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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

Jonathan Rivero, BScOT, OT (c)

Family life: I was born and raised in Regina, Saskatchewan by my parents who immigrated from the Philippines in the early 1970's. I currently live in Edmonton, Alberta with my girlfriend Paula.

Education: I graduated from Dr. Martin Leboldus High School in 2000 and was honored by being the recipient of the Canada Millennium Leadership Scholarship. This allowed me to pursue post-secondary education at the University of Alberta. In May 2004, I graduated from the Faculty of Rehabilitation Medicine with a BScOT.

Career path as an occupational therapist:
Having grown up with a disabled father, I have come to fully understand the term "meaningful occupation". In 1984, my father was diagnosed with a brain tumor and was not expected to live longer than a year, yet lived for 17 more years of my life. My mother, who was a teacher in the Regina Catholic school system, became the sole breadwinner for our family and the one who taught my brother and I how to engage our father in meaningful activities at home such as martial arts, dance, and musical participation (activities that he enjoyed as an able-bodied person). Everyday after school, my brother and I would adapt and grade therapeutic activities to enable my father to participate in these occupations. As we were in school, he would either lie in bed, sleep, or depressively watch television, but as soon as we got home his mood and spirits were raised. My brother and I looked forward to spending this time with our father as it created a special bond between us all.

Over the years, my father's condition puzzled doctors, his tumor was still impacting his daily cognitive, affective, and motor functions yet he continued to enjoy life through adapted occupations. It was not until both my brother and I left home to pursue our post secondary educations that we understood the therapeutic power of "meaningful occupation" and the impact it had on my father's life. Shortly after I left for Edmonton, my father was admitted into a long-term care facility. During this time, my father shared with my mom that he felt as though he was ready to leave this world. He expressed that his role as a father was what gave meaning to his life and was what kept him alive for all those years.

"Meaningful occupation" is not simply a term that my family understood but rather lived by in order to cope with the struggles we encountered. All the after school martial arts sessions, tae kwon do tournaments, and organ competitions that my father helped us prepare for helped him feel valued as a father and a teacher.

I chose a career path in occupational therapy because it has been something I have understood my entire life and it is a profession that mirrors my own personal philosophy: live undeniably with passion and meaning and reap the benefits of unlimited potential (evidence of my dad's survival). As an occupational therapist for children with autism, I have gravitated towards helping children engage in therapeutic activities that incorporate martial arts, dance, and musical participation, all of which I learned from my father. I am able to mix my own 'leisure' passions with my therapeutic 'productivity' philosophy and have created a balance that sends my clinical energy levels through the roof. My job is food for my soul.

Some current roles;
Qi Creative Consulting
Occupational Therapist (Owner)
Centre for Autism Services Alberta
Program Leader- Occupational Therapy Department
Young Master Club: Self-Regulation and Adapted Tae Kwon Do Creator/Instructor
Occupational therapy group designed to teach families with autism spectrum disorder socially appropriate self-regulation skills through adapted tae kwon do, yoga, and sensory integration strategies.

Other volunteer work:
Balikbayan Project
Founder/Program Leader
International development program that travels to the Philippines to increase the quality of life of underprivileged urban youth.

Global Youth Assembly 2007-2009: Ignite Now and Change
Keynote Motivational Speaker/Facilitator/Executive Committee Member
Bringing youth between the ages of 16-28 together from diverse geographical and personal backgrounds

to learn from each other and become part of a movement to advance peace and human rights.

No Sweat Fashion Showcase 2006-2009

Artistic Director/Choreographer/Playwright
Edmonton based talent show that raises money for international development charitable organizations and raises awareness with respect to global citizenship and the affects of consumerism and promotes fair-trade fashion.

Awards

Sunrise Therapist Award at the 2006 Alberta Rehabilitation Coordination Council (for innovations and creative contribution to the field of Rehab Medicine through therapy groups such as Young Master Club).

Other hobbies/interests:

- 3rd Dan Blackbelt with the World Tae Kwon Do Federation
- Sing in quartet male a cappella group
- Hip Hop choreographer and DJ
- International marathon charity runner: Calgary 2004, Rome 2005 (Team Diabetes Canada), Honolulu 2005 (Team Diabetes Canada), and Athens 2008 (Balikbayan Project)
- Spoken word artist/poet

If you would like to be profiled, or know someone who should be profiled, please contact the Managing Editor at otnow@caot.ca.

Column Editor: Heidi Cramm

Why urban design matters to occupational therapy

Susan Mulholland, Sherrill Johnson, Brian Ladd and Bonnie Klassen

The design of our cities can affect how we perform occupations. Some forms of urban design facilitate physically active forms of transportation such as walking, cycling, or wheelchair propulsion, whereas other forms encourage the use of a car. For example, think about how you get to work. Do you drive, walk, ride a bicycle or take public transport? Now think about why you choose this form of transport.

The purpose of this article is to outline current research linking urban design to active living and health outcomes and to examine why this matters to occupational therapists. The conclusion outlines some practical suggestions for those interested in this topic and identifies a potential role for occupational therapists in advocacy for health-promoting urban design.

Linking the built environment with health is relatively new; many different disciplines are starting to take interest and get involved, such as population health consultants, health promotion advocates, urban planners, exercise specialists, and policy makers. In order to work within this diversity, new terminology needs to be defined and understood. The *built environment* refers to everything that humans construct on, in, and over the earth. This is an altered definition to what we often refer to as the *physical environment* in the Canadian Model of Occupational Performance (Townsend & Polatajko, 2007).

Active transport is any non-motorized form of movement used to get to a particular destination such as school or work and includes walking, running, cycling, in-line skating, self-propelling a wheelchair, and, less commonly, skiing, ice skating or kayaking. Walking and cycling are by far the most common modes (Statistics Canada, 2006). Active transport may also be combined with other modes such as walking to catch a bus. However movement done solely for leisure, such as biking, walking or running for exercise or recreation purposes are not considered as active transport. *Land-use planning* includes all factors that affect how land is used, including zoning, land ownership, infrastructure, economic growth policies/practices, and demand for different land uses including transportation.

Urban sprawl can be described as the outward growth of low-density neighbourhoods at the edge of urban areas with a strong reliance on cars for transportation.

Linking urban design and health

Land-use planning that emphasizes urban sprawl and transportation infrastructure (such as highways) engineered for motor vehicle travel only biases culture away from active transport (Turcotte, 2008). It is important for occupational therapists to be aware that there is growing evidence of the connection between land-use planning and health, particularly related to physical activity, injury and death from motor vehicle crashes, respiratory and cardiovascular conditions, and mental health issues.

Physical inactivity increases risk for almost all chronic conditions (e.g., heart disease and stroke, obesity, diabetes) as well as contributing to the severity of these conditions once they have developed. About 50% of Canadians are not physically active enough to obtain health benefits (Canadian Fitness and Lifestyle Research Institute, 2005). Land-use planning, transportation infrastructure, and building design that support sedentary modes of transport reduce opportunities for incorporating physical activity into daily life. For example, when the grocery store is too far to walk to, or there are no sidewalks, many people would choose to drive.

Motor vehicle use itself is a risky activity. In Canada motor vehicle crashes and collisions kill and cause debilitating injury in about 3,000 and 15,000 people respectively each year (Transport Canada, 2006). Again, land-use planning biased towards car transport increases exposure.

Fine particulate matter and other traffic related pollutants are implicated in many respiratory and cardiovascular conditions, and there is evidence that living in

About the author –

Susan Mulholland, MSc, BScOT, works at the University of Alberta and has a long standing personal and professional interest in the interaction between urban design and health. She is an avid cyclist and hiker who believes in "walking the talk"! Susan can be reached at Susan.mulholland@ualberta.ca.

Sherrill Johnson, PhD, is a population health consultant with Alberta Health Services in Edmonton, Alberta. Her academic training is in the areas of geography and environmental studies. She has a long-standing interest in the influence of urban design on health behaviours, and in fostering connections between health professionals and urban planners.

Brian Ladd, MSc, is an epidemiologist working with Alberta Health Services in Edmonton, Alberta. He is interested in the relationship between community design, social environments, and health, and also in public health theory and ethics. Brian is fortunate to live close enough to work that he can bike or walk.

Bonnie Klassen, MSc(OT), is an occupational therapist in Camrose, Alberta. She works in Home Care, Community Rehabilitation Program and the Chronic Pain Program.

close proximity to major roadways increases risk, especially in children (Krzyzanowski, 2005; Janssen et. al., 2003).

There are growing concerns regarding possible correlations between urban sprawl and mental health. For example, there is some evidence indicating that time spent commuting by car is time not spent with others or in physically active transport; lack of amenities within walking distance increases time pressures; and loss of green space makes it difficult for children to appreciate and enjoy nature (Louv, 2005).

Increasing active transport

Active transport is affected by two primary domains of the built environment: land-use planning and building design.

When considering land-use planning, a number of features can be designed into the built environment that factor into an individual's choice to use active transport in order to perform work, leisure or self-care activities. How well roads and paths are linked to a neighbourhood with a mixture of buildings such as houses, stores, parks, schools (mixed land-use), and moderate to high population density all contribute to increases in levels of active transportation. Other factors include: perceived safety, the proximity of desirable destinations such as stores, schools, restaurants, and the presence and condition of sidewalks. Cultural and social motivators also need to be considered such as the perception that others are using active modes of transport or that active transport is a socially acceptable and positive trend.

