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Everyday stories . . . profiles of your CAOT colleagues



Bonnie Klassen



Bonnie Klassen

Bonnie Klassen, MSc(OT) is an occupational therapist in the Community Rehabilitation Program and the Chronic Pain Clinic in Camrose, and in private practice in Edmonton, Alberta.

Bonnie set out to find occupational therapists working in primary health care in Alberta and to find out what they see are the challenges and rewards of pushing the boundaries in the profession. Here's what she found out...

Health 4 Life, Alberta Health Services, Vegreville



Terri Feltham

Terri Feltham is an occupational therapist working as part of an interdisciplinary team known as "Health 4 Life", a chronic disease management (CDM) program located in the Vegreville Commu-

nity Health Unit. Team members include a registered nurse, a clinical dietitian, and a physical therapist. The CDM team works closely with a pharmacist, a respiratory therapist and mental health therapists. her unique role as being the one who ensures that the team assessment includes the areas of affect, cognition, meaningful activity, sleep, and sexual health. All team members are trained in motivational interviewing techniques and work collaboratively to facilitate goal setting and behaviour change with clients. They assist clients to develop the skills and confidence to become better managers of their own health.

Terri described the clients they see as adults aged 18 and older who have risk factors or who have been diagnosed with a chronic condition. Physicians or other health professionals can make referrals, or clients can self-refer.

Terri participates in initial client assessments with all team members and, depending on client needs, in follow-up appointments. Terri screens how the client is functioning in all domains, including physical, affective, cognitive, social, and environmental, during client

visits. She asks about activities of daily living, instrumental activities of daily living, self care, productivity, leisure, sleep, pain management and sexual health. She refers clients to other health programs and services for further assessment and/or appropriate treatment. Due to the large number of diabetic clients, Terri provides regular lower leg assessments as per Canadian Diabetes Guidelines that include sensation testing, ankle brachial indexes, photoplethysmography toe pressures and footwear/foot care education. Clients may be referred for specialized footwear, custom orthotics, pressure gradient stockings or other needs as identified. Terri also facilitates group education sessions on joint protection, goal setting, memory enhancement, footwear/foot care, and other health topics.

Terri acknowledges that there are challenges to being in a unique role and describes how interesting it has been to build and develop the role of the occupational therapist on the team. Through her efforts she has seen the benefits of increased understanding from her team members of the role and the insights that occupational therapy can provide. One challenge she finds is as a part time position there is plenty of room for growth and development to better meet client needs. She also finds it challenging not to be involved in active intervention as there is a strong emphasis on facilitating self-management, education, and assisting clients through transitions in the health system.

Terri describes the most energizing aspect of her work as being a part of this very synergistic group of health professionals. It is a role that she feels utilizes her occupational therapy knowledge and expertise in an effective and efficient manner, as well as that of her team members. She strongly believes that this model of care best meets clients' needs and facilitates strong self-management and health promotion skills.

Services for Seniors, Allied Health - Edmonton Zone, Alberta Health Services

Amy Lau works with three other occupational therapists for Services for Seniors. They are based in three urban locations: Rutherford Health Centre, Eastwood Health Centre and Woodcroft Health Centre in Edmonton. All four participate in a unique entity called the "Healthy Aging Resource Team" where the occupational therapists partner with community nurses to provide early identification, intervention, and health promo-



Amy Lau

tion services to seniors living in the community. They also partner with Edmonton Southside Primary Care Network, as part of a multidisciplinary team with physicians, nurses, social workers and dietitians.

Amy describes the client population as mature adults, 50 and over, living in the community. They receive referrals from many sources including self-referral, primary care networks, community health nurses, family physicians, geriatricians, seniors' clinics and geriatric outpatient clinics.

The occupational therapists role with seniors in the community is multifaceted and diverse. They provide early identification of functional decline, particularly in mobility and self care, and provide intervention to maintain and improve function in these and other areas of daily living. This is achieved in Health and Wellness clinics in seniors buildings, by education, by enhancing the capacity of caregivers in the Coping with Caring Program, and by connecting clients and caregivers with community resources. The team works hard to enhance the capacity of clients to participate in occupations of their choosing.

One of the challenges identified by the team is that they do not have enough staff to meet the needs of the population served due to the broad and varied mandate of service delivery. They have also come to realize that there is a significant challenge to maintain and continue their professional development to meet their own identified learning goals.

One of the most satisfying aspects of Amy's work is hearing clients express their satisfaction with the services and programs provided. She is also proud of the way her team uses client-centred, evidence-based approaches and that they are always looking to improve on their use of coaching and problem solving to tap into the strengths of the clients.

Wood Buffalo Primary Care Network, Fort McMurray

Gail MacDonald works in a unique role with the Wood Buffalo Primary Care Network in Fort McMurray. She is a part of an interdisciplinary team consisting of nurse practitioners, Certified Diabetic Educators (CDE), registered nurses, social workers, dietitians, exercise therapists, and a pharmacist. Gail acknowledges that her role at the primary care network is very diverse and it



Gail McDonald

usually takes some time before new staff members develop a good understanding of what she does. She enjoys being a member of an interdisciplinary team and feels very valued by her colleagues. She also

enjoys the variety of patients that she works with in this role: primarily clients who have diabetes, weight management issues, post cardiac event, post stroke, and geriatric clients. She works part-time, by choice, and her workload is steadily increasing.

Gail assesses ankle brachial indexes on high risk clients, provides stress management education, cognitive testing, activities of daily living assessments, advice regarding activity tolerance for cardiac and geriatric clients, facilitates a community falls prevention program, and is a group educator for an hyperlipidemia/hypertension group and for cardiac rehabilitation. She is the area facilitator for "Choices and Changes" and runs a weekly geriatric day program.

Gail feels pride in what she has been able to contribute to program planning and development, especially the geriatric day program.

Summing up...

Some common themes can be observed from these three occupational therapists working in primary health care. They have diverse areas of involvement with clients and groups including health promotion, prevention of injury or decline, and functional rehabilitation; their partnerships and teamwork with clients and other health professionals are energizing; and their responsibilities and caseloads grow over time. Although the occupational therapists role in primary health care is not well known outside of some small circles such as these, there is potential for occupational therapists to develop an increasingly strong presence in this area of health care.

If you are interested in developing your own role in primary health care, CAOT publishes the workbook *Interdisciplinary Primary Health Care: Assembling the Pieces*, a valuable tool that takes you step by step through the process of developing professional relationships in a primary health care setting and establishing a role for occupational therapy.

What's new

Not lost in translation: The CAOT delegation to China

Sue Forwell



For twelve days at the end of September 2009, as a result of collaboration between the People to People Ambassador Programs and CAOT, a delegation of Canadian occupational therapists visited China and experienced the health care facilities, philosophies and occupational therapy of that country. The delegation was made up of 18 occupational therapists that included clinicians, private practitioners, academics, and administrators (and five of their guests) from across Canada. Six health care and university facilities were visited. These were:

1. The Intech Rehabilitation Hospital in Beijing, a rare private facility that opened in 2006. It has 60 rehabilitation and 50 nursing home beds with an average stay of three months. The patient mix is 65% post-stroke, 15-20% hip/knee replacements and the remainder motor vehicle injury and neurological conditions with the cost of treatment partially covered by insurance. Following a tour, a question and answer session took place with local therapists about assessment approaches for stroke patients, evaluation of patients in coma, assessment of physical and psychological issues for those with spinal cord injured (SCI) and the treatment of spasticity.
2. The China Rehabilitation Research Center (CRRIC) in Beijing opened in 1989 and is the largest state-owned rehabilitation institute affiliated with the China Disabled Person's Federation and is designated the national rehabilitation centre for all work-related injuries. Key areas of practice and research are: hemiplegia, SCI, orthopedics and amputation, neurology and neuro-rehab and a small pediatrics program focused on cerebral palsy (CP). The CRRIC currently employs 120 therapists in occupational, physical and speech therapies. After a tour of the multi-building facility, four presentations were given, two by Canadian delegates and two from the CRRIC by a student and a therapist, which was then followed by lively discussion.
3. In Xi'an we were warmly greeted at the Shaanxi Boai Hospital (established in 1968). Shaanxi Boai is the third largest rehab centre in China (5 physical therapists/5 occupational therapists/3 speech therapists) with a focus on pediatric rehabilitation (particularly CP and autism) and adult rehabilitation. The role of occupational therapy primarily involves upper extremity function/coordination and fine motor skills. They also offer acupuncture, music therapy, and multi-media rooms. Following a tour, the Director of Pediatrics CP Division gave a history of their program and two Canadian delegates followed with presentations.
4. Also in Xi'an, we visited the Shaanxi Traditional Chinese Medicine (TCM) Hospital, Department of Acupuncture and Moxibustion. Funded in 1956 to provide in-patient, out-patient and research services, it now boasts a staff of 600. The visit began with a question and answer session where several topics were addressed including: the use of both western and TCM approaches to treatment, the domain and philosophy of TCM, and population-specific treatment for chronic pain, stroke, mental illness, cancer, Parkinson's Disease and children with disabilities. The visit then moved onto an experiential tour of the hospital including observation of patients receiving acupuncture and massage, delegates receiving demonstration of treatment as well as observation in the herb dispensary.
5. At the Kunming Medical University we were greeted by two 2009 graduates from the first graduating class in occupational therapy, as well as a Professor and the Director of the Rehabilitation Department. The therapy programs are taught by a mix of "general therapists", physicians, and physical therapists and are supported by professors from the Hong Kong Polytechnique University. The occupational therapy program consists of two years of study with physical therapy students followed by two years specialized study in occupational therapy for 30-40 students per year.
6. Associated with the University of Kunming is the Huaxia Hospital and Rehabilitation Centre, where we were able to meet and mingle with many staff from multiple professions as well as clients and families. We were given a tour of treatment spaces on several floors and a retail store supplying aids and devices, which was followed by interactions with three clients (child, adult and older adult) and their families. A cultural program was also included for the delegates. The group visited the Forbidden City, Tiananmen Square, and the Great Wall in and around Beijing; the Terra Cotta warrior museum and the Big Wild Goose Pagoda in and around Xi'an; and Green Lake, Stone Forest and a traditional Chinese village in and around Kunming.

