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OCCUPATIONAL THERAPY NOW

july/august 2009 • VOLUME 11 • 4

Table of Contents

ISSN: 1481-5532 Canada Post agreement #40034418

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OT Now is indexed by: ProQuest and OTDBase.

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Occupational Therapy Now is published 6 times a year (bimonthly beginning with January) by the Canadian Association of Occupational Therapists (CAOT).

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Everyday stories . . .
profiles of your CAOT colleagues

CAOT · ACE

Carri Hand

Family life:

I was born and raised in Barrie, Ontario. After a few years living and working in Toronto, I moved to Hamilton, Ontario. I live there with my husband and two children (in the yellow and pink life jackets in the kayak picture). My extended family is scattered across Ontario and British Columbia.

Education:

While I am currently a doctoral student in Rehabilitation Science at McMaster University, my university education started off in a slightly different direction. I come from a family of nurses, lab technologists, and occupational therapists, and I wanted to find my own path. I started university in science and completed a BSc in Physics at McMaster. During that program, as I contemplated my career options, I considered transferring into a program that might open up a greater variety of job opportunities and settings. First on my list was engineering, but after some investigation I decided it was not the right fit for me. I then started to explore occupational therapy, and realized that occupational therapists work in many interesting settings and do important, practical work with their clients. I then completed a BScOT at the University of Western Ontario.

Career path as an occupational therapist:

Upon graduation, I worked in a variety of settings with adults, each time learning more about what occupational therapy can offer clients and what clients give back. I was always amazed at the experiences that my clients shared with me and felt I was able to see the world a little differently as a result. My work ranged from assessing and treating adults with work-related injuries to facilitating leisure and social functioning among people with mental health issues to promoting health with older adults.

Current role:

I am a full-time student, and although there is a downside to not maintaining a clinical role, I consider myself lucky to be able to immerse myself in my work. I spend most of my days reading, writing, and discussing issues related to the projects I am working on. Recently, I attended a meeting to discuss the contribution that occupational therapy can make to chronic disease research. I've also been looking at the evidence for occupational therapy interventions for adults with chronic diseases. I learned about how to measure participation in occupations, and worked with a rehabilitation practice to incorporate a participation scale into their practice. I also have many questions, such as: How can neighbourhoods, facilities, and services be designed to encourage participation in occupation among the residents? How can satisfaction be incorporated into measuring participation? Where can I get a decent cup of coffee? I hope to have an answer to at least one of these questions by the time I finish my degree.

What's on-line

The Call for Papers for the CAOT Conference in Halifax, 2010 has been posted with a deadline of August 1st, 2009 (October 1st for current entry-level occupational therapy students). Links for submitting abstracts are available at http://www.caot.ca/default.asp?pageid=173

What's new

The CAOT launched two new publications at the Conference in Ottawa:

You, Me and My OT, written by Paulette Bourgeois and illustrated by Kristi Bridgeman, tells the story of a young girl, Emma, who has cerebral palsy, and who works with her occupational therapist to go on a class trip to the science centre.

Interdisciplinary Primary Health Care: Assembling the Pieces, written by Mary Ann McColl and Jackie Dickenson, is a practical resource for developing a successful partnership in primary health care.

Both publications are available at the CAOT online store at www.caot.ca

Occupational Therapists and Older Adult Driving: CAOT Update

Janet Craik, MSc, OT (C)

CAOT recently updated the position paper on *Occupational Therapy and Driver Rehabilitation* (2009). The position paper provides background information, recommendations and CAOT's initiatives for promoting driving as a meaningful occupation, advancing the role of occupational therapy in driving rehabilitation and collaborating with stakeholders to inform and influence policy, research, education and practice activities related to driver safety and driving rehabilitation services. Such activities include work to implement the *National Blueprint for Injury Prevention in Older Drivers (Older Driver Blueprint).*

The Older Driver Blueprint is an innovative initiative funded by the Public Health Agency of Canada that aims to enhance the capacity of older adults to maintain their fitness to drive and ability to drive safely for as long as possible.

The CAOT has recently received additional funds from the Public Health Agency of Canada to continue with a series of objectives relating to the *National Blueprint for Injury Prevention in Older Drivers* project. The *Blueprint's* philosophy that "older drivers in Canada will be supported in maintaining safe driving practices" has commanded respect and interest from many stakeholders interested in promoting injury prevention in older drivers. CAOT is committed to keep this momentum and the further development of this public health strategy to ensure the safety of older drivers in Canada. CAOT has received funds to support the following objectives:

Objective #1: Expand membership and continue the role of the *National Advisory Committee for the dissemination and use of the Blueprint* and the development and dissemination of materials and resources relating to the *Blueprint*.

Objective #2: Provide knowledge translation opportunities for the *Blueprint* and related materials to stakeholders.

Objective #3: Create a series of brochures for a target audience of older drivers, their families and friends, and the Canadian public at large. The focus of these brochures will be the impact of normal aging and the impact of prevalent health conditions on safe driving with useful tips based on scientific evidence of high risk situations and risk-reducing strategies.

Visit www.caot.ca/driving

Delegates gather in Canada's capital city for an inspirational conference experience

Cheryl Evans, CAOT Communications Coordinator

Engaging in healthy occupation: *Partners for change*

CAOT Conference 2009
Ottawa • ON • June 3-6

2009 Conference Host Committee, from Left to Right: Lara Haddad, Jean-Pascal Beaudoin, Cathie Kissick, Sandy Alexander, Catherine Lanoix, Diana Bissett and Crystal Morris

The Canadian Association of Occupational Therapists (CAOT) in partnership with The Ontario Society of Occupational Therapists (OSOT) held their 2009 Annual Conference from June 3 -6, in Canada's capital city of Ottawa. A venue chosen for its vast culture, art, history and politics, Ottawa offered delegates the chance to explore diversity and renew their Canadian heritage.

The opening ceremonies set the tone for what conference delegates could expect – inspiration. Keynote speaker Dr. Rachel Thibeault, Associate Professor in the Faculty of Health Sciences at the University of Ottawa, opened the conference with her meta-analysis of a touching collection of narratives, gathered over the past 30 years of her work, from vulnerable people and/or people with disabilities who have shown incredible resilience in the face of war, hardship or trauma. Her comparison of their occupational strategies for mental health and well-being with the principles put forth by modern psychology and spiritual traditions left many in awe and inspired to make a difference.

Inspiration continued to weave its way through the three-day learning experience as Conference delegates delved whole-heartedly into the 250 thought provoking sessions. Delegates were pleased to see unique, diverse, and relevant topics covered and for the chance to dialogue with colleagues from across Canada and disciplines. In particular, delegates enjoyed uncovering new ground in the one-day occupational science stream that united occupational scientists, occupational therapists, health care consumers and other academics. The science stream, a Conference first, expanded their knowledge of occupation and provided implications for further research directions and integration into practice. Delegates also enjoyed sponsored sessions, professional issues forms, consumer presentations and a new symposium format that brought like-minded colleagues together to present on a common topic.

Keynote speaker Rachel Thibeault

Conference Profile

Anita Petzold

Montreal, QC

Anita Petzold is a Master's student at McGill University and is currently writing her thesis on rehabilitation science. Upon graduation, Anita hopes to work in acute care and stroke-rehab, and maintain a commitment to clinical research. Conference delegates had the chance to sample her impeccable work in her poster presentation on driving post-stroke.

As a student, she felt attending conference was the ideal way to stay up-to-date with innovative practices and treatments and was grateful for the immense networking opportunity it provided.

"The Conference experience has been very gratifying and has allowed me to broaden my horizons and gain experience, which as a new graduate is so important."

Conference Profile

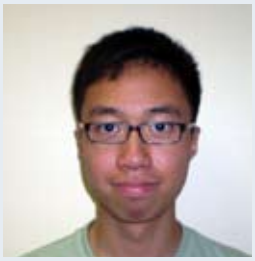
Serge Parent

Dieppe, NB

Serge Parent helps renal and dialysis patients find ways they can gain meaning and purpose in their lives. Through techniques like music therapy and gardening, Serge can often help patient's find interests and skills they didn't even know they had.

Serge is dedicated to the occupational therapy profession and hopes to make a difference in the field by travelling abroad and pursuing research. He travelled to conference to learn new and innovative practices that will assist in helping with his patients.

"The networking opportunities at Conference have been phenomenal. It is interesting to see what my colleagues are doing in different areas and what's working and what isn't. I can't wait to bring back and apply what I have learned!"



