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OCCUPATIONAL THERAPY·NOW

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Cover photograph:
(L to R) Scott Bainard and occupational therapist Joanna Quanbury have fun playing a game of Monopoly during the 2007 session of the GROW program. You can read more about the program on page 7 of this issue. Thank you to the GROW program and participants for providing this photograph for the cover of *OT Now*.

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Dear *OT Now* readers,

When I began to work as an editor, I transferred my belief in client-centred practice from my years as an occupational therapist to my new role. The result has been many opportunities to collaborate with a terrific group of individuals who believe in the wisdom and power of occupational therapy to enable individuals to live a meaningful life. As this is my last issue as editor of *OT Now*, I would like to thank all of the readers and volunteers for your support, and welcome Brenda McGibbon Lammi as the incoming editor. Working as the editor of this dynamic publication has been a great honour and privilege.

Fern Swedlove, OT Reg (MB), OT(C)
OT Now Managing Editor

The occupational therapy workforce in Canada: A review of available data

Claudia von Zweck, CAOT Executive Director

In November 2007, the Canadian Institute for Health Information (CIHI) released the first annual report on occupational therapists in Canada (CIHI, 2007a). This report, together with data from periodic surveys provides new insight for health and human resources planning for occupational therapy in Canada. The following summary provides a glimpse of the occupational therapy workforce as it exists today.

Supply and distribution of occupational therapists in Canada

The growth of occupational therapists in Canada over the past 15 years has outpaced increases in the overall Canadian health workforce. The number of occupational therapists grew by 68% between 1991 and 2001, far surpassing the Canadian health workforce growth rate of 8% (CIHI, 2007b). Between 2000 and 2005, the number of occupational therapists grew by 27%, from 8,948 to 11,378 (CIHI, 2007c). This growth rate was higher than for other health professions such as physiotherapists, nurses, doctors and psychologists. However, the growth has not occurred at the same rate in all areas of Canada, resulting in large variations in the distribution of occupational therapists. For example, Prince Edward Island and Newfoundland/Labrador reported among the lowest rates of occupational therapists per capita in 2001. These provinces actually experienced a slight net loss of occupational therapists between 2001 and 2005 (CIHI, 2007c).

The growth in the number of occupational therapists does not appear to have met demand for services in many areas of the country. Significant shortages in the workforce have been recently reported in British Columbia (Canadian Association of Occupational Therapists [CAOT] & British Columbia Society of Occupational Therapists, 2007), a province with a provider population ratio close to the Canadian average (CIHI, 2007a). Quebec has also reported large workforce shortages (Québec Santé et Services sociaux, 2002) despite experiencing one of the highest growth rates between 2000 and 2005 and consistently having the highest provider population ratio of all provinces. In 2005 Quebec had over 43 occupational therapists per 100,000 people (CIHI, 2007a), compared with the national average of 35 per 100,000.

Occupational therapists report among the lowest per capita rates of regulated health professions in Canada, only falling behind professions working with very specific populations such as midwives, optometrists and audiologists (CIHI, 2007c). As occupational therapists work with populations of all ages and with a wide variety of occupational barriers, this finding suggests that our distribution per population served is severely limited in Canada. Per capita rates of occupational therapists in other countries also indicate occupational therapy services are underutilized in Canada. The per capita ratio is lower in Canada than in many countries with similar health systems, including Denmark (105 occupational therapists per 100,000 people), Sweden (89), Australia (60), Belgium (58), Israel (52), United Kingdom (49), Norway (47), Germany (44) and New Zealand (43) (Ishikawa, Matsuhashi & Watanabe, 2007).

> *"...we are fortunate to have better data regarding occupational therapists in Canada."*

Occupational therapists have one of the lowest rates of rural practice, when compared with other health professionals (CIHI, 2007b). In 2006, less than 5% of occupational therapists were employed in rural areas in provinces such as British Columbia and Ontario that reported the highest levels of urban

practice (CIHI, 2007a). Occupational therapy, however, is one of the most mobile of all health professions. Census data indicated that over one third of occupational therapists moved between 1996 and 2001. Quebec and Newfoundland reported the highest net loss of interprovincial migrants in 2001, while Alberta and Ontario experienced the highest gains (CIHI, 2007b).

Education of occupational therapists

Data collected by CIHI in 2006 in all provinces except Quebec indicates that over 81% of occupational therapists possess a baccalaureate degree in occupational therapy (CIHI, 2007a). Almost 11% of occupational therapists had master's degrees in occupational therapy, a finding partially explained by the shift to master's level entry education in the past decade in Canada. In addition, almost one third of occupational therapists have completed post-secondary education outside of occupational therapy, 23 % of these at the master's or doctoral level. The remaining completed another baccalaureate degree, reflecting the traditionally large number of entrants to bachelor's or master's entry level programs that have completed another degree prior to beginning their occupational therapy education. Students are required to meet higher academic standards to enter occupational therapy education programs and have above average achievement scores in reading and science when compared with other health occupations (Allen, Ceoline, Ouellette, Plante, & Vaillancourt, 2006).

The number of occupational therapists educated in Canada remained stable between 1995 and 2004, with approximately 590 new graduates entering the workforce each year (CIHI, 2007a). However, available seats in occupational therapy education programs per capita vary greatly across Canada, from a low of 23,570 /seat in Manitoba to 108,186/seat in British Columbia (Statistics Canada, 2007). Quebec has recently increased capacity for occupational therapy education in response to reported shortages of occupational therapists in the province (CIHI, 2007a). Other provinces are also considering program expansions or developing new programs.

The number of occupational therapists has grown because of the stable and increasing rate of education in this field, as well as the immigration of internationally educated occupational therapists to Canada. CIHI data collected outside of Quebec suggests that approximately 6% of occupational therapists in Canada were educated in other countries (CIHI, 2007a). This rate is similar to the number of registered nurses coming to work in Canada from other countries, but is much lower than other professions heavily reliant on international graduates such as medicine and pharmacy (CIHI, 2007b). Consistent with the findings of the 2006 CAOT Workforce Integration Project (von Zweck, 2006), CIHI data indicates internationally educated occupational therapists came to Canada most frequently from the United Kingdom, United States, India and the Philippines (CIHI, 2007a).

"The growth in the number of occupational therapists does not appear to have met demand for services in many areas of the country."

Demographic profile of occupational therapists

Occupational therapy is a predominantly female profession with less than 8% of males reported in the Canadian workforce in 2006 (outside of Quebec) (CIHI, 2007a). The gender profile of occupational therapists has remained largely unchanged and is consistent with several other health professions such as nursing, speech language pathologists and dental hygienists and technicians (CIHI, 2007b). This profile is reversed for professions dominating in power and reimbursement rates such as physicians, dentists and chiropractors that report female workforce rates of 30% or lower (CIHI, 2007c).

The average age of occupational therapists in Canada rose from 34.7 years in 1995 to 37.0 in 2005 (CIHI, 2007c). However, this is still one of the youngest professions, with a mean age much lower than the 41.9 years reported on average for all health providers in 2005 (CIHI, 2007c). 1991 census data indicates some regional variation in the age of the occupational therapy workforce. Prince Edward Island and British Columbia reported the highest average ages at 44 years and 39 respectively. Expected retirements will exacerbate the existing low supply of occupational therapists in these provinces. The youngest average ages were reported in Newfoundland/ Labrador (31 years) and Quebec (34) (CIHI, 2007b).

Although the occupational therapy workforce is aging, the rate of change is much lower than in other professions. Outside of Quebec in 2006, for

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each practitioner over the median age of 37 there were more than two occupational therapists at the beginning of their careers with less than 15 years experience (CIHI, 2007a). This trend is reversed for the nursing profession. More than 38% of registered nurses were over the age of 50 years in 2006 (CIHI, 2007d), in comparison with 16% of the occupational therapist workforce. It appears few occupational therapists currently continue to work until the normal retirement age of 65 years (CIHI, 2007b).

Employment of occupational therapists

CIHI data collected outside of Quebec in 2006 indicates that the large majority of occupational therapists (80%) work for only one employer (CIHI, 2007a). While most of these occupational therapists were permanently employed or self-employed over 9% were casual or temporary. Casual and temporary positions are cause for concern as research in nursing indicates the associated lack of employment stability has led to higher levels of attrition (Hall, 2007). Self-employment varied significantly across Canada. Ontario had the highest rate of self-employment at over 20%, twice the rate of other provinces (CIHI, 2007a). However, the self-employment rate jumped nationally to an average of 34.7% in secondary employment positions, reflecting the large number of occupational therapists that supplement their regular work with private practice.

