



# OCCUPATIONAL THERAPY · NOW

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## Table of Contents

- 3**    **Rehabilitation in the context of HIV: Implications for occupational therapists**  
Todd Tran, Sheila Thomas, Deb Cameron and Gillian Bone
  
- 7**    **Theory Meets Practice: A new OT Now column**  
Heidi Cramm
  
- 8**    **Meet the OT Now column editors**
  
- 10**   **Introducing StrokEngine: The stroke rehabilitation intervention website**  
Nicol Korner-Bitensky
  
- 13**   **The SCIRE project: Evidence from the spinal cord injury rehabilitation literature**  
Bill Miller and Sandra Connolly
  
- 14**   **OT Then**  
Judith Friedland
  
- 15**   **Sense of Doing**  
**Redefining occupations for individuals living with a mental illness**  
Melissa Heidebrecht and Melissa Monardo
  
- 18**   **Critically Appraised Papers**  
**Clients' perceptions were the strongest predictor of assistive technology use after discharge**  
Joan Versnel
  
- 22**   **Enabling occupation by changing the fit between person and environment: A role for occupational therapy at The University of Western Ontario**  
Michele MacIntosh, Stephanie Taylor, Lisa Klinger and Linda Miller
  
- 25**   **Update from the Canadian Occupational Therapy Foundation**
  
- 27**   **Canadian Association of Occupational Therapists endorsed courses**
  
- 32**   **Occupational therapy strategies for people living with HIV/AIDS**

On the cover is the Narrows, St. John's Harbour in Newfoundland, where this year's CAOT conference will be held from July 11 to 14. Thank you to Newfoundland and Labrador Tourism for the use of this photograph.

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# Rehabilitation in the context of HIV: Implications for occupational therapists

Todd Tran, Sheila Thomas, Deb Cameron and Gillian Bone

*In the 2007 January issue of OT Now, part one of this article described the involvement and opportunities for occupational therapists with the Canadian Working Group on HIV and Rehabilitation (CWGHR). Part two discusses what occupational therapists need to know about working with clients who have human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS). Future trends dictate that as more people live longer with HIV/AIDS, they will require more rehabilitative services. Occupational therapists must be prepared with the tools and knowledge to assist this emerging population.*

## Biology and pathophysiology

Before addressing what occupational therapists need to know about working with clients living with HIV/AIDS, an initial discussion of the biology and pathophysiology of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) is required to understand how the disease affects an individual's overall functioning. This understanding will direct the rehabilitative approach.

The terms HIV and AIDS are often used interchangeably but it is important to know the difference. HIV is a virus that targets the body's immune system. People can live many years without any symptoms, however as more years pass their immune system becomes more compromised. The weakened immune system leads to acquired illnesses that the body is not able to fight. As a result, the individual develops opportunistic infections or an AIDS defining illness. The term AIDS is used to denote a chronic, life threatening condition that is caused by the HIV virus.

HIV is caused by a virus that belongs to a family known as retroviruses that targets white blood cells called leukocytes (sometimes referred to as T4 cells) because they have CD4 receptors on the surface. Without these cells to protect the immune system, ubiquitous organisms such as bacteria, viruses, fungi and parasites, multiply and the body succumbs to infections. A normal CD4 count for a healthy individual is between 550 to 1250 cells per cubic millimetre (cells/mm<sup>3</sup>) (Patterson & Robichau, 1999) and the higher the CD4 count, the better the immune func-

tioning. According to the HIV/AIDS Palliative Care Module compiled by Mount Sinai Hospital and Casey House Hospice (Ferris et al., 1995), the module states that any CD4 count below 300 cells/mm<sup>3</sup> puts the individual at risk of acquiring an AIDS defining illness such as Kaposi's sarcoma, thrush or Pneumocystis carinii pneumonia (PCP). HIV has a systemic impact on the body involving the musculoskeletal, metabolic/endocrine, cardiopulmonary, neurological, gastrointestinal and integument systems (Galantino, 2001).

*"Future trends dictate that as more people live longer with HIV/AIDS, they will require more rehabilitative services."*

HAART (Highly Active Anti-Retroviral Therapy) is the name given to a drug treatment of HIV/AIDS and is aimed at decreasing viral activity. A viral load test measures the amount of virus circulating in the blood (Patterson & Robichau, 1999). With the advent of HAART, many people living with HIV/AIDS are able to decrease their viral load to undetectable levels. Despite these undetectable blood levels, the individual is still HIV positive as the virus is present in the other bodily fluids and organs.

## Demystifying transmission

It is important to discuss the transmission of the virus to clarify any misconceptions. As practicing occupational therapists working on the frontlines of health care and taking universal precautions, you should have no concerns about contracting the HIV virus from our clients. Occupational therapists are rarely exposed to any personal risk from their clients living with HIV/AIDS because they rarely come into contact with their bodily fluids. However some occupational therapists may have a greater risk, particularly if they work in settings such as emergency or wound care. Occupational therapists working in environments such as these should take all the necessary precautions, which can include gowning, wearing gloves and other situation specific precautions.

Prevention of HIV infection from established transmission routes includes: using safer sex guide-

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lines; harm reduction strategies; screening of blood, blood products and bodily components; universal precautions for all health care workers and prenatal guidelines to prevent vertical transmission.

### Population trends

In the early 1980s, the North American population most affected by HIV was men who have sex with men (MSM). According to Statistics Canada 2005 (Public Health Agency of Canada, 2006a) those at greatest risk of contracting HIV are still MSM, but the number of heterosexual men and women infected through unsafe sex is rising. The number of women being infected in North America now represents 20 per cent of those living with HIV/AIDS. Aboriginals are three times more likely to be infected with HIV than are other Canadians. HIV/AIDS also affects other vulnerable populations, including inmates, people who inject drugs, at risk youth, women and people from places where HIV is endemic such as in sub-Saharan Africa.

### Psychosocial issues

As therapists working with clients who have HIV/AIDS, we need to consider our own cultural, religious and socioeconomic backgrounds and how they might differ from those of our clients. In North America, many newly diagnosed cases are occurring in marginalized communities that include MSM, intravenous drug users, at risk youth and women. As when working with other populations, an occupational therapist must be able to

separate their own personal belief system from the practice of their profession and avoid having a judgmental attitude. To establish rapport and gain the trust of our clients we have to empathize, listen and be aware of the psychosocial issues facing individuals living with HIV/AIDS. Occupational therapists have a professional responsibility to provide care. Each provincial regulatory organization and the Canadian Association of Occupational Therapists (CAOT) have a code of ethics to guide us in the way that we interact with our clients (CAOT, 2007). For example, according to the College of Occupational Therapists of Ontario (COTO), the integrity of the clients with whom an occupational therapist works with shall be respected at all times. This includes respecting and supporting the choices of her/his clients, regardless of whether they conflict with the occupational therapist's professional and personal values and beliefs (COTO, 2002).

Confidentiality is paramount as some clients may have disclosed their HIV status to their health care providers but have not informed their family members, insurers and friends. This reticence to disclose one's status comes from the stigmatization and discrimination that many people face living with HIV/AIDS. Every client must be treated on an individual basis; regarding disclosure, their wishes must be respected.

### Empowerment

Mental health concerns play a large role in the lives of HIV/AIDS clients. Mental illnesses such as mood disorders and substance use may contribute to the high risk behaviours related to acquiring HIV. Other psychosocial issues may disempower an individual and can include internalized homophobia, abuse, poor social support, low self-esteem, lack of knowledge about modes of transmission, gender roles based on cultural norms, poverty and use of recreational drugs such as ecstasy, crystal methamphetamine and alcohol. These issues can make people with HIV/AIDS feel less control over their own lives. Particularly vulnerable populations are young women with a low self-image who feel unable to stand up for themselves. They may engage in high risk behaviours and make poor decisions that may lead to acquiring the HIV virus. Thus it is important for occupational therapists to support our clients by educating them and linking them to the appropriate resources in order for them to feel empowered and to make informed life decisions.

## Occupational therapy role

Studies have indicated that people living with HIV are exceeding the 10-year median from the time of contraction of the virus to AIDS diagnosis (Public Health Agency of Canada, 2006b). With the advent of HAART medications, people living with HIV/AIDS are surviving much longer, up to 20 years or more after diagnosis in some cases. Living longer with HIV/AIDS, however, does not necessarily mean living without any disabilities, impairments or handicaps. The British Columbia Prevalence Study (Rusch, Nixon, Schilder, Chan & Hogg, 2004) demonstrates a remarkably high prevalence of disablement among people living with HIV in British Columbia. The study states that 80 per cent to 93 per cent of individuals with HIV/AIDS experienced at least one impairment, activity limitation or participation restriction. This level of disablement demonstrates a high need for rehabilitation among persons living with HIV.