In contrast, people tend to choose active transport less when areas have curved street patterns (e.g., cul-de-sacs) with long blocks, neighbourhoods are predominantly comprised of single-family dwellings, there is a low population density (http://www.vtpi.org/tdm/tdm116.htm), and there is a lack of desirable destinations such as stores or parks.

While many research questions remain about the association between building design and active transport, some features are intuitively known to help stimulate more physically active options. Buildings with bicycle racks, lockers and showers facilitate active commuting. Stairs that are well lit in easy to find locations feel safe and encourage walking, as opposed to taking the elevator. Buildings that have applied concepts of universal design ensure that people regardless of abilities and age have choices that allow them equal access to space and services. Ramps ensure that wheelchair users, parents pushing children in regular or running strollers, and those using walkers and so forth can access a building.

Implications for occupational therapists

It is important for occupational therapists to make the connection between urban design and health for three reasons.

First, occupational therapists may work with clients who have diagnoses directly related to car dominant environments. For example, motor vehicle crashes result in acquired brain and spinal cord injuries and obesity, respiratory and cardiovascular conditions, and mental health issues all have implications on an individual's ability to participate in life occupations. As professionals, it is our responsibility to continuously update our knowledge base related to research and newly identified factors impacting on health.

"Increased levels of physical activity can be beneficial for populations as small shifts in physical activity may have substantial health impacts through life."

Second, as we continue to develop as a profession we are gaining momentum within health promotion. Increased levels of physical activity can be beneficial for populations as small shifts in physical activity may have substantial health impacts through life. For those who are sedentary, one of the most promising ways to do this is by incorporating physical movement (e.g, active transport) to perform self-care, productivity and leisure activities. As occupational therapists, we need to question where occupations occur and how people get there. For example, where does Mrs. Wood (diabetic and heart and lung concerns) grocery shop? How far away is the store? And, how does she get there? Are there health benefits if she walks there and carries her groceries home? What would those benefits be?

Third, to promote healthy transport occupational

therapists have opportunities to strategically position themselves to influence change at systems, governmental or policy levels. Within Canada various municipal, regional, provincial and national land-use planning initiatives are starting to include health in their dialogue and professionals are being consulted for input. Occupational therapists bring a unique perspective to "the table" with strengths in activity analysis, holistic practice (particularly the interaction between people and environment), and concepts of universal design.

Examples of strategies for increasing active transport and how to incorporate these concepts into professional practice

- Set an example by walking/biking/running to work and take stairs whenever possible.
- Introduce concepts of active transport to clients.
- Know bike options, potential adaptations and funding for clients (e.g., tricycles, baskets for groceries etc.)
- Pursue research regarding the relationship between built environment, active transport, and occupation.
- Change the conversation... shift the focus towards fostering health promotion.
- Get involved in creating environments in which active transport is the easier choice because it is safer, cheaper, more convenient and fun.
- Get involved in local government and advocate for...
  - policies to ensure disability groups are included in land-use planning (e.g., multi-disabilities, wheelchair access)
  - accessible showers, change rooms and lockers in work sites
  - bylaws for clear sidewalks
  - more benches and washrooms along trails or in public areas
  - detailed path accessibility descriptions posted at the start so people can make informed route decisions
  - safe bike paths and sidewalks

Challenges for integration into practice

The study of the interaction between urban design/land-use planning, active transport and health is a relatively new field and the evidence is not yet clear. The health benefits from increased active transport (e.g., prevention of some chronic disease) may take years to manifest, and future health benefits are often discounted in the present. In reality, there are forces other than health concerns, especially short term economic interests, which powerfully shape the built environment. The relevance of active transport for rural environments also needs to be considered.

Case Study: A Place to Start

One rural setting has attempted to address inactivity and related health issues in its population by incorporating health promotion into routine rehabilitation practice.

In Camrose, Alberta, the Community Rehabilitation Program is based within a large recreation facility. The clinical services consent form includes the question "Are you currently making changes, or thinking of making changes in the following areas of behavior in order to improve your health: exercise, nutrition, weight management, alcohol use, tobacco use, stress management" (yes/no)?

When a new client indicates an intention to learn more or to make healthy lifestyle changes, the occupational or physical therapist provides health promotion materials related to the topic of interest. These materials are available from Health Canada, Alberta Centre for Active Aging, and other sources. In some cases, referrals to other services might be made to provide additional support.

Conclusion

We would like to leave you with this challenge. Ponder the information presented and see how you can incorporate these concepts into both your personal and professional life. We would be more than happy to hear your thoughts!

Selected Web resources

Walkability Audit: www.walkscore.com/

Walk 21 Conference Series: www.walk21.com

UBC Active Transportation Collaboratory: http://www.act-trans.ubc.ca

Transport Canada: http://www.tc.gc.ca/programs/environment/UTSP/activetransportation.htm

Public Health Agency of Canada (PHAC): http://www.phac-aspc.gc.ca/pau-uap/fitness/active_trans.htm

Acknowledgements

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Accessibility is the law: A review of environmental assessments to improve access

Jessica Malpage, Pei-En Shih and Lisa Klinger

Part one of two

Part one includes the descriptions and review of home assessments. Part two, coming in the May issue of OT Now, will include the descriptions and reviews of the public facility assessments.

Over the past few years, there has been increasing recognition that built environments can either limit or enable participation in home and community life, especially for someone with a disability. Canadian federal and provincial governments have responded with human rights laws forbidding discrimination based on mental or physical disability. In the province of Ontario, legislation was enacted in 2005 to eliminate barriers by 2025 (Government of Ontario, 2005); enforceable standards for the built environment, to which all sectors of the economy will have to comply, are currently being drafted. Organizations like the Canadian Centre for Policy Alternatives are pushing for measures to be enacted across Canada to ensure rights for persons with disabilities to participate fully in society, which will include reducing poverty and barriers to employment, equalizing access to transportation and electronic resources, and eliminating barriers in the built environment (Healy, 2008).

Although the experience of clients, who are experts in their own context, must lead the way, occupational therapists have a great deal of expertise to offer, particularly when they are able to combine their professional knowledge with good assessment tools. Assessments of the built environment can be purchased, but these may be expensive or time-consuming to obtain, whereas many assessments can be found online. We felt there would be value in systematically identifying and reviewing home assessments and public facility assessments that are available free of charge in the public domain.

The search

We conducted a comprehensive literature search using electronic bibliographic databases (Medline, Ei Compendex, CINAHL, PubMed, SCOPUS, and OTDBASE), Google® and Google Scholar® search engines, in combination with a review of relevant literature, consultation with authors of the assessments, clinical experts, and academics with expertise in the area, as well as searches within various association, public agency and government websites. Search terms included "(architectural) accessibility", "home assessment", "environmental assessment", "physical environment", "physical access", "occupational therapy", "community", "public building", "disability", "barrier-free design", and "universal design", individually and combined.

Literature on the assessments was located using titles of the assessments as keywords and the reference lists of all selected articles (Pai et al., 2004). Assessments were included if they evaluated the home or at least one kind of public facility, addressed physical attributes of the environment for accessibility, usability, and/or safety, provided sufficient instructions for administration, were published in English between 1994 and January 2008 and were available in the public domain.

Research articles were selected if they provided information (i.e. instrument development or reliability and validity testing) on any of the assessments that met the inclusion criteria. Applicable sections of the Outcome Measures Rating Form and Guidelines previously developed by Cooper, Letts, Rigby, Stewart, and Strong (2001; 2005) were used to organize information and evaluate each instrument. Information is organized into tables, using column headings and definitions according to the model developed by Law (1987; 2005).

One drawback was that few of the identified tools are standardized.. Another drawback of all the reviewed assessment tools was that none of the tools consider relative access, as discussed by Church and Marston (2003). These authors note that many built

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Jessica Malpage, BA(Kin), MSc(OT), OT Reg (Ont), CanTRA AI, is currently filling a maternity leave at Guelph General Hospital, and works on a casual basis in the motor vehicle claim field. She volunteers as a therapeutic horseback riding instructor in her spare time. She can be contacted at jessica.malpage@gmail.com.

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Lisa Klinger, BSc(OT), MSc, OT Reg (Ont), is a lecturer at the School of Occupational Therapy at the University of Western Ontario. She can be contacted at lklinger@uwo.ca

environments have absolute access (i.e. persons with disabilities can get in), but when access is, for example, through a back door that requires a roundabout route to reach or is hidden away in a non-descript part of the building, relative access is denied. Thus, the quality of access also needs to be considered.

Home Assessments

A search of databases did not locate any specific home assessments, but yielded six research papers naming two tools available on the internet. An additional ten tools were located on the web. Of these, eight were retained based on our inclusion criteria. Three were discarded because they provided no evaluation of whether modifications were necessary but simply listed potential modifications to make homes accessible or safe. A fourth, *The Enabler*, previously appraised by Cooper et al. (2005) and found acceptable, was also discarded because, while the assessment forms were available at no cost on-line, the manual needed to be purchased. See Table One for a description and evaluation of the eight included home assessments. Please note that recommendations may be found under both the Clinical Utility and Comments columns.