Conference Profile

Derek Cheung

Hamilton, ON

Derek is an aspiring occupational therapy student at McMaster University that is so taken by the profession he travelled all the way to Ottawa to help out as a volunteer in return for exposure to Conference. He enjoyed the diversity of topics covered and most of all the chance to network with some of the leaders of the profession. Derek was grateful for the opportunity to explore Conference workshops and found it helpful to identify the major issues in the field and what steps are being taken to resolve them. He was particularly interested in the occupational science workshops and was happy to see the focus on research was not just clinical.

"As a student and aspiring occupational therapy practitioner, it has been extremely inspiring to see things through the eyes of practicing occupational therapists. Conference provides valuable insights you can't always get from the classroom and I feel it is important that more students take advantage of it."

Conference Profile

Shone Joos

Toronto, ON

After going on a hospital tour with her high school class, Shone Joos knew right away, at the age of 16, that being an occupational therapist was the only profession for her. From then on she made sure every move she made advanced her a step closer to achieving her goal to become an occupational therapist. Today, after 15 years of practice in the community and private practice settings, she is still as passionate as ever about her work.

Shone specializes in working with children and in particular focuses on motor difficulties and developmental coordination disorder. She believes strongly in client centred care and encourages and challenges her clients to set their own goals upon which they then work together as a team to achieve them.

"Conference has been inspirational — it's provided me with the chance to think outside of the box and work collaboratively with colleagues to discover new ways to open doors in occupation."

Muriel Driver Memorial Lecturer Nicol Korner-Bitensky

Inspiration continued to gain momentum as Muriel Driver Memorial Lecturer Nicol Korner-Bitensky offered Conference delegates the opportunity to take a journey exploring how occupational therapy touches all aspects of life. Her encouraging words provided delegates with a feeling of belonging and a renewed sense of purpose and meaning as occupational therapists.

Outside of Conference workshops and guest speakers, delegates enjoyed a trade show of 67 exhibitors (a Conference record); the launch of two new publications: *You, Me and my OT*, written by Paulette Bourgeois and illustrated by Kristi Bridgeman, and *Inter-Professional Primary Health Care: Assembling the Pieces* by Mary Ann McColl and Jackie Dickenson; and sharing laughs together at social events, which included dining alongside the Rideau Canal and a live auction, and mingling with aspiring occupational therapists at the student social while clad in red and white.

CAOT President, Liz Taylor, was pleased with the outcome of Conference 2009 and felt delegates did a remarkable job in realizing their potential as occupational therapists. She credits the support and efforts of the steering and planning committees, guest speakers, workshop presenters, and the dedication of all who attended for the events success.

"It was an honour to be among so many creative therapists as we discovered the benefits of partners in practice," says Dr. Taylor. "The passion delegates bring to Conference each year never ceases to amaze and inspire me."

CAOT looks forward to reconnecting with Conference delegates again next year for the 2010 Conference in Halifax, NS and discovering an ocean of possibility ...

See you there!

Meaningful Occupation : Enabling an ocean of possibilities
CAOT Conference 2010
Halifax • NS
May 26-29

Conference Profile

Lorraine Mischuk
Winnipeg, MB

Lorraine brings 20 years of remarkable experience to the field of occupational therapy and has her own private practice, Maximize Human Capabilities (MHC). Lorraine and her team help individuals achieve the highest level of ability in the workplace and in their homes and community.

As chair of the Occupational Therapy Practice committee she was happy to share her immense knowledge in private practice with conference delegates through a pre-conference workshop and an extended discussion session. Even with 20 years in the field, she is still excited to be learning new things and this year's conference was no exception.

"The theme of this year's Conference, *Partners for Change, was an excellent choice – engaging in partnerships allows us to always keep in mind a broader perspective, something that is so important."*

Conference Profile

Corinne Nadeau
Quebec, QC

Since she was young, Corinne Nadeau always knew she wanted to work in health care. Once she heard about occupational therapy she knew she had found the career she was looking for. Today, she brings 15 years of experience to her work with clients of traumatic brain injury (TBI) and is always looking for ways to improve and update her skills.

Corinne came to Conference with the goal to discover new developments in the profession and to learn ways she can implement them into her work.

"Conference has been very inspirational and motivating. I will leave excited and with a big boost and hopefully be able to inspire my colleagues."

What are people saying about Conference 2009?

"It's been a great learning experience, particularly as a student – I couldn't have asked for a better networking opportunity." – Victoria Fung, Toronto, ON

"The highlight for me was Rachel Thibeault - she was inspirational and truly amazing." – Mary Clarke, Sunnybrook, ON

"It's been amazing to see everyone come together as an occupational therapy family and have the opportunity to learn and share together."
– Jean-Pascal Beaudoin, Ottawa, ON, (2009 Host Committee co-convenor).

"It has been a wonderful opportunity to reconnect with old friends and meet new ones. I look forward to continuing this dynamic and much more at Conference 2010." – Avai Kochanoff, Hammonds Plains, NS, (2010 Host Committee co-convenor).

"It's been a terrific experience to connect with colleagues across Canada and have exposure to all the innovative ideas being generated for implementation in practice — it has certainly broadened my horizons." – Sue Street, Halifax, NS

"The information provided was relative to my work and the speakers were especially inspiring. Overall, it has been a phenomenal experience." – Jen Sibley, Windsor, ON

"This year more, than in others, has reflected the benefits of joint partnerships. By having people come together from different parts of Canada it provides a true sense for the national perspective. It shows us what works and what doesn't, and what we can do to advocate. All the presentations have been extremely beneficial and applicable to practice." – Kelly Winkiewicz, Hamilton, ON

"Very stimulating – it has been a fabulous Conference ... there is just no other word for it."
– Heather Gillespie, Nanaimo, BC

"It's been a great Conference; the level of communication was very high. One thing I will remember for sure is Rachel Thibeault's lecture." – Isabelle Matte, Sherbrooke, QC

"It has been invigorating to be among some of the leaders in our profession." – Sandy Alexander, Manotick, ON, (Chair of Conference 2009 Registration sub-committee).

"It was great to see such a variety of topics covered in the sessions; even the ones I went to by accident were stimulating. I am very much looking forward to doing this again next year!"
– Donna Dennis, London, ON

"Conference provided a great chance to catch up with occupational therapists and see what they are doing in different fields. I particularly enjoyed the occupational science topics as they really showed the diversity of occupational therapy." – Jennie MacIntosh, Ottawa, ON

"It has been a very positive and enlightening experience, the guest speakers helped us reflect on who we are as occupational therapists and gave us a feeling of belonging." – Carmen Moliner, Sherbrooke, QC

"Rachel Thibeault's opening speech brought us all together and centered us in preparation for Conference, while the other speeches allowed us to reflect on why it is important to be an occupational therapist and provided hope for the future." – Patti Erlendson, Vancouver, BC

All conference photographs have been provided by **Nicole Raftis** *who besides being a photographer, is an occupational therapist currently on maternity leave. For more than six years Nicole has been capturing real moments in time for children and their families in their natural settings. From stills to action, colour to black and white, Nicole captures the emotion and personality present in daily life.* **To view more Conference photographs or to purchase copies of your own, please visit www.kandidphotography.com.**

Through the lens of an older driver

Patricia Clark

There are many organizations, associations, government departments, and others at all levels (local, provincial, and national) that are addressing the needs of older adults, and for good reason:

- Within the decade, adults over the age of 65 will outnumber children under the age of 14.
- In 2021, 1 in 5 adults will be over the age of 65, while 1 in 3 adults will be over the age of 55.
- In the year 2040, there will be double the number of older drivers in Canada.

The *National Blueprint for Injury Prevention for Older Adults* (CAOT, 2008) is one more important step to being proactive to positively respond to the changing needs of the population. The underlying philosophy of the *Blueprint* is to encourage older adults to maintain their health and well being, thereby allowing them to be as independent as they chose in their later years.

The Active Living Coalition for Older Adults (ALCOA) strives to promote a society where all older Canadians are leading active lifestyles that will contribute to their overall well being and independence. The goal for most older adults is to be able to live independently, wherever it is that they chose to live. Independence is one of the most important factors that allows older adults the opportunity for social connectedness, participation in cultural events, activity classes, volunteering, shopping, getting to appointments, and so on. An active lifestyle promotes physical and emotional well being which are also essential elements that allow an older adult to drive safely, thereby maintaining their independence.

About the author –
Patricia Clark is the National Executive Director for the Active Living Coalition for Older Adults.