Approximately 40% of occupational therapists work in community based settings such as clinics, businesses or schools in their primary employment (CIHI, 2007a). An additional 49% work in facilities such as hospitals, rehabilitation centres and residential care homes. Eighty percent are involved as direct service providers to clients. Another 9% are employed as managers or professional leaders. Occupational therapists most frequently work with populations with general physical health issues (28.9%) or neurological system problems (13.6%). Twelve percent of occupational therapists work primarily in mental health.

Summary

This review has identified a number of areas requiring further exploration and action. For example, the reasons for the apparent underutilization of occupational therapists in Canada need further examination. This may be partially explained by chronic workforce shortages, requiring continued initiatives to increase the supply of occupational therapists. Underutilization may also occur where policy-makers do not understand the potential role and contribution of occupational therapy to the health of the Canadian population. This highlights the importance of ongoing CAOT initiatives to develop workforce capacity and advocacy for occupational therapy. Factors that contribute to retaining occupational therapists in the Canadian workforce also require study. Little is known about the reasons for the apparent attrition of occupational therapists from the workforce before age 65, although it is known that many cease to use their professional title when not providing direct service to clients (von Zweck, 2006).

Stronger professional identity must be engendered among occupational therapists. For example, the publication of the new Profile of Occupational Therapy Practice in Canada promotes a more inclusive and realistic vision of the work of occupational therapists, including roles outside of direct client service involving policy, research and education (CAOT, 2007). As the Canadian population becomes more dependent upon immigration, we must continue to ensure the success of international graduates wishing to work as occupational therapists in our country. Other issues that influence work satisfaction also require exploration. For example, the findings of a 2003 Canadian Community Health Survey that examined stress in the workplace raise questions about the quality of work life of occupational therapists (Wilkins, 2007). The findings indicated occupational therapists experienced an above average level of high stress when compared with other health providers, second only to physicians, nurses and ambulance attendants.

"Stronger professional identity must be engendered among occupational therapists."

As this analysis indicates, we are fortunate to have better data regarding occupational therapists in Canada. Gaining an understanding of this information is necessary to allow organizations such as CAOT, as well as policy-makers, employers, educators and regulators to plan strategically for the development of an occupational therapy workforce that effectively meets population health needs.

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Occupational therapy in partnership to enable a dream: The development of a residential life skills program

Pamela Wener, Wanda Snow and Gary Altman

A dedicated group of people is helping young adults and their families ease the transition to independent living. The Gaining Resources Our Way (GROW) in Gimli Program situated in the small community of Gimli, Manitoba is in its sixth year of operation. The partnership of a philanthropist, occupational therapist and community planner spearheaded a program dedicated to supporting individuals aged 18 to 24 years with developmental and cognitive difficulties. The goal of the GROW program is to enable the development of skills required for independent or semi-independent living.

GROW is a two-week intensive residential life skills program that uses a combination of one-on-one and group formats to deliver opportunities for learning in the following five key areas (see Table One): life management, healthy eating, managing, finances, recreation and socialization (Rose and Max Rady Jewish Community Centre [Rady JCC], 2006). In some cases, involvement in the program provides an experience for these young adults to separate from their families for the first time in a safe environment with the support of their peers. This is an important first step for both the participant and the family in redefining the individual as a young adult, with the capacity to work towards personal independence. Gaining independent living skills often becomes a focus for these young adults and their parents as the adult child reaches 21 years of age (Renty & Royers, 2006). In Manitoba, the age of 21 signals the end of support from the school system (Manitoba Education, Citizen and Youth), which may leave families with few other avenues to assist their children in gaining independent living skills.

Inception of GROW

From its inception, GROW has been a community endeavour, working in partnership with the umbrella organization of the Jewish community in Winnipeg. The program was originally envisioned by Karyn Lazareck, a former chair of the Persons with Disabilities Steering Committee of the Jewish Federation of Winnipeg. As a philanthropist and concerned parent, she recognized that the program options for her son to realize his potential for independent living were limited and she believed other families must have similar perceptions and needs. Although Karyn had the means to fulfill her immediate family needs, she envisioned developing a program that would fulfill the needs of other families. One key aspect of her vision was that these young adults would have an opportunity to have a summer experience similar to their peers, one that provides a natural summer environment to socialize and develop ones' skills.

With this dream in mind, Karyn thought that her summer cottage in Gimli was an ideal setting for such an experience. The town of Gimli is part of Manitoba's cottage country and home to numerous amenities such as a movie theatre, grocery stores, banks, and restaurants all within walking distance of the cottage. While the mid-size town emulates a city

Table 1: Educational Life Skills Modules for the GROW in Gimli Program

Life Management	• Activities of daily living • Home skills and living situations
Healthy Eating	• Recipes • Grocery shopping • Food preparation
Managing Finances	• Identifying needs and wants • Budgeting
Recreation	• Identifying leisure interests • Planning for and participating in leisure activities • Sportsmanship
Socialization	• Conversation • Body language and listening • Compliments • Expressing emotions • Dealing with anger • Assertiveness and setting boundaries • Cooperation and compromise • Social problem solving

and provides an environment where learning and practicing life skills opportunities abound, Gimli is also small enough that participants feel a sense of comfort in their surroundings.

To bring her vision to fruition, Karyn began by consulting with members of the community, including both parents and leaders. Having had personal experience with occupational therapy, she was confident that involving an occupational therapist at the ground level was a key component to the program's development. With a focus on enabling occupation, the first author enthusiastically joined the development group of three and began to lay the foundation for the program. Agreeing with the importance of providing a natural peer group and an environment where skills development could occur, the occupational therapist's dream included a program where the targeted skills were essential to the day-to-day living and thus skill development would occur in the course of the day. Now the stage was set to enable occupation, rather than simply build skills. Together, this small group met for the next one and half years to create the program and to initiate the program's first year of operation.

Partnerships for GROW

In partnership with the Department of Occupational Therapy at the University of Manitoba graduating students and the first author worked to create a draft of the program and accumulate resources that would serve as a framework. Each resource was organized in resource binders with a similar format. The resources included the following: identification of the component skills, samples of worksheets and activities to enable development of the component skills, as well as a method for monitoring participant progress towards attainment of skills. The modular resources encouraged a flexible individualized client-centred application.

(L to R) - Sarah Briggs, an occupational therapy student and GROW participants Casey Rittinger and Karen Cuttington enjoy a round of miniature golf in Gimli, Manitoba.

"...the stage was set to enable occupation, rather than simply build skills."

GROW in Gimli applies an interprofessional approach to its life skills training. Directing the overall program, the Advisory Committee (AC) is made up of parents and professionals from the fields of health and education. Over the past five years, the employed GROW program staff has consisted of a variety of professionals with backgrounds from both health and education, as well as students from occupational therapy, social work, physical therapy, special education, pre-medicine and psychology. In addition to the employed staff, senior occupational therapy students have completed their final fieldwork education with the GROW Program. This placement is exceptional for the students as it provides the opportunity to work in a community-based interprofessional environment in a unique program with a relatively under serviced population.

The program relies heavily on its many partners. In addition to those already mentioned, the Rady JCC supports both the staff and the AC throughout the year and especially during the summer months (Rady JCC, 2005). While most of the programming at the centre does not have an advisory board, GROW's desire to have community and parental input was strongly supported. Financially, the program receives support from the Jordan Lazareck Special Needs Fund established with the Jewish Foundation of Manitoba. While parents contribute a portion of the cost of the program, the remaining costs are absorbed by the fund and the Lazareck family. In addition, the program has received financial support from other philanthropic groups including The Winnipeg Foundation and the Thomas Sill Foundation. The collaboration and cooperation that exists between interested community members and the GROW Program not only benefits the participants and their families, but also the University of Manitoba through the involvement of the School of Medical Rehabilitation.

Structure of GROW

Currently the GROW Program runs three, two-week sessions in the summer. Each session provides intense skill training for up to four individuals, allowing for a total intake of 12 participants per year. Those families who are interested in the program apply in April. Previous participants are encouraged to continue in the program for up to three years, allowing for continuing evolvement of their skills and confidence. Individuals who apply participate in a life skills assessment that assists the staff as well as the AC in determining the needs of the individual and their ability to work with others. While the majority of the participants may receive diagnoses such as Down's Syndrome, Pervasive Development Disorder or Asperger's Disorder, one of the unique traits of the program is the emphasis on the participant's level of occupational performance rather than his/her diagnosis. This emphasis ensures the environment is conducive to participants developing their skills and in particular their social abilities, to the highest degree possible. As such, factors such as the applicant's present life skill abilities, social skills and coping strategies, as well as whether the individual has had previous experience with the program, are taken into account during the application process.

On the steps of the cottage for the GROW program, participants and staff come together for a group photograph.

