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Tel. (604) 536-4575 (BC)
e-mail: otnow@caot.ca

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Contents

VOLUME SEVEN • ISSUE THREE • MAY/JUNE • 2005

3 **Migraine — not just a “bad” headache: An opportunity for occupational therapy practice**

Discover a new avenue of practice with Cheryl Lake’s description and case study.

WATCH YOUR PRACTICE

7 **Ask a lawyer**

Jasmine Ghosn joins our team to answer your practice questions.

9 **Creating a sustainable and diverse occupational therapy workforce in Canada: Update May 2005**

Multi-faceted problems require multi-faceted strategies. Donna Klaiman and Claudia von Zweck provide an update on several projects, including the most recently funded project to facilitate the integration of internationally educated occupational therapists into the Canadian workforce.

CRITICALLY APPRAISED PAPERS (CAPS)

13 **Introducing a new column**

Coming soon to *OT Now*. Lori Letts is the new column editor of these peer reviewed papers. Read the details on how you can join a national advisory team, write a paper, or benefit from the CAPS.

14 **CAOT thesis directory**

15 **CAOT 2004-2005 mid-year report**

Occupational Therapy Now is indexed by CINAHL, OTBIBSYS and OTDBASE.

SENSE OF DOING

19 **Mothering with a disability: Listening and learning**

All mothers struggle with their perceived abilities to fulfill mothering occupations. Linda Del Fabro Smith suggests ways to burst the "Perfect Mother" myth.

22 **Increasing access to multi-level residential homes: An occupational therapy approach**

After several coroner's inquests into deaths due to poorly installed lifts, a group of 15 Quebec occupational therapists came together to develop guidelines to help educate everyone regarding the complexities of recommending home adapatations.

27 **News from the Canadian Occupational Therapy Foundation**

28 **Relief of Chronic or Resistant Depression (Re-ChORD): A clinical research program for chronic depression**

Occupational therapist Sandra Hale and colleagues describe this multi-discipline approach and research into treatment for depression.

32 **CAOT Learning Services — Endorsed courses**

The mission of the Canadian Association of Occupational Therapists (CAOT) is to advance excellence in occupational therapy.

Visit our web site at www.caot.ca for authors' guidelines and additional news and information.

Occupational therapist Pam Andrews is a facility planner with Vancouver Hospital. Occupational therapists bring additional insights into assessing accessibility.
See page 22.

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Migraine — not Just a "bad" headache: An opportunity for occupational therapy practice

Cheryl Lake

Imagine for a moment if you will, awaking in the morning with severe throbbing head pain that renders you unable to function. Even a slight movement worsens your nausea and pain. The morning sunshine peeking through your bedroom window and the usual household noises intensify your pain. You only wish that you could turn off the world around you, and for this headache pain to release you from its grip.

Understanding migraine

It is quite likely that you or someone you know has had the experience of a migraine attack (see Table 1). In fact, according to a 1990 Angus Reid survey, 3.2 million Canadians over the age of 15 years have been diagnosed with migraine. This figure is only an approximation, as it is largely believed that migraine is under-diagnosed or misdiagnosed in the general population. Migraine may be considered by some as a silent health epidemic that remains unrecognized, disregarded and misunderstood in society.

Migraine is believed to be a hereditary condition whereby one is prone to developing headache pain as result of a biochemical imbalance in the nervous system. Onset of migraine typically occurs from puberty through the early twenties, with incidence highest among women aged 35 and 45 years of age[1]. Furthermore, women are three times more likely to experience migraines than are men[2]. Migraine attacks can be triggered by a number of different factors, either alone or in combination, including hormones, food additives and preservatives, too much or too little sleep, stress, weather changes, exercise, and skipping meals to name a few.

Migraine is recognized by the World Health Organization (WHO) as nineteenth among the top twenty health conditions that contribute to years lived with disability (YLDs)[3]. Migraine disorders have been shown in population-based studies to have a significant negative impact on health-related quality of life[4]. The profound individual social and emotional costs of migraine cannot be accurately measured. From a functional perspective, many individuals experiencing migraine are unable to carry out their normal activities during an attack. The economic impact in Canada is significant, with an estimated cost of $500 million in lost productivity and 5.4 million lost work days per year[5].

continued

Table 1
International classification of headache disorders

1.1 Migraine Without Aura

A history of at least five attacks that meet the following criteria:

Duration of 4-72 hours

Two of the following characteristics:

- unilateral head pain
- pulsating pain quality
- moderate to severe pain intensity
- pain aggravated by routine physical activity

One of the following features:

- nausea and/or vomiting
- photophobia and phonophobia

Headache not attributed to another cause

Cephalagia 2004; 24(Suppl 1)[6]

Although not life threatening, headache pain, whether intermittent or chronic, impacts on an individual's ability to engage in their self-care, leisure and productive occupations.

A specialized multi-disciplinary program

The Calgary Headache Assessment and Management Program (CHAMP) is a unique three-year pilot initiative supported by Alberta Health and Wellness and the Alberta Medical Association. The program was the vision of Calgary-based neurologist Dr. Werner Becker, a recognized specialist in headache disorders. The objectives of the program include:

- delivery of health care resources in an efficient manner through the use of a multi-disciplinary team;
- reduce utilization of more costly health care resources by those with headache (i.e., emergency room visits);
- reduce the impact of disability experience of individuals with difficult headache disorders; and
- promote a health and wellness approach to headache self-management.

The target population for CHAMP includes adults who experience between eight and 15 days of migraine headache per month who are referred to the program by their family physicians. The program employs three consulting neurologists, a nurse coordinator, occupational therapist, psychologist, kinesiologist or other specialist.

Individuals are assessed by a neurologist, and a medical management plan is developed. Individuals are also seen by either the nurse, psychologist or occupational therapist for a more detailed assessment of lifestyle factors, including basic nutrition, exercise habits, sleep routines, posture, social supports, work status, sources of stress, etc. Based upon the needs and areas of concern identified, individuals are offered the opportunity to participate in various aspects of the program, including an education session as well as a variety of lectures and workshops. The majority of the program is designed to be offered in small group settings, providing participants with the opportunity to experience collaborative learning, support and understanding.

CHAMP places an emphasis on the importance of a self-management approach to headache disorders. The focus of the program is to encourage healthy lifestyle choices as a foundation for making oneself less prone to headache pain, and enabling individuals to be better prepared to cope with headaches when they may occur. CHAMP encourages individuals to develop individual management plans that include a balance of medication and non-medication approaches. They may explore and develop specific skills in the areas of migraine trigger investigation, pacing and energy conservation strategies, relaxation techniques, postural awareness and correction, ergonomics, stress management approaches, sleep hygiene and exercise.

An emerging role for occupational therapists

Although not life threatening, headache pain, whether intermittent or chronic, impacts on an individual's ability to engage in their self-care, leisure and productive occupations. As occupational therapists, we are well-positioned to work with individuals experiencing occupational dysfunction as a consequence of migraine disorders. The occupational perspective allows us to appreciate how compromised engagement in one aspect of occupational performance can create disequilibrium.

The Canadian Model of Occupational Performance (CMOP) describes the dynamic relationship between individuals, their environments and their occupations[7]. This model can be used to help conceptualize how migraine can compromise the interface between a person, his/her environments and chosen occupations. Individuals experiencing migraine describe how their headache attacks impact on the physical, cognitive and affective aspects of self. The physical features of migraine pain including pain quality and intensity, fatigue, hypersensitivity to light and sound, aggravation of pain by movement and activity further limit occupational performance. They may report that their migraine pain is so intense that it affects their ability to concentrate, and compromises their attention span during habitual tasks.

The affective impact of migraine is significant for many individuals. Depression is three times more likely in those individuals experiencing migraine[8]. Those with frequent and/or severe migraines may become withdrawn from their occupational habits and routines; they may feel limited control over their health, and often report guilt associated with being unable to participate in occupations within their work, social and cultural environments.

As occupational therapists, we have the theoretical frameworks and clinical expertise to understand the impact of migraine disorders on individual occupational performance. Frameworks that can be applied with this clinical population include occupational performance models, cognitive-behavioral approaches, psychoeducational models and narrative therapy. We can work with this population through use of daily occupations as a therapeutic medium.

The skills that the individuals learn in CHAMP include an occupational focus. As they explore migraine triggers, and their thoughts around their health and pain, we can help them to see how these thoughts may influence their occupational choices. On the flip side, we may also explore using occupations or adapting the ways in which the occupations are performed to decrease the occurrence and/or severity of migraine attacks.

Encouraging re-engagement and control over one's occupational choices and routines can help to shift the focus and perceived control away from headache pain.

Encouraging re-engagement and control over one's occupational choices and routines can help to shift the focus and perceived control away from headache pain.

With time, the role of the occupational therapist with the program has evolved to include both individual and group-based work, focusing on a health promotion and occupational performance perspective through education, development of self-awareness, specific skill development and individual support. It has become increasingly apparent that there is much potential and need for occupational therapists to work with clients with headache disorders to facilitate improved engagement in daily occupations and to thereby enhance health-related quality of life. Individuals experiencing headache disorders may not have access to a specialized multi-disciplinary headache program; however, occupational therapists are increasingly present in community and private practices to which these individuals may have access. As a profession, we must stop to evaluate the often overlooked impact of headache disorders on occupational performance, and work with these individuals to support enhanced engagement in occupations.

About the author

Cheryl (Hovell) Lake, BSc(OT) is a registered occupational therapist currently working with the Calgary Headache Assessment and Management Program (CHAMP) based at Foothills Medical Centre in Calgary, AB. Cheryl has been with the program since its inception in October 2003. She is a Dalhousie University School of Occupational Therapy graduate, and has been practising for six years. Cheryl has worked in private practice in Nova Scotia, as well as in acute care settings in Calgary. She can be reached by e-mail at cheryl.lake@calgaryhealthregion.ca.

