OCCUPATIONAL THERAPY NOW

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OT Now Call for Papers
The September, 2011 issue of OT Now will be a special issue on 'Promoting Self-management and Self-management Support: An Occupation Focused Perspective'.
The Guest Editor will be Tanya Packer, PhD, OT(C) NS(Reg).
Deadline for submission: April 1st, 2011
Please contact Brenda McGibbon Lammi (blammi@caot.ca) if you have any questions or would like more information.

Everyday Stories . . . profiles of your CAOT colleagues

Jennifer MacKendrick Weber

From the Prairies to the Great Lakes, and from the Rockies to the National Capital Region, I have been fortunate to experience the different regions of Canada, and the range of opportunities a career in occupational therapy can offer. Originally from Manitoba, my interest in occupational therapy started in university while working for the Society for Manitobans with Disabilities. After completing my Bachelor of Science in Biology at the University of Winnipeg, I moved to southern Ontario where I attended McMaster University and graduated in 1999 with my Bachelor of Health Sciences in Occupational Therapy.

Upon completion of my occupational therapy degree, I began working at KidsAbility Centre for Child Development in Waterloo, Ontario. At KidsAbility, I had the opportunity to develope my skills as a clinician and to participate in research projects through CanChild Centre for Childhood Disability Research and McMaster University. I also enjoyed guest lecturing to the occupational therapy programs at University of Western Ontario, McMaster University and the Occupational Therapy and Physiotherapy Assistant program at Conestoga College. During my five years in the Waterloo Region, I volunteered for Track 3, a non-profit program that teaches children and youth with disabilities to learn how to down-hill ski. Waterloo is also where I met my husband, Chris.

In 2004 my husband's career led us to Calgary, where my own career transitioned to adult health. In pursuit of a position that would enable me to focus on practice and professional development issues, I took on the role of educator, providing support to therapy and allied health staff at Carewest. Carewest provides long term care, rehabilitation and recovery services and community programs throughout Calgary. In addition to facilitating education, this role provided me with a greater understanding of collaborative care and relationship management. While in Alberta, I chaired the Society of Alberta Occupational Therapists (SAOT) Education Committee and was invited to sit on the Certificate Program Advisory Council for the Faculty of Rehabilitation Medicine at the University of Alberta. To keep my hand in pediatrics, I volunteered at the Alberta Children's Hospital, primarily with infants and their families. Living in Alberta gave us the chance to experience amazing hiking, camping and fly-fishing adventures. Also during this time, our son MacK was born.

During my maternity leave we relocated to Ottawa, where I have been fortunate to work for two strong health care teams. Over the past year and a half, I have worked as an independent contractor for CommuniCare Therapy, providing school health support services and in-home services. Living in a picturesque region of Quebec, our work life is complemented by biking and swimming during the summer months, hiking in the fall and snowshoeing in the winter.

Throughout my eleven years as an occupational therapist, I have enjoyed variety in occupations both personally and professionally. However, there are interests I have yet to pursue and skills I need to acquire to progress my career. My experiences growing up in Manitoba along with a student placement at a solvent abuse treatment centre for First Nation youth, lead to an interest in aboriginal health issues and the role for occupational therapy. In hopes of pursuing this interest and to make a contribution to professional development initiatives, I have approached CAOT to become a member of the Occupational Therapy Aboriginal Health Network. I am also exploring the pursuit of a Master's in Health Management and looking forward to life's next adventure with my family.

What's new

- CAOT welcomed Dr. Helene Polatajko as CJOT's new Editor-in-Chief. The transition to the new editor began in February, 2011. CAOT would like to thank Dr. Marcia Finlayson for her leadership in advancing excellence in the production and dissemination of CJOT.

- CAOT is representing occupational therapists at the Alzheimer's Disease International Conference in Toronto, March 2011.

- CAOT is preparing for our annual conference in Saskatoon, we hope that you will participate in:

  - CAOT's Professional Issue forum on Pain Management and Occupational therapy

  - CAOT's Professional Issue forum on Occupational Therapy and Cancer Survivorship

  - CAOT's update on the creation of guidelines for the management of Elder Abuse/Mistreatment

The Canadian Journal of Occupational Therapy (CJOT) joins HINARI

CAOT is pleased to announce that CJOT is joining HINARI. HINARI is an international development initiative sponsored by the World Health Organization that provides free journal access to users in qualifying institutions. Researchers, academics, students, clinicians, health workers, economists, government departments and policy makers in countries such as Afghanistan, Bolivia, Congo, Nepal and Tajikistan will have opportunity to read CJOT.

What's online

Online occupational therapy practice networks

CAOT supports online networks for members with similar practice interests.

New networks for 2011 include:

Occupational therapy and Aboriginal health network
Rural occupational therapy network

Existing online networks are:

Occupational therapists working in Mental Health and Addictions
Occupational therapists working in Oncology
Occupational therapists working in Private Practice
Occupational Therapy Practice Leadership
Occupational therapists and Sensory Processing Disorder

Practice resources

Stay informed by reviewing some of the latest documents posted by CAOT such as the Enabling Occupation II Professional Issue forum report (http://www.caot.ca/default.asp?pageid=578) and new CAOT position statements: Occupational Therapy and Client Safety, Occupational Therapy and Cultural Safety, Occupational Therapy and Aboriginal Health, and Tele-Occupational Therapy and E-Occupational Therapy (revised).

Online learning

CAOT offers a series of one hour web supported teleconferences on a wide variety of practice and research topics. The Lunch & Learn series is $50 per session for members and the Water Cooler Talks (that review a variety of CAOT initiatives) are free for members. The 2011 schedule is posted at www.caot.ca.

STUDENT-TO-STUDENT

COLUMN EDITOR: TOM GRANT

Sharing of wisdom (part I): Shaping the transition from student to occupational therapist

Laura Thompson and Erin Fraser

Congratulations! You have earned your degree and college registration number. You are now part of this exciting and innovative profession. This is a time of great excitement and optimism. After years in the classroom it is time to enter the 'working world'. Soon, the realities of practice begin to surface and certain thoughts creep into your mind. Do I have enough to offer my clients? How will I know what to 'do' with them? Does anyone else feel the same way I do? It was not long ago that we experienced this; two eager new graduates entering practice with our first jobs as occupational therapists.

This article chronicles how we came to answer these questions through reflection undertaken during our first eight months of practice. The reflection involved integration of literature on the transition from student to occupational therapist with wisdom shared with us by clients during a research project done in our final year of study. Ultimately, this process brought clarity to the value of being client-centred and the importance of learning from clients during the formation of our professional identities.

"Do I have enough to offer my clients? How will I know what to 'do' with them? Does anyone else feel the same way I do?"

Transition from student to therapist

We explored literature on the transition into occupational therapy practice during our journey of reflection in the first few months of employment. Although not an exhaustive review, our search revealed several articles that we found quite informative at a time when we were asking ourselves "what does it mean to be an occupational therapist?" Many articles described qualitative studies examining experiences of those entering the profession and the stages of transition, from the eager optimist during the final fieldwork placement to the therapist who is beginning to adapt to the realities of practice (Toal-Sullivan, 2006; Tryssenaar, 1999; Tryssenaar & Perkins, 1999). The literature discussed the transition as a complex process spanning formal education, fieldwork, and first work experiences that involves incorporation of the discipline's values and norms into one's identity (Moreley, 2006; Toal-Sullivan, 2006).

A common thread in the literature was the angst that surfaces in the early days of practice, from not knowing "what to do" with a client and in "wanting to have the answers instead of the questions" (Toal-Sullivan, 2006, p. 519; Tryssenaar, 1999, p.111). We could both relate personally to these statements and, in a way, were relieved to have our feelings validated.

Influence of clients

We began to wonder about the factors that inspire new graduates to persevere when they are feeling most unsure of their professional identities. The literature cited mentorship and peer support among the many influences (Morley, Rugg, & Drew, 2007). Despite limited research, collaboration with clients was also highlighted as an important factor during this period, especially in the adoption of a client-centred professional identity (Toal-Sullivan, 2006). One particular quote from a phenomenological case study spoke to us. With reference to the 'lived experience of becoming a professional' captured during interviews of her former student turned entry level clinician, Tryssenaar (1999) stated:

"I often tell the students that the clients will teach them to become therapists – people who render service, heal and help others to grow in their occupational lives" (p. 111).

This stood out as particularly meaningful in the context of experiences we had at the beginning of our transition to practice while completing a research project prior to graduation. The wisdom that the client participants shared with us helped to shape our transition and, in turn, the values we ultimately hold as clinicians. Although we realized at the time that we were involved in a unique experience, reading and reflecting on the literature many months later helped us realize the true impact that the participants had on us.