Living with HIV/AIDS is termed episodic when there are periods of wellness as well as illness. These periods of wellness and illness can be similar to other chronic conditions such as multiple sclerosis (MS), lupus, arthritis, cancer and mental illness. People living with episodic conditions such as these will at times experience levels of participation restriction, difficulties facing life situational roles and activity limitations and/or have problems executing an activity. By enabling these individuals, this is an area where occupational therapists can facilitate optimum occupational performance and play a vital role (Beauregard & Solomon, 2005).

The physical challenges with HIV/AIDS are similar to those for individuals living with other episodic disabilities and some of the same occupational therapy interventions may prove helpful and include: energy conservation strategies, seating/mobility needs, home/office/environmental modifications, adaptive devices and resources that address activity of daily living (ADL) and instrumental activities of daily living (IADL).

The two most common neurological manifestations of HIV infection are HIV associated cognitive impairment and peripheral neuropathy. This cognitive impairment affects the subcortical areas of the brain responsible for executive functions such as attention, motivation and emotionality (Myers, 2005). Individuals living with HIV/AIDS dementia are less likely to experience cortical dementias affecting memory, language, problem-solving and reasoning which are more common among people living with

Alzheimer's disease. Occupational therapists apply similar compensatory strategies to those used in Alzheimer's disease or dementias to overcome these barriers so clients can live independently within their community or with minimal supervision.

*“Many occupational therapists have experience and expertise in dealing with episodic disabilities and can transfer this expertise to assist clients with the functional impact of HIV on their lives.”*

The second common neurological condition is peripheral neuropathy. About one third of people with HIV develop peripheral neuropathy in their feet including numbness, tingling, burning pain, muscle weakness and foot deformity. Affected individuals should see a clinician with expertise in this area for specific advice regarding proper foot care, footwear advice, protective insoles and in some cases, custom-made foot orthotics. The goal is to prevent injury and foot deformity which limits occupational performance (J. Giroux, personal communication, December 4, 2006).

## Future trends

As the life expectancy for living with HIV/AIDS increases, some individuals could benefit from being supported in their return to work. However, for many people there are significant disincentives to employment based on stigmatization, discrimination and risk to continued medical and financial support should they need to leave work due to another episode of illness related to HIV. Other barriers to a return to work include significant gaps in time from previous employment, loss of a previous job title or position, as well as changes to job demands and technological advances. Greater challenges to employment occur with individuals who are from marginalized communities; these people may have limitations in education, opportunities for gainful employment and development of adequate life skills, whereas others may have engaged in illegal activities to procure an income.

There is also the dilemma of disclosing one's HIV status due to the risk of discrimination, loss of benefit coverage (many insurance companies policies have a pre-existing condition clause) and fears from potential employers that the individual would take off too many days for illness or medical appointments and be a burden to the organizations. Although there

is legislation governing such forms of discrimination such as Federal and Provincial Human Rights Codes and the Ontarians with Disabilities Act (ODA) which require employers to provide reasonable accommodations for employees living with HIV/AIDS, their application can vary from situation to situation and be difficult to predict with any level of accuracy.

For many individuals living with HIV/AIDS, participation restrictions result in the need to access income support programs. Government social and income support programs and many private pension programs are inadequate for individuals living with HIV/AIDS. This handicap is exacerbated by the few affordable supportive housing options. Currently the supportive housing facilities in large urban settings in Canada are at capacity and waiting lists are extensive. Traditional facilities that offer the level of support or care that might be required for an individual living with HIV/AIDS are in long-term care centres. These places may not be appropriate for such clients due to their relative youth and autonomy. At this time, individuals are being discharged from hospital or supportive housing to reside with a family member or in sub-optimal accommodation on their own.

Although HIV/AIDS was first recognized in the early 1980s, the psychosocial and rehabilitation issues continue to be a factor and will need to be addressed in the future. John Taccone, an individual who along with his partner have lived with HIV for collectively 38 years, reflected on the challenges of living with this condition and how it impacts caregivers. John has met and spoken with several occupational therapy and physical therapy caregivers, all excellent and capable but in John's opinion, not as available as they would be in an ideal world. John also believes that all service needs for people with HIV/AIDS must be transparent for accessibility to be universal and the ultimate goal is for a multi-disciplinary approach to be part of a holistic system delivery of care. "That is the first thing - it seems that HIV is not treated as often, or as early as it can be because of division within the systems/specialties and delivery of service or care," says John.

Occupational therapists are extremely well positioned to assist individuals living with HIV/AIDS. The advent of HAART has diminished the lethal impact of the virus in North America such that individuals may now face a more chronic, episodic disability. Many occupational therapists have experience and expertise in dealing with episodic disabilities and can transfer this expertise to assist clients with the

functional impact of HIV on their lives. The chronic nature of HIV and AIDS will likely mean that occupational therapists will be increasingly involved with this population. Thus we need to be informed, sensitive, and equipped with the knowledge to assist in their care.

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Column Editor: Heidi Cramm

# Theory Meets Practice: A new OT Now column

Heidi Cramm, OT Now column editor

Welcome to Theory Meets Practice, a new column designed to bring theory to the forefront of occupational therapy practice. Occupational therapists increasingly look to theory to evolve their evidence and research bases; yet many occupational therapists struggle to incorporate theory into their daily practice settings. For some, theory remains a murky entity that has little place in practice. Many others rely on the theories they learned while taking their degree and may become overwhelmed when they critique a theory or try to integrate other theories into their way of thinking.

Theory Meets Practice endeavours to create a forum where understanding and using theory can become clearer. The column hopes to assist clinicians to gain confidence in their reliance on theories used in occupational therapy, offer practical support in bridging theory to practice and clarify their ongoing clinical reasoning.

## What is theory?

Theories are how you think about what you do. They are ways of thinking (conceptual models) and ways of doing (models of practice) that can directly inform how you practice. Theory can be about occupation, developed by and for occupational therapists; it can

also come from other fields, including education, social work and behavioural science. Theory can also be broad, informing your general orientation to practice. For example, you may begin with an assessment of occupational performance issues and investigate performance component issues as they arise, or you may begin your

involvement by assessing performance components, eventually building towards understanding the occupational performance issues. Theory can also be specific, for example helping you understand the biomechanics of the hand to help you create an adaptive splint. In any event, theory is always present in what you do, although you may not be mindful of it.

### About the author –

**Heidi Cramm** is an occupational therapist working in child and adolescent psychiatry at Hotel Dieu Hospital, Kingston, ON. You can reach Heidi at [hcramm@cogeco.ca](mailto:hcramm@cogeco.ca)

## How can theory help me in practice?

It is helpful to reflect on the presence and utility of theory as it can provide an underpinning for our practice and help justify our service. A comfortable grounding in theory helps us to further the profession by better articulating our unique domain of concern. This is imperative in today's competitive and fragmented marketplace. Transparent practice demands this; frameworks such as the Occupational Performance Process Model help you to structure and prompt your access to theory in practice. Theory also

*"... a new column designed to bring theory to the forefront of occupational therapy practice."*

expands how you think about a given situation and offers you alternate explanations so that you can gradually refine your clinical reasoning abilities.

## What can I expect to see in Theory Meets Practice?

Theory is a diverse category, so the column will evolve to offer a variety of articles to support the reader's theory needs. For example, case studies that share practical innovation in the application of theory in practice will be featured so that we can learn from the approaches of our colleagues. Discussion of how theory could be best integrated into practice is another essential feature of the column, as are critical reviews of applying theory to practice. To reduce confusion about theories, discrepancies between theories and current practices will be broached, as well as how they might be redressed. Terms found in different ways across the literature will be clarified so the therapist has a better sense of how to think and use them in practice.

# Meet the OT Now Column Editors

## CRITICALLY APPRAISED PAPERS

Column Editor: **Lori Letts**

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A Critically Appraised Paper or CAP is a succinct appraisal of a single research study and is comprised of a declarative title, structured abstract and commentary. The declarative title and structured abstract provide a précis of the article. The com-

mentary is written by a clinician or methodologist with expertise in the practice area discussed in the study. The CAP commentary highlights methodological strengths and weaknesses of a study, places the study in the context of other research, as well as discusses implications for practice, education and future research. The CAP is designed to provide therapists with information about recently published evidence so that the research can be more readily incorporated into practice. Both the structured abstracts and the CAPs are peer reviewed.

## IN TOUCH WITH ASSISTIVE TECHNOLOGY

Column Editors: **Josée Séguin and Roselle Adler**

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Josée Séguin



Roselle Adler

This column aims to assist occupational therapists to gain knowledge or remain current in the area of assistive technology. For the column, the definition of assistive technology is any item, piece of equipment or product system whether acquired commercially off the shelf, modified or customized that is used to increase, maintain or improve functional capabilities of individuals with disabilities. Potential topics for articles include an overview of a range of products and/or reviews of specific devices; case studies that

demonstrate the creative use of assistive technologies to enhance independence; and descriptions and application of technology.