Back (L to R) - Participant, Riley Morwick; Joanna Quanbury, occupational therapist/ senior staff person; and participant, Ryan Morwick. Front (L to R) - Participant Scott Bainard; student occupational therapist/ staff person, Sarah Briggs; and student physical therapist/staff person, Rachel Borkowsky.

After applicants are chosen, the *Canadian Occupational Performance Measure* (COPM) (Law et al., 2005) is administered to prospective participants and their parents in their home. This measure was chosen because of its ability to identify client's perception of performance and satisfaction thus promoting client-centred practice among the staff. It helps identify the participants' strengths, needs, and interests and thereby assists with individual and group program planning. While adjustments have been made in using the *COPM* such as using a proxy respondent when necessary, it has been very helpful in ensuring that parents and participants each recognize their vital role in the success of the program and ultimately in the success of each participant, to gain the maximum level of independent living skills.

During this home visit, both the participant and his/her parent(s) each choose three goals they would like to accomplish during the course of the program. The participant's goals are to reflect life skills for which they deem themselves to be deficient and would like to improve. Parents set three goals and develop a plan in which they set out to improve their ability to support the growth and development of their child. Structured in this way, the core philosophy of the program is realized, which is the recognition that each person is an individual, with strengths and goals. By tailoring the skill development program on an individual basis, the program strives to meet the personal goals of these young adults and their families.

Upon completion of the intensive two-week residential experience, a written report is provided to participants, detailing practical strategies for continued improvement and skills development. The scope of the program, however, goes beyond the three weeks during the summer, by informal reassessment of the identified goals of both the young adults and their families throughout the year. Phone calls and a mid-year get together are additional methods to assist

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participants and families to continue their work on the gains made during the summer program.

Conclusion

Since its inception in 2003, the GROW program has been helping young adults feel a sense of pride in what they can achieve, as well as enabling families learn to view their children as more and more independent and capable young adults. The program has not only made an impact locally, as those who have been involved in the program attest; GROW has also garnered international attention through recognition at the Jewish Community Centers Association of North America annual meeting in 2006 for its innovative approach to improving the lives of those with cognitive and developmental disabilities.

With funding provided by the Jewish Foundation of Manitoba and The Winnipeg Foundation, as well as in partnership with the Department of Occupational Therapy through the Master of Occupational Therapy Independent Study course, the GROW program is undergoing a formal evaluation process using the *COPM* and indepth interviews. This is being undertaken to document the program's many successes and validate its efficacy in helping clients and families achieve their goals.

Acknowledgements

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Canadian Association of Occupational Therapists – On Your Behalf

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Accreditation of Interprofessional Health Education (AIPHE)

The Canadian Association of Occupational Therapists (CAOT) was recently notified of the approval of a grant from Health Canada for the AIPHE project. This project is expected to run from September 2007 to March 2009. Eight national organizations that accredit pre-licensure education for six health professions in Canada will partner in the AIPHE to create and support the use of core joint principles/guidelines in formulating standards for interprofessional education. The partnership, representing the disciplines of physiotherapy, occupational therapy, pharmacy, social work, nursing and medicine will consult with a wide range of stakeholders to develop principles/guidelines to formulate accreditation standards for their organizations and to promote their use among other stakeholders. The partnership will also share knowledge about the value of interprofessional education and best practices in program accreditation review processes. Activities include face-to-face discussion through two joint steering committee/advisory group meetings (of which CAOT is a member) and a Forum on Accreditation of Interprofessional Education for stakeholders from the six participating professions.

Canadian Collaborative Mental Health Initiative (CCMHI)

www.ccmhi.ca

The CCMHI is a collaborative project in its second phase. The goal of this phase is to disseminate the CCMHI toolkits and research developed in the first phase. Phase two is funded through a grant from Health Canada. A steering committee meeting was held in Ottawa on October 2, 2007. Dr. Terry Krupa represents CAOT on this initiative.

Based on demonstrated interest, readiness and support for collaborative care, CCMHI targeted Nova Scotia, Quebec, Manitoba and Saskatchewan for engagement in CCMHI. CAOT Board members in these provinces helped CCMHI identify leaders in their provinces who were invited to a regional meeting with the following goals:

- Build awareness and test interest levels in promoting collaborative care.
- Utilize CCMHI toolkits and seek feedback on their value and usefulness.
- Identify provincial and federal champions that will support further implementation of CCMHI tools.

Strengthening Collaborative Education Using E-Learning Technologies

This project is based on the Canadian Collaborative Mental Health Initiative (CCMHI) Education Toolkit. It involves developing and delivering interactive tele- and web-based seminars to promote the toolkit. Toolkit authors Dr. Thomas Ungar and Vernon Curran, as well as two to three experts from the CCMHI Steering Committee facilitated the seminars. Dr. Terry Krupa provided the occupational therapy expertise for these seminars which were targeted towards professionals, consumers, families and caregivers. The project was funded by the Canadian Council on Learning and the project lead was the College of Family Physicians of Canada. CAOT endorsed the seminars, which ran from July to November 2007.

National Blueprint for Injury Prevention in Older Drivers

In March 2007, the Public Health Agency of Canada (PHAC) solicited a proposal from CAOT for a national project regarding older drivers' safety. The National

Blueprint for Injury Prevention in Older Drivers Project was approved by PHAC for funding from October 1, 2007 to September 30, 2008. Dr. Nicol Korner-Bitensky is leading this CAOT project, which will develop a national framework to enhance the capacity of older drivers to sustain their ability to drive safely for as long as possible, ultimately extending their independence, community participation and social networks. This blueprint will include a vision, guiding principles, priority goals and identified directions for action.

Stable, Able and Strong Post-Fall Support Project

The goal of the Stable, Able and Strong (SAS) Project is to develop supports for community dwelling older adults who have experienced a fall. SAS has developed a post-fall support model and component strategies to promote older adults' engagement in healthy occupation and to reduce their risk for future falls. These strategies have included community presentations through post-fall support modules. As well, the SAS newsletter and over 3500 copies of SAS brochures have been widely disseminated to pharmacies, hospital emergency rooms, churches and seniors' residences and other facilities and organizations. National Advisory Committee members have also received these SAS materials. Drop-in activities at the community centres where the pilot sites are located have been a means for older adults to gain comfort in learning about SAS.

SAS has developed a number of resources including a program manual, peer mentor training manual and the SAS Resource Database hosted on the CAOT website www.otworks.ca. The database helps sustain the SAS project by making these resources accessible to older adults, caregivers, health professionals and community stakeholders.

Presentations on SAS have been made at the International Union of Public Health Promotion and Education conference in Vancouver in June 2007, the CAOT Conference July 2007 and at the Canadian Injury Prevention Conference in Toronto in November 2007.

Tool to Develop Practice in Primary Health Care

CAOT is working with Dr. Mary Ann McColl of Queen's University on this project. The purpose is to create a tool or framework to assist members with developing a plan to offer occupational therapy services in primary health care. An interprofessional advisory group is providing feedback and input on the design of the project. The completion date is spring 2008. A pre-conference workshop on this topic will be held at the CAOT Conference in Whitehorse, June 2008.

National Coalitions

Active Living Coalition for Older Adults (ALCOA)

www.alcoa.ca

The mandate of this coalition is to promote the health of older adults through active living. ALCOA's core partnership totals nearly 80 members, including 22 non-profit organizations (roundtable members) and 57 corresponding members across the country.

ALCOA received $300,000 funding from the Public Health Agency of Canada (PHAC) for a one-year diabetes project to educate older Canadians and their families on measures to avoid and/or manage type two diabetes. The project also seeks to increase awareness, improve attitudes and increase knowledge amongst high-risk populations, supporting the longer-term result of healthier behaviours and decreased risk factors among seniors.

ALCOA also received funding for one year from PHAC for the project: Creating Multi-Level Communication and Collaborative Mechanisms for Improved Physical Activity Level in Older Adults. This project seeks to further strengthen the effectiveness of ALCOA by looking at meaningful communication between community-based members of ALCOA and other agencies within the community, for example health agencies and civic authorities. For previously published research updates see the following website: http://www.alcoa.ca/e/research_ update.htm.

Canadian Alliance on Mental Illness and Mental Health (CAMIMH)

www.camimh.ca

CAMIMH is the national voice on mental illness and mental health issues, with 19 national members representing professional associations, service providers, caregivers and consumer and family organizations.

CAMIMH organized a successful Mental Illness Awareness Week (MIAW) from September 30 to October 6, 2007 (http://www.miaw-ssmm.ca/en/default.aspx). James Huff, the CAOT Board Member for Ontario and Donna Klaiman, the CAOT Director of Policy attended the MIAW Fifth Annual Champions of Mental Health Awards luncheon on Wednesday October 3, 2007.

