

Iwama, M., (2004c). The kawa (river) model; nature, life flow & the power of culturally relevant occupational therapy. In: Kronenberg F., Algado S.A., Pollard n. (eds), *Occupational Therapy Without Borders — Learning from the Spirit of Survivors*. Edinburgh: Churchill Livingstone, Elsevier.

Hearing voices: The pedagogy of mental illness in an occupational therapy curriculum

Joyce Tryssenaar (tryssen@mcmaster.ca)
2004

PhD in Educational Studies – University of Western Ontario

Recomposing their lives: Resettlement and women's participation in leisure

Melinda Suto (msuto@interchange.ubc.ca)
2004

PhD – University of British Columbia

Continuity of identity through meaningful occupation: The experience of older adults living in long-term care facilities

Staci Caron - now Kalmek (staci.kalmek@vch.ca)
2003

MSc Rehabilitation Sciences - University of British Columbia

A partnership model to transform a sheltered workshop to a consumer-run business: Reconstructing the work environment toward consumer empowerment

Debbie I. Radloff (gabriel@pccchealth.org)
1997

MSc Rehabilitation Sciences – Queen's University



Whatever you can do or dream you can, begin it. Boldness has genius, power and magic in it. (Johann Wolfgang von Goethe, German writer)

CAOT Learning Services

Continuing Professional Education

CO-HOSTED WITH CAOT

May 26-28

CAOT 2005 Conference: Celebrating diversity in occupation. Vancouver, BC. Co-hosted with the B.C. Society of Occupational Therapists. Contact: CAOT, Tel: (800) 434-2268, ext. 228; e-mail: conference@caot.ca.

ENDORSED BY CAOT

April 1-2

Return to Work: Building Blocks for Success. Winnipeg, MN. Contact: Carolyn Hay, The Positive Approach, P.O. Box 32, Fonthill, ON, L0S 1E0. Tel: (905) 892-8845; Fax: (905) 892-8845; e-mail: cmhay@iaw.com.

April 13-17

Specialized Techniques for Measuring Sensory Integration – Course 2. Saskatoon, SK. Contact: Judy Bodnarchuk, Events of Distinction, 104 – 2002 Quebec Avenue, Saskatoon, SK S7K 1W4. Tel: 306-651-3118; Fax: 306-651-3119; e-mail: eofd@sasktel.net.

May 12-13

A view from the floor: Integrating the neurological and emotional development of the child. Presenters: Beth Osten and Sherri Cawn. Hotel Ruby Foo's, Montreal. An optional clinical day will be held on May 14. Contact: Caroline Hui, OT, Tel: (450) 242-2816; Fax: (450) 242-2331; e-mail: carolinehui@yahoo.com

September-April

(Distance Learning)

1. Modern Management, 2. Continuous Quality Improvement for Health Services or 3. Risk Management and Safety in Health Services. Contact: Cheryl Teeter, Canadian Healthcare Association, 17 York St., Ottawa, ON K1N 9J6. Tel: (613) 241-8005, ext. 228; www.cha.ca.

ONGOING

Myofascial Release Seminars: Myofascial Release I, Myofascial Release II, Fascial-Pelvis Myofascial Release, Cervical-Thoracic Myofascial Release, Myofascial Unwinding, Myofascial Mobilization, Paediatric Myofascial Release. Various Canadian and U.S. dates. Instructor: John F. Barnes, PT. Contact: Sandra C. Levensgood, Myofascial Release Seminars, 222 West Lancaster Avenue, Paoli, PA 19301. Tel: (800) FASCIAL (327-2425); Fax: (610) 644-1662; e-mail: paoli@myofascialrelease.com; www.myofascialrelease.com.

WEB-BASED DISTANCE EDUCATION

Acquire an Expertise in Driving: Evaluation, Adaptation & Retraining. Bilingual Program. McGill University, in partnership with the Société de l'assurance automobile du Québec, the Ordre des ergothérapeutes du Québec and the Constance-Lethbridge Rehabilitation Centre (CLRC), has

developed this specific training program. The courses are accessible by Internet and some are complimented by practical workshops supervised by the CLRC staff. These courses will reinforce the professional expertise required to carry out evaluations related to safe driving abilities and how to use new technologies to adapt vehicles and retraining.

Dates: January-April; May-August; September-December. Provider: School of Physical and Occupational Therapy at McGill University. Contact: Isabelle Gélinas, PhD, 3654, Promenade Sir-William-Osler, Montreal, QC H3G 1Y5. Tel: (514) 398-4514; Fax (514) 398-6205; e-mail: isabelle.gelinas@mcgill.ca; www.autoeduc.ca.