## INTERNATIONAL CONNECTIONS

Column Editor: **Sandra Bressler**

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Many Canadian occupational therapists have worked abroad establishing client services, developing educational program or in previously established settings experiencing another country's practices and customs. In this column we invite

Canadian occupational therapists to share their international experiences. International trade agreements are encouraging professional mobility and occupational therapists need information to prepare for global marketing of their expertise and services. In addition to submitted articles, information regarding CAOT and WFOT international activities will also be featured in the column along with other resources to help you in your international connections.

## PRIVATE PRACTICE INSIGHTS

Column Editor: **Lorian Kennedy**

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The shift to community-based practice has opened new opportunities for occupational therapists, many of whom own and operate successful private practices. This column focuses on ways to enhance the success of private practice and ensure

access to quality occupational therapy services. Authors are invited to submit articles regarding profiles of successful occupational therapy practitioners describing how and why they entered private practice, their motivations and what sustains them; specific market(s) and how occupational therapy services are delivered; challenging business situation(s) and how they were resolved; successful management practices; and examples of collaborative projects that enhance business success for occupational therapy practices.

## THEORY MEETS PRACTICE

Column Editor: Heidi Cramm

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Many occupational therapists seek to understand how theory interfaces with practice. Theories are ways of thinking and ways of doing that can directly inform practice and may include conceptual models and frameworks. It is helpful to reflect on the

presence and utility of theory as it can provide an underpinning for our practice. This column endeavours to support practitioners in understanding theory and its relevance and application to daily practice. The following are examples of the types of articles for the column: case studies that share practical innovation in the application of theory in practice; discussion of how theory could be best integrated into practice; discrepancies between theories and current practices and how they might be redressed; and clarification of terms used in a variety of ways across the literature.

## SENSE OF DOING

Column Editors: Helene Polatajko and Jane Davis

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Helene Polatajko

Our primary role as occupational therapists is to enable people's occupation and to do this well we need to understand occupation to its fullest. This column will provide a venue for dialogue about occupation; it will feature discussions pertaining to questions which are asked by practicing occupational therapists and occupational scientists. The focus of the column will be on those aspects of the sense of doing that are of greatest concern to practitioners so that we, as occupational therapists, can make sense not only of what



Jane Davis

other people do but also what we do. It is the intention that the column will address the needs of occupational therapists trying to use occupation in their day-to-day practice. The column will feature articles addressing topics that relate the occupation, its study and its enablement.

## TELE-OCCUPATIONAL THERAPY

Column Editors: Lili Liu and Masako Miyazaki

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Lili Liu



Masako Miyazaki

This column examines occupational therapists' experiences with using technologies to provide services at a distance. Occupational therapists use a wide range of technologies that range from low-tech to high-tech. These include video-phones and stand alone telehealth units. Technologies may also be used for conducting assessments, interviews, team conferences or continuing education. As more occupational therapists incorporate technologies into their practice, they are faced with new issues and challenges. These issues include distance supervision of students and rehabilitation assistants and

the roles of occupational therapists as expert consultants at working from a distance. We invite clinicians to submit articles, vignettes or success stories on their experiences with tele-occupational therapy. The editors encourage clinicians, students and researchers to submit questions and answers that will help the clinical community to understand tele-occupational therapy.

## WATCH YOUR PRACTICE

Column Editor:

Sandra Hobson

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Today's occupational therapy practice is increasingly complex and fast-paced, so it is both helpful and efficient to establish a routine in professional life. Routines are

important because they provide structure to our daily activities. However, as routines become firmly established, they can also serve to prevent us from looking at alternative ways of practicing occupational therapy. The purpose of the Watch Your Practice column is to present alternative ways to practice and foster engagement in thoughtful, reflective and evidence-based practice. The column will explore some of the practice challenges and provide a forum where we can reflect on these together. The column seeks to engage in a dialogue about these issues and to further build our collective capacity to make ethical, legal and deliberate practice choices in the best interests of our clients and our profession.





Figure 2: Quick Review

example, a medical resident on a stroke unit could be asked by a family member of a person who has had a stroke about the value of a treatment to improve unilateral spatial neglect. By looking on the StrokEngine website for an answer, they will have accurate and quick access to a summary paragraph on the evidence of effectiveness. It is also a helpful section for the busy occupational therapist who wants a quick overview of the evidence regarding an intervention, such as constraint induced upper limb intervention for an individual in the sub-acute phase of recovery. By referring to the Quick Review button, a clinician can decide whether to take the time to read more about the intervention and its applicability for use in their clinical practice.

The second button, In Depth Review (Figure 3), is aimed at health professionals, typically occupational



Figure 3: In-depth Review

therapists or physical therapists, who require in-depth knowledge of the effectiveness of specific rehabilitation interventions to assist them in making informed treatment decisions for their clients. The information in this section includes relevant publications, a summary of the findings of each study, a critical appraisal of the quality of the publication, hyperlinks to the actual publication, the level of evidence of effectiveness in the area of questioning. For example, a potential question could be regarding spatial neglect: Is unilateral spatial neglect retraining using prisms effective post-stroke when compared to convention therapy? The information provided to the reader includes any conflicting reports of effectiveness and plausible reasons for these conflicts.

Finally, the Patient/Family Info (Figure 4) button provides a concise description of the topic in lay language aimed at individuals who have had a stroke



Figure 4: Patient/Family Info

and their families, friends or care partners. The information is based on scientific evidence. Using the example of assistive devices the family related topic headings include: What is an assistive device? Does it help a person to do daily activities, such as walking, dressing or bathing? Who should provide advice and training for the assistive device? Can an assistive device help me go back to work? Because this section focuses on lay person education, the information is written at a Grade 6 reading level, which is consistent with recommendations regarding written materials for older adults and the general public.

The Patient/Family section of StrokEngine has undergone pilot testing with families and people who have had a stroke to determine its appeal and

usability. The overall impression of the site was extremely positive. The feedback allowed us to make adjustments to the look, content and structure of the site that will facilitate its use by the general public. Our ultimate goal in creating StrokEngine – Patient/Family is to empower families and clients to understand stroke rehabilitation and the effectiveness of interventions.

As we go forward with StrokEngine it is our goal to update the intervention modules every six months so that clinicians will always have access to the latest information.

### Where can StrokEngine be accessed?

StrokEngine is usable in hospitals, outpatient clinics or anywhere in the community where there is a computer and Internet access. Each module has also been created with a printer friendly version so that pages can be printed for those who prefer to have a hard copy or for those who do not have access to a computer. There is no cost associated with using StrokEngine.

### Where do we go from here?

In Phase 2 of StrokEngine development, we are creating a clinician website that focuses on assessment tools - StrokEngine-Assess (Figure 5) that was introduced for international use in January 2007. StrokEngine-Assess provides a summary of the psychometric properties and the usability of assessment tools for stroke rehabilitation including the following information:

1. Practicality and usability with specific clients. For example, the tool may only be appropriate for an individual with a stroke who has certain functions intact such as vision, sensation, and speech. The testing position and time for administration are included to assist clinicians to decide whether the assessment tool is appropriate based on the client's phase of recovery and the setting. The required cost of equipment, the skills needed to conduct the assessment and other usability information is also provided for each tool.
2. Psychometric properties of the tool. Each tool is reviewed for its psychometric properties including whether it has a standardized procedure for administration, proven validity and reliability, as well as whether it is an evaluative tool that is responsiveness to change.



Figure 5:StrokEngine - Assess

### Please keep in touch

With the incredible proliferation of assessment tools and interventions for people who have had a stroke it is difficult to keep abreast of all of the stroke literature. Our research team is working hard to make the website valuable for clinicians so we welcome your feedback. If you visit the website you will notice a link to contact us. We read each E-mail and appreciate your comments. Come visit us! The website is [www.mcgill.ca/strokengine](http://www.mcgill.ca/strokengine)

Visit the CAOT Information Gateway for direct links to the StrokEngine and the SCIRE project (see page 13 of this issue for details). You can access these clinical knowledge translation websites through the following link: <http://www.caot.ca/default.asp?pageid=1143>. The goal of these sites is to bridge the gap between research findings and current clinical practice.

