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Call for Papers

Special Issue - September, 2009 Occupational Therapy Now

Sensory processing and occupation: Their intersection and impact on everyday life

Guest Editor:
Winnie Dunn PhD, OTR, FAOTA

Introduction:
Nancy Pollock M.Sc., O.T. Reg. (Ont.)

We are looking for papers that:

- Describe situations in which a person's sensory processing patterns may be supporting or interfering with participation in everyday occupations.
- Outline the role of occupational therapy as we support participation using our sensory processing knowledge.
- Explain and illustrate strategies with which we can differentiate participation that has a sensory processing basis from other types of participation challenges.
- Examine how we can link sensory processing knowledge with interdisciplinary practice models and frames of reference.
- Consider how occupational therapists link participation issues with differences in sensory processing.
- Review how occupational therapists are addressing participation challenges using sensory processing knowledge:
  - With which populations?
  - With what age groups?
  - What is effective, what isn't?
- Examine what the research tells us about sensory processing and occupational therapy.

Deadline for submission: April 1st, 2009
If you have a question, or an idea for a paper, please contact:

Brenda McGibbon Lammi **blammi@caot.ca**
Managing Editor, OT Now

Everyday stories . . .
profiles of your CAOT colleagues

Margit Sampogna

This is a new column in *OT Now* in which members of the CAOT will be profiled. If you would like to be profiled, or know someone who should be profiled, please contact the Managing Editor at otnow@caot.ca.

Our first profile is Margit Sampogna, an occupational therapist and an artist.

Name: Margit Sampogna (nee Andersen)

Family life:

Margit married shortly after graduation and four years later delivered identical twin girls, now 28 and actively pursuing careers. Spare time is devoted to family, travel, cycling, photography, gardening, and painting. Cooking is not part of this repertoire and is avoided at all costs.

Education:

Graduated from Occupational
Therapy at the University of Toronto in 1976.

Career path as an occupational therapist:

Following graduation, Margit initially worked in pediatrics at the Cerebral Palsy Centre at Chedoke Hospitals in Hamilton followed by the Peel Infant Development Program in Mississauga. She eventually transitioned to adult physical medicine and has worked in the private sector (auto primarily) since 1993, both as a clinician and case manager.

Margit's reflections on herself as an occupational therapist:

I have always introduced aspects of art and creativity into the task at hand. Using my "right brain" has greatly assisted me in thinking "outside the box" for the benefit of my clients when developing assistive devices and alternative strategies for function. Everyone is capable of artistic expression and art therapists recognize the value of this modality to support the recovery process for individuals.

Margit's life as an artist:

At the time that I applied for university, I also applied to the Ontario College of Art (now OCAD) and repeated this when applying for entry into the Occupational Therapy program at the University of Toronto. Each time the choice was difficult but occupational therapy strongly appealed to me, and it was a good decision.

Life in the early years was very busy with work, raising twins and volunteer work. As much as I enjoyed occupational therapy, I always maintained a strong interest in the arts and indulged my creativity with home decorating projects, handiwork (such as needlepoint, knitting and sewing) and gardening. I took interest courses. Time was slipping by and I'd had my fill of the handiwork. The visual arts beckoned and in 2005 I enrolled in an introductory course offered locally. I viewed the botanical art display while attending Canada Blooms and was hooked. Ironically, the botanical drawing course was offered at U of T and taught by the Director of Art as Applied to Medicine! Life had come full circle; a blend of art and science.

While botanical art remains a primary interest given my profound love of the natural world, I find myself constantly exploring and experimenting with media and subject matter. The ordinary becomes extraordinary.

Of interest:

Margit is now offering workshops. One of her botanical paintings was recently accepted for publication in an art book of local artists designed to promote awareness of the Oak Ridges Morraine, a percentage of book sales goes to the Moraine preservation projects. The link is http://gallery.me.com/artcures/100032.

Botanical art can be viewed at
http://www.botanicalartistsofcanada.org/

The unmet needs of those aging with schizophrenia

Column Editor: Sandra Hobson

Chris M. Dixon

Occupational therapists need to be able to respond to both physical and mental health needs of clients. One of the health populations where this is especially important is in older adults with schizophrenia who experience age related physical issues. General hospital admissions in Canada for individuals with schizophrenia disorders aged 65 through 90+ years averages about 703 admissions per 100,000 (Stewart, Lips, Likaski & Upshall, 2002).

Individuals aging with schizophrenia can range from the active community dweller to the frail long-term care resident. These individuals need to cope with age-related changes and coexisting medical conditions. When medical and psychiatric disorders coalesce, attention may be diverted away from mental health issues to focus on age related changes such as physical frailty and the possible lifelong consequences of smoking, alcoholism, poor diet, and sedentary lifestyles that result in chronic medical illnesses (Bartels, 2004). There are generally few or no mental health workers in physical health practice settings available to address psychiatric symptoms and it is particularly difficult to meet mental health needs in a long-term care setting (Canadian Coalition for Seniors' Mental Health, 2006). For example, approximately 3.1% of individuals in residential care facilities in Ontario had a diagnosis of a schizophrenia disorder (Goeree et al., 2005). However 40% of nursing homes in Ontario received no direct psychiatric consultation and 88% of long-term facilities had five or less hours of care per month from a psychiatrist (Canadian Coalition for Seniors Mental Health, 2005). Addressing both physical and mental health needs is within the scope of occupational therapy.

About the author –
Chris M. Dixon, MSc, BSc is an occupational therapist for the Interior Health Authority in Kelowna, BC. For further information she can be reached at rnwdixon@silk.net.

What are the needs?

People aging with schizophrenia demonstrate high levels of unmet clinical and social needs whether they live in their own homes or in residential care (McNulty, Duncan, Semple, Graham, & Pelosi, 2003). These needs include managing psychosis, medication side effects, anxiety, depression, cognitive difficulties, socially embarrassing behavior, social life, hygiene, dressing, domestic skills, finances, transportation, amenities, and accommodation. Elderly persons returning to community care after psychiatric hospitalization may rely on providers in the general medical sector for both physical and mental health care (Proctor, Morrow-Howell, Rubin, & Ringenberg, 1999). They may also have difficulty complying with care regimes, such as those for diabetes and hypertension (Lantz, 2004).

"When medical and psychiatric disorders coalesce, attention may be diverted away from mental health issues to focus on age related changes..."

Those aging with schizophrenia in rural under-serviced areas face the additional challenge of geographic distance limiting access to mental health services (Tryssenaar & Tremblay, 2002).

There is also an increased risk of hip fracture and falls for the elderly with schizophrenia (Misra, Papkostas, & Klibanski, 2004; Howard, Kirkwood, & Leese, 2007). Sedation, orthostatic hypotension, or extrapyramidal side effects from neuroleptic medications may predispose these individuals to falls. Further, bone mineral density loss was found to be highly prevalent in persons with chronic schizophrenia who were treated long term with prolactin-raising typical or atypical antipsychotic medication, which is a significant predictor of an increased risk of hip fracture. Practitioners need to be aware of these barriers to therapeutic intervention and make necessary accommodation.

A significantly greater risk for falls has also been found in elderly persons using both antidepressant and antipsychotic medications (Ray et al., 1997). There is a high prevalence of depression in middle aged and older adults with schizophrenia disorders (Zisook et al., 2006). Depression diminishes functional activity and increases health risks. Evidence indicates that the use of antidepressants in persons with both schizophrenia and depression produced worsening of psychotic symptoms (Kramer et al., 1989).

Anxiety symptoms were shown to account for more variance in quality of life for those aging with schizophrenia than depressive symptoms (Wetherell et al., 2003). Anxiety was associated with poorer outcomes of well-being, vitality, social functioning, and role functioning.

The stress of environmental changes, such as when an individual is relocated or there is a loss of continuity of caregivers, can exacerbate anxiety and facilitate psychotic manifestations in elderly persons with schizophrenia (Inventor et al., 2005).

Elderly people with schizophrenia are more predisposed to residential care than other older persons (Walkup & Gallagher, 1999). They are less likely to have maintained a social support network, if they did not marry, maintain a marriage, or raise children; and siblings may be the only family support when those aging with schizophrenia outlive their parents (Lefley & Hatfield, 1999). They are also less likely to have completed advanced education or developed a career or significant work history that would have established a sustainable financial situation. Marked positive symptoms, such as auditory hallucination and persecutory delusion, and negative symptoms, such as apathy and social withdrawal, may be more evident for those living in long-term facilities than for elderly community dwellers (Harvey et al., 1998).

What can occupational therapists do?

Occupational therapists can address both anxiety and depressive symptoms in those aging with schizophrenia using psychosocial intervention.

