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Table of Contents

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TRANSLATION
De Shakespeare à Molière, Services de traduction

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Everyday stories . . . profiles of your CAOT colleagues

Nadia Imbrogno Noble

Family life

I am a full time mom, wife, occupational therapist, and business owner! My husband Michael and I have two children Emma (almost 5 years old), and Matthew (almost 1 year old).

Education

As a volunteer during high school at a local hospital, the application of therapy to activities of daily life, helping people to live a fulfilling life through occupation, and splinting, really grabbed my attention and drove me to pursue occupational therapy.

I attended the University of Toronto at 256 McCaul Street –and enjoyed my four years, both the course work and all the hours of placement at various settings around Toronto. I continue to cherish the friends and colleagues I met there. My graduation was topped off with the honour of Valedictorian for my 1997 graduating class.

Career path as an occupational therapist

After my journey at 256 McCaul was complete, and my well-earned (and needed) two month vacation through Europe was done, real life began. As a new graduate, I took my first position with an insurance company. Realizing that line of work was not for me at that time, and with the vigour and excitement of youth, I was hired by a hospital in the deep south of Texas.

There, I learned the value and importance of team work and interdisciplinary treatment. I worked on an in-patient rehabilitation unit with six occupational therapists, six physiotherapists and two speech language pathologists (all for a 36 bed unit!). I was there for two years, and once I felt that it was time to return home to Canada, I decided to first enjoy a trip to Australia, New Zealand, and Fiji.

Upon my return, I joined COTA Health (York Region) and I began working with children - my passion! I was also lucky enough to work with one of my biggest mentors, Paula Aquilla, who taught me many things related to therapy, business, people, and life – lessons that have served me well over many years! I have also worked as a consultant for various therapy centres around the Greater Toronto Area; these experiences shaped my personal philosophy of practice.

In recent years, I worked at the Milton and Ethel Harris Research Initiative at York University with a multidisciplinary team (occupational therapists, speech and language pathologists, and social workers) to implement the DIR® (Developmental, Individual Difference, Relationship-Based) / Floortime™ Model in a research study with children on the autism spectrum. I enjoyed working with the children and their families and developing my learning of the DIR® Model. I am now in the final stage towards earning my certification in the DIR® Model. Throughout my career, I have always had a small private practice, however after the birth of my son, I decided that it was time to make my dream practice a reality.

Current role

My current role is that of sole proprietor of Kids Therapy Services, a private occupational therapy practice offering services to children and families. We are located in Bolton, Ontario and I enjoy the flexibility of "being my own boss", and the opportunity to create a therapeutic centre that is a fun place to be, play, work, and grow. I love meeting new families, helping them to become comfortable working with and learning more about their children, and helping the children to become comfortable with their strengths and challenges. I love using my DIR® training to help children to grow and expand into even more amazing kids! I envision my practice being a place where families come for the benefit of their children as well as themselves – where family life is supported so that it does not always revolve around "the child with special needs" and where being a family is not just a state of being, but a life that is full of promise and joy for all!

Hobbies/Interests

I love spending time with my family. We love to be outside - going to the park and the cottage, boating, swimming, exploring, and seeing cool things around Toronto and London. I also love to play with my camera, take pictures, and scrapbook. Now that we are getting the hang of being a "family of four", I hope spend a few extra moments working on "my craft" and balancing out the "leisure" component of my life!

Nadia can be contacted at; 416-899-7400, nadianoble@kidstherapyservices.ca, or www.kidstherapyservices.ca.

What's new

CAOT Launches Older Driver Safety Resources

As part of the *National Blueprint for Injury Prevention in Older Drivers* (Blueprint), CAOT released important new resources for older drivers, their families and health care professionals. A series of information brochures (see Figure 1) and a website (www.olderdriversafety.ca) (see Figure 2) promoting older driver safety were unveiled on February 18, 2010, at a public forum held at Good Companions Senior Centre in Ottawa, Ontario.

Figure 1. The series of brochures on older driver safety.

The focus of the brochures is on the impact of normal aging and health conditions on safe driving. The brochures provide useful tips based on scientific analysis of high risk situations and risk-reducing strategies. The website provides occupational therapists, other healthcare professionals, older drivers, and their families with the latest information regarding driving screening, assessment, and treatment options. The brochures are available for free download from www.olderdriversafety.ca or may be purchased from CAOT, $14.99 for a box of 50.

Figure 2. The website www.olderdriversafety.ca

CAOT has taken older driver safety as a key priority and will continue to invest our efforts in projects related to the Blueprint to promote safe driving practices, reduce injury, and advocate for community mobility services that enable a just and inclusive society so that all people may participate to their potential in the daily occupations of life.

For more information on safe driving practices, please visit www.olderdriversafety.ca or contact practice@ caot.ca.

CAOT is offering a one-hour Lunch & Learn
Cognitive Impairment in the Aging Driver: Assessment Issues and the Use of Simulators

Presenter: Dr. Michel Bédard
Date: September 21st, 2010
Cost: $50 (member)/ $75 (non-member)
Visit www.caot.ca for more information and to register.

A small group treatment model: Supporting performance in children with sensory processing problems

Joan Vertes

It is has been suggested that some of the positive outcomes for children with sensory processing disorder (SPD) who participate in treatment can be attributed to intervention that occurred in small groups (Case-Smith, 1997; Case-Smith 2007; Davidson, 1996; Davidson & LaVesser, 1998). Enhanced competition and motivation facilitated by group participation may also influence outcomes (Parush & Markowitz, 1997). In addition, a study of small groups for children with developmental coordination disorder (DCD) reported "a positive effect in the majority of cases on the children's self-esteem" (McWilliams, 2005, p. 399). Cummins and colleagues (2005) studied social behaviour in children with motor coordination problems. Based on their results, they proposed that future treatment to improve function include enhancing the social as well as the physical skills of children with DCD.

This paper describes a program utilizing a small group treatment model that has been developed by the author at SickKids in Toronto, Ontario for children with SPD. The program addresses current pressures experienced by occupational therapists, children, and their families resulting from long treatment waiting lists. Feedback on the program from clients, therapists, and teachers has been extremely enthusiastic.
In addition to child and family-centred goals, the group approach to sensory motor therapy provides opportunities for identifying and ameliorating social emotional difficulties in a safe, playful setting and the opportunity for therapists to collaborate

About the program

Physicians refer children to the program for difficulties due to SPD, DCD, poor coordination and/or poor handwriting who are between five to eleven years old. The referred children must have a minimum average IQ and no diagnosed central nervous system condition such as cerebral palsy. The small groups are organized according to age, grade, and occupational therapy needs. Scheduling is done over the phone by the therapist.

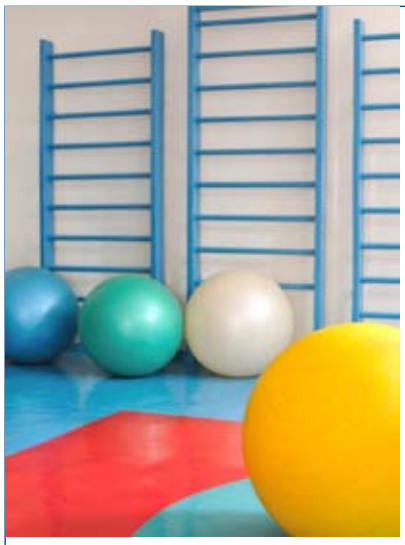
Groups may contain two to six children with one or two occupational therapists and are provided weekly for one hour, in blocks of six to eight sessions. There are further opportunities for therapy following a break of approximately 12 months. Children and parents have time to consolidate their new skills during the break (Miller, 2006).

A sensory motor approach is used and is strongly influenced by sensory integration (SI) theory. Perceptual-motor, cognitive, psycho-social and neurodevelopmental therapy frames of references are also incorporated. By emphasizing the importance of organizing sensations for use and foundation skill development, parents are shown how their children's difficulties may affect behaviour and occupational performance.

Sessions consist of a sequence of a) warm up activities, such as gym ball, scooter boards on ramps or Theraband activities; b) warm up and organizing games on suspended equipment; and c) a combination of fine motor and visual motor activities while at a board, lying on the carpet, or sitting at a table.

*Jaclyn, *Gregg and *Alex, ages between 6 and 7, arrive for their third group and head for the bolster swing. Jaclyn and Alex sit on it, one moving back and forth and one bouncing up and down, while Gregg stands in the middle holding onto the ropes above. A targeting game with bean bags and plastic hats is set up on the mat. The therapist asks how they can work as a team to swing, aim at and flip the hats. Jaclyn falls onto the mat. Alex reaches out to help pull her up. They take turns aiming. When Gregg moves too quickly Alex tells him to slow down and to help them direct the swing. Gregg hops off, puts on boxing gloves and suggests that the others throw bean bags into a barrel while he tries to block them. The aiming successes for Jaclyn and Alex increase dramatically, along with the cohesiveness of the group. Gregg is surprised how hard it is to block the bean bags. He frequently looks around him at the crucial moment. The therapist comments "Wow! What a great game you invented. You really have to keep your attention on those bean bags, don't you?" Gregg replies," My teacher says I have lousy attention". Jaclyn responds, "I have good attention with the bean bags, but I can't balance on this thing like you can" as she falls off laughing. The next few times, the therapist prepares Gregg calling "ready, set, block it!" and provides physical cues to ensure that Gregg succeeds.
*not their real names

Children collaborate to plan sessions. They set up obstacle courses by writing or drawing pictures of steps on the blackboard. The therapist follows the lead of the group while incorporating individual needs to the greatest extent possible. The environment (gym)



is set up to be rich in proprioceptive, tactile and vestibular sensory input. Active, as opposed to passive, sensory stimulation is emphasized along with the need for adaptive responses. The therapist grades activities and arranges for the 'just right challenge' through careful clinical observation and by providing support and suggestions as required. Many of these children tend to avoid sensory motor situations that they find challenging.

