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A new strategic plan for advancing excellence

Claudia von Zweck, CAOT Executive Director

October 2005 marked the start of the implementation of a new strategic plan for CAOT. This strategic plan was developed with input provided by CAOT members and stakeholders at forums held across Canada. The new plan adopts a guiding vision that all people in Canada will value and have access to occupational therapy. This vision will lead CAOT action over the next three to five years.

Our mission to advance excellence in occupational therapy remains unchanged. However, our means of addressing our mission, articulated through our strategic priorities, have progressed to reflect our vision and the work and policy environment we face in Canada today.

Our new strategic priorities include promoting leadership in occupational therapy through initiatives such as innovative professional development tools and resources. An example of such initiatives is our new online OT Education Finder which allows members to search an extensive database to identify professional development opportunities that meet their individual learning needs. The CAOT awards program also recognizes and promotes the leaders of our profession. Look to our new awards section on the CAOT web site to view available awards, obtain profiles of past award winners and retrieve nominations information and application forms. Nominations are now being accepted for all awards with a deadline of February 1, 2006.

A second CAOT strategic priority involves fostering evidence-based occupational therapy. CAOT has sponsored the development of a new, evidence-based practice web portal. This is being developed by an international group of evidence-based practice experts led by Dr. Mary Law and will be available in early 2006. We also offer members a number of additional methods of accessing evidence for practice including our new critically appraised papers introduced in this issue of *OT Now*.

A third priority to advocate for occupational therapy as an essential service involves the implementation of a two year pan-Canadian strategy to promote the role of occupational therapy in primary health care. Other initiatives include continued participation in national coalitions and partnerships as well as leading national projects such as a new post-fall support program for seniors to demonstrate the integral role of occupational therapy in the Canadian health system. The successful theme "Yes I can" will continue to be used in the next two years to promote awareness of occupational therapy through our OT Month activities.

Our mission to advance excellence in occupational therapy remains unchanged. However, our means of addressing our mission, articulated through our strategic priorities, have progressed to reflect our vision and the work and policy environment we face in Canada today.

Our fourth strategic priority involves the continued development of workforce capacity in occupational therapy. In addition to ongoing activities relating to the national certification examination and academic accreditation, CAOT is involved in projects that address the occupational therapy human resources plan developed in 2004. These projects include a review of the CAOT document *The Profile of Occupational Therapy in Canada*, the identification of issues that influence the workforce integration of international graduates in occupational therapy in Canada and the development of a national occupational therapy health human resources database.

Last in order but first in importance is our fifth strategic priority to advance CAOT as your national occupational therapy professional association. To meet this priority we will continue to ensure effective governance practices as well as provide you with valued member services and products. If you have comments on how CAOT can better serve you as a member, please contact me at (800) 434-2268, ext. 224 or by e-mail at: cvonzweck@caot.ca.

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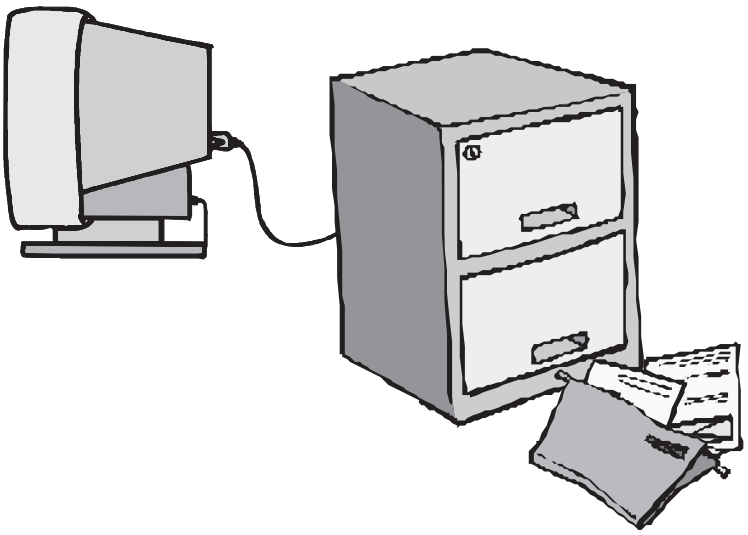
A BOLD Story – Going on-line with occupational therapy documentation

Lynda Dunal, Janet Murchison, Sheryl Tenenbaum, Heather Colquhoun and Gilda Waltman



The term electronic documentation elicits a range of reactions, the most common of which appears to be anxiety. Certainly this was the reaction in our department when in 2003 our organization announced a new initiative for the client health record. We were to move from the familiar 'low tech' paper chart to what our organization described as a 'standardized, computerized, integrated client health record, within a collaborative care documentation model'. We embarked on this new venture without any guidelines. Even though many facilities are moving toward the implementation of electronic patient records (EPR) we found little in the literature that discussed the actual process and certainly nothing from the perspective of an occupational therapy department. Discussions focused more on the features of online and/or electronic documentation and the terminology was not defined. We had a steep learning curve which began with some basic understanding of the difference between an electronic health record (EHR) and an electronic patient record (EPR) system.

EHRs are longitudinal health information systems "of an individual that is accessible online from many separate, interoperable automated systems within an electronic network" (Office of Health and the Information Highway – Health Canada, 2001, January, p.12).

The electronic patient record (EPR) is the provider or facility-based record contained in the health care system that consists of "a complete patient record accessible from a single, automated provider-based system (e.g. a physician's or hospital's system)" (Office of Health and the Information Highway – Health Canada, 2001, January, p.12). The EHR can provide appropriate patient information to care providers through the local electronic patient record.

Every organization implementing an EPR will make choices around which health information system (HIS) they purchase, and each of these systems will have advantages and disadvantages which impact on the mechanics of documentation. Most occupational therapy departments, as in our case, will not have input into which system is chosen. This article focuses on the process that the Baycrest occupational therapy department in Toronto has undertaken to transition from manual documentation to electronic assessment templates and progress notes. Details about the features of the HIS chosen are system specific and will vary according to which HIS an organization employs.

The Baycrest Centre for Geriatric Care is a multi-level health care system which is organized according to a matrix model. This supports individual professional departments alongside a continuum of service programs. The new documentation initiative was undertaken in an effort to create a more complete client health record and to reduce redundancy.

A team was brought together of external HIS experts along with representatives from different sectors of the organization (e.g. clinical, administration, and information technology) to create the Baycrest On-Line Documentation

Although initially done under pressure, the BOLD project turned out to be a good catalyst.

Table 1
Survey questions

What guides our current documents? Are they occupational therapy based, program-based or interdisciplinary?
What is being reflected in various documentation styles and formats?
How do we/others use them?
Do they work for us?
Do we like them?
What needs to be changed?

or BOLD Team. This team has been leading the organization through the process of transitioning the documentation of care delivery from a paper chart to an EPR. This includes all aspects of care delivery: client database, assessments, treatment/care, progress notes and outcomes.

Over a period of several years there has been a move in our occupational therapy department toward the adoption of the Occupational Performance Process Model (OPPM) as a guiding framework for practice (Fearing & Clark, 2000). Like so many other departments, we have had to concentrate on ways to integrate the OPPM into practice within the confines of an overarching medical model.

Although initially done under pressure, the BOLD project turned out to be a good catalyst. It forced us to take a critical look at our assessments. A small departmental committee was formed to survey our existing forms (Table 1), and time was taken to discuss many aspects of our documentation.

Results from this survey and our own reflection made it clear that many documents were in transition and had not yet integrated the language of occupation or the OPPM.