In the palliative care setting, the occupational therapist can address the complexity of dying with schizophrenia and co-morbid depression or anxiety. It was found that addressing schizophrenia symptoms through effective communication involving active listening and exploring emotion and meaning improved quality of life in individuals with co-morbid advanced cancer in a hospice setting (Miovic & Block, 2007).

As the number of Canadians over the age 65 years increases, so will the number of those aging with schizophrenia. Practitioners, including occupational therapists, who are well versed in both physical and mental health needs are in a unique position to provide therapeutic intervention to this aging population. Occupational therapists and others in both physical and mental health settings need to be sure that they are assessing and treating these clients in a holistic manner and be aware of any preconceptions introduced by the practice context.

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Health STEPS clinic: It's more than just helping people with schizophrenia to lose weight

Column Editor: Sandra Hobson

Barb Cortens

The stories of hope . . . some brief case descriptions from the Health STEPS clinic

Mary is a 28 year old female with schizophrenia who has been living in isolation. She has also experienced the frustrations of weight gain. She began to attend the Health STEPS clinic. Although her weight loss has been minimal, she has accomplished many other things. She has set goals for learning how to cook something new each week. She also has formed several positive friendships. She has gone for a walk with some other group members and has socialized with them at different program events.

Irene is working hard on her wellness and recovery from mental illness. Since beginning one of the newer antipsychotic medications, she successfully lost over 44 pounds. Irene is now working full time, but has asked to have "Tuesdays off", so that she can see her doctor, occupational therapist, and attend the Health STEPS clinic. She attributes her wellness to these activities.

Roger had been attending the Health STEPS clinic for over a year and lost 16 pounds. He then began Clozapine in November 2007. Using a proactive approach to potential weight gain, Roger learned to monitor weight and make adjustments to his eating and activity. After 6 months, he had gained 5 pounds, which he felt was a success. He continues to attend the Health STEPS clinic weekly and was recently very proud that he attended a family event and was able to control his food portions.

About the author –
Barb Cortens, OT Reg (Mb) is an occupational therapist with over 26 years of experience. She is currently working in the outpatient area of the Schizophrenia Treatment and Education Program in Winnipeg, Manitoba. She loves hearing client success stories. Barb can be contacted at bcortens@hsc.mb.ca.

Background

People with schizophrenia are at risk for serious health problems such as obesity, hypertension and diabetes. Life expectancy can be reduced by up to 10 years for persons living with this illness (Bradshaw, Lovell, & Harris, 2005). Several factors seem to contribute to these health problems (Shirzadi, Ghaemi, 2006; Khazaal, et al., 2006):

- Antipsychotic medications are a well-documented source for weight gain. The greatest weight gain is for Clozapine, followed by Olanzapine and then Quetiapine;
- There is some evidence that persons with schizophrenia may engage in binge eating and crave carbohydrates;
- People who struggle with negative symptoms of the illness are also likely to be less active in their occupations of exercise, work or leisure activities;
- As a result of low income, people with schizophrenia may buy inexpensive foods with lower nutritional value;
- Some people with schizophrenia eat irregularly and have an irregular living schedule. They also may be limited in their knowledge of healthy living principles and be restricted in their ability to access community health programs.

"Structured, module-based programs focusing solely on weight loss, instead of the whole person, do not meet the needs of this population..."

2001, body mass indexes (BMIs) were calculated on 183 persons in the Schizophrenia Treatment and Education Program (S.T.E.P.) in Winnipeg, Manitoba. The program has a large database of present and former clients, composed of men and women who live with schizophrenia or schizoaffective illness. The mean BMI for men was 29.02, compared to the National Population Health Survey (NPHS) mean of 26.3, and the mean for women was 30.02 compared to the NPHS mean of 24.3. The prevalence of obesity in this group was 3.5 times the national average (Coodin, 2001).

Addressing the problem

Structured, module-based programs focusing solely on weight loss, instead of the whole person, do not meet the needs of this population that consists of people with varying cognitive abilities and varying attendance. As occupational therapists, we are aware that general health encompasses physical, emotional, and spiritual wellness.

Experience led the members of the S.T.E.P. rehabilitation team to develop the Health STEPS clinic to accommodate the unique needs of this population.

The Health STEPS clinic

The Health STEPS clinic was initiated in September 2005 and is available only to S.T.E.P. rehabilitation readiness clients. The clinic consists of three essential elements, which are summarized in TABLE 1.

TABLE 1: Health STEPS clinic components

1. Meeting with the nurse
- Weight and body mass index are recorded.
- Once every 4 weeks additional measurements are taken, including heart rate, blood pressure, and measurements of waist, upper arm, hip, upper thigh and mid thigh.

2. Meeting with either the occupational therapist or the recreation coordinator
- Engage in SMART goal setting related to his/her own healthy living goals (Goals must be Specific, Measurable, Achievable, Realistic and Time limited).
- Example of a SMART goal might be "Drink 5 glasses of water every day."

3. Supportive, educational group participation
- Often participants request a theme, which is then developed into a group by the occupational therapist and recreation therapist one week in advance. The agenda is flexible so the theme can move in a direction that meets the needs of the participants.
- Practical groups are enjoyed. Participants tell us that they do not want to just sit and listen. Stories are shared and there is often laughter emanating from the room.
- Previous groups have included:
  a) Reviewing food portion sizes by measuring items
  b) Walking or engaging in physical activities and then monitoring one's reaction to the activity (this could be done using a pedometer or focusing one's breathing or rating one's emotional state pre and post activity).
  c) Demonstrating how to make different salads, keeping in mind nutrition and costs.

Components contributing to program success:

The benefits of a multidisciplinary team:

The nurse is a vital team member for the clinic. She is able to conduct physical assessments with the patients and is familiar with the participant's medication regime. The recreation therapist has first hand knowledge of client functioning. She also leads follow up groups in the community, such as a YMCA fitness group. Having an occupational therapist in the clinic has many benefits. Because the occupational therapist is well aware of individual abilities, flexibility is offered in the goal setting and the group. Communication styles can be adjusted. Clients' dignity is maintained because they participate at their level of ability. An occupational therapist's training in group planning and facilitation is crucial. The three leaders offer flexibility and collaboration, which helps insure the success and smooth running of the group.

Health benefits:

It is a challenge to focus all outcome measures on weight loss and reduction of body measurements, especially when we are dealing with a population of persons who may be struggling with positive and negative symptoms, poverty and difficulty with applying the teaching. There have been objective changes, as outlined in Table 2.

TABLE 2: Health STEPS clinic outcomes

Weight loss/waist measurement
- In the period from January 2007 to April 2008 two participants each lost 40 pounds. Another person lost 19 pounds.
- One person, who lives in a group home and therefore must eat the given meals, began to come to our exercise group at the local YMCA. He lost 15 pounds in that same time period.
- Overall, 6 people lost between 1-7 pounds (a mean of 5.4 pounds), 5 people reduced their waist measurement by 1"-3"; 2 people gained weight (2 and 7 pounds).

Attendance

Attendance remains strong even in the depths of our Manitoba winters! In the 6-month period from September to the end of February attendance ranged from 7-10 persons, with a mean of 7.7 and a mode of 8. (Attendance at other rehab readiness groups ranges from 2-5).

Flexibility and empowerment:

Probably the most beneficial outcome we see is that we have created an environment that is non-threatening, fun and educational. Participants who have declined other group activity are coming to the clinic. They may begin attending when they desire and they decide on the duration of their participation. They do not have to commit to weekly attendance but for some people it is an essential part of their weekly schedule. As they wait for the different parts of the clinic they are socializing with one another.

We have enjoyed seeing the personal growth of participants in the clinic. We do not discuss "illness" in the clinic; instead it is very health focused. The participant also has a personal record book, so they can see their individual progress and be reminded of their weekly goal. Incentives are given periodically during group for people to take home. These may include pedometers, cups for measuring foods, or healthy food items.

Conclusions

The Health STEPS clinic has incorporated an individualized approach to goal setting. The multi-disciplinary approach, the flexibility, and the empowering of people seem to contribute to its success. It is a joy to hear participants speak positively of the clinic and the weight loss has been a nice side benefit. We will continue to use this very winning approach as we attempt to assist persons with the many health struggles they face.