# The SCIRE project: Evidence from the spinal cord injury rehabilitation literature

Bill Miller and Sandra Connolly



The pressure to incorporate evidence into practice is essentially old news. The special issue of the *Canadian Journal of Occupational Therapy* on evidence-based occupational therapy hit our mailboxes in June 1998. Even at that time, Mary Egan and her colleagues noted that health care practitioners have been encouraged to incorporate evidence into practice for over 300 years. The news today is that nine years later there is certainly no shortage of evidence; libraries are jammed from floor to ceiling with journals conveying the latest findings in print and access to the internet has further accelerated the opportunities to tap into a broad base of electronic literature with a minimum environmental barrier. Despite the fact

that many investigators publish occupational therapy relevant literature in non-professionally oriented, more generic rehabilitation journals, now the primary barrier is not necessarily related to accessing the literature, but how to cope with the volume of available evidence. The Spinal Cord Injury Rehabilitation Evidence (SCIRE) review is a new tool to enable and assist busy therapists to manage the volumes of reading.

The SCIRE project is a comprehensive synthesis of over 700 reviewed articles of the published evidence related to rehabilitation interventions and strategies designed to improve the function, occupations and quality of life for people with a spinal cord injury. Included in the SCIRE project is a review of outcome measures used with this population. Version 1.0 of the SCIRE review was completed in October 2006 and is available free by download at the following web site: <http://www.icord.org/scire>. This review is the first step in the knowledge transla-

tion process to provide clinicians, clients and their families, researchers and policy makers with user friendly information to assist with making better-informed decision for people with a spinal cord injury.

The advantage of the evidence presented in the 22 SCIRE chapters is that it represents a one-stop shop for occupational therapists who work with the spinal cord population. Some examples of how SCIRE may help you in your practice include:

- Searching for evidence to support the idea of early attendance at seating clinic to avoid funding cuts by hospital administrators or to prevent a long-term care facility from purchasing only one type of cushion. A quick review of Chapter 20 in the SCIRE review provides a summary and a rating of the quality of the studies.
- Need to convince your client that splinting will promote function and prevent contractures for people who have a high level lesion (tetraplegia)? Check out Chapter 5.
- Having problems justifying vehicle modifications or purchase of environmental control units for your clients? Take a peek at Chapter 4.
- Want to know how to capture quality of life or occupation/participation related outcomes? Peruse Chapter 22.

SCIRE is a joint initiative between the Universities of British Columbia and Western Ontario, as well as St. Joseph's Health Care - Parkwood Hospital (London, ON) and G.F. Strong Rehabilitation Centre (Vancouver, BC). The review brought together over 40 clinicians and investigators from across Canada to conduct the reviews. Version 1 was funded by the Rick Hansen Man in Motion and the Ontario Neurotrauma Foundations. This version is simply the beginning of SCIRE activities. In the near future, additional versions are anticipated as well as efforts to develop clinical guidelines and identify gaps in the rehabilitation research, policy and evidence to support best practice for people with a spinal cord injury. Despite the recent release date of Version 1, efforts are underway to advance the SCIRE initiative by including new chapters on activity, assistive technology and anxiety. But don't wait for future versions; check out the SCIRE project today at <http://www.icord.org/scire!>

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Bill and Sandra are two of the editors who lead the SCIRE project.

## OT Then

On June 22, 1918, following a 6-week tour of ward occupations (i.e. occupational therapy departments) in Canadian Military Hospitals, Elizabeth Upham, a professor of applied arts and director of the art department of Milwaukee-Downer College in Wisconsin, wrote to her College President stating:

I have found a treasure in Edmonton, Alberta, [at Strathcona Military Hospital] a Miss Goodman who could organize and supervise practice teaching in the Milwaukee Hospitals ... She earns \$1200 a year and is to be given a higher salary and I believe several assistants. She is to become head of the work for the entire Province. They have also promised to pay her expenses and give her a trip through the States. Therefore if we should be able to secure her, we would have to make it worth her while ...

Not only would Milwaukee-Downer have to make it worth her while – they would also have to find a way to get Hilda Goodman across the border into the U.S. for, as the American Consul General said: “In going over the list of professions admissible to the United States, no mention is made of what is known as occupational therapy.” Hilda Goodman did eventually make it to Milwaukee.

To read about her work in Edmonton and in Milwaukee, visit OT Then on the CAOT web site at <http://www.caot.ca/default.asp?pageid=2115>

### Photograph of the Strathcona Military Hospital 1919



City of Edmonton Archives EA 257-21

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# Redefining occupations for individuals living with a mental illness



Column Editors: Helene J. Polatajko and Jane A. Davis

Melissa Heidebrecht and Melissa Monardo

Thinking back on the first few days of our student placement at St. George House, a local community residence for individuals living with a mental illness, we were filled with mixed emotions. As this was to be our first experience working within a mental health facility, we were fearful and intimidated by the unknown, and excited to be starting a new challenge. This was exceptionally true as we were embarking on an opportunity to bring the occupational therapy principles recently learned in school, to a brand new setting where no occupational therapists had worked before. To our surprise this placement taught us more about occupation and mental health than we ever imagined possible.

*“... we were not provided with the residents’ diagnoses which ... enabled us to view the residents and our environment through an occupational lens rather than a diagnostic one.”*

As St. George House was a new placement, there was no existing framework for the role of an occupational therapist in this setting. In an attempt to establish our overall goal we had a meeting before the placement began with the fieldwork coordinator, our supervising occupational therapist, the house staff and the agency’s program director. The resulting consensus of this meeting was that we were to “activate” the residents into doing things, whether that was gainful employment, volunteer activities or more participation in the house activities. Guided by this information, we began to think about ways to enable the residents to engage in productive and leisure occupations.

When we arrived at St. George House, it was hard for us to imagine how we could apply occupational therapy principles to enable the residents’ occupations. We spent the first few days observing and interacting with the residents and building rapport with both the staff and residents. As with the staff who were previously oriented to their new positions at St. George House, we were not provided with the residents’ diagnoses, which helped us to be open to all that we saw and enabled us to view the residents and our environment through an occupational

lens rather than a diagnostic one. These first few days exposed us to the daily routines and occupational patterns of the residents which generally consisted of rising late for breakfast each day, taking medications, spending most of the morning smoking either in the “smoke room” or outside, eating lunch, watching favourite soap operas, more smoking and eating supper. Very few of the residents left the house to engage in employment, volunteer activities or community groups, all of which were theoretically available to them in the community. Of all the residents, only two were gainfully employed while a third resident left the house occasionally to volunteer in the community.

The staff at St. George House worked hard to organize evening activities whenever possible but when no activity was available, residents spent the evening watching TV or socializing in the smoking room. The most persistent observation we made was the absence of interactive and group activities or socialization during the day. These observations are similar to the ones discussed in recovery literature. For example, Patricia Deegan, a well known consumer/survivor and author, points out that she herself used to sit in the same chair all day smoking, using the cigarettes as a measure of time, leaving the chair only to sleep or eat (Deegan, 1996). Deegan talks about this as the “hardened heart” state where the individual is afraid to hope, care or enjoy anything for fear of more disappointment.

After just a few days at the house, it became apparent based on our initial observations that the original idea of activation into the community was a worthy, but lofty goal. Thus, we decided that it was unrealistic to assume we could enable these individuals to actively pursue involvement in community-based occupations in just seven weeks. So our focus became smaller and client-centered. Furthermore, to reach the maximum number of individuals, we devel-

**CSOS**  Canadian Society of Occupational Scientists

Edited by Polatajko and Davis, on behalf of CSOS.  
visit CSOS at [www.dal.ca/~csos/index.htm](http://www.dal.ca/~csos/index.htm)

oped simple interactive and sustainable groups that could be carried on by the residents after our placement was over.

In an attempt to begin our role as activation facilitators or occupational enablers, we needed to ensure that the people living at St. George House understood who we were and why we were in their home. We created a poster about occupational therapy using a variety of information from websites and courses to illustrate how we could work with them to enable their involvement in meaningful occupations. The poster was mounted for all to see and we subsequently held an information session for the residents where we spoke about our poster and answered the residents' questions. Once the residents understood our role, we decided that we needed to develop a client-centered process for uncovering the occupational desires of the residents and how best to facilitate those within the house.

Patricia Deegan (1996) offers insight into how best to approach stimulating engagement in occupations. She writes:

Choice, options, information, role models, being heard, developing and exercising a voice, opportunities for bettering one's life – these are the features of a human interactive environment that support the transition from not caring to caring, from surviving to becoming an active participant in one's own recovery process. (p. 96)

Using this approach and considering the residents' right to occupational choice and control, we designed and distributed an interest survey. Most of the residents responded with being interested in leisure and productive occupations such as knitting, sewing, painting, as well as discussing and learning about world events. After much consideration of the residents' occupational performance goals, their abilities and our skills, we realized that exposure to different occupations was key if we hoped to

enable the residents to initiate participation in occupations that they would continue after we left. Both of us also sought to model hope, and continued to offer choice and control despite the continuous refusals from some residents.