At the same time we were evaluating our documents, the BOLD team indicated that ideally they wanted one assessment form to be used by all the therapists in the department. We tried to comply. In a sense we believed that it was right that we should be able to create one form. After all, we were all working from the same practice model. A 12-page occupational therapy assessment form was created. It was thorough, inclusive and focused on occupation. We looked upon it as a versatile document with the thought that we could edit out the portions that were not relevant to a particular practice area. This illustrates how little we knew and highlights the assumptions we had made about how the online documents would function. We had assumed that the screens of the EPR would function in a similar way to word processing programs with the ability to scroll to see text, cut and paste, and delete sections. This was in fact not the case, and the form we had designed would be unmanageable in the HIS. Without the flexibility to tailor the 12-page assessment we realized that it was not possible to have one form. We had held high hopes for the EPR so when it didn't work as we had expected we were disappointed and more resistant to the changes it would bring.

The key problem was a knowledge gap. We were trying to work with Information Management (IM) but we didn't share a common language. They were working in the language of the HIS, which was foreign to us. We didn't know what questions to ask to get the answers we needed. We had to reframe our mindset and try to see the EPR as a tool which could offer a framework and structure, and provide cues and guides to help in documentation. We were very fortunate to have an occupational therapist from our department on the BOLD team as she was immersed in the HIS and learning about its strengths and limitations. With her expanding knowledge she was able to provide encouragement, guidance and some bridging of the knowledge gap.

BOLD was to be implemented within 18 months and in stages beginning with two pilot care sites. Because Complex Continuing Care (CCC) was going on-line first, this was the occupational therapy assessment form that was given priority. We developed a form that was occupationally focused but tailored to the population served. The IM/BOLD architects built the template screens from this form. The quick pace of the project meant that our CCC group was not able try out the assessment on paper prior to going on-line. Once on-line, however, and starting to use the template the group was able to provide vital feedback. One key issue arose from the fact that our HIS has a limit of five days in which an assessment can be edited. After this time it can no longer be accessed to add information. Therapists found that this did not allow enough time to complete all aspects of the assessment. It became clear that we had to better match the timing and content of documentation to the flow of what happened in practice. This led to significant changes to the assessment template. We looked at subdividing the assessment into modules which then became distinct assessment templates. This acquired knowledge was invaluable in developing subsequent assessment templates.

Therapists are starting to talk about the link between practice and documentation.

Lessons learned

We found that having a member of our department designated to oversee and coordinate our documentation was critical. This coordinator served as a link between the department and the builders of the system and helped sort out issues related to the system, to the assessment documents and to occupational therapy practice. She met with therapists to work on their documentation and to help them plan what they needed. This initial phase of planning and getting online required a substantial amount of support. We also found that ongoing support was important and initiated a monthly one-hour meeting facilitated by the documentation coordinator. These meetings allowed for information sharing, and leaders began to emerge among our staff. One of the therapists worked on both CCC and rehab. She was invaluable in her ability to see what would and wouldn't work on Rehab. As therapists went on-line they went to her for help in understanding the functionality of the EPR.

We recognized the value of having a culture of honesty and trust where we could learn from our mistakes and where we had confidence that what we were doing was actually going to make a difference to our practice. It has been surprising to hear therapists saying that they are documenting more frequently (one of the reasons being that they can access the chart from any computer in the centre). They are also more concerned about what they write and they will ask for feedback from peers about their documentation. They are more conscious of the college requirements. They see how their documentation not only guides them in practice but reflects what they have done in relation to occupation.

Therapists are starting to talk about the link between practice and documentation. In one of the monthly documentation meetings, therapists found that not everyone was using one of the assessments the same way. The discussion that followed was informative regarding practice, and identified recommendations for improving consistency based on mutual understanding and rationale. With the occupational therapists being part of the process they had a greater commitment to improving documentation and practice.

It was invaluable to base our documentation on an occupational therapy framework. This gave us a language and a model to guide us in our practice and our documentation. Taking the time to plan what was most important to us at the beginning of this process, and to evaluate our documentation and create an initial outline, was critical; having support available to the therapists when we needed it was enabling. It takes time to appraise, develop and revise documentation. It takes time for training, for ongoing support and for information sharing.

Tips

Evaluate existing documentation. Converting from paper to electronic documentation does not resolve fundamental problems.

Look at how your paper documentation matches practice and work flow and how they do or do not integrate — certain things in practice happen at certain times. Does your documentation reflect and allow for this?

Assessment forms may need to be subdivided into separate modules which become individual templates.

Base documentation on an occupational therapy framework.

Involve therapists in the planning, implementation and evaluation of their documents.

Plan and trial new assessment formats on paper before going online.

Advocate for a designated occupational therapy documentation coordinator to serve as an important link between the therapists, the department and the builders of the system.

You need the time and support to do all this.

Collective knowledge grows with experience.

About the authors

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Deriving occupational meaning and balance: The story of Claire

Katie Lee & Anne Fourt[1]

Ever since my introduction to occupational science over three years ago, I have considered this basic science to be fundamental to my practice. Without this purely occupational perspective, I believe I would lack my identity as an occupational therapist. It was with this mind-set that I entered my last clinical placement and had the privilege of meeting Claire.

With Anne as my supervisor and mentor, I had the experience of interacting with women recovering from childhood abuse. I viewed these women as occupational beings each struggling to cope with the long-term and devastating effects of abuse, yet dreaming of a life full of happiness, peace, well-being and occupation. One of these women was Claire. A frustration about which Claire spoke with considerable passion was her inability to find steady and meaningful employment, although she was very motivated to do so. My challenge was to work with Claire to uncover what had prevented her from achieving this goal for nearly twenty years. I drew on basic principles derived from occupational science, such as occupational balance, occupational justice, and occupational meaning to guide the discovery and intervention processes, to enable occupational success for Claire.

To better appreciate Claire's occupational success story, an understanding of occupational justice and balance is helpful. Occupational justice is "the opportunity and resources (personal, environmental, societal) for individuals and communities to select and engage in a range of purposeful occupations that are culturally and personally meaningful" (Townsend & Wilcock, 2004, p. 245). Occupational justice enables occupational balance, health and good quality of life. Townsend and Wilcock (2004) suggest that occupational injustice leads to occupational imbalance. Occupational imbalance is the lack of balance in the amount of time spent between "physical, mental, and social occupations; between chosen and obligatory occupations; between strenuous and restful occupations; or between doing and being", according to Wilcock (1998, p. 257).

Claire grew up in an abusive home. During her childhood[2] she was sexually abused by her father and neglected by both her father and her mother. Despite this childhood trauma, Claire grew up to be an intelligent, talented and loving woman. At the time she joined the program she was a devoted single mother and a gifted musician; she inspired group members and therapists alike with her ability to use her music to express her pain and struggles, and to support her own personal growth. Members of the program respected her for her leadership and keen, sensitive, and earnest insights into her own challenges, and those of other group members.

Our aim as occupational therapists was to support Claire in her goal of finding steady and meaningful employment. Although Claire had many strong skills, she frequently found herself bouncing from job to job, with periods of unemployment, throughout her adult life. When I began working with Claire she was unemployed again and struggling to decide what her next steps would be. In our first session it was clear

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

[1] This story is based on my, Katie Lee's, experience as an occupational therapy student in clinical placement with Anne Fourt, MEd, OT Reg (Ont). Although both of us contributed to this paper, and have co-authored it, we felt that it was best written in the first person. We hope you agree.

[2] Some details were changed to maintain confidentiality, however the process and outcome of the situation are the same.

Through exploring the meaning that Claire's employment occupations held for her, she also began to realize the meanings that she attributed to her home-based occupations, especially mothering, cleaning, and maintaining a functional home.

that, while finding steady employment was Claire's goal, staying employed was an overwhelming and daunting undertaking for her. She had an extensive and varied employment history, from working in the vineyards of California, to working as an administrative assistant at a high-stakes technological firm. Claire said that, oddly enough, she was never fired from a job; instead she would, time and again, make the choice to quit, often after just a few months on the job. Since it appeared that Claire had the skills and opportunities to get a job, the challenge was to uncover the barriers to her occupational performance to determine why she quit repeatedly.