This opportunity was an incredible experience for the Canadian occupational therapists that formed the delegation. We built friendships and professional associates across the country and across the Pacific.

The Effect of Pain Scale: A tool to assist in evaluation of client reports of pain and disability

Janet Hunt, Latifa Kassam, Gerard Kerr, Tania Percy and Linda Waithman

Occupational therapists specialize in the evaluation of functional performance, specifically in the areas of self-care, productivity and leisure (CAOT, 1997; 2002). Occupational therapists also assess functional abilities and limitations through functional capacity evaluations. Two key elements of functional capacity evaluations are; (1) determination of effort and (2) consistency of client reports of pain and disability, compared to demonstrated function. Determination of effort establishes the degree of confidence the clinician can place on test results to accurately identify functional abilities and limitations. Determination of consistency of client reports of pain and disability, compared to demonstrated function, assists the clinician in establishing how much confidence should be placed on client reports.

It is possible to evaluate consistency by comparing reported disability (gathered through client interview and disability questionnaires) to demonstrated function during testing. However pain reports are more difficult to assess because there are two distinct factors to consider, pain intensity and the impact pain has on function. Validation of pain intensity reports is also difficult because pain is a subjective experience and cannot be quantified although it is possible to assess client reports of functionally limiting pain when it is correlated with actual observed performance. In recognition of this, some functional capacity evaluation protocols use functionally based pain scales to gather client reported pain levels during testing.

In addition, some functionally based pain scales also simultaneously link pain intensity to disability. When these scales are used, clients are asked to rate their pain using a numeric scale (typically 0 to 10) with associated indicators of pain intensity and disability levels. For example, a pain rating of 10 might be identified with, “Worst pain imaginable requiring immediate emergency hospitalization. Causes you to be completely incapacitated and barely able to talk”. The use of linked pain intensity and disability descriptors is based on the hypothesis that changing levels of pain should correspond with observable changes in function. A review of the literature indicated varying opinions as to whether or not pain is directly correlated with function (Lechner, Bradbury, & Bradley, 1998). In our clinical experience,

clients may report pain or a change in pain intensity without necessarily an observable impact on their performance.

A review of the literature also identified several existing pain scales that focused on the following: rating pain intensity (e.g., Numeric Pain Intensity Scale, based on the Rating of Perceived Exertion Scale [Borg, 1982]); linking pain with function (e.g., Functional Pain Scale [Matheson, 2008]); or gathering information regarding the extent to which pain interferes with various activities (e.g. Neck Pain Disability Index [Vernon & Silvano, 1991]).

The Effect of Pain Scale

The purpose of this article is to introduce the Effect of Pain (EOP) Scale. The EOP Scale is unique because it gathers client ratings of functionally limiting pain in real time, for specific activities, that are distinct from their pain intensity. The EOP Scale allows clinicians and clients to focus on the impact of pain on function independent of changes in pain levels, recognizing there may not be a direct correlation between pain intensity and performance. There were no scales similar to the EOP Scale found in the literature review.

Description of the EOP Scale

The EOP Scale is a self-rating scale used to determine a client’s opinion of the extent to which pain is affecting their ability to perform activities (see Table 1).

About the authors – Janet Hunt, BSR, Latifa Kassam, BSc(OT), Gerard Kerr, Reg OT (BC), Tania Percy, BSc(OT) and Linda Waithman, BSc(OT) work as occupational therapy contractors with Progressive Rehab, OrionHealth in British Columbia. Their areas of practice include work capacity/functional evaluations, cost of future care evaluations, medical-legal consultation, case management/community based rehabilitation, and return-to-work support. Author profiles are available at www.orionhealth.ca.

TABLE 1. THE EOP SCALE EXAMPLE.

Effect of Pain (EOP) Scale Rating the effect of pain on strength, movement, or ability to stay in one position
A = Normal ability B = Slight limitation C = Moderate limitation D = Severe limitation E = Unable to apply strength, move or stay in one position

If normal ability (A) is reported, there should be normal behaviours relative to the task and no clinical evidence of limitations. If slight limitation (B) is reported there should be subtle changes in function, such as mildly decreased strength, movement quality, or ability to maintain a posture. If moderate limitation (C) is reported, there should be objective signs of deteriorating function, such as guarding, slowing, and/or taking breaks. If severe limitation (D) is reported, clinical indicators of limitation should be more pronounced and frequent. If inability to continue (E) is reported, indicators of limitation should be marked, with inability to continue the task. If testing can be resumed after a recovery period (usually within five minutes), there should be a corresponding decrease in the degree of reported limitation.

The EOP Scale is usually administered in conjunction with selected use of a Numeric Pain Intensity Scale, 0-10+, where 0 represents no pain and 10+ represents maximal pain requiring emergency hospitalization (Borg, 1982). This scale allows clients to express levels of pain intensity separate from the context of function. Numeric pain ratings are recorded at the beginning and end of testing and at other intervals as deemed necessary. Numeric pain ratings are considered separately and should not be directly linked to ratings on the EOP Scale.

Assessment process

At the beginning of an evaluation, the clinician provides descriptions of both scales to the client. The clinician explains to the client that pain and function are not the same, and it is normal to have pain but still be able to perform an activity. The Numeric Pain Intensity Scale (Borg, 1982) is used to record pain response in relation to activity. The EOP Scale is used to gather information regarding the extent to which the client judges pain to be impacting on their ability to perform a specific task. The clinician is then able to compare the client's EOP Scale rating with observed function in order to evaluate consistency between the reported disability and the actual functional performance. The focus of testing is to evaluate how much pain impacts function and therefore the EOP Scale is used to a greater extent than the Numeric Pain Intensity Scale (Borg).

A case example using the EOP Scale

Mrs. Jones is a 55-year old nurse with a low back injury. During testing she sat continuously for one hour while participating in an interview. During the first half hour, she sat evenly with minimal weight shifting. Following this, she shifted her weight more frequently and stood briefly on one occasion. Upon completion of the inter-

view, Mrs. Jones stood up using support from both arm rests and walked slowly. During the break immediately following the interview, she stood rather than sat. Following the break she was able to resume sitting, with occasional weight shifting.

Using the EOP Scale, Mrs. Jones was asked to rate the degree to which her low back pain affected her ability to sit at various times during the assessment. She rated sitting ability as normal (A) for the first half of the interview, despite slight low back discomfort. She identified moderate limitation (C) over the next half hour, reduced to between normal ability (A) and slight limitation (B) following the break. In this case, Mrs. Jones's EOP ratings were consistent with her demonstrated function. The EOP Scale was also useful in describing recovery rates following symptom elevation.

Discussion

The EOP Scale is used when pain is reported to be causing functional limitations. It is a clinical tool that is helpful in evaluating the accuracy and consistency of client reported disability. By using this scale, feedback can also be provided to clients in a manner that does not focus on their subjective experience of pain but rather looks at their function in response to pain. This can be helpful in educating clients regarding the separate concepts of pain and disability.

The EOP Scale may be less effective for some clients within specific population groups, such as those with minimal or no English language skills, those with limited cognitive capacity, and/or those who have firmly entrenched pain beliefs that make it difficult to distinguish varying pain intensities from performance.

Anecdotally, clinicians have found the EOP Scale to be a useful and practical clinical tool and it has been well received by clients. Clinicians can confidently rely on client reports of pain and disability in conjunction with objective test results when client ratings on the EOP Scale are consistent with observed function. If client ratings are not consistent with observed function, more weight will be placed on objective findings, provided the client gave high effort. If client ratings are not always consistent with demonstrated performance, the clinician can more easily identify discrepancies and weight consideration of client reports accordingly.

Over the past three years, the EOP Scale has been fully incorporated into functional capacity evaluation protocols used by the authors. It is currently being used with a broad spectrum of client populations including clients with soft tissue, orthopedic, and/or neurological injuries, chronic pain and varying medical conditions. It is also being used in a variety of clinical practice areas,

including cost of future care evaluations and community rehabilitation. The scale has been equally useful with clients in the acute phase of their recovery, those participating in active rehabilitation, or those who have functionally plateaued.

Development and application of the EOP Scale is ongoing. This article is intended to introduce the EOP Scale as a concept, not as an administration manual. Further research regarding the utility and psychometric properties of the EOP Scale is needed.

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Column Editor: Sandra Hobson

Your practice style trait: Understanding your personalized trait and how it helps explain your practice behaviours

Nicol Korner-Bitensky and Anita Menon

There is growing pressure on occupational therapists to stay current regarding best practices. In today's health care system, new assessment tools and intervention strategies are constantly being introduced with the expectation that we will incorporate them into our clinical practice.

What is a practice style trait?

Each of us is different, both in our learning styles and how we perceive new information and its value for our daily clinical practice. This recognition that health professionals differ has resulted in intensified efforts to identify the "traits" that we each have. Green and colleagues suggest that each clinician differs (Green, Gorenflo, & Wyszewianski, 2002)

- in what they consider to be credible sources of evidence (i.e., the value of evidence vs. experience);
- in the weight they assign to practical concerns (i.e., the importance of managing workload vs. patient satisfaction);
- in their willingness to diverge from group norms (i.e., issues of non-conformity and the importance we place on doing things the same way as our peers).