CAMIMH released their report on Mental Health Literacy (MHL) during MIAW, looking at what Canadians know and how they think about mental

illness and mental health. Although MIAW has existed in Canada for 15 years and there are a growing number of local and provincial public education efforts, there is limited evidence of what works best for public education and anti-stigma efforts. CAMINH found that while most Canadians understand that mental health problems are common and appreciate causes and triggers, shame and stigma still play a significant role in why people do not seek help for their mental health problems. The MHL project findings are important for policy makers and funders to allocate money for activities that will have an impact on stigma and improve people's ability to manage their mental health effectively. The complete report and some of the background documents are available at http://www.camimh.ca/mental_health_literacy.html.

Joint Committee of the Cancer Workforce

The joint committee's mandate is to develop, implement and evaluate a Pan-Canadian integrated cancer workforce strategy to meet the needs of Canadians living with or at risk of cancer. This strategy is predicated upon quality services being delivered to Canadians in a timely fashion by the most appropriate health systems and team of caregivers across the cancer continuum (from prevention to palliation). Diana Bissett represents CAOT on the committee's working group.

Canadian Institute of Health Research (CIHR) Institute of Mobility in Aging Symposium

Claudia von Zweck attended a September 2007 symposium sponsored by the CIHR Institute of Mobility in Aging. The purpose of the meeting was to mobilize and link experts across professions and sectors to address mobility in aging challenges and to advance research and research-to-action priorities in mobility and aging. Outcomes of the symposium included the following:

- Better mutual understanding of the importance of different expertise and experience across disciplines and sectors in addressing challenges in mobility in aging.
- Approaches/strategies for mobilizing the community in the design of relevant research-to-action programs.
- Input on useful activities and mechanisms to support researchers and research users under the mobility in aging initiative.

Column Editor: Sandra Bressler

The Canadian Association of Occupational Therapists advances excellence in occupational therapy in Russia

Janet Craik, Maiya Kogan and James O'Brien

The mission of the Canadian Association of Occupational Therapists (CAOT) is to advance excellence in occupational therapy. As part of our mandate, CAOT is committed to producing texts that provide conceptual grounding, processes and outcomes in occupational therapy. Many of CAOT's publications are translated into various languages, printed and distributed for sale around the world (see Table 1).

One such translation project came from a request received in October 2006 from the European Union (EU) TACIS Project EuropeAid/119954/C/SV/RU: Social Integration of Disabled People in the Privolzhsky Federal Okrug, Russian Federation. The project was implemented from July 2005 to December 2007. This project team wanted to develop a university training course in social rehabilitation incorporating many of the principles and methodologies of occupational therapy. A team of EU and Russian experts developed the course in cooperation with the Russian Association of Occupational Therapists (St. Petersburg). A comprehensive training program was delivered to eight teachers from five universities, by experts from the Russian Association of Occupational Therapists, EU project experts and the University of Jönkörping in Sweden.

One problem the project team faced was a lack of teaching materials in the Russian language. This group wanted to translate the CAOT 2002 book *Enabling Occupation: An Occupational Therapy Perspective* as a resource for the eight teachers. The translated material would be used as a reference for teachers of the university course and also by the Russian Association of Occupational Therapists.

Occupational therapy is not yet recognized as a profession in Russia where services still focus primarily on medical rehabilitation. Presently, there are only 30 specialists in St. Petersburg who have trained as occupational therapists with support from the Swedish Occupational Therapy Association and several Swedish universities. These specialists have formed the Russian Association of Occupational Therapy. This association has very limited resources but they are doing what they can to lobby authorities to recognize their profession and to promote the use of occupational therapy in rehabilitation programs. The Russian association is also developing a bachelor level course in occupational therapy so more specialists can be trained. The introduction of the profession of occupational therapy is still very much in the developmental stage in Russia and translation of materials such as *Enabling Occupation: An Occupational Therapy Perspective* is considered to be essential.

CAOT granted the project team the license to translate, print and publish *Enabling Occupation: An Occupational Perspective* into Russian. CAOT also contacted members asking for a Russian speaking member to volunteer to review the translated text. Maiya Kogan volunteered to read the translated text to check for accuracy and verify that the translated version upheld the intended purpose and meaning. Maiya set out to read the text in its entirety and provide the project team feedback and assistance with the translation of the text. All of this was done within a tight timeline as the group wanted to have the books printed by September 2007.

The following comments reveal some of Maiya's

Table 1: CAOT Publications Translated and Distributed Internationally

Title	Language(s) available
Canadian Occupational Performance Measure	English, French, Spanish
Enabling Occupation: An Occupational Therapy Perspective	Danish, English, French, Russian
Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-being, & Justice through Occupation *upcoming publications	Danish*, English, French*
Enabling Occupation in Children: The Cognitive Orientation to Daily Occupational Performance	English, German

experiences on a personal and professional level. Maiya writes: "I was delighted to get an e-mail from CAOT asking if I would be interested to participate in this project. I realized how important it was for newly trained occupational therapists in Russia to get access to the book that would provide them with understanding of the core concepts and basis for the practice of occupational therapy. I did not need time to think and volunteered to participate in this project immediately. The timeline was tight. I really tried my best to get this project done quickly knowing that the textbook would be needed for September. I put some of my personal chores aside to get this project completed on time. In total I have spent about 23 hours reviewing the translation and making corrections."

"I had the most difficulties in the first three chapters of the book and in the preface. I needed to make sure that the main concepts of occupational therapy were translated correctly. The work on the last four to seven chapters became a little easier due to the fact that Julia (the project's translator) had integrated the feedback provided in the first few chapters and used my recommended phrasings and wordings. It was very challenging to translate concepts that are integral to occupational therapy in Canada but do not have any meaning in Russian (i.e. *Canadian Occupational Performance Measure* , targeted outcomes, client-centered, accessibility, and many others). One can translate those terms verbatim but the translation may not have the same meaning to the reader. It was also difficult to explain examples used in the book (e.g. there is no home care in Russia, no retirement village). Hopefully, my corrections would make the terms easier to understand."

"Reflecting on my experience, I am grateful to CAOT for supporting this exciting initiative and providing me the opportunity to participate in this project. I also applaud my colleagues, the occupational therapists in Russia for their efforts to promote occupational therapy as a profession in a country where there is limited existence of core concepts of rehabilitation. I would like to wish the Russian Association of Occupational Therapy best of luck in their efforts to advance occupational therapy as a profession in their country."

The Russian translation project is just one example of the commitment Canadian occupational therapists have to advance occupational therapy internationally. Table One highlights CAOT publications which have been translated or will be translated in the future. CAOT would like to thank and honour the commitment of volunteer efforts of all Canadian occupational therapists serving colleagues here and abroad.

About the authors –
Janet Craik, MSc OT(C), OT Reg. NB is the CAOT Professional Education Manager and she coordinated the translation of the *Enabling Occupation: An Occupational Therapy Perspective* text in Russian. Janet can be reached at jcraik@caot.ca
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Acknowledgement

Special acknowledgement to Kathy van Benthem who was the CAOT Professional Education Manager at the time this project was initiated.

Column Editor: Heidi Cramm

The McMaster Lens for Occupational Therapists: Bringing theory and practice into focus

Bonny Jung, Penny Salvatori, Cheryl Missiuna, Seanne Wilkins, Deb Stewart and Mary Law

Over the last two decades, excellent work has emerged from many Canadian occupational therapy authors on new theoretical concepts, frameworks and practice models (Canadian Association of Occupational Therapists, 1991, 1997; Law, 1998; Law et al., 1998; Law et al., 1996; McColl et al., 2003). However, challenges still remain for students and practitioners to integrate the various concepts into a clear and consolidated understanding of how theory can be used to guide clinical practice. To address the learning needs of students, the McMaster University occupational therapy faculty who teach the Inquiry and Integration seminar courses grappled with ways to improve how theory was taught.