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Acknowledgements:

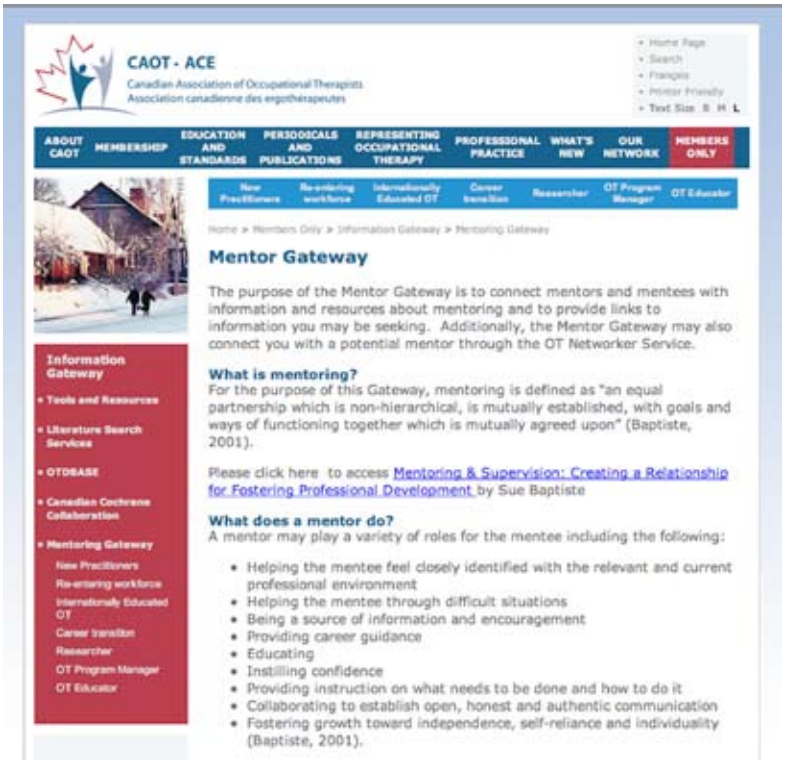
The success of this clinic is also due to the very hard work of my colleagues, Nola Apsit, (Recreation Therapist) and Bonnie Singleton (Registered Nurse). I also would like to acknowledge the support of Tracey Dowson (Occupational Therapist), Stephanie Benson, (Manager of Patient Care) the S.T.E.P. team and all of the Health STEPS participants.

Mentor Gateway

CAOT is pleased to provide its members with a new service on www.caot.ca - the Mentor Gateway.

Using a series of questions, the Mentor Gateway guides you to our online information related to mentoring and/or helps you connect with a potential mentor, who can help if you are unable to find the answers you are looking for or are looking for more than information.

The Mentor Gateway provides links for a range of questions including; clinical questions, practice questions, workplace questions and/or mentoring questions. It is a useful tool to navigate the CAOT website.



Experiences of a practicum in Bangladesh

Erline Wong-Sing

I wanted something different for my final eight week clinical placement as part of my occupational therapy degree. I had a desire to see what practising occupational therapy is like outside a Canadian context. Based on positive experiences of previous students who had gone to the same facility, a classmate and I decided to go to the Centre for the Rehabilitation of the Paralysed (CRP) in Bangladesh in July and August of 2007.

Figure 1: Source: United States Agency for International Development, 2007

Bordered by India to the west, north and east and Myanmar in the southeast, Bangladesh is a densely populated country situated at the Bay of Bengal on the Indian Ocean (Figure 1). Its population is approximately 158.7 million, average income per capita in 2006 was $480 US and main industries are agriculture and textiles (Canadian International Development Agency, 2008). With approximately 90% of the country lying less than 10 metres above sea level (United States Agency for International Development, 2007), numerous rivers flowing into the Bay of Bengal and an annual monsoon season, flooding and other natural disasters are recurrent – most recently in November 2007 cyclone Sidr devastated coastal Bangladesh.

CRP, approximately 25km west of Dhaka (the capital), is a non-profit organization that provides services to people who are disabled and raises awareness about disability in communities. CRP provides a number of services, which clients pay for based on family income, including:

- 100-bed hospital service for people with spinal cord injury;
- Outpatient paediatric programs and a recurrent 2-week mother-child inpatient program;
- Variety of rehabilitative outpatient services for orthopaedic and neurological conditions;
- Vocational training;
- Orthotics, prosthetics and special seating workshop;
- Inclusive schooling education for children with and without disabilities; and
- Training for nursing, physiotherapy, occupational therapy and speech language therapy professions at the Bangladesh Health Professions Institute (CRP 2005-2006).

My experiences

Once arrived, I quickly settled into my accommodation on the campus grounds of CRP. With assistance, I bought appropriate clothing to wear – salwar kameezes (loose fitting trousers, long tunic-like top) and ornas (scarves to be fastened at the shoulders and loosely draped across the chest) (Figure 2). Now I was ready to start working!

During my placement I mainly spent time in the inpatient areas of spinal cord injury and paediatrics. I also had opportunities to go on community home visits, visit a vocational training centre for women and spend time at the outpatient occupational therapy department. The occupational therapists I worked with were extremely accommodating to my learning needs and kept me informed of opportunities that might enrich my experience. Working a 6-day week from Saturday to Thursday, I quickly gained insights into occupational therapy practice in Bangladesh.

Figure 2: The author, Erline Wong-Sing, ready for work in her salwar kameezes and omas.

The main causes of spinal cord injury in Bangladesh are falls from a height (e.g., trees), falls while carrying heavy loads on the head and road traffic accidents. As it was the mango fruit season, there was an overcrowding of the inpatient beds due to the number of falls from individuals climbing mango trees. When monsoon rains came, some clients could not return home due to the floods that restricted road access or caused their homes to be inhabitable. These aspects of Bangladeshi life were eye opening (Figure 3).

Communication

Bengali, or Bangla, is the official language of Bangladesh. However all health professionals complete their education in English and documentation at CRP is done in English. As clients predominately spoke Bengali, I was able to call on staff to interpret for me when needed. However, I quickly learned key words and phrases in Bengali (e.g., How are you?, well done, try again, raise your right arm) so I could more effectively work with clients and their families. I also learned subtleties of non-verbal communication; a slight cock of the head to one side without necessarily a smile often meant "okay" or "yes". Furthermore I had my trusty Bengali phrasebook with me at all times, as a means to communicate as well as simply open the doors to exchange. Children especially enjoyed showing me what English they knew and teaching me Bengali words. I was not afraid of trying to speak Bangla outside of work and soon the shopkeepers outside the campus said hello as I walked by! Learning the language was a great way to connect with people.

About the author –
Erline Wong-Sing, BSW, MScOT is an occupational therapist in geriatric medicine at Mount Saint Joseph Hospital, Vancouver, BC. She can be contacted at ewongsing@gmail.com.

Culture-specific occupational therapy

On my first assessment, I quickly learned that questions about the environment had to include type of toilet, its location (e.g., inside or outside the home) in addition to water source (e.g., water pump, municipal supply, or river). Additionally, transfer to a bicycle rickshaw and water pumping ability had to be assessed. I also learned that utensils are considered assistive devices, as the norm for feeding is when a person eats with their hands. When working with children, I learned that independence with toileting requires one to be able to balance and maintain a squat position, feet flat on the ground about shoulder width apart.

While treatment approaches focused on improving strength, range, balance, endurance and mobility in order to address occupational performance issues, assessments, interventions and evaluations to specifically address toileting and dressing with adults were not undertaken. However, the paediatric unit did consider these activities of daily living. The amount of discussion around toileting and dressing appeared dependent on therapists' comfort with the issue, cultural norms and inter-gender dynamics. I questioned this, as one fundamental of occupational therapy practise is to address self-care. Yet as a short-term foreign student guest I was conscious about challenging the status quo.

Searching for opportunities

While at CRP, I encountered many staff who expressed determination to leave Bangladesh with hopes to succeed in their professions elsewhere. I was often questioned about Masters programs, schooling costs, scholarships, how to immigrate, living costs and how to go about working in Canada. I was caught by surprise at the inundation of questions on a regular basis seeking my "expertise". During spare time, many staff were studying for their TOEFL/IELS (English language proficiency) exam, taking extra courses at the local university and researching ways to successfully work and study abroad. When I mentioned how much I paid for my degree, rent, or my plane ticket to Bangladesh, frustration was apparent as the amount of money they would need to save was inordinate. What struck me the most during these discussions was the determination people had to leave their country in search of better opportunities.

Figure 3: Clients with spinal cord injury partaking in recreational activities. Wheeled beds are used to encourage mobility around the centre while offering pressure relief from sacral areas.

Living in Bangladesh

Outside of work-time, I spent time with newly formed friends playing card games and sports, going to the market, visiting museums, watching movies, trying new foods and simply chatting over a late night snack from the local street vendor. Being a woman in a country where gender differences are apparent, I was much more aware of my actions both in practicum and in public. I sought insight from female colleagues and friends on what was appropriate when working with male clients, had numerous discussions with female and male friends about gender roles and expectations and spent time reflecting on my views. The generosity of people continues to be the defining memory for me: invitation to weddings and dinners, sightseeing trips and assistance from strangers above and beyond expectations.