Conclusion

In light of legislative changes, many sectors of business and the economy are already considering ways to make environments fully accessible. For example, many municipalities, educational institutions, hospitals, government departments and large businesses have committees working on accessibility issues. Smaller

Table One: Description and evaluation of home assessments

Title, Year of Publication, and Author(s)	**Purpose**	**Type of Clients**	**Clinical Utility** (+) = positive attribute (-) = negative attribute	**Comments** (+) = positive attribute (-) = negative attribute
Comprehensive Assessment and Solution Process for Aging Residents (CASPAR) (2002) Assessment forms available online at: www.ecaspar.com/ehls/documents/caspar.pdf	• Assesses home accessibility • Client-directed assessment of high-priority problem areas in the home	• Originally designed to assess the homes of elderly individuals; can be used with any age group and diagnosis	+ Extensive detailed manual describing how to complete the assessment; short-form instructions also available on assessment forms + Allows clients to prioritize the rooms that need most attention + Includes functional assessment + In-depth evaluation, measurement and photography of the home + Potential to use results and pictures to consult with contractors and builders - Could be lengthy to complete - No indication how to use measurements obtained - Does not intuitively provide solutions for problem areas	+ Client centred + Detailed description and evaluation of the home Reliability and Validity: + Rate of correct problem identification (sensitivity + specificity)=96.4% which is significant at p=.000 (Sanford & Butterfield, 2005) + Inter-rater reliability=35 of 59 items had reliability of .80; validity= 85-98.5% based on comparison with on-site assessment by a clinical expert (Sanford, Pynoos, Tejral, & Browne, 2002).
Easy Access Housing: A Safe Home is no Accident: A Checklist for your Family (2005) Available online at: www.easterseals.com/site/PageServer?pagename=ntlc_easyaccesshousing_tips_checklist_print	• Assesses home safety and hazards	• Not specified	+ No manual; intuitive to use + Client-completed questionnaire + Allows clients to identify areas of safety concern + Short general overview of measures to ensure a safe home - No disability specific considerations - Limited list of safety recommendations	- Very basic - Strict focus on safety - No assessment of accessibility or usability

Title, Year of Publication, and Author(s)	**Purpose**	**Type of Clients**	**Clinical Utility** (+) = positive attribute (-) = negative attribute	**Comments** (+) = positive attribute (-) = negative attribute
Gerontological Environmental Modifications (GEM): Environmental Assessment - Apartment Safety & Design (2005) AND Environmental Assessment - Studio Apartment (n.d.) Available online at: www.cornellaging.org/gem/enviro_assessment.pdf OR www.cornellaging.org/gem/enviro_studio_assessment.pdf	• Evaluates safety and accessibility of an apartment • Some assessment of usability of the home • Indirect measurement of client's mobility and ability to carry out basic self-care tasks	• Designed for a geriatric population, but could be used with any disability	+ No manual, but easy and intuitive to use + Easy administration and interpretation, no scoring + Observation, client demonstration and client interview + Addresses usability by evaluating mobility in the home, ability to complete some transfers, and self-care tasks + Allows clients to identify areas that are functionally limiting or are safety concerns + No examiner qualifications required + Does a good job of providing recommendations and suggestions for modifications to address each problem area	+ Developed based on geriatric research and experience of the author, in consultation with occupational therapists and review of literature (personal communication: Rosemary Bakker, April 11th, 2008) - Lacks evaluation of important elements such as entrances to the apartment building, laundry area, parking spaces/ garage, and environmental controls (eg: television and thermostat)
Home Assessment Form (HAF) (2008) Available online at: http://lifecenter.ric.org/content/2288/index.html?topic=6&subtopic=211	• Assists in making recommendations for home modifications • Measurements of commonly used areas of the home; layouts of the home; evaluates accessibility	• Not specified	- No instructions available - Requires measuring tape and pencils for sketching - Relatively short assessment form but lengthy to administer due to number of measurements - Difficult to interpret as no indication how to use measurements obtained - No recommendations generated from the assessment	+ Evaluates main areas of the home + Unique feature: includes an evaluation of the client's vehicle + Useful for recording and organizing measurements - Neglects certain areas of the home (eg: laundry room, garage and yard)
How Well Does Your Home Meet Your Needs? (1996) Available online at: http://www.kued.org/productions/caregiving/pdf/16-a%20How%20Well%20Your%20Home%20Meets%20Your%20Needs.pdf	• Identifies safety concerns or problem areas that decrease ability to live independently	•Geriatric population	+ No manual; meant for clients + Instructed to list daily activities/meaningful occupations and personal goals to determine a plan for modifying the home + Safety checklist provided + Checklist to be redone for every room - Would be better to list each room to ensure no room is overlooked	+ Provides a list of tips to improve safety in the home and decrease the risks of falls (following checklist). Greater focus on floor surfaces and electrical safety than other assessments - No specific instructions given for developing the modification plan

organizations will follow suit as legislative changes in Ontario take place and as barrier-free measures become more common across the country. This presents an opportunity for occupational therapists to become involved. It is hoped that the information contained in this article will assist therapists in using a systematic approach to evaluating environments and in educating clients in strategies to facilitate cost-effective and simple modifications both in the home and in public spaces. Occupational therapists may also be stimulated to participate in the development and standardization of future assessments.

Maintaining Seniors' Independence Through Home Adaptations: A Self-Assessment Guide (2003) Contact: Canada Mortgage and Housing Corporation Available online at: https://www03.cmhc-schl.gc.ca/b2c/b2c/init.do?language=en&shop=Z01EN&areaID=00000000017&productID=0000000017000000000013	• Evaluates home safety and accessibility Determines areas in need of adaptation or modification to improve or maintain independence in the home • Assessment questions emphasize usability of the environment	• Developed for a geriatric population, but could be useful for anyone with any disability	+ Client-centered assessment + Includes functional assessment - Does not explicitly evaluate living and dining rooms which may lead to clients overlooking these rooms	Reliability and Validity: + Inter-rater reliability = >80% for 30/72 items, and >60% for 42/72 items. + Content validity = excellent as tool was established based on review of literature and through consultation with seniors, architects and occupational therapists using group methodology and field-testing (Cooper et al., 2001).
A Modification Checklist: Accessibility Using RRAP for Persons with Disabilities Contact: Canada Mortgage and Housing Corporation Available online at: https://www03.cmhc-schl.gc.ca/b2c/b2c/init.do?language=en	• Prioritizes and discusses possible modifications that qualify for Residential Rehabilitation Assistance Program (RRAP) funding	• Anyone with a disability who qualifies for loans from the government of Canada to improve home accessibility	+ Self-administered checklist + Clear instructions + Short booklet about common accessibility problems and potential modifications + Administration and interpretation are easy -Requires careful consideration, insight, knowledge of fundable modifications and measurement skills to determine best adaptations;	+ Based on building codes/standards Requires measurements and dimensions + Client-centered because client identifying own needs and preferred modifications

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Column Editor: Sandra Bressler

Report on the World Federation of Occupational Therapists Council Meeting

Sandra Bressler

I had the privilege of attending my first World Federation of Occupational Therapists (WFOT) Council Meeting in Ljubljana, Slovenia, September 8th -12th, 2008 and a Focus Day preceding the meeting, with Sue Forwell, President of CAOT.

Focus Day

The Focus Day promoted long term planning and discussion amongst delegates to ensure that WFOT continues to meet the needs of its member associations and the occupational therapists they represent. Alana Officer, Coordinator, Disability and Rehabilitation from the World Health Organization (WHO), introduced the Council to the activity of the day. The activity began the process of developing a rehabilitation intervention matrix related initially to people with physical impairments, irrespective of cause or nature. The matrix includes:

- ICF components of body function and structure, activities and participation.
- Relevance to different time frames that are acute, post acute, maintenance or habilitation.
- Applicability to different care settings which could be tertiary, secondary, primary and include community and family.
- Emphasis on the need for continuum of care.
- Relevance to different contexts taking into consideration an individual's resources.

The plan is that the WHO will integrate the information we shared into the development of this matrix. It is also of note that this group was the first group to contribute to the matrix.

Highlights of the 28th Council Meeting

Position papers and statements were presented:

1. *Cultural Diversity and Occupational Therapy Position Paper* – a first draft was presented and member countries were invited to give feedback.
2. *Inclusive Occupational Therapy Education Position Paper* was approved. The authors are Sue Baptiste, Bonny Jung, Mary Tremblay, Penny Salvatori, all from the School of Rehabilitation Science at McMaster University,.
3. *Academic Credentials for Occupational Therapy Educators*- a draft was discussed and delegates were asked for feedback.
4. *Occupational Therapy Entry-Level Qualifications* was approved with corrections.
5. *Recruiting Occupational Therapists from International Communities* was approved.

A network was established for editors of occupational therapy journals to discuss impact factors for occupational therapy journals worldwide. It was felt that their mandate may go beyond impact factors and will be at the discretion of this network.

WFOT is working on the development of the profession in Egypt, Ghana and Mongolia by advocating for the development of education programs. The projects in each country are at different stages of development.

As was announced in to a CAOT news blast, Sharon Britnell, CAOT Vice-President Finance, was elected to the office of WFOT President. It is very exciting to have a Canadian President! It was also mentioned that Anne Carswell has completed 2 years of her term as Vice-President, also a Canadian!

It is expected that each Delegate assigns herself/himself to a project in a program area. I have joined the International Cooperation Program and am leading a Mentorship project. As well, I have been appointed Deputy Program Coordinator for this Program. I was also elected to the Nominations Committee.