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Case Study

Christine* is a 38-year-old married mother of three school-aged children. She works four days a week as an administrative assistant in a large law firm. Christine has had migraines since her adolescent years but in the last year her attacks have been more frequent and disabling. She also has a strong family history of migraine, including her mother, brother, two aunts, and maternal grandmother. She has been diagnosed with migraine without aura, and is currently experiencing 11 days of headaches per month. Her individual migraine attacks usually last for 24-48 hours, with some prolonged attacks of three to four days in duration. Her identified triggers include skipping meals, lack of sleep, red wine, unmanaged stress, neck musculature tension, fluorescent lights and her menstrual cycle.

Christine was assessed by the neurologist in the headache clinic and has been provided with both preventative and symptomatic medication suggestions. The following illustrates her Lifestyle Assessment completed by the occupational therapist and conceptualized within the Canadian Model of Occupational Performance.

PERSON

Physical

- moderate to severe left-sided head pain
- significant photo/phonophobia
- severe nausea with loss of appetite
- fatigue
- pain worsens with activity, therefore avoids

* not her real name

Affective

- frustration with sense of loss of control over self
- lack of motivation to participate in activities for fear will not be able to participate fully

(i.e., no longer goes to art classes because she missed several sessions because of headaches)

- guilt over missing work days because of headaches
- sadness and guilt that she may miss planned activities/ events with her children
- fear that there may be something malignant responsible for her headaches (i.e. tumor)

Cognitive

- reports impaired ability to concentrate and attend to tasks during a migraine attack
- difficulty with calculations and short-term functional memory during attacks
- describes that she thinks that she will never be able to manage her headaches
- does not think that she is a good employee because she has to miss work at least one day a month because of her headaches
- thinks that she should work through the pain no matter what, and when unable to do so, considers herself a failure

Spirituality

- has difficulty describing what spirituality means to her
- feels that the disabling nature of her headaches have "gotten in the way" of who she is and what she values as an individual

ENVIRONMENTS

Physical

- describes concern with potential migraine triggers in her workplace — including fluorescent lights
- reports that her workstation is small and uncomfortable to work in

Social

- cites that she does not initiate social activities with her friends as much as she used to
- describes having lost contact with some of her friends as her headaches became a more frequent problem

Cultural

- describes feeling less connected with her church community as she has been limited in her level of participation in activities

OCCUPATIONS

Self-Care

- reports that she is generally able to perform basic activities of daily living (BADLs) despite the presence of a migraine
- describes difficulty performing instrumental activities of daily living (IADLs), particularly preparing meals and managing finances

Leisure

- describes a loss of interest in her leisure activities
- enjoys watercolor painting, but reduced frequency
- avoids participation, as she feels she must reserve energy for work and family

Productivity

- misses one to two days of work per month because of severe headaches
- reports she does not feel as productive with work, family and community-related tasks as she once did

Recommendations based on identified occupational performance issues

- Christine joined a five-week self-management group which provided her with the opportunity to learn new skills. She focused particularly on pacing strategies and goal-setting. She discovered that by learning to better manage her energy with her daily occupations, she was able to avoid some potential trigger behaviors (i.e., overdoing it, skipping meals). Being able to identify realistic goals, Christine was able to re-engage in occupations that she had previously avoided, including her art classes. The experience in a group setting helped her to share and work through her frustration with the support of others having similar experiences. With the initial accomplishment of some of her goals, she felt a renewed confidence in herself and her ability to manage her headaches and engage in occupations.
- Christine has developed an awareness of how her body and mind respond to pain. She also learned relaxation strategies that she uses in both a preventative and reactive context. She particularly uses diaphragmatic breathing and visualization. These skills have provided her with a sense of control over her pain experience. This control has facilitated improved self-confidence and subsequent re-engagement in leisure and productive occupations.
- The occupational therapist visited Christine in her work environment and assessed her physical work environment and her performance of work tasks. Recommendations for postural correction were provided, in addition to recommendations for re-organizing her work tools, changing the lighting in her workspace and getting an ergonomic office chair.

Jasmine Ghosn, BSc (OT), LLB

Ask A Lawyer is a new addition to the Watch your Practice Column. If you have a question, please e-mail it to: otnow@caot.ca.

Jasmine has volunteered to answer three questions a year for us and we will choose those questions that could be the most beneficial for the majority of our membership.

Ask a Lawyer

Dear Jasmine,

The expectation for documentation of my services doesn't match the hours allowed. I am fed up with staying late or taking home client records to do my charting, but if I don't, I get behind and my supervisor and team members get annoyed. What is the minimal amount of charting that is needed?

Signed,
No-time-to-write.

Dear time-constrained occupational therapist,

Finding the time to create complete, accurate and reliable records has been a challenge for occupational therapists in a variety of settings for many years. I recall back in the mid 1990s, complaining of similar workload challenges imposed by cutbacks and restructuring. Reading case law on medical negligence was enough to scare me into putting more details into my charts while working as an occupational therapist for the summer after my first year of law school. Yes, it was fear of being sued that fueled my motivation.

Legal standards imposed by provincial/territorial occupational therapy legislation, as well as privacy and other laws governing hospitals, health-care organizations and other sectors (e.g. insurance) generally dictate the minimum requirements for documentation. These legal requirements can vary across jurisdictions and workplace settings, and may address content, forms to be used, electronic record keeping guidelines and frequency of charting. The requirements may also include:

(1) how to alter or change a record;
(2) how to permit access and disclosure of information to clients and third parties;
(3) how long to retain records; and
(4) how to secure, maintain and store health information and records, etc.

Legal standards are imposed for many reasons such as public safety, quality assurance, protection of privacy, and for the purpose of ensuring that evidence is available for legal proceedings before a regulatory body or the courts.

Sometimes, compliance with the minimum legal standards that are applicable to your workplace setting may not be enough to protect you as a health professional. This is especially true if these records may be part of your defence in a negligence law suit or a complaint with the regulatory body. Therefore, you should also be concerned about ensuring that your records will be sufficiently detailed for your own protection, as well as your employer's protection.

If you are ever in the unfortunate position of having to defend yourself, your evidence in support of your version of the events will generally come from three sources:

(1) your recollection.
(2) your explanation of what your usual practice is in similar circumstances; and most importantly.
(3) your documentation.

Evidence based on recollection is not always helpful, as many professionals don't always recall the client. Evidence on usual practice is helpful, but everyone knows that each client is unique. Your best defence is having clear, accurate, complete and detailed documentation. If your notes are sufficiently detailed, your memory can be refreshed, and you can rely on your notes to corroborate your verbal evidence.

Ideally, it is best to do your documentation as soon as possible, as courts have recognized that records generated contemporaneously with an assessment are more reliable than those generated sometime later, since a person's ability to recall events has the potential to decrease with time. Making the time to

Ask a lawyer, continued

document contemporaneously can also be a time-saving tip since you are more likely to prepare a better quality report than if you wait until a point in time when you may have forgotten some of the details or are required to go back to get the information again.

To assist in taking contemporaneous notes, some occupational therapists are using personal digital assistants, laptops, dictaphones and other electronic devices. While such technology may be helpful in storing information as it is obtained for the purpose of generating complete and accurate reports later on, there are obvious risks associated with security and protection of personal information. You must bear in mind that the obligation to keep the information confidential and secure continues to rest with you — the health care provider.

Some health organizations have adopted a charting by exception policy whereby it is not necessary to document everything that is done – only that which is not the usual. Such a practice can only work if all members of the team, including you, are consistent in their usual approach. A detailed policy defining what is the usual is worthy of consideration. A downside to charting by exception is that the patient/client may argue that the routine care claimed to be done by the health-care provider was not actually done. Then you are in the situation where credibility of the witnesses must be weighed and it is open to the adjudicator to determine whether to believe you or the client. Again, an incomplete record might be viewed as evidence that the work was not actually done, even though it very well might have been.

Charting is a mechanism by which team members communicate to each other. Not only is it important that you make the time to document, but it is also important that you make the time to review the records of others on your team. They, like you, are entitled to rely on the assumption that others on the team have read their notes.

Your clients might also want to rely on your records to prove their injuries in a legal proceeding. Although you may not be a party to such a proceeding, your written records may still be relied upon by others. If you are not called as a witness, your written documentation is the only information that an adjudicator will have from you, and the quality of your documentation becomes a significant reflection of your work.

In conclusion, you should always be aware of the legal requirements imposed on you and your employer regarding documentation. You should never be afraid to report any challenges in compliance to your employer as he or she should have a similar interest in compliance. Charting and record keeping should be a high priority task in your practice. You may want to be proactive by auditing your own records to identify any deficiencies. Also, while documenting, don't just think about meeting the minimum amount of detail legally required, but ask yourself: "What if this person were to complain about me in the future? What information should I include to protect myself?"

Jasmine Ghosn, BSc (OT), LLB, was an occupational therapist for five years before studying law. She now practises health law in Toronto and can be reached at Tel. (416) 985-0362 or e-mail at: jghosn@healthlawyer.ca.

The information provided above is not intended to be legal advice. Readers are encouraged to contact their provincial/territorial regulatory organizations for the specific legal requirements for documentation and other matters pertaining to client records. A list of occupational therapy regulatory organizations can be found on the CAOT web site in the contacts section.

Creating a sustainable and diverse occupational therapy workforce in Canada: Update May 2005

Donna Klaiman and Claudia von Zweck

CAOT recognizes that a sustainable and flexible integrated health human resources workforce (HHR) is essential to respond to the health needs of the Canadian population. All people of Canada should have access to the right professional at the right time in their community throughout their lifetime. CAOT believes that occupational therapy is an essential service and resource to promote health and support well being, and has developed a strategic HHR plan to ensure an effective occupational therapy workforce for the future. The HHR plan addresses the broad areas of supply, utilization, retention and career promotion.