Motivation seems to be enhanced in therapy. By the last session the group members often function almost independently of the therapist; pulling out equipment, arranging mats, and setting up games. They appear organized individually and as a group. They challenge themselves more and more while socializing with their peers. Remarkably, the therapist continues to learn new ideas and ways to use equipment through the children's creativity.

Gregg avoids the challenging game the others are playing (Simon Says while balancing and changing positions on gym balls). He throws himself onto the mats repeatedly. The therapist rolls the huge gym ball (almost the same height as Gregg) towards the group. They begin to use various body parts to push it to one another. Gregg is delighted to join in. The therapist gives him a weighted vest to try which also helps him to settle. Gregg was able to benefit from proprioceptive input and at the same time remain engaged with his peers while working on balance and motor planning tasks.

Jaclyn spots the hula hoops laid out on the floor. "What are we supposed to do with those?" The therapist responds, "I'm not sure. Maybe you should ask Gregg to tell you his plan for the hoops." Gregg feels important. Jaclyn relates independently to her peers.

Individualized strategies that will provide sensory input throughout the day are explored and recommended to assist with self-regulation. The 'mat sandwich' is a favourite calming game (children are carefully squeezed between mats using body weight). To optimize attention and postural control, children are encouraged to hold fidget toys or to use core discs or gym balls to sit on at the table. They can stand on rocker boards or sit on t-stools to participate in activities at the large mirror. Sensory routines for home and/or school may also be developed with parents.

Gregg and Alex are finger-painting on the mirror. Gregg is covered in blue paint up to his elbows. He sees Alex putting only two dabs on the mirror with his index finger. Gregg reaches over to show Alex how to spread his paint, dirtying him and smudging his drawing. Alex shrieks loudly for several minutes; Gregg flees. The therapist asks Alex to talk about his reaction. He reports that he had been making an animal. Gregg returns and says, "I ran away because I didn't like the loud noise Alex was making." Alex seems surprised. Alternate ways to deal with frustration and with getting dirty are discussed. Gregg makes room for Alex to have a clean part of the mirror and makes Alex laugh by painting with his elbows.

Parent involvement

A key component contributing to the success of the program is the one-way mirror in the waiting room where parents can watch the group. Parents also receive education via videos and handouts, exchange information, and share strategies and concerns while waiting for their children. Simply by virtue of meeting other parents/guardians who have children with similar issues or worse, their anxiety appears to decrease. In studying parents of children with SPD, Cohn (2001) found that this exchange of information helped parents to "reframe their expectations for their children and for themselves" (p. 291). "Young children's self-esteem is often more related to their perceptions of parental acceptance than perceptions of competence... children are generally unable to accurately verbalize their level of self-esteem until eight years of age" (Willoughby et al., 1996, p.124). The three most important outcomes for parents of children with SPD are social participation, self-regulation, and perceived competence. Parents seek strategies to help their

About the author – Joan Vertes, BScOT, OT Reg (Ont), is an occupational therapist working part time at SickKids in Toronto, Ontario and in privatepractice. She has close to30 years of experiencein pediatrics using an OT-SI approach. She has a status appointment at the University of Toronto School of Occupational Science and Occupational Therapy. Joan can be contacted at joan.vertes@sickkids.ca.

children as well as validation of themselves as parents (Cohn, Miller, & Tickle-Degnen, 2000).

During the second session, parents watch a 20-minute video containing clips of previous groups that describe sensory motor therapy. The video may be borrowed or purchased to share with the adults in their child's community.

Time is included at the end of each session to discuss the children's performance with their parents. One activity from that week's session is chosen to be reinforced at home for ten minutes a day. They are encouraged to have fun and be creative; for example, using the gym ball while watching TV, or hopping on the way to school. It is explained that this is not mandatory but that children who have done this seem to progress more quickly.

Group feedback questionnaire for parents

A parent feedback form is provided to parents at the end of each therapy block. Comments have been very encouraging:

- "His (my son's) teachers were reluctant to go along with strategies ...but they had to admit they saw an improvement - and encouraged us to go on!"
- "Confidence in participating in physical activities, trying new ones, wakeboarding, kayaking, tubing; won't Joan be proud of me?"
- "For the first time he came home from school and mentioned a friend".
- "Most significantly – 'good' days at school! He has more awareness of his own needs and to ask for what he needs. Better homework sessions."

Summary

Outcomes of the program involving a small group treatment model at SickKids appear encouraging based on therapists' clinical observations, informal assessments, and parent surveys. In addition, wait-list times have been reduced and occupational therapists have the opportunity to combine their knowledge of sensory-motor development and psychosocial skills in providing client and family-centred care. Children are motivated to participate in motor and social occupations.

Parents have expressed relief in gaining a better understanding of their child's behaviour and feel more equipped to advocate for their children at school and in the community. However, there is limited literature on the use of sensory motor groups and more research is required to support its' use in clinical practice.

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Safety at home for seniors: A comprehensive approach by occupational therapists

Anne Brasset-Latulippe, Abdallah-Georges Al-Hazzouri, Michèle Hébert, Sylviane Bourgault-Coté and Valérie Meilleur

Occupational therapists who work with seniors are often recognized as experts in safety at home. They are called upon to assess safety and the presence of risks, and then act to minimize them. Occupational therapists are also asked to give an opinion on the possibility of safely keeping a person at, or returning a person to, home. This is a significant responsibility, particularly when the aging population and trends in government health policy mean that there are an increasing number of seniors who are staying at home. Safety in the home is an important social issue (McNulty & Fisher, 2001) and occupational therapists need to take an interest in the concept of safety itself in addition to intervention approaches.

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Safety: a multidimensional concept

The danger of falls is often a primary concern when it comes to safety at home for seniors. Falls are the primary cause of deaths by injury among seniors (Isberner et al., 1998) and the second cause of hospitalization among older women and the fifth among older men (Ward-Claws et al., 2004). Seniors older than 65 years of age are the most at risk for falls (Ward-Claws et al., 2004). It is estimated that annually 30-40% of seniors fall, most often in their own homes (Shobha, 2005; Ward-Claws et al., 2004), and that an environmental factor is to blame in 25-45% of the falls (Shobha, 2005; Stevens, 2001). It is also recognized that falls can have disastrous consequences for the autonomy of seniors (Hart-Hugues, Quigley, Bulat, Palacios, & Scott, 2004).

However, the risk of falls is not the only threat to the safety of seniors. Seniors who have physical, cognitive or emotional disorders can have greater difficulty handling dangerous situations. Seniors with Alzheimer's disease will be at greater risk because of their cognitive decline, doing things such as welcoming strangers into their homes, clumsily handling dangerous objects, and/or consuming expired food. The physical deterioration that is inherent to aging can also create risks in carrying out activities.

The interaction between the abilities of individuals, their activities and their environment is seen as an important determinant of the level of safety (Chiu & Olivier, 2006). This triad is consistent with various international health models, such as the disability creation process of the World Health Organization (2001), and occupational therapy models, such as the Canadian Model of Occupational Performance (Canadian Association of Occupational Therapists, 2002). From an occupational therapy perspective, safety is the outcome of enabling individuals to carry out their activities in physical, social, cultural and institutional environments that are free of real risks. Safety is defined with respect to a set of determinants, ranging from individual characteristics of seniors to municipal policies on residential development (Chiu et al., 2006). Occupational therapy assessments regarding the safety of seniors should therefore take into account the multidimensional factors that can affect everyday safety.

Assessment of seniors' safety at home

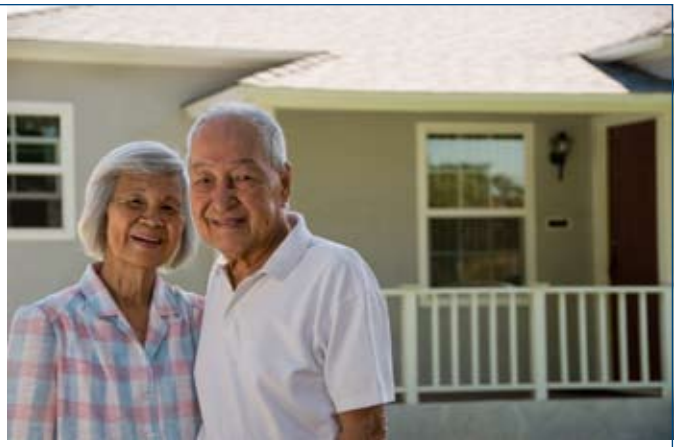
Concerns related to the capacities of individuals, their occupations and their environments should be part of a comprehensive assessment of safety (Diener & Mitchell, 2005). However, a review of assessments of the safety of seniors in the home found tools that focus primarily on the assessment of the risk of falling. Fifteen tools were appraised in a literature review of assessments of the safety of seniors by Bourgault-Coté, Brasset-Latulippe and Meilleur (2007): Nine dealt with the risk of falls, two assessed factors in the physical environment alone, two more were aimed at specific populations, namely seniors with cognitive deficits and seniors with mental health disorders, and one was used to identify disabilities that undermined the safety of the individuals assessed. When the literature search was done, only the SAFER-HOME V.3 (Chiu et al., 2006) seemed to be based on a multidimensional concept of safety and its assessment. It

took into account a wide range of risk factors, including risk of falls and activities in the bathroom, the place where the risk of falls is the greatest (Tanner, 2003). In addition, the SAFER-HOME V.3 offered the occupational therapist a set of concrete, multifactorial solutions that took into account the context of the person in order to reduce risks of all kinds and therefore improve safety in the home.

