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A Tribute to Ethel Clark
1916 - 2009

Ethel Clark, born in Chelmsford, N.B., graduated in occupational therapy from the University of Toronto in 1949. She began her career as a staff therapist at the Kingston Psychiatric Hospital. She later became the Director of Occupational Therapy, a position she held until her retirement in 1977. Her special ability to challenge her staff to use all their assets and abilities to organise workshops, create new treatment approaches, and use evidence based practice was well recognised. Ethel was also an active participant in the education of student occupational therapists. She offered fieldwork placements for students and contributed to the establishment of occupational therapy educational programs in Kingston, initially under the auspices of the Canadian Association of Occupational Therapists (CAOT) and later at Queen's University.

As an active member of CAOT, Ontario Society of Occupational Therapists (OSOT), and the Kingston Branch of OSOT, Ethel held many committee and leadership responsibilities at all levels including the Board of Directors of CAOT. She was awarded an Honorary Life Membership in OSOT in 1980, this prestigious award recognizes distinguished and long standing contribution to the profession and/or OSOT. Ethel was a passionate professional who contributed enormously to both!

Ethel's many interests included golf, bridge, travelling, reading, quilting and researching her family tree. She was a member of the RCAF during the Second World War and was the first female in the armed forces to successfully parachute from a plane crash. Thus she became a member of the renowned Caterpillar Club.

Ethel passed away on January 4, 2009 in Miramichi, New Brunswick, surrounded by her family. Ethel will be remembered by her many friends, former colleagues, and family.

Everyday stories . . . profiles of your CAOT colleagues

Alison Sisson and Karen Mills


Karen Mills


Alison Sisson

Alison Sisson and Karen Mills were the co-conveners of the CAOT Conference in June, 2008 in Whitehorse, Yukon and became familiar faces to those of us attending the Conference. The Yukon Convention Bureau awarded the Association of Yukon Occupational Therapists a Bravo Award for their role in the 2008 CAOT Conference. The CAOT Conference was one of the largest conferences held in the Yukon last year.

Karen Mills

Family life:

Married with four children, age 23, 20, 18, 15.

Education:

- Bachelor of Science in Occupational Therapy, University of Western Ontario,1985
- Bachelor of Arts, University of Western Ontario, 1985

Career path as an occupational therapist:

- First worked as an occupational therapist at St. Mary's Hospital in London, Ontario with chronic pain clients and amputees.
- Moved to Vancouver and worked at Holy Family Hospital in outpatient neurology.
- Next position was at St. Mary's Hospital, New Westminster, as the Clinical Supervisor of Occupational Therapy Services for thirteen years.
- In 2003, moved my family north to the Yukon and started fresh at Whitehorse General Hospital in a 100% clinical role covering inpatients and outpatient services. I've now added splinting, arthritis, diabetic footcare education, and thermal injuries to my clinical skills. Moved into the Manager of Therapy Services position a year after moving to the Yukon and continued to carry an outpatient clinical caseload. Have recently moved into a non-clinical role at the hospital as Director of Special Projects.
- Member of CAOT and the Association of Yukon Occupational Therapists

Hobbies/interests:

- I enjoy quilting and fabric dying. Am an active member of a local quilting guild and teach quilting at Bear's Paw Quilts.
- Enjoy kayaking and camping.

Alison Sisson

Family life:

Originally from Haliburton, Ontario
Single, with one lovely, black cat named Kawaii

Education:

- Honours Bachelor of Science (Biology), Queen's University, 1994
- Bachelor of Science in Occupational Therapy, McGill University, 1999
- Masters of Rehabilitation Science, expected graduation in May, 2009, McMaster University

Career path as an occupational therapist:

- Moved to Toronto in 1999 following graduation from McGill and worked for COTA doing community occupational therapy with a psychogeriatric and phys-med caseload.
- Worked at the Toronto Rehabilitation Institute with an outpatient stroke caseload.
- In January 2003, moved north to Whitehorse to work for Yukon Continuing Care providing occupational therapy to Copper Ridge Place, a long term care facility in Whitehorse, and for the Regional Therapies program, providing home care occupational therapy to communities throughout the Yukon.
- In 2007, went to India on a Rotary exchange to meet other occupational therapists and observe rehabilitation services throughout central India.
- Currently working for Yukon Continuing Care as a Policy & Standards Analyst which includes both policy development for the branch and the lead role for branch-wide accreditation.
- Very interested in the effective provision of rehabilitation services to rural and northern communities.
- Board member of Yukon Learn Society
- Member of CAOT and Association of Yukon Occupational Therapists

Hobbies/interests:

- Love hiking, cross-country skiing, canoeing, traveling, knitting, yoga

National Blueprint for Injury Prevention in Older Drivers

National Blueprint
for Injury Prevention in Older Drivers

Janet Craik, Director of Professional Practice and Claudia von Zweck, Executive Director, CAOT

The Canadian Association of Occupational Therapists (CAOT) has recently collaborated with McGill University, and Dr. Nicol Korner-Bitensky in particular, to develop the *National Blueprint for Injury Prevention in Older Drivers*. The *Blueprint* was successfully launched on February 26th, 2009, in Ottawa, Ontario, gaining national media attention.

What is the Older Driver Blueprint?

The *Older Driver Blueprint* is funded by the Public Health Agency of Canada. It is an important and innovative initiative that aims to enhance the capacity of older adults to maintain their ability to drive safely for as long as possible. The ultimate goal is to maintain older adults' engagement in the occupations that give meaning and purpose to their lives such as social and leisure activities, work and volunteerism. The *Older Driver Blueprint* document itself comprises several major topics and includes a vision, guiding principles, priority goals, and directions for action.

Why is the *Older Driver Blueprint* important?

Older adults are the fastest growing segment of the driving population. While it has long been believed that the older driver is actually the safest and most cautious driver on the road, statistical analysis reveals otherwise. The leading cause of accidental deaths for persons 65 to 75 years old in Canada today is driving-related accidents with those over the age of 75 having a 3.5 times higher crash rate per miles driven compared to 35 to 44 year olds. Given that there will be almost double the number of older drivers in Canada by 2040, this issue is likely to increase in the coming years if strategic actions are not put in place.

How was the *Older Driver Blueprint* developed?

A National Advisory Committee of individuals representing stakeholders in older driver safety came together to create the *Blueprint*. Stakeholders include older adults in Canada and those concerned with older driver safety such as national and local seniors agencies, health care professionals, insurance and automobile industries, traffic safety professionals, law enforcement representatives, provincial, territorial and federal health agencies and ministries. The intent is that the *Older Driver Blueprint* will be used by many stakeholders and will inform future policy, practice, education and research regarding older driver safety.

Occupational therapy's role in injury prevention in older drivers

Occupational therapists have education and training to evaluate physical, cognitive, visual-perceptual, and behavioral aspects of driving using standardized pre-road and on-road assessments. These assessments help to alert the driver to areas that require driving refresher or retraining. Occupational therapists can also provide recommendations on vehicle modification and adaptive equipment to enable safer driving practices.

For more information about the *Blueprint* visit www.caot.ca/driving and www.mcgill.ca/spot/ot/driving

The CAOT has recently updated their Position Statement: *Occupational Therapy and Driver Rehabilitation*. Visit www.caot.ca for the full document.

Launch of the National Blueprint for Injury Prevention in Older Drivers. (L) to (R) spokespeople: Patricia Clark, National Executive Director, Active Living Coalition for Older Adults; Dr. Nicol Korner-Bitensky, Ph.D., OT(C), erg., Principal Investigator for the Blueprint, McGill University; Dr. Colin Carrie, B.Sc. (Hons.), D.C., M.P., Parliamentary Secretary and representing the Minister of Health - The Honourable Leona Aglukkaq, P.C., M.P.; Dr. Claudia von Zweck, Ph.D., OT Reg. (Ont.), OT(C) Executive Director, CAOT; Dr. Elizabeth Taylor, Ph.D., President, CAOT.

Occupation-based program development in primary health care

Melissa Howey, Tania Angelucci, Dawn Johnston and Elizabeth Townsend

Inclusion of occupation-based programs in primary health care increases the availability of services that contribute to comprehensive, quality primary health care and to occupational community development (Lauckner, Pentland, & Patterson, 2008). In this article we illustrate how a theoretical understanding of occupation and enablement may be applied to develop primary health care occupational therapy.

Occupation-based primary health care

Primary health care places attention on health promotion, disease prevention, and identifies needs to increase access to services for all individuals (Health Canada, 2006). The goal of primary heath care is to provide preventative services as opposed to reactive services that focus on the diagnosis and treatment of illness and injury. Primary health care encompasses services beyond traditional health care to include education, income, housing, and environment (Health Canada, 2006).

Client-centred, occupation-based health care has been the implicit if not explicit theoretical foundation for remedial occupational therapy for many years (Townsend & Polatajko, 2007). Occupational therapists have a role in primary health care by focusing on the occupational needs of populations, and on enabling occupational performance and engagement as a means of preventing injury and promoting health (CAOT, 2003). This involves responding to the occupational needs of clients. Practitioners use a combination of enablement skills in adapting communities and programs, and advocating for health promotion programs that emphasize occupational engagement (Townsend & Polatajko, 2007). The aim is to provide more population health, illness prevention, chronic disease management, and health promotion by all professions (Heuchemer & Josephsson, 2006). It is within the primary health care context that occupational therapists have increasingly had the opportunity to develop and deliver community-based services at a primary level of care.

Community-based and primary health care occupational therapy

Both community-based and primary health care occupational therapists work with clients in their environment with a focus on client-centred occupations (Wittman & Velde, 2001).

The difference between the two approaches is the focus on disability and illness *prevention* in primary health care and the *remediation or rehabilitation* of existing disability or illness through community-based occupational therapy. In the past twenty years there has been a shift from institution-based, remedial occupational therapy to community-based remedial occupational therapy. Now the shift is extending occupational therapy into primary health care within the community, redefining health as physical, mental, and social well-being rather than simply the absence of disease (Perrin & Wittman, 2001).

Community-based occupational therapy aims to remediate the impact of everyday life changes in a client's community, including changes within the multiple systems of clients: psychological, emotional, physical and social, by using occupations that clients define as meaningful (Ward et al., 2007). *Primary health care occupational therapy* aims to enable clients to live and interact within their community, preventing disability and illness (Ward et al., 2007). Primary health care's focus on building healthy and supportive communities goes beyond individualized disability and illness prevention to improve the physical, social, and institutional environment (Baum, 1998). Improving the environment for occupational engagement assists in creating healthy surroundings that contribute to future health, well-being and justice (Townsend & Polatajko, 2007).