Public policy facilitates HHR strategy

In 2002, CAOT identified a shortage in the occupational therapy workforce[1]. Since that time CAOT has undertaken several projects to move ahead with its HHR strategy and prepare for possible federal government support[2,3,4,5].

In 2005, the Government of Canada announced its commitment to the study and development of an effective health services workforce in Canada[6]. The Pan-Canadian Health Human Resources Strategy addresses interprofessional education for collaborative patient-centred practice; health human resources planning; recruitment and retention; and recognition of international credentials.

Strategic planning

In February 2004, CAOT brought together internal and external stakeholders to participate in an occupational therapy human resource planning exercise. This was jointly funded by CAOT and Health Canada. The Canadian Institute for Health Information (CIHI) was invited to participate in the planning process.

The internal stakeholder groups formed the HHR Leadership Group. This group contributed to the development of a comprehensive occupational therapy human resources plan and continues to provide leadership and strategic direction concerning human resources planning for occupational therapy. ***Moving Forward with Next Steps in Occupational Therapy Human Resource Planning: Summary Report***[7] details the health human resources plan, funding and partnership requirements.

The HHR Leadership Group is formed by representatives from:

- Association of Canadian Occupational Therapy University Programs.
- Association of Canadian Occupational Therapy Regulatory Organizations.
- Professional Alliance of Canada.
- Educators of support personnel.
- Canadian Health Professionals Secretariat of the National Union.
- CAOT.

Supply of occupational therapists

Gathering reliable data

In 2004, CAOT provided input to the CIHI on a proposed national minimum dataset for health providers in Canada. The resulting document, the ***Guidance Document for the Development of Data Sets to Support Health Human Resources Management in Canada***,[8] presents the results of the pan-Canadian consultation process aimed at identifying and validating priority HHR information needs and the related indicators. This document also identifies data elements that should be collected in a standardized method across Canada.

Successful lobbying by occupational therapy organizations throughout Canada has paid off. In September 2004, Health Canada announced that occupational therapists were selected for funding of the Health Human Resources Database Development Project. This Health Canada funded initiative will be coordinated by CIHI. Occupational therapy is one of five professions (occupational therapy, physiotherapy, pharmacy, medical radiation technology and medical laboratory technology) that were identified to be part of this five-year project.

continued

Beginning in October, the Pan-Canadian Awareness Strategy will focus on the establishment of relationships with targeted politicians at all levels of government.

The goal of this project is to develop a database of supply data for HHR planning. Formal meetings of the project began in February 2005. CAOT, representatives of the occupational therapy provincial regulatory organizations, and Stats Canada are part of the working team. Regulators are the primary data providers. CAOT may become the data provider for the Yukon, Northwest Territories and Nunavut as these territories are not regulated and do not collect their own workforce data.

Changes in entry-to-practice credentials for health professions

The transition to the Master's entry level represents another landmark in CAOT's history to ensure that Canadian graduates are well prepared for the practice environment[9]. CAOT will continue to research and monitor the change in entry-level credentials through the academic accreditation process.

Recently the Health Ministers approved a new approach for assessing proposals by professional associations and provincial governments for changes in entry-to-practice credentials for health professions. CAOT provided input to the consultation for this new process. According to the Health Ministers, this process will contribute to a sufficient supply and health professionals to provide timely and high quality care in Canada. The process will help governments determine whether a proposed change in credentials for entry-to-practice serves the interests of patients and the health care system. Quebec, having its own process, will collaborate on this initiative by supporting the ongoing exchange of information. Occupational therapists are not governed by this approach as the change to a Master's level entry was implemented before this process was adopted.

Working for increased funding

CAOT advocacy efforts will continue to focus on the issue of access to occupational therapy by the people of Canada. Current strategies are focused on improving interdisciplinary collaboration in primary health care. Primary health care is the gateway to the health care system and is Canadian's first contact for with regulated health providers. Interdisciplinary collaboration in primary health care delivery is necessary to attain better health outcomes, greater efficiency, increased job satisfaction and a more sustainable and stable national health system.

CAOT is one of ten partners leading a Health Canada funded initiative to develop a national framework and guiding principles to enhance interdisciplinary collaboration in primary health care. The Enhancing Interdisciplinary Collaboration in Primary Health Care initiative aims to have a significant impact upon the reform of the primary health care system in Canada by exploring conditions necessary for health providers to work together as effectively as possible to produce best possible outcomes for clients[10]. The Canadian Collaborative Mental Health Initiative is a second, two-year Health Canada funded national project that seeks to improve interdisciplinary collaboration in the provision of mental health services. CAOT is also one of the partners in the consortium of national organizations representing providers, consumers and families leading this primary health care reform project. The expected outcomes of the project include an analysis of knowledge and practice in shared collaborative mental health care, development of a charter that reflects a shared vision for collaborative mental health care principles, and identification of strategies to implement this shared vision[11].

Later this Spring and early in the Fall, CAOT will conduct a series of members' forums throughout Canada to consult on these two primary health care initiatives supported by Health Canada's Primary Health Care Transition Fund.

CAOT to launch the Pan-Canadian Awareness Strategy

Beginning in October, the two-year strategy will focus on the establishment of relationships with targeted politicians at all levels of government. We intend to influence the development of municipal, provincial/territorial and national policy on issues such as the importance of occupation for the health and well being of the population and recognition of occupational therapy as an essential service in key areas such as primary health, home, community and end-of-life care.

Integrated interdisciplinary HHR planning

Over the past 14 years, CAOT has been an active member of The Health Action Lobby (HEAL), a coalition of 28 national health and consumer associations and organizations dedicated to protecting and strengthening Canada's health care system. In the Fall of 2004, HEAL conducted a survey regarding the strategic significance of HHR planning. Three key issues emerged and will focus HEAL's HHR agenda[12].

- There is a need for a capacity-building among national health organizations on health human resources. This requires better internal data and research capacities, and

The other area of workplace disparity that has been identified by occupational therapists is caseload assignment and management issues.

an enhanced capability to work between organizations and other partners on where there is added value from an inter-disciplinary approach.

- National health organizations would like to see more meaningful and strategic engagement with governments on HHR issues, not just at the formative, fact-finding level but in the development and assessment of policy options as well.
- There is a need for a population health needs assessment. This could greatly benefit from a collaborative approach.

Retention

Workplace factors play a significant role in recruiting and retaining occupational therapists[13]. In response, CAOT developed a position statement on ***Quality Occupational Therapy Services***[14] which identifies strategies to attract and retain occupational therapists. The other area of workplace disparity that has been identified by occupational therapists is caseload assignment and management issues. CAOT has taken steps to address this through a Health Canada funded project to review best practices in caseload assignment and management, as well as their utilization and applicability to the diversity of occupational therapy practice in Canada. The report will be available after June 1, 2005.

Utilization

Occupational therapy support workers

CAOT recognizes occupational therapy support workers are an important component of the occupational therapy workforce. A recent CAOT review indicated large variations in the utilization of support workers across Canada by CAOT members[15]. CAOT will continue to collect and analyze this data to identify initiatives that will assist members with appropriate support personnel utilization. A new CAOT Support Personnel Practice Committee was established in the Spring of 2005 to help with this planning and to identify member services and resources that will assist support workers with their practice. Planned initiatives include the development of a new web site section and discussion board for support workers and updating of on-line support personnel education program listings in Canada.

Profile of Occupational Therapy Practice in Canada

This Fall, CAOT will initiate a review of the ***Profile of Occupational Therapy Practice in Canada*** (***Profile***)[16]. The ***Profile*** is used by CAOT for many important activities such as defining the blueprint for the national certification examination and expected outcomes of occupational therapy education for academic accreditation. Our 2005 review of the ***Profile*** will consider the integration of new information and models such as the ***International Classification of Functioning, Disability and Health*** for occupational therapy practice and reflect the continuum of skills and knowledge needed by the occupational therapy workforce to meet the health needs of Canadians.

Workforce integration of internationally educated occupational therapists

CAOT acknowledges that many internationally educated occupational therapists experience difficulties with integration into the Canadian workforce. Unfortunately, these human resources may be lost to the occupational therapy workforce unless this is addressed immediately.

In September 2004, Health Canada and Human Skills and Resources Development Canada (HSRDC) invited CAOT to consult regarding the government's initiative on Recognition of International Credentials.[17] With the support of the HHR Leadership Group, CAOT submitted a proposal and funding was recently received for a project that will analyse the issues that facilitate and challenge workforce integration of internationally educated occupational therapists. The leadership group will be nominating representatives from their jurisdictions to form a steering committee to guide the project.

Discussions with HRSDC and Health Canada are underway to secure funding for work to address the following identified issues:

- Standardized assessment of the credentials;
- Information for international applicants, prior to arrival in Canada, on the Canadian context of practice; and
- A bridging process to assist these professionals to become integrated into the occupational therapy workforce.

Career promotion

CAOT provides special features on its web sites for attracting high school and university students to consider occupational therapy as a career. A new Careers in Occupational Therapy powerpoint presentation was added to the CAOT web site that can be easily downloaded for members' use. Career Pathways in Occupational Therapy is a web-based project under development that will appeal to those seeking information on career change and career development based on occupational therapy skills and knowledge.

Conclusion

HHR research and planning are very complex activities and require the support of many partnerships to be effective. CAOT is pleased with the advances made in the development and implementation of its HHR strategy to date. HHR will remain a key strategic area on the Association's agenda. CAOT recognizes that Canadians value their health care system. They need reassurance that our national health care system will continue to be accessible and equitable. CAOT's current and future work is respected by its many partners, and will continue to contribute to the overall sustainability and ultimate reform of the health system for future generations.

About the authors

Donna Klaiman is the CAOT Director of Standards and Professional Affairs. You may reach her by Tel. (800) 434-2268, ext. 229 or e-mail: dklaiman@caot.ca.