The *Older Driver Blueprint* specifically states that this initiative aims to "enhance the capacity of older adults to maintain their fitness to drive for as long as possible and maintain their engagement in the occupations which give meaning and purpose to their lives."

The idea of a 'continuum of mobility opportunities' as we age is an important principle:

1. In our early youth, our options for travel are numerous – by foot, by bicycle, by a parent,
2. Then when we turn that magic age of 16, we are provided with both the opportunity and the privilege to learn to drive,
3. And as we age, we then require opportunities to ensure that we are still fit and able to drive safely, so that we do not harm ourselves or others.

This *Older Driver Blueprint* addresses this issue for older adults – to provide the necessary services and resources for older drivers that are appropriate and accessible.

But even with those services, resources, and knowledge translation, at some point, driving may no longer be an option. How then do older adults maintain their independence, social connectedness and their well being? The *Blueprint* also addresses this concern. The World Health Organization published a document in 2007 entitled, *Global Age-Friendly Cities*. The premise is obvious. With the shift in the age of the population, our cities and towns must become 'age-friendly.' As an example, sidewalks that are well lit with flat pavement making it safe to walk on, benches to rest on, long enough light changes to cross the road, and access to transportation, for those not able to drive or walk. The *Older Driver Blueprint* specifically identifies age-friendly communities as a direction for action, based on their priority goals.

The principle of 'optimal defaults' (coined by Kelly Brownell from Yale University) I think is the cornerstone for behaviour change for older adults and the rest of the population. When a choice has to be made, the right choice has to be the easy choice. When an older adult needs services or resources, the right choice must be the easy choice and must be accessible. When an older adult is no longer able to drive, the right choice must be the easy choice.

There are many organizations developing strategies to positively influence the lives of older adults, and the *Older Driver Blueprint* is another example of the work that can be accomplished when groups and individuals work together for the betterment of Canadians.

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Editor's Note:

Patricia Clark was a member of the Advisory Council for the *National Blueprint for Injury Prevention in Older Drivers* and an invited speaker for the launch of the *Older Driver Blueprint* February 26, 2009 in Ottawa.

Visit **www.caot.ca/driving** to attain a free download of the *National Blueprint for Injury Prevention in Older Drivers*.

CRITICALLY APPRAISED PAPERS

Column Editor: Lori Letts

The experience of driver's license cancellation for Australian older adults evoked overwhelming feelings of shock and loss

Katie-Ann Berry

Summary of Whitehead, B. J., Howie, L., & Lovell, R. K. (2006). Older people's experience of driver licence [sic] cancellation: A phenomenological study. Australian Journal of Occupational Therapy, 53, 173-180.

Research purpose: To develop an understanding of the experience of driver license cancellation for older adults and to describe the essential structure of the participants' experience.

Design: A qualitative, phenomenological study that included individual interviews with five older adults who had their driver's licenses cancelled.

Setting: Interviews were conducted in the participants' homes in an unspecified community in Australia.

Participants: A convenience sample of five adults between the ages of 68 and 87 participated in this study. The participants had their driver's licenses cancelled within the past 18 months because they had failed an occupational therapy driver assessment or had failed to meet the medical guidelines for fitness to drive. The participants had no cognitive impairments, understood the study, and were willing to provide a detailed description of their experience.

Methods: Participants were asked to describe the experience of having their driver's license cancelled in a one hour, semi-structured individual interview. Interview transcripts were analyzed using Colaizzi's (1978) Method of Phenomenological Analysis. Using this seven-step analysis procedure, nine themes emerged which were reduced into an essence statement that described the fundamental structure of the participants' experience.

About the author – **Katie-Ann Berry,** BA, MSc, was a student occupational therapist in the MSc(OT) program at Dalhousie University at the time of writing this article. She may be reached at katie.ann.berry@Dal.Ca

Main findings: The experience of driver's license cancellation for these adults involved nine themes which emerged from the interview data: Having their driver's license cancelled was a *severe shock* for the participants, as they had always seen themselves as good

drivers. The participants experienced a period of *wanting to drive and wishing to be re-assessed* as the *loss of the license was felt deeply.* The participants *reflected on life with and without driving* and felt a loss of independence. The act of *handing in the license* evoked a sense of finality and drew the participants' attention to the multiple losses in their life. Over time, the participants began *making sense of the situation*. They began to accept the situation and decided to *soldier on*.

Authors' conclusions and clinical significance:
The findings highlight the intense and overwhelming experience of driver's license cancellation for older adults. The researchers describe this as a very significant and challenging event in the lives of the participants. The researchers suggest that health care professionals should be aware of the emotional and functional impact driver's license cancellation has on their clients so that they can enable their clients to maintain a sense of independence, autonomy, and a positive identity.

Contact information for the appraised paper's corresponding author is: Dr Linsey Howie, School of Occupational Therapy, Faculty of Health Sciences, La Trobe University, Victoria 3086, Australia.
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Commentary on Whitehead, B. J., Howie, L., & Lovell, R. K. (2006). Older people's experience of driver licence cancellation: A phenomenological study. Australian Journal of Occupational Therapy, 53, 173-180.

Having one's driver's license cancelled is a significant event in the life of an older adult. Whitehead and colleagues completed a study with the purpose of understanding the experience of driver license cancellation for a group of Australian older adults. While researchers have explored the impact of driving on the identity of older adults (Eisenhandler, 1990), the experience of losing the ability to drive (Gillins, 1990), older women's experience of their decision to stop driving (Bonnel, 1999), and the experience of driving cessation for older adults (Yassuda, Wilson, & von Mering, 1997), only one study has explored the experience of having one's driver's license cancelled (Lister, 1999). Whitehead and colleagues, therefore, have made an important contribution to an area of research that has received little attention thus far.

Overall, Whitehead and colleagues have conducted a study where the methods of data collection and analyses are consistent with the phenomenological tradition and are used appropriately to address the purpose of the research. The results section includes an essence statement that summarizes the themes that emerged from the data analyses. Although the study is generally well-designed, certain methodological issues affect the trustworthiness of the study.

First, the researchers did not report keeping a reflective journal, nor did they report engaging in any bracketing activities. The authors have clarified that these activities were undertaken but space limitations prevented inclusion of these details in the manuscript. The reader, however, is not made aware of the researchers' assumptions and biases and cannot determine how these may have affected the researchers' portrayal of the phenomenon.

Second, the transferability of the study is adequate but could be improved. The description of the participants was clearly presented in a table and included a description of each participant's marital status, age, medical history, time since the cancellation of the driver's license, and reason for cancellation of license. However, the authors did not describe how it was determined that the participants did not have cognitive impairments.

Third, while the findings of the study appear to be consistent with the interview data, this is not immediately evident because the essence statement does not include direct quotes from participants, and only one example is provided of how a statement from a participant was transformed into a meaning statement. This affects the dependability of the study. Interview data are included in the discussion section. The findings are presented this way because the essence statement is meant to be representative of the essential features of participants' experiences and presenting excerpts from individual interviews would interfere with the presentation of these essential features. However, presenting the findings without interview data removes the participants' voices from the findings and gives the

impression that the participants' data are used to support the literature addressed in the discussion section rather than the findings of this particular study.

An important strength of the study is that the researchers provide a good description of the process of data analyses and illustrate it with examples using the interview data. This strengthens the dependability of the study. These examples are helpful to the reader, as the process of data analyses is often abstract and difficult to understand.

The researchers conclude that the findings of the study "highlight the intense and often overwhelming feelings evoked when an older person's driver licence is cancelled" (p. 179). The researchers' conclusions reflect the findings of the study, based on a group of Australian older adults. While the researchers' conclusions reflect the findings of the study, more research will be needed to ensure that the findings are similar in other countries; however the similarities between Australia and Canada would suggest that this is likely. These findings may be clinically significant as they illustrate the impact of a therapist's recommendations regarding a client's ability to drive. The researchers suggest that health care professionals should be aware of the impact of license cancellation on their clients so that they may work with the clients to maintain a sense of independence and a positive identity. The findings of this study may also be used to encourage therapists to prepare their clients for the possibility of dealing with the cancellation of their license before they go through a driving assessment.

Whitehead and her colleagues have described the essential features of the experience of driver license cancellation for five Australian adults. This study may prompt other researchers to explore this experience for other groups of adults in different contexts. It also provides a starting point for researchers who wish to investigate methods of enabling clients to cope with this significant event.