The lack of a healthy environment has a negative impact on physical and mental health (Wilcock, 2005). With an increasing shift to primary health care and increasing attention on prevention and (inter)dependence, there is an increased need and opportunity for occupational therapy services to enrich the services available through primary health care (Baum, 1998).

About the authors –

Melissa Howey, MSc(OT), is an occupational therapist at the Vancouver General Hospital Vancouver, British Columbia.

Tania Angelucci, MSc(OT), is an occupational therapist in the Living Sky School Division in North Battleford, Saskatchewan.

Dawn Johnston, MSc(OT), is an occupational therapist for Harbourstone Enhanced Care Sydney in Cape Breton, Nova Scotia.

Elizabeth Townsend, PhD., OT (C), Reg. NS, is a Professor and the Director of the School of Occupational Therapy at Dalhousie University in Halifax, Nova Scotia.

Occupation-based primary health care: An example

In collaboration with a community primary health care centre, occupational therapy students generated a business proposal aimed at enhancing primary health care services for community members. The program goal was to enable target populations within the community to increase their occupational engagement and community participation in the areas of:

- Safety and independence
- Re-engagement into the community and daily occupations
- Capturing their potential
- Social inclusion

Based on a community needs assessment conducted by talking with the staff of the community health centre and members of target populations, options for specific occupation-based programs were discussed. Two client situations are presented in which the primary health care needs were for transportation, communication, community support and safety. These examples of occupation-based primary health care implemented by one of the authors are presented here; the aim in both situations was to increase participation through facilitating occupational re-engagement.

Situation #1

Joe- worked with the occupational therapy student who was initially asked to see what could be done to enhance his writing skills. Additionally Joe expressed concern about going out in the community with his wheelchair because he was concerned about going over curbs and downhill; he would go outside more often if he had greater confidence in his abilities. A referral was sent to the local Wheelchair Skills Training Program, two dates for Joe to participate were received. Due to inaccessible and unreliable transportation Joe cancelled his appointment.

In Situation #1, the aim was to facilitate Joe's occupational engagement within his environment. Due to gaps in existing services regarding transportation, enablement to acquire wheelchair skills was hindered. Joe, according to the Canadian Model of Client-Centered Enablement (CMCE), experienced what has been called "missed enablement" (Townsend & Polatajko, 2007). Joe was unable to engage in education in terms of wheelchair safety due to a lack of coordination of services that hindered his overall engagement (Townsend & Poatajko, 2007).

Situation #2

Linda- worked with the occupational therapy student on enhancing Linda's exercise routine and setting daily goals. Linda was provided with routine planning agenda sheets to write down daily goals the night before; when waking up in the morning there was a concrete list of things to accomplish. The occupational therapy student accompanied Linda to YMCA on a day pass to try exercise equipment and see what Linda could do; Linda enjoyed the gym and is now thinking about joining a community network that offers a YMCA membership for individuals living in the community with mental stresses.

Situation #2 is a second example of an occupation-based program implemented to assist in Linda's sense of accomplishment and to facilitate change for the future. The approach began by capitalizing on Linda's strengths to ensure successful completion of goals (Schultz-Krohn, Drnek, & Powell, 2006). Linda seemed to accomplish her objectives by setting goals that were important to her. The sense of accomplishment was taken forward to facilitate community engagement both within the mental health community and the community at large. By collaborating with Linda, coaching her to achieve her goals, working to coordinate services between the health care centre, mental health community resources and local community services, Linda and others in the population living with a chronic mental health disorder would more likely experience "effective enablement" (Townsend& Polatajko, 2007).

Reflections

These two situations highlight the opportunities for occupation-based program development in primary health care. In Joe's situation there is a continued need to promote primary health care and a coordination of services. Although services began with community-

based rehabilitation, a primary health care approach evolved by gathering resource information and advocating with members of the community to improve accessible transportation. The primary health care aspect

"Occupational therapists have a role in primary health care by focusing on the occupational needs of populations, and on enabling occupational performance and engagement as a means of preventing injury and promoting health (CAOT, 2006). "

was the shift to a population approach with a focus on prevention of community dis-engagement by those using mobility devices that are not easily transported in regular buses or taxis, particularly for those on low incomes. In Linda's situation, a psychosocial rehabilitation occupational therapy approach was extended into primary health care occupational therapy. Occupational therapy took a population perspective on access to community resources, and began to improve service access for prevention and community development.

The project took the initiatives on primary health care from both the CAOT and Health Canada from theory to practice. Occupational therapy in primary health care can facilitate occupational engagement through the use of occupation-based programs. By using the enablement skills of an occupational therapist, focusing on the strengths of clients and the communities in which they live, and taking a population and prevention approach, occupational therapists are poised to advance health, well being and justice through occupation.

The marginalization of communities affects the health of community members and the availability of services. The impact of this project has been the successful development of a collaborative relationship between the community health centre and an occupational therapy education program at Dalhousie University in Halifax, Nova Scotia. The collaboration has continued and a budget request for full time primary health care occupational therapy services is pending. The application of theory to practice, as seen in Joe and Linda's situations, helped to build the business proposal by highlighting the need for a preventive, population-based approach for underserviced clients.

In the next phase of program development, stakeholders will be interviewed to further understand their occupational needs and the potential for occupation-based programming to enrich an existing primary health care service.

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Column Editor: Christel Seeberger and Jon Rivero

Evidence based practice in private practice occupational therapy: Perceptions, barriers and solutions

Donna Barrett and Margo Paterson

Evidence based practice (EBP) requires therapists to access, appraise and integrate research literature with clinical expertise and clients' values (Bennett & Townsend, 2003). Although research indicates that therapists support the principles and importance of EBP (McClusky 2004), challenges such as time, appraisal skills, workloads, and a perception that there is a lack of evidence to support occupational therapy intervention have resulted in therapists using experience and information gleaned from practice related courses to inform their clinical decision making (McCluskey, 2003).

The findings of a qualitative study using a focus group with five private practice occupational therapists are presented here. The aim of the study was to understand the unique experiences, perceptions, barriers, and feasible solutions to implementing EBP in private sector occupational therapy.

Perceptions

One participant identified the analogy of EBP as a filter which clinicians can put their clinical experience, knowledge, and client perceptions through before making treatment plans and solving clinical problems:

"It [EBP] is the filter. My intuition is the foundation and I'm going to put the research through that sort of filter ... and if it still hangs tight at the end, then I am going to make that choice. ... even if the evidence says this is the sort of treatment for this person with cognitive issues if there are other diagnoses and family issues ... that is the primary filter ... that's what I need to add more purposefully to the tree of decision making that happens in my brain when I'm choosing an intervention.".

"It's probably a combination of that pool of clinical experience and what you read and know and learn through the research in terms of the interventions you choose. Pull all those pieces together ... and help it direct your way of thinking. To me, even though you do your research ... and are reading the articles, you're still reviewing and critically appraising them. The bottom line still comes down to clinical experience and expertise and that filter."

Barriers

Participants were asked to reflect on the barriers to adopting EBP that are unique to the private sector. Common themes that emerged included isolation, heightened accountability, administrative demands, time and money. Working in the community and in private practice presents an inherent isolation which one participant described as: "we're all islands." Participants indicated that although, as sole practitioners, efforts are made to meet and connect with other practitioners, taking that initiative to make it happen at a frequency that allows for discussion about specific EBP issues is challenging. It was acknowledged that when working in a group setting (i.e. hospital, clinic etc.) information gets shared spontaneously and motivates the practitioner to inquire more deeply about EBP issues.

"Participants discussed how the very nature of private practice work demands a higher level of accountability and yet is designed in such a way that EBP strategies are viewed as hurdles "

Participants discussed how the very nature of private practice work demands a higher level of accountability and yet is designed in such a way that EBP strategies are viewed as hurdles because of other demands placed on them. They reflected that lack of time to adopt EBP may be more of a factor when operating in a fee for service type of environment. Practitioners perceive that a large amount of time is required to research evidence and appraise the literature. Frustration with their skill level in efficiently finding applicable information was also noted, as were financial implications of completing tasks that are not part of the fee for service reimbursement schedule. Sole private practitioners can typically bill for time spent directly providing occupational therapy to clients and indirect time spent relating to their care. One participant explained: "we don't get paid for continuing education." It is not common practice for the therapist to bill for time spent researching the evidence to set up treatment plans or support funding requests.

Solutions

This focus group explored how to overcome these EBP hurdles in the private sector and the strategies that were discussed fell into two categories: internal and external factors to facilitating change.

a) Internal factors to facilitating change

It is important to recognize that as professionals our **internal values** facilitate change. Considering EBP as part of client care in order to provide best practice occupational therapy and ultimately reduce costs by knowing that what we are providing, from both the literature AND our experience, is current and proven effective and therefore included as billable time.

Internal factors to facilitating change included debunking the **underlying fear** that exists about using EBP. Specifically, participants discussed fears about their skills and abilities to search and critically appraise the literature accurately. Fears regarding how EBP were expressed as: "I would hate to lose the empathetic reaction that therapists should have ... replaced with numbers."

In a competitive private practice setting there is an inherent resistance to share **intellectual property** with competitors. Overcoming the barriers to using EBP in the private sector will be eased if practitioners are willing to adopt the belief that finding and using the evidence is important enough to work together to minimize issues such as time, lack of skills and financial reimbursement. Practitioners discussed how to overcome these internal factors with suggestions such as: "sharing the work would be helpful to me ... I'd be willing to research one component and present it to you [as a group] and give you a literature list."

b) External factors to facilitating change

The external factors that would facilitate the use of EBP in the private sector were more easily addressed and include: partnership with students; a resource of web-based, simple, user-friendly EBP sites; and paying external bodies to provide the service of search and appraisal of the evidence and thereby decrease the demand on the practicing therapist.

Partnering with students was the primary solution that participants discussed as a way to marry the skills of a practicing therapist (who may hold many questions to be researched) and the skills of the new Master's graduate students who have high level of skills in searching and appraising the evidence. One participant said: "linking up with students ... partnerships ...would be a nice trade of skills and knowledge" or "answering some of these questions and doing some of the research, to help identify best practice in certain areas." We recognize that access to students is not easy for all private practitioners but most universities in Canada have adjunct status appointments

for preceptors who take students on fieldwork placements. This has a two-pronged advantage of students who can assist with doing the EBP searches as well as an online access to the university library resources.