Using this client-generated information, we designed five groups with the following themes: crafts, skills for life, exercise/recreation, current events and vocational issues. Participation in all groups was on a volunteer basis, thus the membership varied each week, but all groups were set up to involve both group and individual work to complete a task. For example, in the Skills 4 Life group, the residents made candy treats to share with everyone in the house at the Christmas party and every Friday afternoon the Current Events group members sat in the dining room enjoying a snack and reading the newspaper together. It seemed that our most successful group was the latter which was less structured. The Current Events group involved sharing interesting articles chosen by individuals with the other group members followed by a discussion of what it meant to us individually. We anticipated that this group would continue after we left this placement as one resident with the support of staff, agreed to assume the responsibility for collecting newspapers during the week and hosting the group each Friday.

After the initial plans were in place we began to focus more on the residents themselves. One of them was particularly instrumental in demonstrating the difference between living and passing away time, and began to make sense of her doing as it related to living. Maggie typically spent her days in bed or smoking with very little interaction with anyone. Her best friend was a little stuffed monkey, which she took everywhere and used to relate to other residents. In a conversation over lunch one day, Maggie told us about her favourite game that she plays with family when they come to visit. We asked her to show us how to play it with her, so Maggie and her monkey taught us the rules of the game. Having this time with Maggie provided her with an opportunity to demonstrate her strengths in playing games. This game playing became a regular event in the home. Other residents participated and everyone chatted about life and daily troubles while we played. They also took turns teaching each other new card games. Through enabling engagement in this one occupation Maggie was able to integrate better into the home, construct an occupational routine and establish relationships around a commonly enjoyed leisure occupation.

On reflection, we learned so much from the residents, far more than we thought was possible in just seven weeks. We learned how difficult it can be to live

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with a mental illness; how debilitating fear and obsession can be for an individual; how mental illness can take away individuals' occupations and leave them feeling empty of value in their lives; and how having choice and control over occupations can motivate and stimulate participation. This experience has helped us to understand the significance and impact that doing can have on the physical and mental health of individuals. We are proud to say that we now see the residents as individuals with hope and commitment to their future, with occupational desires and goals, instead of individuals living with a mental illness.

When we began our placement, our wish was to inspire hope for the future through our work with the residents of St. George House, by revealing that life can be more than passing each day away. We wanted them to realize that they have control and choice in what they do, and can use their voices to advocate for the things that are important in their lives and that will enable their occupational participation. At the end of our placement, one of the residents said to us: "Thanks for coming and making us do things." This simple statement helped us realize we had made a difference in these residents' lives by enabling their exposure to different occupational possibilities that could be done right in their own home. Engagement in these occupations appeared to provide them with

*"This experience has helped us to understand the significance and impact that doing can have on the physical and mental health of individuals."*

a sense of purpose, enjoyment and structure for each day. Through their occupational participation the residents established relationships with others and appeared to form a sense of community and belonging. Our work was rewarded each day with smiles and laughter throughout the home as the residents engaged in and enjoyed the daily occupations that allowed them to live their time with others, instead of passing away their time alone. We left St. George House knowing we had begun the process of enabling these residents to engage in long-term occupations of their choice.

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### Acknowledgements

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Column Editor: Lori Letts

## Clients' perceptions were the strongest predictor of assistive technology use after discharge

**Summary of Wielandt, T., McKenna, K., Tooth, L., & Strong, J. (2006). Factors that predict the post-discharge use of recommended assistive technology (AT). *Disability and Rehabilitation: Assistive Technology*, 1, 29-40.**

Prepared by Joan Versnel, CAPs Advisory Group Member.

**Research objective:** To investigate the influence of factors related to the client, assistive technology and interventions on the post-discharge use of grab bars, bathing, toileting and dressing devices.

**Design:** A prospective correlational study with face-to-face, in-depth interviews conducted prior to hospital discharge with clients who were being recommended assistive technology devices. Telephone interviews were completed to collect the post-discharge data. Data collection for the study took place over nine months.

**Setting:** Orthopedic and rehabilitation wards of two metropolitan hospitals in Australia.

**Participants:** Clients in the hospital who received recommendations by an occupational therapist for assistive technology devices. The participants had no cognitive, perceptual or speech impairments so they could provide informed consent and participate in the interview process.

**Methods and outcome measures:** Each participant engaged in a 45 to 60 minute face-to-face interview prior to discharge. At baseline, data was collected on the perceptions of their illness/disability and the recommended assistive technology, presence of anxiety or depression, completion of a home visit, type of assistive technology recommended and participants' functional status and demographics. Data collection measures for these predictor variables included:

- Modified Barthel Index
- Hospital Anxiety and Depression Scale
- Motivation-Embarrassment Scale
- Questionnaire on assistive technology device characteristics

A follow-up telephone questionnaire was administered four to six weeks post-discharge. The questionnaire was developed for this study using literature review and peer input and piloted on the first 15 participants. No further modifications were made following the pilot. Questions were scored on a five point Likert-type scale and gathered data on the following aspects of the assistive technology: post-discharge use, perceptions of the benefits, input into decision-making on the recommendations, training (type and presence of significant others at sessions), understanding of the need, as well as questions for their rationale to not use the recommended device.

**Data analyses:** Descriptive statistical analyses were performed to generate data on demographics and predictor variables. The dependent variable was use or non-use of assistive technology post-discharge. Data were inspected and recoded to deal with skewness and extreme splits. Chi square analyses using Fisher's Exact Test were used to determine the relationship between the predictor variables and the participants' use of the devices and other predictor variables. The data for the variables with statistically significant relationships was then entered into a logistic regression model using backward elimination until the model contained only those variables with significant main effects and their interactions. Odds-ratios and confidence intervals of 95 per cent for the odds-ratios were calculated.

**Main findings:** During the nine months of data collection, 204 clients were deemed eligible to participate in the study. Twenty-four declined to participate. Six were too ill and 7 participants were lost to follow-up. In total, 167 clients participated in the study. The mean age of participants was 69.2 years, 61 per cent were female and 39 per cent male. Sixty-one per cent of participants reported being married or having a partner. The diagnostic categories included total knee replacement (41 per cent), total hip replacement (31 per cent), other orthopedic conditions (10 per cent), neurological conditions (13 per cent) and other conditions (5 per cent). At the follow-up interviews five to

six weeks post-discharge, 66 per cent of participants were using the recommended devices.

The univariate statistical analyses of predictor variables by assistive technology use (looking at the relationship of each individual predictor variable with the dependent variable) found 12 predictor variables to be statistically significant. Two predictor variables (positive and negative perceptions) had insufficient data for analyses in some cells. The best regression model was statistically significant ( $p < .01$ ), and included perceptions of the devices, anxiety, and training. Participants whose perceptions of the characteristics were mainly positive were 6.8 times more likely to use devices post-discharge than those who had a negative perception of devices. Participants who were not anxious were 4.3 times more likely to use their devices than those who were mildly or severely anxious. Finally, participants who were able to remember their assistive technology training were 3.6 times more likely to use the devices following discharge than those who could not recall being provided with training.

#### **Authors' conclusions and clinical relevance:**

The authors state that three predictor variables influence the post-discharge use of assistive technology:

1. Perceptions of the characteristics of the recommended devices. If the perception is positive, the person is more likely to use the devices.
2. Anxiety of the client. Presence of anxiety may interfere with use of assistive technology. The higher the anxiety, the less likely that a person will use recommended devices.
3. Ability to recall whether or not they had received training in AT use. Training that was recalled had a positive influence on the use of devices.

Several reasons for participants' non-use were discussed by the authors. Regarding clinical relevance, the authors highlight the importance of ensuring that recommendations for devices be client-related. With new models of health influencing occupational therapy practice, it will be necessary to shift from a focus on functional ability and independence to a focus on the interaction between the client, context and technology. The authors propose a Model of Matching Person and Technology (Scherer, 1998) which provides guidance to practitioners recommending assistive technology. This model identifies factors that could interfere with optimal use of

devices. The model is predicated on collaboration with the client to prevent discontinuing the use of devices post-discharge. The study illustrates the need to consider client perceptions, characteristics of the assistive technology, presence of anxiety, and training when making assistive technology recommendations.

Contact information for the appraised paper's first author is: Trish Wielandt, E-mail: [trish.wielandt@ualberta.ca](mailto:trish.wielandt@ualberta.ca)

#### **Commentary on Wielandt et al. (2006). Factors that predict the post-discharge use of recommended assistive technology (AT)**

Wielandt and her colleagues have conducted a recent empirical study on a question that has been raised by occupational therapists for decades: Why do clients discontinue the use of assistive technology recommended by occupational therapists? Specifically, the authors have attempted to identify predictors that influence whether or not clients use the recommended devices. The authors describe that historically assistive technology recommendations used a medical model; the main purpose was to improve clients' functional ability and independence. As our understanding of health expands, social models of health such as the International Classification of Functioning (World Health Organization, 2001) are guiding health care delivery. Clients' needs, wants and perceptions are increasingly driving forces in the decision-making process for interventions. These notions are not new for occupational therapists, so it should come as no surprise that the strongest predictor for post-discharge use was the participants' positive perceptions of the devices' characteristics.