Shared wisdom

During our final year of study, we were involved in a research project examining the usefulness of Electronic Aids to Daily Living (EADLs) on the occupational performance and satisfaction of adults with physical disabilities. EADLs are devices that enable individuals to control electronic appliances in their environments (e.g., television, lights, door openers). We had the opportunity to complete standardized

assessments with participants in their homes during data collection. The formal curriculum taught us about the value of research and outcomes measurement in occupational therapy. However, the informal learning that emerged from our interactions with participants turned out to be equally valuable. As students entering participants' home environments, we were seen as individuals with whom they could impart wisdom. As individuals about to graduate, we welcomed these valuable lessons and held onto them for future use. Two case examples will be used to illustrate our experiences.

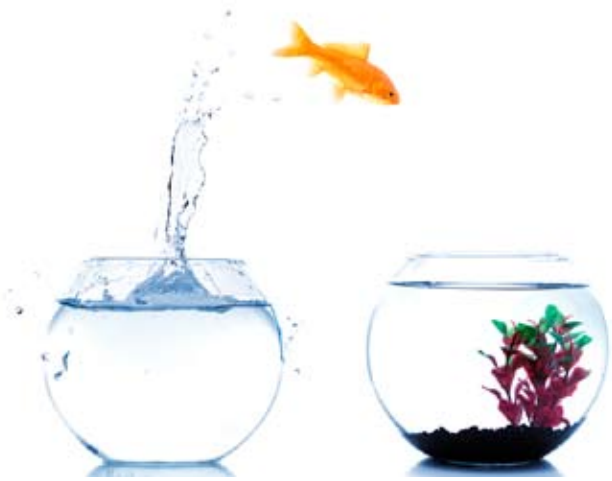
"We hope that sharing our story sparks candid discussions about the realities of moving from the classroom to clinical work among those about to graduate, new clinicians, and established therapists reflecting back to their first days of employment"

Tom*

Tom was a man in his mid fifties who acquired a spinal cord injury several years ago. He graciously invited us into his home and gave us a tour of his independent living apartment. We spent quite some time completing the assessments because of the engaging conversation that flowed between the standardized questions. Tom shared with us stories about his life before his injury, when studying at the same university we were about to graduate from, and then talked about his past employment as a health care professional. He discussed how his life had changed since his accident, what it was like to redefine his identity, receive care as opposed to provide care, lose his ability to have a full time job, and find meaning in other daily occupations. We could not help notice his graduation picture from so many years ago hanging on the wall, and began to wonder what our futures may hold. Tom asked about our plans after graduation and emphasized the importance of really listening to the clients we were about to serve; their past experiences, needs, wants, and aspirations.

Sandra*

Sandra was a young woman with a high-level spinal cord injury living in a long term care facility. As soon as we entered her room, it was clear that Sandra was very focused on 'getting things done' as a master of directing her own care. There to measure the functional impact of her EADLs, we were a bit surprised that the devices were housed in Sandra's closet rather than set-up for use at her bedside. Sandra was one of the few participants who scored quite low on the standardized assessments, due to her perceived importance of independently completing several daily activities and the ease of performing them using EADLs. However, she indicated that she was quite satisfied with her situation. In her environment, it was much more efficient and socially enjoyable to direct caregivers to complete certain tasks for her (i.e., dialing a phone number). This allowed Sandra to focus her energy on other important activities (i.e., talking with the person on the other end of the line). Sandra exemplified the importance of truly understanding our clients' perspectives when delivering services. She did not value 'independence' as defined in our outcome measure but instead appreciated engaging in occupations in a way that she found to be more efficient and meaningful.



Reflections and integration into client-centred practice

Both Tom and Sandra taught us about the expertise our clients hold, knowledge about their occupational history, current needs, and environment, and about the importance of respecting clients' goals and values. Ultimately, they emphasized the significance of using a client-centred perspective, a core principle and competency of occupational therapy (CAOT, 2007; Townsend & Polatajko, 2007). This lesson became more apparent once we entered the working world and were reflecting upon our entry into practice. At a time when we were wondering 'what to do' and 'where to find the answers', we realized that many of the answers we were seeking were shaped by our clients' expertise.

We were taught in school that as therapists, we would bring skills and knowledge in enabling occupation that is most valuable when applied in collaboration with our clients' needs, goals, and personal expertise (Falardeau & Durand, 2002; Townsend & Polatajko, 2007). This lesson became a reality within the first few months of practice that began to transform the way we approached our clients. Similar transitions are noted elsewhere. For example, in a qualitative study of rehabilitation students in their final fieldwork and first year of employment, Tryssenaar and Perkins (1999) found a "growing emergence and awareness of the client as the heart of health care" as participants' "perspectives shifted from a preoccupation with self as a therapist to an awareness of the clients' needs as fundamental to the therapeutic relationship" (p. 25).

Conclusion

Our experiences illustrate the importance of incorporating clients' narratives into occupational therapy education to provide opportunities for knowledge exchange and the adoption of a client-centred perspective.

The process of exploring the literature and reflecting upon our shift from students to clinicians was extremely valuable in aiding our transition to practice. We feel that formally addressing the progression of becoming occupational therapists in the curriculum will help prepare upcoming graduates for the experiences they are about to encounter, and may decrease some of the anxiety that emerges from the ambiguities of practice not typically discussed.

Mostly, we hope that sharing our story sparks candid discussions about the realities of moving from the classroom to clinical work among those about to graduate, new clinicians, and established therapists reflecting back to their first days of employment. Many valuable learning opportunities can emerge from sharing of experiences and wisdom among those at all stages of the career-long journey of becoming occupational therapists.

Acknowledgements:

We thank Dr. Patty Rigby and Anne Martin, OT Reg. (Ont.), for their support and guidance in writing this article. As well, we thank the many mentors who have fostered our professional development over the past year.

*Participants names have been changed.

References

CAOT. (2007). *Profile of occupational therapy practice in Canada.* Ottawa, ON: CAOT Publications ACE.

Falardeau, M., & Durand, M. J. (2002). Negotiation-centred versus client-centred: Which approach should be used? *The Canadian Journal of Occupational Therapy, 69*(3), 135-142.

Morley, M. (2006). Moving from student to new practitioner: The transitional experience. *British Journal of Occupational Therapy, 69*(5), 231-233.

Morley, M., Rugg, S., & Drew, J. (2007). Before preceptorship: New occupational therapists' expectations of practice and experience of supervision. *British Journal of Occupational Therapy, 70*(6), 243-253.

Toal-Sullivan, D. (2006). New graduates' experiences of learning to practice occupational therapy. *British Journal of Occupational Therapy, 69*(11), 513-524.

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

Tryssenaar, J. (1999). The lived experience of becoming an occupational therapist. *British Journal of Occupational Therapy*, *62*(3), 107-112.

Tryssenaar, J., & Perkins, J. (1999). From student to therapist: Exploring the first year of practice. *The American Journal of Occupational Therapy*, *55*(1), 19-27.

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Restructuring of the occupational therapy and physiotherapy practices in an acute care hospital

Rachel Gervais, Gina Doré and Frédéric Beauchemin

The Canadian health care system has undergone many changes during the last decade. A trend observed in many institutions during this period has been the adoption of a program management model for the delivery of health care services. Program management organizes care delivery around groups of patients with like needs and promotes multidisciplinary team work. Operational decisions are made at the program level that has the control over the budget, instead of at the level of traditional discipline-specific departments. After conducting interviews with occupational therapists, Rappolt, Mitra and Murphy (2002) concluded that participants in a program management model reported low confidence in their professional accountability in the areas of continuing education, evidence-based practice, and quality assurance. It was felt that a model supporting peer-mentoring, quality monitoring, continuing education, evidence-based practice, and quality assurance would ensure professional accountability. In their 2002 study on how program management affected the professional practice of physiotherapists, Miller and Solomon recommended new structures that support informal collegial networks, a sense of community and professional identity (in time and space), and formal mentoring programs.

"The goal was to recommend a new structure for occupational therapy and physiotherapy professional practice that would allow both professional groups to address current and future challenges of health care within the existing program management model."

The Ottawa Hospital

Following amalgamation in 1998, The Ottawa Hospital (TOH) re-asserted their commitment to a program management structure at all campuses. It was based on the premise that health care professionals are independent, regulated practitioners and therefore individually responsible for meeting their professional standards, continuing to upgrade their skills with respect to professional practice, and functioning autonomously within their clinical programs. However, the authors experience with the program management model at TOH has shown that the health professionals need structured and comprehensive professional practice support that the current program management model, on its own, does not provide.