Participants discussed how a **user-friendly, web-based resource list** could facilitate their use of web-based resources such as a summary of websites or resources for practicing therapists to have in one location for easy reference. This may include a list of "favourites" on the internet, or a cue card. Practitioners in this focus group had perceptions that the search and appraisal of the research is too complicated and they would welcome more user-friendly process like *"Google is really easy."*

Participants discussed **external sources for search and appraisal** services by providing a summary of the relevant information that is applicable to their area of practice which could be a role for professional associations or librarians to assist and support private practitioners with innovative suggestions such as: *"there should be an icon that says Ontario Society of Occupational Therapists recognized website."* The amount of literature and number of research questions are immeasurable and overwhelming. Therapists would benefit from a system in which information is provided

About the authors –

Donna Barrett, BSc (OT), MSc(OT), OT Reg (Ont), works in private practice in Belleville, Ontario, providing occupational therapy to clients with acquired brain injury. This research study contributed to her fulfillment of her Master's degree in Occupational Therapy at Queen's University in Kingston, Ontario. She can be reached at dbarrett@kos.net

Margo Paterson, PhD, OT Reg (Ont) is an Associate Professor and Chair, School of Occupational Therapy at Queen's University. Margo has developed expertise in qualitative methodology and she was Donna's supervisor for this critical inquiry project. She can be reached at margo.paterson@queensu.ca

by clinical topic and the fields are narrowed down to a manageable number of articles to review thereby making the use of EBP more user-friendly.

Private practitioners indicated that they would appreciate more external supports to assist with this transition and are willing to pay for such services if made available to them. Using secondary resources such as professional associations, students, libraries or independent practitioners (from a variety of clinical backgrounds) to pre-appraise and synthesize evidence can help in reducing time related to these activities. The development of "tripartite therapists" who combine clinical work with teaching and research may be another method for private practitioners to partner with external supports to facilitate the use of EBP in their clinical decision-making.

As a result of this study, a pilot project was initiated and was modeled after Sudsawad's (2005) proposal that accommodates private practitioners needs, whereby the therapist is included in the development of clinically relevant research questions to be studied and an external researcher presents the information back to the therapist in a manner that makes it easy to translate the findings into practice and see the implications for practice clearly. Two private practitioners have partnered with two occupational therapy students at Queen's University in Kingston, Ontario, to research clinical questions that they, due to the barriers identified in this study, have not been able to explore. The therapists set the parameters of how the research information is to be presented, including a summary designed as a client handout, a summary of best practices for the practitioners and a critically appraised topic (CAT).

In summary, private practitioners are motivated to use EBP in their decision-making. This study has revealed some barriers to implementing EBP and offered some strategies to overcome these challenges.

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The authors would like to acknowledge the work of Paola Durando for compiling the information found in the chart below.

Table: Key Occupational Therapy Evidence-Based Databases & Journal Literature Indexing Tools

	Evidence-Based Resource (studies are critically appraised & rated)	Journal Citation Database (journal article index with abstracts)	Country of Origin	Content	Searchability
OTseeker http://www.otseeker.com/	•		Australia	abstracts of systematic reviews & controlled trials; 5500 reviews and growing	quick search box and advanced search screen
REHABDATA http://www.naric.com/research/		•	U.S.	emphasis is on disability research; indexes books, articles, reports and A/V materials	quick search box and advanced search screen
Google Scholar http://scholar.google.ca/		•	U.S.	useful for "discovery" (but not comprehensive) searches, highly-cited articles, interdisciplinary topics, grey literature	quick search box and advanced search screen
PubMed www.pubmed.gov		•	U.S.	world's biggest biomedical database; indexes CJOT and AJOT	quick search box and advanced search screen
CINAHL (Cumulative Index to Nursing & Allied Health Literature)		•	U.S.	most comprehensive OT/PT citation database	best searched in a structured manner
Cochrane Database of Systematic Reviews	•		international	highest level of evidence but few OT reviews	best searched in a structured manner
OT Search		•	U.S.	Indexes books, proceedings, reports, selected journals & newsletters	provides quick access to popular topics

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

Column Editor: Heidi Cramm

Jessica Malpage, Pei-En Shih and Lisa Klinger

Part Two of Two

Home Assessments available on-line were described and reviewed in the March issue of OT Now. *In this second part, Public Facility Assessments are described and reviewed.*

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

Please see Part One of this paper, published in the March/April 2009 issue of Occupational Therapy Now for a complete description of the search strategy and inclusion criteria.

Public Facility Assessments

No published assessments of public facilities were found following a search of various on-line databases. An internet search located 12 public facility assessments, most of them being checklists; one was collected from a co-author of this paper. After preliminary evaluation, eight were retained for evaluation; three were discarded because they lacked sufficient instructions; author and publication date could not be located for a fourth. See Table 1 for a description and evaluation of the eight included public facility 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 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.

Table 1: Description and Evaluation of Public Facility Assessments

Title, Year of Publication, and Author(s)	Purpose	Type of Clients	Clinical Utility (+) = positive attribute (-) = negative attribute	Comments (+) = positive attribute (-) = negative attribute
Accessibility Checklist (2001) Available online at: http://ada.ky.gov/documents/Checklist_2000.pdf	•Identifies and assists in planning for removal of architectural and communication barriers encountered by individuals with disabilities in private and public facilities	•Individuals with mobility, visual, and/or hearing impairments.	+No manual but easy to administer +Brief introduction to the checklist and instructions provided +Most checklist items are accompanied by relevant diagrams for clarity and ease of use +Completion time varies depending on the number of areas of a facility	+Checklist developed based on the Americans with Disabilities Act Accessibility Guidelines (ADAAG) and Chapter 11 (Accessibility) of the Kentucky Building Code 1997
Accessibility Checklist – A Self-assessment Tool (2004) Available online at: http://www.auscamps.asn.au/accessibility	•A self-assessment of buildings, activities, campsites, accommodations and sport and recreation areas	•For people with or without a disability	+Informative manual to guide assessment process +Easy and intuitive to use +Helps facility managers/operators complete a detailed and objective assessment +Encourages the user to think about possible actions to take to improve access +Most sections provide general recommendations about adaptations +Provides a column for users to contribute ideas to improve access	+Based on guidelines in the Disability Discrimination Act of Australia (DDAA) and a variety of other resources +Detailed assessment tool for anyone who wishes to evaluate or improve accessibility and usability of indoor and outdoor facilities +Offers valuable guidance for adaptation & improvement.
ADA Accessibility Checklist For Existing Facilities (n.d.) Available online at: http://www.ghi.com/pdf/adachecklist.pdf	•Identifies accessibility barriers based on compliance to ADAAG and recommendations to make public facilities physically accessible	•Anyone with a disability	+Single-page description of the purpose of checklist +Provides helpful, possible actions for each identified barrier -No instructions available; does not prepare assessor to conduct the evaluation although somewhat intuitive to use	-Contains references to applicable sections in ADAAG and some to the New York State Uniform Fire Prevention and Building Code -Useful checklist for assessors who are familiar with the ADAAG and the NYS uniform Fire Prevention and Building Code
ADA Checklist for New Lodging Facilities (1999) Available online at: http://www.ada.gov/lodgesur.htm	•Evaluates compliance with the accessibility requirements of the ADA •For owners, franchisors, and managers of hotels, motels, inns, and other places of lodging •Measures physical characteristics of facilities	•People with physical, hearing, and visual disabilities	+Brief introduction and instructions assist examiners in conducting an on-site evaluation using the checklist +A section lists required tools and explains how to make certain measurements +Some sections of the checklist have diagrams to illustrate how to measure	+Based on the ADA Standards for Accessible Design with references to applicable sections

Title, Year of Publication, and Author(s)	**Purpose**	**Type of Clients**	**Clinical Utility** (+) = positive attribute (-) = negative attribute	**Comments** (+) = positive attribute (-) = negative attribute
ADA Checklist for Polling Places (2004) Available online at: http://www.ada.gov/votingck.htm	•Determines if a polling place is accessible to most voters with disabilities by identifying physical barriers	•Individuals with mobility and visual disabilities	+Instructions and checklist questions easy to understand and accompanied by illustrations +Suggests temporary solutions at end of each evaluation section	+Checklist based on ADA Standards for Accessible Design and has references to applicable sections
Checklist for Existing Facilities (version 2.1) – The Americans with Disabilities Act Checklist for Readily Achievable Barrier Removal (1995) Available online at: http://www.usdoj.gov/crt/ada/checkweb.htm	•Assesses public areas for architectural and communication barriers that can be readily removed	•People with physical, hearing, visual, and cognitive disabilities	+2-page introduction assists user in administering checklist +Recommends having people with various disabilities and accessibility expertise participate +Provides possible solutions for each identified barrier	+Checklist based on the ADAAG +Authorized by the National Institute on Disability and Rehabilitation Research as an adequate measure of ADA accessibility (Kaplan, Hernandez, Balcazar, Keys, & McCullough, 2001) +Helpful tool to develop an implementation plan for barrier removal, including timelines
Greater Toronto Hotel Association Hospitality Accessibility Checklist (2003) Available online at: http://www.gtha.com/dsp_Hosp-CheckLst.cfm	•Helps those in the hospitality industry to evaluate the physical accessibility of their buildings	•Individuals with mobility, visual, hearing, and cognitive impairments	+No manual but intuitive to use +Brief introduction to the checklist and instructions provided +Includes illustrations for some items in the checklist +Some recommended solutions provided in two sections of the checklist	+Checklist based on accessibility requirements identified in the Ontario Building Code and those described in the Canadian Standards Association Barrier Free Guidelines and the ADAAG. +In addition to the checklist, there are lists of keywords, online resources, and product resources to facilitate the assessment process and support accessibility changes
University Campus Accessibility Measure (UCAM) AND Physical Accessibility Measure for Schools (PAMS) (2003) By: The Research Alliance for Children with Special Needs Contact: Lisa Klinger (lklinger@uwo.ca)	•Evaluates the physical accessibility of buildings on a university campus AND in elementary or secondary school buildings	•Students, faculty, staff, or visitors with physical or mobility impairments	+No manual but does include a section on measurement instructions (with illustrations), tips, and glossary of terms +In-depth evaluation and measurement +All measurements in metric units -No section specifically providing recommendations for improvement	+UCAM adapted from the Physical Accessibility Measure for Schools (PAMS) to suit a university campus (Ah Yong et al., 2003; Bains et al., 2004). +Detailed assessment of physical characteristics of buildings related to accessibility -Tools do not identify environmental barriers faced by people with visual, hearing, or cognitive impairments

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What's on-line

hOT topics

hOT topics are resource sheets compiled by CAOT member experts, for CAOT member clinicians, and include lists of references, websites and pertinent information regarding current 'hot' topics in practice. hOT topics currently available at www.caot.ca include:

- Cultural Competence
- Leadership
- Occupational Community Development
- Dysphagia

Position Statements

Look for these new or updated position statements at www.caot.ca

- Occupations and Health
- Access to Occupational Therapy
- Autism Spectrum Disorder and Occupational Therapy
- End-of-Life Care
- Home Care
- Mental Health Care
- Occupational Therapy and Driver Rehabilitation

Mentor Gateway

CAOT is please to provide its members with this service on www.caot.ca.