I suggested to Claire that we explore the past five years of employment through the use of a graphic timeline to look for any patterns that may be occurring. Although Claire initially engaged in this task willingly, she quickly became overwhelmed by a strong sense of failure and hopelessness, feeling as if it would be impossible for her to change. It was obvious that this factual timeline approach was not helping Claire, as it did not get to the core of her occupational performance issues. It was not until she was encouraged to explore the meaning her varied employment occupations held for her that the crux of her occupational performance issues came to light.

Through exploring the meaning that Claire's employment occupations held for her, she also began to realize the meanings that she attributed to her home-based occupations, especially mothering, cleaning, and maintaining a functional home. Claire began to talk about her childhood and her experiences with her mother and father. We explored how those experiences shaped her present views on what it meant to be a good mother. Claire's mother had been adamant about maintaining a clean and organized home, so she had devoted a good deal of her time at home to this occupation, often at the cost of neglecting her own children's needs. Claire's mother had also held a full-time job, and thus was away from the home a great deal of time. During this time Claire's father often abused her. Claire came to view her mother's work as exposing her to abuse, a view that stayed with her into adulthood. Therefore, as an adult, whenever Claire managed her own home as well as a job, she inevitably found herself afraid that she would neglect her children and put their safety and happiness at risk. When this occurred, she would struggle with maintaining her home and end up quitting her job.

We also explored how Claire's childhood experiences, especially those with her father, affected the type of jobs she sought and the meanings they held for her. Claire felt torn between working at creative jobs and seeking out employment that she saw as more responsible but much less creative. Claire described her father as very musical and free spirited, qualities that Claire found in herself. Whenever Claire took on a job that expressed this part of her, she felt that she was embracing her father's qualities and becoming like him, so she would quit. Feeling ashamed that she had expressed qualities that she felt represented abuse, she would swing in the opposite direction and seek employment that seemed more responsible and less like her father. She felt trapped in this dichotomous occupational pattern and did not see a way out.

As these meanings were uncovered, Claire began to understand how the meanings she attributed to her various occupations had developed, and how growing up in an abusive home had led her to ascribe very definitive and negative meanings to many of her occupations. The abuse she experienced disempowered her occupationally by robbing her of the ability to derive a positive sense of meaning from numerous personally and culturally valued occupations. This disempowerment manifested itself as occupational imbalance, as Townsend and Wilcock (2004) suggested. Claire cycled between what she perceived to be two opposite choices of occupational engagement. At times she would work full-time in a job she disliked, maintaining her home and parenting with very rigid boundaries. At others times she would choose a position she enjoyed, but worry that she was putting her children at risk; therefore she would consistently feel the need to quit these jobs. This cycle left Claire in a constant state of occupational imbalance.

Intervention with Claire focused on challenging these rigid, negative childhood meanings to help her move towards less dichotomized "all or nothing" meanings. Through this process, Claire began to ascribe more flexible and personally relevant positive meanings to various occupations. These insights liberated her to take up an array of occupations and afforded her the flexibility to embrace the various sides of her occupational being. She made the decision to complete her music degree and found the financial support to achieve this. Claire and I worked on time management skills and developed a weekly plan to keep her on track with home manage-

ment. She also reported feeling less guilty about setting clear structural boundaries with her children, which allowed her to spend more quality time with them. All of these changes enabled her to be more effective in the occupation of mothering. As the chaos in her life lessened, she found the time to focus on herself through yoga, meditation, and writing. Claire finally found the occupational balance that she had been lacking most of her life.

Through Claire's story, we should all be reminded what occupational science teaches us of the complexity of occupation and its ubiquitous, yet, at times, delicate presence within our lives. The significance of incorporating occupational science into practice is well captured by Whiteford, Townsend and Hocking (2000): "To enable occupation is to be guided by values, beliefs, and a philosophy of occupation" (p. 65). As an occupational therapist, my occupational perspective centers me. It reminds me to view each client as a unique occupational being; to work with him or her to enable opportunities for free occupational engagement; and to work to empower each client to live his or her life to the fullest. Both Anne and I look forward to being a part of many occupational success stories to come.

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Brief occupational therapy increased self-management behaviour in adults with early rheumatoid arthritis but had no effect on functional or health status at two year follow-up

SUMMARY OF

Hammond, A., Young, A., & Kidao, R. (2004). A randomized controlled trial of occupational therapy for people with early rheumatoid arthritis. *Annals of Rheumatic Disease, 63,* 23-30.

Structured abstract prepared by: Lori Letts

Research Question/Objective

To evaluate the effects of a pragmatic, comprehensive occupational therapy program on self-management and health status of people with early (<2.5 years) rheumatoid arthritis (RA).

Design

Randomized, controlled, assessor blinded trial, with assessments done at baseline, 6, 12, and 24 months, with intention to treat analysis.

Setting

11 hospitals in the North Thames Regional Health Authority, United Kingdom.

Patients/participants

326 participants were recruited (162 in a treatment group and 164 in a control group). Eligible participants were over 18 years, diagnosed with RA within the past 2.5 years, required active medical treatment, had had no or minimal occupational therapy previously, and could speak and read English. The control group was significantly older than the treatment group by an average of 3.2 years.

Intervention

Five occupational therapy sessions, four individual and one, two-hour group arthritis education program (average: 7.6 hours, ranging from 0-19) over a one-year period, with all but two hours provided within eight weeks of referral. Experienced occupational therapists offering the intervention were trained and monitored. Essential interventions included: information about RA, ADL training, joint protection and energy conservation, posture and positioning advice and a ROM hand exercise program. The group education session included information about RA, and emphasized self-management using exercise, joint protection and energy conservation, and coping strategies. Optional intervention components were also used depending on the needs of individual participants, and included: splinting, referrals to physiotherapy, social work, or podiatry, advice on leisure, work, sexual relationships, and general coping skills.

Outcome measures

Functional assessments: the Health Assessment Questionnaire (HAQ) and physical function subscales of the Arthritis Impact Measurement Scale 2 (AIMS2). *Disease activity*: 28 swollen joint count; 28 tender joint count; early morning stiffness (in minutes); American College of Rheumatology (ACR) functional grade; pain visual analogue scale (VAS). *Hand status*: grip strength using the Jamar dynamometer, Jebsen hand function test. *Psychosocial status*: Arthritis Self-Efficacy Scale; Rheumatoid Attitudes Index; Affect Scale from AIMS2. *Adherence*: frequency of adherence to hand, arm, and fitness exercise, energy conservation, joint protection, use of assistive devices and splints.

Main findings

There were no significant differences between the two groups for any of the functional, disease, hand, or psychosocial measures. Both groups showed improvements in AIMS2 physical function, and total self-efficacy scores; neither group showed significant changes in pain VAS. Since it was hypothesized that occupational therapy might be more effective for those with more functional problems initially, further analysis was conducted based on the functional classes at baseline, but no significant differences were noted. For self-management behaviours, participants in the treatment group were more likely to adopt joint protection strategies ($p<.01$), adhere to hand and arm exercises ($p<.001$), and rest (statistically significant only at 12 months, $p=.05$). >

Authors' conclusions

The authors conclude that occupational therapy improved self-management behaviours but not health status in early RA. They suggest that longer follow-up may be needed to detect the effect of the self-management behaviours on health.

Contact details of authors of appraised paper:
E-mail address for Dr. A. Hammond:
ah14@brighton.ac.uk

COMMENTARY — *by Rachel Devitt*

Self-management programs are essential for enabling persons with chronic diseases such as rheumatoid arthritis (RA) to cope with and become active and confident in managing their condition. Occupational therapists are ideally suited to provide self-management programs because of their client-centred and comprehensive approach to practice.

This randomized controlled trial (RCT) was the first to examine the effectiveness of a comprehensive occupational therapy program for persons with early RA. Hammond, Young, and Kidao (2004) found that occupational therapy improved self-management behaviour; however, no significant differences were found in function or health status between the treatment and control groups. A potential explanation for the lack of significance is the inherent difficulty in conducting RCTs in the area of comprehensive chronic disease management (Vliet Vlieland, 2002). Although Hammond et al. managed to address some of the limitations of previous RCTs in this area (e.g., adequate sample size, intention to treat analysis, and long-term follow-up), conclusions should be interpreted with caution as several methodological limitations exist.