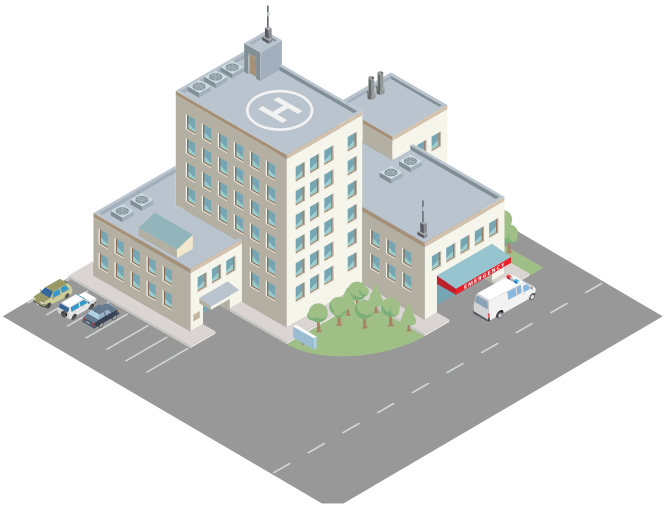
In December of 2006, led by the Vice-President of Professional Practice and the leadership of both Occupational Therapy and Physiotherapy disciplines, TOH initiated a review of its organizational and professional practice structure. The goal was to recommend a new structure for occupational therapy and physiotherapy professional practice that would allow both professional groups to address current and future challenges of health care within the existing program management model. Consequently, a Corporate Occupational Therapy/Physiotherapy Organizational Structure Review Committee was created with representation of members from the two different disciplines and key players from within the hospital.

The terms of reference and objectives of the Committee were established and agreed upon by all members. The review included (1) an examination of the medical and health administration literature on various models of organizational structures for occupational therapy and physiotherapy and (2) a national survey of benchmark hospitals and other best practice tertiary care and rehabilitation organizations to identify and assess other occupational therapy and physiotherapy organizational models. A template to evaluate the scope of responsibility between the Chief of Occupational Therapy, Chief of Physiotherapy, the Clinical Director, the Medical Director, and the Clinical Manager was also developed.

While reviewing the collected data, key guiding principles were identified to serve as a base to formulate recommendations. The key guiding principles stipulated that the proposed new model must (for each discipline): promote professional accountability within their scope of practice, include a consistent professional practice support across all campuses, and demonstrate effective and efficient use of resources.

Literature review

A systematic search strategy using the Internet and hand searching of relevant literature identified nine articles relevant



to the review. The following keywords were used for the Internet-based search: Professional Issues, Professional Roles, Physiotherapy, Physical Therapy, Occupational Therapy, and Organizational Structure. Through the review, it became evident that few studies were conducted to compare the measurable impact of different types of organizational models. Most articles consisted of anecdotal commentary, case studies, or the utilization of qualitative structured interviews to assess and publish the impact of various models of structure on professional groups. Common elements were extracted from the material studied. A theme that emerged was a need for an organizational model that supports the following areas: professional supervision and mentoring; quality monitoring; continuing education; student supervision; research; evidence-based practice; continuous quality management; performance evaluation and management; professional standards, credentialing, recruitment and hiring; profession appropriate workload; and accreditation by national bodies.

National survey

A national survey of benchmark hospitals was conducted using a structured questionnaire with a standard list of questions. Facilities were selected because of their comparable size and/or services. The questions were asked to the most responsible person for occupational therapy and physiotherapy in those organizations. The review of benchmark facilities highlighted two common themes. The first one revolved around space and equipment. The occupational therapists and physiotherapists working within a centralized space (or with a centralized location for equipment for occupational therapy) expressed more satisfaction than those working in a structure with a decentralized space. The second theme indicated that occupational therapists and physiotherapists working within a program management model do not appear to be satisfied with their structure.

The survey results indicated a positive relationship between the level of satisfaction for occupational therapists and physiotherapists and the centralization of professional functions and operations (including management of discipline related equipment).

Impact at TOH

TOH has been functioning in a program management model for over a decade, and the committee was mandated to propose a model that fit within the existing framework. Boyce (2001) and Rowe, Boyce, and Boyle (2002) described the Decentralized Integration Model that is a complex matrix arrangement for the internal organization of allied health. In this model, the Directors of the clinical units and programs do not have managerial control over allied health but negotiate with the senior allied health staff about service issues.

Given the constraint of program management already existing at TOH, the restructuring committee recommended that the Decentralized Integration Model be adopted for the management of occupational therapy and physiotherapy services at TOH hospital. This change would provide an organizational model for both occupational therapy and physiotherapy that is integrated for professional practice and decentralized in the respective programs for operations. The application of the proposed model would produce an integrated management structure for professional practice that would be aligned with the corresponding resources and budget while decentralizing the deployment of the resources and operations within the units and programs.

Putting the model in place

The Royal Columbia Hospital (2004) in British Columbia created a matrix that was identified as a good example of a tool to guide and define the TOH intra-program relationships.

The TOH re-structuring committee members adapted this tool and identified a clear matrix of responsibilities including primary responsibility, shared responsibility, and provision of input between the Chief of Occupational Therapy, Chief of Physiotherapy, the program clinical managers, the program clinical director, and the medical directors. The committee members were intentionally selected to be representative of

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the various management and campuses stakeholders in this future structure. This was believed to be essential to ensure the stakeholders' adherence to the established matrix of responsibilities upon the implementation of the new proposed occupational therapy and physiotherapy structure.

The outcome

At the end of the review, the organization approved a new role for each discipline to help support professional practice: the Professional Practice Coordinator (PPC). The PPC would be discipline and campus specific and would carry three key functions: 1) a professional practice role; 2) an operational role; and 3) a clinical role. The clinical role would ensure the incumbent remained abreast of practice related issues and stayed clinically competent. The operational role would allow him/her to engage in the site specific operational functions such as: vacation approval process, sick call replacement, students and new staff orientation, shifting of day-to-day allocations of resources to better meet the campus specific needs, monitoring and supporting non-patient care tasks, and participation in the interviewing and performance appraisal process. The PPC would have a corporate role and would seek to standardize processes and procedures across campuses related to mentorship, education, evidence-based practice, research, and communication.

Conclusion

The adopted professional organizational structure for occupational therapy and physiotherapy at TOH focuses on the standardization and centralization of professional practice within the existing program management model. This will help minimize variations that exist between clinical units, clinical programs, and campuses for support, mentorship, education, and opportunities available to the professionals. In turn, it will strengthen professional accountability, raise standards of practice, and help professionals meet future professional practice challenges.

References

Boyce, R.A. (2001). Organizational governance structures in Allied Health services – A decade of change. *Australian Health Review, 24*, 22-36.

Davis, B., Heath, O., & Reddick, P. (2002). A multi-disciplinary professional practice model: supporting autonomy and accountability in program-based structure. *Canadian Journal of Nursing Leadership*, *15*(4), 21-5.

Lopopolo, R., & Keehn, M. (1997). The effects of hospital restructuring on the role of physical therapists in acute care, *Physical Therapy*, *77*(9).

Lopopolo, R.B., Schafer,D.S., & Nosse, L. (2004). Leadership, administration, management and professionalism (LAMP) in physical therapy: A Delphi study. *Physical Therapy, 84*(2), 137-150.

Miller, P., & Solomon, P. (2002). The influence of a move to program management on physical therapy practice, *Physical Therapy*, *82*(5), 449-458.

Rappolt, S., Mitra, E., & Murphy, E. (2002). Professional accountability in restructured context of OT practice. *Canadian Journal of Occupational Therapy, 69*(5).

Rowe, P.A., Boyce, R.A., & Boyle, M.V. (2002). Modes of organizing at two health services organizations: A case study approach. *Contemporary Nurse, 13*, 83-93.

Royal Columbian Hospital. (2004). Respiratory Therapy Department Decentralization Proposal (derived from form originally designed by Royal Columbian Hospital, Respiratory Therapy department, British Columbia, Canada).

Internationally educated occupational therapists in Canada: A status report on acculturation initiatives

Claudia von Zweck, PhD, OT(C), CAOT Executive Director

Throughout history, immigration has been integral in enriching Canada's social and cultural life and stimulating economic growth. Today, an aging population and falling fertility rates have led to a large dependence upon immigration for growth of the Canadian workforce.

Professionals are now the largest group of immigrants coming to Canada, with increasing numbers intending to work in professions with defined entry-level requirements (Citizenship and Immigration Canada [CIC], 2003a). The rise in professionals coming to Canada reflects both labour market demand as well as federal immigration legislation that favours highly skilled individuals (CIC, 2003b). Canada is not self-sufficient in producing health professionals and has long relied upon graduates of foreign education programs as a partial solution to meet health human resource shortages.

Acculturation occurs when different cultural groups come together, such as when health professionals emigrate from their homelands to settle and work in Canada. Acculturation results in the need for individuals to develop new relationships and behaviours to adapt to their changing environment (Berry & Sam, 1997). Workforce integration is the acculturation strategy promoted in Canadian society for immigrants settling in this country (CIC, 2001). This approach allows professionals to work in Canada within their fields of expertise while respecting their individual needs and desires to retain their social and cultural identities. Integration is considered to be a two-way process, involving both a commitment of newcomers to adapt to life in Canada as well as an adaptation of Canadians to new people and cultures (CIC, 2003a). Integrationist societies are considered to be welcoming to immigrants through the availability of a range of social and cultural groups and networks that may assist an individual with the acculturation process (Berry, 1997).