Green and colleagues postulate that all of these underlying factors may influence how a clinician responds to new scientific evidence and whether he or she ultimately changes their practice patterns when evidence supports the need for change.

Wyszewianski and Green (2000) have gone on to develop a framework for classifying four clinician traits (seeker, receptive, traditionalist and pragmatist) by using a validated Practice Style Questionnaire. Some examples of items for each factor are: "Clinical experience is more important than randomized controlled trials" (evidence vs. experience factor), "I am comfortable practicing in ways different than other doctors" (non-conformity factor), and "I follow practice guidelines if they are not too much hassle" (practicality factor). Trait classification that categorizes a clinician into one of four traits is based on cut-off scores for each factor. NOTE: A small percentage of clinicians are not trait-classifiable.

Where do you see yourself in these four traits, if anywhere?

- The **seeker** guides his or her intervention practices using published data, rather than personal experience or authority. This individual actively reads professional journals, frequently uses electronic resources for learning, and is willing to diverge from traditional practice if evidence-based sources support this change.
- The **receptive** is also evidence-oriented and is inclined to change practice, but is more likely to rely on the clinical judgment of respected authorities. His or her practice may differ from local medical culture, given that there is enough evidence to support change.
- The **traditionalist** views clinical experience and respected authorities as the most reliable basis for practice.
- The **pragmatist** focuses on practicality and is likely to change practice according to workload demands, patient flow, and patient satisfaction, rather than on scientific validity.

Wyszewianski and Green (2000) point out that these human traits are inherent to how one responds to new information. So, wouldn't it be important for us to understand these traits in ourselves and in our colleagues?

What did we find in our research on clinicians and their traits?

We recently studied the practice style traits of 117 occupational therapists and 126 physical therapists working in stroke, randomly sampled from across Ontario (Korner-Bitensky, Menon-Nair, Thomas, Boutin, & Mohammad-Arafah, 2007). The findings tell us that there are generally very few seekers and that most clinicians are pragmatic. Similar findings of prevalence have been noted in physician studies (Wyszewianski & Green, 2000).

Why should we identify our personal practice styles?

Identifying clinicians' practice styles may have important implications if the argument holds that an understanding of these traits enables customization

of knowledge translation strategies to the individual clinician. Certainly one could imagine that an interdisciplinary team consisting of only individuals who are seekers would function very differently from a team consisting of only pragmatics. It is probable that neither team would function optimally. At their most rudimentary, the seekers might constantly seek change to the point of clinical chaos, whereas a team consisting of only pragmatics might well dig in their heels against change to the point of stagnation. Also, it is highly probably that the knowledge translation strategies used to encourage change in these two teams would need to be different. So interestingly, while we began this research thinking that a high prevalence of seekers within a clinical team would be desirable, we started to realize what a simplistic thought that was.

So where do you and your colleagues fit?

Are you a seeker who typically enjoys seeking out new assessments and interventions by independently searching the scientific literature? Or, are you a pragmatic clinician who is inclined to make assessment and intervention choices based on resource availability within the worksite, or the practicalities of time? And what about the traits of your colleagues or the team you work with on a daily basis? Understanding the general distribution of practice styles among a team may be a very important first step towards the next logical inquiry aimed at exploring the effect of matching knowledge translation strategies to clinician traits.

So where can go with this knowledge?

When we discuss these traits in conference presentations and seminars, clinicians are often relieved to learn about these traits. They indicate that it helps clarify much of the frustration they sometimes feel when working in a team with people clearly having different traits and as such, place different emphasis on novelty versus practicality. Empowering clinicians, not only through understanding their own practice style trait but also through understanding the traits of others, is worthwhile.

As our health care system increasingly moves towards interdisciplinary health care provision, organizations will benefit from reflecting on how their teams are put together. We would venture that most group formation is currently done out of necessity or function, without much consideration of how the individual parts effectively constitute a whole. While understanding practice traits is clearly not going to be the single solution to closing the knowledge translation gap, it may help to build the bridge that is so badly needed to

help us with best practice implementation.

It would be interesting to see if understanding these four traits could help strengthen our own practice behaviors. For example, we could envision that a seeker may come to realize that a “keener” approach to introducing new therapies is exhausting colleagues. By taking on a more pragmatic approach, the seeker might bring new ideas to the table only after considering the practicalities of the idea and the stress that this change will likely cause. In contrast, the pragmatic clinician may come to realize that many good opportunities for improved patient care are being bypassed because of overriding concern regarding daily practical issues. Thoughtful reflection about practice style traits and the strengths of each may well help clinicians to consider taking a plunge, or maybe a cautious first dip into new waters.

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Priority guideline development: A team building experience

Lynnda Swan, Heather Boyes, Kathy Williams, Darlene Russell and Sharon Campbell

Due to the rapidly changing nature of health care service delivery and associated pressures on caseload demands, a lack of standardization in the delivery of occupational therapy services was recognized across the sites in the

Interior Health Authority (IHA), British Columbia (BC) (see Figure 1). A set of priority guidelines for all occupational therapists in IHA was developed to address this challenge, and a closer working relationship among IHA occupational therapists was an unexpected consequence. This paper discusses and reflects on the development of the priority guidelines.

IHA organizational background

The complexity and geographical size of IHA has contributed to the challenges of standardization and consistency of occupational therapy services. IHA is one of five geographically based health authorities created by the BC provincial government in 2001. IHA serves a large geographic area covering almost 215 thousand square kilometers and includes a multitude of rural and remote communities and two large urban cities. The area's population is 732,000, covering 58 municipalities, 10 regional districts, and 53 First Nations communities. The approximate number of occupational therapists working in IHA is 160.

Challenges we faced

Through discussions at the Interior Health Occupational Therapy Professional Practice Council (IH OT PPC), it was identified that clinicians routinely struggled to meet workload demands and had difficulty prioritizing referrals and caseloads.

clinicians routinely struggled to meet workload demands and had difficulty prioritizing referrals and caseloads.

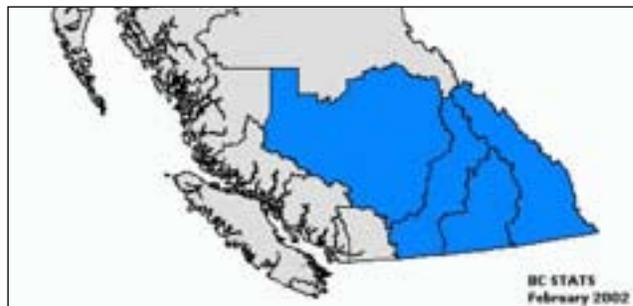


Figure 1. B.C. Interior Health Authority

These problems were consistent in all settings, whether in a large department at an urban hospital or for a sole charge therapist position in a small rural setting. The challenge was to develop practical and useful sets of guidelines that would transcend all areas of occupational therapy practice within our large health authority.

Process

Priority guidelines had been developed in isolation in a few sites across the region and the clinicians using them reported beneficial results. In January 2007, the IH OT PPC recognized the importance of developing standardized priority guidelines across the entire region and began the process of priority guideline development. The priority guidelines were initially called priority intervention criteria. It was determined that the term "guidelines" more accurately mirrored the purpose of the tool by defining a meaningful process rather than a prescriptive directive.

The first step in the development process was to gather data. A literature search was conducted to gather current information reflective of best practice. The authors networked with occupational therapists within BC and across the country to discuss this common issue and to review existing examples of prioritization criteria. The Ottawa Hospital Occupational Therapy Prioritization Guidelines (Gauthier, Straathof, & Wright, 2006) were chosen as a key resource.

Separate sub-committees were established for each area of service (acute care, community, residential care, outpatient, and acute mental health) that was to have its own priority guideline. Each sub-committee worked on their guidelines using an agreed upon common template. Occupational therapists across the region were consulted during the development of the guidelines.

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Multiple methods were employed to enable an inclusive process including face-to-face meetings, e-mails, teleconferences, and individual phone calls. These steps were important to ensure a collaborative and inclusive process that addressed the diversity of occupational therapy services across IHA.

Two draft priority guidelines were presented at an IH OT PPC meeting which assisted the other sub-committees in completing their guidelines. The completed guidelines from all sub-committees were then submitted to the Interior Health Professional Practice Office (IH PPO) and the Interior Health Rehab Quality Service Team (IH Rehab QST) for approval. Once approved, the priority

guidelines were rolled out across the region. The implementation process varied greatly across the region and is discussed in the last section of this article.

After a trial period of six months, a formal survey (Content and Usability Review Form) was sent to all occupational therapists to evaluate the effectiveness of the priority guidelines. There were 25 responses and we were encouraged by the positive feedback. Since implementation, occupational therapists across IHA have informally expressed satisfaction with the guidelines.

For an example of one of the priority guidelines see Table 1.

TABLE 1. IHA COMMUNITY OCCUPATIONAL THERAPY PRIORITY GUIDELINES.