Throughout the Council meeting, Sue and I felt the respect that WFOT countries and the Executive have for Canadian occupational therapists and the CAOT. Our contribution to the international community of occupational therapists is very well known and highly regarded.

About the author –
Sandra Bressler, MA, BSc(OT), is the WFOT Delegate representing the CAOT. Sandra is a Clinical Assistant Professor in the School of Rehabilitation Science, University of British Columbia and a Senior Consultant with Corpus Sanchez Inc.

Practice profile for support personnel in occupational therapy

Claudia von Zweck, PhD, OT Reg (Ont), OT(c) - CAOT Executive Director

CAOT is pleased to introduce the new *Practice Profile for Support Personnel in Occupational Therapy*. The development of this document is a culmination of work by CAOT over several years and provides an innovative vision for the knowledge, skills and abilities required by occupational therapy support personnel in Canada. A number of key features and assumptions guide this new document to ensure an occupational therapy workforce that is flexible and responsive to meet the needs of the Canadian public for our services.

Support personnel practice continuum

Support personnel in Canada are employed in Canada in many diverse practice contexts, with different expectations of roles and levels of competence. The new *Profile* recognizes the existence of this practice continuum. The continuum reflects the diversity of roles support personnel may play in the delivery of occupational therapy services, as well as the varying contexts and expectations of their practice.

Relationship of support personnel and occupational therapists

The *Profile* acknowledges the synergistic relationship between support personnel and occupational therapists in the delivery of occupational therapy services. Support personnel provide valued assistance to occupational therapists. Occupational therapists assign service components and supervise occupational therapy support personnel in their work. The work of support personnel therefore complements but does not replace the role of the occupational therapist. The CAOT *Guidelines for the Supervision of Assigned Occupational Therapy Service Components* (2007a) guide the assignment and supervisory functions of occupational therapists.

Support personnel roles

The *Profile* builds on previous work of CAOT that articulates the knowledge, skills and abilities of occupational therapists in relation to seven roles. Roles include acting as an expert in enabling occupation, professional, communicator, scholarly practitioner, collaborator, change agent and scholar (CAOT, 2007b). Support personnel competencies in the new *Profile* are depicted as subsets of these roles, as outlined in figure one. Required involvement and level of competence of support personnel in each role varies along the practice continuum, influenced by factors such as who the client is, where the work is being done, and what the client needs. Support personnel in occupational therapy may enter their career at any point in the support personnel continuum and may possess skills, knowledge and abilities along varying points of the continuum. Consistent with the Canadian Model of Client-Centred Enablement (Townsend & Polatajko, 2007), "expert in enabling occupation" is considered the central role, expertise, and competence of occupational therapy support personnel. Work in this core function is interconnected with all other roles, drawing upon required competencies in order to effectively use occupation as both a medium for action and an outcome for occupational therapy intervention.

Exemplar classifications of occupational therapy support personnel

Three exemplar classifications of support personnel are described within the practice continuum:

1. *Support personnel with basic competencies* demonstrate selected competencies to service specific populations, occupational performance issues, and practice contexts within occupational therapy prac-

Figure One:
Occupational Therapist and Occupational Therapy Support Personnel Practice Profile Continuum

tice. Support personnel in this group have typically received training on the job and work in one or two service areas.

2. *Support personnel with focused competencies* demonstrate similar occupational therapy competencies as described above, in addition to highly developed and complex competencies in a focused area of practice. Such support personnel have specialized competencies outside of occupational therapy that are specific to a practice context and may include skills and knowledge related to such domains as augmentative communication, carpentry, and seating. These competencies are depicted in figure one as an eighth role, the focused-skill specialist.
3. *Support personnel with broad-based competencies* demonstrate comprehensive competencies that facilitate providing service with ease and efficiency to various populations (ages/conditions) with a wide range of occupational performance issues within a variety of practice contexts. Support personnel in this group have acquired competencies through formal education and training.

Uses of the *Practice Profile for Support Personnel in Occupational Therapy*

The Profile was developed with the intent that it may be used as a basis for a qualifications recognition process for occupational therapy support personnel. It recognizes that occupational therapy support personnel are valued and needed at all levels of the practice continuum. The *Profile* therefore may be used as a tool to assist with recruitment, compensation and career planning to ensure the competencies of occupational therapy support personnel match requirements of a specific practice context. Determination of the competency level of support workers using the profile may also assist occupational therapists with appropriate assignment of service components. In assigning components of occupational therapy, occupational therapists have the responsibility to ensure that a support worker has the necessary knowledge, skills and abilities to competently carry out the task.

"The Profile *acknowledges the synergistic relationship between support personnel and occupational therapists in the delivery of occupational therapy services."*

In addition, the *Profile* may assist with workforce planning to ensure that occupational therapy services are carried out by practitioners at the appropriate knowledge and skill level. Lastly the *Profile* may assist with planning appropriate education for support personnel that meet workforce needs. CAOT will be working with the Accreditation Council for Canadian Physiotherapy Academic Programs to develop an accreditation process for support personnel in occupational therapy that reflects the vision and outcomes outlined in the *Profile*.

For more information about the *Profile* please check the CAOT website. The *Practice Profile for Support Personnel in Occupational Therapy* will be available on the web site for free download for CAOT members.

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Is there a generation gap in occupational therapy?

Mary Lou Boudreau

As occupational therapists, we acknowledge the sociological, historical and technological differences that shape our clients' values, and we honour them in our interventions. The same sociological, historical and technological trends that have occurred over the last 60 years for our clients have also shaped our professional values and expectations. Knowledge of the generational differences within the occupational therapy workforce can help us to understand and collaborate with our colleagues. The generations currently represented in the occupational therapy workforce include Traditionalists, Baby Boomers, Generation X and Millennials (see Table One).

This article describes the trends for the years when the generations were growing up, when values and standards were being established. It outlines the characteristics of each generation in terms of their values, preferred learning styles, workplace ethics and the impact these have on the workplace. As in any characterization of a group of people, there are individual variations.

Traditionalists (born before 1946)

World War II had just ended leaving a sense of optimism and hope (Hammill, 2005; Hart, 2006; Weston, 2001). Rules and expectations were clear and authority was respected. You could own a home and raise a family comfortably on one salary. Most people grew up with little ethnic diversity in their daily life. School discipline problems would be considered mild by today's standards. Traditionalists grew up doing math

by hand, writing longhand or using a typewriter. They had distinct role models like war heroes and political figures. This generation saw the beginning of television.

Traditionalists believe that hard work and sacrifice are rewarded. Obedience is valued over individualism. They are reluctant to criticize authority, and may be upset when younger people question decisions made by management. They grew up with human teachers, and prefer traditional classroom learning and presentations by experts. They are not comfortable with role play. To get information, they physically went to the library. Now they tend to pick up newspapers and magazines they trust, and watch network news with reliable and familiar anchors.

Traditionalists intended to work in big corporations for a lifetime. They expected to move up through hierarchical ranks and retire with a pension. Experi-

Table One: The Occupational Therapy Work Force

	Traditionalists	Baby Boomers	Generation X	Millennials
Born ...	Before 1946	1946-1960	1961-1978	Post 1978
Age in 2008...	62 and older	48 – 62	30-47	under 30
In the workforce in 2006...	2% (129)	34% (2,799)	59% (4,821)	4% (352)

[1]The Occupational Therapy Data Base collects demographic, geographic, education and employment information on occupational therapists who are registered with their provincial regulatory body prior to October 1 of a given registration year as well as members of the CAOT that are residing in the Yukon Territory, the Northwest Territories or Nunavut. Data from the 2006 Occupational Therapy Data Base do not include Quebec.

ence and seniority are important to them, and they expect to be rewarded for loyalty. Changing jobs holds a stigma because it indicates commitment problems. They are motivated by promotion, interacting with people up the hierarchy and with increased status.

Baby Boomers (born between 1947-1960)

This was the era of civil rights and anti-Vietnam demonstrations (Hamlin, 2006; Hammill, 2005; Hart, 2006; Weston, 2001). Watergate shook people's respect for political authority. They learned to challenge authority and not trust those in charge. They grew up thinking that they were special. If one's family was different, it was not acknowledged or was kept secret. This was the first generation to choose whether and when to have children. Children grew up with a large cohort and had to compete for everything. The Information Age was just beginning, with the introduction of calculators, automation and computers.

Baby boomers still held politicians and authority figures in esteem (e.g. Kennedy), although rebels and protesters were beginning to emerge as heroes. Popular television shows included The Donna Reed Show, Father Knows Best, Leave it to Beaver (with traditional families) and Gunsmoke (with distinct good guys & bad guys.) Baby Boomers were the "Me" generation. Because of their numbers, attention focused on them. They tend to be competitive, optimistic, driven and dedicated, with a sense they could change the world. This generation felt they could do it all – work, family, healthy living and keep a sense of idealism.

Baby boomers prefer interactive learning sessions more than lectures. They appreciate a variety of means of learning (books, videos, someone to answer questions). Like the generation before them, they grew up with human teachers and physically went to the library. To get information, they tend to pick up newspapers and magazines they trust, and watch network news with reliable and familiar anchors.