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This issue's Critically Appraised Paper (CAP) column was written by Katie-Ann Berry, a student occupational therapist at Dalhousie University. The paper was initially written as an assignment for an evidence-based practice course at Dalhousie. Dr. Joan Versnel, who organizes the course and also sits on the advisory group for the CAP column, recommended Katie-Ann's paper for publication, it was very well written and is on a very relevant topic in occupational therapy practice. The column has gone through the same blind peer-review process and consultation with the original authors as all other CAP columns.

If you have a suggestion for an article that you would like to see reviewed in an upcoming CAP column, or want to participate in writing a CAP column, please contact the column editor, Lori Letts at lettsl@mcmaster.ca or the *OT Now* managing editor Brenda McGibbon Lammi at blammi@caot.ca.

Occupational therapy intervention in early multiple sclerosis: Evidence to support involvement

Column Editor: Sandra Hobson

Melanie Reimer, Meg Evans, Mandy Qingwen Feng, Alison Hofer, Man Yan (Mandy) Lau and Lori Mackay

One year ago, when my doctor first told me that my fatigue was a symptom of multiple sclerosis (MS), I was at a loss as to how my life would continue. How could I continue my job? How could I manage my fatigue? How could I pursue my dreams? Since receiving my diagnosis, my MS has gone into remission and I am continuing in my line of work as an air traffic controller. I have gained control over my fatigue and raised over $4000 for the MS Society. I am also participating in the annual MS walk for charity and am planning to go to Europe with my best friend this summer. Life is looking up. – Hannah , 24 years old

What is Multiple Sclerosis?

Multiple sclerosis (MS) is a slow progressive disease of the central nervous system that affects 55,000-70,000 Canadians. Symptoms of MS include fatigue, balance issues, and weakness, which interfere with an individual's ability to perform their activities of daily living. There are four categories of MS including relapse-remitting, secondary-progressive, primary-progressive, and progressive relapsing. The most common type of MS is relapse-remitting, which affects approximately 70% of individuals. It is identified by its clearly defined relapses which may or may not result in permanent deficits. The average age of onset is between 15-40 years of age, affecting individuals in the prime of their lives while they hold a variety of roles which contribute to formation of their self-identity, or sense of self.

One of the most disabling symptoms of MS is MS-related fatigue. Daily fatigue levels in those with MS have been found to be 125% greater than those of healthy individuals. MS-related fatigue is described as a subjective lack of physical and/or mental energy that interferes with an individual's activities, including employment (Crayton & Rossman, 2006; Mathiowetz et al., 2007). Unfortunately, MS-related fatigue occurs in 65-97% of persons with MS, of whom approximately one third report fatigue as their most disabling symptom.

There are four main components of MS-related fatigue – physical, emotional, behavioural, and cognitive. When individuals with MS are unable to cope physically, they express emotional perceptions of worthlessness, despair, sadness and sorrow (Crayton & Rossman, 2006). Fatigue is exacerbated by sleep disturbances, depression, and physical disabilities that frequently accompany MS. In the past, individuals with fatigue were generally advised to rest and avoid physical activity, a behaviour which is now known to reduce cardiovascular fitness, promote poor muscle conditioning, and consequently contribute to the fatigue experience (Smith, 2006).

Keeping in mind the disabling symptoms of MS, how can occupational therapists ease the transition of newly diagnosed individuals through the application of theory and evidence-based practice to aid clients in contributing to their own rehabilitation efforts? Focusing on early intervention, we aim to outline and describe various techniques employed by occupational therapists to support those newly diagnosed with MS. Techniques include, but are not limited to, education, compensation, and focus on aiding clients in managing their symptoms and participating in occupations to support future engagement.

What is the occupational therapy role?

Occupational therapists use three therapeutic strategies to produce changes in occupation – remediation, compensation, and advocacy (Chisholm, Dolhi, & Schreiber, 2004). Because MS is a degenerative disease, the focus of occupational therapy intervention will be on compensation and advocacy.

About the authors – All of the authors are in the MScOT program at Queen's University in Kingston, Ontario and are scheduled to graduate this year.

The fatigue affected me in many areas of my life. I had difficulties in completing most of my regular tasks (including showering, cooking, and shopping), as the fatigue was so severe. Additionally, the stress upon receiving the diagnosis caused me grief and eventually I broke up with my long-term boyfriend. I started seeing a psychologist to help me cope with my new diagnosis and my grief, and return to work was our main topic of discussion. – Hannah

As compensation entails identifying ways to overcome performance deficits, educating Hannah on energy conservation techniques can significantly reduce the impact of fatigue on her occupational performance. Energy conservation is defined as "common sense ideas to improve task efficiency and reduce energy expenditure during all occupational performance tasks" (Fasoli, 2002, p.p. 696). The occupational therapist, with his/her focus on the person, environment, and occupation, plays an important role in employing beneficial strategies for energy conservation, such as planning each day according to fatigue levels, incorporating frequent rest periods, using adaptive equipment, altering work heights, simplifying activities, and delegating part or all of an activity to others (Packer et al., 1995).

Substantial increases in adoption of energy conservation behaviours have been found following participation in energy conservation education (Mathiowetz et al., 2007). This suggests the benefits of energy conservation interventions in managing MS-related fatigue and improving daily occupation participation. However, such an intervention needs to be more than just providing information; an occupational therapist must induce a change in current behaviours and target individuals who are more likely to adopt these new behaviours (Matuska et al., 2007).

I was just starting off in my career as an air traffic controller when I received my diagnosis of MS. As my most severe symptom was fatigue, I feared meeting my job requirements of focused attention. I disclosed my diagnosis to my employer and was put on an indefinite leave of absence. During this time, I received testing by a neurologist from the MS clinic to determine my capabilities to continue in this line of employment. Luckily, I passed the tests and returned to my job three months later. However, throughout my career I will require similar job-testing annually to ensure that I am capable of meeting the demands of my job. -Hannah

In addition to educating about energy conservation techniques, the occupational therapist can also support Hannah in changing her work environment, such as reducing distractions to help her maintain attention. Increasing social support through educating family and friends about MS can positively impact Hannah's social environment. The occupational therapist can also enhance occupational performance by recommending assistive devices and modifying the task (e.g., showering in sitting to reduce the amount of energy required). Advocacy addresses system-level barriers to independence (Chisholm et al., 2004). The occupational therapist can advocate for Hannah with her employer for work-related compensations, such as regular breaks and modified tasks. The occupational therapist can also teach self-advocacy skills to Hannah and her family so they can self-advocate when further compensation is required in the future.

When the doctor first told me I had MS I did not know what it was, I did not know how to proceed, I thought my life was over. –Hannah

Occupational therapists are well informed and connected with community resources and can act in a mediatory role with the client, linking them with various resources in the community for support. The occupational therapist working with Hannah could provide her with basic education, as well as link her with her local MS Society branch, MS support groups, and non-profit organizations that provide support to individuals with MS.

In a multi-disciplinary rehabilitation approach, the role of occupational therapy on the MS care team is well recognized (Feigenson, 1981; Freeman, 1997). One meta-analysis article suggested that occupational therapy-related interventions have positive outcomes on clients' capacity/ability (e.g., muscle strength, range of motion) and task/activity level (e.g., dressing, bathing) (Baker and Tickle-Degnen, 2000). However,

there is insufficient evidence to support the effectiveness of mono-disciplinary occupational therapy intervention, because a systematic review conducted in 2003 identified only three studies satisfying inclusion criteria with inconclusive results (Steultjens et al., 2003).

Occupational therapy should be utilized early in the disease process to prevent disengagement in activities and life roles, influencing overall quality of life.

More studies are being published to support the effectiveness of occupational therapy intervention. Because MS-related fatigue is regarded as one of the most disabling symptoms, many studies point to the importance of education on energy conservation. A recent randomized control trail of an occupational therapy-delivered energy conservation course supported occupational therapy efficacy, because it demonstrated significant reductions on fatigue impact, increased self-efficacy, and increase in some aspects of quality of life (Mathiowetz et al., 2005).

Occupational therapy is one of the leading disciplines to practice with a client-centered philosophy. However, clients' satisfaction with occupational therapy services in MS care, ironically, receives little attention. A recent study reported a low occupational therapy service utilization rate of 38% (Finlayson et al., 2008). More importantly, of those using occupational therapy services, almost all indicated that these services were very important to their health and well-being (Finlayson et al., 2008). Many people with MS were found to discontinue occupational therapy services after initial contact, which could be an indicator of effective early occupational therapy interventions. Early occupational therapy interventions and education are suspected to enable clients to better handle ongoing challenges with less reliance on future professional input (Finlayson et al., 2008).