NIDMAR COURSES 2005 Effective Disability Management Programs (Module A). Dates: on-line March 28-April 3.

Legislation and Disability Management (Module I). Dates: on-line May 9-22.

Workers' Compensation and Return to Work (Workshop Module J). Dates: on-line Feb. 28-March 6.

Insurance and other benefits (Module L). Dates: on-line April 18-24.

Disability Management in Unionized Organizations (Module N). Dates: on-line May 9-15.

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For information on how to register a CAOT endorsed course, call (800) 434-2268, ext. 231 or e-mail: education@caot.ca

CAOT endorsed courses, continued

Disability Management from a Human Resources Perspective (Module P).

Dates: on-line June 13-19.

Marketing and Education in Disability Management and Return to Work (Module U). Dates: on-line April 18-24.

Information Management (Module V). Dates: on-line May 2-8.

Job Analysis (Module E). Dates: March 15-20.

Provider: National Institute of Disability Management and Research (NIDMAR). Contact: Heather Persons, NIDMAR, 830 Shamrock Street, Suite 202, Victoria, BC V8X 2V1. Tel: (604) 736-2578; Fax: (604) 733-2519; e-mail: Heather.Persons@nidmar.ca; www.nidmar.ca.

Graduate Certificate Program in Rehabilitation Sciences (University of British Columbia and McMaster University). Five required courses offered Jan.-April & Sept.-Dec. each year include: Evaluating Sources of Evidence (RHSC 501), Reasoning and Clinical Decision Making (RHSC 503), Measurement in Practice (RHSC 505), Developing Effective Rehabilitation Programs, (RHSC 507) and Facilitating Learning in Rehabilitation Contexts (RHSC 509). For instructors, deadlines, program and course details please visit <http://rhsc.det.ubc.ca>.

Graduate Program in Post-Secondary Studies (Health Professional Education). Memorial University of Newfoundland. Centre

for Collaborative Health Professional Education and Faculty of Education. Tel: (709) 737-3402; Fax: (709) 737-4379; e-mail: edugrad@mun.ca; Internet: www.mun.ca/sgs/.

L'art de la supervision clinique.

Series of web-based workshops or in-person, two-day workshops (in French only). Provider: Consortium national de formation en santé and the University of Ottawa. Contact: Michèle Clermont, Consortium national de formation en santé. Tel: (877) 221-CNFS (2637); www.cnfs.ca.

April 21 Explorer les divers modèles de supervision
May 26 Apprendre à gérer les problèmes

Occupational therapists across Canada are Getting a Grip on Arthritis!

Sheila Renton and Sydney Lineker

Occupational therapists across Canada are involved in Getting a Grip on Arthritis®, a National Primary Health Care Community Initiative. This initiative, developed by The Arthritis Society and several partners, is funded through the Primary Health Care Transition Fund of Health Canada. The goal of the program is to improve chronic disease prevention and management, by increasing the capacity of primary health care providers and people with arthritis to work together to manage osteoarthritis and rheumatoid arthritis. Prevention, early arthritis detection, comprehensive care, appropriate and timely referral to specialty care, and self-management are emphasized.

One component of the program is a 9-hour workshop for primary health care providers who provide community-based care for people with arthritis. The content of the workshop is based on current best practices for arthritis care and is delivered by a multi-disciplinary faculty of local providers including occupational therapists.

If you are interested in attending a workshop or finding out more about the program, contact our regional coordinators.

Wendy McCrea in Alberta and British Columbia, wmc-crea@arthritis.ca; Iris Bussey in the Atlantic Provinces, ibussey@arthritis.ca; Sheila Renton in Ontario, srenton@arthritis.ca; Sylvia Jones in the Prairies, sjones@arthritis.ca; and Jocelyne Gadbois in Quebec, jgadbois@arthritis.ca.

Visit www.arthritis.ca/gettingagrip or call (866) 668-7804.

Apr 8/9 Saskatoon, SK
Apr 15/16 Kamloops, BC
April 20/21 Quebec City, QC (French) (tentative)
Apr 28/29 Brandon, MB
May 7 Owen Sound, ON (tentative)
May 14 Ottawa, ON
May 26/27 Thompson, MB
June 4 Hamilton, ON
June 10/11 St. John's, NL
June 17/18 Prince George, BC

It doesn't take much to get everyone moving. Make a plan, set some goals, and have some fun!