First, the duration and intensity of the program (i.e. eight hours of treatment over one year) may not have been adequate to notice an effect in the outcomes of interest. Second, the intervention was predominantly delivered on a one-to-one basis using a "pragmatic" approach. Alternative approaches, such as group interventions based on cognitive-behavioural or self-efficacy theories, for example, (Barlow, Wright, Sheasby, Turner & Hainsworth., 2002) may be more effective. Third, comprehensive multicomponent interventions are intended to improve a variety of outcomes at the level of body function/structure, activity, and participation. Although a measure of work ability is included in the AIMS2, important aspects of participation were not adequately measured. For example, outcomes that may have responded to treatment such as participation in leisure activities and productive activities other than work were not addressed. In particular, because the items measuring work ability in the AIMS2 exclude those who are unemployed, disabled, or retired, participation in productive activities other than paid work, homemaking, and school was not measured. Hammond et al. acknowledge that other measures may more appropriately capture performance at the level of participation, and that individualized outcome measures may better capture issues of importance to clients. Thus, further investigation of measures at the level of participation would benefit similar studies in the future.

Clinically, this study highlights the important challenge of timing of self-management interventions in the management of RA. Although Hammond et al. (2004) suggest that the benefits of self-management may not be apparent in the early stages of RA, it is still important that persons with RA have the opportunity to receive information about occupational therapy interventions early in the disease process. Occupational therapists can help improve the effectiveness of early intervention approaches for RA by taking into consideration factors such as clients' self-efficacy and their readiness for change. To date, research has not adequately addressed the effectiveness and appropriateness of self-management programs and rehabilitation interventions at different stages of clients' adjustment to their disease. Future research could examine these challenges using alternative research designs such as observational studies, which may be more suitable for collecting data on the timing and content of comprehensive occupational therapy programs. For example, Vliet Vlieland (2002) recommends the "…systematic analysis of data from uniform comprehensive standardized assessments in routine practice, aggregated into high quality databases…" (p. 295), to evaluate the outcomes of comprehensive chronic disease management. Until further information is known, arthritis management should entail self-management programs regardless of stage of disease, with clients and occupational therapists working together to determine the optimal timing and content of such programs.

References

Barlow, J., Wright, C. Sheasby, J., Turner, A., & Hainsworth, J. (2002). Self-management approaches for people with chronic conditions: A review. *Patient Education and Counseling, 48,* 177-187.

Hammond, A., Young, A., & Kidao, R. (2004). A randomized controlled trial of occupational therapy for people with early rheumatoid arthritis. *Annals of Rheumatic Disease, 63,* 23-30.

Vliet Vlieland, T. P. M. (2002). Managing chronic disease: Evidence-based medicine or patient-centred medicine? *Health Care Analysis, 10,* 289-298.

Critically Appraised Papers: An introduction for readers

Lori Letts

This issue marks the beginning of a new column in *OT Now*, with our first Critically Appraised Paper, or CAP. A CAP is a succinct appraisal of a single research study. It is comprised of a declarative title, a structured abstract and a commentary. The declarative title and structured abstract provide a précis of the article. The commentary is written by a clinician or methodologist with expertise in the area of practice discussed in the study. It highlights methodological strengths and weaknesses of a study, places the study in the context of other research, and discusses implications for practice, education and future research. The CAP is designed to provide therapists with information about recently published evidence so that it can be more readily incorporated into practice. Both the structured abstracts and the CAPs are peer reviewed.

The articles in this and upcoming CAPs columns are chosen because they are high quality evidence, of relevance to occupational therapy practice, and represent a range of methodologies. This first CAP is focused on a randomized controlled trial on the effectiveness of occupational therapy for people with early rheumatoid arthritis. Future CAPs will discuss systematic reviews and qualitative studies in several other areas of occupational therapy practice.

How can you use the evidence summarized and discussed in the CAP, and apply it to your practice?

Consider the following possibilities:

- If you are offering an intervention similar to the one described in a CAP, or working with a similar population, what does the article mean to you in your practice? Should you change anything? Reviewing the commentary may give you some hints.
- Does the article suggest that you should be expanding your role in any way? Or does it support your current practice? If so, you can use the information in the CAP to guide you in writing funding proposals for your work. Many occupational therapists need supporting evidence as they complete Requests for Proposals in a variety of contexts. Use the CAPs as one strategy to stay up-to-date on evidence in your area of practice.
- Not sure how to apply the findings? The on-line discussions offered through the CAOT web site may be just what you need. These time-limited discussions offer therapists the opportunity to discuss and debate how they can use the CAP in practice.

The first CAP discussion will be held from November 21 to December 2, 2005. Visit the CAOT web site and click on Critically Appraised Papers on the home page. We look forward to your participation.

Referencing and citations for CAPS

There are two parts to each CAP, each of which requires different referencing.

Commentary

For direct quotes or paraphrases of material, use the declarative title with (Critically appraised paper — commentary) following immediately.

Example

On-line version

Devitt, R. (2005). Brief occupational therapy increased self-management behaviour in adults with early rheumatoid arthritis but had no effect on functional or health status at two year follow-up. (Critically appraised paper — commentary). *Occupational Therapy Now, 7*. Available at: http://www.caot.ca//default.asp?pageid= 1295.

continued on next page

Print version

Devitt, R. (2005). Brief occupational therapy increased self-management behaviour in adults with early rheumatoid arthritis but had no effect on functional or health status at two year follow-up. (Critically appraised paper — commentary). *Occupational Therapy Now, 7*, 11-12.

In text citation

Devitt (2005)
(Devitt, 2005)

Structured Abstract

For direct quotes or paraphrases of material, use the declarative title with (Critically appraised paper — structured abstract) following immediately. It is recommended, when citing information related to the original paper, that you obtain the original paper for review rather than relying strictly on the structured abstract. If this is not possible, be sure to use a text citation which refers to original paper.

Example

On-line version

Letts, L. (2005). Brief occupational therapy increased self-management behaviour in adults with early rheumatoid arthritis but had no effect on functional or health status at two year follow-up. (Critically appraised paper — structured abstract). *Occupational Therapy Now, 7*. Available at: http://www.caot.ca//default.asp?pageid=1295.

Print version

Letts, L. (2005). Brief occupational therapy increased self-management behaviour in adults with early rheumatoid arthritis but had no effect on functional or health status at two year follow-up. (Critically appraised paper — structured abstract). *Occupational Therapy Now, 7*, 11-12.

In text citation

Hammond, Young, and Kidao's study (as cited in Letts, 2005)

Celebrating the strengths of Aboriginal consumers: Community consultation and partnerships

Alison Gerlach

As consumers of health care services Aboriginal people identify cultural respect, trusting relationships and shared decision-making as important elements of positive interactions with health professionals (Browne & Fiske, 2001). These elements guided the experiences of this author in co-writing *A Guide for Culturally-Focused Early Intervention Therapy Programs for Aboriginal Children & Families in British Columbia* (Gerlach & Zeidler, 2004). The guide was written by non-Aboriginal health professionals for Aboriginal consumers who are interested in learning more about early intervention therapy programs.

Community consultation

The need for this publication was identified by an established non-profit, charitable organization, the B.C. Aboriginal Child Care Society (BCACCS). They felt it was one way of sharing with other Aboriginal communities the story of 'lessons learned' from positive cross-cultural community partnerships. Although both of the authors of this guide, an occupational therapist and a speech language pathologist, had many years of collaboration with Aboriginal colleagues and clients, they were very cognizant of the potential influence of their own unconscious cultural assumptions and biases. Community consultation with Aboriginal child and health care providers from around B.C. was facilitated by BCACCS and was fundamental to the success of this project. It allowed for careful exploration of and discussion about the potential for culturally biased practice beliefs and language. This ensured that the publication was not only culturally respectful but also culturally meaningful to communities who had yet to develop partnerships with professionals offering early intervention therapy. The guide was funded by the B.C. Ministry of Child & Family Development through BCACCS.