Baby boomers learned to be in touch with their feelings and focus on communication. They want lots of feedback and lots of documentation. They prefer face to face feedback. They selected their profession based not on salary but on the intent to make the world a better place.

Baby boomers inherited the model of working vertically - enter at the ground level and work your way up. They felt that changing jobs hinders your progress. They are motivated by recognition, being valued and appreciation.

Generation X (born between 1961-1978)

This was the first "latchkey" generation, with many growing up with both parents working (Hamlin, 2006; Hammill, 2005; Hamlin, 2006; Hart, 2006; Hart, 2006; Weston, 2001). There was a high divorce rate, with 40% of children coming from single parent homes (Weston, 2001). Children formed strong bonds with friends when family was not available. They learned to manage on their own and be an equal participant in family discussions. Friends and classmates began to be more ethnically diverse.

Generation X children watched their Baby Boomer parents work long hours and sacrifice their leisure time for work. They were born in the computer age, learning to use them from infancy. Generation X saw role models fall, and much of the mystique of movies and politics stripped away through media documentation and exposé. Popular television shows included All in the Family (dysfunctional families), One Day at a Time, Alice (single parent families), The Mary Tyler Moore Show (single working person) and The A team (hard to tell the good guys from the bad guys).

Generation X adults tend to be assertive, self directed, clever and resourceful. They are skeptical, having learned to put more faith in themselves and less in institutions that have failed them. They are true multi-taskers. They like to learn with CD-ROM, interactive video and internet resources. Role play is seen as opportunity to practice skills, get feedback and coaching on the spot. They can learn from the experience of others and appreciate shared stories of a manager's own shortcomings and learning experiences.

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They are highly selective and proactive in gathering information. This is the CNN generation, who want a continual flow of information updated often. They prefer to be given a task and left alone to figure out how to do it themselves. Generation X views all team members as equal, with the manager just filling a different role than the others. They feel that everyone should contribute to solving issues or problems. They want feedback that is direct and immediate.

Generation X wants to make money, but also to balance job satisfaction and quality of life. They entered the workforce when large corporations were downsizing. They expect to change jobs and move laterally. When they were growing up, there was a surge of success for people starting their own business and

becoming millionaires. They expect success at an early age. Their goal is to build a portable career – a resumé with a variety of experiences. They look for career stability rather than job stability.

Millennials (born after 1978)

They have been heavily programmed and structured most of their lives (Hamlin, 2006; Hammill, 2005; Raines, 2002; Hart, 2006). Some carried day-timers in primary grades. Millennials were affected by violence and terrorism such as the Columbine shootings and September 11th attacks. They grew up in a "no one left behind" philosophy with tolerance of multiple cultures, abilities and lifestyles. These are the children of "soccer moms" - parents who have been heavily involved in their children's lives. Technology is both a tool for work and a source of entertainment. Firemen, police and civic workers emerged as heroes following terror attacks and response to disasters. Popular television shows included Seinfeld, Friends (peer group as family) and The Nanny (child care issues).

Millennials are practical and techno-savvy. They are realistic about the challenges of modern life, and aware of threats of violence, illegal drugs, etc. They grew up with the internet, and expect many choices in everything they do. They also grew up in a computer gaming environment. They don't want to be shown how to do things; they just want to jump in and try it. They are used to dealing with simulated situations and environments. They live in a contradiction of spending time alone on computers, but being structured into group work in schools.

Millennials rarely get news from print. To them, television is a source of entertainment, not news. They prefer to communicate immediately through text message or instant message (IM). They are connected; they can spread the word to thousands with the click of a mouse. They are accustomed to giving feedback, and want feedback available whenever they want it, at the press of a button. This generation saw young entrepreneurs become millionaires, and expects more success at an early age. They have always multi-tasked and expect to be able to do more than one job at a time. For them, motivation comes from work that has meaning, achieving results and the opportunity to make tangible changes.

Implications for the workplace:

- Work values and motivation of the different generations has an impact on staff recruitment and retainment (Hart, 2006). Traditionalists and Baby Boomers will be more interested in security, recognition and the opportunity to make a difference in the world, Generation X in balance between work and home life and in portability of skills, while the Millennials will be drawn to positions where there are opportunities to learn a variety of skills and fill a variety of roles.
- Understand the preferences in communication styles, and be explicit in how you expect communication to occur within your workplace or team (Hamlin, 2006). (e.g. "I will check my e-mail at least twice a day to see if there are any questions.", or "I don't like e-mail. If you want me, call me.")
- When planning education sessions, keep the learning preferences of the generations in mind (Hamlin, 2006). To teach new technology, offer classes with a live instructor for Traditionalists and Baby Boomers, offer a variety of methods (CD-ROM, on-line instruction) for Generation X, and let the Millennials jump in and figure it out for themselves.
- Be sensitive to the emotional issues that might come up in teams (Pelletier, 2005). Be sure that the Traditionalists know that their experience and history are valued, the Baby Boomers know that their dedication and hard work are making a difference, Generation X know that their skills and knowledge are helping to reach goals and Millennials know that their comfort with technology is valued and that they are learning new and valuable skills.

This information was presented as a poster at Exploring the Frontiers of Occupation, the CAOT Conference held in Whitehorse, Yukon in June, 2008.

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CAOT introduces ... "You, Me & My OT"

Janet Craik and Claudia von Zweck

Emma wants to be an astronaut. She also has a disability. That's no problem because Emma and Katie, her occupational therapist, make a plan so that Emma can blast off with the rest of her class (Bourgeois, in press).

In June 2009 CAOT will be blasting off and celebrating the launch of our newest publication entitled, *"You, Me & My OT"* written by Paulette Bourgeois and illustrated by Kristi Bridgeman. Paulette was educated as an occupational therapist at the University of Western Ontario and is the author of the renowned *Franklin the Turtle* series. This publication is one of many CAOT initiatives directed towards promoting the profession of occupational therapy.

This CAOT project began with a campaign to recruit young people to the occupational therapy profession in response to shortages of occupational therapists across Canada. Access to occupational therapy services is currently limited by the supply of occupational therapists in Canada. Because of the need for occupational therapists, a number of provinces have expanded existing education programs or have created new programs.

As part of our recruitment campaign, CAOT surveyed occupational therapy university education programs, professional associations as well as school guidance counselors regarding career recruitment initiatives. We determined that secondary and post-secondary students most frequently search for career information on the internet and therefore comprehensive career information was created and posted on our web site (see http://www.caot.ca/default.asp?ChangeID=278&pageID=285) However, the development of a children's story book was also frequently identified as a needed resource to introduce the role of occupational therapists to younger children in the primary or intermediate school age group. Our research informants suggested that role models introduced to individuals early in life in children's literature influence later career choices. This new publication was therefore initiated in order to introduce young people to the occupational therapy profession as an important health care service and as a possible career choice.

Work began in March 2007, for the creation of a 32 page, full colour, soft cover book that tells the story of Emma, a feisty young girl with cerebral palsy who participates in everyday classroom occupations with the help of her occupational therapist Katie. This book is targeted towards an audience of children in grades 1-3 as well as their parents, teachers and other caregivers. The book was researched and written by Paulette with the assistance of consulting occupational therapist Shone Joos. Kristi Bridgeman was contracted to create brightly coloured illustrations that bring Emma, her classmates and Katie her occupational therapist to life. Advisory assistance for the illustrations was provided by occupational therapists Shone Joos, Margit Sampogna and Kathy van Benthem.

A public book launch is scheduled for Saturday June 6, 2008 from 1-3pm in Ottawa. The launch will be hosted by Kaleidoscope Kids' Books, an independent children's bookstore with 3 owners, one of whom also works as an occupational therapist. Author Paulette Bourgeois will be in attendance to do a reading and book signing. Paulette will also be delivering the plenary address Saturday morning at the CAOT conference. Books will be available for sale ($5.95 CAOT members/$6.95 nonmembers) in French and English at the CAOT booth at conference, at the Kaleidoscope Kids' Books launch and after June 8, 2009 through CAOT's online store. Free promotional copies of the publication will be sent to libraries and school boards across Canada. CAOT would like to thank Paulette and the many other volunteers involved in this project for their donation of time and effort for this exciting project.

ABCs of CTCs: An introduction to Commitments to Change

Mandy Lowe, Debbie Hebert and Susan Rappolt

Have you ever left a conference or other educational event with great plans for implementing your new learning and become discouraged as your plans don't come to fruition? Have you struggled to provide evidence of how you have translated your learning from a course or reading a journal article into practice? Have you delivered educational sessions and wondered if it was going to make any difference in your audience's practice?

Ensuring translation of knowledge/skill to practice is often understood as an effortful and reflective process – a process that has been encouraged by regulatory bodies when we set forth goals and strategies to improve our practices. Moving new learning to practice often requires one to reflect on how this knowledge/skill applies to one's current situation. Part of this reflection may result in the determination of the value of making this change with respect to expected outcomes. If the value can be seen, then one ought to commit to that change, think about how to carry it out, enact the change and evaluate it. It is therefore no surprise that this effortful process is often reserved for only the most personally relevant and timely educational events. As both educators and learners, we are eager to find tools which can facilitate this implementation of learning into practice and measure it. Commitments to change (CTCs) (Mazmanian & Mazmanian, 1999) hold promise for both educators and learners as they provide the opportunity to document, track, and facilitate the implementation of learning into practice. CTCs also hold value for educators who are challenged to provide evidence of learners' implementation across practice settings that are diverse and unique to each therapist.