Challenges

One of the hardest issues were the limited resources in Bangladesh compared to those in Canada. Access to up-to-date evidence-based information was limited by the textbooks donated to the library and internet availability (power outages were recurrent; internet speed was unable to support large document downloads). Moreover, opportunities for people with disabilities are much more limited due to larger issues of poverty. For instance, the use of assistive technology (e.g., communication devices, power wheelchairs) is not available. Environmental barriers such as societal views on disability and physical factors (e.g., mud roads) also impact on the opportunities available. Furthermore, as CRP is the only comprehensive rehabilitation facility in the country, many families must travel a great distance in addition to paying the cost of care, sacrificing their land, animals or other means of livelihood. Clients who become quite independent and empowered at CRP often return home to face barriers in their community and loss of hope due to the limited opportunities for meaningful activity. These issues, compounded by frequent questions from staff about life in Canada, were humbling as I was constantly reminded that I come from a rich country – a country not without its own problems, but with comparatively more opportunities for people.

Final reflections

Overall, this placement was a great opportunity to see what practising occupational therapy is like outside a Canadian context. I gained a richer understanding of factors that impact practice: communication, cultural norms, societal views of disability, gender roles, expectations of family, resource availability and physical environment. I recommend the following for any students interested in pursuing an international placement:

- Expect only one thing: that it will be unlike your previous Canadian placements;
- Be open, flexible and immerse yourself in the culture; and
- Enjoy!

For more information on CRP go to http://www.crp-bangladesh.org/

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Augmentative and alternative communication: International perspectives

Deb Cameron and Lindsey Markowicz

Introduction

Many occupational therapists and speech language pathologists work with clients whose communication abilities are impaired. This article will provide readers with information from a review of articles on international augmentative and alternative communication (AAC) services completed by a professional Master's occupational therapy student and place this discussion in the context of personal experiences of working group members of the International Centre for Disability and Rehabilitation (ICDR) at the University of Toronto. It is hoped that this article will not only help paint a picture of AAC service provision in developing countries but will also inform occupational therapy practice in Canada and other developed countries.

Communication disabilities affect individuals of all ages and are well recognized to negatively influence one's overall sense of well-being and social competence (Enderby, 1997). In developed countries, where free-market economies are well established, studies estimate the prevalence of communication impairments to be around 0.15% of the population Sutherland, Gillon, & Yoder, 2005). In developing countries where the United Nations grants foreign aid for development purposes, (ISAAC, n.d.), the prevalence of impairments is considered to be much higher (Fujira, Park, & Rutkowski-Kmitta, 2005), due to factors such as poverty and pollution. It is estimated that by 2025 there will be between 165.3 and 213.2 million people in these nations with communication disabilities (Hartley & Wirz, 2002).

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Definitions and background

AAC is an area of clinical practice that provides treatment to compensate for limited or inadequate communication abilities (Cumley, 1992). AAC systems are defined by Gary Cumley (1992) as "an integrated group of components, including the symbols, aids, strategies, and techniques used by individuals to enhance communication." Access to AAC services are lacking for people with disabilities in developing countries. It is estimated that less than 2% of the disabled population in need in developing countries receive rehabilitation and educational services (Kisanji, 1993;). For example, in Tanzania, which has a population similar to Canada's, there are currently only two speech language pathologists, in the country. Current AAC services in these nations are based on the developed nation specialist-model (Hartley, n.d.), in which AAC services are provided by specialist teams at a tertiary level of care (McConkey, 2005).

International trends and perspectives

Speech language pathologists appear to be the largest group of professionals providing AAC services in developing nations. Although occupational therapists are commonly members of AAC interdisciplinary teams in developed nations, the evidence does not reflect their presence as sole service providers worldwide. This trend highlights the potential for occupational therapists to help improve AAC service coverage in developing countries by adding to the current number of specialists in these regions.

The establishment of training programs for professionals, including speech language pathologists, occupational therapists and teachers was the focus of many articles reviewed. In Tanzania there are currently programs for occupational therapists and physiotherapists but no school for speech language pathologists. There is a clear need for continuing professional education that includes both theoretical and applied components. Furthermore, the high percentage of informal caregivers (family members and community workers) in developing countries reinforces the need to increase sharing of knowledge between specialists and non-professionals. Informal caregivers need to develop skills in AAC as well as information on the importance of communication for child development, learning, socialization, and quality of life and how AAC can compensate for communication impairments (Wormnaes & Malek, 2004) in order to counteract negative views of AAC.

The need for culturally relevant communication technology systems is particularly evident. The necessity of creating AAC services that meet local needs, fit well with cultural-linguistic values, and merge well within the existing community services is

readily emphasized. The benefit of such integration has been validated by research studies and first-hand experiences by occupational therapists working in the developing context. The Communication Disability Model, developed by Hartley and Wirz (2002) from the inductive analysis of five qualitative studies involving parents, professionals, caregivers and community workers for persons with complex communication needs in Nigeria and Uganda, emphasizes the impact of social and environmental factors on an individual's communication disability. The implementation of such a model in developing countries would represent a paradigm shift in this context from the dominant specialist model to one involving non-specialists as central players. For example, Penny Parnes, a speech-language pathologist at the University of Toronto, described a situation in which she met a preschool teacher with little or no formal training in AAC in Tanzania who had developed a simple communication board with hand drawn pictures reflecting the local community life for a young boy with cerebral palsy who was unable to communicate functionally. In this preschool program context where paper is hard to come by and professional AAC services are limited, such a simple culturally relevant system that could be created by front-line community workers is the most useful type of tool by providing services that respond to local need.

"Many barriers to service delivery are apparent."

Many barriers to service delivery are apparent. The lack of culturally appropriate resources and materials and the fit of AAC services into local cultures are two such barriers. Limited numbers of personnel and insufficient specialist knowledge of AAC and local cultures also appear to affect the quality of service delivery in the developing context. For example, Alant (1996) found that out of five special schools for children with severe disabilities in Pretoria area of South Africa, two had no professional support. Only one school had a speech therapist for 15 hours/week and a full-time occupational therapist. A physiotherapist who has travelled several times to Kenya provided an excellent illustration of these barriers. She reported that she worked with one child who had cerebral palsy who was sent to a local school for the deaf to receive assistance with communication because of oral motor challenges. Although it may have better for this child to receive some service, the school was far from ideal as he was being taught sign language and did not have the dexterity to control his signing.

A couple of further points are worthy of discussion. First, the articles reviewed from developing countries completely lack any information on the evaluation of AAC services. While this is not surprising due to the emergent nature of AAC services in these contexts, it makes it impossible to determine if the existing services and training programs are meeting the needs of the individuals with communication impairments and the personnel. Second, there appears to be little recognition of the need to increase the community participation of AAC users in the developing context. Third, most of the articles describe services for children or adolescents. It is possible that this trend is reflective of the general lack of personnel to carry out AAC interventions as well as established AAC services for persons of all ages, and a focus on investing in services for children with communication impairments. Children may develop secondary disabilities due to lack of treatment whereas adults with disabilities often have short life spans and poor functional outcomes due to poverty in developing nations (Hogg, Lucchino, Wang, & Janicki, 2001; Olusanya, Ruben, & Parving, 2006).

ISAAC

The International Society for Augmentative and Alternative Communication (ISAAC) is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations. ISAAC has members around the world who share the goal to improve the lives of all persons with communication difficulties and increase the global awareness of augmentative and alternative communication (AAC). Please refer for ISAAC's website (http://www.isaac-online.org/en/home.shtml) for further information.

Conclusions

Overall, the review points to the elementary nature of AAC services in developing countries. There is a struggle to develop new models of service delivery. Much of the evidence suggests that current traditional professional-dominated AAC services adapted from the Western cultures do not translate well into the developing context. Collaboration between specialists and informal workers appears crucial to merge AAC services into the local cultures and infrastructure. Although there has been great recognition of the need for alternative models of AAC service delivery and a couple sound models have been proposed and used, there is limited evidence in the literature for their translation into practice.

It is the hope that these themes will help ISAAC in

informing future directions for AAC service delivery and research and provide motivation for the advancement of AAC service provision in developing nations to ultimately improve accessibility for persons with communication disabilities. Of particular relevance, the potential benefit of increased occupational therapy involvement is clearly apparent. Although this sample of articles was focused on AAC in a developing context, those working in this area in Canada can also relate to the need to educate informal caregivers, to make AAC systems relevant to local needs and to continue to evaluate the impact of the services on the client.