Service Priority Level	Definition of Priority Level	Examples
Immediate	1. Immediate and significant safety concerns are present, which can only be addressed by occupational therapy to prevent deterioration or exacerbation	1. Same day discharge from hospital for client living at high risk either alone or with minimum/limited support 2. Referral from hospital emergency department for client who does not need hospital admission but requires immediate follow-up at home e.g., fall risk
High (response within three working days)	1. Function will improve immediately and significantly with occupational therapy intervention 2. Significant decline in medical condition or function will be prevented or delayed with occupational therapy intervention 3. High risk (consider probability and consequences) of injury to staff or informal caregiver exists and will be significantly decreased with occupational therapy intervention 4. Established and appropriate protocol calls for occupational therapy intervention at this time. For example, hip fracture or joint replacement care map	1. High risk of hospitalization without occupational therapy intervention 2. Sudden and dramatic change in functioning e.g., recent fall with significant injury, rapidly deteriorating palliative client 3. Unable to transfer and/or mobilize safely 4. Recent discharge from hospital for client living at risk (may include arranging short term home support services) 5. Existing skin breakdown or at high risk for breakdown 6. Pre-discharge home visit when discharge anticipated within 1 week 7. Change in function in client when client is a primary caregiver 8. Access to call system/phone (for example, environmental controls)
Moderate (response within three weeks)	<ul style="list-style-type: none"> • Function will improve with occupational therapy intervention • Progress in other health issues will be delayed until occupational therapy provides service • Moderate risk (consider probability and consequences) of injury to staff or family exists and will be decreased with occupational therapy intervention • Significant time has elapsed since referral or identification of issue/need 	1. Move to new physical environment requires assessment of functioning in new environment 2. Request for bathing assessment when no other needs or health issues for client or caregiver have been identified 3. Palliative client slowly deteriorating 4. Moderate falls risk 5. Pre-discharge home visit when anticipated discharge 3+ weeks away
Low (response within 4-6 weeks)	<ul style="list-style-type: none"> • Delay in service will not significantly impact client's health or functioning • Predicted outcome of intervention is minimal or no change • Limited potential for functional gains with intervention • Decline in medical condition or function will be prevented or delayed, but decline would be minimal 	1. Equipment prescription for replacement equipment where equipment is still functioning 2. Equipment prescription/funding for equipment to be used for social activities e.g., wheelchair for family to take client on outings 3. Condition is long standing, and past recommendations have not been followed 4. Education e.g., energy conservation 5. Cognitive/perceptual testing when client in low risk environment 6. Recommendations re: non urgent home renovations
Not appropriate	1. Able to get out of home to access other resources AND does not require assessment within the home environment 2. Has VAC funding and does not meet IH established guidelines 3. Third party funding for occupational therapy services i.e., ICBC/WCB 4. Referral is primarily related to mental health dysfunction	1. See admission criteria for IH CRS service 2. See guidelines for services to VAC clients: drive IH CRS

Practice implications

The development of a standardized tool was imperative due to the increased pressure on front-line clinicians to make daily decisions about prioritization of service delivery. There have been many positive outcomes since the implementation of the priority guidelines, some expected and some unexpected. The expected outcomes have included

- an increased consistency in service delivery across the region;
- the clients in greatest need of service receive service in a timely way;
- the assistance to, and validation of, clinical reasoning around prioritizing;
- the modeling of decision making for new graduates;
- the reduction of stress among clinicians when setting limits around workload pressures;
- the assistance in the orientation of new staff;
- an education tool for referral sources regarding the role and scope of occupational therapy and our prioritization for services.

Some unexpected but helpful outcomes have included

- a decrease in the sense of isolation, especially for sole charge occupational therapists in rural practice;
- a tool to guide performance evaluations;
- the assistance with pandemic planning and developing essential service levels;
- the occupational therapy template has been adopted regionally as the template for the development of priority guidelines by other professional groups;
- increased networking with other professional practice councils.

Reflections

We were successful in developing standardized priority guidelines for occupational therapy services in our organization. The process of writing this article offered the opportunity to reflect on the experience, an opportunity often missed as we rush onto the next client, project, or crisis. Reflection allowed us to further recognize the benefits of the collaborative process and clarify areas for improvement for future initiatives.

In retrospect, we see that although we had initially discussed an implementation process, we did not develop a consistent plan. We lacked a standardized process to carry out the guidelines across the region which resulted in managers implementing the guidelines in different ways. In some areas the priority guidelines

implementation was comprehensive, including involvement of numerous stakeholders (e.g., intake staff, physicians, occupational therapists, physical therapists, nurses and other referring sources). These areas experienced more substantial benefits in comparison to areas with a less detailed implementation plans. For example, the program management model used in mental health, without occupational therapy managers, presented a significant challenge to a successful implementation of the guidelines.

Similarly the evaluation process was not as comprehensive as intended as we distributed the evaluation tool only to occupational therapists, not to other stakeholders. The responses were not representative of the entire region. We realize that the majority of our time was invested in the development of the resource or tool, but not enough in the implementation or evaluation plan and process. In the future, IHA occupational therapy initiatives will attempt to include consistent strategies for implementation and evaluation.

Our experience through the development of the priority guidelines was invaluable. We were able to build on the work of colleagues across the country. We developed an increased awareness of common ground and issues across the continuum of occupational therapy services in both urban and rural communities. The recognition of similar challenges in service delivery reduced feelings of professional isolation. This opportunity enabled us to work collaboratively, effectively and efficiently on other regional projects, such as developing an IH Occupational Therapy Performance Evaluation tool, working on electronic charting initiatives, and co-authoring this article. Working on one initiative together has led to much more than we expected.

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For Priority Guideline resources and more examples, please contact one of the authors.

An extreme occupational therapy experience

Claire Dumont

In 2008, Quebec City celebrated its 400th anniversary. Quebec City is one of the oldest cities in North America. The cradle of French America, it was founded

by Europeans who came from France, but many peoples had occupied the territory for thousands of years before its foundation and numerous others, over the last 400 years, have contributed to shaping this city.

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The 400th anniversary year was an opportunity for all kinds of festivities to mark this occasion. All year long there was a full program of cultural, athletic, artistic and educational activities; fireworks, huge multimedia shows, street artists, acrobats, theatre, dance, historical activities, parades and neighbourhood festivities, just to name a few. Among the most spectacular, one after another, Paul McCartney, Céline Dion, Charles Aznavour and many other artists came and sang on the Plains of Abraham. Hundreds of thousands of people attended these large concerts.

Among these many activities, Quebec City hosted many international conferences, including the Rehabilitation International (RI) Conference, held from August 23rd to 28th, 2008. The theme of the conference was: "Disability Rights and Social Participation: Ensuring a Society for All". More than 900 individuals from more than 70 countries took part. In addition, the Conference wanted and expected individuals with disabilities to take part.

The RI Conference provided me with an unusual professional experience, an experience that I call extreme occupational therapy in the context of working in the field of rehabilitation for people with physical disabilities. The purpose of this article is to share the experience with you. In terms of the main models used in rehabilitation, this experience is related to the Social Model of Rehabilitation (as opposed to the biomedical model) (Kielhofner, 2004) and the perspective of the development of capacity and self-determination in individuals, found in many recent approaches and conceptual models (Dumont, 2007).



The participation of developing countries and countries in transition in the RI-Quebec 2008 World Congress

I was on the organizing committee for the Conference and one of my specific tasks was to administer a grant from the Canadian International Development Agency (CIDA) to fund the participation in the Conference of individuals from developing countries and countries in transition. The CIDA program that provides financial support for this kind of event has clear guidelines and is governed by precise criteria.

One of the main goals of the Conference was, in fact, to improve the North-South dialogue, understood as the dialogue between the developed countries and the developing countries. It should be recognized that the reality of developing countries is very different from that of the developed countries, especially of Canada, one of the richest countries on Earth. In addition, our choices and our lifestyles influence the entire planet and shape the available options and the organization of services in the field of rehabilitation for people with physical disabilities. It is generally acknowledged that, among other things, we need to be more aware of the gaps between rich and poor countries if we hope to ever be able to reduce these gaps. Moreover, since resources are scarce, very ingenious strategies are often found in developing

countries or countries in transition, which can sometimes provide examples for improving the quality of our own services.

Steps were therefore taken to support the participation of representatives from developing countries, which had been invited to come to Quebec City for the Conference. The invitees answered the call, ready to live the adventure! The participants had their own journeys to make according to their own capacities and context.

More than 40 participants, coming from 24 different countries, were supported by CIDA to take part in the Conference. These individuals came from the four corners of the world: Africa (Kenya, Tanzania, Mali, Guinea, Uganda, Tunisia, etc.), Asia (India, Nepal, Philippines, etc.), Central America and South America (Costa Rica, Colombia, Uruguay, Argentina, etc.).

Criteria had been applied to select the individuals who would receive financial support to participate in the Conference, the main criteria being:

- active participation in the Conference, either with an oral presentation or a poster, or through participation in the competition held as part of the Conference, or through involvement in the organization of the Conference (Note: the competition was intended to recognize projects that demonstrated how collaboration between partners can eliminate or reduce obstacles to social participation or develop concrete means to promote or ensure the exercise of rights by facilitating the social sustainable participation of individuals with disabilities);
- a resident of a developing country or country in transition;
- an equal number of women and men;
- having a disability.

The complexity of the challenge

Bringing people from developing countries, or countries in transition, to Quebec City to participate in the RI-Quebec 2008 Conference was a substantial challenge. There were obstacles and several contributing factors making the situation especially complex, making it an extreme occupational therapy experience.

Considering how long it takes to send documents by regular mail, this facilitation was made possible by modern means of communication, electronic plane tickets and other such technology. Without modern electronic means only a small part of the project could have been carried out, even taking into account the risks inherent in this type of communication.

The fact that the project was international in scope meant that I had no control over many contextual

factors: the political, social and economic situations in the countries the delegates were coming from, the airlines involved in the transportation, and so on. The obstacles, problems and complexities that made this project an extreme experience included: 1) complexities related to the political situation and obtaining visas (each country is subject to specific rules according to their political context and their relations with Canada and each person must be evaluated individually according to the criteria established in order to obtain a visa); 2) complexities related to the trip itself (risks associated with international travel involving several stages and connections, availability of ground transportation and roads in the country, availability of international flights, etc.); 3) complexities related to socio-cultural factors (life habits, language, religion, disability, time differences, people who had never visited an industrialized country before and having almost no knowledge about our social organization, economical context, climate, etc); 4) complexities related to economic factors (countries with high currency devaluation, where the banking system is not reliable, people having to use different currencies during their trip, who had no credit cards, reimbursement of expenses directly influenced by the fluctuation of the market price and of monetary value, and so on).