[1] The author has used the term Aboriginal rather than First Nations as it reflects the choice of wording by members of the community consultation for this project.

Cultural relevancy

To ensure that the guide provided personal meaning and relevancy for the children and families in their own communities, fictional stories were used in a way that supported the strong oral tradition that is a foundation of Aboriginal culture (Ing, 1991). The stories were written in the first person narrative and reflected fictional experiences of family members and colleagues in relation to early intervention therapy and therapy professionals, namely occupational therapists, speech language pathologists and physiotherapists. The authenticity of the language and content were explicitly explored, developed and approved through the community consultation process.

To avoid the cultural bias created by western health practices which categorize people according to their problems and deficits (Vraniak, 1997), diagnostic labels were used rarely in the stories and very cautiously. The exception to this was the decision to develop a story based on a child with Fetal Alcohol Spectrum Disorder (FASD). Members of the community consultation committee recognized the high incidence of this diagnosis in Aboriginal communities, and wanted Aboriginal consumers to know more about the potential role of early intervention therapy services.

Cultural connections

During the writing process the authors explored how their own practice beliefs about 'family-centred' early intervention were transformed through their collaboration with Aboriginal children, families and colleagues. They believed that it was important to provide suggestions to the Aboriginal readers on how they could take a leading role in helping the early intervention therapy professionals to provide services that were meaningful and respectful of the readers' culture and community. This belief was supported by the community consultation committee and became a key feature of the publication. Key concepts of a family-centred framework (Rosenbaum, King, Law & Evans, 1998) were presented within a meaningful context, illustrated by a fictional 'personal

Figure 1

Excerpt from manual shows how the concept of 'all family members are valued' is presented as a 'story' and 'cultural connection'.

WHAT ARE THE CORE VALUES OF EARLY INTERVENTION THERAPY?

ALL FAMILY MEMBERS ARE VALUED

Early intervention therapy that is family-centered values the needs of the family as a whole and supports a collaborative approach towards healthy children and families.

Circles of Support

One of our families has an 18-month-old boy with a developmental delay. We have been helping the Speech-Language Pathologist (SLP) connect with mom to support Dawson at home. We all think that he is doing really well. Dawson is the youngest child in a blended family and he has sisters and a brother who are teenagers and are around a lot after school and sometimes on weekends. They have lots of energy and are always playing with Dawson. We told the SLP about Dawson's older sisters and brother. We talked together with mom and decided that we could set up some times to get together after school so that the older children could find out about more ways to play with Dawson and help him learn.

CULTURAL CONNECTION:

Aboriginal values and practices around family life may be very different from those of a non-Aboriginal early intervention therapist whose view of 'family' has likely been based on a western nuclear family model. Much of this cultural knowledge is implicit and non-Aboriginal people may be unaware that members of Aboriginal communities do not share this western family model.

Can you or someone in your community provide information on:

- ☐ The high value traditionally placed on the extended family;
- ☐ The role of grandparents and Elders in caring for children and passing on traditional beliefs and values;
- ☐ Family stories, origin stories and legends;
- ☐ Games and songs for language practice and recovery, and
- ☐.....

An early intervention therapist may inadvertently view 'family' and 'parenting' in relation to their own cultural beliefs and practices (Llewllyn, 1994). They need to be aware of the important role that extended family members may play in a child's daily life, and be ready to involve other members of the family in early intervention therapy.

FAMILY MEMBERS ARE THE EXPERTS ON THEIR CHILDREN

Families are the constant in their children's lives and know their children best. Early intervention therapy that is family-centred respects that parents and extended family members are knowledgeable about their children.

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story' and by a 'cultural connection'. The excerpt appearing in Figure 1 shows how the concept of 'all family members are valued' is presented as a 'story' and 'cultural connection'.

Resident expertise

The descriptions of the cultural connections guided the consumers to reflect on what role they could play in supporting therapy professionals to become community partners. Potential differences in cultural values and beliefs about family, raising a child with special health care needs, making decisions, and language were highlighted in this way. The guide was also written to encourage the consumers to consider their own resident expertise, and thereby develop partnerships and sustainable knowledge and skills within the community.

Due to the remote location of many Aboriginal communities there is frequently not only a 'social distance' in terms of socio-cultural diversity with health professionals, but also a very real geographical distance. Thus the authors' therapy practices have evolved to ones in which the community as a whole is the 'client'. Encouraging sustainable community initiatives driven by community members has become a strong feature of their role within a community-based, interdisciplinary early intervention team.

Members of the community consultation committee introduced the term 'resident expertise' as a strong focus for all Aboriginal communities, particularly those that may have infrequent contact with early-intervention therapy professionals. The 'cultural connections' were therefore further developed to prompt the consumers to reflect on their existing community strengths and resources and how these may be further enhanced if partnerships with therapy professionals could be initiated and developed.

Cultural competency

Aboriginal families of children with special health care needs have identified cultural knowledge and respect as essential for all health professionals working with their children (Gerlach, 2003). While the authors were fully aware of the responsibility that individual therapists have to become active and curious learners in Aboriginal culture and history (particularly about the residential school system), they also wanted to make it possible for Aboriginal consumers to play an active role in this ongoing learning process. Through the consultation process and much reflection by the authors the 'cultural connections' were also developed to empower the consumer in this learning process. How could they help therapists learn about their community's strengths and cultural beliefs, about health and healing, and about becoming more engaged in learning about the unique cultural context in which their services are being provided?

On reflection

This author's experience in the collaborative writing process reinforced how learning more about Aboriginal culture and equitable partnerships with Aboriginal communities provides an enormous opportunity for our profession to uncover and explore how our practice values and beliefs are culturally biased. It was also an opportunity to consider how our practices need to be transformed so that we provide authentic family-centred services which respect both the strengths and the real needs of Aboriginal families and communities.

Copies of the Guide

A Guide for Culturally-Focused Early Intervention Therapy Programs for Aboriginal Children and Families in British Columbia can be ordered from:

BC Aboriginal Child Care Society
708-100 Park Royal South
West Vancouver, BC V7T 1A2
Phone: (604) 913-9128
Fax: (604) 913-9129

Or download a pdf from the publication page of the society's web site at: http://www.acc-society.bc.ca.

References

Browne, A. J., & Fiske, J. (2001). First Nations women's encounters with mainstream health care services. *Western Journal of Nursing Research, 23*(2), 126-147.

Gerlach, A., (2003). *Cultural issues & Canadian Aboriginal families: Implications for collaboration.* Unpublished Master's thesis.

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Ing, R. N. (1991). The effects of residential schools on Native child-rearing practices. *Canadian Journal of Native Education, 18*, 65-118.

Rosenbaum, P., King, S., Law, M., King, G., & Evans, J. (1998). Family-centred service: A conceptual framework and research review. P*hysical and Occupational Therapy in Pediatrics, 18,* 1-20.

Vraniak, D. (1997). Mapping contexts for supporting American Indian families of youth with disabilities. *Families, Systems & Health, 15*(3), 283-302.

Canadian Framework for Ethical Occupational Therapy Practice Coming in 2006

Jean-Pascal Beaudoin

The Professional Issue Forum (PIF) held on May 27, at the 2005 CAOT Conference in Vancouver, B.C. provided an opportunity for CAOT members and other participants to learn about and review a proposed model for ethical occupational therapy practice. The *Canadian Framework for Ethical Occupational Therapy Practice* was well received and will be published in 2006 after feedback from the forum is integrated and the publication undergoes standard review processes. The framework will be web-based and available in both English and French.