The development of SAFER-HOME was started in early 2000 at COTA[1] Health. The third version, SAFER-HOME V.3 (Chiu et al., 2006) is now available, as is the French version, the Protocole d'évaluation de la sécurité à domicile (PESAD). The process of cross-cultural validation suggested by Vallerand (1989) was used to guide the production of the PESAD. Like its English-language counterpart, the theoretical basis of the PESAD is that the characteristics of the person, the activities in which they take part and their environment can influence safety (Hébert et al., 2008). The SAFER tool and the PESAD list 74 items in 12 categories: living situation; mobility; environmental hazards; kitchen; household; eating; personal care, bathroom and toilet; medication; addiction and abuse; leisure; communication and scheduling; and wandering.

The assessment is done in the home in the presence of the person and their caregivers. The methods used to gather the information are; interview, task observation, activity analysis, and environmental assessment. The process, which takes about one hour, can be spread out over several visits if necessary. Using the information obtained, the occupational therapist scores the level of risk on a four-level ordinal scale ranging from 0 (no problem) to 3 (serious problem). The assessor can also include comments for the problem items. Using this scoring, weighted results (with a severity factor), an overall result and, on follow-up, a differential result are obtained.

The psychometric qualities of the SAFER tool and the PESAD were examined. An internal consistency study revealed a Cronbach of 0.93 for the PESAD (Bourgault-Coté et al., 2007) and 0.86 for the SAFER-HOME (Chiu et al., 2006B). A study was also done on the test-retest reliability of the PESAD (same assessor repeats the assessment twice with a short interval in between) and obtained a Pearson correlation of 0.97, for a significance level of $p < 0.0001$. A study of inter-rater agreement, which involved multiple occupational therapists assessing a single subject and comparing their scores (repeated for several subjects) showed perfect agreement between assessors for 44% of the items in the PESAD and an acceptable level of agreement (no difference or a single level of difference on the scoring scale) for 90% of the items (Bourgault-Coté et al., 2007). The properties of the PESAD were therefore shown to have a high level of stability.



The assessment of safety with a tool that has been shown to be valid and reliable, such as the SAFER HOME V.3 and the PESAD, provides an unbiased report supporting the recommendations of the occupational therapist. In addition, this comprehensive assessment process makes it possible to offer individuals, their families and the interprofessional team a clinical opinion that will be easy to support and defend. In this way, the occupational therapist will have carried out an assessment congruent with disciplinary perspectives and will be able to design an intervention plan focusing on the individual, and his or her occupations and environments.

Intervention for the safety of seniors' at home

Occupational therapists who have participated in the study of the psychometric qualities of the PESAD told the authors that the home safety assessment itself often induces individuals and their families to take various actions to improve their safety even before any interventions by the occupational therapist are provided. This observation had been seen on a few occasions in the literature review that preceded the design of the PESAD.

A rigorous and comprehensive assessment makes possible the design of an intervention plan that is rigorous and comprehensive. With the results of the assessment, the occupational therapist will be able to, jointly with the individual and their family, design a plan based on; the importance of potential harm, the priorities of the individuals, and on the capability to act on the risk factors.

The assessment makes it possible to identify those factors that are at a higher risk of causing unfortunate situations for the individual and family. The

1 The legal name of COTA Health is COTA Comprehensive Rehabilitation and Mental Health Services, formerly known as the Community Occupational Therapists and Associates.

occupational therapist is then able to provide a summary and plan to the individual, the family, and team members that identifies the interventions and resources that can address the prioritized risks. In addition, the occupational therapist is able to provide a comprehensive vision while ensuring that no risks are neglected.

NB: *The authors do not have any ownership interest in the PESAD, though they are responsible for the translation into French of the SAFER-HOME. COTA Health and its affiliate organizations are the sole owners of the copyright.*

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Rehabilitation with the Nintendo Wii: Experiences at a rehabilitation hospital

Column Editor: Roselle Adler & Josée Séquin

Jonathan Halton

Since early 2007, the rehabilitation community has seen the emergence of a new therapy medium, the Nintendo Wii. 'Wii-habilitation' consists of using the Wii and its accessories to provide engaging activities to work toward rehabilitation goals. The use of the Wii in rehabilitation has grown quickly and is becoming a common rehabilitation tool around the world.

Increased use of the Wii in rehabilitation may be attributed to a combination of factors: it engages the client's interest in treatment; it can easily be incorporated into a variety of treatment goals; it is relatively inexpensive; it has acceptability with the general population (i.e. not viewed as only a treatment activity); and its use has been highlighted in many forums, including both popular and professional media (see 'News & Media' at http://wiihabilitation.co.uk/news.shtml).

My previous article described the theoretical background and rationale on using the Wii within rehabilitation (Halton, 2008). The purpose of this article is to; describe the experiences of using the Wii at the Glenrose Rehabilitation Hospital (Glenrose) in Edmonton, Alberta; to provide interested practitioners with information on implementation; and to encourage additional critical thought on the treatment method.

Background

In early 2007, the Glenrose began to use the Wii as a therapy tool for upper extremity rehabilitation. The initial interest was due to the Wii's unique wireless controller that allows the game to respond to a variety of physical movements of the user, rather than more traditional 'joystick' manipulation.

Soon after its introduction, therapists at the Glenrose realized the therapeutic potential was not limited to upper extremity rehabilitation, the Wii could also be used in the areas of; balance, coordination, visual attention and scanning, and problem solving. In addition, in May 2008, Nintendo released the Wii Balance Board, which provided additional therapeutic opportunities. The board has pressure sensors that measure weight and centre of balance, and this information interacts with the Wii software (Nintendo of America Inc., 2008). The Balance Board can be used in treating balance, trunk stability, and lower extremity motor issues, but also for arm and shoulder weight bearing, upper trunk movement, and more. A recent study by Clark and colleagues (in press) found that the Balance Board performed as well as the 'gold standard' force platform in assessing balance, and as such is a valid tool for assessing standing balance.

The evidence

The evidence on the Wii's effectiveness in rehabilitation is limited primarily due to its recent introduction into rehabilitation settings. Most media and journal content have been anecdotal reports, profiling clients and their experiences with the Wii. However, there are researchers who are investigating use of the Wii to provide evidence for practitioners (Hemsworth, 2009; Olsen, 2008; Tanner, 2008).

To date, published reports have included anecdotal reports, individual case studies, or small pilot studies (Brosnan, 2009; Brown, Sugarman, & Burstin, 2009; Deutsch, Borbely, Filler, Huhn, & Guarrera-Bowlby, 2008; Goldberg et al., 2008; Halton, 2008; Herz, 2009; Saposnik et al., 2010).

Why the Wii

The experience at the Glenrose has shown that the Wii's ability to fully engage the client in the activity has led to increased motivation and engagement within therapy, which has influenced participation, length of time, and overall effort within therapy. Some clients have had more spontaneous movements than other therapy mediums. Acting like rudimentary biofeedback, 'Wii-habilitation' is augmented with real-time visual feedback that has helped the client see how they respond to specific stimuli.

The Wii also allows clients to track their progress within the game's scoring system, and monitor how well they are performing the activity. Therapists are able to encourage controlled responses that work toward the client's rehabilitation goals. Intervention using the Wii also provides a supportive social environment as the activity encourages socialization with other clients and staff members. By immersing our clients within the

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activity, we are able to provide a functional, relevant, and controlled environment, letting clients focus on the task and be positively engaged (Burdea, 2003; Schultheis & Rizzo, 2001).

There are many ways to adapt the Wii to each client and their goals. Users can play sitting in a chair or wheelchair, some play while standing, kneeling, or sitting on an unstable or uneven surface for increased challenge. Clients can sit or lean on the Wii Balance Board rather then the suggested method of standing on the board. A universal cuff can be used to hold the Wii remote if the client's grip is inadequate. The Wii remote can also be mounted in alternate ways, such as attached to a belt or on a chest strap to use the waist or trunk to control movements. Hands that are dominant, non-dominant, affected or non-affected can be used.

Examples of how the Wii may be used for specific physical therapeutic goals can be seen in Figure 1; this is not a comprehensive list, but rather a glimpse of potential areas. There are many ways the technology can be used by being creative and keeping client needs in mind. We suggest doing an activity analysis of each game prior to client use to better identify which activities are appropriate for various client groups or conditions.