Claudia von Zweck is CAOT Executive Director. You may reach her by Tel. (800) 434-2268, ext. 224 or e-mail: cvonzweck@caot.ca.

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Visit www.caota.ca for frequent updates on health human resources planning for occupational therapists.

Introducing Critically Appraised Papers (CAPs)

Supporting occupational therapists to use evidence in practice

A new column to be introduced in OT Now will help occupational therapists identify and apply research findings in practice. Therapists want to incorporate evidence into their practice, but face a number of barriers related to searching, appraising and applying the evidence. We hope to address many of these concerns in this new column edited by Lori Letts, Associate Professor in the School of Rehabilitation Sciences at McMaster University.

Therapists don't always have time to search for the most recent and best evidence.

An advisory group from various areas of practice is being recruited to contribute ideas and recent research articles of high quality for reviews. The articles will include randomized controlled trials, qualitative studies, systematic reviews and meta-syntheses of qualitative research that apply to areas of occupational therapy practice.

Therapists find some research articles long and sometimes need help identifying the most important features of the research and findings.

Critically appraised papers will begin with a synopsis of the research article being reviewed. A structured abstract will provide readers with an overview of the methods and results of the research.

Therapists need to work together to apply evidence into practice.

The critically appraised papers will include a commentary that will discuss the implications of the methods and results for policy and practice. The commentaries will be written by clinical experts in occupational therapy. As well, an on-line discussion forum will be organized for a short period of time following the publication of each CAP. This will enable therapists to discuss the application of the article in their own settings.

Therapists need to know that they can trust the synthesis of the evidence.

All CAPs will be written by methodological or clinical experts, or ideally, a combination. The papers will undergo peer-review prior to publication. These strategies should provide readers with confidence that they can trust the CAPs as a synthesis of a research article, and as a source to consider how the evidence may be applied in practice.

Interested? You are invited to:

- Recommend research articles to be reviewed in the column.
- Join the CAPs column advisory group – members will be sought who represent the diverse practice areas and geography of Canada.
- Volunteer to write a structured abstract or commentary within your area of methodological or clinical expertise.

Please complete the CAPs Interest Form on the CAOT web site or e-mail either: Lori Letts, CAPs Editor at lettsl@mcmaster.ca, or Mary Clark Green, Managing Editor, OT Now at otnow@caot.ca.

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.

Reliability and validity of a quality of life measure
Dawn Tunks (Laffey) (dlaffey@sympatico.ca)
1993; MA - Instruction and Special Education
Ontario Institute for Studies in Education

Supported employment program outcomes: The participants' perspectives
David Liu (dliu@cha.ab.ca)
2003; MSc; University of Alberta

The relationship between self-regulated learning readiness and the use of a deep approach to learning in a group of advanced occupational therapy students
Aliki Thomas (aliki.thomas@mcgill.ca)
1999; MEd); McGill University Department oF Educational and Counseling Psychology

Use of the Revised Bayley Scales of Infant Development with high-risk infants: Exploration of changes in scores and relationships between risk variables and performance
Karen Koseck (karen.koseck@grtc.ca)
2000; MSc in Rehabilitation Sciences; University of British Columbia

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Active, autonomous and responsible: A critical discourse analysis of contemporary newspaper constructions of retirees
Debbie Laliberte Rudman (drudman@uwo.ca)
2003; Doctor of Philosophy
Department of Public Health Sciences, University of Toronto

Clinical services for offenders with mental illness in the Correctional Service of Canada
Crystal Grass (grasscl@csc-scc-gc.ca)
2003; MSc Rehabilitation Science, Queen's University

"It is just a whole package": Life stories of women with non-progressive, congenital disabilities.
Jennifer E. Landry (jennifer.landry@sympatico.ca)
1999; MSc; The University of Western Ontario

Sensory processing in post-institutionalized internationally adopted children from Eastern Europe and Russia
Jennifer H. Smart (smartot@onlink.net)
2004; MSc; Dalhousie University

Participatory research for health promotion: Seniors organizing for a voice in the newly amalgamated city of Toronto
Lori Letts (lettsl@mcmaster.ca)
2002; PhD; York University

Power or partnership? Occupational therapy students and client-centred practice
Sheila V. Heinicke (sheinicke@sympatico.ca)
2003; MEd; Ontario Institute for Studies in Education of the University of Toronto

Assessing the effectiveness of sensory stimulation on individuals who have moderate to severe dementia
Rita Bakshi (bakshi@telusplanet.net)
2004; PhD in Occupational Therapy from the Steinhardt School of Education, New York University, New York

Consciousness, complexity and chronic pain: Exploring the occurrence and implications of incongruent beliefs about 'important' chronic pain treatment components
Cary A. Brown (cabrown@liv.ac.uk)
2005; PhD, Primary Care; University of Liverpool

Consumer initiatives in rehabilitation and recovery
Heather Boyes (heather.boyes@interiorhealth.ca)
2004; MA in Leadership and Training; Royal Roads University

Measuring client satisfaction with outcomes following an inpatient rehabilitation program: Is there a correlation with functional outcome measures?
Kathryn M. Flegg (kf3@post.queensu.ca)
2001; MSc Rehabilitation Science, Queen's University

CAOT 2004-2005 mid-year report

Executive Director Claudia von Zweck

What activities has CAOT undertaken since October 2004 to meet member needs for information, services and advocacy? It has been a busy year to date. Highlights of our activities are outlined below in relation to the Association's five strategic priorities.

STRATEGIC PRIORITY #1
Foster partnerships and alliances

Whenever possible, CAOT works in partnership with other organizations and groups to ensure our positions and advocacy efforts are well grounded and widely supported. Alliances with consumers, other health professions, policy makers and funders also help to make others aware of the role and importance of occupational therapy and the issues involved in the development and delivery of quality services. CAOT currently represents occupational therapy in over 30 coalitions, projects and task forces. Update reports of our work on these representational activities are available on the CAOT web site and in *OT Now*.

Increasing our ability to provide occupational therapy services

CAOT continues to be heavily involved in ensuring a sufficient supply of occupational therapists in all areas of Canada. To do so means advocating for national health human resource planning for occupational therapy. CAOT spearheaded the development of an advisory committee with representation from the Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO), the Association of Canadian Occupational Therapy University Programs (ACOTUP), the Professional Alliance of Canada, health profession unions, occupational therapy support worker education programs and other relevant stakeholder groups. You may recall that CAOT produced a strategy document in 2004 for health human resource planning in occupational therapy. One of the outcomes was the continuation of this committee to oversee ongoing projects that relate to the appropriate recruitment, retention and deployment of the occupational therapy workforce. These projects include a multi-year initiative funded by Health Canada and coordinated by the Canadian Institute for Health Information to develop a human resource database for occupational therapists. Other projects address a review of approaches to develop caseload guidelines for occupational therapists, an analysis of issues faced by internationally educated occupational therapists who wish to integrate into the Canadian workforce and the planned development of a new section of the CAOT web site regarding career paths in occupational therapy.

Expanding the ways we deliver our services

CAOT also continues to work in coalition with other national groups on two major interdisciplinary initiatives to ensure occupational therapy is recognized as an essential service in the reform of primary health care in Canada. These projects have involved consultations with Association members across Canada on several issues. The discussions are designed to help reform the primary health care system and enable health professionals to work together effectively to produce the best outcomes for clients. Additional forums to discuss these projects with members are planned for later this year.

STRATEGIC PRIORITY #2
Market and advocate for occupational therapy

The Fall, CAOT will introduce a new Pan-Canadian advocacy strategy to establish relationships with targeted politicians and influence the development of municipal, provincial and national policy that recognizes occupational therapy as an essential service. Based on the successful model used for the 2004 federal election action team, volunteer members will be trained and provided with resources to develop an advocacy network across Canada. The goal will be to promote the value of occupational therapy in a continuum of services which includes primary health, mental health, home and community care, as well as long-term care and end-of-life care.

Occupational Therapy Month was celebrated in October 2004 and addressed workplace mental health, a leading cause of disability and productivity loss in Canada. OT Month activ-

Mid-year report continued

ities targeted employers and funders of occupational therapy services to increase their awareness of the valuable role we play in addressing the essentials of workplace mental health. CAOT activities included development of several promotional resources such as the special issue of *OT Now* on workplace mental health that was distributed to third party payors and employers across Canada. In 2005, CAOT will celebrate the theme "Yes – You Can!" during OT Month. CAOT will highlight the role of occupational therapists in promoting inclusion and diversity and breaking down barriers to occupation and participation.

The otworks.ca web site provides a valuable source of information to consumers and funders regarding occupational therapy services in Canada. Members may also download a number of resources from the web site to assist them in their representation and promotion of occupational therapy. New information was added to the web site, including OT Tips related to making snow removal safer and easier, and ways to encourage children to be more active at school and at home. The Ask an OT service was reinitiated to allow members of the public to ask questions of qualified occupational therapists. A free, downloadable new powerpoint presentation on occupational therapy as a career was also added to the CAOT web site in the popular Careers in OT section. Association members have used this for presentations at secondary schools across the country.

Strategic Priority #3
Create an evidence-based culture

CAOT has invested in many new initiatives to promote the development, dissemination and use of evidence in occupational therapy. The Association continues to provide an annual donation to the Canadian Occupational Therapy Foundation (COTF) to promote funding for research and scholarship in occupational therapy. Our partnership with COTF has resulted in the development of a new COTF research fund for critical reviews. These will be published in *Canadian Journal of Occupational Therapy* (*CJOT*) as systematic reviews and in *OT Now* as summaries of evidence to help communicate the value of occupational therapy to decision makers.