There were a lot of risks for the participants and the organizers, risks due to: health problems, security, not being able to follow the planned itinerary for all kinds of reasons, the management of expenses, and the reimbursement of expenses. For the organizers, there was financial risk, the risk of being held responsible for illegal immigration or refugee claims by participants during their stay in Canada, and so on. It would have been less complicated to organize a trip to Mars. In fact, it is hard for me to imagine a more complex situation.

The human experience

In order to facilitate the process of accommodating participants, for those who wished it, low-cost lodging was offered in the student residences at Université Laval. This made it possible for many of the participants to meet and socialize. It was very satisfying, for example, to see three participants supported by CIDA arriving together to take part in the Conference, as if they were old friends, one from Nepal, another from Uruguay and a third from the Philippines. Another surprise, in certain cases, was seeing how well they managed, despite their disabilities, in the hotels and restaurants, in getting around, and in using English as a second language.

Canada's reputation as a rich, hospitable country

raised the hopes of many and I was sometimes faced with painful decisions. What do you say to someone from Afghanistan, who was prepared to risk their life to go from Kabul to Islamabad in Pakistan to obtain a Canadian visa, just for the privilege of spending a few days in Canada? And even risking having the visa refused after all that? What do you say to the woman from Burundi who wanted to come to Canada with her brother so she would feel safer, who obtained her visa but not one for her brother?

Everything eventually worked out, with no major incidents, and everyone returned home safely, enriched by a unique experience, with many new friends from the four corners of the globe. I will never forget Myriam's smile, a woman who was deaf and gave a presentation in Kenyan sign language, who had to travel alone because her attendant could not come; the kindness of Kamal, a man from India who was blind, who offered to be my guide if I wanted to visit his country; the daring of Hari, who can see Mount Everest from his apartment in Kathmandu, and many others.

What did I get out of this as a therapist? With such an experience, I had to learn to balance contradictory factors, to adjust my methods with a lot of discretion. I tried to avoid overprotection and provide a delicate balance between security and encouraging autonomy. With all the risks of abuse, fraud and errors, I had to trust people, without being careless or naive, and re-

main as strict as necessary. I needed to find a balance in shared responsibility while fostering the development of capacity and self-determination, and at the same time providing a safety net in case of problems. Decisions were made in a spirit of openness to differences, while at the same time applying the rules defined for our context.

Conclusion

Overall, this event contributed to fostering the autonomy and participation of individuals with disabilities, to increasing their feeling of self-efficacy and to reducing many environmental obstacles. In this experience, several situations might appear incomprehensible for a person who has never encountered the realities of developing countries. All therapists should, at some time in their careers, experience contact with these realities. Our understanding of our own world and our views on our daily practice will inevitably be changed. With the unprecedented challenges that humanity now faces, this enhanced awareness will no doubt prove essential.

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Score a hit with the mitt: Implementing a Constraint Induced Movement Therapy program

WATCH YOUR PRACTICE



Column Editor: Sandra Hobson

Cherie Henderson and Phillip Wendt

There are approximately 300,000 Canadians living with some form of disability caused by stroke (Heart and Stroke Foundation of Canada, n.d.). Some researchers estimate that 80% of stroke survivors experience acute arm weakness, with only one-third achieving full recovery (Beebe

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& Lang, 2009). Until recently, the occupational therapist working in neurorehabilitation was presented with the problem of few traditional treatment methods backed by strong evidence. Constraint Induced Movement Therapy (CIMT) is an approach to treatment that has demonstrated a significant improvement in a client's ability to engage in functional activities in a real world environment. Although evidence for its use is strong for clients with some active hand extension (Foley, Teasell, Jutai, Bhogal, & Kruger, 2009), it is our experience that there are relatively few sites in Canada that have adopted evidence based CIMT programs. We suggest that this is due to a lack of knowledge about how to structure an evidence based CIMT program and the perception that CIMT is

too time consuming and burdensome on staffing. Both of these reasons have led many occupational therapists to either bypass CIMT completely or to adopt some, but not all, of the treatment strategies.

This article will define the basic components of an evidence based CIMT program (Morris, Taub, & Mark, 2006), describe the logistics involved in setting up such a program, and share lessons learned during implementation of a modified CIMT program at two sites.

What is CIMT? (and what is it NOT)

CIMT is a family of rehabilitation techniques with foundations in both rehabilitation science and behavioural psychology. This is an important point because the combination of key concepts from each of these fields equals more than the sum of the parts and, as such, a protocol should

contain all components to truly be considered CIMT (see Table 1).

The first component is repetitive, task-oriented training, which takes the form of "shaping" and "task practice". Shaping, or 'adapted task practice', employs common arm and hand activities, such as coins, pegs, or cones, performed in 30-second trials for 10 trials in total, with explicit feedback given throughout. The tasks are chosen based on movement goals, individual preferences and potential for improvement. Task practice involves more functional activities such as folding towels, typing, and playing cards, which are performed continuously for 15 to 20 minutes with more generalized feedback. The nature of shaping requires one-on-one intervention but, in our programs, a therapy assistant carries out the task practice with one or two clients simultaneously. Evidence supports repetitive, task specific training (Foley et al., 2009), but the ratio of shaping to task practice is not well established. In our experience both are valuable because the shaping provides specific movement gains that are then translated to real-world skills during task practice.

The second component is a behavioural package, which uses a number of different tools to promote transfer of upper extremity function to the real world. These "adherence-enhancing" strategies focus on client monitoring, problem solving, and behavioural contracting. The tools include a home diary, home skills assignment, and daily administration of the motor activity log. In our experience this is a critical piece, with a small amount of time spent reinforcing behavior having big pay off at home.

The final component is the constraint of the less affected extremity in a padded safety mitt for 90% of waking hours for the duration of the program. A contract is completed that outlines activities during which the mitt should be worn, when to remove it while still using the more affected arm (i.e., anything involving water), or when the mitt should be removed because of safety concerns (e.g., to use mobility aid, driving, drinking hot liquids). Although we have found the mitt to be a useful cue, even those clients with poor compliance have shown good success as long as they continued to engage the weaker arm when not wearing the mitt. In the words of Dr. Steve Wolf (2007), a leading CIMT researcher, "there is no need to be smitten with the mitten" (p. 1218).

Table 1. Essential components of a CIMT program

Essential Components of CIMT Program		
Repetitive, Task Specific Training	Shaping or Adapted Task Practice (focus is on performance components)	e.g., moving cones, grasping pegs, manipulating coins
	Task Practice (focus is on client centered tasks)	e.g., setting tables, typing, playing games
Behavioural Package	-Behavioural contract -Home skills assignment -Home practice -Home diary -Daily administration of Motor Activity Log	Focus on problem solving, increased awareness, and accountability
Restraint of Less Affected Upper	-90% of waking hours -Encourage use of more affected	

Setting up a program: The five “W’s”

In the fall of 2007, occupational therapists at a hospital-based outpatient stroke program in Edmonton piloted a modified CIMT program based on the described protocol, which was soon followed by a trial at Calgary’s Community Access Program, a neurorehabilitation clinic. Clients at both sites were screened at and recruited from existing regional stroke and adult brain injury programs.

Who:

The program is suitable for clients with traumatic brain injury or stroke that present with all of the following criteria:

- Minimum active wrist extension of 20 degrees and MCP/IP extension of 10 degrees, who are able to pick up and release a ball or have a Chedoke-McMaster Stroke Assessment Score of four in the arm and hand (studies have shown that active finger extension is the best predictor of success for CIMT [Fritz, Light, Patterson, Behrman, & Davis, 2005]).
- Decreased functional use of the weaker arm in everyday activities.
- Are able to follow simple instructions, indicate personal needs, and tolerate three to four hours of therapy, with short rest breaks.

Other potentially limiting factors such as cognition, spasticity, and caregiver involvement have not been found to impede progress. Nonetheless, we have found better mitt compliance when caregivers were available and improved motor outcomes for clients with spasticity when timing their Botox injections to peak during their CIMT program.

What:

CIMT includes:

- A modified program of approximately four hours daily, for ten treatment days, over a two week period. Both sites run their programs intermittently, approximately once every two to three months.
- A combination of shaping and task practice activities, a behavioural package, and constraint of the less affected limb.
- A ratio of three clients to one occupational therapist and one therapy assistant.
- No particular equipment or supplies beyond what would normally be utilized by occupational therapists in neurorehabilitation.

Where:

The program can be in the community or a facility-based outpatient neurorehabilitation program.

When:

Evidence is strong for the use of CIMT with people who are more than one year post-stroke (chronic), and conflicting for those who are acutely post-stroke (Teasall, et al., 2009). On a practical level, clients need to be able to concentrate on CIMT exclusively for the duration of the program and should wait until they are medically stable and multi-disciplinary therapies are less demanding.

Although there is evidence that clients benefit from CIMT as long as 18 years post-stroke, it is unclear whether they benefit as much as those with more recent strokes (Fritz et al., 2006). Resources may dictate the upper time limits. As a matter of practicality, clients in our programs are seen between three months and two years post-stroke.

Why:

Evidence supports this therapy and, although it is labour intensive, success can be tremendous for the appropriate clients.