Create indoor and outdoor play areas

Children need indoor space to run where it's safe and they can't break or damage anything. Make over rooms to encourage physical activity. For example, set your family room up as an exercise room with a re-bouncer in front of the television, a basketball net on the wall, a rocker board, skipping ropes, a chin-up bar, a rope ladder, boxing gloves, etc.! Outdoor spaces can also meet their needs with basketball and/or hockey nets, play structures, sand/and or water stations, tire swings, a tether ball, and the list goes on!

Find the time

Right after a meal, most kids have energy to burn. Crank up the tunes and dance your way around the kitchen during clean up time. Movement gives kids energy. A ten-minute game of tag or pick-up basketball before sitting down for homework will "wake up" your child, increase his concentration and he'll finish his homework faster. Keep a cap on homework. Most schools offer realistic homework time guidelines; learn about them and don't go over that time.

A principal in Ontario leads the whole school (teachers and students) in a daily, vigorous 20-minute walk around the schoolyard before afternoon classes begin. She has found that this not only gives the students 20 minutes of vigorous activity, it also helps to calm and focus them before class time.

Margy Fairbairn, OT Reg. (Ont.), is an occupational therapist with the York Region District School Board. She has four children who are always kept active and the whole family can be seen on weekends at the cottage, skiing, skating, tobogganing, swimming, hiking or hauling firewood!



For more suggestions and information visit Health Canada's web site and download their physical activity guides. www.phac-aspc.gc.ca/pau-uap/paguide/child_youth/index.html

© Canadian Association of Occupational Therapists
For more information on how occupational therapy can help you and your children play, visit www.otworks.ca or call (800) 434-2268, ext. 237.

Keep it simple

Try the 30:30 plan. Your child reduces his screen-time by 30 minutes and increases his physical activity by 30. Your child could wear a pedometer to measure the number of steps he walks in a day. Challenge him to increase the count each day.

Rethink our reward systems

Rather than...

"If you don't finish your dinner, there's no dessert for you and you can't go out to play!"

Put the dinner in the fridge, give your child two bites of the treat (if he asks for it), and send him out to play. If he comes in hungry after the play, offer the dinner or a healthy snack alternative.

Rather than...

"Jason, you have interrupted the class one too many times, you'll have to stay in for recess to finish your work."

Ask the teacher to make Jason do 10 pushups each time he interrupts the class. Recess may be just what Jason needs to burn off excess energy so that he can settle better in class.

Rather than...

"We have to stop the game. You are too out of control." If a few children are not managing their behaviour properly, they need to be removed from the activity. However, rather than have them sit out, set up a time-out area where they can do 25 jumping jacks, 20 push-ups or running on-the-spot while hitting their knees 100 times. Once they complete the time-out area activities, they could be invited back into the game.



Let's get moving! Strategies for increasing children's physical activity

Play is the number one occupation for children. It's important for their development in all areas including physical and mental health, social and communication skills, fine and gross motor skills and academic readiness. Unfortunately, play often competes with passive "screen time." Most homes have a variety of screen-based activities. If there's nothing good on TV, children can choose a DVD, a video game or a computer. And let's not forget the hand-held entertainment devices such as game boys™, IPODs™, cellular phones and palm pilots™. The list is endless and they all take time away from physical play.

Occupational therapists can help. They look at three things to help children become more physically active: the child himself, his occupations or activities and his environment.

By making changes in all three, they help children get enough exercise to prevent not only obesity but a variety of other physical and mental illnesses such as heart disease, diabetes and depression. Here are some ideas from occupational therapy.



The Facts

There are dramatic increases in the number of overweight and obese Canadian children.

1981	→	1996
11% of boys and 13% of girls were overweight		33% of boys and 27% of girls were overweight.
2% of boys and 1% of girls were obese		10% of boys and 9% of girls were obese

Age Sampled: 7-13 years
Source: Tremblay, M. S., Katzmarzyk, P. T., & Willms, J. D. (2002). Temporal trends in overweight and obesity in Canada. *International Journal of Obesity*, 26, 538-543.

Start with your child's ideas

Ask your child to list his favourite active activities and anything new he'd like to try. Suggest he consider activities to do on his own, with friends and/or with family. Remember that organized sports are only part of a child's active time and many activities don't have to cost anything at all.

Be a positive role model

Participate in activities with your child whenever possible. Set up a "walking pool" (rather than a car pool). Together, as a family, plan weekend activities such as skating, skiing, swimming, biking, walking or hiking and follow through.

please turn over