The future outlook:

The World Health Organization (2001) focuses on activity participation, which sets the stage for occupational therapists working with individuals with MS. Through early intervention and the use of education, compensation, and advocacy techniques, occupational therapists support individuals with MS in regaining roles, participating in activities, and incorporating symptom-management into their daily lives (Mathiowetz et al., 2001, 2005; Steultjens et al., 2003). Occupational therapy should be utilized early in the disease process to prevent disengagement in activities and life roles, influencing overall quality of life. Occupational therapy-specific studies should focus on measuring outcomes at the life roles level, identifying how occupational therapy influences participation in work, leisure, and community, because evidence has already accumulated for levels of capacity, activity, and task (Baker et al., 2000).

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Column Editor: Lili Liu & Masako Miyazaki

eHealth: What's out there and what does it mean for occupational therapy?

Laura Dumas, Priscilla Mutepfa and Simone Reid

We are about to graduate with the Master of Science degree in occupational therapy and would like to share one of our most profound learning experiences we had in our final year of the program.

Our introduction to eHealth in occupational therapy came through an elective course by Dr. Masako Miyazaki at the University of Alberta. It turned out to be an ideal learning experience, as only three of us in a class of eighty-six signed up for the course.

We all acknowledged a need for an increased use of technology in occupational therapy despite being unaware of the vast applications of eHealth or the variety of technology available to practicing occupational therapists. The course challenged our way of thinking. Throughout the rest of our occupational therapy careers, eHealth and technology will be considered when treating clients.

In this article, we focus on an introduction to the world of eHealth, and provide an overview of how eHealth and technology can help therapists working in urban and rural settings including both largely populated and remote communities.

A definition of eHealth published in the Journal of Medical Internet Research (Eysenbach, 2001) is as follows:

> *eHealth is an emerging field in the intersection of medical informatics, public health and business, referring to health services and information delivered or enhanced through the Internet and related technologies. In a broader sense, the term characterizes not only a technical development, but also a state-of-mind, a way of thinking, an attitude, and a commitment for networked, global thinking, to improve healthcare locally, regionally, and worldwide by using information and communication technology.*

The primary focus of eHealth is not technology. It is the adoption and use of e-discoveries in medical sciences and advances in information technology for the development of eHealth solutions for broader public access to care and health education services, and the delivery of these services., eHealth is an enabler.

An introduction to eHealth

Throughout our eight week module we were introduced to a variety of eHealth and technology. Our first site visit was to the telehealth centre at the Glenrose Rehabilitation Hospital in Edmonton. We were introduced to Ms. Katie Woo, OT (C), who taught us about telehealth in Alberta and the many telehealth programs and projects utilized at the Glenrose. During this session we were also introduced to Ms. Diane Fraser, a registered nurse in home care that routinely uses technology in her practice such as wound management and chronic disease management. She provided us with a variety of ideas regarding using technology in occupational therapy.

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The following week, we participated in a videoconference with Mr. Tim Patterson in Toronto who presented us with his initiative about Canadian Connection Collaboration (CCC) which aims to help provide continuing medical and paramedical education for underdeveloped countries. All medical programs in Canada have joined the CCC and will try to accomplish sharing knowledge, education and services with underserved regions. Mr. Patterson felt that health care, not war, would lead to world peace. Therefore, by supporting our colleagues in Canada and throughout the world we can help make the world a better place to live. He promoted technology as a tool of enablement.

Our next site visit was a trip to TR Labs Smart House in Calgary. We were introduced to the collaborative efforts of research and industry with the main focus on eHealth, e-home, and connected media. We took a tour of the traditional lab that had camera monitoring sensors, alarms, a wellness centre, a kitchen, and a living room, all which

contained eHealth equipment. Many technologies introduced at the smart house are already being marketed or are close to reaching the market.

What e-technology is out there now?

The commission of European Communities describes eHealth as a tool and solution to ensure individualized patient health care, and to assist health professionals (Evers, 2006). Examples include personal wearables, health records, health portals, telemedicine services, health information networks and portable communicable systems (Evers, 2006).

Information and communication technologies are used to provide health services and professional development remotely (Liu & Miyazaki, 2000). Telehealth includes a variety of professional domains such as telemedicine, teledentistry, telepharmacy and telenursing. Tele-occupational therapy is the remote delivery of occupational therapy education and services through information and communication technology.

Research and evaluation, health management, and professional education are enabled by e-technology where barriers such as geography, transportation and socio-economic disparity exist (Frequently Asked Questions, 2007). It encompasses a variety of methods of delivering health related service including, but not exclusive to, telephone calls (one-to-one), video conferencing, teleconferencing, supportive counseling, and health monitoring (Finlayson, 2006). Health care professionals, including occupational therapists, have also used telehealth for direction or consultation support.

Tele-occupational therapy is the remote delivery of occupational therapy education and services through information and communication technology.

Telemedicine incorporates practicing medicine at a distance and providing medical care to patients separated from the specialist care they need. This may include distance consultation between physicians, therapists, or the treatment of patients remotely (Biermann et al., 2006).

How can occupational therapists and other health professionals use e-technology?

Occupational therapists and other health professionals are currently using a variety of e-technology and the internet. For example, in education e-technology and the internet are used in environments like continuing and distance education and research. They are also used for data collection (i.e. internet-based surveys), participant recruitment and health promotion (Evers, 2006). The internet and eHealth have been used as channels of intervention, specifically for health information distribution and interventions aimed at helping individuals make health changes (Evers, 2006).

Telehealth was initially developed to improve access for people living in rural areas but is increasingly used in urban areas where public transportation is an issue or where there are mobility problems (Finlayson & Holberg, 2007). Finlayson (2006) notes that "research has demonstrated the effectiveness of telehealth interventions in mental health, smoking cessation, chronic pain management, peer-support for cancer patients and vocational counselling" (p. 338). In areas such as diabetes management, hypertension treatment and myocardial infarction, studies have shown positive effects when using technology such as automated telephones for monitoring clients' health (Finlayson, 2006).

In a rehabilitation program, self-efficacy is regarded as a very important aspect in terms of patient's ability to engage in a program, as well as a measure of the result of the program (Sanford et al., 2006). Sanford and collegues (2006) conducted a study to examine the effect on mobility self-efficacy of an individualized, multifactorial, occupational/physical therapy intervention delivered through in-home visits or teletechnology. They found a trend in the direction of increased efficacy regardless of the rehabilitation delivery mode. This means telerehabilitation can be a feasible alternative or a supplement to home therapy (Sanford et al., 2006).

Self-efficacy is also encouraged in clients with chronic health conditions. It is noted that telemonitoring is cost-effective, reduces the number of readmissions to hospital, reduces how long clients stay in the hospital, and provides an increase in quality of life, self-efficacy, perception of health status, and encourages changes in behaviour (Bondmass et al., 2000, as cited in Hudson et al., 2005).

Table One describes the eHealth trends and solutions in Canada.

What eHealth means to us

We are all still trying to become familiar with eHealth and technology. However we are aware of the global shortage of occupational therapists and we feel that technology may be the way to treat a greater amount of people in a shorter period of time. At the end of the course we realized that we are our class innovators in the field of eHealth and technology. It is now our responsibility to spread the knowledge we have learned in this module to our classmates and clinicians.