Enhancing on-line resources

Lists of completed thesis titles and author contact information are now available in *OT Now* and on the CAOT web site. A new section of announcements regarding funding opportunities from external research organizations will also be added to the web site, and the OT Researcher database was expanded to allow researchers to include a link to their individual web sites where further information regarding their research interests and projects may be found. Hands-on education sessions were held in several provinces to assist members to become familiar with the resources available on the CAOT web site for evidence-based practice, in particular Information Gateway. Our on-line resources will continue to be enhanced over the course of the next year with development of a new web portal for evidence-based practice, developed in conjunction with an occupational therapy international advisory group. CAOT assisted with funding for the development of this portal and to support the OT Seeker web site that provides access to systematic reviews in occupational therapy. A link to the OT Seeker web site is available for members on the Information Gateway of the CAOT web site.

Improvements to our periodicals

The new early electronic edition of *CJOT* was initiated this Spring to provide members with quicker access to papers that were accepted but are awaiting print publication. Changes made to the content and format of the journal have allowed space for at least one additional peer reviewed paper in each issue. Over the volume year, this is the equivalent of an entire issue of *CJOT*. A theme issue on occupation was published in December of 2004 and plans are underway for the next theme issue on outcomes for 2005. Beginning later this year, *OT Now* will publish summaries of critically appraised papers relating to occupational therapy. See page 13 for details.

Strategic Priority #4
Prepare members for current and emerging market conditions

New position statements were published this Spring on mental health care, driver rehabilitation and end-of-life care. A revised position statement on tele-health and tele-occupational therapy will also be published. These evidence-based position statements reflect input received from consultations with CAOT members and relevant stakeholder groups.

Several new CAOT publications were introduced including the *Paediatric Activity Card Sort* (*PACS*), the ***ADL Profile and Play***, and ***Children with Physical Disabilities and Occupational Therapy: The Ludic Model***. A face-to-face workshop was held in Alberta to introduce the new Ludic Model publication. A new fourth edition of the ***Canadian Occupational Perfor-mance Measure*** (***COPM***) will also be available later this spring as well as an annotated bibliography for the COPM. CAOT has initiated discussions regarding the development of a new companion publication to ***Enabling***

Occupation. It is expected that this publication will be available in 2007 for the 10th anniversary of the initial introduction of this benchmark publication.

CAOT continues to develop resources for self-employment in response to the growing trend of members who are moving to private practice. The revised self-employment toolkit will be posted on the CAOT web site for free member access, and co-sponsored workshops on the topic of getting started in self-employment were held in several locations. A third annual pre-conference workshop on private practice will be hosted by the CAOT Occupational Therapy Practices Committee. A session has also been added to the conference program this year to provide mentoring and advice to occupational therapists who are considering self-employment.

A new on-line database for continuing education will be posted later this Spring on the CAOT web site. This database will allow members to obtain information regarding professional development events and resources that meet their individual learning needs. The database has been developed with input from occupational therapy organizations in Canada including ACOTRO, ACOTUP, COTF and PAC.

Planning continues for our future conferences. The call for papers for our 2006 conference in Montreal "Evidence and occupation: Building the future" was recently circulated with a deadline for conference abstracts of August 1, 2005. A new CAOT Abstract Review Board will be used for the peer review of submitted abstracts. Our site visit was completed and planning can begin for our 2007 conference in St. John's, Newfoundland. Discussions are under way with the American Association of Occupational Therapy regarding a joint conference in 2008.

Conference 2005 promises to be a stimulating and fun-filled event with over 200 presentations, 47 exhibitors and 120 volunteers to help us "celebrate diversity in occupation". Co-hosted with the British Columbia Society of Occupational Therapists, the Conference will be held in Vancouver from May 26-28 and will be preceded by four workshops on topics ranging from cultural competency to sensory integration. These workshops and the Conference itself will provide you with an amazing opportunity to hear about the best ideas and newest innovations in occupational therapy practice and research. CAOT will host professional issue forums to discuss our primary health care projects, the use of clinical practice guidelines in occupational therapy, and our draft ethical decision-making framework. Information from this latter session will be used to revise the CAOT code of ethics and provide a new tool for members on the CAOT web site to assist their ethical decision-making.

STRATEGIC PRIORITY #5
Develop and promote standards and education

The Academic Accreditation Indicator Project concluded in the Fall of 2004 with the adoption of proposed indicators for the academic accreditation process. The indicators will provide factual information on each university occupational therapy program's level of attainment regarding accreditation standards. This will also allow reported results to be compared, including the trends over time and differences between programs to identify issues and quality-improvement initiatives. The new indicators will be used in conjunction with the existing accreditation system for all program accreditations, and will be formally re-evaluated after three years.

The CAOT Certification Exam Committee has undertaken several initiatives to assess the certification exam for unintended barriers which might disadvantage internationally educated occupational therapists, including a review of exam items which yield lower scores by internationally educated candidates because of culturally biased language. A pilot project to explore the application of plain language principles to exam vignettes and questions was also initiated.

To ensure knowledge of good governance practices, an education session on governance roles and responsibilities was held in November 2004 for the CAOT Board of Directors. A follow-up education session will be provided by Willis Canada in May 2005 on the topic of accountability and liability. The Board has fully integrated a risk management process and a policy audit procedure to minimize risk and liability for the Association and ensure compliance with outlined policies. Later this Spring, the Board will also complete an overall review of current CAOT policies and procedures regarding CAOT awards. The CAOT Board utilized feedback from our member forums held in 2004 across Canada to review and revise the CAOT strategic plan. The revised strategic plan will be presented for approval at the May 2005 Board meeting, for implementation in the 2005-2006 membership year.

The CAOT Board of Directors invites you to attend the Annual General Meeting in Vancouver on Saturday, May 28 to review the success of our many activities. Due to the positive financial results of our last fiscal year, it will not be necessary for CAOT to propose a fee increase for 2005-2006. We are also pleased to announce that the higher-than-anticipated attendance at Conference 2004 and a one-time savings in National Office expenses have allowed CAOT to meet its long-term financial goal of achieving six months of operating expenses in CAOT net assets at the end of this fiscal year. We look forward to meeting with you and celebrating the valuable work of CAOT in advancing excellence in occupational therapy.

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Mothering with a disability: Listening and learning

Linda Del Fabro Smith

My motherhood experience

I am a wife, a mother, an occupational therapist, a research assistant and a full-time graduate student. Of these roles, the one most difficult for me to describe is that of mother.

Recently I attended a workshop on parenting. The speaker told us that the main job of mothering was preparing to relinquish our children to the world. As a parent of a preschooler, I struggle with this idea, this *occupation of preparation.* On a daily basis, I wonder if I am encouraging his special gifts, if I am listening to his fears about holes in his bedroom floor in the early hours of the morning, if I am present for him. Certainly, with school, work and other adult responsibilities, I feel a sense of mother guilt: wondering if I ascribe to the myth of *The Perfect Mother* — this week's headline in Newsweek magazine.

The perfect mother achieves a balance between mothering and non-mothering roles. Mention this to any over-extended mother and you will get a knowing look. We juggle our own occupational goals, our family life, and our sense of responsibility to others, wondering if balance can be achieved. A friend relating her own experience with motherhood and working told me she was wishing for

> *… just a little bit more slack in our lives because right now, we have, like, every minute is accounted for, and I think the thing that makes me the most tired is that I'm constantly rushing from A to B, like I'm constantly rushing to the next thing — you know, it just seems like it's just endless."*

Thus the *meaning* of mothering, the stuff that keeps us up at night, is closely tied with how we struggle to *be* mothers; how we balance mothering occupations with our other roles. I found that I was not alone in trying to make sense of *doing* and of *being* a mother. When I asked mothers with and without disabilities, "Why did you want to be a mother," and "What is most important about mothering," they were inevitably stumped; some were stunned and speechless. Perhaps the occupations of mothering have hidden, unspoken meaning. As occupational therapists, we know the meaning of *being* and *doing* is difficult to describe, yet we recognize it when we have a moment of deep understanding and sharing with our clients during therapy in our role as therapist and enabler. These moments give meaning, self-worth and funnel our purpose — but are often indescribable.

Mothering with disabilities

I am currently studying mothers who have physical disabilities. Mothers care for children, teach them, and protect them; these are mothering occupations. Motherhood is also an identity with rich significance. Women with physical disabilities face challenges in the *doing* and *being* occupations of mothering. Challenges may include physical limitations, the ability to ask for and receive help, and dealing with others who may think mothers with disabilities are not able to suceed

CSOS Canadian Society of Occupational Scientists

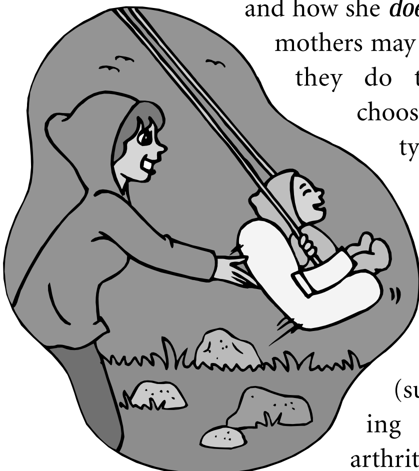
Edited by Dr. Helene J. Polatajko, PhD, FCAOT and Jane A. Davis, MSc, OT(C) for CAOT and CSOS. Visit CSOS at www.dal.ca/~csos/index.htm

as parents. These women may not be included in young mothers' support groups, invited to Gymboree™ or asked to participate in neighbourhood walks. Further, ***doing*** motherhood in an ordinary way within mainstream motherhood may be challenged; mothers may not be seen as practical problem solvers, but as mothers with limitations arising from their disability[1]. What can we learn from the voices of mothers? How do we listen to them describing their balance of occupations, and how do we make sense of the meaning of their occupations as mothers?