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

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

Update Report on the CAOT Strategic Plan

Claudia von Zweck PhD, Executive Director, CAOT

In October of 2005, CAOT adopted a new strategic plan that outlined 5 priorities for the Association. This plan was approved by the CAOT Board of Directors to guide the work of our organization for 3 - 5 years to address our mission of advancing excellence in occupational therapy. As the Board of Directors once again prepares to develop a new strategic plan for CAOT in the fall of 2009, it is helpful to reflect on the work that was undertaken since 2005 to meet the priorities set out for the Association. The report below reviews the major achievements of CAOT, plus highlights activities undertaken in this membership year. The Board of Directors will be seeking input from members for the new strategic plan in forums in locations across Canada, as well as through a survey posted on the CAOT website.

Advocate for occupational therapy as an essential service

2005 – 2008 Achievements

CAOT advocated for occupational therapy using a range of approaches, including representation on task forces and alliances, participation in national projects and lobbying decision-makers. CAOT was represented on over 30 groups to ensure an occupational therapy perspective on initiatives that support our strategic priorities. CAOT completed the development of guiding principles and a framework for interdisciplinary primary health care as a member of the Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative. Involvement in the Canadian Collaborative Mental Health Care Project resulted in endorsement of a national charter among 12 national Steering Committee organizations to support the delivery of mental health services in primary care through interdisciplinary collaboration.

CAOT worked with other occupational therapy organizations in addition to interdisciplinary stakeholders to address issues influencing the profession. The Occupational Therapy Council of Canada (OTCC) was developed for information sharing and coordinated planning among CAOT, COTF, the Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO) and the Association of Canadian Occupational Therapy University Programs (ACOTUP). The mandate of the Professional Alliance of Canada (PAC) was also reviewed, with the approval of new terms of reference in 2008. A joint position statement on diversity in occupational therapy was developed by CAOT, COTF, ACOTUP, ACOTRO and PAC, and work is underway to revise the 1998 joint statement on evidence-based occupational therapy. Successful OT Month celebrations were held annually in collaboration with provincial occupational therapy professional associations using the theme *Yes I Can!*

In December 2005, the Chief coroner of Ontario requested that CAOT respond to recommendations emerging from an inquest into the death of a pedestrian hit by a driver who had a progressive neurological disease. A national panel, including CAOT members and other experts, created recommendations based on a systematic review of scientific evidence, provincial legislation and jurisprudence. With Dr. Nicol Korner-Bitensky, CAOT provided a presentation on the issues relating to older driver safety and findings of this work to the Public Health Agency of Canada (PHAC) in early 2007. Subsequently, PHAC invited CAOT to submit a funding proposal to develop a blueprint for injury prevention of older drivers.

Spring 2009 Update

A national action symposium was hosted by CAOT to promote implementation of the objectives and directions for action outlined in the 2008 *Blueprint for Injury Prevention in Older Drivers*. The *Blueprint*, now available on the CAOT website, was a collaborative effort of CAOT with McGill University and a national advisory committee of individuals representing stakeholders in older driver safety.

CAOT also completed the three year PHAC funded project *Stable, Able and Strong* in collaboration with the University of Ottawa for older adults who have experienced a fall to enable them to maintain or resume engagement in meaningful activities. A number of resources from the project are available on the otworks.ca website, including the *Program Implementation Manual, Peer Mentor Workbook* and *Post-Fall Support Modules*, plus brochures and a resource database.

CAOT worked with Dr. Mary Ann McColl to create a framework to assist members with the development of a plan to offer occupational therapy services in primary health care. The framework includes four planning steps with supporting tools and resources and can be accessed on the CAOT website. *Interdisciplinary Primary Health Care: Assembling the Pieces,* a new CAOT publication featuring this framework will be launched later this spring.

CAOT has also published several new position statements on areas of advocacy, including a statement on autism spectrum disorder based on a brief provided to the Senate Standing Committee on Social Affairs, Science and Technology.

CAOT met with federal government representatives to lobby for increased access to occupational therapy for members of the Canadian Forces and veterans. In addition, meetings were held to promote inclusion of occupational therapy services on the list of insured services with insurance providers to the public service. To assist members in their lobby for insurance coverage, work has been undertaken to update an online toolkit and resources.

CAOT also provided a pilot educational session to the members of the Association of Professional Executives of the Public Service on *Creating a Healthy Workplace: How Occupational Therapy Can Help*. This was a key opportunity to develop new markets for our members and increase access to occupational therapy services for members of the public service.

Other recent events involving CAOT representation included a stakeholder dialogue regarding mental health system transformation hosted by the Mental Health Commission of Canada.

Develop workforce capacity in occupational therapy

2005 – 2008 Achievements

Driven by reported shortages of occupational therapists across Canada, CAOT worked to address a health human resources plan for occupational therapy. A collaborative project with the Canadian Institute for Health Information (CIHI) and occupational therapy regulatory organizations led to the development of a national human resources database, with annual reports that describe the practice of occupational therapists in Canada. Using information from this database to demonstrate the low supply of occupational therapists in Saskatchewan, CAOT and the Saskatchewan Society of Occupational Therapists held several meetings with representatives of the University of Saskatchewan and the provincial government to promote the establishment of an occupational therapy education program at the University of Saskatchewan. CAOT also advocated for the development of pilot site projects in Saskatchewan that demonstrate the role of occupational therapy in innovative areas of practice.

CAOT worked with the British Columbia Society of Occupational Therapists to address the shortage of occupational therapists in British Columbia. Several meetings were held with provincial government ministers to advocate for increased seats in occupational therapy education programs and for supports for the workforce integration of internationally educated occupational therapists and re-entry candidates.

The *Profile of Occupational Therapy Practice in Canada* was revised in 2007, in addition to the development of a conceptual model for a competency profile for occupational therapy support personnel. New supervision guidelines for assigned work components were also published on the CAOT website, as well as a revised code of ethics and new ethical decision-making framework. Indicators were developed for the accreditation of university occupational therapy education programs. Policies and processes were reviewed to ensure use of best practices in the CAOT academic accreditation program. Work was completed in 2006 on the Workforce Integration Project, a project funded by the Government of Canada's Foreign Credential Recognition Program to investigate barriers and facilitators of success of internationally educated occupational therapists in the Canadian workforce. A number of initiatives have since been undertaken to address the recommendations of the report, including the development of an *Access and Registration Framework for Internationally Educated Occupational Therapists* and the initiation of a project to create a web portal for persons wishing to come to Canada to work as an occupational therapist.

Spring 2009 Update

CAOT worked with Paulette Bourgeois, author of the popular *Franklin* children's book series to develop the new publication, *You, Me and My OT*. Geared toward early readers, this publication is intended to introduce occupational therapy as a future career choice. Paulette was educated as an occupational therapist and will be featured as a plenary speaker at Conference 2009, where the new publication will be launched.

The Dean of Medicine at the University of Saskatchewan announced in December 2008 that it is expected that 40 students will be admitted to a new occupational therapy education program beginning in 2012 in Saskatoon. Together with the initiation of new education programs at the Université de Sherbrooke in 2007 and Université du Québec à Trois-Rivières in 2008, these new seats will increase the annual new graduate supply of occupational therapists in Canada by over 10%. A number of other education programs have also announced or are considering seat increases to meet workforce demand.

An external review of the national certification examination was commissioned with ACOTRO to ensure a transparent, objective, impartial and fair assessment for candidates wishing to enter practice as an occupational therapist in Canada. A new blueprint for the examination was also developed for implementation in 2010 that uses descriptors of the roles of occupational therapists outlined in the revised *Profile of Occupational Therapy Practice in Canada*. The

Practice Profile for Support Personnel in Occupational Therapy, approved by the CAOT Board in November 2008, serves as a new companion document to the *Profile of Occupational Therapy Practice in Canada*. The new document recognizes that occupational therapy support personnel are valued and needed at all levels of a practice continuum. CAOT signed an agreement to work with the Accreditation Council for Canadian Physiotherapy Academic Programs to develop an accreditation process for the education of support personnel in occupational therapy that reflects the vision and outcomes outlined in the new *Profile*.

After several delays, CAOT recently received funding approval from Health Canada for a caseload guidelines project that will be completed in conjunction with the Canadian Physiotherapy Association (CPA) and the Canadian Association of Speech Language Pathologists and Audiologists (CASLPA). The project will address the recommendations of the 2005 CAOT report *Toward Best Practices for Caseload Assignment and Management for Occupational Therapy In Canada*.

Foster evidence-based occupational therapy

2005 – 2008 Achievements

CAOT worked to promote occupation-based research as a priority in collaboration with organizations such as Research Canada, the Canadian Cochrane Centre, Canadian Health Services Research Foundation and Canadian Institutes for Health Research (CIHR). In addition, CAOT provided financial support for the operation of the Canadian Occupational Therapy Foundation to advance occupational therapy research and scholarship. Close collaboration was fostered by the move of the Foundation office to co-locate with CAOT in Ottawa.

To promote the dissemination of occupational therapy research, a new strategic plan was developed for the *Canadian Journal of Occupational Therapy (CJOT)*. New policies and procedures, including new author guidelines were developed to implement the new strategic plan. These measures, in addition to a one year increase in journal pages, resulted in a significant reduction in the wait time to publish in the *CJOT*. Accepted articles are now published within 6 – 8 months. Agreements were signed with organizations such as Ingenta to increase online exposure of CJOT articles. Special issues of the *CJOT* were published on several topics, including the International Classification of Functioning, Disability and Health.

CAOT worked with an international group of occupational therapy researchers to develop the evidence-based practice web portal on the CAOT website. CAOT also continued to update and add content to the online Information Gateway to help members search for evidence for their practice. New resources include free member access to the WORK Journal and the Cochrane Library.