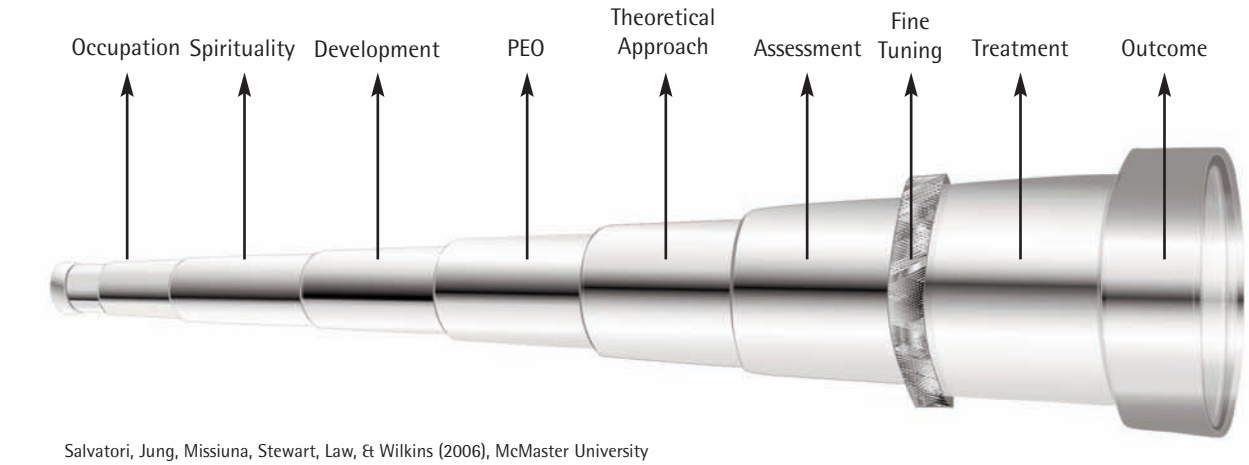
When considering how to best achieve this goal, first we identified the need to articulate the unique perspective of occupational therapists when viewing the needs of a client, in comparison to the unique views of other healthcare professionals. These discussions ultimately led to the development of the McMaster Lens for Occupational Therapists (Salvatori et al., 2006), which we believe is a useful metaphor for bringing theory and practice into focus.

Merriam-Webster's Dictionary (2005) defines a lens as something that "facilitates and influences perception, comprehension, or evaluation" and also suggests that lenses can be "combined in an optical instrument for forming an image." The McMaster Lens for Occupational Therapists is thus pictured as a telescope that consists of a series of nine lenses - occupation, spirituality, development, person-environment-occupation, theoretical approach, assessment, treatment and outcome used by the occupational therapist to view each and every client (both individual and groups/organizations). (see Figure 1 below)

Each lens or piece of the telescope is moveable and must be adjusted by the occupational therapist to bring each client's situation into focus. Adjustments of the various lenses reflect decisions made by the occupational therapist throughout the therapy process. Choosing a theoretical approach, selecting assessment strategies and planning a treatment program require independent decisions for each client. Every client situation is viewed through the same series of lenses; however, they are adjusted differently in every situation to reflect a client's unique circumstances and to bring theory and practice clearly into focus. The McMaster Lens for Occupational Therapists represents the unique perspective that an occupational therapist brings to every client situation and may provide guidance to facilitate the clinical reasoning process. The following case scenario demonstrates how the Lens concepts can be applied in practice.

Robert is a 40 year old married man and has two

Figure 1:
McMaster Lens for Occupational Therapists



Salvatori, Jung, Missiuna, Stewart, Law, & Wilkins (2006), McMaster University

daughters, aged 10 and 12. He is a sales representative for a small company that manufactures electronic and computer equipment. He is the prime wage earner in the household and five years ago they bought a new home. Robert enjoys an occasional round of golf and spending time at home with his family. He is currently experiencing back pain related to an injury that occurred on the job but is anxious to return to work. The following is an application of the nine lenses contained in the McMaster Lens for Occupational Therapists:

1. Occupation

- What occupation(s) does this client engage in as part of his/her normal routine?
- Which occupation(s) is/are currently difficult for this client to perform?

Using the *Canadian Occupational Performance Measure* (COPM), the occupational therapist discovers that up until recently, Robert completed all of his occupations related to self-care, productivity and leisure without any problems. He is currently experiencing back pain which has created difficulties for him to go to work, sleep at night, dress his lower extremities, complete his household responsibilities (such as yard work) and golf with his friends.

2. Spirituality

- What is the meaning/ importance/value of these occupations for this client? Consider the cultural context and groups that this individual belongs to such as family values, ethnic background, religious affiliations, employmentand/or professional relationships and associations.

Work is of utmost importance to Robert as the prime wage earner. He also enjoys the travel and meeting new people associated with his job. His wife and daughters are currently carrying out his household responsibilities. Although he enjoys golfing, he can live without engaging in this leisure activity.

3. Development

- From a lifespan perspective, at what stage of development is this client? Consider both the client's chronological age and cognitive status as well as the expectations of this client with regard to the demands of the occupation(s).

Robert is entering his middle years and is actively involved with raising his family. This is likely a busy time in his life because of work, home and family responsibilities.

4. Person-environment-occupation (PEO) analysis

- What are the underlying PEO factors that influence the client's ability to perform these occupations? Consider how each occupation is typically performed in this client's environment when attempting to explain the client's current occupational performance issues (OPIs).

Robert's priority occupational performance issue is returning to work as a sales representative. The PEO analysis is as follows:

- Person factors impeding his ability to return to work are primarily related to the physical domain; back pain and fatigue limit his sitting and standing tolerance as well as his overall motor abilities. The cognitive domain is not affected. The affective domain is a facilitating factor in that he is motivated and anxious to return to work.
- Occupation factors impacting his ability to return to work are related to specific physical demands of the job such as driving for long distances, as well as his lifting and carrying equipment. Other aspects of the job such as making appointments, interacting with people and accounting are not posing problems.
- Environment factors affecting his ability to return to work might be related to institutional elements such as sick leave policy, employer support, financial pressures to maintain volume of sales and/or physical elements such as the ergonomic support and comfort provided in his vehicle. Cultural or social elements of the environment may play a role depending on his participation in household duties and the willingness of his family to assist with these tasks.

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5. Theoretical approach

- What theoretical approach(es) and/or conceptual model(s) will guide the assessment process? Consider the fit/lack of fit among the underlying PEO factors in relation to the OPI(s) in selecting a theoretical approach(es).

Because Robert's ability to return to work is impacted by the lack of fit between the physical abilities of the person and the physical demands related to his job, it is appropriate for the occupational therapist to select a physical rehabilitative theoretical approach.

6. Assessment

- Based on your selected theoretical approach(es), what is the overall assessment plan? Consider what assessment strategies for data collection purposes, for example an interview, direct observation, use of standardized measures or consultation with professional colleagues.

The occupational therapist hypothesizes that the lack of PEO fit is the result of biomechanical issues and, therefore chooses a biomechanical model of practice within this theoretical approach. Assessment is focused on the evaluation of the physical demands of his job and the biomechanical components of the person (e.g. range of motion, muscle strength, body mechanics/lifting techniques, posture, endurance and pain).

7. Fine tuning

- Was/were the selected theoretical approach(es) useful in explaining the client's OPIs? If yes, then develop an intervention plan that is consistent with the chosen theoretical approach(es). If no, then consider whether to select another theoretical approach for intervention or to conduct further assessment of the client's OPIs.

Based on the findings of the assessment, the occupational therapist may fine tune the assessment approach before planning the intervention. If the findings showed that Robert had decreased range of motion and muscle strength due to inactivity, then a physical biomechanical approach would continue to be appropriate. Suppose that the physical assessment indicated that Robert's biomechanics were not the source of the difficulty with his job. Further exploration might have shown that the most important factor is the length of time that Robert spends in his car and that he must lift very heavy equipment on his sales calls. The most appropriate theoretical approach would then be an environmental approach. Further assessment may be needed to explore the physical, social, economic and political aspects of his work environment. As a final example, if the assessment results indicated that Robert's pain was more chronic in nature then the occupational therapist might choose a psychological-emotional theoretical approach and further explore the client's daily routine and its relationship to his experience of chronic pain.

8. Treatment

- What is your overall intervention plan? Consider the occupational therapist role, e.g. direct service, education, consultation, referral, mediator training, advocacy and identify intervention strategies.

Based on the assessment findings, the occupational therapist works with the client to identify treatment goals and negotiate specific targeted outcomes. The occupational therapist then uses theory to develop and implement an intervention plan. In Robert's case, using a physical biomechanical approach, intervention might focus on body positioning, postural training, muscle strengthening and education regarding lifting techniques. With an environmental approach, intervention might focus on changing the seating in his car, using special lifting devices for transporting equipment, using computer-simulated demonstrations for sales purposes and/or providing a modified work schedule. A psychological-emotional approach might focus on cognitive restructuring to implement a paced approach to his work routine.

9. Outcomes

- How will you determine if intervention/treatment has been successful? Consider how to measure change in occupational performance and client satisfaction.

Regardless of the theoretical approach(es) through which the occupational therapist viewed this client, the outcome measured is change in the occupation initially identified as an issue. In this case, Robert's desired outcome of returning to work as a sales representative is evaluated. The occupational therapist would re-administer the *COPM* to assess Robert's performance and satisfaction.