The present study adds new knowledge in the following areas:

1. Few of the existing studies on clients' satisfaction with the use of assistive technology have used well validated instruments (Dijcks, Wessels, De Vlieger & Post, 2006). In part, this is in due to the lack of agreement about what criteria should be included in such measures. The use of logistic regression in the present study is a step to identify those criteria in a systematic fashion.
2. Wielandt and her colleagues have used logistic regression to determine which factors are the

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strongest predictors of use post-discharge. In this study the Odds Ratios from the logistic regression analyses indicate that:

- People with mainly positive perceptions of assistive technology were 6.8 times more likely to use recommended devices than those whose perceptions were negative;
- People without anxiety about using the devices post-discharge compared to persons with anxiety were 4.3 times more likely to use them;
- People who were able to recall receiving training in the use of devices were 3.6 times more likely to use them.

The results of logistic regression in research can be extremely useful to assist occupational therapists to determine which clients are more likely to use devices post-discharge. This finding has policy implications for funders as well as for clients and health care practitioners.

3. The identification of factors that influence the post-discharge use can also provide justification for the provision of new services. These new services have the potential to decrease people not using recommended devices and promote the appropriate use of resources.

### From the column editor – More on the analysis

Regression analyses provide information about relationships between and among variables. One of the strengths of the regression analyses is that they take into account the relationship among variables that may predict the dependent variable. Logistic regression is used when the dependent variable is a dichotomous variable and the independent or predictor variables are continuous, categorical, or both. For instance, in this study:

- the dependent variable is whether the participant does or does not use the recommended assistive technology;
- the predictor variables are scores on the measures for functional status, motivation, anxiety, and characteristics of the devices.

Logistic regression produces Odds Ratios (OR) associated with each predictor value. The "odds" of an event is defined as the probability of the outcome event occurring given one variable compared to another.

### Methods issues:

While the authors are to be applauded for designing a study that clearly delineates factors that influence the use of devices post-discharge, there are some methods issues which must be considered in the overall appraisal of the study. The authors have identified some of these in the discussion of the study limitations. There are others which need attention. First, the authors used a non-validated protocol for the follow-up interview. The protocol was piloted on the first 15 participants and deemed to be adequate. We are not given any other information on the validation process. Another difficulty is that logistic regression is indicated when the dependent variable is dichotomous. The description of the protocol in the article did not indicate how the value of the dependent variable was derived. It is not clear how participants were allocated into the use/non-use categories, especially if they had received more than one device. These related issues can be considered threats to the internal validity of the study. The issue of selection bias, while recognized by the authors, may have had more influence on the findings than the authors claimed. The participants were recruited by occupational therapists who had recommended the devices and it is quite possible that participants felt obligated to participate in the study. Finally, we are told very little about the more than 10 per cent of eligible participants who declined to take part in the study.

### Clinical application:

The results of the study are interesting and applicable; they support previous research and add a new factor to consider - anxiety. Important issues to consider are raised related to training such as the timing and training designs matched to learning styles, not only for clients but also their caregivers. Finally, the relationship between positive perceptions of assistive technology and their subsequent use by clients provides a clear mandate for client-centred occupational therapy. When clients identify devices as having a positive influence on their daily life, the likelihood of them being used post-discharge is much greater. When they are provided irrespective of the clients' wishes they are less likely to be positively perceived or to be used. The authors' suggestion that using Scherer's Model of Matching Person and Technology (MPT) (1998) would lead to a more thorough consideration of clients' perceptions, features of the device and contextual details is interesting. However, the Person-Environment-Occupation model used in occu-

pational therapy (Law et al., 1996) would not only address the issues inherent in the MPT Model but would also keep the focus on the relationship between the device, person, context and occupation.

### Future research:

Wielandt and her colleagues have completed an interesting study that could lead to future research, such as investigating the effectiveness of training. This would not only benefit the area of assistive technology but other clinical interventions where teaching and learning are integral to successful outcomes. Additionally, the factors identified as individually significant but were not included in the regression analyses could be examined to determine their potential influence.

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### Discussion questions

1. *How can occupational therapists best introduce AT to clients to enhance clients' perceptions of the devices?*
2. *How can training be best handled pre-discharge to help ensure that clients remember receiving the training?*
3. *What can occupational therapists do to detect and address client anxiety in order to increase the likelihood of using AT post-discharge?*
4. *Are generic models of occupational therapy practice like the Canadian Model of Occupational Performance or the Person-Environment-Occupation model sufficient to guide the practice of prescribing assistive devices?*

# Enabling occupation by changing the fit between person and environment: A role for occupational therapy at The University of Western Ontario

Michele MacIntosh, Stephanie Taylor, Lisa Klinger and Linda Miller

Mounting interest in inclusive design, coupled with the exciting recent advancements in accessibility legislation has greatly enhanced environmental inclusion and public access for people with disabilities. These developments have also provided significant opportunities for occupational therapy involvement, such as evaluating accessibility of the physical environment beyond the home to include schools, universities and facilities in the community.

Currently, there are many barriers to physical accessibility in Ontario's buildings and institutions. These barriers often prevent individuals from engaging in meaningful and purposeful occupations. Before June 14, 2005 Ontario legislation did not hold businesses and institutions accountable for inaccessibility. On June 13th, the Accessibility for Ontarians with Disabilities Act, 2005 (Bill 118) was passed (Office of the Legislative Assembly of Ontario, 2006), making barrier removal and prevention mandatory and requiring accessibility standards to be developed (Ontarians with Disabilities Act Committee, 2005).

By creating barrier-free environments in Ontario buildings and institutions, every individual is enabled to participate in their desired occupations. Although barrier-free environments are a necessity for individuals with a disability, they are also highly beneficial for general use. For example, individuals with a temporary impairment, pushing a stroller or a cart, or carrying an armful of items can all benefit from a physically accessible environment.

Occupational therapists can play a key role in maximizing the accessibility of the physical environment. Through clinical reasoning, observational skills, task analysis, and with the guidance of occupational therapy theoretical frames of reference (for example the Person-Environment-Occupation Model), occupational therapists have the ability to contribute to the development of physically accessible environments.

Through an ongoing research project evaluating the physical accessibility of The University of Western Ontario campus, occupational therapists and occupational therapy students have begun this process.

## University Campus Accessibility Measure

A thorough assessment of The University of Western Ontario campus was performed to assist the university in their commitment to meeting the accessibility standards required by Bill 118. The University Campus Accessibility Measure (UCAM) (Lee et al., 2001) was used for the assessment, which is an accessibility measure that was developed in order to evaluate the physical accessibility of university campuses. Data was collected using this measure during the summers of 2003 and 2004 by work-study students. Four key buildings were analyzed and prioritized in 2004 and 2005 by two M.Sc.(OT) students (MacIntosh, Taylor, Klinger, & Miller, 2005). There were three stages to the project:

### 1. Collecting and synthesizing the data

The UCAM produces an overwhelming amount of data and in order to be used by the university in a functional manner it had to be analyzed and prioritized. Clinical reasoning was relied on to eliminate insignificant data and concentrate on features that had the greatest impact on the physical accessibility of campus buildings. For example, the UCAM states that in order for a door to be physically accessible, the midpoint of a door handle must be between 900 mm and 1000 mm from the floor. However, it was decided that even if the midpoint of the handle is moderately higher or lower, it does not make the door inaccessible because a person would still be able to reach a part of the handle.

### 2. Prioritization system

Once the insignificant data was eliminated, it was then feasible to develop a prioritization system for the remaining data. To help prioritize, the measurements obtained by the UCAM were supplemented by onsite assessments of the campus buildings. This is a key role that occupational therapists can play in the evaluation of the physical accessibility of environments, using their observational skills and clinical reasoning. The onsite assessments provided important information concerning procedural issues that are not directly addressed by the UCAM, but are critical to enabling all individuals to engage in their

desired occupations. For example, on the university campus and in the buildings, there were not enough clear signs to direct people to accessible entrances and pathways. Even if there are excellent entrances in terms of physical accessibility, they are not being used to their full potential if they are not easily found (MacIntosh et al., 2005).

To further inform prioritization, the literature was consulted to explore current physical accessibility plans at Ontario universities and colleges. In addition, in order to obtain a sense of the practical issues that face students with disabilities at The University of Western Ontario, a discussion was held with staff from Services for Students with Disabilities (SSD). SSD is a branch of the Student Development Centre at The University of Western Ontario, which addresses the needs of students with disabilities at the University. SSD provided a number of recommendations concerning common accessibility issues and general safety concerns on campus (D. Stuart, W. Dickinson and S. Burns, personal communication, March 18, 2005). The literature and discussion assisted in the prioritization process by providing insight into current and applicable issues for individuals with disabilities using a university campus (MacIntosh et al., 2005).