Spring 2009 Update

Led by Dr. Lori Letts from McMaster University, CAOT hosted a CIHR funded exchange meeting to develop a research agenda for collaborative chronic disease research that includes occupational therapy-related themes. A new CAOT position statement on research in occupational therapy was approved by the Board of Directors in November 2008 and published in *Occupational Therapy Now*. Special project funding was provided by the CAOT Board of Directors to host a training session in June 2009 for new CJOT reviewers. Following this session, the face-to-face workshop material will be adapted for an online training process. Special project funding was also approved for the development of a new strategic plan for the *Occupational Therapy Now* practice magazine. Members were invited to participate in an online survey to provide input for this new strategic plan. A special issue of *Occupational Therapy Now* in the fall 2008 focused on knowledge and was geared toward a non-occupational therapy audience to promote understanding of the profession.

A CAOT review of economic literature regarding occupational therapy services initiated a call for papers for a special issue of *CJOT* that describes research influencing policy.

CAOT negotiated an agreement with the British College of Occupational Therapists for CAOT members to receive free online access to the *British Journal of Occupational Therapy.* Members of the British College are also now able obtain the *CJOT*. This "win-win" agreement promotes member access to research evidence for CAOT and the British College, in addition to broadening the audience of readers for both journals.

Advance leadership in occupational therapy

2005 – 2008 Achievements

CAOT undertook initiatives to recognize existing leaders as well as to foster leadership in occupational therapy. A new section was added to the CAOT website to chronicle the achievements of past award winners. A review was undertaken to ensure an appropriate range of awards are offered and promote consistency and fairness in the adjudication process. A new leadership award was established, with Élisabeth Dutil named as the first recipient. A new

tradition of hosting a luncheon for CAOT Fellows at the annual conference was started in 2008.

A number of new non-periodical publications were developed, including the *ADL Profile, McGill Ingestive Skills Assessment, Functional Capacity Evaluation, Business in Clinical Practice, Research on the Canadian Occupational Performance Measure* and our latest guidelines for the client-centred practice of occupational therapy, *Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-being & Justice through Occupation*. CAOT also offered a range of other continuing education opportunities and resources for members, including regional workshops, online webinars and new hOT topic resource sheets. The OT Education Finder database allows members to easily search for professional development activities and resources. Successful annual conferences were held in locations across the country, including the first ever in the north held in Whitehorse, Yukon. New procedures and additional resources were established for abstract reviewers. An online handbook for conference presenters was also developed, in addition to a new process for consumer presentations that was successfully trialed at the 2008 conference. Professional issue forums were held at conferences to obtain input for the development of new CAOT position statements, including the topics of aboriginal health, obesity and healthy occupation, and access to occupational therapy.

Spring 2009 Update

Conference 2009 will be held in Ottawa with a theme of *Engaging in Healthy Occupation: Partners for Change*. Members are invited to celebrate the achievements of 2009 award recipients at the annual Awards Ceremony at the conference. The Muriel Driver lecture will precede the Awards Ceremony, this year provided by Dr. Nicol Korner-Bitensky.

CAOT introduced the French language version of *Enabling Occupation II* after extensive consultation with French-speaking members and translation experts. A number of CAOT activities were designed to help members to integrate the guidelines into practice, including a calendar that features concepts and models of this publication, an upcoming preconference workshop on *Enabling Occupation II* and development of a new practice guide.

CAOT partnered with CPA and CASLPA to host the Primary Health Care Leadership Summit in Toronto, November 6-7, 2008. Session presentations are available for download from the CAOT website. CAOT also worked with CPA and CASLPA to host a workshop on Rehabilitation in the Context of HIV in collaboration with the Canadian Working Group on HIV and Rehabilitation.

A new webinar was posted on our website on ethical decision-making and new hOT topic resource sheets on the topics of community development and obesity will also be available.

The Mentoring Gateway was added to the CAOT website to provide information, resources and contacts for members planning or making transitions in their occupational therapy career.

Advance CAOT as a national occupational therapy professional association in Canada

2005 – 2008 Achievements

CAOT introduced innovative member services and benefits to provide value to membership as well as sought to improve and optimize operations. Risk management and policy audit processes became well-established and new policies and procedures were implemented regarding the collection and retention of personal information as well as for emergency preparedness. A new green initiative was introduced to reduce our environmental footprint. Our financial success allowed investment in a number of the important special projects, several outlined in this report. Member forums were regularly held across Canada on a variety of topics to gain input and inform members about the work of CAOT. Comments from members in such forums as well as ratings in annual surveys indicate a high level of membership satisfaction with the work of the Association. CAOT contributed to occupational therapy internationally through our membership and support of the World Federation of Occupational Therapists, as well as with our publications and products. CAOT publications are distributed throughout the world and several are published in languages such as Danish and German.

Spring 2009 Update

The CAOT annual general meeting will be held on Saturday, June 4, 2009. Issues to be discussed include a small 3% proposed membership fee increase needed to help balance projected revenues and expenditures in our next fiscal year. This is the first fee increase proposed for CAOT membership in five years.

At the request of provincial professional associations in both British Columbia and Alberta, CAOT has investigated potential partnership models to promote cooperation and collaboration between professional organizations at the national and provincial/territorial level. It has been recognized that working towards a partnership between the organizations provides an opportunity for innovation, better service for the profession and a stronger approach to meeting member needs.

A review of the governance of CAOT was initiated in 2006, with subsequent membership approval of changes to the Association bylaws at the 2008 annual general meeting. The CAOT rules and regulations were revised in the fall of 2008 to reflect approved changes to Association bylaws.

The Person-Environment-Occupation Circle Tool: A simple way to bridge theory into practice

Column Editor: Heidi Cramm

Heidi Cramm

Liam, an 11-year-old boy, has anxiety and learning disabilities that challenge his ability to engage in his school occupations.

Charles is a 45-year-old municipal worker who has experienced a low back injury on the job. He has been attending a work hardening program and is about to receive clearance to return to work.

Both individuals are involved with occupational therapy. How might an occupational therapist embed practice in the Person-Environment-Occupation (PEO) model (Law et al., 1996) in a way that is accessible to both Liam and Charles?

Introduction

Clinicians continue to face challenges in implementing occupational therapy theory during client collaboration. Many clients also struggle with our professional domain of interest, focusing on the "therapist" in our title rather than the "occupational" descriptor of our enabling approach. In this article, I propose a simple and practical tool that can help occupational therapists communicate the profession's unique perspective on occupational performance and broaden the therapeutic process to include barriers in the environment and occupational form.

As occupational therapists may experience discomfort when pressed to use the term "occupation", they may instead offer supposed synonyms such as "activity" or "function"; such terms fail to fully convey the meaning and purpose inherent in occupation and thereby diminish our profession's unique contribution to the health and wellness of our clients. By avoiding use of the term "occupation", we perpetuate the public's confusion regarding our professional perspective. This tool provides a way to facilitate use of occupational therapy language and communicates the breadth and scope of our potential.

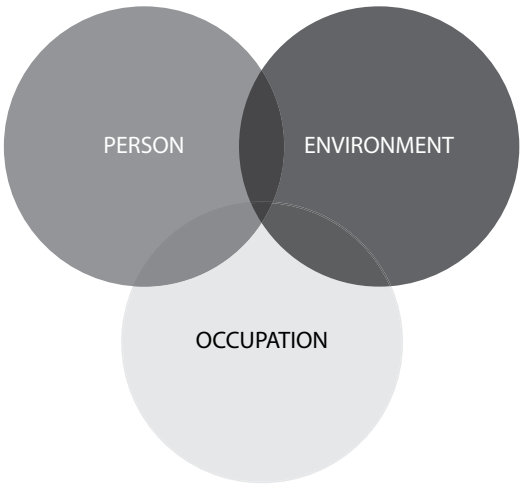
Bridging theory and practice

The PEO model (Law et al., 1996) is a well-known and established conceptual model and model of practice within Canadian occupational therapy. It offers a foundation for guiding assessment and intervention across all practice settings and client populations. The proposed tool brings the PEO model to life in the form of a simple and inexpensive tool that can provide clinicians a practical theoretical foundation for their clinical process. The circle tool acts as a vehicle for describing what occupational therapy is, what the foci are, and what the clinician can provide to the client.

The tool consists of coloured, translucent circles for each of the person, environment and occupation factors (see Diagram 1). The three circles are printed onto an overhead sheet and cut out. The circles can be used in a physical and interactive way to provide occupational therapists and clients a tangible and visual tool that clarifies the foci of occupational therapy. By using the translucent coloured person, environment, and occupation circles, the therapist is able to demonstrate how intervention directed at the person, the occupation, and the environment converges to optimize occupational performance. As the coloured circles overlap, the shared area gets darker so that this convergence is obvious. Therapists and clients are able to move the circles in relationship to one another, focusing if they wish on the person-environment, occupation-environment, and person-occupation dynamics.

About the author –
Heidi Cramm is a doctoral candidate in Rehabilitation Therapy at Queen's University in Kingston, Ontario. On leave from her clinical practice in child and adolescent psychiatry, she has a particular interest in occupational therapy and children and youth who experience mental health issues. Heidi welcomes feedback at 7hac1@queensu.ca.

Diagram 1



Use of this tool places the term "occupation" inescapably at the fore of the interaction, enabling the clinician to inject theoretical knowledge into practice. By framing the relationship using this tool at the outset of the therapeutic interaction, a solid theoretical and practical basis of the relationship is established. Furthermore, using the tool ensures that the therapeutic relationship attends not only to the person, which health care systems can emphasize, but also the environment and the occupation.

Case Scenario #1 – Initial interview with Liam and his mother

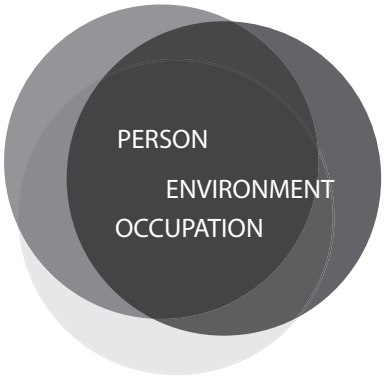
Liam has been experiencing considerable difficulties in doing written work at school, has poor spelling, and struggles with organization. He was referred to school health occupational therapy for assessment. Both mother and son are able to engage with the theoretical application, generating examples that might fall under each of the person, environment, occupation components. For example, when talking about the nature of the environment, the boy asks if his school might let him do his tests somewhere quiet outside of the classroom, as he tends to experience high levels of anxiety that interfere with his ability to show what he knows (person-environment).