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Understanding the context of occupational therapy practice in Canada

Claudia von Zweck, PhD, OT Reg (Ont), OT(c)

As occupational therapists, we are well aware of the influence of the many factors in the environment that shape participation in important occupations of life. In the same way we analyze the fit of the person, occupation and environment for our clients, we must too understand the context in which we work for influencing the nature of our practice and the skills, knowledge and abilities required to provide quality and effective services. An environmental scan was therefore commissioned by CAOT to analyze issues and trends that affect the work of occupational therapists now and into the future. It is planned that this information will be used to work with members to identify opportunities and risks that exist for occupational therapists and plan priorities for the work of CAOT in the next three to five years. The summary below outlines the major factors identified in the environmental scan completed with the assistance of our government relations consultant (Emerson Communications, 2008).

Economic Factors

The economy currently dominates discussion in the popular media. The recent financial market turmoil precipitated by mortgage lending practices in the United States has triggered a global economic slowdown. Although Canadian financial institutions remain strong and viable, our dependence on international trade, particularly with the United States has created concerns of a looming recession in Canada. This gloomy economic forecast has implications for future investments in health and social programs and funding for research and innovation. Canada experienced the highest inflation rate in over five years in 2007-2008, driven primarily by increasing costs for energy resources. A shifting global economy, with increasing strength and purchasing power of developing countries such as China and India has influenced international trade and pricing for products such as oil and other energy resources. The demand for such resources has created wealth in energy rich provinces in Canada and is shifting the balance of power away from provinces such as Ontario and Quebec that are heavily dependent on the manufacturing sector and hard hit by plant closures and loss of jobs.

Political Factors

The October 2008 federal election resulted once again in the failure of one party to attain a majority of the seats. As a result, collaboration will be necessary among political parties on new legislation. The economic slowdown in Canada is now expected to heavily influence the federal government agenda, as well as changing political powers in the United States. Past priorities of the Conservative government have focused on tax cuts, law and order and increased military spending. Record high federal government spending has occurred in the past two years with substantial investments in the military. A decentralized model has been favoured for health and social programs, promoting provincial autonomy for spending in these areas.

"This gloomy economic forecast has implications for future investments in health and social programs and funding for research and innovation."

Access to health care was a top ranked concern of Canadians going into the recent federal election, following environmental issues and the economy. Governments have previously responded to this concern by centering health care priorities on primary health care reform, promotion of interdisciplinary health teams, wait time strategies, mental health care and cancer control. Investments in technology have been geared toward improved service access, such as the use of telehealth to link communities for specialized service provision or for enhanced training of local health professionals. Greater interest in privatization of health care has been spurred on by organizations such as the Canadian Medical Association.

Aside from service access, growing inequities exist in other crucial factors that influence population health, including income, housing and nutrition, education and child care, particularly for aboriginal populations. In addition, work/life balance issues and living environments that limit access to healthy foods and discourage physical activity have created increasing social and health concerns associated with obesity. The importance of pandemic planning was recognized following the SARS crisis, resulting in the formation of the Public Health Agency of Canada.

Public health emergencies related to food and water quality however have recently followed cutbacks in government enforcement policies and practices.

Social Factors

Aging of the Canadian population has changed the scope and nature of services available to older adults. This trend is expected to continue as the first of the large baby boomer cohort reaches usual retirement age at the end of this decade. Older adults are healthier than in previous generations, have a longer expected lifespan and wish to remain active. Services and policies in the public and private sector are beginning to cater to this growing population group. Examples include new housing developments that permit aging-in-place, modification of roadway design to promote safe driving practices and the elimination of mandatory retirement policies to permit continued workforce participation.

Human resource planning issues remain in the forefront with the aging population, particularly with growing shortages of health professionals. Strategies to address these issues include expansion/creation of new education programs and promotion of the workforce integration of internationally educated professionals. Dependence on immigration as a workforce growth strategy requires responsiveness to increasing diversity within Canadian society. Greater attention has been paid to the influence of workplace health on economic productivity.

Federal government initiatives in the area of mental health such as the establishment of the Mental Health Commission acknowledge the costs of disability within the Canadian workforce. Large scale natural disasters in the past few years have also heightened the awareness of the need for emergency planning and preparedness. Greater information access through mechanisms such as the internet and all news channels has created a more knowledgeable public and opportunity for faster response to events and issues occurring throughout the world.

Occupational Therapy in Canada

Occupational therapy is a small profession among the many health care providers in Canada. Over 11,750 occupational therapists practiced in Canada in 2006 (CIHI, 2008). Occupational therapy is growing in many areas of Canada, influenced by factors such as the economy, accessibility of occupational therapy education and government support. The highest growth rates between 2000 and 2006 were reported in Alberta (62%), Nova Scotia (48%) and Quebec (47%). Conversely little growth was reported in the same period in Newfoundland/Labrador (2.2%) and Prince Edward Island (2.9%). Not surprisingly, these same provinces, along with Saskatchewan had the lowest number of occupational therapists per capita in 2006, less than half than reported in Quebec (48/100,000 population).

Access to occupational therapy education is improving with the start of two new programs in Quebec and a majority of Canadian schools planning or implementing seat expansions. Beginning in 2009 all education programs in Canada for occupational therapists will lead to a Master's level credential. Formal education programs for occupational therapy support personnel are also growing and are now found in most provinces. Work has begun to establish an accreditation process for occupational therapy education programs based upon a newly developed CAOT profile of knowledge, skills and abilities for support workers in Canada.

Most registered occupational therapists in Canada remain in publicly funded practice settings in urban centres. Over eighty percent are direct service providers in their primary role, most frequently working with populations with physical health issues (CIHI, 2007). Hospitals account for just under half of employers of occupational therapists in Canada. Expanded practice opportunities have been identified for occupational therapists in a number of areas, many outside of health care such as universal design, driver rehabilitation, retirement planning and disability management. At the same time, occupational therapists are facing increasing competition with other health professionals that are better known to the general public. CAOT member reports indicate recruitment and retention of occupational therapy staff represent significant concern and expense for many employers, particularly in Quebec, British Columbia, Alberta and parts of Ontario and Saskatchewan.

Attrition from the profession exacerbates reported shortages. Seventy percent of registered occupational therapists are currently less than 45 years of age, with the majority leaving the profession prior to usual retirement ages. Practice inquiries received in National Office most frequently relate to workforce planning issues. Such issues include mentoring and professional development, use of support personnel, staffing ratios, scope of practice, and self-employment. Inquiries are also often received regarding the management of ethical practice issues and the availability/use of tools and resources for specific populations (e.g. assessments).

Given these trends and issues, how can CAOT and the profession best position occupational therapy for the future? CAOT members are invited to member forums that will be held across the country in the coming months. Plan to attend to provide your ideas and innovation. CAOT needs your input to ensure we remain a strong and accessible profession in Canada.

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Understanding intellectual property rights in new or advanced therapeutic treatment methods

Tapas K. Pain

Therapists inevitably and continuously develop improved rehabilitation techniques, sometimes on the job, sometimes on their free time, and sometimes during both. These improvements are "intellectual property", that is; innovations in the science of occupational therapy borne of intellectual effort and skill. Therapists who develop these improved techniques are often unsure of the consequences of doing so in light of possible employer-employee or teacher-student obligations. Who "owns" that new method? Who gets "credit" for it? Can anyone practise it? Can the therapist go on a lecture circuit and charge speaking fees for teaching other therapists? Who "owns" research publications and findings stemming from the discovery? Should testing (validation) and development of the improved technique be done in a clinical or academic setting, and regardless of which, who decides? This is just a sample of the questions that can arise, and inevitably there are further context-specific questions to ask.

Regardless of context, there are instructive general principles to always consider:

1. Most clinics and educational institutions have a formal written intellectual property policy. These policies typically build on a basic legal principle that an employer owns intellectual property advancements made by an employee in the course of employment. Employers do not necessarily own all employee advancements. Factors in determining ownership include whether employer resources were used, what (meaning when, where, and how many, inclusively) hours the employee worked on the advancement, and any other employer-employee understanding in place. Most policies are geared toward constructive participation, stimulating employees to produce further advancements and innovations.

2. Copyright[1] protects expression of ideas by way of writing, sound recording, image, and the like. Copyright vests automatically on "creation", and "credits" an author/creator. It is possible to register copyright

with the federal government. Authors can assign copyright ownership to others, but cannot assign their "moral rights" (an author's ability to object to use of their work out of context). Copyright registration grants sole and exclusive rights to re-distribute

[1]http://www.cipo.ic.gc.ca/epic/site/cipointernet-internetopic.nsf/en/wr00037e.html

protected works, and others cannot do so without paying royalties to the registered copyright owner. Copyright agreements are important when dealing with employee notes, research manuscripts, textbook publications, promotional publications, fundraising literature, and public speaking engagements.