Depending on client needs, the games themselves can be increased or decreased in complexity and difficulty. The client is continually monitored for appropriate responses to the game, to ensure the desired responses are used, as well as for fatigue and overexertion. Therapist involvement ranges from verbal encouragement only, to supporting the client with a transfer belt, providing hand-over-hand assistance or playing alongside the client.

Therapists must remain critical thinkers and be continually assessing the therapeutic benefit of rehabilitation activities, including the Wii. 'Wii-habilitation' is not simply playing the Wii, but an interactive process where therapists are involved throughout the experience; guiding movements, encouraging performance, and monitoring for safety and appropriateness.

Profile of use

Since its introduction at the Glenrose, the Wii has been used across the lifespan and with different client diagnoses and populations. The Wii is used by occupational, physical, and recreation therapists. In adult occupational therapy at the Glenrose, information was collected on the clients who used the Wii in 2008, using a voluntary demographic questionnaire. Of the 1441 adult patients seen by occupational therapy services, at least 74 individuals utilized the Wii as a part of their therapy (this is a conservative number, as not all instances were documented). The age of the clients was varied (Figure 2), but approximately 75% of the clients were male. Most clients had a diagnosis of stroke, brain injury, or spinal cord injury; fewer clients had musculoskeletal problems (e.g., post MVA fractures) or other neurological diagnoses.

Suggestions for implementation

The Wii is currently listed at approximately $220 CDN and the Wii Fit Balance Board is listed at $100 CDN. Additional Wii remotes are $45 CDN and 'nunchuk'

Rehabilitation goal	Example of Wii activity
Increase range of motion	Games with big, natural movements to end ranges (e.g., tennis).
Improve strength	Games that require sustained arm elevation/use; games can be played with wrist weights on.
Increase distal motor control	Using the remote to control game pieces, requiring steady, controlled distal movements (e.g., marbles).
Improve gross motor coordination	Games requiring hand-eye coordination, with positive feedback for appropriate movements. Familiar games are good; tennis, baseball, ping-pong, and so on.
Improve dynamic trunk control/balance	Using the Balance Board for games (e.g., skiing, Wii Fit balance games); or, remote attached to a chest strap in sitting to play (e.g., airplanes, racing)
Practice visual scanning	Any game with a visual problem-solving component (e.g., Wii Play, puzzles, Boom Blox).
Practice visual attention	Games with continual challenging stimuli (e.g., returning tennis ball, puzzles).
Improve bilateral motor control	Games that require coordinated bilateral movement. Sports are a good example; boxing, cycling, rowing, and so on.
Increase endurance	Games requiring full body action (e.g., using both arms and trunk in a boxing game or paddling a canoe).

Figure 1. Examples of rehabilitation goals for Wii therapy.

AGE	NUMBER	
20-29	16	21.6%
30-39	10	13.5%
40-49	15	20.3%
50-59	9	12.2%
60-69	9	12.2%
70-79	4	5.4%
80+	4	5.4%
not documented	7	9.5%

Figure 2. Age of adult clients using Wii in occupational therapy at the Glenrose.

controllers are $25 CDN. The Wii Motion Plus ($25 CDN) is a small attachment for the Wii remote that adds an additional accelerometer to offer more precise and responsive controls. Games range from $20 CDN to $70 CDN.

Along with the console, a display of some sort is required. A noteworthy feature of the Wii system at the Glenrose is that it is connected to a projector, and the entire system is on a small cart, improving the Wii's ease-of-use and accessibility (photo). The projector can significantly increase overall costs for the system (costs range from $500 CDN to $1500 CDN).

Once the console and display have been setup, an appropriate space to use the Wii must be identified. Considerations include open space to allow full movements, a stable surface to stand or sit on, a power outlet, a nearby chair or mat in case of fatigue, the option of privacy if desired, and secure storage (photo).

The Wii is not appropriate for every client, and some may not enjoy the task in place of other mediums of therapy. The Wii was not designed for persons with disabilities or injuries, and will often be too difficult to operate. Certain games give negative feedback on poor performance, which may upset clients. Considerations of use include adequate vision and cognition to interact successfully with the game, adequate motor control, and adequate hand eye coordination, all of which enable a "just right" challenge. As with any other therapy, clinicians must use their professional judgment on appropriateness of use of the Wii in rehabilitation.

Like many therapies, there are associated risks with using the Wii (Nintendo of America Inc., 2006). Since clients may be motivated to continue longer than may be therapeutic, over-exertion or repetitive strain injuries from extended use may need to be addressed. Clients with increased seizure activity may be susceptible to seizure-inducing stimuli from the game. Clients with pacemakers must keep the Wii remote at least nine inches away from their chest.

Looking to the future

There are a number of considerations in looking to what lies ahead for the Wii in rehabilitation.

The first is research. While the amount of anecdotal evidence continues to grow, there is a need for research studies that assess the effectiveness of this method. These studies must go beyond case studies, toward robust research designs with rigorous methods.

Second, partnerships within the gaming industry and within computing science are worth pursuing. Without being designed specifically for a rehabilitation setting, the Wii has seen a great deal of success as a rehabilitation tool. The potential of the Wii may be increased if games, accessories, or future systems were designed with rehabilitation in mind.

Third, we cannot assume the Wii will be relevant forever. Technology continues to change and advance. Since the Wii's release, there have been reports of additional technologies, such as Microsoft's Project Natal (Project Natal, 2009). There are additional tools and methods just waiting to be commandeered for rehabilitation practice; it may be a video game, a smart

phone, an iPhone application, a computer accessory or a high-tech toy. Clinicians should be ready to take advantage of technological advances, using them to provide therapy that is culturally relevant and therapeutically sound.

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2009 – 2010 Midyear Report

Claudia von Zweck, PhD, CAOT Executive Director

Each year CAOT undertakes a wide variety of initiatives to address the priorities outlined in our strategic plan. The following report outlines how CAOT members have worked to together to ensure a strong national voice that promotes visibility and access for occupational therapy.

Advocacy

CAOT government relations initiatives are focused on increasing access to occupational therapy in health services under the jurisdiction of the federal government, including those directed towards the armed forces, veterans, public service and aboriginal populations. For example, CAOT believes occupational therapists can assist the Department of National Defence on a much broader basis to ensure the prompt and timely return of soldiers to active duty, or, as needed, facilitate transition back to civilian life. Despite our origins as a profession in working with veterans after World War I, few occupational therapy services are offered for Canadian military personnel. CAOT therefore met with the Department of National Defence to promote inclusion of occupational therapy services in primary health care teams. We are pleased that new positions for occupational therapists are now planned for teams that serve the armed forces in centres across Canada. In addition, CAOT believes occupational therapists need to provide a broader range of services to veterans of our armed forces. Despite a well regarded reputation for delivering high quality services on a timely basis to Canadian veterans, occupational therapists are still not being used to their full potential. CAOT met with Veterans Affairs to promote the utilization of occupational therapists in a number of additional critical areas to reduce the number of Canadian soldiers discharged for medical reasons and provide interventions for post traumatic stress disorder and operational stress injuries. Our meetings led to a successful presentation to the Parliamentary Veterans' Affairs Committee and visits by members of parliament and other high ranking individuals to occupational therapy services to better understand our potential contribution to the programs provided to military personnel.

"CAOT therefore met with the Department of National Defence to promote inclusion of occupational therapy services in primary health care teams."

In addition to activities related to the armed forces and veterans, CAOT met with representatives of aboriginal health organizations to discuss the role of occupational therapy in addressing the health needs of this population and identify opportunities for collaborative action. A position statement on this issue is under development. CAOT also continued to meet with executives of the public service as well as the unions that serve this group to explore methods to increase access to occupational therapy, particularly for addressing workplace health issues. CAOT is advocating for employer led occupational therapy programs as well as extended health care insurance coverage of occupational therapy services.

Promotional material including new brochures and a video are currently in development to assist with our lobby efforts. These tools complement other resources which are also designed to help members with their advocacy at the grassroots levels. During OT Month members used the CAOT reading circle kit featuring our new children's book *You, Me and My OT* (Bourgeois, 2009) in schools and libraries across the country as an effective and easy way to promote understanding of our profession. CAOT also profiled leaders within our profession in a calendar that was distributed to our advocacy partners and members during OT month. The profiles celebrate and promote understanding of the diversity of roles occupational therapists play in enabling occupation. Additional profiles of members are highlighted on the CAOT website.

Leadership

CAOT leads national projects that demonstrate the valuable role of occupational therapists in addressing significant population health needs. Given that falls and driving related accidents are the leading causes of hospitalization and accidental deaths in older adults, CAOT has undertaken a number of national projects to demonstrate the role of occupational therapists in fall prevention and older driver injury prevention programs. This work has positioned occupational therapists as key health professionals in injury prevention with older adults. For example, since

our February 2009 launch of the *National Blueprint for Injury Prevention in Older Drivers* (Blueprint), many stakeholders have used the document as a tool to inform and influence policy, practice, education and research regarding older driver safety. CAOT continues to work towards the goals of the Blueprint with the assistance of funding from the Public Health Agency. Work is underway for a special issue of *Occupational Therapy Now* in September of 2010 that outlines the role of occupational therapists with older driver safety. In February 2010, we introduced new older driver safety resources including consumer brochures and the www.olderdriversafety.ca website at a media conference and public forum in Ottawa (see p. 4). These events were followed by a successful one day strategic planning symposium attended by stakeholders representing consumers, researchers, educators, clinicians, law and government that reviewed progress towards the Blueprint goals and identified priorities for future action. CAOT will continue to advocate for action on these priority areas through planned activities such as a lobby day on Parliament Hill.