In January, 2004, CAOT began the process of revising its code of ethics. The Association wanted the code aligned with its organization's strategic objectives, and better able to support best practice among occupational therapists and to guide their professional development. CAOT was keen to develop a tool that induced more reflective practice. Drawing in part on the ethics work of David Seedhouse (1998), the CAOT Membership Committee began working on a framework to support best ethical occupational therapy practice in Canada, with the invaluable contribution of Dr. Margaret Brockett and Ron Dick, experts on ethics.

This proposed framework introduces a new set of guidelines to help occupational therapists reflect ethically on their daily practice. It includes an ethical model based on the Person-Environment-Occupational (PEO) Model (Law et al., 1996) and a workbook to guide self-reflection and decision-making. This framework tries to reconcile the legal side with the thinking and caring side of practice. By using this framework, it is hoped that occupational therapists will have a tool to help them understand and address daily practice situations which are becoming more and more complex.

Professional Issue Forum

Over 45 therapists participated in this interactive forum. It began with presentations by Margaret Brockett and Ron Dick with input from Jean-Pascal Beaudoin, Chair of the CAOT Membership Committee and Kathy Corbett, Chair of the Association of Canadian Occupational Therapy Regulatory Organizations. Through both large and small group discussions, as well as individual-reflection exercises, participants learned about the proposed framework plus the accompanying workbook, and provided valuable feedback.

With the publication of the *Canadian Framework for Ethical Occupational Therapy Practice*, occupational therapists will discover a user-friendly tool offering strategies and resource information for improved reflection and to assist with decision making around ethical issues arising in the workplace. It will allow professionals to build their own ethical knowledge, develop their clinical reasoning and problem solving skills, improve client outcomes and satisfaction with services, and contribute to the quality of occupational therapy service provision.

Jean-Pascal Beaudoin is the present chair of the CAOT Membership Committee; members include: Lara Haddad, Josée Lévesque and Karine Moreau with CAOT staff Diana Aarons and Donna Klaiman.

Law, M., Cooper, B. A., Strong, S., Steward, D., Rigby, P., & Letts, L. (1996). The Person-Environment-Occupation Model: A transactive approach to occupational performance. *Canadian Journal of Occupational Therapy, 63*, 9-23.

Seedhouse, D. (1998). *Ethics: The Heart of Health Care* (2nd ed.). Rexdale, ON: John Wiley & Sons.

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 in OT Education Finder and/or to access the most recent listings. If you have any questions, please e-mail otnow@caot.ca.

Activity in psychosocial occupational therapy: An exploratory study of therapists' perceptions
S.E. Hayman (Moll) (molls@mcmaster.ca)
1993; MSc – The University of Western Ontario

A comparison of male and female performance on the Assessment of Motor and Process Skills
Leslie J. Duran (leslie.duran@viha.ca)
1995; MSc – Colorado State University

An experimental study of hypnotically solicited recall and the search for the "error prone" individual
Beverlea K. Tallant (beverlea.tallant@mcgill.ca)
1994; Doctor of Philosophy (Psychology)
Concordia University

A screening/referral instrument for school-based occupational therapy: An item validation study
Anu Tirrul-Jones (tirruljones@shaw.ca)
1991; MSc – University of Alberta

Bridging that gap: Occupational therapist experiences of client-centred practice
William B. Mortenson (ben.mortenson@vch.ca)
2002; MSc – University of British Columbia

Client-centred care means I am a valued human being
Deborah J. Corring (Deb.Corring@sjhc.london.on.ca)
1996; MSC – The University of Western Ontario

Continuing professional education: Is it effective? An exploration of how occupational therapists implement the Assessment of Motor and Process Skills into existing practice
Gill Chard (gill.chard@ualberta.ca)
2003; PhD – St Martin's College, Lancaster University, UK

Evaluation and retraining of driving skills in clients with stroke
Barbara Mazer (barbara.mazer@mcgill.ca)
2001; McGill University

Évaluation des effets liés à la participation à un groupe de soutien pour les proches de personnes atteintes de troubles alimentaires selon une approche pluraliste
Genevieve.Pepin (Genevieve.Pepin@rea.ulaval.ca)
2004; PhD médecine expérimentale spécialisation adaptation-readaptation et évaluation de programme – Université Laval

Feeling Pain: Social representations of repetitive strain injury
Lilian Magalhaes (lilicavm@yahoo.ca)
1998; PhD – UNICAMP State University of Campinas, Brazil

In the name of science: The effects of the clinical guidelines movement on the autonomy of the medical profession in Ontario
Susan G. Rappolt (s.rappolt@utoronto.ca)
1996; PhD – University of Toronto

It's all about me: Subtle change through personal mastery
Mark Blandford (mark.blandford@viha.ca)
2005; MA Leadership & Training – Royal Roads University

L'identification des facteurs qui vont favoriser la participation sociale des adultes présentant des séquelles de traumatisme cranio-cérébral
Claire Dumont (Claire.Dumont@rea.ulaval.ca)
2003; PhD – Université Laval

Occupational therapists' use of cognitive assessments with older adults: A Canadian survey
Alison Douglas (Alison.Douglas@ualberta.ca)
2005; MScOT – University of Alberta

Participation in paid and unpaid work by adults with rheumatoid arthritis
Catherine L. Backman (backman@interchange.ubc.ca)
2001; PhD – University of British Columbia (Department of Health Care & Epidemiology)

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CAOT · ACE

New CAOT Initiatives

CAOT is pleased to announce funding for two important new initiatives: A workforce integration project and a post-fall support project.

Workforce Integration Project

Funded in the amount of $369,000 by the Government of Canada's Foreign Credential Recognition Program, the workforce integration project began in May 2005 and will continue until October 2006.

The development of this project was prompted by the recognition that a significant number of individuals educated as occupational therapists in other countries experience difficulties with workforce integration in Canada. As a result, many are lost to the workforce at a time when Canada faces a high demand for occupational therapy services and an undersupply of occupational therapists. The CAOT workforce integration project aims to gain a comprehensive picture of issues that facilitate or inhibit the integration of International Graduates of Occupational Therapy, and it is an important component of a broad health human resources strategy for occupational therapy in Canada.

Reports on Project work will be shared with CAOT members through reports in *Occupational Therapy Now,* the CAOT web site and at the 2006 Conference in Montreal. Project findings will be used to develop recommendations for future action to address the identified issues in the future.

For more information, please contact Pamela Burnett Hicks, Workforce Integration Project Coordinator, at pburnett@caot.ca.

DID YOU KNOW?

Over the past five years, CAOT and various partners have received over $11.3 M in grant money for special projects. These projects enable us to advance excellence in occupational therapy and build strong partnerships.

Stable, Able and Strong

The Stable, Able and Strong project is sponsored jointly by the Canadian Association of Occupational Therapists (CAOT) and the University of Ottawa, Occupational Therapy Program. The project is funded by the Population Health Fund, Health Canada, from September 2005-June 2008.

The Stable, Able and Strong project will develop a Post-Fall Support Model and component strategies for seniors who have experienced a fall, to enable them to maintain or resume engagement in meaningful activities at home and in the community. The Post-Fall Support project will address the fear of falling, and personal, environmental, and activity-related risk factors for subsequent falls, and strategies to safely resume daily occupations.

A community development model using senior volunteers will be used to enable seniors to create post-fall support services. Peer learning principles will address the emotional and social sequelae of falls through the development of self-help support groups and resource collections. Seniors will lead post-fall support groups to provide inspiration and motivation for seniors who have experienced a fall. Resource collections, which will build on information from the 2001-2003 CAOT Tools for Living Well Project, will be developed to provide information for seniors, caregivers and health professionals regarding post-fall supports. A peer-leader manual will also be created to enable communities and seniors to develop post-fall support groups. Pilot testing of the Post-Fall Support Model will occur in three sites across Canada. The model, manual and resources will be disseminated to community partners, regional, provincial and federal organizations.

For more information, please contact Mary Lou Boudreau, Project Manager, at boudreauml@cogeco.ca.