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3. Natural scientific principles and mathematical formulae cannot be protected, but application (i.e. a series of steps) of scientific principles and mathematical formulae can[2]. Consider for example, computer software – ordinary mathematical statements innovatively strung together to produce an unexpected result (like a software firewall). Methods of rehabilitation treatment are (in a sense) no different than software, and it is possible to protect those methods (see below).

4. Patents protect functionality[3] (an innovative solution to a known problem). Patents grant exclusive rights (a 20 year monopoly) to make, use, practise, and license patented methods, such that others cannot without paying royalties to the patentee. North American universities fundraise substantial amounts annually by licensing patented methods.

5. The venue (academic, clinical, or strictly private) chosen to test, validate, develop, and (if applicable) market an improved method is important, and these venues differ significantly in matters of funding and "rights". A change of venue means a change in "rights", and initial funding always has long-term implication. There is no "legally correct" venue, and selection is based ultimately on what a market bears.

6. Everything is negotiable, and a good rule of thumb is "Greater risk, greater share, greater credit. Less risk, less share, less credit." One's stomach for risk affects venue, which in turn affects "rights".

In everyday practise it is useful to identify intellectual property advancements early. Early identification is invaluable in ensuring fair treatment, and preservation of "rights".

[2]A statutory (legislated) prohibition – see Patent Act, R.S.C. 1985, s. 27(8) – "no patent shall be granted for any mere scientific principle or abstract theorem."
[3]http://www.cipo.ic.gc.ca/epic/site/cipointernet-internetopic.nsf/en/wr00102e.html

Pre-Conference workshops

Janet Craik and Graeme Burk

If you're attending the CAOT Conference in Ottawa this coming June, why not consider going a little early? CAOT has lined up a number of pre-Conference workshops that will help you keep abreast of current issues facing occupational therapists today and help you, in the words of the Conference theme, engage in occupation and be a partner for change!

2009 pre-Conference workshops include:

CO-OP: Discovering strategies for enabling occupational performance

June 2 & 3, 2009

Presented by Angela Mandich, Director of the School of Occupational Therapy, Faculty of Health Sciences, University of Western Ontario, and Rose Martini, Assistant Professor, Occupational Therapy Program, School of Rehabilitation Sciences, Faculty of Health Sciences, University of Ottawa.

This two-day workshop will look at how the Cognitive Orientation to Occupational Performance (CO-OP) approach can be used as an intervention with children with mild motor and/or learning difficulties. Through this multimedia presentation therapists will learn the framework necessary for the development, application, and generalization of cognitive strategies to help children overcome performance difficulties and engage in their daily occupations.

Note: *This two-day workshop will be facilitated in French and English. Participants will receive a copy of Enabling occupation in children: The Cognitive Orientation to Daily Occupational Performance (CO-OP) approach and the Pediatric Activity Card Sort (PACS) with their registration.*

Tapping into Cochrane: How can an evidence-based approach support you in your practice?

June 2, 2008

Presented by Laurie M Snider, Associate Professor, School of Physical & Occupational Therapy, McGill University, and Cheryl Arratoon, Knowledge Broker, Canadian Cochrane Network and Centre.

Recently, CAOT partnered with the Cochrane Network and Centre to provide CAOT members with free web access to the Cochrane Library. This one-day interactive workshop will provide hands-on learning opportunities to support our pursuit of evidence-based practices. Participants will learn how to utilize and apply information from the Cochrane Library to use in clinical practice, policy making and research. This workshop will be held at a University of Ottawa computer lab with workstations for up to 60 participants.

Perspectives and strategies for responding to tensions in private practice in occupational therapy

June 3, 2009

Presented by Andrew Freeman, Assistant Professor in the Rehabilitation Department at Laval University, Ron Dick, an occupational therapist and contributing author for CAOT's Framework for ethical occupational therapy practice in Canada and Brian Gomes, Vice President with Aon Reed Stenhouse.

This workshop will examine the dilemmas that occupational therapists face in private practice in terms of accountability and ethics and the possible consequences of the choices made addressing them. This workshop will provide participants with tools and strategies for navigating their way through these complex tensions as well as practical opportunities to analyze and respond to possible practical dilemmas occupational therapists might encounter.

Enabling occupation II: Tapping the power of Canada's new practice guidelines

June 4, 2008

Presented by Elizabeth Townsend, Director of the School of Occupational Therapy, Dalhousie University, Helene Polatajko, Department of Occupational Science and Occupational Therapy and Graduate Department of Rehabilitation Science, University of Toronto, and Denise DeLaat from the Children's Hospital of Eastern Ontario.

Occupational therapists will explore the application of Canada's latest guidelines for client-centred enablement in your day to day practice. This one day workshop will provide opportunities to work with leading practitioners and the primary authors of Enabling occupation II to consider how your practice could be informed and enhanced by the new tools the guidelines offer the practitioner.

Note: Participants will receive a copy of *Enabling occupation II: Advancing an occupational therapy vision for health, well-being & justice through occupation* with their registration.

For more information, please visit www.caot.ca

CAOT Position Statement: Access to occupational therapy

The Canadian Association of Occupational Therapists (CAOT) advocates for equitable access to quality occupational therapy services for the health and well-being of the people of Canada. CAOT recognizes engagement in meaningful occupations is an important determinant of health. Through occupational therapy, Canadians are enabled to maximize their productivity, reduce lifestyle restrictions and avoid unnecessary dependency.

CAOT Initiatives

To advance access to quality occupational therapy services, CAOT will:

1. Promote the development and dissemination of research evidence and economic data that demonstrates the value of occupational therapy.
2. Develop and promote standards that advance excellence in occupational therapy education and practice in Canada.
3. Develop capacity of members for management and leadership positions and for innovative and cost-effective delivery of programs.
4. Work with university occupational therapy education programs in Canada to increase occupational therapy workforce supply and research capacity.
5. Participate in innovative projects to support inclusion of international graduates within the Canadian workforce.
6. Promote retention of the professional identity of occupational therapy leaders in sectors including management, policy development, education, research as well as clinical service.
7. Develop tools and resources and participate in advocacy activities to ensure optimal utilization of the occupational therapy workforce.
8. Partner with consumers, policy makers, researchers and other stakeholders to identify innovative solutions to address the barriers to accessing publicly and privately funded health services. For example, advocate for the repositioning of current policy priorities on wait times for medical procedures to perspectives more inclusive of other health issues; continue to develop and implement strategies to lobby insurance companies to include and expand coverage for occupational therapy services; work with provincial/territorial associations to target policy decision-makers at the provincial/territorial, regional and local levels to promote access to occupational therapy services; and promote workplace environments that foster interprofessional collaboration.

Recommendations for occupational therapists:

1. Articulate the costs and benefits of occupational therapy services in rational ways to be recognized as an essential and necessary health service in all Canadian communities.
2. Develop innovative models of service delivery and create powerful and reciprocal relationships and partnerships with public and private sector organizations that allow Canadians increased access to occupational therapy services.
3. Advocate for adequate funding, resources and support to allow occupational therapists to comply with professional standards for the practice of occupational therapy and the delivery of quality occupational therapy services to the Canadian public.
4. Utilize effective strategies to recruit and retain occupational therapy practitioners, particularly in under-serviced areas.
5. Educate the public regarding the role of occupational therapy in positively influencing occupational engagement.

Background

Research by the Canadian Policy Research Network identified vulnerable, at-risk and marginalized populations throughout Canada with health needs that go unmet (Hay, Varga-Toth & Hines, 2006). Health is largely dependent on how we work, learn, live, and play (Canadian Institute for Health Information [CIHI], 2006), in other words, by our participation in occupations of life. Many populations in Canada have limited or no access to opportunities to engage in meaningful occupations.

Occupational therapy services enable people to have the opportunities and resources to engage in occupations for their health, well-being and justice. Occupational therapists are the primary service providers for occupational therapy. Occupational therapists are regulated health professionals and university educated at the master's degree level in Canada. The education of occupational therapists is devoted to the study of occupation and occupational engagement. As an expert in occupation, they understand the effects of factors such as disease and injury on the ability of individuals, groups and communities to engage in the occupations of life. Occupational therapists use evidence–based processes that focus on their clients goals to participate in valued activities (CAOT, 2007a; Townsend & Polatajko, 2007).

Current debate and dialogue in Canada on access to health care is primarily restricted to consideration of waiting times for access to certain diagnostic tests and medical interventions (e.g. joint replacements, cancer treatments). However people of all ages who are unable to access occupational therapy services may face unnecessary medical treatment, re-hospitalization, permanent unemployment, premature placement in long-term care facilities and even death. The costs to the individual and their families are great; the costs to society are felt in our already burdened health care system as well as in the social and economic fabric of our country.