Learning from research

While there is research that describes the experience of mothers with a disability, it is limited and often given from a professional perspective. My historical review of recent literature revealed two reasons why this population has been overlooked: (1) Women's health has been neglected until recently; and (2) Disabilities were treated as the main problems, instead of looking at the disabled women's satisfaction with their motherhood roles and occupations. The result: limited knowledge about the experiences of mothers with chronic illness or disability, and how to enable them to best fulfill their mothering role. We are now starting to learn how mothers with disabilities experience their lives and make sense of their ***doings.***

Some mothers with physical disabilities characterize themselves as "just like other mothers," "not like other mothers," and "not like other mothers but OK to be different"[2]. Based on this, how a mother sees herself compared to other mothers affects how she carries out every action throughout her day, how she manages daily demands, and how she ***does*** motherhood. Some mothers may physically adapt how they do things, others may choose not to do an activity, still others may do it like any other mother does. If a mother loses an activity with her children that is fun and meaningful to her (such as no longer playing basketball due to arthritis in her wrists), she may experience dissatisfaction or sadness. The age of her children might have an impact on how she approaches mothering activities, such as physically demanding diapering or bathing. Some mothers may ask for help while others may not want to share this task, viewed as intimately entwined with their identity as mother. These factors influence the occupations that mothers plan and carry out.



Reid and colleagues[3] suggested that mothers may feel out of place when using a mobility device. Using a mobility device may have an important effect on how a mother feels welcomed and gains adequate support within her community, or changes the meaning of going out for a walk with small children. Research that describes mothers' challenges and strategies for coping helps us to gain insight into what it means for a mother to simultaneously manage her disability and fulfill her mothering occupations.

Listening to mothers with disabilities: Implications for practice

Moving out of the literature and into the clinical scenario, I feel we must come alongside each mother we meet with an active knowledge of the depth of meaning that the occupations of mothering may impart to her, as well as how she wishes to balance her roles. We need to understand that articulating the aspects of motherhood is not easy, but is usually very important to most mothers. Some health care providers have difficulty recognizing how mothering and disability are intertwined.

Meaning

The illness experience is as unique to each individual as is motherhood. As therapists, we need to be aware of the meaning mothering occupations hold and how a mother's self-perception influences her daily occupations. Practical questions may help: What do you feel when you are giving your child a bath? When is playing with your child a challenge? What activities are most fun for you and your children? How does your disability influence what you find satisfying during a day? Observe, ask and listen.

Balance and the mothering ideal

We can appreciate the demands, needs and values placed on mothering. We can also pay special attention to what it takes to achieve a balance of occupations. We need to understand how the planning of occupation is affected by differing abili-

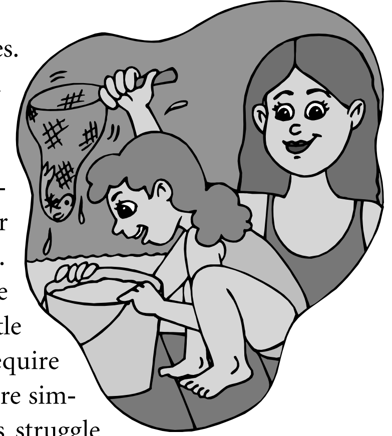
ties. How does a mother balance the energy needed for a trip to the park, knowing there is not enough left to prepare a meal in the evening?

Many mothers constantly judge their performance in daily tasks by comparing it to normal mothering, an ideal that is highly influenced by their specific culture and social environment[4]. This is not always a positive comparison. In a recent Newsweek article (February 21st, 2005), this mothering ideal is called "the phenomenon of manic motherhood". Do mothers with disabilities align themselves with the mothering ideal? Or do they have a different construct of what mothers do based on their own ideals? I have found that mothers with disabilities often say, "This is how we do things."

In one case, this was walking around a track and watching her children ride their bikes instead of biking alongside. It may be hard for women with disabilities to live up to the norms in their everyday occupations, but all mothers seek ways to engage in play and occupational activities with their children in ways that are constantly balanced with their own fatigue levels, responsibilities and tasks, despite what the ideal might be. As mothers we need to take this to heart, and not be so hard on ourselves. As occupational therapists, we should be aware of our own biases about childcare and family work. We should explore how mothers consider their disability, and in turn how this perception impacts the balance of a mother's day. In other words, how does her identification with her disability influence the planning and carrying out of occupation?

To restore balance, we often suggest informal and formal support. Support is only helpful if it fulfils specific needs identified by the parent/family, encourages adaptation and problem solving in occupations that are intrinsically important to the mother, and allows the mother to direct the care of her children in a satisfying way. We can examine the mother's occupations across all areas of self-care, productivity and leisure when considering practical help and community services.

Mothering is profoundly significant. In mothering we plan, organize, balance, anticipate, interpret and future-plan our activities, something Larson[5] labeled as orchestrating our role. I like this thought of conducting the family orchestra, deciding which section is important at which time, in order to achieve the desirable performance and melody. We should not hold up our offerings of motherhood to a motherhood ideal, the perfect mother, but try to come to peace with our own musical performances. The intense satisfaction we derive from being mothers should not be affected by our angry outburst at the dinner table or our sleep-deprived bodies. Each time we perform the piece of music it is a little different; some parts require more practice and some are simply stunning. All mothers struggle with their perceived abilities to fulfill mothering occupations. We need to listen, learn, and determine what holds intrinsic value to mothers, encouraging a mother's pride and a sense of belonging in meeting the challenges of parenting. We need to help mothers achieve a ***sense of doing*** mothering that matches the meaning they ascribe to that role. Are we listening?



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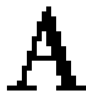
About the author

Linda Del Fabro Smith, Reg OT (B.C.) is currently a graduate student at the School of Rehabilitation Sciences, University of British Columbia, Vancouver, B.C. Her best days are spent with her three-year-old son, Hayden. Linda can be reached by e-mail at: delsmith@shaw.ca.

Increasing access in multi-level residential homes: An occupational therapy approach

Claude Vincent and Gisele Damecour


lthough the concept of universal access has been discussed for many years, it is rarely taken into account in the construction of private residences. Occupational therapists sometimes have to devise ingenious means to make it possible for people with disabilities to access their homes. Access from the outside and the inside, particularly between the different levels of a residence, poses various challenges and sometimes costly renovations. The role of the occupational therapist in this area is recognized by the funding bodies in Quebec, and the process is relatively well regulated by rigorous protocols and measuring instruments. However, the latter are sometimes difficult to apply in front-line services such as community access centres in Quebec due to both funding and time constraints. Quite often, the work of a front-line occupational therapist is limited to establishing access between the two levels of a home. Recently, fatal accidents caused by lifts in living environments[1] have made us re-examine our procedures in Quebec. A consultation team made up of 15 occupational therapists from the province discussed the issue of technical aids. A summary of the guiding principles of the occupational therapy process, the steps to follow and some solutions are proposed in terms of suitable walkways, access ramps, stair lifts and lifts. By following this process, funding agencies and other decision makers may better understand the reasoning behind the occupational therapy recommendations.

Literature

The occupational therapy process must take into account the client needs, their environment and their significant occupations[2]. In the literature we found standardized approaches for complete residential evaluation, using measuring instruments[3,4,5,6,7]. On the topic of vertical access planning alone, Martel and de Sart[8] propose various solutions (ramps, walkways, lifts) and the conditions under which they are applicable, without, however, elaborating on the process of identifying the client's specific needs. For instance, they specify certain features to which the occupational therapist must pay special attention, such as the dimensions of the floor of the vertical platform lift, types of levers and control buttons. Christiansen and Baum[9,10] emphasize that the occupational therapist is responsible for specifying which residential conversion features are required for facilitating vertical access for the client concerned, but do not specify the occupational therapy procedure to be used. In the literature accessible to the general public, there is technical information on walkways, ramps and lifts, together with the name of the manufacturer, model, use, type and product characteristics, e.g. hydraulics, dimensions, speed, controls, lock, etc.[11,12]. On the Internet we find the manufacturers and distributors of the products as well as technical information. The national building code stipulates that the ways to access different levels of a house must comply with standards set by the Canadian Standards Association (CSA) which include: Private Residence Lifts for Persons with Disabilities - CAN/CSA-B613-00[13], Accessible Design for the Built Environment - CAN/CSA-B651-95[14] and Lifts for Persons with Disabilities - CAN/CSA-B355-94[15]. CSA provides a framework for the standards required for overall accessibility of buildings and residential lifts in particular. In Quebec, the Régie du bâtiment (2005) publishes these standards, informs the public about them and ensures compliance within the public sector. Since January 20, 2005 a list has been available on the Internet of 16 home lifts for people with disabilities for installation in Quebec in compliance with the CAN/CSA-B613 standard.

Guiding principles of the occupational therapy process

The consultation team on technical aids proposes that the principles guiding the occupational therapy process in residential vertical access planning be based on the Canadian Model of Occupational Performance (CMOP)[16] and ***le Processus de Production du Handicap*** (Accessible Creation Process) (ACP) model[17]. The CMOP is a disciplinary model recognized in occupational therapy and is based on the interaction between the person, his environment and his occupations. This approach encourages the occupational therapist to make the needs of the client the focal point of the work. ACP is a generic model recognized in the field of rehabilitation and social integration for its universal nomenclature and definitions. It emphasizes the ***quality*** of the interaction between the person, his environment and daily activities: positive interaction facilitates social participation while negative interaction gives rise to dependence and/or isolation. Both models

encourage the occupational therapist to collaborate with the environment, i.e. with funding bodies and other participating parties that may come into the process to provide technical and architectural solutions. The abilities of the person and the environment are discussed in detail in the ACP model and allow for a comprehensive collection of data. The following sections describe an occupational therapy process and take into account personal and environmental factors as well as occupations including daily activities.

First interview

Ideally, the first interview is conducted in the client's home to see the actual physical challenges experienced. The client discusses his needs, his problems in entering or leaving his house, moving from one room to another and/or the difficulties in moving from one level to another. The occupational therapist makes a complete list of data to have a clear picture of the person, his daily routine and his environment.