The McMaster Lens for Occupational Therapists is a 44-page booklet published by McMaster University in 2006. During the past academic year, the McMaster University occupational therapy program used the Lens within our curriculum with reassuring outcomes. Student occupational therapists have identified that the Lens is a useful educational tool to guide thinking and practice within both

academic and clinical settings. Student feedback was solicited and representative quotations are presented below from two students:

"The Lens serves to bridge the major tenets/theoretical models of occupational therapy with practice, facilitates client-centered practice by focusing on the essence of the individual (i.e. values, goals, beliefs) and, thus, shows that occupational therapy is interested and in tune with the needs of the client. It provides a holistic view of the client since it provides a multifaceted perspective on an individual."

"When using the Lens, I find that I explore spirituality and development in more detail and consider their role in the [formulation of the] client's OPIs [occupational performance issues]. The Lens does allow theory to be incorporated into the framework and effectively used to guide clinical reasoning."

Informal feedback from tutors in the occupational therapy program has been very positive. Many tutors have used the Lens to guide discussion in problem-based learning courses, as well as to promote client-centred practice, problem-solving and clinical decision-making. More formal evaluation of the Lens as an educational and clinical practice tool is currently being planned by our faculty.

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Copies of the McMaster Lens for Occupational Therapists are available at a nominal cost from the Titles Bookstore at McMaster University. The website for the bookstore is http://titles.mcmaster.ca/

Acknowledgements

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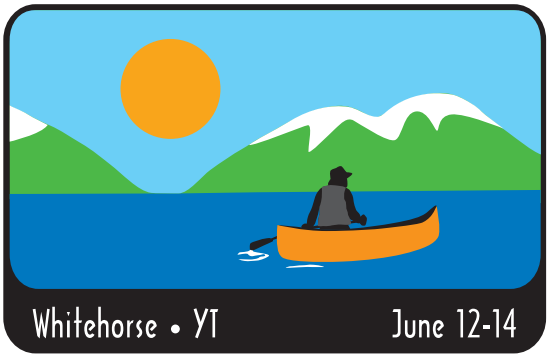
Conference 2008 - For a truly unique experience come and explore the frontiers of occupation in Whitehorse

Erica Lyle, CAOT Communications Coordinator



Exploring the frontiers of occupation

The Canadian Association of Occupational Therapists (CAOT) and the Association of Yukon Occupational Therapists (AYOT) are excited to be hosting occupational therapists for the first time north of 60 at this year's annual CAOT conference. This event attended by occupational therapists from across Canada and the world has alternated locations between eastern, western and central provinces. But when the conference management team was selecting the 2008 site, AYOT expressed an interest to co-host the event.

About the author – **Erica Lyle** is the CAOT Communications Coordinator. You may reach Erica at 613-523-2268 ext.225 Toll Free: 1 (800) 434-2268 or at her e-mail address: communication@caot.ca .

The decision for the conference location involves careful consideration. "There are a number of criteria that need to be met before we designate a site for a CAOT conference," said Claudia von Zweck, CAOT executive director.

"Whitehorse will provide our members with a unique and interesting experience," explains Gina Meacoe, the CAOT conference manager. "Giving provincial associations with a smaller membership base the ability to co-host a conference of this size is a terrific opportunity. CAOT co-hosted the 2004 conference in Prince Edward Island and it was a very successful conference."

According to their department of tourism, Yukon is "the land of larger than life experience." We hope you will take advantage of this rare occasion to visit a region truly out of the ordinary.

Hot topics

This unique setting provides an opportunity to address health issues existing in northern communities and throughout Canada. Be sure to join CAOT for one or both of the professional issue forums addressing populations with limited access to occupational therapy services.

On Friday morning, professional issue forum participants will discuss current research and identify possible strategies to address concerns of access to services among First Nations and Inuit populations. Participants will have the opportunity to achieve a greater understanding of the health status, cultural, social and political reality of First Nations and Inuit populations, as well as the impact of limited access and barriers to occupational therapy services in these communities. Take this opportunity to be part of a plan to improve access to occupational therapy services and identify strategies and resources that will facilitate participation in healthy occupations.

The following day you will not want to miss participating in a forum addressing one of the hot topics in health care today: Obesity and Healthy Occupation. Statistics Canada reports that two out of every three adults in Canada are overweight or obese and this number has increased dramatically over the past 25 years. Join fellow occupational therapists concerned about the growing impact of obesity issues for occupational engagement and performance. This forum will provide an excellent opportunity for people to discuss current research and identify possible strategies to address these issues.

New for 2008

This year the scientific program committee launched a new and thought-provoking presentation opportunity that brings consumers to the forefront - come to hear delegates insightful and perceptive stories. Be sure to watch for one or more of these inspiring presentations:

- Pioneering Partnerships: Mental Health Consumers and Future Occupational Therapists
- Changing Minds, Changing Lives: Rehabilitation Through Sport
- Consumers as Research Collaborators, Knowledge Brokers and Policy Advisors
- A Mother's Perspective: How Duchenne Muscular Dystrophy Affects Boys' Brains

Are you prepared?

More than ever, today we are immersed with reports of emergency or disaster situations occurring around the globe. Knowing what to do when a disaster strikes will help to better control the situation and be in a position for faster recovery. Join this CAOT sponsored session as the United States delegate to the World Federation of Occupational Therapists discusses the role of occupational therapists in disaster preparedness and response. This is a session you definitely should attend!

Discover Yukon's history, tradition and culture

From the opening ceremony, delegates will be exposed to the rich history and culture that the north has to offer. Your conference experience will have a true northern feeling including our keynote speaker Madeleine Dion Stout, a Kehewin First Nation Band member, will speak from personal knowledge and experience about the state of health care in northern communities.

Madeline Dion Stout will be the keynote speaker at Conference 2008

Be sure to register early for this year's social event: Rendezvous Under the Midnight Sun. It is a journey to the past where delegates will celebrate the Yukon's Klondike days and enjoy entertainment by the Snowshoe Shufflers and local musicians. Delegates will once again be transported back in time with a visit to the MacBride Museum. The museum provides a historic review of the birth of Whitehorse with a display of Klondike gold, the truth behind Robert Service's legendary Sam McGee's cabin or local First Nation culture through a collection of crafts and artefacts. Take advantage of this rare opportunity to explore this northern frontier!

Finally, plan to attend the most popular show in the north. You can order your tickets now for the Frantic Follies – a turn of the century vaudeville revue. This show has been enjoyed by more than one million people so be sure to reserve early as there are limited tickets available. Join us for the Saturday evening show at the Westmark Whitehorse Hotel at 9:15 pm. You can purchase a ticket for only $20.19 (plus GST).

Did you know ?

- Whitehorse's population is 24,041 - almost three-fourths of the Yukon's population (June, 2007).
- Total land area of Whitehorse is 413.48 km^2.
- The mean temperature in Whitehorse in June is 14.1 Celsius.
- 25% of Yukon population reported at least one Aboriginal origin (Census, 2001).
- The sub-alpine fir is the official tree of the Yukon.
- The Alaska Highway was constructed in 1942-43.
- There are 247.6 km of road surfaces made of pavement in Yukon.

Sources:
Yukon Bureau of Statistics, Statistics Canada, Yukon Territorial Government

Remembering an occupational therapy leader: Joy Huston Bassett (1912 – 2007)

Erica Lyle, CAOT Communications Coordinator

Joy Huston Bassett

After a short illness, Joy Bassett passed away peacefully on Tuesday, September 18, 2007 in her 96th year.

The daughter of Irish missionaries, Joy was born in China and lived there until the age of 14 when she moved to the United Kingdom. Originally trained as a Cordon Bleu chef with a degree in domestic science from Edinburgh University, Joy drove about the country during World War ll showing families how to cook with limited rations. After the war, she returned to her education where she studied at the London School of Occupational Therapy in England from 1946 to 1949. Following graduation, Joy became a lecturer and chief examiner at the London school and was later appointed to the position of chief occupational therapist of the Rehabilitation Clinic at the Royal Northern Hospital in London. She held this position until 1962 when she immigrated to Canada to become the chief occupational therapist at the Manitoba Rehabilitation Hospital in Winnipeg (now part of the Health Sciences Centre) where she was instrumental in setting up the department.

In 1968 Joy moved to Toronto to become the consultant in rehabilitation to the Ontario Ministry of Health. Among her many honours, Joy was the first recipient of the Muriel Driver Memorial Lectureship which was awarded by the Canadian Association of Occupational Therapists in 1975. Two years later, she received the Queen's Silver Jubilee Medal for her many contributions to rehabilitation in Canada.