Despite Canada's acculturation strategy, workforce integration has unfortunately been unattainable for many professionals coming to this country. Immigrants arriving in Canada since the 1990s have achieved a lower level of labour market success than persons coming to the country in previous decades (Ruddick, 2000; McIsaac, 2003). Many recent immigrants to Canada, particularly those who belong to visible minorities, have not been able to access jobs that match their formal qualifications. The education received by immigrants outside of Canada frequently does not obtain an equivalent market value in Canada (Metropolis, 2003). As a result, many professionals coming to Canada have become marginalized in their attempts to work in their areas of expertise.

The apparent disconnect between Canadian policy that promotes workforce integration and the reality faced by immigrants when arriving in Canada comes at a great cost. The Conference Board of Canada estimated that the economic impact of not recognizing the credentials of new Canadians amounts to over $2.3 billion in lost productivity (Delaney, 2005). Difficulties with acculturation in Canada have also been linked to negative personal outcomes for internationally educated professionals such as lower motivation and community participation, reduced health status and increased social deviance and conflict (Berry, 1997).

The Government of Canada and the provinces and territories agreed at a First Ministers Conference in 2004 to accelerate the workforce integration of internationally educated health professionals in order to address shortages and reduce waiting times for health care. Successive Canadian federal budgets have since allocated funding to support a range of initiatives to create a foundation for the efficient assessment and integration of internationally educated health professionals. In 2009, the Forum of Labour Market Ministers articulated a public commitment in the Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications to hasten the integration process for newcomers to regulated professions. The Framework requires that within one year, internationally-trained workers will know whether their qualifications will be recognized, or be informed of the additional requirements necessary for registration, or be directed toward related occupations commensurate with their skills and experience (Forum of Labour Market Ministers, 2009). While this requirement will eventually be applicable to all regulated professions, occupational therapy is one of the first professions obligated to meet this commitment. As occupational therapists mandated to enabling the occupation of others, we have been responsive to address the issues that impede the internationally educated within our own profession. A number of initiatives to assist internationally educated occupational therapists (IEOTs) to work in Canada are already in place or underway in order to meet this requirement.

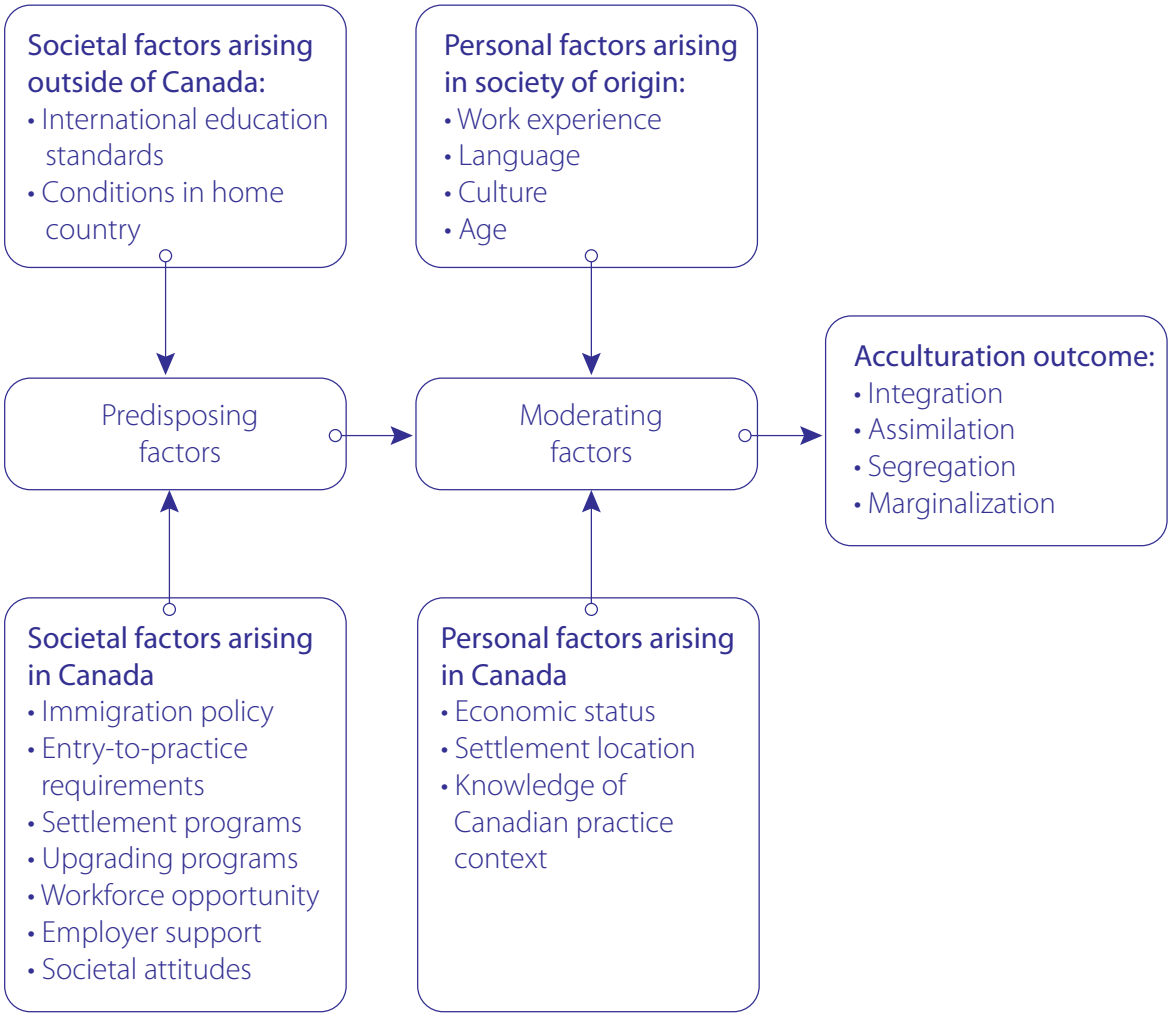
Environmental scan

Our journey for better acculturation outcomes for IEOTs began with a 2006 environmental scan funded by the Government of Canada's Foreign Credential Recognition Program that investigated issues and barriers influencing workforce integration (von Zweck, 2006). Information for this scan was gathered through analysis of research literature, organizational records and policy documents, consultations with regulators, educators and professional associations, employers and provincial settlement agencies and a survey and personal interviews of IEOTs.

The environmental scan used the acculturation framework first described by Berry (1992) to identify and understand issues that impact the ability of IEOTs to work within their chosen profession (Figure 1). Berry's framework separates factors arising in the society of origin and those that become prevalent during the time of acculturation, as well as influences common to all group members and those unique to specific individuals. The interaction of the predisposing group-level factors and the moderating influence of individual factors arising during the acculturation process result a potential range of outcomes including integration, assimilation, segregation and marginalization (Berry, 1992).

Results of the scan indicated that IEOTs who wish to work in Canada must successfully manage an acculturation process involving several steps, including meeting Canadian immigration requirements, fulfilling professional entry-to-practice criteria, finding employment as occupational therapists and relocating and settling in Canada. A number of societal and personal factors outlined in Figure 1 affected the process and outcome. Several points within the acculturation process were identified where international graduates became marginalized. Recommendations were developed in consultation with a wide range of occupational therapy stakeholders to address the identified problems. These recommendations have since served as an agenda for change for the profession.