Lessons learned:

1. You can use your current skills. CIMT provides a systematic approach to how much and when you treat, not a complete redesign of occupational therapy treatment techniques. It provides the structure that you fill in with your clinical expertise.
2. CIMT is more than just the mitt. Despite many reports in the literature of programs with a restraint and some component of functional practice or circuits, the strongest levels of evidence for CIMT include all of the components described.
3. Make sure you have a staffing coverage plan. Due to the systematic and methodical approach in CIMT, be sure to have a plan in case a therapist is ill or cannot complete a course of treatment. Rescheduling of therapy is not a supported option.
4. Make sure clients/families/referral sources have realistic understanding of CIMT. It is not a panacea and will not work with every client. Clients and families must understand that they are required to take a very active role in the treatment. The goal is not only improved motor function but also increased real world use of the weaker arm.
5. Ensure proper documentation. This allows monitoring of treatment progress as well as being valuable in proving efficacy of a new program. After successfully implementing our program, management approved an additional 0.8 FTE of occupational therapy to work in CIMT. Our programs use the following outcome measures: Motor Activity Log (Uswatte et al., 2006), Canadian Occupational Performance Measure (Law et al., 1994), Box & Blocks (Mathiowetz et al., 1985), and Chedoke Arm & Hand Activity Inventory (Barreca et al., 2006).
6. CIMT is worth it! Our outcomes have been very positive and sustained through twelve months of follow-up. The majority of our clients are tremendously satisfied. As one client stated "It was like I fired my left arm after my stroke, but now I've had to re-hire it!"

As occupational therapy treatment for survivors of stroke continues to evolve, CIMT has emerged at the forefront of evidence-based treatment. By incorporating the elements of repetitive practice, behavioural techniques, and constraint, it is possible to set up a CIMT in your clinic.

The authors continue to work in and present on their respective CIMT programs, and would invite questions from readers.

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An innovative algorithm for cognitive assessments

Denise Groves, Laura Coggles, Jutta Hinrichs, Shayne Berndt and Lindsey Bright

The older adult population is rapidly increasing. Lichtenberg and MacNeill (2003) indicate that the population of older persons will quadruple in the next thirty years, thus increasing the need for healthcare services. Critically ill elderly patients have changes in their mood, behavior, and cognition which can cause a negative effect on their health status and the ability of others to care for them. In a review of the characteristics of elderly patients in one region's acute care sites, Haggarty, Harris and Hinrichs (2003) indicate that "one in four clients experience cognitive changes that affect their functional abilities. Cognition is also noted to be one of the highest risk factors precluding return to their previous living situation" (p. 2).

In adult acute care, the aging population with its increasingly complex medical needs is expected to lead to an escalating demand for occupational therapy services. Specifically, there is a trend towards increased demand for cognitive assessments as part of a patient's functional evaluation in order to ensure efficient and effective discharge planning.

Prompted by the rising number of referrals for cognitive assessments, a group of novice and experienced occupational therapists identified a need for an inventory of cognitive assessment tools and a clinical reasoning process to ensure a consistent approach to conducting cognitive assessments across three acute care sites in one health region. This article describes the development of a cognitive assessment tool inventory, a clinical reasoning algorithm for cognitive assessments, and guidelines for the application of this algorithm in clinical practice.

Cognitive assessment tool inventory

The development of a cognitive assessment tool inventory was based on best practice literature and supports therapists in choosing the most appropriate cognitive tool to evaluate an adult patient. It is not an inclusive inventory, but it does include those assessments available and accessible to our clinicians. Therapists can make appropriate decisions related to cognitive assessments when they are aware of: the target population, the specific dimensions the tool is designed to assess, the range and quality of information a specific tool can provide, and the time required to administer the test.

The cognitive assessment tool inventory includes

assessments such as the Mini-Mental Status Examination (MMSE), the Montreal Cognitive Assessment (MoCA), the Cognitive Performance Test (CPT), the Cognitive Competency Test (CCT) and the Allen Cognitive Level Screen (ACLS), to name just a few. This useful inventory, which has a description of the assessment format, the target population, length of administration and a summary of the pros and cons of each assessment tool, may be found at <http://www.caot.ca/pdfs/cati.pdf>.

Clinical reasoning process to cognitive assessment

The clinical reasoning process supports therapists' decisions regarding the extent of cognitive assessment interventions. To clarify, a clinical reasoning process involves planning, directing, performing, and reflecting on patient care (Schell, 2003). Hagedorn (1996) found that the extent and applicability of the therapist's experience has an impact on the quality of clinical decision-making. An experienced therapist is able to link various pieces and sources of information throughout the occupational therapy process in an automatic, even unconscious fashion.

Novice clinicians, on the other hand, highly attend to their observations and knowledge of specific medical conditions and consciously sort through relevant data. They also rely heavily on following the rules or guidelines of the occupational therapy process (Hagedorn, 1996; Schell, 2003; Rogers & Holm, 1991). This suggests that specific guidelines for novice therapists to structure the clinical reasoning process may assist them to effectively plan the timing of their services and manage cognitive assessments efficiently.

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Figure 1. A clinical reasoning algorithm for cognitive assessments.

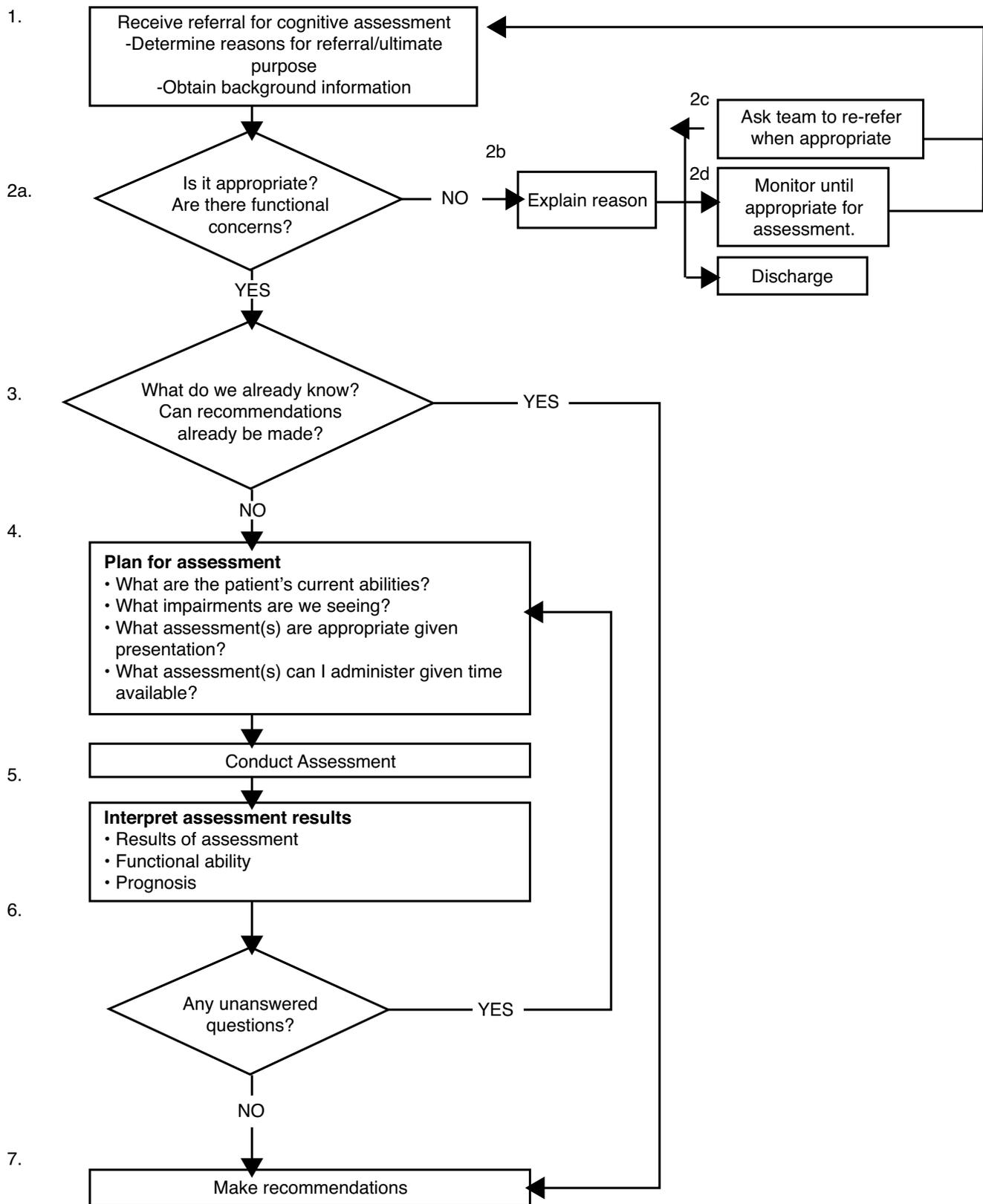


Figure 2. Algorithm guidelines

1. Determine the Reason for Referral. Obtain background information.

Goal: To identify the rationale of the physician or team referring a patient for a cognitive assessment in an attempt to aid the therapist in prioritizing her caseload.

Considerations:

- Who is requesting this information?
- Has testing been completed by other team members?
- What information is desired by the team?
- Are the cognitive concerns a new issue or a long-standing problem?
- What information do I want? Why am I evaluating this patient? (e.g. level of support required, d/c planning, capacity assessment)
- What information, other than that given to me by the patient, needs to be obtained from the family or the team? (e.g. agitation, unusual/unacceptable/inappropriate behaviours)
- What was the patient's pre-morbid level of functioning? (e.g. home environment, level of support)

2.(a) Is it Appropriate? Are there functional concerns?

Goal: To clarify if the timing and rationale of the referral is appropriate relative to the patient's medical status and discharge planning. Also aids in the prioritization of a therapist's caseload.

Considerations:

- Is there an acute medical reason for their cognitive status? (e.g. UTI, sodium levels, delirium, pain, post-op)
- Is the patient medically stable?
- Can the patient tolerate testing? (e.g. fatigue level, sitting tolerance)
- Can the patient cooperate with testing?