The main diagnosis, prognosis and related conditions that may influence the person's movements inside and outside the house all constitute important information to be taken into account. All the person's abilities which may influence the movements on foot or in a wheelchair should be documented (motor, cognitive and perceptual abilities, behaviour, endurance in cases of sustained effort and temperature fluctuations).

Certain daily activities explain why some levels have to be made accessible. For instance, outside access becomes very important for a person who leaves his home regularly for medical treatment, work, school, leisure, and/or to participate in social and community activities. Internal access between the different levels is often necessary for daily hygiene or parental and household responsibilities. Mobility may be complicated by the transportation of additional equipment such as an oxygen tank. The presence and the capabilities of a guide or caregiver are equally important factors to be taken into account when looking for solutions. Table 1 lists all the information to be gathered on personal factors and daily activities.

Lastly, information related to the home is also recorded. Information should include a description of the urban or rural environment, the type of residence, the type of building, and the availability of alternative housing in the region which would provide easier access and better suit the client's identified needs. Information on the occupants, the financial implications of the residential conversion project and socio-economic considerations are also taken into account.

The occupational therapist may end the first interview by explaining the next steps and the need to carry out a more detailed evaluation of the environment with a view to finding solutions. The time required and details concerning funding of the residential conversion project are also discussed.

Evaluation in the home

The consultation team on technical aids recommends that certain daily activities be examined during the evaluation in the home. For instance, the occupational therapist must evaluate the client's mobility near the home, between levels and between rooms, his ability to transfer and access to bathroom and laundry facilities. The presence of a guide dog should be noted if applicable. Family members should also participate in documenting the client's daily activities.

Outside the home, the occupational therapist may use the ACP to note any particular details regarding the client's environment, such as the location of the house with respect to the road, topography (slope of the property) and the nature of the soil (gravel or other). Every access should be documented: the distance between levels (e.g. number of steps and their position), thresholds, balconies or landings as well as adjoining interior areas. The main access used by the client must be identified. Inside the home, rooms and household equipment considered important for the client's daily activities should be identified, as well as their location and size. The overall space available and its influence on vertical and horizontal movement is assessed. Alternatives such as relocation of a room or furniture, extension of a room, or moving must be discussed with the client and the caregiver before any proposal for facilitating vertical movement is made. Table 2 lists all the information to be gathered regarding the client's environment.

The information gathered during the occupational therapy process is generally documented in an evaluation and recommendation report on the residential conversion project and sent to the funding body. This report may then serve as a basis for other parties who will participate in seeking possible solutions, especially if such solutions prove to be complex. Other parties likely to influence decision-making may include a residential-conversion consultant, municipal authorities, the landlord of the building concerned, suppliers of equipment, and funding bodies.

Solutions for facilitating vertical access

The solutions outlined here were agreed upon by the entire consultation team on technical aids. They may help the occupational therapist in choosing among the possible alternatives for vertical access once the personal, occupational and environmental factors have been analyzed. These solutions are based on the clinical judgment of 15 occupational therapists qualified to evaluate abilities and skills necessary to facilitate vertical mobility (external access, internal access between two levels and external access to more than one level within). The solutions consider the type of vertical access and take into account the abilities and skills of the person. They comply with the CMOP and ACP models, which attach considerable

Table 1
Personal factors and daily activities to justify vertical access solutions

PERSONAL FACTORS

a) DIAGNOSIS, PROGNOSIS AND ASSOCIATED CONDITIONS:

Note the degree of severity:

- diagnosis justifying access modification.
- affected organic system(s): nervous, inner ear (vertigo, equilibrium), muscular, skeletal, cardiopulmonary (involving contraindication against physical effort) systems.
- prognosis: progressive, stable, aggravating factors, associated conditions.
- morphology: weight, height, posture, deformations.

b) ABILITIES (ABILITIES AND INABILITIES):

Note the level of ability:

- ability to walk or move in a wheelchair.
- motor ability: amplitude, strength and control of upper limbs; type of grip; amplitude, strength and control of lower limbs, if indicated.
- endurance in cases of sustained effort and variations in temperature.
- cognitive and perceptual ability (ability to operate a specialized device).
- Behavioural ability: person's ability to stay alone without risk or need for supervision (justifying access to the different levels of the residence, or degree of need for an attendant).

DAILY ACIVITIES / OCCUPATIONS
(involving movement from one place to another)

Note degree, frequency, level of difficulty and type of help needed with regard to the following:

- going out for medical care, study, work, leisure activities, social and community life.
- moving between levels in the residence for the following purpose:
    - personal care.
    - parental responsibility (children's room, family room).
    - domestic activity (laundry, carrying laundry baskets or shopping bags).
    - household maintenance (basic systems: heating, fuse box).
    - a significant activity (carpentry workshop, computer room, other).
    - transferring from a sitting to a standing position and from a sitting to another sitting position: specify the transfer surfaces.
    - moving from one room to another and from one level to another[note1].
    - moving outside on level or sloping ground (gradient), on stairs (riser height)[1].

[note 1] Specify the distances covered, the safety aspect, the use of mobility aids (volume, weight and dimensions), the presence of other equipment (oxygen tank, communication system) carried along when moving, and assistance by humans or dogs.

Table 2
Environmental factors to justify vertical access solutions

ENVIRONMENTAL FACTORS
Note facilitating elements and obstacles :

HOUSING
- rural, semi-rural or urban area.
- type of housing: private single family property, apartment (total number of units), other type of housing.
- administrative restrictions: landlord, tenant or co-landlord.
- type of building: bungalow, multi-level house, number of levels.
- availability of a more accessible accomodation in the region which meets the needs of the client.

OCCUPANTS OF THE SAME RESIDENCE
- presence of an attendant to help the patient move about (person, dog).
- abilities and limitations of the attendant (in using equipment, taking care of the client, snow removal…).
- number, age, occupation & tasks performed by the other occupants.

FINANCIAL AND SOCIO-ECONOMIC DATA
- support given by a funding body, modalities of such support (maximum amount disbursed for aid, acceptable number of rooms/levels, time necessary for conversion).
- landlord's ability and willingness to assume the total expenses or costs in excess of the subsidy granted for realising the conversion.
- additional maintenance or installation requirements (shelter) for the intended solution.
- ability and willingness to carry out such maintenance (e.g. snow removal) or to pay installation costs.
- aesthetic impact subject to requirements of municipalities and landlords.
- availability of equipment and its cost (new, second-hand, reclaimed or recycled equipment).
- customer service: reliability, guarantee, availability of a repair service
- estimated cost for implementing possible solutions and other intended conversion work.

ARCHITECTURE
- location of the building on the property, characteristics of the property (type of soil, slope, surface), seasonal influences.
- special characteristics of existing outside access areas: garage, patio, gallery, veranda.
- degree of rise in level in each of these areas (number of stairs, gradient, height of thresholds), available space.
- special characteristics of existing internal vertical access: characteristics of the stairs, i.e. length, width, curve, gradient), differences in levels.
- number and location of internal rooms to be made accessible to client, depending on the importance of his daily activities (e.g. bathroom or carpentry workshop in the basement).
- number and position of household furniture depending on the importance of daily activities (e.g. washer and dryer, computer equipment in the basement).
- available space inside home: present and future horizontal movement.
- possibility of relocating rooms and repositioning furniture to create more space inside, or of expanding outwards.
- complexity of the solution to be implemented, impact on other planned conversion work.

importance to person and environmental factors. The solutions must then be submitted to the funding body (unless the person is willing to pay privately) and building experts. In addition to the evaluation of the functional aspect and the architectural context, a practical look at economic and security factors relating to the solutions must be considered too. Presenting alternative solutions in an ascending order of complexity is wise. Occupational therapists should always consider the availability of space, the implications of year-round maintenance, the needs of the attendant (or caregiver) as well as accessibility standards.

Access from outside

1. If the client is able to move about and if his condition is relatively stable, he may perhaps be able to use the following:

- A walkway with landings, taking into consideration the number of stairs, their height, the distance to be covered, and the type of support required.
- A sloping walkway with a maximum gradient of 1:20, taking into consideration the entire distance to be covered. This solution can also be considered for wheelchairs.

2. If the client is in relatively stable condition, moves around in a wheelchair, has good endurance, is able to propel his wheelchair and move up and down a ramp as needed for his daily activities, then he may be able to use a ramp. The occupational therapist should consider both the capacity of the client (or of his attendant) and the properties of the ramp, i.e. the total length resulting from a given difference in level and a projected gradient.

3. If the client's condition puts him at risk when moving up and down steps, or if he requires assistance in using a wheelchair or other mobility device, and if the difference in level or the length of the ramp is too great, a lifting platform with a vertical path will probably be the preferred solution.

Internal access between two levels

1. If the client is in a stable condition, is able to move about by himself on each level and is able to transfer without assistance and maintain a safe sitting posture, a stair lift can be considered. Some modifications to the position of the chair might be necessary for the clients' safety and to prevent falls.

This solution works best with straight stairs or stairs with one curve only, and which are 91 cm (36 inches) wide. In Quebec, measurements must be validated by a residential-conversion consultant. If the client uses mobility aids which he cannot carry with him, (e.g. wheelchair, walker), they should be within reach of the client, on both levels, where the stair lift ends.

2. If the client is able to move about but cannot use stairs; if he is in a wheelchair or planning to obtain one in the near future; if he is able to operate it but not able to transfer without assistance, it is advisable to use a lifting platform with a slanting ramp. The dimensions of the staircase should: 1) be at least 91 cm (36 inches) wide; 2) have a clear height of at least 152 cm (60 inches) between the ceiling and the floor of the lifting platform along its entire length; and 3) have an approach area of 122 cm (48 inches) on the upper level as well as 137 cm (54 inches) and 259 cm (102 inches), depending on the access angle on the lower level. A folding floor allows a person who can walk to use the stairs.