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How are CTCs used?

CTCs are generally utilized after an educational event (Wakefield, 2004) but their use has been demonstrated for other forms of learning such as journal article reading (Cole & Glass, 2004; Neill et al., 2001). In completing CTCs, participants are asked to first identify between 1-5 possible changes based on the education event. They are then asked to indicate a level of commitment to the change utilizing a Likert scale ranging from 1-5. Thirty to 45 days later, the participant is reminded of the commitments by providing her/him with a list of these changes. The person is asked to indicate if a change occurred or only partially occurred. If it did not occur, s/he is asked to explain why.

These three steps seem to work for several reasons. Timing of the administration of the tool immediately after the learning gives the participant an opportunity to reflect on what salient pieces of information might be useful to put into practice. It is thought to provide an opportunity to extract meaning in a personalized fashion from education material. Rating the level of commitment is a mechanism to reflect on how strongly one feels the goal should be actualized and may also be a form of prioritization. The follow-up sets up a sense of accountability. This fairly simple tool seems to both enhance the reflection process (Mazmanian et al., 2001; Lockyer et al., 2001; 2005) and give reason to see these goals through.

The history of CTCs

CTCs have been largely examined in the medical literature and are based on self-reported change. Rates of compliance to CTCs are usually between 47 – 87% (Wakefield, 2004). In one instance the use of the CTCs has been shown to relate to actual changes in practice for prescription behavior in physicians (Wakefield et al., 2003). The types of commitments that are more likely to be achieved are those which are relatively easy to do and those which individuals feel they have control over (Fidler et al., 1999, Haberman et al, 2002, Lockyer et al. 2001). The greater the presence of envi-

ronmental constraints, the less likely the individual will be able to follow through on the CTCs (Parochka, 2001). Despite the promise of CTCs and successes in their use for other health care professions, CTCs have not been used widely in occupational therapy. The authors therefore sought opportunities to explore the use of CTCs through research projects and informal experiences.

CTCs and occupational therapy

In one study (Lowe, Rappolt, Jaglal, & Macdonald, 2007), occupational therapists completed CTCs after a short continuing education course and reported progress made towards CTCs (either full or partial achievement) on 75% of all CTCs set, similar to other reported rates of compliance. In follow-up interviews and surveys, study participants reported that CTCs prompted them to reflect on the course material. However, there appeared to be a differential effect of CTCs as some participants indicated that CTCs prompted them to reflect and make practice changes that they may otherwise not have made whereas others reported that CTCs made no difference to their usual practices (they would have reflected on the course material and subsequently made changes in their practices without CTC use). All participants indicated they would be supportive of using CTCs again in the future.

CTC use was further explored through continuing education short courses and workshops. Although participants informally reported that they made changes in practice beyond what they may have achieved without CTC use, the key elements of successful CTC use remained unclear. As the literature speaks to the role of CTCs in promoting reflection (Mazmanian et al., 2001; Lockyer et al., 2001; 2005), the authors wondered if reflection alone at the end of the course or workshop itself was sufficient to promote practice change or if CTCs were required. Therefore, the purpose of a recent study by Hebert, Lowe and Rappolt (in preparation for press) was to examine the effect of the use of CTC statements, coupled with post workshop follow-up, on sustained integration of new learning from the workshop into practice in comparison to reflection alone. In this study, half of the participants completed CTCs and the other half were prompted to reflect on the workshop itself using the Critical Incident Questionnaire (CIQ) (Brookfield, 1998). Two months post workshop, there was a small difference in favour of the CTC group for achieving practice change, that is 67% of the individuals who used CTCs made changes in practice whereas 50% of the CIQ group reported making changes. CTC follow through was also analyzed to determine the existence of patterns; participants reported no progress regarding CTC statements which were vague or unmeasurable. Despite the strengths of the methodology, the small sample of this study limits the conclusions that can be drawn and further study appears warranted.

The overall effectiveness of CTCs as a tool to promote the integration of new learning into clinical practices is still under study, but there is some evidence to suggest that CTCs increase practitioners' chances of making positive practice changes after they gain new knowledge. Clinicians' use of CTCs or similar tools, along with their professional development objectives and specific continuing education goals, could stimulate more active listening to, or reading of new information. Complementary use of peer consultations and case studies may also assist therapists to implement learning in practice (Craik & Rappolt, 2006). Following or even during an educational workshop, participating therapists can ask "How can I use this new knowledge?" and "Where does this information apply in my practice?" Practitioners could also consider writing specific objectives for applying new knowledge to address their pressing needs using the CTC format (refer to Figure 1). CTC follow through may be further enhanced through: incorporation of timelines for achievement of commitments; checking in with colleagues to discuss progress toward meeting commitments; and involvement in a study group or an on-line professional support network that provides peers with common goals and opportunities for mutual encouragement (Egan et al., 2004).

Educators teaching theory or skills in clinical, community, or academic settings may enhance their entry-level or post-grad students' retention and application of material from their courses by building program objectives, structures and time allotments for students to develop indicators for their CTCs. Consider incorporating CTCs or other mechanisms to facilitate students' reflection and transfer of learning to practice as a standard component of your course development and evaluation processes.

The authors look forward to hearing about your experiences in using or promoting practice changes following educational programming using CTCs or similar tools. Use the blank CTC form (Figure 1) to formulate your own commitments to improving your practice with new learning. We welcome the opportunity to communicate with other practitioners, educators and researchers who are interested in collaborating on studies to evaluate mechanisms to facilitate practice changes following educational programming.

Figure 1: Commitment to Change Statements (adapted from Mazmanian et al., 1998)

In considering this learning activity (e.g. attending a course, reading an article), please specify one or more changes you intend to make below. Record as many as are appropriate for you. Please ensure that they could be completed in the next one to two months.

I commit to complete the following in the next 2 months:

Commitment to Change Statement 1:

_____

_____

_____

How committed to making the above change are you? (Please circle a number)

1	2	3	4	5
Lowest level of commitment				Highest level of commitment

Commitment to Change Statement 2:

_____

_____

_____

How committed to making the above change are you? (Please circle a number)

1	2	3	4	5
Lowest level of commitment				Highest level of commitment

Commitment to Change Statement 3:

_____

_____

_____

How committed to making the above change are you? (Please circle a number)

1	2	3	4	5
Lowest level of commitment				Highest level of commitment

Please keep this form for your records and record a follow up date for yourself in order to keep you on track. You may also want to share your commitments with a colleague now and in 2 months time in order to enhance accountability.

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An inspiring 25+ years of international occupational therapy fieldwork

Column Editor: Sue Baptiste

Laura Van Iterson

I dreamed of doing an international occupational therapy placement even before I got accepted into occupational therapy school. I knew where I wanted to go: France! My dream came true, my final fieldwork was in a suburb of Paris at a psychiatric facility in 2001. I had to first get used to kissing my colleagues on both cheeks when I arrived in the morning (weird), then I had to develop a tolerance for second-hand smoke (yuck), and get in the habit of drinking very strong coffee with my colleagues (addictive). I gradually settled in and learned how Canada and France had different perspectives on mental illnesses and their treatment, as well as divergent views on the role of occupational therapy in mental health. I gave talks to the French hospital staff about occupational therapy in Canada and mental health services in Canada, and was surprised at how shockingly "anglo-saxon" it was all perceived to be by my audience. Overall, I really enjoyed the experience and vowed to keep in touch with my supervisor and occupational therapy colleagues in la région Parisienne.

In 2003, two years after I graduated, I moved to Paris when my husband's job transferred us there. My French placement experience and contacts served as a great starting point for occupational therapy involvement in my new home. I began participating on an occupational therapy research team in Paris, and giving more lectures about Canadian occupational therapy at schools of occupational therapy in suburban Paris and Bordeaux. In 2006, I found myself presenting at an international occupational therapy conference near sunny Montpellier, France, about OTDBASE (http://www.otdbase.org), a Canadian occupational therapy search engine that had been indispensable to my French research team. In the audience were people I had met during my initial fieldwork in France. Faces I had first laid eyes on when I was a student arriving abroad full of nerves and excitement, were now familiar and friendly. After my presentation about OTDBASE, the audience insisted that the French occupational therapy association, Association Nationale Française des Ergothérapeutes, subscribe to the tool for all of its members.

I then e-mailed the inventor and manager of OTDBASE, Marilyn Ernest Conibear, in Vancouver. Marilyn mentioned that she was busy creating bursaries for students who did overseas fieldwork, explaining that it was something she had helped to initiate in Canada. Marilyn recalled that in 1983, she had agreed to send a student to Australia, despite some reservations from colleagues about whether a placement outside Canada should count. This was the first Canadian occupational therapy student to do fieldwork abroad. When Marilyn agreed to allow the student to do a placement in Australia, she did what fieldwork coordinators still do today, she based her decision on her knowledge of the student's personal and academic skills:

> "Going abroad means entering a different society and culture than the one in which you have been raised. Culture shock actually exists - and the student could spend her whole time just 'surviving' - instead of reasonably quickly fitting in, being open to learning quickly from 'locals' - and then thinking and contributing to that situation without having the old contacts to lean on. You have to be a pretty independent type of personality (M.E. Conibear, personal communication)."
>
> Fieldwork coordinators are careful when deciding which students will do overseas fieldwork, applying indicators such as a determined minimum GPA level, a minimal predetermined grade on prior fieldwork as well as proven strong interpersonal skills and judgement.