2.(b) Explain Reason

Goals: To provide the referral source with the rationale as to why the patient is not appropriate for cognitive assessment at this time.

Considerations:

- Is there an acute medical reason for the patient's cognitive status? (e.g. UTI, sodium levels, delirium, pain, post-op)
- Will a cognitive assessment impact discharge planning for this patient? (e.g. hospice, LTC)
- Was the patient confused prior to admission (i.e. not related to current reason for admission) and coping with previous supports in place?

2.(c) Ask Team to Re-Refer When Appropriate

Goals: To provide assessment and/or treatment to the patient at the most appropriate time to ensure valid results, and to contribute to discharge planning with the healthcare team.

Considerations:

- Is the patient medically stable?
- Is the patient displaying appropriate / safe behaviors to engage in testing?
- Is a medical diagnosis established?
- Have consultation services provided any new information about the patient?
- Are there new concerns expressed by the patient's family/team?
- Is the patient being discharged soon?

2.(d) Monitor Until Appropriate for Assessment

Goals: To liaise with healthcare team members to determine when the patient is able to engage in a cognitive assessment with the OT.

Considerations:

- Please refer to #2(c) as considerations are very similar between #2(c) and #2(d).

3. Can Recommendations be Already Made?

Goals: To identify that testing is not required to provide a safe and effective discharge for this patient, and that suggestions can be made without a full work-up.

Considerations:

- Based on the patient's prognosis, can future care or environmental needs be predicted?
- Based on functional information and observations of the patient,

does the patient require additional support or alternate living arrangements?

4. Plan for Assessment

Goals: To ensure that the patient is assessed in a timely and appropriate manner based on the information required by the team.

Considerations:

- What instrument(s) are available at the facility I'm working in?
- What standardized vs. non-standardized instruments are available?
- What information am I needing (i.e., functional status vs. cognitive skills)?
- What are the patient's current levels (e.g. sitting tolerance, attention, written/verbal language, and fine motor control)?
- What assessment is appropriate given the time frame available?

5. Interpret Assessment Results

Goals: To interpret the assessment findings in an objective and accurate manner, and to document the findings in an understandable format for all stakeholders.

Considerations:

- What do the assessment findings indicate regarding the patient's cognitive capacity at this point in time?
- Do the assessment findings correspond to the functional observations and behaviors of the patient while on the unit, or prior to admission?
- What are the patient's strengths and limitations observed throughout the assessment process?
- Does the patient have insight into their condition?
- If a standardized test was used, was it administered in a standardized fashion / protocol?
- What other factors could have influenced the assessment findings?
- Mood (anxiety, depression)
- Language barrier
- Vision or hearing impairment
- Motivation
- Fatigue
- Other medical conditions
- Psychiatric history
- Environmental distractions
- Are the cognitive deficits permanent or temporary?

6. Any Unanswered Questions?

Goals: To ensure that all information required has been addressed by the assessment or by observations of the patient.

Considerations:

- Does the patient have external resources to assist with their cognitive deficits?
- Does the patient already have strategies in place to compensate for their cognitive deficits?
- Is further testing required due to uncertainties in the information obtained from the assessment process?

7. Make Recommendations

Goals: To provide information and recommendations to the healthcare team, the patient and the patient's family regarding level of support/supervision needed for ADLs, IADLs, and decision making.

Considerations:

- Does the patient have the mental capacity (insight, problem-solving, memory, etc.) to understand decisions and consequences regarding safety and independence?
- What formal (e.g. Home Care, Meals on Wheels) and informal (e.g. family, neighbors) supports are available to support the patient?
- What supports are accepted by the patient, if any?
- Is the level of support needed by the patient static or dynamic? Is the patient's medical prognosis stable?

A literature search demonstrated that there is little information available regarding specific clinical reasoning processes to manage cognitive assessments. This knowledge, combined with the variability in occupational therapy practice, indicated that a clinical reasoning algorithm was needed to guide therapists in decision-making around cognitive testing. An algorithm (Figure 1) for clinical reasoning process promotes a consistent and standardized approach to decision-making around cognitive assessment management.

There are multiple and complex considerations when making decisions related to performing cognitive assessments in adult acute care. The algorithm articulates the clinical reasoning process that can be applied by an occupational therapist when requested to complete a cognitive assessment. The algorithm identifies the key questions clinicians should consider prior to determining the appropriateness and timeliness of cognitive assessments. Each step in the algorithm has corresponding guidelines outlining the goals and considerations involved in the decision-making process. The goals and considerations are necessary to ensure that therapists can assess and interpret assessment results and provide appropriate recommendations for appropriate discharge planning.

Both novice and experienced therapists can use the algorithm. Less experienced therapists and occupational therapy students report that the algorithm assists them with decision-making to guide more efficient processes. Both experienced and novice therapists report that the algorithm helps them to justify the delay or refusal to perform standardized cognitive assessments within the structure of acute care. Having a concrete document outlining 'acceptable' reasons helps therapists prioritize the demands on their time and justify this to other team members.

Our experience indicates that the algorithm facilitates a consistent approach to requests for cognitive assessments across the local acute care sector and helps to justify the rationale behind assessment tool selection. It has been useful in orienting new staff and students, prioritizing clinician caseloads, and facilitating communication within the multidisciplinary team. The algorithm supports a clinician's professional judgment in determining when a cognitive assessment should be performed to ensure that testing realistically reflects the client's cognitive abilities. The team can then use the information to assist with safe discharge planning.

Conclusion

The increasing number of seniors will continue to escalate demands on occupational therapy resources

and service delivery in adult acute care. Occupational therapy services will need to be focused, efficient and consistently applied, in order to effectively manage rising caseload volumes. The clinical reasoning algorithm will support best practice, to ensure that the timing and choice of cognitive assessment tool will facilitate outcomes that are reflective of a patient's actual level of function and will support appropriate discharge planning from the adult acute care setting.

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Column Editor: Heidi Cramm

Mundane occupations: Providing opportunity for engagement and being-in-the-world

Denise Reid

Individuals with chronic mental illness often do not engage in productive occupations (Krupa, Kirsh, Gewurtz, & Cockburn, 2005). This lack of participation influences how these individuals are grounded in the world (Heidegger, 1962). Heidegger proposes that being-in-the-world is when one becomes attuned to and present to the task, environment, time, and space with a sense of connection. When engaged in occupations, there is a conscious presence to or attunement to the self or the immediate physical or social environment in mental health survivors (Sutton, 2008). Reid (2005; 2008) proposed the concept of occupational presence to refer to the conscious attunement and connection one can experience while engaged in an occupation.

The occupational presence experience reported in this paper was the watching and participating with mental health consumers who engaged in occupations that were made available through two occupational therapy services in relatively small cities of Tagahashi and Tamano in the Okayama prefecture of Japan. These observations suggested that the individuals with mental illness experienced being occupationally present while they were engaged in some productive occupations. These occupations were washing and wiping walls and railings (grab-bars) in a residence for seniors, making garbage receptacles for a nursing service in a hospital, and downloading data from a computer in a University professor's office.

Drawing from observations, participation, and conversations with the occupational therapists, the occupational engagement sessions of mental health consumers are analyzed. It is suggested that participating in these unremarkable occupations helped organize, give meaning and a sense of presence in these individuals, a requirement for being-in-the-world. As a result of being engaged in the occupations of washing, computer data downloading, and making paper garbage receptacles, the individuals' intentions toward their world are expressed in activity and participation.

Downloading data on computer

A.S. was a 47-year-old man who was diagnosed with schizophrenia ten years ago. Prior to his illness, he was employed as a business executive in a large company in Japan. Currently, he attends a local sheltered work-

shop program three days a week where he engages in piece-work in an assembly line for local companies. The sheltered workshop program is not intended to be therapy; however, staff are present to provide support and social skills training.

The sheltered workshop program runs daily from 9:00am to 2:00pm and jobs are selected primarily by the staff who have social welfare and psychology training. An occupational therapist consults to the program and organizes weekly community work opportunities for participants. The number of times a participant can choose to work outside the workshop is pre-determined by the occupational therapist and workshop staff. There are approximately 15 people in the sheltered workshop program.

In addition to the piece-work, on one day during the week A.S. can choose his community work experience from a list that the occupational therapist has created. Eberle (2003) suggests that if a person has limited opportunity to exercise choice and control the unfolding of the self does not develop. A.S.'s intention and sense of control contributes to an engagement experience in which he anticipates and is committed to even before he attends the community work site.

There are three community sites offered by the occupational therapist where work opportunities have been negotiated: a University site, a public hospital, and a senior's residence. Some individuals select the same site so they have continuity in their community work experience; others decide to change from week to week.

Observing A.S. at the University allowed me to watch his logical, sequential approach to turning on the computer, finding the desired program, and locating files from a large NASA database to download and patiently wait until the selected files were transferred. He did not tire and was transfixed on the computer screen while he performed this occupation. In this environment I felt he wore a label closer to that of a research assistant or a graduate student as he sat at a computer in a faculty member's office.

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A.S. worked independently at his own pace and left work when he had finished the task and not at a pre-determined time. I watched his attunement to the computer, and observed that the job he engaged in was not too challenging and was familiar to him. A task

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that is not too frustrating and one that a person has a degree of familiarity with is suggested to be necessary for an occupational presence experience (Reid, 2008).

The occupation of downloading computer data files gave A.S. a sense of accomplishment and empowerment. He expressed to the occupational therapist that he did not want the job to end as he recognized that he was already three quarters of the way to completion. His preoccupation with the future, the job ending, demonstrated that he was no longer in a state of presence where he was focused on the now (Tolle, 1999).