CAOT work on injury prevention has recently expanded to address risks for older adults associated with caregiving. CAOT recently completed a review of the research literature regarding older caregiver injury on behalf of the Public Health Agency in Canada. The report was presented in January 2010 to the Public Health Agency and advocated for action on a series of recommendations to address this growing issue. The report is available on the CAOT website (www.caot.ca).

CAOT leadership efforts continue to serve as a catalyst to bring together top Canadian scholars and researchers to develop the theory and practice that underpins our profession. At our annual conference in Halifax this May, Drs. Mary Law., Helene Polatjko and Elizabeth Townsend will provide an opening keynote presentation on the past and future of occupational therapy in enabling occupation. A professional issue forum on the following day will provide delegates with an opportunity to provide feedback and explore how CAOT enabling occupation guideline documents resonate with current practice. A number of CAOT activities are currently underway to assist with knowledge translation of concepts outlined in *Enabling Occupation II* (Townsend & Polatjko, 2007), including practice scholar groups, online webinar presentations and a new interactive workbook scheduled for publication in late 2010.

A preconference workshop by Dr. Terry Krupa is also planned in Halifax to promote knowledge and utilization of our newest mental health publication *Action Over Inertia* (Krupa, et al., 2010).

A delegation led by Past CAOT President Dr. Susan Forwell in the fall of 2009 provided an enriching leadership opportunity for Canadian occupational therapists to share knowledge and expertise for development of the emerging occupational therapy profession in China. Another delegation is planned for Russia in the fall of 2010.

Workforce development

CAOT advocates for increasing the supply of occupational therapists in Canada to meet the health needs of the Canadian population and address critical workforce shortages. Our work is informed by data collected by the Canadian Institute for Health Information (CIHI) in the occupational therapist workforce database. CAOT worked with CIHI and other stakeholders to establish this database and annually contributes membership information to monitor workforce trends of occupational therapists. A third annual CIHI database report released in late December 2009 indicated that the per capita average of 38 occupational therapists per 100,000 population remains low in comparison with other countries with socialized health systems such as Denmark (114/100,000), Sweden (104), Belgium (54) and Australia (50) (World Federation of Occupational Therapists, 2009). Saskatchewan has the lowest per capita average at 24 occupational therapists per 100,000 population (CIHI, 2009). CAOT therefore continues to lobby for the establishment of a new occupational therapy education program at the University of Saskatchewan. Approved by the university, this program is currently awaiting funding from the provincial government for a projected start date in 2012. CAOT also continues to advocate for an increased number of seats in the occupational therapy program at the University of British Columbia. The ratio of education seats/population base in British Columbia is less than one half of what is available in all other Canadian jurisdictions (CAOT & British Columbia Society of Occupational Therapists, 2007). As a result, more than two thirds of new entrants to the profession come from education programs outside British Columbia to address chronic workforce shortages that exist throughout the province (College of Occupational Therapists of British Columbia, 2009). CAOT recently participated in a strategic planning session in British Columbia with other occupational therapy organizations and representatives to develop an action plan to address

these workforce issues.

CIHI data indicates that occupational therapists in Canada are younger, on average, than most other health professionals (CIHI, 2009). Seventy-one percent of occupational therapists are less than 45 years of age, a substantial difference when compared to other professionals such as physiotherapists (59%), pharmacists (54%), nurses (41%) and doctors (30%). While this figure reflects the growing number of new entrants from Canadian education programs, it also raises concerns regarding attrition from the profession prior to a usual retirement age. Recommendations of a 2009 professional issue forum on workforce retention are guiding CAOT initiatives on this issue, including working with other occupational therapy organizations in Canada for a leadership forum in May 2010 to develop a joint position statement on the topic of use of the occupational therapist title. The intent of the position statement is to foster inter-organizational attention and action on strategies that ensure occupational therapy theory and values inform valued occupational therapy roles outside of clinical practice such as research, policy development, administration and education. CAOT has also established a task force with representation from different stakeholder groups to develop a common definition of advanced practice and will further explore this topic with members at a professional issues forum in Halifax.

*"CAOT has also established a task force with representation from different stakeholder groups to develop a common definition of **advanced practice** and will further explore this topic with members at a professional issues forum in Halifax."*

Standards

CAOT is working with the Canadian Physiotherapy Association and the Canadian Association of Speech Language Pathologists and Audiologists on the development of an Interprofessional Caseload Management Tool. This tool will be an evidence-based set of factors and considerations that will assist individual professionals, organizations and policy makers in determining effective caseload/workload management for a wide variety of client populations and service delivery models. The tool is undergoing pilot site testing in 2010 and is expected to be completed in early 2011. In late 2009, new indicators were approved for the academic accreditation program, the result of a multiyear project involving the work of many volunteers. The new indicators will be integrated in the academic accreditation self study guide for use with occupational therapy university education programs across Canada. Work has also begun on the establishment of an accreditation process for occupational therapy support personnel educational programs, a collaboration between the Accreditation Council for Canadian Physiotherapy Academic Programs (ACCPAP), support personnel educators, and CAOT. This new program will validate the quality of the program for students and the public, provide an opportunity for faculty professional development, as well as a framework for quality improvement for educators.

In our own quality assurance initiative, CAOT participated in an external review of the national occupational therapy certification examination in 2009 with the Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO). The review validated the use of the examination for assessment of entry-to-practice competency. Work is underway to address several recommendations of the review with our new examination consultant. CAOT transitioned to a new examination consultant in early 2010 following a decision of our former provider at the University of Alberta to focus solely on in-house examinations offered to their faculty of medicine. CAOT will also be introducing a new blueprint for the July 2010 sitting of the certification examination. The blueprint was revised to ensure continued currency with entry-to-practice expectations for occupational therapists in Canada.

In October 2009, CAOT launched a new web portal http://www.gocanadaot.com for internationally educated occupational therapists (IEOTs) at a reception in Ottawa attended by government representatives and other stakeholders (see p. 23). This project was funded by the Government of Canada Foreign Credential Recognition Program (FCRP), with ACOTRO and the Association of Canadian Occupational Therapy University Programs (ACOTUP) as project partners. The creation of the IEOT web portal was the result of recommendations of the 2006 CAOT Workforce Integration Project that identified potential barriers for IEOTs for working in Canada. The web portal was developed to meet the identified need of IEOTs for a central source of information regarding entry to occupational therapy practice in Canada (von Zweck, 2006).

We are very pleased that FCRP recently provided CAOT with new funding for a three year project to work with McMaster University to develop a generic

educational curriculum for IEOTs who wish to work in Canada. The National Occupational Therapy Examination and Practice Preparation (OTepp) project will build upon previous work to develop a flexible national curriculum that can be delivered by occupational therapy education programs across Canada. This initiative will address the 2006 Workforce Integration Project recommendation for increasing access to academic upgrading and language training to help IEOTs meet registration requirements. The 2006 project identified IEOTs that do not meet entry-to-practice requirements need assistance to acquire the additional skills and knowledge required for practice in Canada.

Research

CAOT fosters the development and use of new knowledge in occupational therapy in a number of ways aside from undertaking our own research in national projects. Initiatives include our annual donation of member fees plus *in kind* assistance towards the operation of the Canadian Occupational Therapy Foundation. In partnership with Dr. Lori Letts and Carri Hand at McMaster University, CAOT also received funding from the Canadian Institutes of Health Research to bring stakeholders together to create an agenda for occupational therapy's contribution to collaborative chronic disease research. A survey was conducted in late 2009 to validate the agenda that was developed at a spring 2009 meeting attended by an interdisciplinary group of stakeholders. CAOT is now using this document to advocate for occupational therapy's role in collaborative chronic disease research with researchers, clinicians, chronic disease organizations, associations and research funders. As a member of the coalition Research Canada, CAOT also lobbies government agencies for increased health research funding.

In October of 2009, CAOT added access to the Journal of Occupational Science to the growing list of benefits provided free to members. A cost neutral agreement was also signed with the New Zealand Association of Occupational Therapists modeled on the arrangement that CAOT negotiated in 2008 with the British College of Occupational Therapists. These agreements provide a mutual exchange of online access to membership journals, a win-win arrangement that increases the readership of the publications for authors and allows members to access a broader range of research articles to support their practice.

The number of CAOT communities of practice continues to grow to bring together members with similar clinical interests for research and scholarship. A new community of practice on sensory processing was established in late 2009.

Continuous improvement

CAOT initiatives to continuously improve the quality of our products and services include the successful implementation of online membership registration and renewal this past fall. This initiative decreased the time required to send out membership cards and receipts and allowed association resources formerly allocated to this renewal process to be redirected to other activities. Other improvement initiatives include development of a webinar training module for *Canadian Journal of Occupational Therapy* (CJOT) reviewers and a new strategic plan for the *Occupational Therapy Now* practice magazine. A recent restructuring has developed separate editorial boards to oversee the CJOT and *Occupational Therapy Now*. Plans are also underway for an online submission and review process for CJOT articles.