My overseas placement was such an important experience for me that I was interested to know how international fieldwork began. To round out my knowledge, I explored and learned that Canadian students have been placed in 53 countries since the first placement overseas occurred over 25 years ago. Just take a look at the accompanying map - inspiring! (see Figure One)

After more than twenty-five years of international fieldwork experiences by Canadian occupational therapy students, it is important to recognize the effort and generosity of the preceptors who assumed supervision responsibility for those students. Iain Barclay, an occupational

About the author – **Laura Van Iterson, BA, BSc(OT)**, returned home to Ottawa from France in 2006. She would be happy to hear from you to share her contacts and experiences from doing occupational therapy fieldwork research, and teaching in France. She is currently home-based as a full-time mother. Laura may be contacted at laura_vani@hotmail.com

Figure One: International occupational therapy placement locations

therapist in Levern Valley, Scotland, expressed having been nervous beforehand:

> "Taking a Canadian student did seem a bit daunting for a couple of reasons. The first being the reputation Canadian occupational therapists have with regard to very high academic standards. I did have a worry that I would be asked some awkward questions that I wouldn't be able to answer. The second concern was the student's place of learning being so far away... what to do if there was a problem on the placement which I've always found is best solved with actual meetings with academic staff (Barcley, 2007)."

He described why thoughtful selection of students is important, stating that the key to the placement's success was the student, citing social and cultural adaptability. "Terri Malchow, my student, was excellent. She settled into the team really well and was soon fluent in the Glaswegian accent (Barcley, 2007)!"

Learning to see similarities in occupational therapy practice around the world is something Marilyn Conibear sees as being one of the main benefits of an occupational therapy placement abroad. "It gives the student an opportunity to actually see how basic occupational therapy principles apply anywhere - even if they have to be adapted to fit a different social/cultural situation. And it makes them think what to adapt and how to adapt given the circumstances. Problem-solving in action in real life (M.E. Conibear, personal communication)."

Terri Malchow, of McMaster class of 2007, echoed these ideas in her description of her placement experience. "It was great to see some similar assessments and theories being used as sometimes you begin to question if occupational therapists elsewhere in the world are practicing the same as we do in Canada. From what I can tell from my visit here (to Levern Valley, Scotland), it is very similar." She also gave credit to a friendly environment. "The entire team made me feel welcome," helping her get the most of out of her placement: "Beyond developing my skills as a future occupational therapist, I think I have also really grown as a person. I have gained a great deal of confidence in my ability to step outside of my comfort zone (Malchow, 2007)."

Students at the University of Western Ontario (UWO) who went abroad for fieldwork reported their experiences and concurred with Terri's sentiments about doing international fieldwork. Specifically, UWO students appreciated international fieldwork as a way to experience occupational therapy in different cultures and contexts, and as an opportunity for personal growth: "I think it is healthy for people to travel abroad. I think it broadens who you are, allows you to see things. It opens your eyes (Ewert & Knight, 2007, pg 3)!"

Remember how international fieldwork was once a notion that was met with reservations in the occupational therapy community? Today grants and bursaries for students going abroad are on the rise, as well as research dollars to investigate the challenges involved in such fieldwork. Marilyn Conibear is drawing from funds earned through OTDBASE to support international fieldwork. She has maintained her convictions about the value to the students and the profession of distant fieldwork placements, believing that "the world is one country, and mankind its citizens (M.E. Conibear, personal communication)."

What is the impact of over a quarter century of overseas placements? Anecdotal evidence suggests that many placements lead to further international occupational therapy collaboration. For example, as soon as the first Canadian occupational therapy student to go overseas returned from her placement, several Australians came to Canada to do placements here. The ripple effect of all of that far-away fieldwork has surely enriched and connected occupational therapists from all over the world, long after the students have returned home.

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CAOT Position Statement: Universal design and occupational therapy

Universal design creates environments, materials and tools that provide accessibility, adaptability, ease of use, and safety. Occupational therapists have the knowledge and skills to be experts in universal design. Universal design contributes to health and well-being by enabling engagement in self-care, productivity and leisure. Occupational therapy in Canada is based on a model of practice that recognizes the interaction between occupation and the social, cultural, physical and institutional environment.

CAOT Initiatives

To promote occupational therapy in universal design, CAOT will:

1. Work in collaboration with stakeholders such as national and regional jurisdictions, professional associations, health and human service organizations and communities to promote implementation and evaluation of universal design principles for built environments, materials and tools.
2. Promote the understanding of the relationship between engagement in healthy and accessible environments, occupational engagement and health and well-being.
3. Provide continuing professional education and practice resources to support occupational therapists understanding and use of universal design principles.
4. Provide evidence-based universal design resources to consumers for the promotion of occupational engagement.
5. Support collaborative research to promote universal design for occupational engagement.

Recommendations for occupational therapists:

1. Interdisciplinary research be undertaken to understand the relationship between health and the environment including investigating how environmental factors contribute to occupational engagement.
2. Occupational therapists develop partnerships with consumers and stakeholders to promote universal design principles for built environments, materials and tools in order to support occupational engagement.
3. Occupational therapists advocate for universal design principles to decision makers through representation on appropriate committees in governments, associations and organizations.
4. Occupational therapists educate others in their community about the principles and benefits of universal design on occupational engagement.

Background

1. The built environment, including "homes, schools, workplaces, parks, business areas and roads", is an important determinant of health and can influence our physical and psychological well-being (Health Canada, 1999, p. 104). Housing and health are closely related; they have a major impact on quality of life, particularly for older adults and persons with disabilities (Levesque, 2002).
2. Occupational therapists believe that the performance, organization, choice and satisfaction in occupations are determined by the relationship between persons and their environment (Canadian Association of Occupational Therapists, 2002). The Canadian Model of Occupational Performance and Engagement (Townsend & Polatajko, 2007) defines the environment as having cultural, institutional, physical and social elements that can enable or constrain occupational performance. Occupational therapists have the knowledge and skills to identify factors that allow people to engage in daily activities and the means to assist people in removing barriers to participation (Baum & Law, 1998). Occupational therapists may utilize key enablement skills such as adapt, advocate, coach, collaborate, consult, coordinate, design/build, educate, engage and specialize(Townsend & Polatajko, 2007) to ensure principles of universal design are implemented to enable occupational engagement of our clients.

Occupational therapists work with clients who are individuals, families, groups, communities, organizations or populations (Townsend & Polatajko, 2007). *The Profile of Occupational Therapy Practice in Canada* (Canadian Association of Occupational Therapists, 2007) outlines that occupational thera-

pists use knowledge of occupation, occupational engagement, and other appropriate processes and interventions of enablement in the evidence-based provision of client centred services that are current, ethical and are uniquely designed, and flexible to respond to changing conditions in the occupations, persons, and environments of the client, service providers, and service systems.

3. Most typically, occupational therapists perform home, school and work site visits, recommend modifications, assistive technology, and ergonomic tools and materials, to enable clients to engage in meaningful and cultural relevant occupations in their chosen environments.
4. Universal design is a concept that can support the occupational performance of many persons regardless of ability level and age. Universal design principles guide decisions about built environments, materials and tools. The goal is to simplify life for everyone, ensuring usability by a greater proportion of Canada's population. Human performance, social, cultural, engineering and economic factors are also considered in universal design. Developing and promoting environments that enable the performance of persons of all ages and abilities incorporates universal design principles and broadens the potential for occupational therapy services.
5. The majority of persons in Canada live in residential properties that have not been designed according to universal design principles. If each new dwelling was designed and built according to universal design principles, the need for future expensive renovations and changes could be substantially reduced or eliminated (Doble, 2002). There remains significant potential for individuals to be able to remain living in their current homes and existing communities (Doble, 2002).
6. FlexHousing is an opportunity to accommodate the needs of people with diverse abilities (Canada Mortgage and Housing Corporation, 2000). It incorporates universal design principles by building features into a home during initial construction to accommodate the changing needs of persons allowing them to remain independent in their own home. FlexHousing includes adaptable design such as reinforcing walls in bathrooms to make it easy to install grab-bars; accessibility such as wider-than-standard doorways; affordability, and Healthy Housing including air quality and energy efficiency.
7. Visitability refers to newly constructed, single-family homes with the following minimum features: a level entrance at the front, back or side entrance, door openings with a minimum of 32 inches (813 mm), and a half bath on the main floor. The three minimum guidelines to achieve visitability ensure that everyone, regardless of mobility, will be able to at least visit someone else's home, use the washroom and exit the home. (Visitabily Canada, n.d.).
8. Occupational therapists are encouraged to consider the roles they might individually and collectively play in the adoption of universal design principles which include equity in use for people with different abilities, flexibility in use, simple and intuitive use, communication of necessary information effectively to the user, reduction of hazards or adverse consequences, low physical effort, and appropriate size and space for function regardless of the person's body size, posture, or mobility (Center for Universal Design, 1997).
9. Occupational therapists have realized opportunities to use their expertise in community development and have expanded their services to include the promotion of universal design to improve the health of the public. This shift in service delivery has required the development of new competencies such as knowledge of building codes, standards and guidelines; architectural drawings, best practices in universal design and environments beyond housing such as parks and commercial venues (Ringaert, 2002).