All sources of information were compiled to make the following priority system:

- Class A: Items that must be changed or adapted to ensure the safety and accessibility of primary pathways through the physical design of a building and its furnishings. For example, an automatic door that does not stop opening when an object is in its path.
- Class B: Designated to changes that should be made. These are not as urgent as the Class A changes and are geared more towards quality of life issues. For example, a desk that is not height adjustable is in Class B. This is not a safety risk, but is important for the quality of life of students who need a specific height, for example to allow a wheelchair to pass under.
- Class C: Items which can be done if time and funds are available. These are issues that deal with inconveniences. For example, automatic doors that take greater than 3 seconds to open delay an individual requiring the automatic door to enter the building/hallway, causing an inconvenience.

- Class X: Changes that are not feasible unless a major reconstruction is completed. For example, a hallway that is too narrow could not be easily adapted and would require a significant renovation.

### 3. Compiling recommendations

This system was applied to the extensive data and the result was a comprehensive set of recommendations for each of the four buildings assessed. These recommendations were then provided to The University of Western Ontario as a guide to removing existing physical barriers on campus. This provided the university with an organized list to complete, allowing them to focus their limited resources on the most important areas first. The reference for the final report can be found at the end of the reference list.

In addition to the UCAM based recommendations that were specific to each of the four buildings, a number of general recommendations were provided to the university. The general recommendations included the following:

- All doors on major pathways require automatic openers.
- Signage should be posted both outside and inside of buildings directing to the location of accessible entrances and major pathways within the building.
- An evacuation plan for each building should be developed and communicated to faculty, staff and students with disabilities to ensure safety.
- A well-lit area of refuge should be created with proper directional signage.
- Each building should have an alarm system with a visual signal in addition to an auditory signal to notify emergencies to students, faculty and staff who are hard of hearing or deaf of an emergency.
- There should also be one accessible unisex washroom in each building or one fully accessible male and female washroom.

In addition to these guidelines to make existing buildings barrier-free, it is recommended that Western ensures that all new buildings are built to universal design standards. Barrier-free design is necessary in refits and renovations in order to make existing buildings accessible. An example is adding a ramp beside a set of stairs to enable individuals using a mobility aid to enter and utilize a building.

Universal design applies to new developments to make sure that an environment is accessible to all individuals, regardless of ability or disability, age, height, etc. It is recommended that this is best achieved by utilizing up-to-date guidelines on accessibility for all new builds and retrofits, such as the

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City of London Facility Accessibility Design Standards (City of London, 2006), as well as by consulting with persons with disabilities who are likely to use the buildings with respect to the facility design and furnishings.

These environmental improvements will allow access for most people with disabilities. However, adaptations for specific needs will still be required.

Designing buildings to meet the needs of all individuals can be complex because the needs of persons with one disability may be at odds with the needs of those with a different disability. For example, an individual who uses a wheeled mobility aid would benefit from a smooth curb cut, but a more pronounced change in threshold would be advantageous to someone who has a visual impairment.

In conclusion, there is a critical role for occupational therapists in the evaluation of the accessibility of physical environments. The UCAM is an excel-

lent tool that in the future, may be generalized to investigate buildings beyond university campuses. Using the prioritization guidelines outlined above, occupational therapists can maximize their ability to develop functional recommendations from the measurements obtained with the UCAM. Occupational

therapists can prove to be invaluable in assisting to remove barriers in the physical environment by considering the importance of the person and their desired occupations within the environment.

If people are interested in obtaining a copy of the UCAM, please write to Lisa Klinger at the School of Occupational Therapy, Faculty of Health Sciences, The University of Western Ontario, Elborn College, 1201 Western Road, London, ON N6G 1H1. E-mail: [lklinger@uwo.ca](mailto:lklinger@uwo.ca)

## References

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## Additional References

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**Correction Notice:** In the article published in the January 2007 issue of OT Now, "Canadian working Group on HIV and Rehabilitation: Involvement and oppprtunities for occupational therapists", the correct references are as follows: Rusch, M., Nixon, S., Schilder, A., Braitstein, P., Chan, K., & Hogg, R.S. (2004). Impairments, activity limitations and participation restrictions: Prevalence and associations among persons living with HIV/AIDS in British Columbia. *Health Related Quality of Life Outcomes*, 2, 46. Retrieved November 10, 2006 from <http://www.hqlo.com/content/2/1/46>. (doi:10.1186/1477-7525-2-46). Worthington, C., Myers, T., Cockerill, R., Nixon, S., O'Brien, K., & Bereket, T. (2005). *HIV and rehabilitation: Canadian providers' survey of rehabilitation professionals' perspectives*. Fact sheet available at <http://www.hivandrehab.ca/dc/dc.htm>

# Update from the COTF

## Upcoming Competitions:

### Marita Dyrbye Mental Health Award (\$1,000)

**Deadline: March 31, 2007**

Awarded to a member of CAOT or a provincial association for activities that enhance the practice of occupational therapy in mental health.

### SAOT Clinical Research Grants (3 x \$500)

**Deadline: April 1, 2007**

Grants are for occupational therapists in Alberta:

- 1. Education to Allow Research** - To advance knowledge to carry out clinical research.
- 2. Clinical Research Award** - To support clinical research in occupational therapy.
- 3. Financial Assistance for Research Presentation** - To support a presentation on completed research.

## 2007 CAOT Conference in St. John's, Newfoundland:

Plan to attend these three COTF events at the conference!

- 1. COTF Session – Using Research in Practice: July 12 from 3:30 p.m. to 5 p.m.**
- 2. Live Auction: July 12 at the social event**
- 3. Silent Auction: July 12 and 13 at the COTF Booth**  
Auction Guidelines
  - COTF welcomes donated items for the silent and live auctions. COTF appreciates donations such as art work, jewelry, gift items, crafts, cards and photography.
  - If a donated item is purchased for the auction(s), an original receipt is required.
  - If an item is being donated and a receipt is not available, the donor has to provide some form of comparable pricing such as printed information or a web site address.
  - An appraisal must be included for art work.
  - Any item under \$1,000 must be accompanied with printed information or a website

address. If the item is over \$1,000 it must be professionally appraised.

- Income tax receipts will be issued for the value of the items upon the completion of a donor declaration form. Please contact Sangita Kamblé at [skamble@cotfcanada.org](mailto:skamble@cotfcanada.org) for a form. Please return the fully completed form by June 25, 2007.

### 4. COTF Annual General Meeting: July 14 11 a.m. to 11:30 a.m.

### 5. Lunch with a Scholar - Terry Krupa, PhD, M.Ed., B.Sc. (OT): July 14 from 11:30 a.m. to 1:00 p.m.

Occupational therapists frequently work with people who experience positive occupational and social recovery, following lengthy and profound disruption of their occupational performance and experiences. Led by Dr. Terry Krupa, this presentation will discuss research methods focused on revealing such complex processes of change. It will include a discussion of how the influence of occupational therapy services can be captured in research related to complex change processes. Dr. Krupa is a professor in the School of Rehabilitation Therapy at Queen's University. She teaches in the area of occupation and mental health as well as qualitative methods in health care research. Dr. Krupa's research focuses on the community lives of people with serious mental illness.

### New for 2007

Francis and Associates will be awarding a scholarship in the amount of \$1,000 to Master's or Doctoral students in the 2007 scholarship competition. The deadline for application is September 30 and the scholarship is for occupational therapy education.

## Your support counts!

COTF sincerely thanks the following individuals, companies and organizations for their generous financial support during the period of October 1, 2006 to November 30, 2006. COTF will acknowledge donations received after November 30, 2006 in a future issue.