A conference scientific program review task force will provide recommendations later this year regarding the review and selection of abstracts for the programs of annual CAOT conferences. A new design for our website in 2010 will increase ease of navigation and consideration is underway for greater integration of social networking technologies in our communications with members and other stakeholders. CAOT is hosting a series of web-enabled "Lunch & Learn" sessions that allow members to participate in one hour professional development opportunities from the convenience of their home or office. New free "Water Cooler Talks" regularly share information and provide opportunity for interactive discussion regarding the work of CAOT with members.

Governance

In November of 2009, the CAOT Board of Directors held a one day session held to develop a new strategic plan for the Association that will begin in fall 2010. In preparation for the planning session, the Board reflected on input provided during member forums in 2009, as well as on information collected during an environmental scan of issues addressing the profession. Also in November 2009, the Board was informed of excess surplus revenues earned in the previous fiscal year as a result of our successful conference held in Ottawa in June 2009, as well as publication sales and unanticipated grant income. The Board therefore recommended a zero fee increase

for membership rates in the coming fiscal year. The proposed 2010-2011 fee schedule will be presented to the membership for approval at the annual general meeting in Halifax in May 2010. Please plan to join us for this event to provide us with your input regarding the work of CAOT. The success of our organization depends on the collaborative action of you and all our members.

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A New CAOT Strategic Plan for 2010

A new strategic plan has been approved by the CAOT Board of Directors to begin in the fall of 2010 and guide the work of CAOT for the next 3-5 years. The development of this plan was informed by the input of members from across Canada. Within our new plan, our mission to advance excellence in occupational therapy is directed toward a vision of the profession as a primary, priority health service, accessible and valued across Canada.

With this vision, occupational therapists are leaders in health and involved in setting policy and priorities throughout Canada with our unique focus on occupation. Sound relationships are in place with occupational therapy stakeholders and members value the impact of the Association for professional experience and growth. Our values of integrity, accountability, respect, equity, innovation and transparency are rooted in the work of the Association toward four strategic priorities. Priorities include advancing political advocacy to provide a national voice to represent occupational therapy, lobbying for increased funding of services, and creating improved accessibility through workforce development. Ensuring visibility of occupational therapy will involve coordinated national public promotion, projects that demonstrate occupational therapy's valued contributions, and development and implementation of standards for education and practice. Support for the development of research evidence as well as knowledge exchange to support evidence-based occupational therapy will foster research and scholarship. Enabling occupational therapy practice will be undertaken through initiatives directed toward increasing CAOT membership, enhancing member utilization of products and services and ensuring effective governance.

2010 CAOT Strategic Plan

Mission: Advance excellence in occupational therapy.

Vision: Occupational therapy is valued and accessible across Canada.

Values:
- Integrity
- Accountability
- Respect
- Equity
- Innovation
- Transparency

Strategic Priorities:
- Advance political advocacy to promote occupational therapy
- Ensure visibility of occupational therapy
- Foster research and scholarship for evidence-informed occupational therapy
- Enable occupational therapy practice

Column Editors: Jane A. Davis & Helene J. Polatajko

Don't forget the repertoire: The meta occupational issue

Jane A. Davis and Helene J. Polatajko

Emma, 85, lives in a special home for individuals with severe cognitive impairments, although she herself has fairly good cognitive function. Emma has severe arthritis. She has a great deal of difficulty with many simple physical activities. "... she can't play shuffle board or throw bean bags. She's bored beyond measure with the reminiscing group where the majority of people can't even remember their children's names." With each day that passes, she "... ventures outside her bedroom less and less; instead she sits idly...." When asked by an attendant, "Why don't you join us, Emma? What are you waiting for?" She replies, "For the day to end." (Thibeault, 2007, p. 64).

Noah, 10, climbs with "the best indoor rock climbing team in the nation (and 30 minutes from home without traffic). First he climbed two weeknights – right up to but not interrupting family dinners. ... Suddenly, it's Saturdays plus three weeknights, right in the middle of dinnertime, pushing back bedtime, trips to Colorado, California and Montreal. A year into it, he's the No. 1 speed climber in his age group on the continent. ...We get kudos for letting him pursue his passion. But suddenly – although Noah loves it ... he isn't getting enough sleep. Three nights a week, eating dinner as a family isn't an option. What little homework he has is rushed because he simply has no time." (McMullan, 2008, section 3).

At face value, these two scenarios are quite different, yet, fundamentally they illustrate the same meta occupational issue - both Emma and Noah are experiencing an issue with their occupational repertoire. They remind us that although, as occupational therapists, we are often focused on our client's ability to perform specific occupations, we also need to be concerned with the sum total of their occupations, their occupational repertoire. The intent of this article is to bring explicit attention to the occupational repertoire.

The repertoire - the meta occupational issue

In the most recent Canadian practice guidelines, occupational therapy is defined as "the art and science of enabling engagement in everyday living, through occupation; of enabling people to perform the occupations that foster health and well-being; and of enabling a just and inclusive society so that all people may participate to their potential in the daily occupations of life" (Polatajko et al., 2007, p. 27). The use of the phrase "engagement in everyday living through occupation", rather than simply "engagement in occupation", is meant to imply that all aspects of occupation, as they affect everyday living, are of concern, from the performance of specific individual occupations to the full repertoire of occupations in which our clients engage at one period in time out of choice, need, responsibility, or survival (Davis & Polatajko, 2010).

Although we implicitly know the importance of understanding our clients' occupations at a meta level and address them in some areas of practice (e.g., in discussions of energy conservation), it is rare for us to make our concern with this level of occupation explicit [viz. the Canadian Occupational Performance Measure (COPM) (Law et al., 2005) does not explicitly address issues of repertoire]. In reality, the dominant focus of occupational therapy is on increasing competence in the performance of specific individual occupations. But, as with Emma and Noah, the issue is less one of competence and more one of the overall constellation of occupations, the repertoire. Indeed, increasing competency in occupational performance may actually create issues of repertoire, as with Noah, and, in turn, his family. Without explicitly addressing our clients' occupational repertoires we can miss important aspects of enablement; we can fail to understand how changes in the expansion or contraction of occupations can, in and of themselves, affect our clients' engagement in everyday living. By explicitly adding an exploration of our clients' occupational repertoires to our practice concern we can come to understand their occupational lives, in totality; and by extrapolation, the full contribution occupation makes to their health and well-being. After all, health and well-being are not only created through competence in individual occupations but through the sum total of our occupations. Each of us can certainly think of times in our lives when the issue was not competence in specific occupations but rather the totality of the occupations that filled our days.

Considering the repertoire

As therapists we need to be mindful of the nature of our clients' occupational repertoire and the personal,

occupational and environmental situations that can hinder and/or enable it. Here we offer a few tools that can be of help in uncovering repertoires and suggest some repertoire patterns that warrant the attention of occupational therapists.

Some tools

There are a few instruments available to us that can assist with the exploration of our client's occupational repertoires. Some of the tools we commonly use, although not specifically designed to capture repertoire information, can be used, for example, an occupational life course timeline can provide a basis for exploring the contextual nature of an occupational repertoire, both past and present, and for looking forward to possibilities for a future occupational repertoire and how to enable it. As well, the COPM (Law et al., 2005) could easily allow for the incorporation of questions regarding the repertoire. Some tools focus on uncovering our clients' repertoires more explicitly. The Activity Card Sort (ACS; Baum & Edwards, 2008) and versions thereof, such as the Paediatric Activity Card Sort (PACS; Mandich, Polatajko, Miller, & Baum, 2004) specifically identify involvement in a constellation of daily activities or occupations. Kielhofner and colleagues' (2004) Occupational Performance History Interview II (OPHI-II) is another tool that provides a format for capturing clients' occupational repertoires across time. As well, Persson and Jonsson (2009) have suggested a framework that could be used to understand the repertoire through categorizing occupations as exacting, flowing and relaxing, based on the notion of flow.

Some repertoire patterns

Contracted Occupational Repertoire: A significant decrease in the number of occupations in a client's repertoire. The contraction of a client's repertoire may be an indicator that there is an issue that needs attention. For example, contraction of a repertoire may signal the presence of personal issues such as depression, early dementia, or physical deterioration. It may also be suggestive of environmental or occupational changes, a move to a smaller home, retirement, or loss of a career. Contractions can be gradual; for example, individuals with muscular dystrophy or amyotrophic lateral sclerosis will experience a gradual contraction of their repertoires as a result of their decreasing physical capacity. Or contractions may be sudden; for example, the catastrophic natural disaster experienced by the people of Haiti which resulted in a dramatic contraction of occupation for many, and a dramatic increase for others, an increase that may lead to an unmanageable repertoire.

Unmanageable Occupational Repertoire: A sum total of occupations in one's repertoire that is too great to meet expectations, needs or potential, or that is too large to manage. An unmanageable repertoire may herald future problems if the repertoire is not made manageable. In situations in which repertoires become unmanageable, issues around occupational choice and life balance may result, requiring restructuring of how one's repertoire is carried out. Restructuring may involve making choices about the number of occupations, or time and energy spent on their performance, altering one's occupational expectations, or changing environmental supports or systems. Unmanageable occupational repertoires may arise from voluntary or involuntary additions to one's occupational repertoire, such as the arrival of a new baby, an aging parent that needs more help, or new job responsibilities. They may also arise from personal changes in time or energy required to perform certain occupations. For example, for an individual who is living with multiple sclerosis, the time and energy that was once dedicated to the performance of certain occupations may no longer be available.