At the age of 70 Joy attended the Ontario College of Art where she pursued her love of painting – a hobby which she enjoyed until her death. She also studied creative writing and published a number of articles regarding her early life in China. In her 90's she bought a computer to communicate with friends and family abroad and taught herself Braille as her eyesight deteriorated.

Joy lost both her first husband and brother during the Second World War and in 1982 her second husband of only five years passed away followed by her only son in 1997. She moved to the west coast in 1995 to be closer to family and spent several years on Galliano Island before moving to the Cowichan Valley. She is remembered by her many friends and family including her grandchildren and two great-grandsons.

Joy's dedication to her profession, love of life and positive attitude is an inspiration to all.

Sid's Group: The power and significance of occupation in the lives of older adults

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

Jill Stier and Harold Smordin

Health promotion for older adults has increasingly focused on maintaining active and occupationally engaged lives (Health Canada, 1998; O'Brien Cousins, 2005; Public Health Agency of Canada). Ann Wilcock (1999) recognizes that this relationship between the health and well-being of older adults and occupational engagement is complex; however, as the population ages understanding this connection is crucial. She describes engagement in meaningful occupations as critical to the health and well-being of individuals and communities and proposes that the balance of doing, being and becoming is central to a healthy way of life. The concepts of doing, being and becoming and the significance of occupational engagement for older adults are illustrated below through the real life stories of Sid, Cerline and Harold, who are participants in a self-led fitness program called Sid's Group at the Rose and Max Rady Jewish Community Centre in Winnipeg, Manitoba.

Sid, age 83, retired salesman

Approximately 10 years ago, Sid joined a new community centre and used exercises that he had learned from the local Y to start his own program. Today, with Sid at the helm, this self-led fitness group, fondly known as Sid's Group, is held for one hour every Monday, Wednesday and Friday. What makes Sid's Group so fascinating is that "it just happened," Sid says surprisingly. "One person wanted to join and then it just snowballed; a number of other individuals wanted to join," he said. Currently 14 group participants, ages 63 to 87, attend consistently. "We began exercising upstairs on our own doing stretches and weights, swinging them and the centre didn't like it because we monopolized the weights and space," said Sid. Instead of shutting out these older adults, the centre staff astutely recognized the value of the group for their health and provided them their own room, with a variety of weights, benches and exercise mats at no additional cost.

Initially Sid said that he "hated exercise," but is motivated to participate at the centre for health reasons. Since joining the group, he is no longer on any medications for his asthma, has reduced his high blood pressure medications and experiences less leg numbness. However, it is not just what the group does for Sid that contributes to his health and well-being. Sid derives other occupational benefits from participation by giving back to the group: "group members are waiting for me; I am proud that they are following me. I am a people person. I like to help them. In my own mind, I think I am doing the right thing. Without it, I would be confined to a wheelchair in a nursing home," he said.

Cerline, age 73, retired airline stewardess

Cerline was diagnosed with osteoporosis over five years ago, following eight fractures in a five-year period. At her doctor's suggestion, she began swimming at the centre when Sid encouraged her to join Sid's Group. At the time with only male participants in the group, Cerline was reluctant but felt that her social interactions as an airline stewardess would help her to participate actively in the group. "I will do the exercise because it will make me healthier," said Cerline. What she did not know at the time was how much healthier it would make her, which now she so gratefully acknowledges.

It has been five years since Cerline joined the group and she has made enormous physical improvements. She proudly reports that she has not sustained a single fracture and her bone density examinations indicate that she has plateaued. "I want to live independently in my own house. I want to shovel my own snow, cut my own grass, so I come here," she said. Cerline believes that participating in the group has "helped me stay in my home and to live independently."

Beyond the physical health benefits, Cerline feels a sense of social connection with Sid's Group's participants. She is motivated to regularly attend the group because she knows that someone will always

CSOS Canadian Society of Occupational Scientists

Edited by Polatajko and Davis, on behalf of CSOS.
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be there to exercise with her and encourage her. Cerline comments that "there isn't a session we don't have a smile on our faces; they are fantastic smiles the entire time." Cerline misses the group when she goes on holidays but always stays connected by sending the group a postcard.

Cerline has experienced a true sense of belonging with the other participants. "I am comfortable in the group in every respect. I don't know what the group members did in their work, where they live, if they are rich, poor or what religion any of them are because it doesn't matter. We talk about our children, food and news of the day. The immediate interest in the group is not what you have been, but where you are now," she said.

Cerline indicated that participation in the group has meant a great deal to her. "I live alone but I can never feel lonely." She feels that "we [older adults] need to participate, stay fit and healthy." Cerline has clearly described the benefits of occupational participation as positive health outcomes and an improved self-perception of well-being.

Cerline eloquently states: "Society is starting to accept us more and more. We still need to get young people to not see us as old. The only distinction between young people and older people is not of age but of well-being."

About the authors –

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Harold Smordin is a participant in Sid's Group

Harold, age 80, retired chartered accountant*

Everyone has structure in their work and their lives and people do well with some form of structure. Sid's Group provides structure. Everyone gets up at approximately the same time; we typically do the same routine and hear the same commentary, which makes us laugh. We usually all stand in the same spot and use the same benches. The group gives me a sense of purpose and meaning to get up in the morning and do something. It is the start of my morning routine and start to my day and I know it ensures that I stay healthy. I would never book anything else on these days; it is not negotiable or even thought about. When you negotiate, there is often a win or lose. What are you going to negotiate? You know you win when you attend.

Doesn't everyone like to participate in something; here you participate and have company while doing it. Everyone who is getting older goes through what you do, maybe a bit differently but we can all help each other and encourage others to participate. The exercises are enjoyable because you always have a laugh. I feel that I would have lost time, a whole day if I didn't go and have a good laugh.

We all participate at our own pace and do what we can. There would be no comments if a person went through the routine without weights. One group member, Avraham, does not do weights due to a car accident but he holds equal status in the group and is viewed as the second leader with his role as the counter, calling out the number of repetitions. In fact, we all hold equal status despite what we did for a living, what weights we lift and where we come from.

I socialize a great deal outside of the group but also enjoy that as a group we go out for lunches, to plays and have picnics. Everyone is thought of and included.

Some days you may feel tired, you are not feeling well, you have your own personal battle with yourself, but going to the group gives you a sense of companionship, the opportunity to feel healthier, and an environment where you only hear positives, and are allowed to be your own person and to be recognized. What could be better and as Harvey, one group participant says at the end of every exercise, "perfect"!

For Cerline, Sid and Harold, the occupational choices that they made by participating in Sid's Group have provided them with positive physical and

* Harold authored this case study himself thus it is written in first person.

psychosocial health outcomes which parallels research by Ann Wilcock (2005) and Debbie Laliberte Rudman and colleagues (1997). Occupational participation in Sid's Group provides the group members the opportunity to continue doing their meaningful occupations. These individuals are happy, motivated, active and social occupational beings who are on their way to becoming healthier vibrant occupational citizens in their community.

Occupational therapists can help individuals uncover who they are as occupational beings by enabling older adults to participate in programs, find resources and advocate for initiatives that will help them to be active participants in their communities. Occupational therapists need to ensure that our voice is heard to advance social and health policies and to research, plan and promote the programs associated with older adults' health and well-being. Get involved with policy makers, service providers and the individuals themselves in the program design. Occupational therapists have such wonderful opportunities to enable the development of healthy occupational communities with sustainable outcomes, and demonstrate the power and significance of occupation in people's lives.

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Column Editor: Lori Letts

Occupational therapy school services improved children's writing skills but did not adhere to the consultation model

Summary of Bayona, B.L., McDougall, J., Tucker, M.A., Nichols, M., & Mandich, A. (2006). School-based occupational therapy for children with fine motor difficulties: Evaluating functional outcomes and fidelity of services. *Physical and Occupational Therapy in Pediatrics, 26*(3), 89-110.

Prepared by Brenda McGibbon Lammi, CAPs Advisory Group Member.

Research objective: To evaluate the utility of occupational therapy services and the consultation model of service delivery for children with fine motor difficulties.

Design: A program evaluation study using a one-group, non-randomized, pretest and posttest research design. Classroom teachers completed pretest and posttest standardized measures at the beginning and end of the school year. At posttest, teachers and parents completed satisfaction measures and therapists summarized the services they had provided through the completion of a questionnaire.

Setting: Classrooms within various schools in the London-Middlesex area of Ontario, Canada.