Pan-Canadian Awareness Campaign on Interdisciplinary Collaboration in Primary Health Care

CAOT's Pan-Canadian Awareness Campaign on Interdisciplinary Collaboration in Primary Health Care was launched on October 20, 2005. The purpose of this two-year campaign is to advance health reform that embraces interdisciplinary collaboration and recognizes occupational therapy as an essential service in primary health care provided in homes, workplaces, schools and community settings for mental and physical health and end-of-life care.

CAOT is working with the initiative on Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) (view http://www.caot.ca/default.asp?pageid=1170) and the Canadian Collaborative Mental Health Initiative (CCMHI) (view http://www.caot.ca/default.asp?pageid=1172) as part of the change management strategies. These two initiatives are funded through contribution agreements with Health Canada's Primary Health Care Transition Fund.

CAOT is the lead organization working with an Advisory Working Group of representatives from occupational therapy provincial voluntary societies/associations, regulatory organizations, professional union, and educators of occupational therapists and support personnel. The Advisory Working Group will make recommendations on the development and monitoring of the campaign as well as promote it among its constituents.

All occupational therapists, occupational therapy support personnel, and occupational therapy students in Canada are invited to volunteer. Volunteers will represent the profession to key politicians, decision-makers, health professionals, and community groups in the region where they work or live.

CAOT will support volunteers with the following resources:

- On-line campaign materials
- One-hour advocacy training session
- Additional resources and telephone support
- Secure on-line discussion group to share information
- Monitoring of the campaign for its duration
- Mid-term and final campaign evaluations and outcome report
- Formal recognition of volunteer contributions at the campaign's conclusion

For more information on how to participate, visit www.caot.ca or contact Donna Klaiman by Tel. at (800) 434-2268, ext 229, or by e-mail at: dklaiman@caot.ca.

Congratulations!

Micheline Saint Jean, Chair of the Academic Credentialling Council is pleased to announce accreditation awards to the occupational therapy educational programs at the following universities:

Queen's University
November 2004 – 2009

University of Manitoba
March 2005 – 2010

OT Month 2005

Thank you to everyone who organized and participated in events to raise the profile of occupational therapy. Many more people now know the role OT can play in building inclusive communities.

New learning resource at www.caot.ca
OT Education Finder

Looking for a workshop to update your professional skills? Do you have a learning resource you'd like to promote? CAOT's new OT Education Finder offers a one-stop solution for both seekers and providers of continuing professional education resources for occupational therapists in Canada.

OT Education Finder, housed on CAOT's web site at www.caot.ca, is a free, web-based service that will list resources from providers across Canada and internationally.

Occupational therapists seeking resources can search by keyword, language, location, price, resource type, and CAOT endorsement from CAOT. Equally useful for therapists and organizations offering resources, the database will allow promotion to occupational therapists across Canada. Providers can list their own resources via simple on-line registration at no cost for free resources. A CAOT endorsement option is also available.

CAOT invites interested organizations to register any courses, workshops, books, papers, reports, etc., that would help occupational therapists gain knowledge or enhance their professional skills. CAOT members can register resources at a discount.

OT Education finder was developed by CAOT in consultation with other national occupational therapy organizations, including:

- Association of Canadian Occupational Therapy University Programs (ACOTUP)
- Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO)
- Canadian Occupational Therapy Foundation (COTF)
- Professional Alliance of Canada (PAC)

For more information

Visit the CAOT web site at www.caot.ca and click on OT Education Finder

Contact information

General

E-mail: advertising@caot.ca or call (800) 434-2268, ext. 232

For CAOT endorsement

E-mail: education@caot.ca or call (800) 434-2268, ext. 231

Thesis Directory continued from page 19

Personal contributions to the cost of long term care: Policy differences and their impact on community-dwelling spouses
Robin Lee Stadnyk (rstadnyk@dal.ca)
2005; PhD Public Health Sciences – University of Toronto

Playfulness in children with an acquired brain injury: A preliminary study
Patricia Mortenson (pmortenson@cw.bc.ca)
2003; MSc – University of British Columbia

Profile of Community Therapy Services Inc. Clients receiving occupational therapy and physiotherapy through the Winnipeg Regional Health Authority Home Care Program
Barbara L. Siemens (bsiemens@ctsinc.mb.ca)
2004: MSc – University of Manitoba

The effect of aging on long-term outcomes following traumatic brain injury
Rachel Devitt (rachel.devitt@utoronto.ca)
2003; MSc Rehabilitation Science – University of Toronto

The orientation of Ontario's health professions
Susan G. Rappolt (s.rappolt@utoronto.ca)
1990; MSc – University of Toronto

Those children accepted to treatment at the Anna Freud Centre and those not: Are there significant differences between the two groups?
Corinne Gula
1995; MSc – Psychoanalytic Developmental Psychology
Anna Freud Centre, University College London, UK

Validation of the Synactive Theory of Development: Are body movements in preterm infants signs of stress
Liisa Holsti (lholsti@cw.bc.ca)
2004; PhD – University of British Columbia

Work recovery in schizophrenia
Terry Krupa (krupat@post.queensu.ca)
2000; PhD – Ontario Institute for Studies in Education

CAOT Learning Services

Continuing Professional Education

CO-HOSTED WITH CAOT

June 1-3

CAOT 2006 Conference. Evidence and occupation: Building the future. Montreal, Quebec. Tel: (800) 434-2268, ext. 228; e-mail: conference@caot.ca.

ENDORSED BY CAOT

September-April

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

November 1-2

Progressive Goal Attainment Program (PGAP) Training Workshop: A new program for minimizing pain-related disability [in French]. University Centre for Research on Pain and Disability. Quebec City. Contact: Heather Adams, Tel: (902) 471-7864; Fax: (902) 421-1292; e-mail: info@pdp-pgap.com; www.pdp-pgap.com

November 3-4

From Research into Practice. Toronto. Provider: A collaboration by the Canadian Language & Literacy Research Network, Integra, Learning Disabilities Association of Ontario and Toronto District, OISE/ University of Toronto, The Hospital for Sick Children. Contact Person: Mary-Gayle Goebel, Tel: (416) 226-9756; Fax: (416) 221-9926; e-mail: mggoebel@interlog.com.

April 5-9, 2006

Certificat A-One (Arnadottir Occupational Therapy - ADL Neurobehavioural Evaluation). Centre Hospitalier de l'Université de Montréal (CHUM). Contact: Elaine Vachon, Tel: (514) 890-8000, ext. 14124; Fax: (514) 412-7221; e-mail: chum_aone@yahoo.ca

June 9-10, 2006

Evaluation and Treatment of Visual Perceptual Dysfunction in Adult Brain Injury: Part I. Wascana Rehabilitation Centre, Regina, SK. Provider: Regina Qu'Appelle Health Region. Instructor: Mary Warren MS, OTR. Contact: Peggy Bacon, Tel: (306) 766-5613; Fax: (306) 766-5595; e-mail: peggy.bacon@rqhealth.ca

ONGOING

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

WEB-BASED DISTANCE EDUCATION

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

DALHOUSIE SERIES

January-April 2006

Advanced Research Theory and Methods for Occupational Therapists (OCCU 5030). Instructor: Dr. Brenda Beagan

Community Development for Occupational Therapists (OCCU 5042). Instructor: Dr. Loretta de Rozario

Program Evaluation for Occupational Therapists (OCCU 5043) Instructor: Debra Boudreau

Contact: Pauline Fitzgerald, School of Occupational Therapy, Dalhousie University, Forrest Bldg., Room 215, Halifax, NS B3H 3J5. Tel: (902) 494-6351; e-mail: p.fitzgerald@dal.ca.

NIDMAR COURSES 2005-2006

Effective Disability Management Programs (Module A). Dates: on-line Jan. 9 – 15; March 27 – April 2..

Legislation and Disability Management (Module I). Dates: on-line Nov. 21-Dec. 4; May 8-14.

Workers' Compensation and Return to Work (Workshop Module J). Dates: on-line Nov. 28-Dec. 4.