Making paper garbage receptacles

S.T. was a 52-year-old man who attended the same sheltered work program. He also chose to attend a community site: a large public hospital. He was observed on a patient ward where the nurses required that he make newspaper receptacles for waste. The nursing staff were previously responsible for this job, and were glad to pass it onto someone else. S.T. demonstrated a rhythm in picking up one sheet of newspaper from a large stack and proceeded to make the first fold. He then followed with a sequence of folds to make a secure and leak-proof receptacle shape. Becoming engrossed in his method, I attempted to try to make a receptacle. The folds were not positioned at the right places and I caused tears in the paper. I sensed his sense of perfectionism while he stacked his receptacles neatly on the table. He seemed to want to maintain this level of perfection as he looked at my attempt with concern. He demonstrated a planning strategy while he completed the task which used his short term memory. As we were working toward a common goal I sensed that he viewed and accepted me as an equal participant. His attunement to his immediate physical and social environment suggested a presence to his world and a focus on the now.

Washing/wiping walls

E.A. was a 73-year-old man with a history of mental illness. He had chosen to participate in a community

experience other than the sheltered workshop environment where he spent all of his time. E.A. smoked cigarettes and would often take a smoking break. This was permitted at the workshop, but at the seniors' residence where he spent a few hours a week he had to curtail his habit. When I observed E.A. at the seniors' residence, he was filling buckets with water and soap and carrying them along to each resident's room where he set to the task of washing and wiping down the wall surfaces. He seemed to make decisions as to what surfaces needed to be cleaned first and second and so on. The final surfaces were the hand rails that ran along from room to room in the hallways.

He accomplished cleaning all rooms without interruption. He was so much in the moment that he never once went off to smoke. When he was partway through scrubbing the hand rails his finger accidentally scraped some paint and a bit of wall plaster off the wall. He was aware of this and immediately made a sound that he was upset. His attunement to his physical environment was acute as he attended to the accidental wall scrape. As other workers came by to offer advice, E.A. focused on their recommendations and solved the problem with covering the scrape with a piece of cello tape. Being-in-the-world for E.A. was demonstrated by his relationship to others in his social world as well as to his physical world, which enriched his participation.

At coffee break time I offered to share a Japanese sweet with E.A. and the occupational therapist. This social opportunity also created an opportunity for E.A. to live in the world by engaging in conversation. I observed that E.A. had limited conversation ability, but he responded to the occupational therapist's comments with laughter and sounds.

Summary

At first impression, downloading data on a computer, making paper garbage receptacles, and wiping walls seemed to be occupations lacking in significance and meaning. However, after closely observing individuals

“At first impression, downloading data on a computer, making paper garbage receptacles, and wiping walls seemed to be occupations lacking in significance and meaning.”

engage in these occupations, I contend that the occupations are imbued with rich socio-cultural meanings, and that they are satisfying and interesting to the individuals who engage in them. These seemingly mundane occupations were capable of providing opportunities to some individuals who live with mental illness to participate in real life work experiences,

thereby allowing for greater opportunities for being-in-this-world. Although these observations were made while travelling in Japan, I believe there are similarities in Canada. It is up to us to recognize the potential that commonplace experiences have for people.

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Nicole Ebacher Memorial Lecture: A celebration of new ideas

Louis Trudel, Andrew Freeman, Annie Pomerleau and Chantale Marcoux

Occupational therapy is constantly evolving, as is shown by the Masters-level training in Canadian programs and the publication of the book *Enabling Occupation II* (Townsend & Polatajko, 2007). Consequently, one

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of the challenges we, as occupational therapists, face is how to create opportunities for the dissemination of knowledge and the exchange of new ideas for the scientific and clinical community of occupational therapists. With this challenge in mind, the Occupational Therapy program at Laval University decided in 2008 to establish an annual memorial lecture recognizing the outstanding contribution to the development of the profession by a leader from Quebec, other provinces in Canada, or other countries. The purpose of this article is to describe the reasons that led us to organize this lecture and to inform those who may be interested in attending.

Our memorial lecture is named after Nicole Ebacher (1949-1996), an occupational therapist and teacher who devoted herself unreservedly to the development of occupational therapy in Quebec and to the efficient running of the Laval University Occupational Therapy program for 25 years. Following her graduation from the first class in occupational therapy at Laval in 1968, Nicole Ebacher became involved in supervising student practicums and teaching. While working as a clinician, she participated in teaching

laboratories and theoretical classes beginning in 1971. She completed her B.A. in Occupational Therapy in 1980 while continuing with clinical practice, the supervision of practicums, and theoretical and practical teaching.

She also ran the program from 1979 to 1980. Nicole developed a solid expertise in rehabilitation of people with visual impairments. In 1985 she established a self-learning laboratory for our program. In 1994, she received an award of excellence from the Ordre des ergothérapeutes du Québec (OEQ) for her activities in university teaching and her ongoing commitment to the activities of the OEQ.

By recognizing the achievements of a distinguished member of our profession, the Nicole Ebacher Memorial Lecture is intended to stimulate

- professional development for our colleagues in clinical settings;
- the transfer of knowledge;
- the exchange of ideas and enrichment of discussions among students, clinicians and teachers;
- increased visibility of occupational therapy.

The first lecture was given by Dr. Rachel Thibeault, Professor at the University of Ottawa, on November 29, 2008 at a Conference marking the 40th anniversary of the Laval University Occupational Therapy program. Dr. Thibeault is a graduate of Laval University and is an international leader in the field of community-based rehabilitation in developing countries.

On December 7, 2009, Dr. Elizabeth Townsend of Dalhousie University in Nova Scotia gave the second memorial lecture. The title of her presentation was “The World at Our Feet: Walking the Global Talk of Collaborative, Experience-Based Practices.” Among other elements, Dr. Townsend emphasized the fact that client-centred practice requires designing the intervention as a possibility of doing WITH the other and not doing TO the other.

The Nicole Ebacher Memorial Lecture is an annual event for the Laval University Occupational Therapy program. The great enthusiasm shown for first two lectures was very promising for our academic and clinical community.

For further information, contact Andrew Freeman (Andrew.Freeman@rea.ulaval.ca).

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Update from the COTF



Highlight of a first time COTF award recipient:

Annie Carrier

Community Rehab OT Scholarship - \$5,000
Université de Sherbrooke

Research title: Development of a conceptual model for occupational therapy education for seniors who are losing their functional autonomy

Background: Certain seniors who are losing their functional autonomy and living at home experience difficulty doing transfers, that is, movements from one surface to another, that can increase their risk of falls and injuries. A common intervention by occupational therapists working in community settings is to teach their clients safe transfer methods that are suited to their abilities. The effectiveness of this intervention depends, among other things, on the teaching methods used. However, we know little about these methods and how they are chosen.

Objectives: This qualitative exploratory study is aimed at developing a conceptual model that will enable us to better understand how occupational therapists working in community settings decide on teaching methods used in interventions related to transfer activities for elderly clients who are losing functional autonomy. The specific objectives are: 1) describe the teaching methods used by occupational therapists, and 2) explore the clinical reasoning that determines their use.

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Presenter: Brenda McGibbon Lammi, CAOT Professional Development Manager
Date: Thursday, June 24th, 2010; 12:00-1:00pm (EST)

Enabling Occupation II: A review and discussion

Presenter: Janet Craik, CAOT Director of Professional Practice
Date: Thursday, September 30th, 2010; 12:00-1:00pm (EST)

Professional Practice Insurance

Presenter: Brian Gomes, AON Risk Services Vice-President
Date: Thursday, October 28th, 2010; 12:00-1:00pm (EST)

CAOT on Parliament Hill

Date: Thursday, November 25th, 2010; 12:00-1:00pm (EST)

Please go to www.caot.ca to register for a Lunch and Learn Webinar or for a Water Cooler Talk of your choice, or contact education@caot.ca for more information.

CAOT Learning Services Workshop:

Enabling Occupation through Universal Design and Home Modification

Co-hosted with Vancouver Coastal Health
Co-sponsored with the Canadian Mortgage and Housing Corporation
Presenter: Kathy Pringle, BSc(OT), OT Reg. (Ont), Dipl.Arch.Tech
Location: Vancouver, BC
Dates: April 16 & 17, 2010

Contact education@caot.ca for more information

CAOT Endorsed Courses:

The SOS Approach to Feeding:

May 11-14, 2010
Montreal, QC

The SOS (Sequential, oral, sensory) Approach to Feeding is a transdisciplinary program for assessing and treating children with feeding and weight and growth difficulties. This program integrates motor, sensory, oral, behaviour/learning, medical and nutritional factors in order to evaluate and treat children with feeding issues.

Contact Caroline Hui
Tel: 450-242-2816 Fax: 450-242-2331
E-mail: info@choosetolearn.ca
Myofascial Release Seminars:
Myofascial Release I
Myofascial Release II
Myofascial Mobilization
Pediatric Myofascial Release
Fascial-Pelvis Myofascial Release

Cervical-Thoracic Myofascial Release
Myofascial Unwinding
Dates: Various dates and locations
For information: www.myofascialrelease.com

Graduate Certificate Program in Rehabilitation Sciences*

Web-based (Distance Education)
(University of British Columbia and McMaster University)

This interdisciplinary, graduate-level web-based rehabilitation certificate is targeted to occupational therapists, physical therapists and other health professionals who want to update their knowledge and skills to better meet the “best practice” demands of the current health care

environment. The program provides useable, evidence-based skills for the rehabilitation workplace. Each course draws on the research and rehabilitation practice experience of those currently shaping the field.
Contact: info@mrsc.ubc.ca;
Tel: 604-827-5374
Website: <http://www.mrsc.ubc.ca/> / www.fhs.mcmaster.ca/rehab/

Individual courses offered twice each year - from September - December & January - April. *Certificate is granted after completion of 5 courses. These courses can also be applied to master's programs at each university, if candidate is eligible.