3. If the client can walk but can't use the stairs; if he is in a wheelchair or planning to obtain one in the near future, but can't operate it very well; and if he cannot transfer without assistance, the lift with a vertical path would be the preferred solution. This alternative requires available space at every level in order to construct a closed shaft with approach areas. As a last resort, expanding the home to make space for it might be necessary if the space inside the home is not sufficient.

Access from outside and to more than one level inside

1. A lifting platform with a vertical path in a closed shaft with doors opening toward the inside and outside of the house, each with suitable approach areas, can be a good alternative.

2. Depending on the architectural requirements, it may be necessary to consider different solutions for external and internal access. Consider, for example, a walkway with landings or with a gentle slope, a ramp or a lifting platform outside, and a stair lift or a lifting platform with a slanting or vertical ramp inside.

Conclusion

This article has briefly outlined an occupational therapy process which provides the basis for creating vertical access in residential conversion, especially with respect to custom-made landings, access ramps and lifts. The forms (Table 1 and Table 2) are designed to help the occupational therapist when working with clients, funding agencies and other participating parties. Given that residential conversion is very expensive, objective and tangible arguments must support the recommendations. Finally, the solutions suggested in this article can be the basis for discussions with building experts who will examine the feasibility of the solutions proposed.

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continued

About the authors

Claude Vincent is a professor of occupational therapy at the Rehabilitation Department of the Université Laval and an FRSQ research fellow at the Centre interdisciplinaire de recherche en réadaptation et intégration sociale, at the Institut de réadaptation en déficience physique de Québec.

Gisele Damecour has been an occupational therapist since 1975. She specializes in adult physical disability rehabilitation and currently works as an administrative associate for the Programme d'adaptation du domicile at the Société d'Habitation du Québec. You may reach Gisele by e-mail at: Gisele.damecour@shq.gouv.qc.ca

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COTF and BCSOT will be hosting the Silent Auction on the evening of Thursday, May 26. We encourage those of you who are artistically inclined (artists, sculptors, potters, quilters, painters, craftspeople) to donate an item to the silent auction. We welcome donated items that are small enough to fit into a suitcase or that can be taken as carry on luggage. COTF welcomes all contributions and will provide a charitable receipt for the value of the items. To make your gift, contact skamble@cotfcanada.org.

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COTF's 3rd Annual Lunch With a Scholar, featuring Elizabeth Townsend from Dalhousie University, will be held on Saturday, May 28 from 12:30-2:00 p.m. Elizabeth Townsend is known internationally for her 25-year commitment to occupation-focused, client-centred occupational therapy. Her 1993 Muriel Driver Lecture on occupational therapy's social vision will be her starting point for raising critical perspectives on systems and gender. Dr. Townsend is also a founding COTF member. Enjoy lunch with a challenge. COTF will receipt $20 of the $50 ticket as a charitable donation. Order your tickets through the CAOT Conference registration form found in the preliminary program or online at www.caot.ca.

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Relief of Chronic or Resistant Depression (Re-ChORD): A clinical research program for chronic depression

Sandra Hale, Erin E. Michalak, Brenda Hayashi & Raymond W. Lam

The Relief of Chronic or Resistant Depression (ReChORD) program is considered an innovative study in terms of combining clinical practice and research, and takes a novel multidisciplinary approach to the treatment of chronic depression. It was initiated in the Mood Disorders Centre for excellence at the University of British Columbia (UBC) Hospital in Vancouver, British Columbia and will be completed in 2005.

Chronic depression

Major depression is a common medical condition that has severe consequences for both the individual and society. Although many people respond well and quickly to treatment for depression, some go on to develop a treatment-resistant or chronic illness. To be diagnosed with chronic depression, an individual must have experienced a major depressive episode lasting for at least two years. Community studies indicate a prevalence rate of 2% to 6% for chronic depressive disorders with higher prevalence in psychiatric outpatient samples[1,2]. People with chronic depression face high levels of disability, social problems and difficulties at work. They are also more likely to require medical attention, be admitted to hospital and attempt suicide.

Unfortunately, despite these serious consequences, chronic depression is not always treated optimally. For example, many people with long-term depression have never had a proper trial of antidepressant medication or evidence-based psychotherapy. Encouragingly, however, chronic depression responds well to treatment. Evidence indicates that both antidepressant medication and "talking therapies" are effective in treating chronic depression, and interesting new studies suggest that combining their two forms of treatment is particularly effective[3,4]. Although there are problems in a number of functional domains in chronic depression, little is known about the effects of a multidisciplinary approach to treatment.

The ReChORD Program

A musical chord is comprised of several notes played together in harmony. Similarly, Re-ChORD is a multidisciplinary treatment program to address the multiple problems associated with chronic depression. Re-ChORD is an intensive four-month outpatient program with three parts: (1) expert medication management; (2) group-based interpersonal psychotherapy; and (3) occupational therapy.

Expert medication management

Participants receive individualized medication regimens that take into account the numerous factors that contribute to response. Interventions follow Kennedy & Lam's[5] evidence-based recommendations but are individually tailored to the patient's treatment history, tolerability, concurrent medications, comorbidity, drug-drug interactions, adherence and compliance issues, and symptom profiles. These interventions can include augmentation strategies (e.g. lithium, atypical antipsychotics), combination antidepressant strategies, and other somatic treatment (e.g. light therapy) as necessary. Side effects are closely monitored, and issues affecting adherence are directly addressed.

Group interpersonal psychotherapy

Interpersonal stress is a common trigger for major depressive episodes. Social psychology literature documents the association between depression and social disorganization, lower social class, and marital discord[6]. Interpersonal conflict is the most common stress reported in population surveys and the most common psychosocial complaint in family medicine[7]. Whether a contributing factor to, or a consequence of, chronic depression, interpersonal difficulties are commonly found in people with chronic depression.

Individual sessions focus upon personalizing the application of skills learned in the group context in order to better target the issues identified by the client.

Interpersonal psychotherapy (IPT) is an evidence-based psychotherapy that helps people to identify a particular interpersonal problem area and to use practical strategies to deal with the problem. In Re-ChORD, IPT is conducted in an 8-to-10 member group to utilize group support and enhance the interpersonal focus. The IPT group provides 16 sessions designed to address the interpersonal issues associated with depression.

Occupational therapy

The Re-ChORD occupational therapists work collaboratively with the individual to identify the issues of greatest concern in his/her self-care, productivity and leisure. In other words, the occupational therapist determines how the person's depression has affected his/her life and ability to do the daily activities he/she wishes to do. In addition to these occupational performance issues, the occupational therapist also considers the emotional, social, cognitive and environmental context to the person's ability to perform tasks. Individual strengths and resources are incorporated into occupational therapy to facilitate recovery.

Both individual and group-based occupational therapy are provided. Individual sessions focus upon personalizing the application of skills learned in the group context in order to better target the issues identified by the client. Having the individual rank issues according to their importance establishes the motivation to work on them. He/she also attends group sessions designed to assist with skill development, connect with others who have similar issues and engage in activities to reach identified goals. Treatment groups provide an effective milieu for people with common struggles and treatment goals, and allow the individual to learn and practise new coping skills in an interactive environment. For those with chronic depression, group treatment approaches consistent with cognitive or interpersonal frames of reference find support in the literature[8,9]. The occupational therapy groups focus on skill-based sessions that integrate with the interpersonal psychotherapy group. These groups are described below.

The New Directions Group assists people to use cognitive-behavioural strategies to overcome occupational performance problems. Participants learn the inter-relationship between thought, mood and behaviour. Topics include illness management, balanced lifestyle, sleep, nutrition and exercise, understanding fear and anxiety, communication skills and time-management.

The Relaxation Group teaches participants a variety of active and passive relaxation methods. Strategies to apply relaxation in coping with stress and anxiety, and determining which techniques are most helpful in eliciting their own relaxation response, are also discussed in the group.

Because of the impact of chronic depression on day-to-day functioning, occupational therapy plays a much-needed role in the assessment and treatment of individuals in an outpatient program. Occupational performance issues are addressed through both one-to-one and group interventions in an individualized, client-centered approach. When combined with the Canadian Occupational Performance Measure, a relevant outcome measure tool used here, occupational therapy interventions and outcomes can be reassessed. This process provides the evidence for the ongoing evaluation and development of an evidence-based occupational therapy practice[10].

Random control study

The Re-ChORD program is designed to attack chronic depression from several clinical perspectives using a multimodal, multi-disciplinary approach. For any innovative program, it is essential to evaluate the program and determine if it is effective in meeting its objectives. Re-ChORD is being evaluated in a rigorous random-controlled trial. After a detailed assessment, participants are randomly assigned to one of three conditions: (1) 'treatment as usual'; (2) medication management alone; and (3) the full Re-ChORD program. In the 'treatment as usual' condition, individuals return to their referring doctor with recommendations for further treatment. In the medication management condition, participants are followed for six months by a psychiatrist in the Mood Disorders Centre for optimization of antidepressant medications. For both medication management and Re-ChORD conditions, participants return to their referring doctor for ongoing care after six months. All participants are seen by the research team every six months with reassessment and further recommendations provided for at least two years afterwards. Outcome measures include symptom scales, functional scales, quality of life measures, and health economic and utilization data.

This study will determine whether the multi-disciplinary treatment intervention of Re-ChORD is more effective than 'treatment as usual' or medication management alone in reducing the severity and impairment of chronic depression. The program has been designed to be as representative of

ReChORD continued

real-life clinical practice as possible. The information gathered from this important clinical research program will generate better understanding of effective treatment options for chronic depression. This, in turn, may help to reduce costs to employers and insurers and alleviate the devastating impact of this disabling disorder for individuals and their families.

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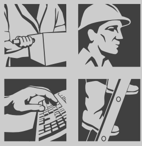

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continued on page 30

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