Insurance and other benefits (Module L). Dates: on-line Jan. 16 – 22; Sept. 1– 16.

Disability Management in Unionized Organizations (Module N). Dates: on-line Feb. 13-19.

Disability Management from a Human Resources Perspective (Module P). Dates: on-line Nov. 7-13; Feb. 27-March 5.

Marketing and Education in Disability Management and Return to Work (Module U). Dates: on-line May 8 – 14; Feb. 5 – 11.

Information Management (Module V). Dates: on-line Nov. 14-20; Feb. 20-26.

Job Analysis (Module E). Dates: on-line March 6-12.

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

Graduate Certificate Program in Rehabilitation Sciences (University of British Columbia and McMaster University). Five required courses offered Jan.-April & Sept.-Dec. each year and include: Evaluating Sources of Evidence,

more listings on page 24

CAOT endorsed courses continued from page 23

Reasoning and Clinical Decision Making, Measurement in Practice, Developing Effective Rehabilitation Programs, and Facilitating Learning in Rehabilitation Contexts. Some courses eligible for online masters programs. Information: www.rehab.ubc.ca or www.fhs.mcmaster.ca/rehab/

Graduate Program in Post-Secondary Studies (Health Professional Education). Memorial University of Newfoundland. Centre for Collaborative Health Professional Education and Faculty of Education. Tel: (709) 737-3402; Fax: (709) 737-4379; e-mail: edugrad@mun.ca; www.mun.ca/sgs/

For more information about CAOT endorsement, e-mail education@caot.ca or Tel. (800) 434-2268, ext. 231

CAOT Conference 2006
Evidence and occupation: Building the future

Jean-Louis Denis to present keynote address

Be sure to join us in Montreal, June 1-3, for Conference 2006, which promises to be an enjoyable learning experience! Kicking things off will be our keynote speaker, Jean-Louis Denis, a professor in the University of Montreal's health administration department. M. Denis, who has more than 15 years' experience in training health care managers, will share his expertise in organizational administration, evaluation and research methodology. He has written numerous publications on strategic change and leadership and is currently researching primary health care reform, health care regionalization and the role of evidence in implementing clinical and managerial changes to health care systems.

Five Pre-Conference Workshops Available

Bilingual Presentations

An introduction to the assessment and treatment of community-dwelling seniors presenting swallowing disorders, with Heather Lambert.

Vocational rehabilitation following a diagnosed professional burn-out : The potential role of the occupational therapist, with Louis Trudel and Micheline Saint-Jean.

The role of the occupational therapist in the screening/evaluation and re-training of driving skills, with Dana Benoît.

English only

The Ludic model, or rediscovering the richness and power of play in occupational therapy, with Francine Ferland.

French only

Utilisation de l'Internet pour intégrer à sa pratique clinique les récents résultats de la recherché with Marie-José Durand and Brigitte Vachon.

Watch the Conference 2006 section at www.caot.ca for more information coming soon!

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Doter le savoir et la recherche

CANADIAN OCCUPATIONAL THERAPY FOUNDATION

To fund scholarship and research

News from the Foundation

Isobel Robinson Historical Research Fund

Isobel Robinson celebrated her 90th birthday on July 1. She graduated from the University of Toronto in 1939 in the occupational therapy program and in 1996 received a Bachelors of Arts from McMaster University.

After graduating from the occupational therapy program, she worked at the Ontario Hospital in Toronto for three years. She then began teaching at the University of Toronto in 1943. She was head of the Occupational Therapy Department from 1967 to 1981. Upon her retirement in 1981, she became the Chair of the CAOT Archives Committee, was the Muriel Driver Memorial Lecturer and received an honourary doctorate from the University of Alberta. The Isobel Robinson Historical Research Fund was founded in 2004 to honour her legacy to the field of occupational therapy. Contributions can be made at any time.

Congratulations to the 2005 Research Grant Winners!

Lynn Shaw
Community OT Research Grant ($5,000)
Lori Letts, Lili Liu, Debbie Laliberte Rudman
Critical Literature Review Grants ($5,000 each)
Claire Dumont
COTF Research Grant ($5,000)
Annette Rivard
COTF Research Grant ($2,000)

Remember to update your contact information

COTF would greatly appreciate it if you would inform Sandra Wittenberg of any changes to your contact information. Sandra can be reached by e-mail at: swittenberg@cotfcanada.org or Tel. 1 (800) 434-2268, ext. 226.

Your support counts!

COTF sincerely thanks the following individuals, companies and organizations for their generous financial support during the period of May 1 to August 31, 2005.

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When swallowing is difficult, continued...

Change how you eat...

- Put less food on each spoon or fork and eat slower.
- Cut food up into small pieces or mash it.
- Avoid foods that are known to cause choking. These include: whole grapes, nuts, and coin-shaped foods (e.g., carrots or hot dogs) and small round or hard candies.
- Eat small meals so you don't get as tired.
- Sit up straight while eating and for 30 minutes after. You may need cushions or specialized seating to help with this.

CAOT wishes to acknowledge the work of Jan Wilson, BSc(OT), OT(C), of Glenrose Rehabilitation Hospital, Edmonton and her colleagues for assisting with this consumer tip.

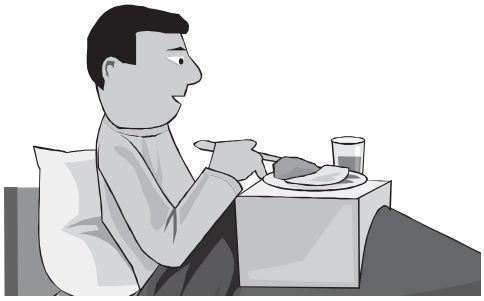
In addition to the above, when feeding someone, try these tips:

- Make sure the person is as upright as possible.
- Always be there or have someone there to watch at meal times.
- Check to see if they want to feed themselves and let them try.
- Allow finger feeding and handling of food if they wish.
- Keep track of changes in how fast they eat and what goes wrong when they eat specific foods.
- Never prop up baby bottles.
- Don't feed children in car seats, especially those foods listed on the left.
- For babies, check the nipple to make sure the hole is not too large and the liquid does not pour too quickly.

These suggestions are general in nature. If you are having trouble, please ask your doctor to see a clinician experienced in swallowing difficulties. He or she may be an occupational therapist, speech language pathologist, dietitian, nurse, physician or psychologist. If you can, find a team made up of these professionals.

Visit www.otworks.ca and click on 'OT Finder' to locate an occupational therapist closest to you.

Dysphagia — When It is Hard to Swallow



If you or someone you care for is finding it hard to swallow, please ask for help.

Dysphagia is the medical term for problems in swallowing (or feeding an infant or adult with severe disabilities). It's important to get help to prevent other health problems, and in some cases to save a life. Infants and children with dysphagia may not grow as fast as other children. Anyone who has trouble swallowing food or liquid may choke or the food/liquid might enter the lungs and lead to pneumonia (infection in the lungs). Some people lose a lot of weight, which can cause even more problems.

Occupational therapists can help people and/or their caregivers to find ways to make swallowing easier. The first step is to identify the problem.

Here are some warning signs

- Weight loss or poor weight gain.
- Concern that the person is not getting enough water or other liquids.
- Difficulty chewing.
- Eating a meal takes a long time.
- Coughing and/or choking while eating or drinking or right after.
- Gagging or regurgitation (person spits up food).
- Heartburn (burning in chest) or indigestion (sore stomach).
- Anxiety about food or swallowing.
- Avoiding or refusing to eat certain foods. Infants refuse to eat more solid, "adult" foods.
- Chest infections not due to any other illness.

What to do

- Ask your doctor to see a feeding and swallowing team (dysphagia service).
- Keep a diary. Write down:
  - The food you tried to eat and what it was like, e.g. if it was meat - what kind, and was it ground or solid?
  - Foods that are easy to swallow, and look for patterns in these.
  - If it's easier to swallow liquids than solid foods, and if this changes.

please turn the page