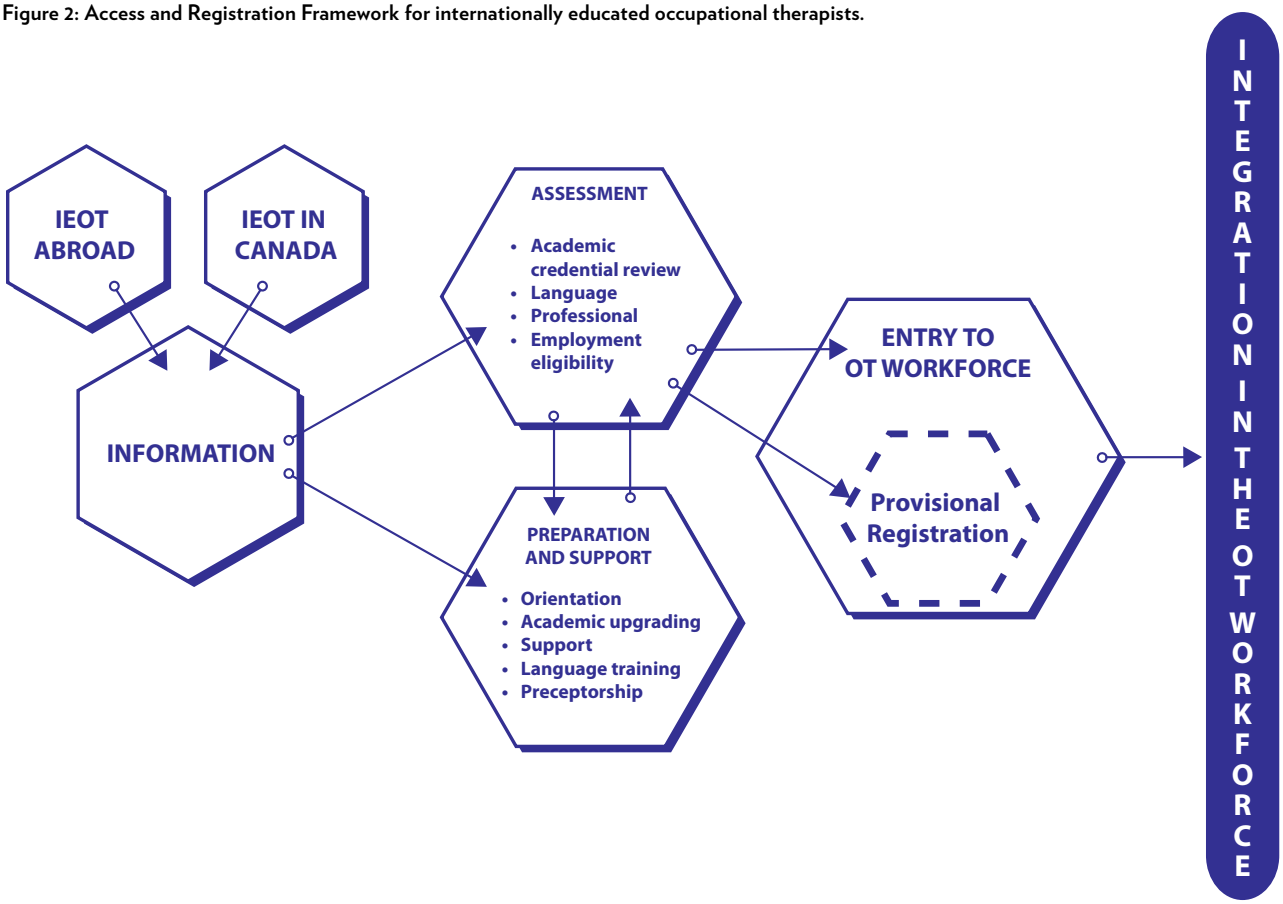
Figure 1: Factors that may influence the workforce integration of internationally educated occupational therapists in Canada (adapted from Berry, 1992).



Access and Registration Framework

Following the completion of the environmental scan, a series of projects were initiated to promote the workforce integration of IEOTs. The first project involved the development of an Access and Registration Framework to better coordinate the acculturation process among differing jurisdictions and stakeholders in occupational therapy in Canada. This initiative was undertaken with federal funding by national occupational therapy organizations including CAOT, the Association of Canadian University Occupational Therapy Programs (ACOTUP) and the Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO). The objective of the framework was to identify the pathways followed by IEOTs, from the point of initial consideration of immigration to Canada, to successful registration as an occupational therapist, and finally to integration into the occupational therapy workforce (CAOT, 2008). An analysis of published and grey literature and consultations with key informants was undertaken to develop the draft framework. A second phase involved validation and confirmation of the proposed framework through a survey and consultations with stakeholders, including IEOTs, regulators, educators, professional associations and governments. Five components were identified in the framework, with a number of decision points along the pathway (Figure 2).

Figure 2: Access and Registration Framework for internationally educated occupational therapists.



IEOT Portal

The IEOT Portal was launched as a joint initiative of CAOT, ACOTUP and ACOTRO in the fall of 2009, assisted by funding from the federal Foreign Credential Recognition Program. The portal serves as an online electronic information gateway to centralize information regarding living and working in Canada as an occupational therapist. Development of the portal first involved interviews with relevant stakeholders including IEOTs, regulators, professional organizations, settlement agencies and governments. Fictional profiles of site visitors were developed to anticipate user needs and create the site architecture. A brand strategy established criteria to design the look and the feel for the site. Search engine optimization was undertaken to guide visitors to the portal and content was developed in collaboration with the project partners. The portal www.gocanadaot.com now links users to information from the Canadian government, professional associations, regulatory organizations, and other sources about Canada and the Canadian health system. Additions to the portal from other CAOT projects include video interviews of IEOTs who tell their stories of working in Canada. A self assessment tool was added to guide IEOTs in recognizing differences in practice experience and identifying areas where they may require additional knowledge and skills. A complimentary self assessment tool

will be developed for occupational therapy support workers in the coming year. Video profiles of occupational therapists working with different client populations are also in production to enhance the self assessment tools.

National occupational therapy certification examination

To prevent concerns regarding potential cultural or language bias, CAOT began ongoing plain language reviews of the content of the national certification examination in 2005, particularly for low-scoring exam items among international graduates. The number of distractors for each multiple choice item was also reduced from five to four in the same year and the length of the overall examination was shortened to ensure knowledge rather than endurance remains the basis of assessment. Recent activities have been directed towards the development of an online Trial Occupational Therapy Test (TOTE) which will provide IEOTs with practice to complete multiple choice questions comparable to the items included on the national certification examination. A complimentary examination preparation course will provide assistance with understanding the critical thinking required to successfully answer certification examination questions. Pilot testing of the TOTE and the online examination preparation course will begin in the spring of 2011. Potential for offshore offerings of the national certification examination is also under consideration to improve accessibility of the exam. The current qualifications recognition process used by CAOT to determine eligibility for writing the examination will be shifted to regulatory organizations in coming years as part of a multi-year federally funded project undertaken by Canadian occupational therapy regulators that seeks to develop a common approach to assessment of qualifications of IEOTs for practice in Canada.

National Occupational Therapy Examination and Practice Preparation project

The National Occupational Therapy Examination and Practice Preparation project (OTepp) currently partners CAOT with McMaster University, and the Universities of British Columbia, Alberta, Manitoba and Ottawa to develop and implement a national curriculum to assist IEOTs to work in Canada (CAOT & McMaster University, 2010). Monitoring of participant outcomes and obtaining written participant evaluations is used for program evaluation as well as conducting interviews with preceptors, instructors and project team members. Initial evaluations indicate that completion of the core curriculum is associated with better certification examination performance and workforce preparation, although learning needs of IEOTs vary greatly, necessitating flexibility in course offerings. Availability of participant time, funding and commitment to program involvement influences success and may be adversely influenced by competing responsibilities faced by new immigrants. Online technology provides optimal program accessibility, but local support is needed for understanding jurisdictional practice requirements and gaining workforce experience. Additional available OTepp modules assist IEOTs develop mentoring relationships and work readiness skills. A career transition module has been developed to provide guidance for individuals wishing to pursue higher education or who are unsuccessful in working as an occupational therapist. Future plans of the project include development of workforce supports to educate and assist employers regarding issues faced by IEOTs. It is also expected that the curriculum may be enhanced or modified to meet the needs of regulators as their work towards a common assessment and recognition process progresses. Methods are under investigation to sustain the program once current federal government pilot funding is no longer available.

Summary and conclusions

At this time, work is underway within occupational therapy to address almost every recommendation of the 2006 environmental scan. The recommendations address the societal predisposing factors identified in Berry's acculturation framework in order to promote personal moderating factors that increase likelihood of workforce success. For example, the recommendations are directed towards assisting IEOTs to be better informed, prepared and qualified by providing more accessible information regarding Canadian practice requirements and offering upgrading opportunities to meet these standards. We have been fortunate that a broad level of support exists to move forward this agenda, both from within the profession as well as from governments and other stakeholders. It is expected that our collaborative work positions occupational therapy to meet our commitments under the new Framework for the Assessment and Recognition of Foreign Qualifications.

"While our interventions seek to influence personal factors or attributes of individual newcomers, we must remember to also celebrate the differences they bring to our profession and resist overzealous efforts that promote assimilation."

This work not only ensures we meet our moral obligation to assist IEOTs, but also affects the profession as a whole by building occupational therapy workforce capacity by preventing an unnecessary loss of human capital.

While our interventions seek to influence personal factors or attributes of individual newcomers, we must remember to also celebrate the differences they bring to our profession and resist overzealous efforts that promote assimilation. Assimilation results in a loss of identity with origin communities and occurs in societies with little cultural diversity or that are less tolerant of differences among people (Berry & Sam, 1997). Integration is our desired and needed goal to allow IEOTs to play an important and growing role in meeting health demands for our increasingly diverse Canadian population. Canada requires the innovation and creativity inherent in a diverse community for a vibrant society and productive economy.

References

Berry, J.W. (1992). Acculturation and adaptation in a new society. *International Migration*, 30, 69-85.

Berry, J.W. (1997). Acculturative stress. In J.W. Berry, M.H. Segall, & C. Kagitcibasi (Eds.), *Handbook of cross-cultural psychology* (2nd Ed.) (pp. 211-215). Boston, USA: Allyn and Bacon.

Berry, J.W., & Sam, D.L. (1997). Acculturation and adaptation. In J.W. Berry, M.H. Segall, & C. Kagitcibasi (Eds.), *Handbook of cross-cultural psychology* (2nd Ed.) (pp. 291-326). Boston, USA: Allyn and Bacon.

Canadian Association of Occupational Therapists. (2008). The Development of an Access and Registration Framework for Internationally Educated Occupational Therapists. Retrieved from http://www.caot.ca//default.asp?pageid=2196.