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# CAOT endorsed courses

## CO-HOSTED WITH CAOT

July 11 - 14

### CAOT 2007 Conference: Leading the way to healthy occupation

St. John's, Newfoundland  
Tel: (800) 434-2268 ext. 228  
E-mail: [conference@caot.ca](mailto:conference@caot.ca)

## ENDORSED BY CAOT

### Progressive Goal Attainment Program (PGAP) Training Workshop: A new program for minimizing pain-related disability

March 2 & 3, 2007 in Halifax, NS  
Provider: Dr. Michael J.L. Sullivan - University Centre for Research on Pain and Disability

Contact: Heather Adams

Tel: (902) 471-7864  
Fax: (902) 421-1292  
E-mail: [info@pdp-pgap.com](mailto:info@pdp-pgap.com)  
[www.pdp-pgap.com](http://www.pdp-pgap.com)

### Cognitive Disorders after Stroke: Recognition and Management

March 16, 2007  
Location: Halifax, NS  
Speaker: Dr. Gail Eskes  
Provider: Dalhousie University School of Occupational Therapy

Contact: Pauline Fitzgerald

5869 University Ave Forrest Bldg, Room 215, Halifax, NS, B3H 3J5  
Tel: (902) 494-6351  
Fax: (902) 494-1229  
E-mail: [p.fitzgerald@dal.ca](mailto:p.fitzgerald@dal.ca)

### Health Leaders Institute

March 30-31, 2007  
Bank of Montreal Institute for Learning, Toronto, ON

Contact: Judith Skelton-Green

Tel: (705) 549-7749  
Fax: (705) 549-8906 E-mail: [Judith.skelton-green@transition-hod.ca](mailto:Judith.skelton-green@transition-hod.ca)

### MORE: Integrating the Mouth with Sensory and Postural Function

Date: April 16 & 17, 2007  
Location: Montréal, QC  
Contact: Caroline Hui  
Tel: (450) 242-2816  
E-mail: [info@choosetolearn.ca](mailto:info@choosetolearn.ca)  
[www.choosetolearn.ca](http://www.choosetolearn.ca)

### Strategies for Engagement, Intervention and Education across the Autism Spectrum

April 19 & 20, 2007  
Location: Montreal, QC  
Speaker: Dr. Rita Jordan and Dr. Michael Powers  
Provider: Abe Gold Learning and Research Centre

Contact: Derek Linetsky

Tel: (514) 345-8330 ext. 319  
Fax: (514) 345-1619  
E-mail: [info@goldlearningcentre.com](mailto:info@goldlearningcentre.com)  
[www.goldlearningcentre.com](http://www.goldlearningcentre.com)

### Insight Following Brain Injury

Date: May 14 & 15, 2007  
Location: Kamloops, BC  
Instructors: Kit Malia and Anne Brannagan

Contact: Hazel Plumbley

The Rehab Group tel: (250) 314-0377 toll free: 1-888-421-5551  
E-mail: [hplumbley@therehabgroup.ca](mailto:hplumbley@therehabgroup.ca)  
[www.therehabgroup.ca](http://www.therehabgroup.ca)

## CANADIAN HEALTHCARE ASSOCIATION

### Risk Management and Safety in Health Services

Course starts every September.

### Continuous Quality Improvement for Health Services

Course starts every September.

Modern Management Correspondence course  
September 2006 - April 2007

Contact: Cheryl Teeter, Director  
CHA Learning, 17 York Street, Ottawa, ON, K1N 9J6  
Tel: (613) 241-8005, ext. 228  
Fax: (613) 241-5055  
E-mail: [cteeter@cha.ca](mailto:cteeter@cha.ca)

## WEB-BASED DISTANCE EDUCATION

### Post Professional Graduate Programs in Rehabilitation Sciences

University of British Columbia and McMaster University

Courses offered twice a year in September to December & January to April. Courses: Evaluating Sources of Evidence, Reasoning, Measurement, Developing Effective Programs, Facilitating Learning in Rehab Contexts. Graduate Certificate is granted after completion of 5 courses. These courses can be applied to Master's programs at each university, if the candidate is eligible.

Contact: [online.support@ubc.ca](mailto:online.support@ubc.ca)

Tel: (604) 822-7050  
Websites: <http://www.mrsc.ubc.ca> or [www.fhs.mcmaster.ca/rehab/](http://www.fhs.mcmaster.ca/rehab/)

### Dalhousie University Series

#### Identity and Transitions (OCCU5040)

Dates: May - June, 2007  
Instructors: TBA

Contact: Pauline Fitzgerald

School of Occupational Therapy, Dalhousie University, 5869 University Avenue, Forrest Bldg, Room 215, Halifax, NS, B3H 3J5  
Tel: (902) 494-6351  
E-mail: [p.fitzgerald@dal.ca](mailto:p.fitzgerald@dal.ca)

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

## Strategies to help with returning to work

As life expectancy increases for people living with HIV/AIDS, they may want support to begin working or return to work. But for many people living with this disease, there are significant employment problems based on stigma, discrimination and risk of continued medical and financial support should they need to leave work. Other barriers with returning to work include significant gaps in time from previous employment, loss of previous job title, changes to job demands and technological advances. These are some occupational therapy strategies to help with these changes:

- Gradually increase the ability to cope with the physical, cognitive and social demands of the job. This may be achieved by vocational rehabilitation.
- An occupational therapist can help with this process by keeping in touch with employers, advocating, explaining ergonomic issues and job matching.

### Fast facts about HIV/AIDS

- Human immunodeficiency virus (HIV) targets the body's immune system. People can live many years without any symptoms, but over time their immune system becomes weak and their body is not able to fight off illnesses or infections.
- Acquired immune deficiency syndrome (AIDS) describes a collection of symptoms and infections caused by the HIV. An individual with AIDS lives with a chronic, life-threatening condition.
- More than 56,000 people in Canada are living with HIV and include men, women and children from all regions of Canada.
- Some people in Canada have been living with HIV for more than 20 years.

## Strategies to help with housing concerns

Many people living with HIV/AIDS have a need for affordable, supportive and accessible housing options. Currently the few Canadian facilities in large urban settings are filled to capacity and waiting lists are extensive.



These are some occupational therapy strategies to help with housing concerns:

- Home adaptations and/or renovations can assist with making housing accessible, easy and safe for moving around, as well as supporting independence in home activities.
- Occupational therapists can assist clients and families to explore the best housing options and assist with successful transitions.

HIV/AIDS has now become a chronic disease. People living with HIV may have periods where they are feeling healthy, but also times where their health is poor. Occupational therapists have the expertise to work with people who have these types of episodic problems. The chronic nature of HIV and AIDS will likely mean that occupational therapists will be more involved with this population.

If you are experiencing some of the difficulties discussed above, please contact an occupational therapist, your health care team and/or physician about rehabilitation and how to access an occupational therapist.

Visit [www.otworks.ca](http://www.otworks.ca) and click on OT Finder to locate an occupational therapist closest to you. For more information on occupational therapy and HIV/AIDS visit the website for the Canadian Working Group on HIV and Rehabilitation: [www.hivandrehab.ca](http://www.hivandrehab.ca). The Canadian AIDS Society, CATIE (Community AIDS Treatment Information) and local AIDS organizations can provide access to resources, advice and support.



CAOT wishes to acknowledge the work of Debra Cameron, Todd Tran, Gillian Bone and Sheila Thomas for assisting with this consumer tip sheet.

# Occupational therapy strategies for people living with HIV/AIDS

*If you or someone you care about is living with HIV or AIDS and finds it difficult to do daily activities or participate in the community, occupational therapy may be able to help. Occupational therapy can provide strategies to help manage living with HIV/AIDS.*

## Strategies to help with physical challenges

HIV can affect the entire body and may involve the muscles, bones, nerves, stomach and/or heart. About one-third of people with HIV develop problems with their feet, which can include numbness, burning pain and muscle weakness. The person with HIV/AIDS may also experience pain in other parts of their body. Other physical challenges may include fatigue, problems moving around and managing daily activities such as bathing, preparing meals or doing errands in the community. These are some occupational therapy strategies to help with these physical challenges:

- Save energy by planning your activities, as well as modifying your home or work environment. This will help you do the activities that you value.
- Be comfortable by choosing the right chair.
- Get around easier by using a cane, walker, wheelchair or scooter.
- Consider trying adaptive devices and resources to make it simpler to dress, bath, go to the bathroom, shop and cook.
- Find out about different types of transportation if you have problems walking.
- If your feet hurt, try to have good foot care, footwear, protective insoles, and in some cases custom-made foot orthotics to help with the pain.
- To manage pain, try using relaxation techniques, pacing and planning your activities.
- Be more aware of your safety by noticing your foot position on stairs and the temperature of the water when bathing.

## Strategies to help with changes in your thinking and mental health

Many people experience changes to their brain which can affect their thinking and their emotional state. People with HIV/AIDS may find their judgment, attention, motivation and ability to deal with emotional situations have changed. They may also experience some form of depression or difficulty coping with the life changes resulting from the illness.

These are some occupational therapy strategies to help with these changes:

- To help remember activities, try using verbal or written cues or memory aids such as a journal or calendar.
- Develop a routine and structure to your time, for example on a regular basis try to meet with someone for support.
- Develop healthy coping strategies to assist with life situations.



## Fast facts about occupational therapy

- Occupational therapists help people to engage in daily activities and participate in any other activities they find meaningful.
- Occupational therapists are regulated health care professionals with post-secondary education.
- As more people live longer with HIV/AIDS, they will require more rehabilitation services including occupational therapy.