Access to occupational therapy services is strongly shaped by Medicare coverage in Canada, as articulated in the Canada Health Act (Government of Canada, 1985). This act provides only for "medically necessary services" which are primarily physician-based. Under this act, occupational therapy services may be provided as optional services in health facilities. With demand for health services continuing to exceed available funding now and in the future, the occupational therapy profession is challenged to reflect on how to finance service delivery in new and creative ways (Casey & Jongbloed, 2007). A 2007 CAOT Professional Issue Forum on Access to Occupational Therapy was therefore used to identify a number of strategies that could facilitate access to occupational therapy services by the Canadian people (CAOT, 2007b).

Access to needed health services is an issue for Canadians (Health Council of Canada, 2007). The research paper Towards a Broader Framework for Understanding Accessibility in Canadian Health Care attempts to broaden the definition of health care accessibility beyond wait times for medical interventions and procedures. It provides a preliminary framework for understanding the host of factors that affect Canadians' ability to obtain a complete range of essential health services. It requires policy makers to address real problems with access to a range of services and service providers that are not part of current debate about wait times (Torgerson, Wortsman & McIntosh, 2006).

Primary health care renewal has focused on the redesign of the of the health delivery model from a single first-provider to an interprofessional team which would provide more comprehensive and client-centred care. While variations of team-based care are being introduced throughout Canada, most Canadians still do not receive health services in a team setting. Teamwork continues to be primarily a voluntary process throughout Canada (Health Council of Canada, 2007).

Canada is facing a skilled occupational therapy workforce shortage in both private and public services in several regions. For example, a recent report advises that the number of annual occupational therapy graduates should be doubled to 80 in order to address the current generalized shortage of occupational therapists in British Columbia (CAOT & British Columbia Society of Occupational Therapists, 2007). Increases in education capacity are also under consideration in provinces such as Alberta and Saskatchewan. Quebec recently initiated two new university education programs to supplement the existing supply of occupational therapists. Governments have placed high priority on promoting workforce integration for international graduates that wish to practice occupational therapy in Canada. CAOT has responded by undertaking a number of initiatives to work with occupational therapy partners to address barriers experienced by international graduates.

In 2007 the Canadian Institute for Health Information (CIHI) published the first annual version of Workforce Trends of Occupational Therapists in Canada that summarizes information from the Occupational Therapy Database (OTDB). The OTDB is a comprehensive data source on the supply of the occupational therapy workforce in Canada and is intended for the use of all levels of government, researchers, stakeholders and occupational therapists. The presentation of clear, objective data and data analysis enables informed decision-making and supports policy formulation. In an analysis of this document and other recent occupational therapy workforce research, von Zweck (2008) confirms shortages currently exist throughout the country despite apparent underutilization of occupational therapists in Canada when compared

with countries with similar health systems. CAOT, the Canadian Physiotherapy Association, and the Canadian Association of Speech-language Pathologists and Audiologists have been working together to obtain funding for the development of a caseload management framework. Ultimately, the outcomes generated by the application of the framework can be used for evidence-informed occupational therapy utilization and human resource planning (Management Dimensions & D. Parker Taillon and Associates, 2005).

The increasing lifespan of Canadians and the rise in numbers of people with disabilities will result in higher demand for occupational therapy services to enable people to do the activities that are important for them, or their occupations. The number of healthy seniors will increase by 2.6 million between 2001 and 2021 (Casey & Jongbloed, 2007). People 65 years and older are expected to seek health care services earlier and remain in care longer thereby utilizing a large proportion of the health care budget. Consumers of services will be increasingly egocentric, demand better timelines, choice and quality regarding service delivery, and be more open to trying complementary non-western approaches to health care (Pierre, Pollack & Fafard, 2007).

A study of Canadian health policies for Aboriginals, Canadian Forces, veterans, persons with disabilities, and policies addressing the growing incidence of obesity, reveals a number of current or emerging gaps in health programs such as occupational therapy services (Pierre, Pollack & Fafard, 2007). There appear to be opportunities to increase the number Aboriginal and non-Aboriginal health care providers in Aboriginal communities on reserves and to improve health care for urban Aboriginal populations; to make an economic case to the Canadian Forces to play a more central role in the delivery of health services to the Forces; to assist in facilitating the integration of veterans into society after service; to conduct research on the prevention of obesity and the optimum coping strategies for obese persons for every segment of the population across the entire lifespan; and to address the unmet needs of Canadians with disabilities regarding assistive devices and supports in the home, education and work spheres.

Occupational therapists may serve their clients by looking at how they can ethically and safely collaborate with various stakeholders (both public and private) in new ways to create powerful, reciprocal relationships that allow Canadians increased access to occupational therapy services (Casey and Jongbloed, 2007; Varga-Toth, 2007). Increasingly such partnerships are dependent on demonstration of the economic value of occupational therapy service delivery. Documenting the costs and benefits of occupational therapy services requires articulating service outcomes in terms of cost and value-added components such as quality of life, increase in role contribution and or satisfaction, decrease caregiver stress, and effects on the Canadian economy (MacDonald, 2006).

Glossary of Terms

Enabling (verb) – Enablement (noun): Focused on occupation, is the core competency of occupational therapy – what occupational therapists actually do – and draws on an interwoven spectrum of key and related enablement skills, which are value-based, collaborative, attentive to power inequities and diversity, and charged with visions of possibility for individual and/or social change.

Enabling occupation: Refers to enabling people to 'choose, organize, and perform those occupations they find useful and meaningful in their environment' (CAOT 1997, 2002, p. 180).

Occupations: Groups of activities and tasks of everyday life, named, organized, and given value and meaning by individuals and a culture; everything people do to occupy themselves, including looking after themselves (self-care), enjoying life (leisure) and contributing to the social and economic fabric of their communities (productivity); the domain of concern and the therapeutic medium of occupational therapy (CAOT, 1997, 2002); a set of activities that is performed with some consistency and regularity; bring structure and are given meaning by individuals and a culture (adapted from Polatajko et al., 2004 and Zimmerman et al., 2006).

Occupational therapy: The art and science of enabling engagement in everyday living through occupation; enables people to perform the occupations that foster health and well-being; enable a just and inclusive society so that all people may participate to their potential in the daily occupations in life.

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CAOT Position Statement: Occupations and health

The Canadian Association of Occupational Therapists (CAOT) strongly supports initiatives that enable all persons of Canada to have the opportunities and resources to engage in occupations for their health and well-being.

Occupations are groups of activities and tasks of everyday life, named, organized, and given value and meaning by individuals and a culture. Occupations include everything that people do to occupy themselves, including looking after themselves (self-care), enjoying life (leisure), and contributing to the social and economic fabric of their communities. Occupations are the core domain of concern and the therapeutic medium of occupational therapy (CAOT, 2002).

Health is more than the absence of disease. The link between everyday life and health has been recognized for centuries. The link has been highlighted internationally (World Health Organization, 1978; 2003) and Canada has been a world leader in emphasizing the importance of healthy lifestyles through health promotion initiatives (Epp, 1986; 1988).

CAOT Initiatives

To ensure Canadians have the resources and opportunities to engage in their relevant occupations of life, CAOT initiatives and activities include:

1. Develop workforce capacity in occupational therapy by ensuring the currency of the Profile of Occupational Therapy Practice in Canada that reflects the continuum of skills and knowledge required by occupational therapists for occupation-based and client-centred practice in Canada.
2. Develop and disseminate guidelines for occupational therapy practice in Canada that are occupation-based and client-centred. Advance leadership in occupational therapy by providing learning opportunities to enhance uptake of the guidelines (e.g. workshops, web-based seminars).
3. Promote and publish research evidence to facilitate knowledge of the concept of occupation and to understand the relationship between occupation and health.
4. Foster evidence-based occupational therapy by providing resources to enhance retrieval, critical appraisal, utilization and evaluation of evidence to support occupational enablement.
5. Advocate for occupational therapy as an essential service by providing a public website that demonstrates the health benefit of occupational engagement and the value of occupational therapy services for occupational engagement.
6. Advocate for funding of occupation-based and client-centred occupational therapy services.
7. Promote accessibility to occupational therapy services by providing the online OT Finder database to assist the public in finding occupational therapists in their geographic area.
8. Contribute to health promotion policy through advocacy and research activities that identify obstacles to occupation and means to improve health.
9. Promote occupational therapy education curriculum centered on occupation and evidence-based practice.