Canadian Association of Occupational Therapists & McMaster University. (2010). *OTepp*. Retrieved from http://www.otepp.ca/.

Citizenship and Immigration Canada. (2003a). *Recent immigration trends, 1980-2000*. Retrieved from http://www.cic.gc.ca/english.research/papers/occupations/occupations-c.html.

Citizenship and Immigration Canada. (2003b). *Immigrant occupations: Recent trends and issues*. Retrieved from http://www.cic.gc.ca/english.research/papers/occupations/occupations-e.html

Delaney,J. (2005). Doors opened to Canadians with foreign credentials *The Epoch Times*. Retrieved from http://www.cic.gc.ca.

Forum of Labour Market Ministers. (2009). *A Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications*. Gatineau, Quebec : Human Resources and Skills Development Canada.

Metropolis Project Team. (2003, October). *Current success and continuing challenges of foreign credentials recognition*. Paper presented at the Symposium on International Labour and Academic Mobility, Toronto, Ontario, Canada.

McIsaac, E. (2003). Immigrants in Canadian cities: Census 2001 - What do the data tell us? *Policy Options*, May, 58-63.

Ruddick, E. (2000). *Trends in international labour flows to Canada*. Retrieved from www.cic.gc.ca/english/research/papers/cbds.html

von Zweck, C. (2006). *Enabling the Workforce Integration of International Graduates: Issues and recommendations for occupational therapy in Canada*. Retrieved from http://www.caot.ca//default.asp?pageid=1384

The Occupational Therapy Examination and Practice Preparation project (OTepp): Effective, popular and growing

Laura Van Iterson

I cannot believe that my dreams are turning into reality. You do not know how much joy and hope I've felt since I joined OTepp. I just cannot wait to share to the world my experiences" writes an internationally educated occupational therapist (IEOT) from the Philippines who completed the OTepp curriculum in 2008, to Elizabeth Steggles, National Project Manager for OTepp (E. Steggles, personal communication, February 24, 2010).

OTepp began over two years ago at McMaster University in the summer of 2008 with funding from the Government of Ontario. The project, set up to help IEOTs prepare for the national certification exam, hit the ground running with four times the registration than was anticipated, forty IEOTs rather than ten. The momentum of the original 2008 program in Hamilton, Ontario, meant that a second site was set up soon after in Vancouver, British Columbia (E. Steggles, personal communication, February 24, 2010).

The more recent success of the Canadian Association of Occupational Therapists (CAOT) in obtaining federal government funding from the Foreign Credential Recognition Program for the expansion of OTepp saw a twenty-seven month initiative with the School of Rehabilitation Sciences at McMaster University begin in February 2010. The funding means that the CAOT, working in partnership with McMaster University, now has resources to increase accessibility to the OTepp curriculum, developed by the McMaster School of Rehabilitation Sciences, across Canada. At the same time, funding was received at McMaster University from the Government of Ontario to continue to offer OTepp to Ontario-based IEOTs. The Ontario program will run concurrently with the courses at the sites across Canada (C. von Zweck, personal communication, April 27, 2010).

What is the purpose of OTepp?

OTepp addresses Canada's chronic shortage of occupational therapists by serving IEOTs as well as Canadian-educated occupational therapists who have not practiced for several years. The project seeks to help its participants integrate into the Canadian occupational therapy workforce by helping them to prepare for the national certification examination, upgrade their knowledge and language skills, and to register in the profession. Integral to OTepp are mentoring and supervised practice opportunities (Baptiste, Dhillon, & Steggles, 2009). A project advisory committee, including an IEOT, provides input into the program development and delivery to ensure that the unique needs of IEOTs are met by OTepp.

How is OTepp taught?

To date, OTepp has been taught the traditional way with instructors and students together in the classroom, and also through distance learning. It was found that face-to-face learning was the approach that retained the most OTepp students (Ferera, 2009). With the new national funding, the plan is to develop face-to-face supports across the country in addition to fieldwork opportunities. Off-shore participants who are unable to engage in a practicum experience are expected to complete an alternate assignment. The result will be programs as local as possible with local styles of teaching, and instruction about local regulatory requirements (E. Steggles, personal communication, February 24, 2010).

Effective as well as popular, research shows that there is a positive correlation between success in OTepp and passing the CAOT exam (Baptiste, Dhillon, & Steggles, 2009). This correlation also tells the OTepp team that the curriculum is appropriate. It is based on the McMaster occupational therapy courses, and taught in a small group, problem-based learning format. The core curriculum elements include learning about occupational therapy practice frameworks, evidence-based practice, ethics, the role of regulatory bodies, and understanding core information. OTepp requires that in order to enter the program participants be eligible to write the national occupational therapy certification examination and meet the language requirements of the College of Occupational Therapists of Ontario, therefore assuming that they do not need to study topics such as anatomy and

About the author

Laura Van Iterson , BA (Psychology), BSc (OT) taught occupational therapy as a Canadian in France and can relate to some of the bureaucratic and cultural challenges encountered by internationally educated occupational therapists, and to the excitement and growth that comes from exposure to a foreign occupational therapy culture.

physiology again. For some, even the core curriculum is not necessary. Learning needs are determined at an assessment interview before starting the program. Depending on the outcome of the needs assessment interview, participants may choose to enroll in modules to learn about exam preparation, work readiness and/or career counseling (E. Steggles, personal communication, February 24, 2010).

The work readiness module is an optional module that educates about Canadian work culture. Topics covered include how to apply for a job, what to wear to work, how to be self-directed in the workplace, and interpersonal communication; addressing behaviours important in Canada such as body language, eye contact, and asking clients direct questions. Some of these behaviours set Canadian occupational therapists apart from those coming from abroad. "Canadian occupational therapists are self-directed, reflective, evidence-based, and client-centred. As opposed to some countries, usually Asia, but some European countries as well, where a doctor tells the occupational therapist what to do, rather than talking to the client to help determine their needs" (E. Steggles, personal communication, February 24, 2010).

The career counseling module is currently being developed and will serve OTepp participants differently depending on their situation. Some sign up in order to learn how to pursue graduate studies to advance professionally. Others enroll because despite their efforts, some IEOTs are unable to transition into practice in Canada and need to seek alternate careers. The OTepp team takes the time to help those who need to find another direction. A promising field for some IEOTs is that of insurance sales as some companies are looking for people with a degree, who speak foreign languages, and understand the diverse culture of the Canadian population (E. Steggles, personal communication, February 24, 2010).

OTepp models client-centredness in its course design. The structure of the course accommodates the fact that participants are usually working. The program is twenty-three weeks long with two classes of three hours each per week and twelve hours of homework each week. In Ontario, successful completion of OTepp counts towards currency hours. To accommodate a maximum number of students, the program offers the courses in the evening, but archived sessions can be viewed over the Internet (E. Steggles, personal communication, February 24, 2010).

Beyond the coursework, OTepp students engage in a supervised practice opportunity and have the option of participating in a mentoring process. The fieldwork hours can be earned part-time too, at least twenty hours a week. That means that occupational therapists who work part-time and often cannot supervise student occupational therapists may enjoy the opportunity to be preceptors for these participants. Even new graduate occupational therapists can be preceptors for IEOTs, because these OTepp participants are already occupational therapists rather than occupational therapy students (E. Steggles, personal communication, February 24, 2010).

Innovative as they are, OTepp's modules and supervised learning opportunities are not the only reason the OTepp participants are grateful for the course. Many have been so isolated from other occupational therapists that they are thrilled to have regular contact with each other and with the OTepp instructors who help motivate them to surmount the obstacles keeping them from pursuing their profession of choice. "I am so grateful that I found the 'team'. You really keep me going despite my situation" writes a Filipino occupational therapist to OTepp's National Project Manager (E. Steggles, personal communicaton, February 24, 2010).

What has CAOT learned from OTepp?

The CAOT partnership with McMaster to offer the OTepp national program reflects the extent of the knowledge CAOT has been gaining about the IEOT experience through its Workforce Integration Project and Access and Registration Framework. These projects looked at the barriers interfering with the integration of IEOTs into the Canadian occupational therapy workforce and the steps involved in that same challenge. The body of knowledge about IEOT challenges is ever-growing as OTepp participants are interviewed at the beginning and end of the program. OTepp is making it possible to further refine the existing knowledge of the pathway followed by IEOTs as they strive to work in Canada (OTepp, 2010).

Some themes that emerge in the interviews have become expected and relatively straightforward to address, such as the need for professional English or French language development. However, other themes are emerging in the interviews for which solutions are harder to find. For example, a perplexing challenge facing many IEOTs came to light as many come to Canada and earn a living by working full-time as a nanny or personal attendant, and do not have time to engage in a practicum experience. In the frustrating position of having completed the OTepp coursework, and passed the CAOT exam, they struggle to find an opportunity to do the fieldwork hours necessary to meet the requirements of the regulatory body (E. Steggles, personal communication, February 24, 2010).

What is in the future for OTepp?