Glossary of Terms

Canada Mortgage and Housing Corporation (CMHC): As Canada's national housing agency, CMHC provides residents of Canada with housing information and resources including research, educational seminars and financial assistance programs for housing. Web site: http://www.cmhc.ca/

Canadian Model of Occupational Performance and Engagement (CMOP-E): is an extension of the 1997/2002 conceptual framework that describes occupational therapy's view of the dynamic, interwoven relationship between persons, environment, and occupation (Townsend & Polatajko, 2007, p. 364-365)

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). Taken from Townsend & Polatajko, 2007, p. 367.

Occupations are groups of activities and tasks of everyday life, named, organized, and given value and

meaning by individuals and a culture; occupation is 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; that brings structure and is given value and meaning by individuals and a culture (adapted from Polatajko et al., 2004; and Zimmerman, Purdie, Davis, & Polatajko, 2006).

Occupational engagement: to involve oneself or become occupied, to participate in occupation (Houghton Mifflin Company, 2004). Involvement for being, becoming, and belonging, as well as for performing or doing occupations (Wilcock, 2006). Taken from Townsend & Polatajko, 2007, p. 370.

Universal design: "the design of products and environments to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design" (Mace, 1997, para.1).

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The following are related CAOT Position Statements and can be found on the CAOT website, www.caot.ca:

Assistive Technology and Occupational Therapy
Occupations and Health
Health Promotion
Home Care

Position statements are on political, ethical and social issues that impact on client welfare, the profession of occupational therapy or CAOT. If they are to be distributed past two years of the publication date, please contact the Director of Professional Practice, CAOT National Office, CTTC Building, 3400-1125 Colonel By Drive, Ottawa, ON. K1S 5R1. Tel. (613) 523-2268 or e-mail: practice@caot.ca.

Update from the COTF

Upcoming Competitions

March 31:

- Marita Dyrbye Mental Health Award (1 x $1,000)

Other Awards:

- Travel Awards partnership between COTF and CIHR-IA (June 1, October 1)

For details and application forms, see the Opportunities for Researchers and Students section at www.cotfcanada.org. Please note that the information can be changed from time to time. For most update information, please contact COTF directly.

New Executive Assistant

COTF would like to welcome Anne McDonald, as Executive Assistant. Anne began in November with COTF. She brings much experience in the not for profit sector with her. Anne is fluently bilingual in both official languages. She works Monday to Wednesday for COTF.

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.

Your Support Counts!

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

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Miller Polgar, Jan
Moliner, Carmen
Moore, Rachel

Neville, Jennifer
Nic Niocaill, Maire

Occupational Therapy Department, The Moncton Hospital

Penny Salvatori
Shoppers Drug Mart (In-kind)
Ed Stack
Rachel Stack
Debra Stewart
Thelma Sumsion

Barry Trentham

Brenda Vrkljan

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

1 anonymous donor

CAOT endorsed courses

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CAOT LEARNING SERVICES

Co-Hosted with CAOT
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Partners for change
Ottawa, Ontario
Tel: (800) 434-2268 ext 232
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CAOT Conference 2009 Pre-Conference workshops

CO-OP: Discovering strategies for enabling occupational performance

June 2 & 3, 2009

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

June 2, 2008

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

June 3, 2009

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

June 4, 2008

For more information, please visit www.caot.ca

The ADL Profile

Date: April 2-4, 2009 8:30AM-4:30PM
Speaker: Carolina Bottari
Location: Nova Scotia Rehabilitation Centre, 1341 Summer Street, Halifax, NS
Contact: Natalie Thornley
Email: Natalie.Thornley@cdha.nshealth.ca

CAOT Endorsed Courses:

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

Web-based (Distance Education)
Courses: Evaluating Sources of Evidence, Reasoning, Measurement, Developing Effective Programs, Facilitating Learning in Rehab Contexts.
Graduate certificate is granted after completion of 5 courses. These courses can be applied to Master's programs at each university, if the candidate is eligible.
Contact: 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)

Date: January - April 2009
Instructor: Professor Jocelyn Brown

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

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

Dates: April 23-24, 2009
Location: Montreal, Quebec
For more information, contact:
Caroline Hui at
info@choosetolearn.ca
http://www.choosetolearn.com

Interactive Metronome Self-Study Certification Course

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

Ergonomics Systems Specialist (ESS) Certification Course from WorkSMART

Dates: Edmonton, Alberta: January 26-30, 2009
Surrey, BC: March 2-6, 2009
Saskatoon, SK: March 16-20, 2009
Speakers: Mike Harnett, BPE (ATC); C.K.; Suzanne Kinney Jackson, H.BSc. (Kin); Nancy Milakovic, H.BSc. (Kin); Sandra Burke, HBKin,. C.K.; Jill Bates, B.Sc.(Kin), PFLC
Contact: Cathy Swystun, WorkSMART, #61-52147 RR 231, Sherwood

Park, AB T8B 1A4 Tel.: (780) 414-6436; fax: (780) 414-6435
E-mail: info@worksmart.ca
Website: www.worksmart.ca

Brain Bootcamp - Basic Awareness Training

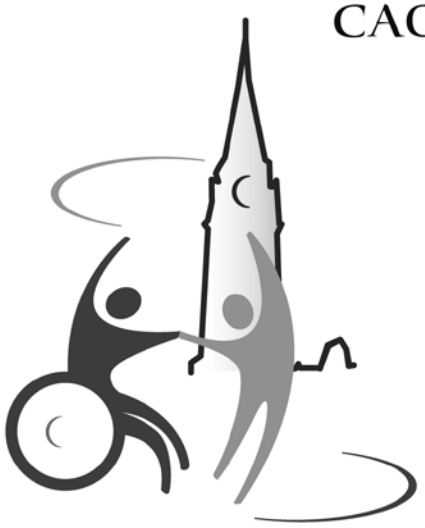
JR Rehab Services
Date: May 4-5, 2009
Facilitators: Mr Kit Malia, BED, MPhil, CPCRT and Ms Anne Brannagan, DIPCOT, MSc
Location: Morris J. Work Centre for Dialogue, Simon Fraser University downtown campus
Contact: Sheryl Thompson, JR Rehab Services, 29-1917 West 4th Ave, Vancouver, BC V6J 1M7 Tel.: (604) 254-0444; fax: (604) 254-0447
E-mail: info@jrrehab.ca

Myofascial Release Seminars:

Myofascial Release I
Myofascial Release II
Myofascial Mobilization
Pediatric Myofascial Release
Fascial-Pelvis Myofascial Release
Cervical-Thoracic Myofascial Release
Myofascial Unwinding
Dates: Various dates and locations
For information: www.myofascialrelease.com

Assessment of Motor and Process Skills (AMPS) Workshop

Date: May 4-8, 2009
Contact: Pauline Fitzgerald at p.fitzgerald@dal.ca Telephone: 902-494-6351 Fax: 902-494-1229



CAOT Conference • 2009 • Congrès de l'ACE

Ottawa • ON • June 3-6 juin

Engaging in healthy occupation: *Partners for change*

S'engager dans la réalisation d'occupations saines : *Partenaires pour le changement*

Conference Program Supplement available
February 1, 2009 at www.caot.ca
Early Bird Registration: February 1 - April 4, 2009
E-mail: conference@caot.ca
Information: 1-800-434-2268, ext. 232

Le Supplément du programme du Congrès sera disponible le 1er février 2009, à www.caot.ca
Inscription hâtive : du 1er février au 4 avril 2009 • Courriel : conference@caot.ca
Renseignements : 1-800-434-2268, poste 232

CAOT · ACE

Ontario Society of Occupational Therapists

CSOS Canadian Society of Occupational Scientists

CAOT Learning Services Workshop

The ADL Profile Workshop

Date: April 2-4, 2009
Location: Nova Scotia Rehabilitation Centre, Halifax, NS

Therapists who attend this workshop will be introduced to the non-structured evaluation approach of the *ADL Profile* and to its theoretical underpinnings. Videotapes of evaluation sessions will serve to illustrate how to administer the assessment as well as the repercussions of executive processes on the performance of daily activities. Video analysis of *ADL Profile* performance-based assessments will be used to familiarize therapists with how to document observable behaviours and how to rate performance. Finally, therapists will learn how assessment results can serve to guide treatment interventions.

Presenter - **Carolina Bottari, M.Sc., O.T.**, is a Ph.D. candidate in biomedical sciences (rehabilitation option) at the Université de Montréal. She is also a lecturer at Université de Montréal and is a clinical specialist in brain injuries. She is a co-author of the *ADL Profile*. Her doctoral thesis centres on the development and validation of the ADL Profile-Revised.

Workshop objectives - *Participants will:*

1. Become familiar with the *ADL Profile* assessment; its basic principles and the user's guide.
2. Gain knowledge related to how to characterise the repercussions of impairments in executive processes in everyday tasks with
   the use of the ADL Profile assessment.
3. Learn how to conduct both parts of the assessment: the performance-based assessment and the interview.
4. Understand how to interpret the results of the performance-based assessment and interview.
5. Gain confidence in analysing the strengths and weaknesses of this ADL assessment.

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See www.caot.ca for more details on this and other continuing education services.
To register contact education@caot.ca or by telephone (800) 434-2268 ext. 231.