Recommendations for occupational therapists:

1. Enable occupations with clients when there is presence of an occupational challenge and evidence of possible solution(s). Clients may be individuals, families, groups, communities, organizations, or populations, regardless of ability, age or other characteristics, who choose and engage in occupations which give meaning and purpose to their lives.
2. Establish a supportive practice environment that is client-centred, occupation-based and is grounded in the enablement foundation principles of change, justice, power sharing, visions of possibilities, client participation, respect for client choice, risk and responsibility.
3. Build alliances and catalyze media to raise client, public and government awareness of the health benefits of occupational engagement.
4. Use research evidence to identify best practices in occupational therapy that focus on occupations, enabling approaches in client-centred practice,

and outcomes related to occupational quality of life, empowerment and justice.
5. Create policies, funding, and legislation to integrate occupation-based enablement in government priorities to meet population needs through diverse programs and initiatives.
6. Target meaningful health outcomes relating to occupation and quality of life in service and workforce planning.
7. Advocate for policies and funding that will ensure access to occupational therapy services and support enabling occupation. For example, naming occupational therapy as an insured benefit in extended health plans will reduce barriers to access.
8. Build alliances to increase scholarship and evidence on an occupational perspective of health, well-being and justice, and occupation as a health benefit.

Background

Occupation is a basic human need as essential as food, drink and the air we breathe (Dunton, 1919). Occupation gives meaning to life and organizes behaviour. People make choices about the occupations they engage in to create a routine or daily pattern (Yerxa, 1998). Health is strongly influenced by having choice and control in everyday occupations.

Occupation has therapeutic potential. Health flourishes when people's occupations give meaning and purpose to life and are publicly valued by the society in which they live. Health and well-being is influenced by the ability to engage in life's occupations (Law, Steinwender, & Leclair, 1998). Engagement in occupation is complex; physical, psychological, spiritual, social, cultural, and political factors influence occupational wellness and dysfunction (Whiteford, Townsend, & Hocking, 2000; Wilcock, 1998). Withdrawal or changes in occupation can lead to increased dependency, lack of confidence and depression. Conversely, restoring an individual's ability to function independently and exercise choice and control over his/her daily activities increases productivity and life satisfaction.

Performance, organization, choice and satisfaction in occupations are determined by the relationship between persons and their environment (CAOT, 2002; Whiteford et al., 2002). The social and physical environment as well as personal health practices, income, education and literacy have a major impact on occupation and health (Government of Canada, 1999). Healthy patterns of occupation are shaped in homes, schools, places of employment, industries, transportation and other aspects of people's environment. For residents of Canada to be healthy and contribute to the economy, the determinants of health must be addressed (CAOT, 2001).

Occupation develops and changes over a lifetime. Health may be challenged during life transitions that require new patterns of occupation. People need to discover new patterns of occupation when they face barriers created by social crises, disability, illness, and the transitions of change over the lifespan. The aim is to assist in the discovery and creation of new patterns of occupation and new environments. Occupational therapists specialize in guiding people through personal and environmental change in times of transition.

Health is an unlimited resource for enhancing the social as well as economic productivity of society. Health is a personal resource through which people realize their own occupational goals and dreams. In developing healthy patterns of occupation, people and communities can flourish, become empowered and move towards social justice (Townsend, 1993). Occupational therapists' broad vision is to enable people who face emotional, physical or social barriers to develop healthy patterns of occupation. The aim is to enable people to choose meaningful occupations that develop their personal and social resources for health.

Occupations are idiosyncratic. People accumulate their occupational repertoires and develop their occupational patterns over the course of their lives according to interest, values ad contexts. Therefore practice must identify client-specific goals or challenges and enable client specific solutions (Townsend & Polatajko, 2007, p. 208).

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Update from the COTF

COTF would like to welcome Anne McDonald as Executive Assistant. Anne brings great experience to COTF, having worked for the Canadian Cancer Society (Ottawa). Anne can be reached at amcdonald@cotfcanada.org or at 1-800-434-2268 x226.

Upcoming Competitions

February 28th:

- COTF Research Grant
- COTF/CIHR-IA Research Grant
- Critical Literature Review Grant
- J.V. Cook and Associates Qualitative Research Grant

March 31st:

- Marita Dyrbye Mental Health Award

Other Awards:

- Travel Awards partnership between COTF and CIHR-IA (March 1st & June 1st)
- Studentship partnership between COTF and CIHR-IA (February 15th)

For details and application forms, see the Opportunities for Researchers and Students section at www.cotfcanada.org.

New Vision

COTF's new vision will be a long term strategic objective. As COTF works towards positioning itself as a philanthropic foundation, the COTF Board will focus its efforts on fundraising outside the occupational therapy community by building relationships with others who use occupational therapy services, benefit from occupational therapy services or provide occupational therapy services.

COTF Board Recruitment

COTF is currently recruiting new board members. If you are interested in being on a board that is working to continue and further develop research and scholarship funding for occupational therapists in Canada, we want you! COTF is your foundation. Let your passion for your profession speak to increase what COTF can offer. To learn more about the COTF Board, please contact skamble@cotfcanada.org

Remember to Update Your COTF Contact Information

Please inform COTF of any contact information changes. In particular, if you have an e-mail address, please share it with COTF. Updates can be made by contacting amcdonald@cotfcanada.org or 1-800-434-2268 x226

COTF FCE

Your Support Counts!

COTF sincerely thanks the following individuals, companies and organizations for their generous support during the period of August 1, 2008 to September 30, 2008. For those whose names do not appear in this listing, please see the next issue of *OT Now*.

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Thelma Sumsion

Barry Trentham

Brenda Vrkljan

Irvine Weekes
Muriel Westmorland
Wildfire Steak House and Bar (In-kind)

1 anonymous donor

CAOT endorsed courses

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

CAOT LEARNING SERVICES

Co-Hosted with CAOT
June 3-6
CAOT 2009 Conference:
Engaging in healthy occupation: Partners for change
Ottawa, Ontario
Tel: (800) 434-2268 ext 232
E-mail: conference@caot.ca

CAOT Learning Services Workshops:

The ADL Profile
Dates: April 2-4, 2009
Speaker: Carolina Bottari
Location: Nova Scotia Rehabilitation Centre, Halifax, NS
Contact: Education Administrator, CAOT
Email: education@caot.ca

CAOT Endorsed Courses:

University of British Columbia and McMaster University Graduate Certificate Program in Rehabilitation Sciences

Web-based (Distance Education)
This interdisciplinary, graduate-level web-based rehabilitation certificate is targeted to occupational therapists, physical therapists and other health professionals who want to update their knowledge and skills to better meet the "best practice" demands of the current health care environment.

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.
Contact: info@mrsc.ubc.ca;
Tel: 604-827-5374
Website: http://www.mrsc.ubc.ca / www.fhs.mcmaster.ca/rehab/

Dalhousie University Series

Program Evaluation for Occupational Therapists (OCCU 5043)

Program Evaluation for Occupational Therapists is a knowledge and skill development class that covers the key issues involved in undertaking evaluation. Elective.
Date: January - April 2009
Instructor: Professor Jocelyn Brown

Advanced Research Theory and Methods for Occupational Therapists (OCCU 5030)

Advanced Research Theory and Methods for Occupational Therapists gives a comprehensive introduction to theory and epistemology underlying qualitative and quantitative research methods in the social sciences, distinguishing between realist and constructivist approaches. Required course. Winter Term.
Dates: January - April 2009
Instructor: Dr. Grace Warner

Contact: Pauline Fitzgerald
Tel: (902) 494-6351
E-mail: p.fitzgerald@dal.ca

McGill University

School of Physical and Occupational Therapy Graduate Certificate in Assessing Driving Capabilities

* POTH-673 Screening for at Risk Drivers (winter);
* POTH-674 Assessing Driving Ability (summer);
* POTH-675 Driving Assessment Practicum (fall)
* POTH-676 Adaptive Equipment and Driving (winter/spring);
* POTH-677 Retraining Driver Skills (summer/fall).

Tel.: (514) 398-3910
E-mail: admissions@mcgill.ca
Website: http://www.mcgill.ca

Zone'in Foundation Series Workshops

Dates: September, 2008 - May, 2009
Contact: Cris Rowan, Zone'in Programs Inc. 6840 Seaview Road, Sechelt, BC V0N 3A4
Tel.: 1-888-896-6346
Email: info@zonein.ca
www.zonein.ca

Therapeutic Listening

Therapeutic listening is a sound-based intervention for clients with sensory processing difficulties to increase treatment effectiveness.
Dates: April 23-24, 2009
Location: Montreal, Quebec

For more information, contact: Caroline Hui at info@chooseto learn.ca http://www. chooseto learn.com

Interactive Metronome Self-Study Certification Course

This self-certification course includes information pertaining to IM-specific and temporal processing research and use of the IM as an assessment and treatment tool for various patient populations. Upon successful completion of the course, you will be granted IM certification.

Dates: July 2008 - July 2009
Contact: Education Department, Interactive Metronome, Inc. 13794 NW 4th St. Suite 204, Sunrise, FL, USA 33325. Tel.: (877) 994-6776 Option 4 Email: imcourses@ interactivemetronome.com