Currently there is no fee for participation in OTepp. To sustain the availability of OTepp when pilot funding is no longer available, it may be necessary to introduce a tuition fee for the program. Because the course is part-time, it may be hard for IEOTs to obtain student loans or other tuition supports for this program (E. Steggles, personal communication, February 24, 2010). Of course, the creative and dedicated OTepp team is working on finding ways around these problems.

The latest funding for OTepp will allow more and more IEOTs across the country to upgrade their qualifications and receive coaching, while the research component of OTepp will continue to help elucidate the situation of IEOTs in Canada. OTepp's popularity and steady growth bodes well for a commensurate increase in the number of occupational therapists serving the Canadian population.

References

Baptiste, S.(2008). The Occupational Therapy Examination Preparation Project (OTepp). *On The Record*, *8*(3). Retrieved from www.coto.org/pdf/publications/OTR_Fall_08.pdf.

Baptiste, S., Dhillon, S., & Steggles, E. (2009). *Application for Certificate Recognition for the Occupational Therapy Entry to Practice Program for Internationally Educated Occupational Therapists*. McMaster University. Retrieved from http://www.mcmaster.ca/univsec/mtgdocs/upc/UPC_MTG_20May09.pdf .

Canadian Association of Occupational Therapists.(2008). *Access and Registration Framework*. Retrieved from http://www.caot.ca/default.asp?pageid=2196).

Canadian Association of Occupational Therapists.(2010). *CAOT receives funding for Occupational Therapy Examination and Practice Preparation (OTepp Project)*. Retrieved from http://www.caot.ca/caot_news_listings.asp?pageid=1002&NewsID=545&offset=30.

Canadian Association of Occupational Therapists. *Workforce Integration Project Brochure*. Retrieved from http://www.caot.ca/pdfs/WIP%20Brochure_ENG.pdf .

Canadian Institute for Health Information. (2008). *Workforce Trends of Occupational Therapists in Canada, 2007*. Ottawa, ON: Canadian Institute for Health Information.

Ferera, S. (2009). New Preparation Programme for International OTs. University of British Columbia Occupational Science and Occupational Therapy Newsletter, *1*(2). Retrieved from http://www.ot.med.ubc.ca/__shared/assets/OT_Lens_-_July_2010_Newsletter17199.pdf

Occupational Therapy Examination and Practice Preparation Project. (2010). *About OTepp Goals and Objectives*. Retrieved from http://www.otepp.ca.

Van Benthem, K. (2009). Information web portal for internationally educated occupational therapists. *Occupational Therapy Now*, *11*(3).

The French connection: OTepp and CAOT's involvement in developing a bilingual index of occupational therapy terms

Marie-Christine Beshay

The Occupational Therapy Examination and Practice Preparation project (OTepp) has come a long way since its inception in 2008. The multiple nationwide collaborations with governments, universities and other stakeholders have allowed for the identification of gaps and the development of strategies to address the needs of internationally educated occupational therapists (IEOTs) during their transition to Canadian occupational therapy practice.

One of the primary goals of OTepp is to offer accessible resources to IEOTs. In addition to the face-to-face and online offerings of the OTepp modules, various supports and networks have been developed across the country. Through partnering relationships, efforts have also been made to offer OTepp in both of Canada's official languages. This process has brought to light a longstanding linguistic issue; that of the consensus on the translation of occupational therapy terms from English to French. As an example, the titles of Enabling Occupation I and II (Townsend et al., 2002; Townsend & Polatajko, 2007) publications have been translated differently in French, the first titled *Promouvoir l'occupation* and the second *Faciliter l'occupation*. Such anomalies in terminology have been recognized for several decades and are a concern for French speaking occupational therapists and the profession at large.

With planning and coordination support by CAOT and OTepp staff, OTepp funded the gathering of eight French speaking occupational therapists from Canadian universities, the Consortium National de Formation en Santé (CNFS), and the CAOT Board of Directors to review the existing translation of terms and to reach consensus on the French equivalent of common English occupational therapy terms such as 'enabling' and 'engagement'. In the fall of 2010, the group of French speaking occupational therapists were given the important task of reviewing the translation of over 300 terms. A number of references including linguistic databases and dictionaries were consulted to validate the consensus for each term. The group took the time to understand the meaning, context and various uses of each English term to be able to identify a French equivalent. Instead of always resorting to the use of a single equivalent for each term, the group occasionally opted to use more than one French word in order to maintain the essence and meaning of the English term. The result of this collaboration is the creation of a bilingual index of occupational therapy terms which will be used to review existing translations and guide future translations of occupational therapy publications and materials.

"The result of this collaboration is the creation of a bilingual index of occupational therapy terms which will be used to review existing translations and guide future translations of occupational therapy publications and materials."

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The McMaster Assessment of Comprehension and Communication: Facilitating the acculturation of internationally educated occupational therapists

Tram Nguyen and Sue Baptiste

The acculturation of internationally educated health professionals is a current area of concern and interest in Canada. These skilled and experienced people can be part of the solution to the current and projected shortages of health care professionals across the country (Health Canada, 2008; von Zweck & Burnett, 2006). Acculturation refers to the overall adaptation process of individuals when they come into contact with a new culture or environment. Canadian researcher and professor Berry (1997) suggests that integration may be the ideal form of acculturation since it incorporates the values and beliefs of both the new and old culture. Comparisons are often made between Canada's approach to integration and that of the United States. Canada's approach to the integration of immigrants into Canadian society has been described as a 'mosaic' which encourages and values multiculturalism (Porter, 1965). On the other hand, the United States' approach to the integration of immigrants into American society has been termed a 'melting pot' which encourages assimilation. Integration is often difficult to engender since it is a two way process, involving both a commitment from individuals from the old culture to adapt to life in the new, as well as adaptation of individuals from the new culture to accepting and supporting people from the old (von Zweck & Burnett, 2006).

"The MACC assessment is a scenario based questionnaire developed to assess comprehension and communication of IEOTs on occupational therapy-specific concepts used in Canada."

Government incentives

Over the past decade in Canada, several government incentives attempted to facilitate the integration of internationally educated health professionals into professional practice including the Internationally Trained Workers Initiative (Health Canada, 2008; von Zweck & Burnett, 2006). The federal government launched the Internationally Trained Workers Initiative in April 2005 to provide financial support for provinces and territories across Canada to enable internationally educated health professionals to enter practice. While Canadian society supports and promotes the integration of internationally educated health professionals, there appears to be a lack of consistency between the policies that promote integration and the reality faced by these individuals (von Zweck & Burnett, 2006). Many internationally educated health professionals struggle with obtaining licensure for entry into professional practice since they face multiple challenges in adapting to their new life in Canada. These challenges may include language barriers and a required shift in values and beliefs. Knowledge of the language used within a specific profession represents a major challenge for many of these professionals (Baptiste et al., 2008). This can result in frustration on the part of the internationally educated health professionals, often causing them to relinquish their goal of entering professional practice, and thus also becomes a loss to the Canadian economy since the skills of its citizens are not being utilized to their full potential (Epp & Lewis, 2004).

The language of occupational therapy

For many internationally educated occupational therapists (IEOTs) seeking entry into practice in Canada, comprehension and communication of the language used within occupational therapy practice can be challenging and frustrating tasks. Furthermore, the language tests required of these professionals for entry into practice tend to be insufficient in preparing them for the workplace. For example, the Test of English as a Foreign Language assesses general language abilities and is not specific to the language demands of

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occupational therapy as a discipline (Epp & Lewis, 2004).

In the case of IEOTs, they must learn and/or sharpen English language skills in order to begin to settle into everyday life in Canada. They need to engage in learning, comprehending and applying the professional language of occupational therapy in order to adapt to Canadian practice. In return, Canadian occupational therapists must learn how best to incorporate IEOTs into Canadian practice by developing educational resources to assist IEOTs with their integration, creating supportive and responsive work cultures. The development of an occupational therapy-specific language tool for IEOTs to assess their comprehension and communication of core concepts, fundamental to the practice of occupational therapy, may prove to be an invaluable aid in assisting them with becoming familiar with the language demands of the profession.

The McMaster Assessment of Comprehension and Communication

In August 2008, researchers at the School of Rehabilitation Science at McMaster University launched the National Occupational Therapy Examination and Practice Preparation project (OTepp). OTepp is a program designed to facilitate IEOTs in acculturating into Canadian practice by passing the national certification examination offered by the Canadian Association of Occupational Therapists (CAOT) to become registered by the regulatory provincial colleges (CAOT, 2009). Preliminary results from the first two cohorts revealed that participants struggled with terms and concepts that are fundamental to the practice of occupational therapy in Canada (Baptiste et al., 2008). These findings promoted the initiative of the development of an occupational therapy-specific language assessment tool.