Unsatisfying Occupational Repertoire: The occupations that comprise one's repertoire collectively have little or no meaning or purpose; one may have an appropriate amount of occupation, yet none, or too few, are of any significance to the individual, or to the individual's context. Personal and contextual factors can play an important role in making repertoires satisfying or not - personal because of fit with interests or sense of self, and societal because of the external values ascribed to occupations. As is the case with an unmanageable repertoire, an unsatisfying one may also herald future problems both for the individual and possibly the community. Unsatisfying occupational repertoires are frequently discussed in the context of immigration. There are many stories of individuals immigrating to our country who are not able to engage in the occupations of significance to them, work or otherwise. Instead,

individuals fill their repertoires with work occupations to which they do not identify, or leisure occupations void of cultural significance. Unsatisfactory repertoires have also been identified at times of life transitions such as retirement, becoming a stay at home parent, or job loss, and at times where personal factors affect the occupational repertoire.

In summary

As indicated at the outset, the intention of this article was to bring the occupational repertoire and its relevance to the health and well-being of our clients into focus. As a start, we have identified some possible tools and described some repertoire patterns that may require attention. The hope is that this article will inspire readers to share their stories regarding repertoires and to develop this aspect of their client services.

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Blast off!
The launch of www.GoCanadaOT.com

Laura Van Iterson

Throughout occupational therapy history, Canada has had a shortage of occupational therapists (von Zweck, 2006). The good news is that recently Canada has had more and more internationally educated occupational therapists (IEOTs) knocking on its doors. In the fall of 2009, 70 of the 540 candidates for the CAOT exam were internationally educated (C. von Zweck, personal communication, November 22, 2009).

Claudia von Zweck, CAOT Executive Director, thinks a large reason for this increase in applications of IEOTs to come to Canada is that our neighbours to the south are demanding a Master's level education (or equivalent) to immigrate. Other reasons occupational therapists are attracted to Canada are its "standard of living and the quality of working life for occupational therapists" (C. von Zweck, personal communication, November 22, 2009).

The bad news is that these foreigners are not always able to work in Canada as an occupational therapist. Coming to Canada to practice occupational therapy is much easier dreamed than done, and the efforts of IEOTs to work here often end in frustration (C. von Zweck, personal communication, November 22, 2009). On behalf of CAOT members, CAOT asked the question why. Demonstrating signature occupational therapy creativity, they set out to problem-solve the difficulty IEOTs have entering Canada and integrating into the occupational therapy workforce.

The CAOT successfully sought funding to do so from the federal government's department of human resources, specifically its Foreign Credentials Recognition Program (FCRP). The FCRP's objective in layman's terms, is to put an end to the notion of "the doctor working as a taxi driver" (S. James, personal communication, October 29, 2009).

"Demonstrating signature occupational therapy creativity, they set out to problem-solve the difficulty IEOTs have entering Canada and integrating into the occupational therapy workforce."

But no intervention plan without first an assessment! CAOT tackled the evaluation of the problem in two phases. Starting in May 2005, entitled the Workforce Integration Project for IEOTs, an exploration was done of the issues that facilitate and/or inhibit the integration of IEOTs into our workforce. Next a project looked at the landscape travelled by IEOTs on their way to work here. The *Access and Registration Framework for Internationally Educated Occupational Therapists* (Van Bentham, 2009), looked at the bureaucracy, associations, and stakeholders encountered and navigated by IEOTs. Opportunities for motion sickness abound on the lengthy IEOT journey that includes; immigration, assessment of credentials and competencies, successful registration, and finally, practice of occupational therapy in Canada.

A major finding was the need for a single information gateway to deliver clear, consistent, and accurate information necessary for workforce integration (von Zweck, 2006). The innovative solution was a web portal that could be accessed on its own, or from the CAOT web site.

The plan to make a portal was developed using what could be called a multi-disciplinary team approach. Working with CAOT, the Advisory Committee included; Fifty (the web site designers); Sylvia Prazias, an internationally educated occupational therapist with experience working in Canada; and two members of each of the following partners: FCRP, Association of Canadian Occupational Therapy Regulatory Associations, Canadian Occupational Therapy University Programs.

Their hard work paid off and on October 29th, 2009, www.GoCanadaOT.com was launched! CAOT's partners gushed about what a pleasure it had been to work with a professional association that was so professional! The result of the merry collaboration is an attractive site with up-to-date information on

how to jump through the many hoops in the process of coming to Canada from abroad to work as an occupational therapist. From the home page one can click on Language, Academic, Currency, Insurance, and Immigration. The bilingual multi-media site is a beauty to behold, invaluable for IEOTs, and of interest to others as well. For example, representatives of other health care professions experiencing shortages in Canada were all ears at the launch, learning about how this type of Internet tool could help boost their own workforce.

www.GoCanadaOT.com is also an opportunity for Canadian-educated occupational therapists to appreciate the tales of adventures and misadventure their IEOT colleagues, present and future, may have to tell. The personal account videos of what it is like to come to Canada to practice occupational therapy are a click away under "Success Stories" and feature breathtaking Canadian scenery, engaging music, and charming IEOTs who are happy to have come here from Great Britain, France, South Korea, Australia, and Brazil. Now they are living and working in Yellowknife, Trois-Rivieres, St. Thomas, Toronto, Calgary, and Vancouver! Braving windchill, learning to speak Canadian, fathoming the idea of snow in May, these occupational therapists have more than passing anatomy under their belt. Jin will tell you how she flew to Vancouver and back from South Korea just to write the CAOT exam. And how she took the spoken-English language test no fewer than ten times before she passed.

"Now that funding has been provided, OTepp will aim to complement the portal's information role by offering courses across Canada that prepare IEOTs (and Canadian-educated occupational therapists who have not practiced for several years) for the CAOT exam and for occupational therapy practice."

While www.GoCanadaOT.com can't improve users spoken English (though it can put users in touch with language resources), it can certainly reduce surprises on the journey to integration into the Canadian workforce. Sung, another South Korean IEOT featured on the site, talks about what he went through to get licensed here and how he could have benefited from having had more information on the required testing, qualification, and educational background before coming to Canada. The video format used on the site is effective at conveying the emotions on the faces of the IEOTs as they discuss the challenges they went through to practice here.

Another clever element of the IEOT web portal that brings it to life is a chat room for visitors to the site. An anxious IEOT asks whether there is truth to the rumour that non-WFOT programs are only going to be recognized until the end of 2009 by CAOT. The tone of that post contrasts with the joy and satisfaction and appreciation for their new life in Canada of the IEOTs in the success stories. The idea is that www.GoCanadaOT.com will put IEOTs' concerns to rest and help them realize their dream of practicing occupational therapy in Canada.

Anxiety and waiting for decisions from the Canadian bureaucracy is not just for IEOTs. CAOT patiently waited for, and finally received in January, 2010, an answer regarding their dream of a sequel to the IEOT portal launch, a dream that depended on government funding to be viable. The dream was for the Occupational Therapy Examination and Practice Preparation project (OTepp). Now that funding has been provided, OTepp will aim to complement the portal's information role by offering courses across Canada that prepare IEOTs (and Canadian-educated occupational therapists who have not practiced for several years) for the CAOT exam and for occupational therapy practice. OTepp addresses the identified need to improve national certification examination access, preparation resources and assistance, and increase access to academic upgrading and language training to help international graduates meet registration requirements. Mentoring and supervised practice are integral components of the program (Baptiste, Dhillon, & Steggles, 2009).

OTepp scored an important coup when a proposal for it to be recognized as a certificate program at McMaster University was accepted. This accomplishment for the program implies access to financial aid for its students as well as insurance during their supervised practice. In another exciting development, the Ontario government has given McMaster a grant to host the program for the next three years. The course developed at McMaster will be piloted at three more Canadian schools as CAOT was successful with its application to FRCP. Fingers are also crossed for funding for a translation and adaptation into French of the OTepp course, for Francophone IEOTs, by the Consortium National de Formation en Santé (J. Lalonde, personal communication, November 17, 2009).

Future directions in encouraging IEOTs to come to Canada, based on the assessment of their experience in attempting to come to work here, could involve advocating for fast-tracking of occupational therapists through immigration processes, coordinating requirements of occupational therapy regulatory

associations across Canada, and promoting a diverse workforce for quality occupational therapy services (von Zweck, 2006).

IEOTs bring diversity and language skills and help the profession of occupational therapy in Canada maintain its status, practice efficiently with short waiting lists, and expand our areas of practice. CAOT members can appreciate the work of their national professional association to help IEOTs integrate into the Canadian occupational therapy workforce, and also the efforts of IEOTs to come and practice here!

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Effective advocacy: The do's and don'ts of influencing change

Elisabeth Ostiguy, CAOT Director of Professional Affairs

Advocating is influencing the factors around us that impact on what we want to accomplish in order to get what we want. YOU influence with your message but mostly with your passion in your profession. Your influence will grow with every visit and/or meeting.