Table One: Canadian eHealth trends and solutions

Trends	Examples of eHealth Solutions	Purpose
Consumer Health Informatics		
Client empowerment	• Health information portals • eLearning systems • Collaborative tools	• Provide access for health information and education material • Connect to others who have the same / similar health conditions • Participate in support groups
Self-Care	• Personal electronic health record • Monitoring devices and bio-sensors • Medical devices • eLearning systems	• Collect data about health status • Monitor health conditions and lifestyle • Perform diagnostic procedures • Perform non-invasive treatment interventions
Personal health record	• Electronic health record / smart card • Document management • Data integration systems • Messaging systems • Privacy and security solutions	• Collect data about health status • Provide a comprehensive and secure clinical view of client health information accessible to authorized persons (e.g., healthcare processionals) from any location at any time
Evidence-based medicine	• Electronic health record • Good health practices • Health information portals	• Provide access to evidence-based guidelines, studies, and health practices • Promote good health practices
Professional Informatics		
Computer-aided decision tools	• Computer-aided clinical discipline / disease-specific practice guidelines • Care pathways	• Provide access to medical information / knowledge anywhere and anytime
Clinical communications	• Electronic clinical communications tools for booking, referrals, clinical documentation	• Communicate electronically with clinical systems and other services providers • Assist in sharing clinical expertise
Knowledge management	• Collaborative tools • Multimedia conferencing systems • E-learning systems • Data mining tools • Data fusion tools • Rule discovery tools • Knowledge capture systems	• Organize and disseminate the existing knowledge • Create new knowledge taking into account tacit and explicit aspects of knowledge
Evidence-based medicine	• Computer-assisted clinical practice guidelines	• Combine the new knowledge with the existing clinical practices

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Adaptive hiking: Visions of possibility

Tamara Thicke

Introduction to adaptive hiking

I have recently had the opportunity to be involved as an occupational therapist in enabling a community organization to work towards developing an adaptive hiking program in Calgary, Alberta. This experience has strengthened my belief in adaptive hiking's potential for creating opportunities for health promoting occupations within the community. Using adaptive hiking to involve clients in meaningful occupation offers visions of possibility for improved health and a more inclusive community. This paper encourages readers to consider how adaptive hiking can be used in occupational therapy to enable involvement in hiking as a meaningful leisure or spiritual occupation that promotes health.

"Adaptive hiking involves people with disabilities accessing park or mountain trails using assistive technology or other personal supports."

Adaptive hiking involves people with disabilities accessing park or mountain trails using assistive technology or other personal supports. Personal supports might include using a guide for people with visual deficits or cognitive disabilities. Assistive technology in adaptive hiking includes specialized hiking chairs, such as the TrailRider. The TrailRider can be propelled over rugged terrain by able-bodied assistants using handles in the front and back, as shown in Figures One and Two.

Health promotion and adaptive hiking

Health promotion enables people to influence their health through opportunities for improved social, mental, and physical well-being (World Health Organization, n.d.). Occupational therapy focuses on promoting individuals' health and well-being through opportunities for involvement in occupations (Law, Steinwender & Leclair, 1998). Equal opportunities for involvement in occupations is believed to promote a more inclusive society (Townsend & Wilcock, 2004). Occupational therapy values of meaningful involvement in occupations and active participation within the community are compatible with health promotion tenets (Thibeault & Hebert, 1997).

The benefits of outdoor adventure activities for clients with disabilities support the use of a health promotion framework when enabling involvement in hiking. Outdoor adventure activities have been shown to contribute to social well-being by creating opportunities for community inclusion and positive social experiences (Cairin-Levy & Jones, 2007). Involvement in outdoor adventure activities contributes to mental well-being through improved self-concept and self-esteem (Beringer, 2004; Levack, 2003). Skill acquisition resulting from outdoor adventure activities can contribute to physical well-being (McAvoy, 2001). Finally, outdoor adventure activities are believed to impact clients' spirituality by influencing the meaning life has for them (Levack, 2003).

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Figure One: Ishan Manerikar experiencing hiking in the TrailRider with the help of Colin Matthews and Rob Braun during an event hosted by Community Recreational Initiatives Society near Canmore, Alberta.
Photo credit: Troy Becker

Occupational therapy and adaptive hiking

Occupational therapy has a role in creating opportunities for involvement in hiking occupations that promote health. Physical, mental, and social well-being through occupation includes enhancement of individual capacities, community support, and social integration (Wilcock, 2006, p. 192). Occupational therapy health promotion involves promoting healthy lifestyles, including occupation in health promotion initiatives, community development, and linking individuals with environmental supports (Brownson & Scaffa, 2001; Trentham, Cockburn, & Shin, 2007). The role of occupational therapy in health promotion can involve interventions at the individual, organizational, community, and population level (Brownson & Scaffa, 2001).

Individual intervention

Occupational therapy includes consultation with individuals who are exploring lifestyle changes (Brachtesende, 2005). Occupational therapists can present adaptive hiking as an option for occupations that promote a healthy lifestyle. Occupational therapists can identify adaptations to the environment or activity, according to clients' preferences and needs, that will promote meaningful involvement in hiking occupations. Adaptations could include determining the appropriate duration, terrain, or type of group for hiking as well as recommending appropriate assistive technology. Occupational therapists can train clients and their assistants in the use of hiking chairs, such as the TrailRider, using their background in body mechanics, lifts and transfers, and seating and positioning.

"Occupational therapy has a role in creating opportunities for involvement in hiking occupations that promote health. "

Organizational development

Occupational therapists have the skills to collaborate with an organizational client to create opportunities for individuals to access occupations (Brachtesende, 2005). Occupational therapists' skills in enabling occupation can enhance organizations' use of adaptive hiking in health promotion. Occupational therapists are able to take on a role of specifying the organizational requirements for adaptive hiking, according to people with disabilities' needs, such as assistive technology and staff training. This role can also include advocacy and education within an organization to enable it to attain the requirements for an adaptive hiking program. Occupational therapists' ability to engage organizational representatives in a process of program planning and evaluation can also support the organization's ability to create opportunities for hiking occupations.

Community development

Community members with a common interest in creating opportunities for adaptive hiking have the potential to contribute resources for a shared adaptive hiking initiative. Occupational therapists can strengthen networks among community members in order to promote their ability to determine goals and action (Trentham et al., 2007). They can also facilitate development of community partnerships that create new opportunities for occupations that meet the needs of the community (Restall et al., 2005). Occupational therapists' role in community development can enable community members to network and form partnerships that will generate support and resources for a community adaptive hiking initiative.

Population health

Occupational therapy population health initiatives view health from a socio-environmental perspective in relation to societal barriers (Townsend & Polatajko, 2007). Adaptive hiking can influence population health because of its impact on societal determinants of health, including social support and disability. Approaches to promoting health within a population can

Figure Two: Diane Mokelky, in a TrailRider powered by Colin Matthews, enjoying nature up close in a Calgary park during an event hosted by Community Recreational Initiatives Society. Photo credit: Troy Becker

include addressing environmental and psychosocial risk factors (Townsend & Polatajko, 2007). Occupational therapists involved in promoting population health through adaptive hiking, can develop environmental supports, such as accessible transportation to the trailhead, and psychosocial supports, such as social policies that are inclusive of people with disabilities.

Future directions for adaptive hiking in occupational therapy

Adaptive hiking can be used by occupational therapists in individual, organizational, community, and population level interventions. Adaptive hiking presents new possibilities for involving clients in occupations that promote health and a more inclusive community. Although more research on adaptive hiking in occupational therapy is needed, it is an area of practice that has great potential for promoting the health and well-being of people with disabilities within their local communities.

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Editor's Note:

For practical resources on Community Development, please see the CAOT's 'hOT Topic' on *Occupational Community Development* found at http://www.caot.ca/pdfs/community%20Dev.pdf

Opening doors to information for injured workers through knowledge exchange and research with consumer community groups

Lynn Shaw, Melissa Knott, Rob Lindsay, Phil Brake, Peter Page Colin Argyle, Joy MacDermid and Anita Kothari

Challenges for injured workers in accessing and using knowledge

Accessing and using knowledge is critical for injured workers to become informed about their health status, rights, and accountabilities in return-to-functioning and return-to-work. However, the information that injured workers need to: make decisions about their injury; understand their responsibilities for reporting and documentation; maneuver the claims management process; and interact with health care professionals in the recovery and return to work processes, is often new and complex. For most, it is a very daunting experience to try and find information on this full spectrum of issues, let alone understand or apply relevant information to help them through their experience. As therapists we become a primary point of access for information and knowledge that injured workers draw upon as they attempt to navigate the informational labyrinth in the return-to-work system. To promote injured worker participation in the return-to-work care processes, therapists are spending time with clients by assisting them in finding, sorting and appraising information, helping injured workers find out what they need to know about return-to-work from the employer and insurance company and helping them manage the future consequences of residual disability. Beyond the therapist-worker dyad, injured workers also desire information that can help them quickly gain an understanding of the claims management process and the relevance of actions required to sustain a source of income while off work and to resume timely employment. Most important to injured workers is the need for a place and space to interpret the information they acquire, and further, to make sense of the emotional and social upheaval they and their family experience with the barriers and challenges encountered in the return to work system.