Despite attending a handwriting group last summer, Liam remains unable to read much of what he prints and cannot do cursive writing. His mother inquires if we could look at changing the nature of the occupation, modifying typical student occupations such as handwriting and organizing written work (person-occupation). She has heard from the school and other parents that some students are getting assistive computer technology to compensate for significant writing and spelling issues, and wonders if this might be an option for Liam (environment-occupation). Liam is relieved that our relationship will not be just about "fixing him" as he believes that if he could just do his written work differently, school would be less stressful.

Case Scenario #2 – Supporting intervention

Charles has been a sanitation worker with the municipality for 22 years. Charles recently injured his low back on the job, having been plagued with low back problems for years. He is almost finished his 6-week work hardening program and has experienced considerable improvement in endurance and reduction in pain. His case manager has reviewed his file and feels that he has made sufficient progress to begin returning to work. Charles is very apprehensive about this recommendation, as he has struggled with his low back for years. The repetitive nature of the job appears to have created a chronic situation that has limited his ability to engage in some of the activities he had previously enjoyed, such as gardening. He reports that the past

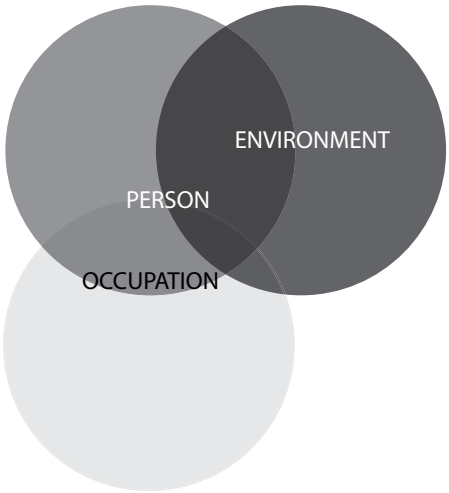
Diagram 2: Optimal P-E-O congruence



few weeks have produced the least amount of pain he can remember, and he fears that a return to his original job will result in losing his gains in reduced pain, improved sleep, and improved tolerance to a variety of physical activities.

The occupational therapist uses the circle tool to allay Charles' fears that the entire responsibility of successful return to work rests on his physical capacity. In fact, Charles' tolerance to lifting has improved (person-occupation). The employer will offer modified and

Diagram 3: P-E-O congruence with Person factor targeted.



graded duties to prevent Charles' symptoms from returning upon resumption of his duties (environment-occupation). He will also start back on an alternate route (person-environment) that is geared to recycling pick up rather than garbage collection.

The combination of factors will likely promote successful participation in the new role. The therapist can use the overlapping circles to show how occupational performance will change if the person, environment, and occupation areas are targeted (see Diagram 2), and compare that favourable overlap to the suboptimal overlap if he were to return to his garbage collection route (see Diagram 3). Should his symptoms return to intolerable levels, a job match will be completed and an alternative municipal position will be offered. By using the circles to demonstrate the shared focus, Charles feels more in control of his return.

"This tool provides a way to facilitate use of occupational therapy language and communicates the breadth and scope of our potential."

Case Scenario #3 – Interprofessional systems

A new social worker and an occupational therapist work together to plan a new group for parents of children with autism spectrum disorder. Occupational therapists were tasked primarily with fine motor and gross motor interventions at the previous workplace of the social worker. The social worker asks the occupational therapist to describe occupational therapy. The occupational therapist uses the circle tool to describe the different areas occupational therapy can address, and how occupational therapy sees each area affecting the other. The focus on the environment is new to the social worker's understanding of the scope of occupational therapy practice, and forges an interprofessional alliance in which both disciplines converge on environmental issues. The group is developed with sessions covering modifications to the environment and structure to expectations, drawing firmly on the environment and occupation areas of the person, environment and occupation.

Conclusion:

By quickly creating the PEO circle tool, an occupational therapist can have access to a simple and user-friendly vehicle for explaining occupational therapy's areas of interest. Its interactive nature allows clients across age groups to see how focus on environment and occupation, in addition to the traditional person and performance-component targets, can dramatically shift outcomes. Grounded in current theory, it helps occupational therapists to feel comfortable in using the term "occupation" and to expand focus outside the person.

How-to

For a colour version of the tool, please visit http://www.caot.ca/images/peocircletool.jpg

The circle tool may be printed onto transparencies using a coloured printer (laser recommended for durability). Cut the circles out of the transparencies, and you will have your own Circle Tool.

The author wishes to thank the Division of Child and Adolescent Psychiatry, Hotel Dieu Hospita, Kingston, Ontario, for their support.

Reference

Law M, Cooper B, Strong S, Stewart D, Rigby P, Letts L. (1996). The Person-Environment-Occupational Model: A transactive aproach to occupational performance. *CJOT 63*(1), 9-23.

This article is based in part on a poster presented at CAOT conference in 2003.

My journey towards "Steps in the Right Direction: Connecting & Collaborating in Early Intervention Therapy with Aboriginal Children & Families in British Columbia"

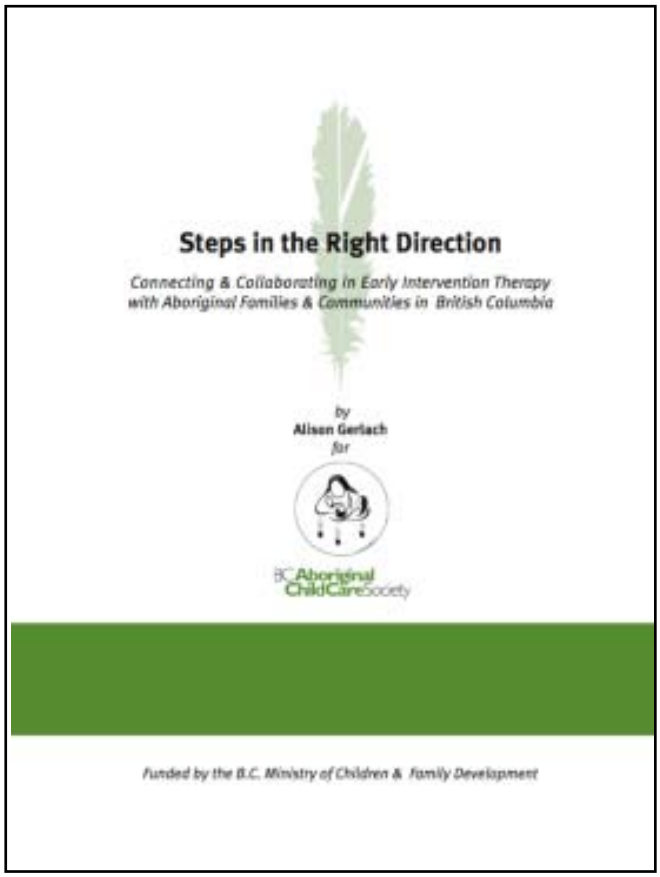
Alison Gerlach

Have you ever driven home from visiting a client in the community and spent your journey reflecting on what you could have done differently or how you could have done something more effectively? For several years, starting in 1998, my journey between Mt. Currie, part of the Lil'wat First Nation in south western British Columbia (B.C.) and my home, an hour away, was spent reflecting on my clinical encounters and experiences with clients and colleagues from the Lil'wat Nation. I had lots of questions and started the journey of looking for some answers. The following is a story of how almost ten years and many kilometers later I published *'Steps in the Right Direction: Connecting & Collaborating in Early Intervention with Aboriginal Children and Families in B.C.'*

As an immigrant to Canada, my knowledge and experience of Aboriginal history, issues and ways of being was extremely lacking. Status versus non-status, reserve versus off-reserve, residential school trauma, historical oppression and colonialism – I had no knowledge of these topics or of their profound influence on health care and occupational therapy. At that time I was also ignorant about my own sense of culture – did I have one? Did occupational therapy have a culture? How did these influence my personal and professional life?

Reflective and critical thinking have proven to be very powerful tools in my ongoing personal and professional self growth. A graduate course in cultural competency introduced me to concepts about culture that were at the time new and exciting. I was subsequently given the enormous honour of being granted permission by a trusting Mt. Currie Chief and Council to conduct a research project with families who had children with special needs. As a qualitative researcher I asked family members questions about raising their child with special needs and their experience of non-Aboriginal health professionals (Gerlach, 2008). Interestingly these were questions that I had never asked in several years of being their therapist – why was that? During this period of study, searches of national and international occupational therapy, rehabilitation and health care literature largely failed to answer my ongoing search for information to guide my practice and answer my questions. However, the literature search did produce readings that began to inform me about the pervasive and intergenerational trauma of the residential school system and its continuing influence on contemporary child rearing and family life in many Aboriginal families and communities. It took several more years of study, including readings on postcolonial theory and cultural safety, for me to start to comprehend the impact that historical and socio-political events have and continue to have on many Aboriginal peoples' health care status, access, and clinical encounters.

Ongoing reflection over the years on my relationships, clinical encounters and experiences with Aboriginal colleagues and clients has also developed my awareness of my personal value system and the influence of my heritage and ongoing life experiences on my own ever evolving sense of culture and how it influ-



About the author –
Alison Gerlach, MSc(OT), is an independent consultant currently telecommuting to Canada from Hawaii. She can be reached at agerlach@hawaii.rr.com.

ences my personal daily life and professional reasoning and practice. It has also generated further questioning about the cultural bias of health care policies and models of service delivery, including those inherent in occupational therapy.

In 2006 the Ministry of Children and Family Development (M.C.F.D.) in B.C. and the B.C. Aboriginal Child Care Society (B.C.A.C.C.S) supported my proposal to write a publication that integrated concepts of cultural safety within a community development model of service delivery in interdisciplinary early intervention. Research from a broad range of international, interdisciplinary literature, my own clinical experiences, and anecdotal evidence provided the foundation for *"Steps in the Right Direction"*. Extensive anecdotal evidence was gathered from interdisciplinary therapy professionals and Aboriginal child and health care service providers from across B.C. through telephone/email interviews, focus groups, and from workshop participants at the B.C.A.C.C.S. 8th Annual Provincial Training Conference.

'Steps in the Right Direction' was written for early intervention occupational therapists, physiotherapists and speech language pathologist, and since its publication has been welcomed by many Aboriginal child and health care service providers. Its launch via a videoconference in July 2007 linked 27 sites around B.C., Alberta and the North West Territories to promote a dialogue between Aboriginal and non-Aboriginal health professionals on early childhood development and intervention issues.