When meeting with Members of Parliament or Provincial/Territorial representatives, it is important to:

- **Use meeting(s) to build relationship with these policy makers:**
  - Be helpful - tie your message to their riding interests. Their number one priority is to be re-elected so they want to be perceived as doing the "right thing" for their constituents.
- **Use clear, simple and concise messages:**
  - Motivating messages hit an emotional chord. Reach them first though a personal story and then educate them. Stories draw from your professional experience and anecdotes are extremely helpful.
  - Keep your message simple - never confuse the issue with too many "asks". Your message should be designed to achieve the goal and support your message with data.
- **Tailor your message to your target audience:**
  - A message will be altered to reflect the priority of the audience. A provincial/territorial representative will address health issues from a delivery perspective; while an MP will approach health issues more from a national policy direction.
  - Do some research about the person you are meeting with to understand their background, their previous experience in, knowledge of, and record on the topic at hand.
  - It is equally important to be aware of the political context within which you are making the case. CAOT will provide analysis of the federal political scene to assist members in gaining this knowledge. Information can be found in the Advocacy section of the CAOT website.
- **Use plain language**
  - To communicate your message effectively, avoid using complex, hard-to-follow and highly nuanced arguments as well as profession centric terms.
  - It is essential to engage your audience by using language that everyone can understand and that invites the person into a dialogue with you.

What to expect during the meeting:

- **Expect to make the case for action to be taken now:**
  - Politicians are barraged with messages all the time. You need to distinguish the importance of the issue and what needs to be done from general conversation. You will distinguish your message from others by indicating how action on the issue can make a difference in people's lives.
- **Expect to listen and to ask questions:**
  - Don't speak for too long. Encourage questions and discuss them. It is important to discover the politician's views first hand. Listen to what they say and be prepared to begin from their position in making your case.
- **Expect tough questions**
  - Why is what you are asking for important? What difference will it make to Canadians (his/her constituents)? Why should he or she care?
  - If you can, prepare an answer for these questions in advance. Check CAOT website for position statements that can help you.
  - Be credible.
  - If you do not have the answer, commit to getting back to them with an answer.

What to expect from the meeting:

- Expect a new relationship with the politician and his/her staff.
- Expect to follow-up with the politicians and/or his/her staff (You initiate!).
- Plan to debrief after the meeting.
- Provide feedback to CAOT about:
  - What went well?
  - How did the politician respond?
  - Was this response due to personal interest, lack of interest or other?
  - What should the next step be?

You have the power to change things!

If you need more information, please contact Elisabeth Ostiguy, CAOT Director of Professional Affairs at lostiguy@caot.ca or 613-523-2268 ext 246

Update from the COTF

Highlight of A First Time COTF Award Recipient:
2009 Scholarship Competition Recipient:
Pauline Cousins, Dalhousie University, COTF Master's Scholarship, $1,500
Title: Driving as an Occupation: The Relationship between Occupational Performance and Driving Performance
Research Question: The purpose of this study is to examine the relationship between driving performance and occupational performance in the older adult population and the influential factors on this relationship by answering four questions: (1) Is there an association between difficulties with driving and difficulties with ambulation among older adults?; (2) Is there an association between difficulties with driving and difficulties with IADL performance among older adults?; (3) Is there an association between difficulties with driving and difficulties with ADL performance among older adults?; (4) What is the impact of the social, institutional, physical, and cultural environment on driving among older adults ?
Methodology: To address these questions, a secondary data analysis of pre-existing data set collected through a random survey of 1702 Atlantic Canadian seniors by the Atlantic Seniors Housing Research Alliance will be completed. Descriptive statistics will be used to provide an overall description of the information collected with respect to each of the variables (DePoy & Gitlin, 2005) as well as vérification of the data obtained with the original study (Finlayson, Egan & Black, 1999).

2010 COTF Awards Program (www.cotfcanada.org):
Scholarship Competition
(deadline September 30th, 2010):
Master's (2 x $1,500)
Doctoral (2 x $3,000)
Thelma Cardwell (1 x $2,000)
Goldwin Howland (1 x $2,000)
Invacare (1 x $2,000)
Francis & Associates Education Award (1 x $1,000)
Community Rehab OT Scholarship (1 x $5,000)

***New**
Blake Medical Doctoral Scholarship
The recipient will receive a total of $15,000 from Blake Medical over the three years ($2,500, $5,000, $7,500). Thank you to Blake Medical for offering this scholarship!

Other:
COTF Future Scholar Award ($100 per university)
Janice Hines Memorial Award (1 x $1,000)
Please note that the information can change from time to time. For the most update information, please contact COTF directly.

Benefits of Monthly Donations:
Small gifts add up quickly. Consider donating on a monthly basis. Monthly donations can be made on-line at www.cotfcanada.org by clicking on the Donate Now! icon. It is an easy way of donating and extremely secure. Monthly donations benefit COTF by providing a regular income for the important awards programs that COTF offers to occupational therapists.

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

Your Support Counts!
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CAOT LEARNING SERVICES

CAOT Conference 2010
Halifax, NS
Co-Hosted with NSSOT
May 26-29
Meaningful Occupation: Enabling an ocean of possibilities

Pre-Conference Workshops
May 25 & 26, 2010
Halifax, NS

Chronic Disease Self-Management: Forgotten populations and new practice opportunities
Presenters: Tanya L. Packer, PhD, MSc, BSc(OT), Joan Versnel, PhD, MSc, BSc(OT)
Date: May 25th, 2010

Wheelchair Skills Training for Manual Wheelchair Users: Practical "boot-camp" for trainers
Presenters: Cher Smith, BSc OT, R. Lee Kirby, MD
Date: May 25th, 2010

Promoting Action Over Inertia
Presenters: Megan Edgelow, MSc, BSc(OT), Terry Krupa, PhD, OT Reg (Ont)
Date: May 26th, 2010

Leading Occupational Therapy Practice through Guidelines: Reviewing, developing, implementing and evaluating for best practice
Presenters: Debbie Hebert, OT Reg (Ont), MSc(Kin), PhD(c), Mandy Lowe, OT Reg (Ont), MSc, Mary Kita, OT Reg (Ont), MSc, PhD(c), Susan Rappolt, OT Reg (Ont), MSc, PhD, Catherine Chater, OT Reg (Ont)
Date: May 26th, 2010

CAOT Lunch & Learn Webinar Series:

Wellness and Bipolar Disorder: Self-Management Strategies for Healthy Living
Presenter: Melinda Suto
Time: 12:00-1:00pm (EST)
Date: June 1, 2010

Evidence for Executive Function Intervention in Brain Injury Rehabilitation
Presenter: Alison M. McLean
Time: Tuesday, 12:00 - 1:00 pm (EST)
Date: June 15, 2010

Cognitive Impairment in the Aging Driver: Assessment Issues and the Use of Simulators
Presenter: Dr. Michel Bedard
Time: 12:00-1:00pm (EST)
Date: September 21, 2010

The Art of Being in a Doing World: Adding meaning for those living with eating disorders
Presenter: Michelle Elliot
Time: Tuesday, 12:00 to 1:00 pm (EST)
Date: October 5, 2010

The McMaster Handwriting Assessment Protocol
Co-presenters: Nancy Pollock & Julia Lockhart
Time: Tuesday, 12:00 to 1:00 pm (EST)
Date: October 19, 2010

Key Software Issues in Assessing Students with Learning Disabilities
Presenter: Heidi Cramm
TIme: 12:00-1:00pm (EST)
Date: November 2, 2010

Pediatric Home Modification Recommendations: Assessing Environments and Future Needs
Presenter: Tanya Eimantas
TIme: 12:00-1:00pm (EST)
Date: November 16, 2010

Low Vision: Tools for Intervention
Co-presenters: Corie Haslbeck and Lara Anderson
Time: 12:00-1:00pm (EST)
Date: November 30, 2010

Integrating Rehabilitation Principles into Chronic Disease Self-Management
Presenter: Dr Lori Letts
Time: 12:00-1:00pm (EST)
Date: December 14, 2010

CAOT Water Cooler Talks: A series of free webinars.

CAOT Presidential Report
Presenter: Liz Taylor, CAOT President
Time: 12:00-1:00pm
Date: June 10, 2010

CAOT Member Benefits: Access to a variety of journals
Presenter: Brenda McGibbon Lammi, CAOT Professional Development Manager
Time: 12:00-1:00pm (EST)
Date: June 24, 2010

Enabling Occupation II: A review and discussion
Presenter: Janet Craik, CAOT Director of Professional Practice
Time: 12:00-1:00pm (EST)
Date: September 30, 2010

Seniors Caring for Seniors: Examining the Literature on Injuries and Contributing Factors Affecting the Health and Well-Being of Older Adult Caregivers

Presenter: Janet Jull,
CAOT Policy Analyst
Time: 12:00-1:00pm (EST)
Date: October 14, 2010

Professional Practice Insurance

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

CAOT on Parliament Hill

Presenter: Lis Oestiguy,
CAOT Director of Professional Affairs
Time: 12:00-1:00pm (EST)
Date: November 25, 2010

Please go to www.caot.ca to register for a Lunch & Learn or for a Water Cooler Talk of your choice, or 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.