Participants: Children eligible to participate were between five and eight years old, in senior kindergarten through to grade three, enrolled in either the public or Catholic school board and assessed to have fine motor difficulties in the 2002 school year. In addition, eligible participants did not receive therapy from any other source nor were they diagnosed with a neurological disorder. Initially, thirty-five students were eligible for the study. However, students were excluded from the study for the following reasons: eight students did not have consent from classroom teachers, four received a diagnosis of a neurological disorder and two were missing posttest measures. Twenty-three students (19 boys and four girls) completed the study.

Interventions: Occupational therapists provided five to ten visits for each participant throughout the school year as mandated by the School Health Support Services Program for the region. Intervention included the following: collaborative identification of target areas, assessment of skills as well as the development and provision of consultation strategies and recommendations to teachers and parents.

Outcome measures:

(a) Measures of function

- Vineland Adaptive Behavior Scales - Classroom Edition (VABS-C)
- School Function Assessment - Version 3.0 (SFA)

(b) Measures of therapy process

- Consultation Summary Form
- Checklist for Strategies Employed by Classroom Teachers
- Client Satisfaction Questionnaire
- School-Based Occupational Therapy Questionnaire

Main findings:

(a) Function

Written communication was found to improve both statistically significantly and clinically meaningfully as measured by the VABS-C ($t(21) = -3.99$, $p<0.001$, one-tailed) and the SFA ($t(21) = -1.96$, $p<0.05$, one tailed). There was also a statistically significant and clinically meaningful improvement in the SFA subscale of using school related materials ($t(18) = -2.31$, $p<0.05$, one-tailed). No significant difference was found in the subscale of the VABS-C fine motor skills. After consultation, 70% of the teachers were found to use individualized task modification, environmental modification, teaching/learning/cognitive strategies along with support and resources in the classroom as compared to 26% prior to consultation.

(b) Therapy process

Eighty-six percent of therapists indicated that they had used some direct therapy to deliver the intervention. Therapists, on average, perceived their services to be moderately successful. One hundred percent of teachers and 52% of parents completed the satisfaction measures. Teachers felt indifferent or mildly dissatisfied with services and parents were mostly satisfied.

Authors' conclusions:

The authors found that the majority of therapists provided some direct therapy to children while working within a consultative model of service delivery. However, they were unable to establish the extent of the direct therapy in comparison with the consultation.

The authors state that the students demonstrated an improvement in functional performance but the mix of consultation and direct service made it difficult to attribute this to consultation alone.

Contact information for the appraised paper's designated author is: Janette McDougall, E-mail: janettem@tvcc.on.ca

Commentary on Bayona, C. L. et al. (2006). School-based occupational therapy for children with fine motor difficulties: Evaluating functional outcomes and fidelity of services

School-based occupational therapy services are becoming more prevalent. According to Chui and Reid (2002), the number of referrals received for school-based occupational therapy for children with fine motor difficulties has increased by almost 500% in the past five years. To meet these increasing demands, the model of service delivery has changed from a direct service model to a consultation model (Sandler, 1997). Despite the increased use of the consultative approach, very few studies have addressed the outcomes of school-based occupational therapy services using this model. In order to attend to this gap, Bayona and her colleagues (2007) chose to evaluate participants' written communication and fine motor skills following the implementation of a consultative school-based therapy program to develop a stronger evidence base for occupational therapy practice.

About the commentators -

Monika Cameron, MSc (OT), OT Reg. (Ont.) is an occupational therapist at the Champlain Community Care Access Centre, Pembroke, Ontario.

Brenda McGibbon Lammi, MSc(RS), BHSc (OT), OT Reg. (Ont) is an occupational therapist at the Champlain Community Care Access Centre, Pembroke, Ontario.

Methods issues:

The single group, pretest and posttest, quasi-experimental design allowed the authors to address the identified research questions. However, some uncertainties remain when trying to interpret the findings.

The authors state that control groups were not used for ethical and service delivery reasons. No guidelines were provided for therapists regarding the content of intervention which may have resulted in an intervention bias. Authors could not provide important information about the relative amounts of time devoted to each model of service delivery as time allocated to consultation and direct service was not recorded. In the findings, 86% of therapists stated they provided some form of direct therapy during the study. It is unclear why these therapists found it necessary to provide direct therapy when the study question was to evaluate the use of a consultative model.

Both outcome measures selected for the study were administered by the participants' teachers. Although this may be a realistic method, in practice this may result in a measurement bias. In addition, the outcome measures selected could have been enhanced by including SMART goals (specific, measurable, attainable, realistic and timely) for intervention to increase the objectivity of the study's results. The authors also acknowledged that the changes observed in this study may have been due to maturation or direct therapy.

Generalizability:

Twenty three participants completed the study of the 35 recruited. Despite justifying the cause of the attrition, 23% of the participants did not complete the study which may have affected the results. In addition, the small sample size and lack of a control group makes generalization to a broader population more difficult.

Outcome measures:

The clinical outcome measures chosen for the study were the Vineland Adaptive Behaviour Scales - Classroom Edition (VABS-C) (Sparrow, Balla, & Cicchetti, 1984) and the School Function Assessment - Version 3.0 (SFA) (Coster, Deeney, Halitwanger, & Haley, 1994). The authors commented on the reliability of the assessments but did not provide specific values. In addition, although the SFA was a key outcome measure there has been no reported testing for validity. It is important to ensure that the outcome measure chosen is measuring the construct it is intended to assess.

Statistical analyses:

The authors appropriately justified the sample size for the study. The results were reported in terms of statistical significance and clinically meaningful changes. Clinically meaningful changes were calcu-

lated and explained in user-friendly terms for a practicing clinician.

Application to practice:

Although the consultative model has not been studied in depth it appears to be a commonly used model as an alternative to direct therapy. It is unclear why direct therapy was provided by the therapists in this study examining a consultative model. Perhaps the therapists felt that in order to be client-centred they needed to spend one-on-one time with the student before leaving recommendations to be carried out by someone else (i.e. they needed to find what would work for these students). Would it have been unethical for the therapists to provide recommendations without spending some time directly with the students? Should this time be considered direct therapy or a necessary part of consultative therapy?

A defined aim of this study was to address the fidelity of occupational therapy consultation services for children with fine motor difficulties. Measuring this defined aim would have been difficult without starting with a clear definition of the term consultation. By initially defining consultation the authors would have been more able to measure the fidelity of intervention in relation to this particular approach. By providing the readers with a definition of consultation, the reader could have used the study to compare to and relate to their current practice.

It is also interesting to note that the teachers reported indifference or mild dissatisfaction with the occupational therapy services. This could have a significant impact on practice since recommendations by occupational therapists using consultation method rely on school staff, including teachers, to carry out the recommendations. A more holistic approach that involves team decision making with the teacher may help to integrate the recommendations into the classroom and provide teachers with a greater satisfaction with the services. It is logical that as a result of the increasing number of referrals that a change needs to be made to accommodate the increasing demand.

A preliminary study by Jarus and Goverover (1999) found that children may not develop new skills as easily as adults within an environment with a lot of contextual interference such as in a classroom setting. Perhaps a combination of direct and consultative models of therapy may be the most beneficial. Throughout the article, the authors acknowledge the gaps in the research and the concerns related to the study's design. It is important that further research be completed to address the possible benefits and consequences for clients receiving consultative models of school based occupational therapy intervention to better guide practicing occupational therapists.

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Discussion questions:

1. What skills and knowledge are needed to successfully use a consultation model in occupational therapy? Are therapists adequately trained to provide consultation services in the schools or other practice areas?

2. The commentators suggest that SMART goals might be a strategy to increase objectivity and address the limitation associated with teachers completing the outcome measures. How can SMART goals contribute to the evaluation of an intervention? Can they be used to look at data for groups of clients?

3. Is there any way to address the challenge of wanting a comparison or control group in this type of evaluation study?

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COTF's 25th anniversary!

COTF will be hosting a gala on November 7, 2008 in Toronto to mark its 25th anniversary when COTF was founded on May 17, 1983. Details will be available throughout the year. Other smaller happenings will also take place. Everyone is encouraged to participate to support research and scholarship funding for occupational therapy in Canada.

COTF Board Members

COTF welcomes Sue Baptiste, a faculty member at McMaster University and Andy Kovacs from Sun Life Financial to its board as of October 1, 2007. COTF thanks outgoing board members for their work and commitment to COTF: Past President Sandra Bressler and Michael Bilas.

Remember to update your COTF contact information

COTF would greatly appreciate it if you would inform Sandra Wittenberg of any changes to your COTF contact information. Sandra can be reached at swittenberg@cotfcanada.org or 1-800-434-2268 x226.

Your support counts!

COTF sincerely thanks the following individuals, companies and organizations for their generous support during the period of August 1 to September 30, 2007. For those whose names do not appear in this listing, please see the next issue of *OT Now*.

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