It is hoped that when early intervention therapists, and other professionals, are reading *'Steps in the Right Direction'* that they use the opportunity to take time, as I have over the years, to reflect on their own personal and professional values, beliefs and practices, and consider how these influence their clinical reasoning and practice with Aboriginal peoples. It is hopefully one small step in the right direction for improving the health care status, access and services for Aboriginal children and families.

A pdf of *'Steps in the Right Direction'* is available on the B.C.A.C.C.S.'s website at www.acc-society.bc.ca - follow the links to library and publications.

Gerlach, A. (2008). Circle of caring: A First Nations worldview of child rearing. *Canadian Journal of Occupational Therapy,* 75 (1), 18-25.

If you are interested in connecting with other occupational therapists who are working with and for indigenous peoples internationally please check out a new and exciting, international Community of Practice –'Occupational Therapy Partnerships for Change' at the following wikispace: http://occtherpartnershipsforchange.wikispaces.com or you can contact the author at agerlach@hawaii.rr.com for more information.

Information web portal for internationally educated occupational therapists

Kathy Van Benthem, CAOT Director of Policy and Standards

The Information Portal for internationally educated occupational therapists (IEOTs) is an innovative and timely initiative with the purpose of developing one unified electronic information gateway or portal to centralize information for IEOTs on the internet. The Portal will also serve as an entry point to access coordinated information related to occupational therapy in Canada for IEOTs, employers, domestically educated occupational therapists, settlement agencies, and other organizations working with IEOTs.

The Canadian Association of Occupational Therapists (CAOT) project partners include the Association of Canadian Occupational Therapy Regulators and the Association of Canadian Occupational Therapy University Programs. The project is funded through the Foreign Credential Recognition Program of Human Resources and Skills Development Canada. CAOT's investment in this initiative stems from the recognition that sustained efforts are needed, in collaboration with key stakeholders, to make certain that a sustainable and effective occupational therapy workforce is prepared to respond to the health needs of the Canadian population.

The portal is a reflection of recommendations resulting from two previous CAOT projects: the *Workforce Integration Project* (CAOT, 2006) and the *Access and Registration Framework for Internationally Educated Occupational Therapists* (CAOT, 2007). *The Workforce Integration Project* explored the issues that facilitate and/or inhibit the integration of international occupational therapy graduates into the Canadian workforce (CAOT, 2006). The *Access and Registration Framework for Internationally Educated Occupational Therapists* project established the context to implement actions to facilitate the workforce integration of IEOTs and identify the key roles and responsibilities of the stakeholder groups (CAOT, 2007). The *Framework* identified pathways for international occupational therapy graduates; from country of origin, to assessment of credentials and competencies, to successful registration, and finally to practice. The *Framework* highlighted critical points for appropriate intervention with resources and assessments (CAOT, 2007).

The need for a centralized information portal was prompted by the recognition that a significant number of individuals educated as occupational therapists in other countries experience difficulties in obtaining the clear, consistent, and accurate information necessary for workforce integration at a time when many parts of Canada are faced with an under-supply of occupational therapists. It is cumbersome, time consuming, and confusing for IEOTs to navigate several web sites, including Citizenship and Immigration Canada, the national occupational therapy association, provincial/territorial regulatory organizations, and other sources of information about Canada and the Canadian health system. Difficulties in accessing information are viewed as a barrier to workforce integration for IEOTs. Designed to specifically address this barrier, the portal will be a central source for all pertinent information and, in addition to the websites mentioned above, will include links to recently developed government web sites for international graduates such as the *Working in Canada* portal. Sustained overseeing of the portal by CAOT will ensure that the information is consistent and as up-to-date as possible.

The portal project partners assembled an Advisory Committee to provide input into the development of the portal to ensure that it addresses the needs of various stakeholders. The Advisory Committee is made up of two representatives of each project partner, the creative team of the consultant group, as well as one IEOT with experience working in the Canadian occupational therapy workforce. Additional stakeholders are invited to join the Advisory Committee at strategic points in the portal's development in order to bring in subject matter expertise as required

With the support of the Advisory Committee, the project partners are working collaboratively in order to ensure that the portal will reflect the combined vision of all the stakeholders, and to develop a unique "brand" and recognizable name for easy access and identification by all visitors to the portal. This project, which began in the summer of 2008, will be completed in November 2009, with a portal launch scheduled for October 2009.

References

Canadian Association of Occupational Therapists (2006). *Workforce Integration Project*. Retrieved February, 2009 from http://www.caot.ca/default.asp?pageid=1384

Canadian Association of Occupational Therapists (2007). *Access and Registration Framework for Internationally Educated Occupational Therapists.* Retrieved February, 2009 from http://www.caot.ca/default.asp?pageid=2196

Professional insurance: What you need to know

Brian Gomes

Is your independent practice at risk?

With the demand for health care services continuing to escalate, CAOT members are increasingly working within independent practice settings.

When practicing in this capacity, all practitioners, including occupational therapists, should carry individual professional liability coverage. As well, the clinic or independent practitioner can be named in legal action in the event of a loss; therefore, independent practitioners should maintain professional liability insurance protection by means of an entity errors and omissions policy. By operating as an independent practitioner or business, the individual and/or clinic is faced with increased exposures, such as liability for bodily injury or property damage to a third party, or loss of property due to fire, theft, and so on; therefore, coverage should be secured for such business-related losses.

While discounted policies and options are available through the CAOT members' insurance program to cover these exposures, occupational therapists are advised to practice sound risk management.

A clinic's or independent practitioner's exposure to liability claims can also be limited by taking a proactive approach to risk management. Commonly referred to as "the duty of care", the safety and well-being of a client is the responsibility of the clinic or independent practitioner and any employees. In the event that this duty of care is breached, the clinic or independent practitioner and any employees can be negligent for causing such harm.

There are many common exposures that independent practitioners or clinic operators may face. However, taking a proactive risk management through thought and analysis can protect your assets well beyond insurance coverage.

A challenged economy challenging your insurance

By now, most occupational therapists in Canada have become aware of, or heard about, current economic and marketplace fluctuations. As economic conditions change, it is imperative to ensure the stability and sustainability of any insurance program. More specifically, for insurance programs that have exposures to a large segment of the population such as the CAOT Professional Liability program, it is fundamental to monitor the financial strength and security of insurers. Since this program is in place to protect an insured occupational therapist's assets in the event of a claim, this is an important due diligence task.

The CAOT members insurance program is the largest and most historical program for occupational therapists in Canada. During times of economic uncertainty, this is a very good thing. A program with well established participation volume builds a historic foundation for insurers to work from when analyzing rating (premium) over a fixed period of time.

Generally speaking and in line with past insurance marketplace cycles, as the economic climate becomes worse, there is traditionally an increase in claims reported. For occupational therapists, this is an increasingly important time to ensure that in addition to liability coverage, risk management and risk mitigation practices are adhered to. Examples include: adherence to sound documentation guidelines, knowing your surroundings, operating within your scope of practice and being familiar with your code of ethics.

As mentioned above, the stability of a group program helps to mitigate market fluctuations and the effects on an insurance program. The CAOT program continues to evolve, and includes features such as a loss of earnings limit designed to pay for occupational therapists' lost wages incurred while preparing for or attending the defense of a claim.

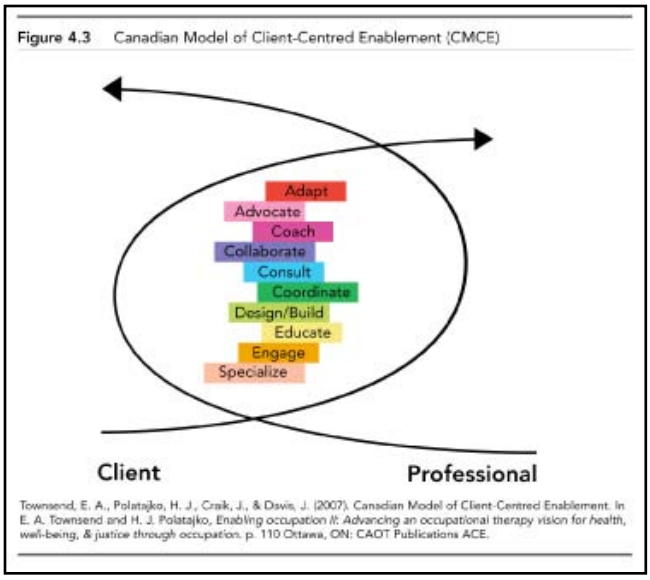
About the author –
Brian Gomes is a Vice President with Aon Reed Stenhouse Inc., and is a director of health care and malpractice insurance products including CAOT member's professional liability insurance program. This article is written for informational purposes only and is general in nature, please reference your policy for specific coverage details.

The Canadian Model of Client-Centred Enablement: Reflections from diverse occupational therapy practitioners

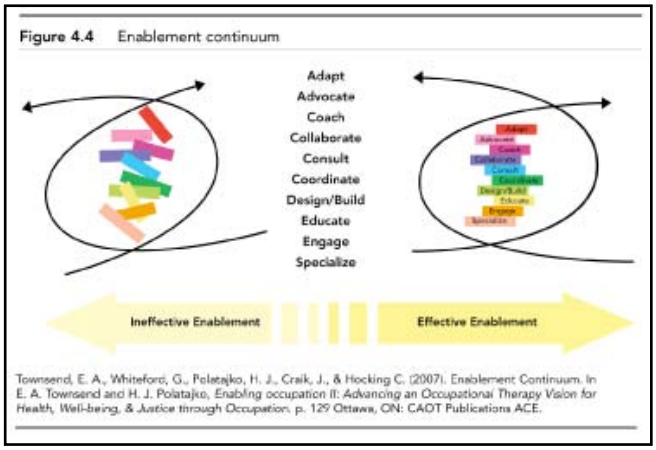
Robin Stadnyk, Jill Phillips, Slavko Sapeta, Alison MacAulay, Margaret Champion, Linna Tam and Janet Craik.