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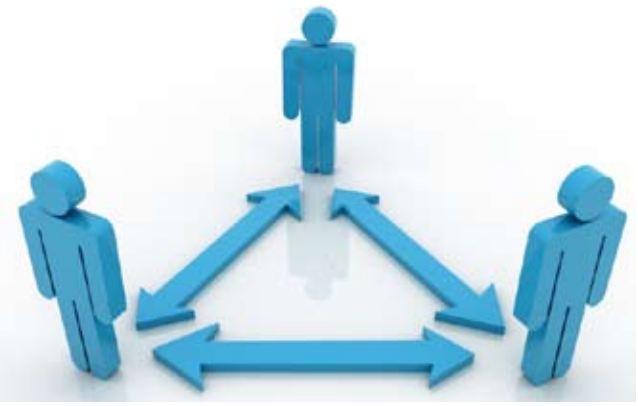
Therapists as knowledge brokers

A knowledge broker is understood to be a professional in the health care sector that turns research into policy or practice. Knowledge brokers are typically situated between the producers of knowledge and the users of knowledge (Lyons et al, 2006). For therapists the realm of knowledge needed to assist injured workers and to help them access the information they need has expanded beyond research-informed clinical advice to include policy information, insurance system information, procedural information, workplace information, counsel about the rights and responsibilities of workers and employers in the process as well as knowledge about available community resources and agencies.

Therapists are, in a sense, becoming knowledge brokers, that help injured workers become effective knowledge users. However, therapists for the most part have limited understanding of knowledge brokers, outside the health care sector, that injured workers can use in the return-to-work process. For instance, other knowledge brokers that injured workers turn to, to fill the void of information and difficulties interpreting information, are injured worker groups (IWGs).

Injured worker groups as knowledge brokers

In the community, IWGs help injured workers find the



information they need and also offer suggestions and direction about information they need to know based upon the experiential and policy knowledge gained through the efforts of IWGs over time. In effect, IWGs are primarily knowledge brokers of policy, legislation, procedural, benefit, and community resources and to a lesser extent, research. IWGs have developed many informal and formal peer support groups and networks of credible sources of information, people, and agencies that can help injured workers in times of occupational disruption and need. For the most part, injured workers groups receive little or no government funding; some groups are funded through labour or donations, and some primarily operate on the commitment of volunteers who have developed a life passion for activism that often emerges through experience in dealing with system inequities and injustices. In Canada, there are structured and informal groups in the community that offer a variety of supports for injured workers. These groups provide information on basic needs, such as temporary financing and food banks, claims and benefits information, advocacy services, networks with other groups, transformation supports and so on (Shaw et al., 2007).

Across Canada there are, however, inequities in access that injured workers have to IWGs, not only due to lack of funding, but also due to burnout, as many persons who support and run groups have chronic disabilities. Despite these barriers, many IWGs are seeking opportunities to network with others and establish communities of practice that can be more effective in meeting the informational needs of injured workers. More educational efforts are needed to help therapists become aware of the support that IWGs can offer to improve access and use of knowledge by the end-users -- injured workers.

Opportunities to promote access and use of information

One step that might assist therapists in helping injured workers access information through community groups is for therapists to become more aware of the role of IWGs and to establish formal or informal collaborations or networks with these groups. Stakeholders, therapists and IWGs share the same goal: to support injured workers in accessing and using the right information at the right time. To assist therapists in understanding the services offered to injured workers, examples of the IWGs that exist in some areas of Canada and their roles in supporting knowledge exchange are outlined in Table One. This list is not inclusive, for further information on groups contact the Canadian Injured Workers Alliance website (see below).

Table One. Examples of Injured Workers Groups in Canada that provide information and supports to injured workers.

Name of Group and contact Information	Purpose and informational services offered
Canadian Injured Worker Alliance (CIWA) Website: www.ciwa.ca Contact: Phil Brake, National Coordinator 853 Hudson Drive, Labrador City, NL A2V 1M6 Ph: 1-709-944-5181 Em: philbrakeciwa@crrstv.net	• Supports and strengthens the work of injured workers' groups, provides training & education, produces & distributes resources, and provides a forum for exchanging information and experiences. • Information dissemination on matters affecting Injured and Disabled Workers. • Provide resources to Injured and Disabled Individuals and Representative Groups and enhance their ability to meet their needs, overcome barriers, keep abreast of developments affecting them and improve access to services. • Injured and Disabled Workers needs are met through the participative actions of CIWA representatives and their efforts to establish better understanding of the gaps between public policy and the provision of and access to services. Our efforts support the adoption of organizational resolutions in support of Injured and Disabled Workers and the advancement of social policy in this area.
Labrador West Injured & Disabled Workers Group Contact: Clive Hamilton, Director Ph 709-2882-4007 Em: clivehami@gmail.com	• Provide Peer Support and some advocacy for and on behalf of injured and disabled persons. • Gather and share information from and between other similar groups, the Canadian Injured Workers Alliance, Labour and Local Union Councils as well as at regular public and board meetings.

Name of Group and contact Information	Purpose and informational services offered
Western Injured Workers Society Robert J. Lindsay, Director Ph: 306-545-6234 Em: roblind@sasktel.net	• Provide Peer Support and some limited advocacy for and on behalf of injured and disabled persons. • Gather and share information between other similar groups, the Canadian Injured Workers Alliance, Labour and Local Union Councils as well as at regular public and board meetings.
OFL Ontario Federation of Labour Contact: Colin J. Argyle OFL Occupational Disability Response Team Services and Promotions Coordinator 1-800-668-9138 Em: cargyle@ofl.ca	• Provides province wide workplace insurance and return to work training from introductory to advanced programs" contact information would be
ONIWG Ontario Network of Injured Workers Groups Contact: Peter Page President Em: info@oniwg.on.ca Website: http://www.oniwg.on.ca	• Promotes the rights of workers who have been injured or have disabilities in Ontario. • Serves workers who have been injured or have disabilities • Dedicated to helping the injured and disabled and their families past, present and future, obtain their rights to Justice, Dignity, Equality, Health and safety and Security. • Unite people and organizations that are democratically governed by their membership. • Work toward the establishment a fair and just system of compensation. • Invite the co-operation of all persons who are dedicated to the abolition of injustice and exploitation of all those injured or disabled in the Province of Ontario.

Partnering in research with IWGs

The other opportunity that can support more effective access to information and use of knowledge is through the establishment of research partnerships with IWGs. Recently, Whalley-Hammell (2007) challenged occupational therapists to reflect on opportunities to include our clients, which include IWGs, in the research process to realize more authentic partnerships that can empower change. Findings from the research partnership between the Canadian Injured Workers Alliance (www.ciwa.ca) and the first author of this paper underscore that the lack of access to the right information at the right time is a pervasive problem for injured workers across Canada (Shaw et al., 2009).

Lack of access to knowledge is further compounded by the lack of awareness of the processes that can support optimal knowledge transfer and translation by IWGs and health care professionals. These findings lend support for more collaboration with community groups to share opportunities, draw upon each other's strengths, promote knowledge use by injured workers and to continue to nurture partnerships to support research needs in the area of knowledge transfer. This partnership is only the beginning of what is needed to work together to address system barriers, inform policy and to mobilize knowledge that can empower injured workers in becoming effective knowledge users in return to work. For further information about the results of the study findings please contact the first author.

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Acknowledgements

We would like to acknowledge the funders who have assisted us in moving research and knowledge forward, The Canadian Occupational Therapy Foundation, Dominion Life of Canada and the Research Advisory Council – Workplace Safety and Insurance Board.

Occupational therapy in the developing world

Column Editor: Sandra Bressler

Ruth Duggan, Jolyane Aube, Lyndsey Clark, Liz McDonnell and Colleen O'Connell

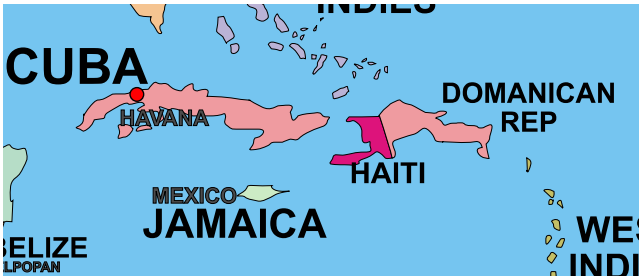
Team Canada Healing Hands

Occupational therapists have offered services beyond traditional borders for some time (Kronenberg, Simo Algado, & Pollard, 2005). By demonstrating the value of occupational therapy in unique settings, we grow as a profession, both in Canada and abroad. Since 2002, occupational therapists have joined Team Canada Healing Hands, a group of rehabilitation workers providing services in the developing country of Haiti. Team Canada sends two to three teams a year to Haiti for one to two weeks at a time (www.tchh.org) and is an affiliate of an international agency called Healing Hands for Haiti (http://www.healinghandsforhaiti.org). Typically, the rehabilitation team consists of occupational therapists, physicians, physiotherapists, speech language pathologists, psychologists, nurses, and a number of support workers totaling from 11 to 30 volunteers from across Canada. Of the four occupational therapists who are the authors of this article, two had worked with Team Canada several times before, and two were new to the team.