This article is the third of a series of articles that introduces new models and concepts presented in the latest set of Canadian occupational therapy guidelines entitled, Enabling Occupation II: Advancing Occupational Vision for Health, Well-Being and Justice through Occupation *(Townsend & Polatajko, 2007).*

In *Enabling Occupation II*, the Canadian Model of Client-Centred Enablement (CMCE) is presented. This model is "a visual metaphor for client-centred enablement" (see Figure 4.3) (Townsend et al., 2007, p. 109) and depicts the relationship between therapist and client, as well as an array of enablement skills used in therapeutic relationships. Chapter four of *Enabling Occupation II* describes how the CMCE, "embraces enablement as the core competency of occupational therapy" (Townsend et al., p. 109). The chapter is exciting to read because it makes explicit the ideas about enablement that have implicitly guided occupational therapy practice for years. The CMCE displays 'what' occupational therapists 'do' with their clients who may be individual, families, groups, communities, organizations or populations. Furthermore the CMCE defines a spectrum of enablement skills that include the actions of adapt, advocate, coach, collaborate, consult, coordinate, design/build, educate, engage and specialize as the key skills for client-centred, occupation-based enablement.



A fascinating idea portrayed in the CMCE is that enablement may fall on a continuum. While we would wish for all enablement to be effective, there are a "continuum of possibilities from ineffective to effective enablement" (Townsend et al., p. 128). Four decision-making points for the enablement continuum have been established and include; ineffective enablement, missed enablement, minimal enablement and effective enablement (see Figure 4.4). The text encourages us to critically reflect on enablement, recognizing that "complex practice conditions as well as therapist choices determine possibilities for enablement" (Townsend et al., p. 130).



Last fall, the CMCE and the enablement continuum was discussed with a group of occupational therapists with diverse practice backgrounds. These 15 therapists were participants in a distance-education theory course at Dalhousie University's School of Occupational Therapy. Here are some of the comments they made in their on-line discussion.

*****

Monday, September 10, 2007 6:43 pm
Jill Phillips

While reviewing the CMCE (Townsend, Polatajko, Craik, & Davis, 2007), I found it to be an interesting experience as it prompted me to reflect, re-visit and re-evaluate what I instinctively do in my practice. This challenge I feel arises as I have been working for some years in this profession, to the point that much of my practice has become internalized, and the phrase that occupational therapy practice is "common sense" is not an unknown phrase spoken amongst experienced

therapists. I feel that this internalization, in part, leads to our profession being undervalued, and that we need to find innovative ways of communicating how valuable our skills are. . . .

I believe that ineffective, missed or minimal enablement can very easily be a part of the dollar driven, efficiency based public health care system. In my particular work area of disability management and injury prevention, opportunities for enablement can be lost because of high caseloads for both the referral source and also for the therapist. Referrals may not be made in an opportunistic time-frame and clients become very stressed and frustrated before occupational therapy intervention can take place. Is this acceptable, obviously not, what can we do about this? Maybe that is a question for discussion.

Monday, September 10, 2007 10:11 pm
Slav Sapeta

Jill, you're not alone. I too work in a program based service as an occupational therapy consultant through our local Community Care Access Centre. I have to admit, I too have felt undervalued as a professional. I often suspect case managers believe that a bath chair and a raised toilet seat will meet the client's occupational needs. It has been my particular experience that what you are saying (if I am reading your post correctly) . . . is true, especially in a program based system. . . .

When asked whether I have ever experienced ineffective, missed or minimal enablement the answer is simply, yes. Speaking again from practical terms, we are frequently allotted a block of two visits in order to assess a client, provide recommendations and follow up with those recommendations ensuring safety within the home and are then to discharge the client to manage independently in the community. I have to admit; I have been a therapist involved in all four decision making points on the disablement-enablement continuum. My question is, when dealing with pragmatic referral sources that although concerned for the client safety also manage a tight purse string budget, do practicing therapists perform effective enablement with the many needs of the client?

Wednesday, September 12, 2007 2:13 pm
Alison MacAulay

Slav and Jill, I can appreciate where your frustrations lie. As a new graduate I found it was challenging to begin working all "bright eyed and bushy tailed" only to come to the further realization that occupational therapy is seen as the "common sense" profession. But acknowledging how we are perceived by some (not all!), I am reflecting upon how we can move forward beyond these misconceptions. . . . I feel others see occupation as a very simplistic topic because they don't understand the complexity of occupation. I must say it wasn't until the end of my second year or even into my third year that I actually "got it".

I think the CMCE brings together an array of descriptors of what it is we "do." It provides us with a framework to promote enablement by reflecting upon the foundations of enablement and realizing the unique and dynamic nature of the client centred relationship. As the *Enabling II* text describes, enablement can be practiced by integrating the ten key enablement skills. But even though we practice the ten key enablement skills enablement may not occur because of an array of factors.

As Jill and Slav describe, policies, funding, and factors related to the institutional, social, and cultural environment often have a profound impact on one's enablement. Although often difficult in a practice setting, I think we need to strive towards promoting change at a systems and environmental level whether that be through becoming involved in policy change, advocating or educating those in power.

About the authors –

Robin L. Stadnyk is an assistant professor in the School of Occupational Therapy at Dalhousie University.

Janet Craik is the Director of Professional Practice for the CAOT.

At the time of writing

Jill Phillips was working in the area of disability management and injury prevention in Newfoundland.

Slavko Sapeta was working in a Community Care Access Centre in Ontario

Alison MacAulay was a full time student in the post-professional Master's program at the School of Occupational Therapy, Dalhousie University.

Margaret Champion was a private management consultant in Nova Scotia.

Linna Tam was working in the area of child and adolescent mental health in Ontario.

Wednesday, September 12, 2007 2:42 pm
Margaret Champion

Such great discussions! I thoroughly enjoyed reading the section on the CMCE, and was excited to see the diverse skills described within the model. I love the notion that enablement is the core competency of the profession. It likely should be the core competency of many professions . . .!

On a regular basis, I have experienced ineffective, missed or minimal enablement. On multiple occasions, when hired to work in positions with established occupational therapy programs, I worked to customize intervention for clients who were idiosyncratic rather than providing all clients with the same services (e.g. stopped prescribing the same set of assistive devices for each person with a particular health condition, switching to only suggesting devices that matched each person's life circumstance; stopped the practice of engaging many clients in a traditional ceramics class, which had unsuccessfully aspired to engage clients to re-enter the workforce in the community).

I think we will always struggle with the missed and the minimal enablement issues within cost constrained systems. As a health services administrator,

a tax payer and a family member of a once very ill and palliative parent, I realize there are limited resources, and it is impossible to fund each profession to the point where the profession can provide all it has to ideally offer. Yes, occupational therapy needs to advocate for more funding many times, but sometimes, we likely need to make some hard decisions about where our practice is best offered, and redirect existing resources to maximize benefits with our clients. We also might think about partnering with our clients and other disciplines to embrace enablement together, so we are not alone in the cause.

The CMCE gives us a way to articulate both the process and the content of enabling, in a way that makes our work easier to understand. I think there is great potential for the use of this model as a starting-point for discussions with student occupational therapists, occupational therapy practitioners, and non-occupational therapists who want to know more about enablement. The disablement-enablement continuum provides a mechanism for occupational therapists to reflect on their practice, rather than placing blame on individual therapists for missed, minimal or ineffective enablement. As discussion participant Linna Tam said, "Since learning about the enablement-disablement continuum, I must admit that I am relieved that there is a framework that describes my recent situations and the results are not due to my poor clinical skills."

Further comments and discussions on your reflections of the CMCE are always welcome at *OT Now* and on the CAOT website's public discussion board. To post a message or visit the Enabling Occupation discussion board, visit www.caot.ca, from the navigation bar select 'Periodicals & Publications', from the drop down menu select 'Enabling Occupation', then click on the link to the public discussion board (right side bar).

The authors would like to acknowledge the contributions of the other occupational therapist participants in the course (OCCU 5010 Advanced Studies in Enabling Occupation) to the formation of ideas expressed in this paper: Rebecca Cabell, Judith Chisholm, Jonathan Halton, Amy Leung, Angela Petty, Lindsay Roysum, Margaret Stanley, Michael Steeves, Kevin Wong, Vivian Yue.

References

Townsend, E., et al. (2007). Enabling: Occupational therapy's core competency. In E. Townsend and H. Polatajko, *Enabling occupation II: Advancing occupational therapy vision for health, well-being and justice through occupation* (pp. 87-151). Ottawa, ON: CAOT Publications ACE.

Townsend, E.A., & Polatajko, H.J. (2007). *Enabling occupation II: Advancing occupational therapy vision for health, well-being and justice through occupation.* Ottawa, ON: CAOT Publications ACE,.

Townsend, E.A., Polatajko, H. J., Craik, J., & Davis, J. (2007). Canadian Model of Client-Cenetred Enablement. In E.A. Townsend and H.J. Polatajko, *Enabling occupation II: Advancing occupational therapy vision for health, well-being and justice through occupation* (pp. 87-151). Ottawa, ON: CAOT Publications ACE.

Update from the COTF

Upcoming Competitions

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.

COTF Events at the CAOT Annual General Conference:

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COTF Session (CIHR's-Institute on Ageing will be participating.): Thursday, June 4, 15h30-16h30

Live Auction: Thursday, June 4, at the social event during the evening

COTF AGM: Saturday, June 6, 11-11h30

Lunch with a Scholar (Michael Iwama): Saturday, June 6, 11h30-13h

The COTF events at the conference serve as fundraising events for COTF. If you have any items that you would like to donate to the auctions, please contact Anne McDonald at amcdonald@cotfcanada.org so that a donor declaration form can be sent to you. Lunch with a Scholar is a ticketed event whereby a portion of the ticket sales is a donation to COTF. Please help us make these fundraising efforts successful by participating!

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Pediatric Myofascial Release
Fascial-Pelvis Myofascial Release
Cervical-Thoracic Myofascial Release
Myofascial Unwinding
Dates: Various dates and locations
For information: www.myofascial-release.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

Sensory Processing Measure (SPM) Workshops

Presented by: Diana Henry
Location: Saint John Trade and Convention Centre, Saint John, NB
Tools for Tots Workshop: May 21, 2009 - Designed to offer practical sensory strategies to improve the ability of toddlers and young children to play and function in their daily environments.
Tools for Teens Workshop: May 22, 2009 - Focuses on children ages 11-19 years, helps to identify alternative and healthy and age appropriate sensory strategies and "tools" to assist teens to participate in age appropriate activities.
Sensory Processing Measure: May 23, 2009 - Learn how to use the SPM to assist in identifying the growing number of children who present with sensory processing difficulties.
Contact info: Christel Seeberger B.Sc.O.T., OT(c), OT Reg. (NB), OTR totalability@nb.aibn.com