The mission of Team Canada Healing Hands is to provide inter-disciplinary rehabilitation treatment, education and training with the primary goal of developing sustainable rehabilitation resources in identified areas of need. Team Canada also strives to increase awareness and acceptance of disabilities while promoting the importance of rehabilitation in underdeveloped and developing regions.

Haiti

Haiti is a developing country that lies in the western one third of the island of Hispanola, sharing the island with the Dominican Republic. Haiti is the poorest country in the western hemisphere with a population of 9.6 million people. Haitians have a 53% literacy rate with an average life expectancy of 60 years and a per capita income of just over $1.25 a day. Historically, Haiti was a French colony, and is the only country in the world that has had a successful uprising of a slave population. The people of Haiti are hard working with a colorful culture, combining African and French traditions, with unique religion, music, theatre and arts. The languages are Haitian Creole and French. For most Haitians, living conditions are very basic, living in cramped shacks, built in the flatlands or on a mountainside, frequently with no access to running water. Their reliance on charcoal for cooking has resulted in extreme deforestation with the inevitable sequelae of soil erosion, reduction of arable land and an increase in devastating mudslides.



The country has had a long history of political insecurity, violence and natural disasters, which have resulted in minimal development of infrastructure, including sanitation, clean water, roads, employment, public education and health care. Team Canada Healing Hands was developed to respond to a need for rehabilitation education identified by Healing Hands for Haiti. Teams make one to two week missions to Haiti to provide focused rehabilitation assessment and training with local health professionals and caregivers. Occupational therapists are an integral part of this team, participating at all stages of the mission including assessment, planning, service provision, re-evaluation, and follow up.

The planning process

Assessment and planning begin well before the team's scheduled visit to Haiti. In order to identify the current rehabilitation needs, the leaders of Team Canada, which normally includes a physician, a nurse, and an occupational therapist, make contact with many other involved groups. The team's resources are then assessed and measured against the needs that have been identified. This allows us to work with our Haitian counterparts to develop a plan for the mission. The preplanning stage is crucial as it ensures that our team

> *"Unfortunately we cannot carry everything we would like to take, so we must, for example, prioritize which children have the greatest need for wheelchairs."*

'hits the ground running' by being equipped with the resources to meet identified needs so that our limited time and energy can be focused on providing education and services and not entirely on assessment and planning.

Preplanning allows our team to take specific rehabilitation equipment to individuals in Haiti who had previously been assessed. Unfortunately we cannot carry everything we would like to take, so we must, for example, prioritize which children have the greatest need for wheelchairs. The children's previous measurements and functional assessments are coupled with current photographs of the children beside a measuring stick (taken by caregivers). On one mission, the team was able to provide a young boy with hemiplegic cerebral palsy with a one-arm drive wheelchair and proper seating system that was donated by a medical supplier.

Providing services in Haiti is a continuous challenge. The difference in culture, and availability of material, human resources and infrastructure, challenges the team's flexibility, creativity and adaptability. As a result, each member of the team must individually identify the strengths and resources in themselves, prior to leaving and continuously while in Haiti.

Consultation and education

Team Canada Healing Hands works to empower local service providers to take responsibility for their own education by providing recommendations regarding learning objectives, educational resources, and encouragement to continue their independent studies. The goal is to have the local service providers teach each other their knowledge and skills in order to expand the community knowledge base. To assist with achieving this, our team provides education sessions tailored to the service providers' education level and language, the educational environment and the space allotment (clinic, formal teaching space or play room at an orphanage). Low-tech teaching aids are typically used due to the lack of electricity and technical resources.

Occupational therapists on this team have had diverse roles that allow us to provide successful transfer of knowledge in a variety of areas. Examples of our roles included:

- Facilitating education regarding relaxation techniques. A client who presented to a rehabilitation clinic with a "tremor", was assessed by the team to actually have issues with anxiety. The client was taught relaxation techniques by the occupational therapist and the local rehabilitation technician. The local treating technician was then provided with ideas on how to teach relaxation techniques to the other rehabilitation technicians.
- Providing education to orphanage workers on how to position, safely feed, stimulate, and promote interactive play among children with disabilities.
- Teaching caregivers how to take measurements for wheelchairs to streamline planning for equipment in the future.
- Teaching a therapy technician how to complete ROM to the hand, and how to modify pencils and utensils to promote fine motor skills and self-feeding.
- Along with a speech language pathologist and physical therapist, providing education to a group of 23 rehab technicians on dysphasia, basic positioning, burn management and taping for orthopedic injuries.
- Observing therapy technicians working in a clinic with their patients, answering questions when asked, and providing clinical education to further develop the technician's skills. For example, while working with a local rehabilitation technician and a young woman with a spinal injury, the occupational therapist was able to clarify the client's long term prognosis so that realistic therapy goals could be set and appropriate therapeutic activities were chosen to work towards the client's goals (e.g. improving sitting balance prior to addressing leg strength).
- Encouraging the therapy technicians to utilize textbook resources such as "Disabled Village Children" (Werner 1987), to assist with developing knowledge on areas such as building wheelchairs and other eating/cooking equipment.

Team Canada Healing Hands tries to teach the rehabilitation technicians and clients to use the materials they have on hand rather than provide them with pre-fabricated equipment that cannot easily be repaired and could end up discarded on the street, due

to the lack of infrastructure. Modifying tasks with local materials allows us to demonstrate to rehabilitation technicians how simple adaptations can make daily activities easier. This challenges us to return to the roots of occupational therapy and explore our creative side. For instance, a local carpenter was taught how to make adapted spoons and a cutting board with the available wood and cardboard. The staff at an orphanage was taught how to better position children for feeding by using their bodies, the sides of the bed and other readily accessible supports. This same group was encouraged to better utilize their current resources (three wheelchairs) by placing one wheelchair in each room and rotating the children sitting in the chair to allow for more children to have benefit from an upright position. Even if more chairs had been provided, there may not have been the staffing resources or the space to allow for every child to be placed in a chair at same time.

"With every mission, the team notices the difference that the education provided to the therapy technicians, caregivers, parents, and individuals, makes over time."

We also provide hands-on assessment of clients when there is not a rehabilitation service provider available to educate and assist with the process. In these circumstances, we provide suggestions and recommendations to other caregivers, for example teachers and parents, to better aid the clients in improving their function. The occupational therapists on this team were able to support ongoing rehabilitation in the following ways:

- In a school for children with disabilities, children with behavioral or sensory issues, developmental delays and neurological/physical impairments were assessed and their teachers were provided with written recommendations and environmental modifications.
- An administrator was encouraged to allocate resources for therapy by setting up an appropriate space for a therapy technician to work.
- A school program facilitator was provided with a simplified developmental scale for use by teachers and caregivers.
- Clients in a community stroke clinic were coached in order to increase their knowledge of their disability/condition and educate them on management and prevention.
- Consultation was provided regarding physical accessibility for wheelchair users.

The whole team is involved with ongoing assessment and follow-up to evaluate outcomes. This is continual and concurrent with our work while we are in Haiti. We make frequent contact with other NGOs, for example, Mediciens Sans Frontiers (http://www.msf.org), and with potential new service recipients such as orphanages or schools. We also receive feedback from the people we serve in order to find out about new agencies and programs that may have rehabilitation needs.

Making a difference

Occupational therapy services can easily be adapted to help meet the needs of people with physical disabilities in Haiti. With every mission, the team notices the difference that the education provided to the therapy technicians, caregivers, parents, and individuals, makes over time. Just as in any occupational therapy program we work with our "clients" to continually reassess and build on their strengths, using creativity and flexibility in the use of resources. The flexibility and creativity practiced in Haiti by the occupational therapists with Team Canada Healing Hands helps each of us to build skills that are transferred back to our work in Canada. In this way, our experiences in Haiti are not only helping the Haitian people, but also our clients at home.

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Update from the COTF

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- COTF Scholarship Competition: September 30
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For details and application forms, see the Opportunities for Researchers and Students section at www.cotf-canada.org. Please note that the information can be changed from time to time. For most update information, please contact COTF directly.

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