The development of the McMaster Assessment of Comprehension and Communication for IEOTs (MACC) followed the steps outlined in the Canadian Language Benchmarks Guide (Epp & Lewis, 2004). The MACC assessment is a scenario based questionnaire developed to assess comprehension and communication of IEOTs on occupational therapy-specific concepts used in Canada. This assessment consists of four of several core concepts fundamental to the practice of occupational therapy as determined by an expert panel of occupational therapists. A practice scenario was developed for each core concept to assess how well IEOTs were able to comprehend and communicate their understanding of each of these four core concepts of occupational therapy practice. The aim of the MACC assessment is to explore and evaluate the knowledge and skills that are fundamental to occupational therapy practice through self awareness and assessment as well as presenting the opportunity for being rated by an objective rater. Each scenario is given a score on a scale of 1-5, with 1 indicating little understanding of any appropriate issues and 5 indicating most relevant issues were addressed. The process of tool validation has begun to ensure the reliability and validity of the MACC assessment tool.

Conclusion

It is hoped that the development of the MACC assessment tool will provide a model of an approach for other professions and trades to consider when creating their own language tools. Furthermore, the MACC assessment will assist IEOTs to enter practice with increased comfort in professional culture and practice expectations for working in Canada.

References

Baptiste, S., Steggles, E., Dhillon, S., Dix, L., McMahon, P., & Rangachari, U. (2008). *The Occupational Therapy Examination Preparation Project (OTepp)*. [Proposal document]. Hamilton, ON: School of Rehabilitation Science McMaster University.

Berry, J.W. (1997). Immigration, acculturation, and adaptation. *Applied Psychology: An International Review, 46*(1), 5-68.

Epp, L., & Lewis, C. (2004). Developing an occupation-specific language assessment tool: Using the Canadian language benchmarks. Ottawa, ON: *Centre for Canadian Language Benchmarks.*

Health Canada. (2008). *Shortage of health professionals*. Retrieved from http://www.hc- sc.gc.ca/index-eng.php.

Porter, J. (1965). *The Vertical Mosaic: An Analysis of Social Class and Power in Canada.* Toronto, ON: University of Toronto Press.

von Zweck, C., & Burnett, P. (2006). The acculturation of internationally educated health professionals in Canada. *Occupational Therapy Now*, *8*(3), 22-25.

THEORY MEETS PRACTICE

COLUMN EDITOR: HEIDI CRAMM

Can theories of behaviour change help us improve practice?

Heather Colquhoun and Heidi Cramm

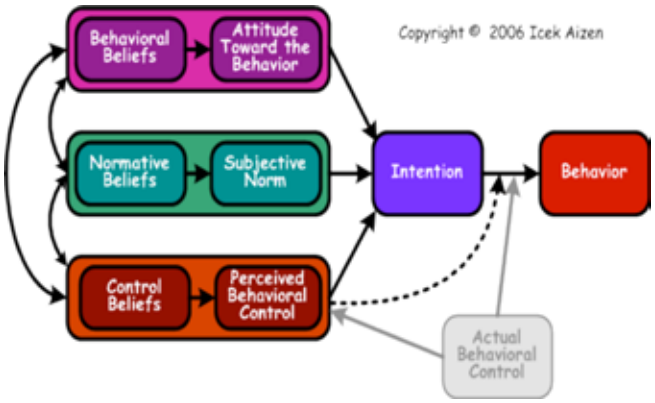
Sandy is struggling to manage the occupational demands of her nursing job, managing her home, and raising a young family with her shift-worker husband. Since she was diagnosed with multiple sclerosis, Sandy hasn't been able to do crafts and baking with her girls, and she gave up going to her knitting group.

As her occupational therapist, you have been trying to get Sandy to adopt energy conservation techniques as a routine part of her life. You have reviewed the techniques with her several times, ensuring you clearly explain the benefits of these techniques and how to incorporate them into her day. Sandy is positive about energy conservation techniques and agrees to use them at home. Yet, despite much clinical effort and time, Sandy has not been using these techniques as part of her daily routine and continues to struggle with occupational balance. You are not sure what else to try in order to help her change her behavior, as your case manager has been suggesting that Sandy is non-compliant with your interventions and should be discharged.

Could a theory of behaviour change help us better understand this dilemma?

Theory of Planned Behaviour (Ajzen, 1991): What can it tell us about Sandy?

Changing our behaviour is difficult in all aspects of life, and clinical practice is not an exception. Behaviour change is relevant to much of what we do with our clients; we often teach clients like Sandy a new way of doing things to help them manage their occupations. Using Sandy as a case example, we can explore how the Theory of Planned Behaviour (TPB) (Ajzen, 1991; Figure 1) describes three modifiable individual variables that predict her intention to enact a specific behavior: attitude, subjective norm, and perceived behavioural control (PBC). Each variable has both a direct and an indirect component. For attitude, the direct level is the overall belief about the value of the behavior—does she believe the behavior to be useful? The direct level for subjective norm involves what important others believe about the behavior. For example, does Sandy believe that her family would like her to demonstrate the behavior? Finally, the direct level for PBC reflects an individual's beliefs about how capable she would be of performing the behavior, addressing whether she believes that changing the behavior will be easy or difficult. This framework helps us understand the conditions in which



people are more or less likely to change their behavior. The greater the levels of intention to change behavior, the greater likelihood there is that the actual behaviour will change. By changing these beliefs around attitude, norms, and behavioural control, one can increase the chance of changing intention to perform behaviour and, in turn, change behaviour (Francis et al., 2004).

The indirect aspects of each of the three beliefs relate to the importance of the belief to the individual and are always a combination of two constructs. For attitude, it is a combination of the perceived consequences of the behaviour (behavioural beliefs) and how much the individual values

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these consequences (outcome evaluation). For a client like Sandy, we would need to understand what she believes are the consequences of using these energy conservation techniques (behavioural belief) and whether she values those consequences (outcome evaluation). If we ask Sandy how she thinks she will benefit from the energy conservation techniques being taught, along with how those benefits relate to things she needs or wants, it would provide us with useful information about her attitude. If she is unable to state specific perceived benefits, responding vaguely that the techniques are 'good' and 'helpful', this may suggest that the techniques are not aligned with changes that the client values. We may then shift our focus to contextualize the specific effects of energy conservation techniques for Sandy's specific situation. For example, by using energy conservation strategies, she may have enough energy to reengage with her knitting leisure and social group.

"The optimum way to use the theory is to determine which beliefs, for a specific behaviour in a specific group of individuals, are more correlated with the intention to perform behaviour."

Understanding the indirect aspect of subjective norm involves determining how much key people or groups want the individual to perform this behaviour (normative beliefs) and how much the individual wants to comply with these key people or groups (motivation to comply). Does Sandy believe that her family would want her to use these techniques (normative beliefs) and to what degree does she comply with family wishes (motivation to comply)? If we determine that Sandy does want to do what is best for her family but that she is not certain of the degree to which her husband and children want her to use these techniques, we may consider discussing the benefits of the techniques together with family members. If Sandy is able to see that her family understands the benefits and wish her to engage in utilizing them, she will likely feel a stronger social pressure to engage in the behaviour.

The indirect PBC measure involves determining what the individual thinks will make it hard or easy to enact the behaviour (control beliefs) combined with the degree of control she feels she has over the difficulty of these issues (perceived power to influence behaviour). In which specific ways does Sandy think that using these techniques will be difficult for her (control beliefs) and how much control does she feel she has over these issues (perceived power to influence behaviour)? Discussing and brainstorming solutions to the difficult issues prior to attempts at using the techniques at home could have a positive influence on behaviour change. In Sandy's case, she states concern that she will have a difficult time 'letting go' of the household duties that have always been her primary responsibility and feels she may have difficulty sharing house management duties with her family or a house cleaner. Helping Sandy develop strategies to assist her in overcoming these concerns prior to utilizing the techniques may be beneficial.

Intention is generally conceptualized by an overarching statement about the strength of intention that the individual has for performing the behaviour (to what degree does the client intend to use these techniques?), resulting from the combination of direct and indirect aspects of the three control beliefs.

How can this theory help us in practice?

Studies indicate that knowledge itself does not predict behavior change (Bonetti et al., 2006). Simply providing individuals with information on why they need to change their behaviour is not effective; providing Sandy with education about energy conservation has not translated into a change in her behaviour. Used extensively for changing health behaviour (Hardeman et al., 2002; Perkins et al., 2007), the TPB helps us identify the beliefs that can facilitate and/or inhibit behaviour change such as why clients do not use their prosthetic limbs (Callaghan, Johnston, & Condie, 2004) and how to improve healthy eating behaviours and increase physical activity in older adults (Kelley & Abraham, 2004). It can also function as a barriers assessment for the beliefs we hold related to a particular behaviour. The TPB encourages an approach more focused on behaviour and the relevant antecedents to behaviour change than on the client's need for knowledge. It offers a way to unpack what might appear to be an unsuccessful clinical interaction so that we can begin to generate alternatives on what might be contributing to the difficulty in enacting the therapeutic change.

The optimum way to use the theory is to determine which beliefs, for a specific behaviour in a specific group of individuals, are more correlated with the intention to perform behaviour. This provides a set of beliefs to target for behaviour change, although it does not explain how to effectively target those beliefs or change subsequent behaviour. The use of the theory more generally to develop an intervention plan, as demonstrated with our scenario, is a rational extension of the TPB but one that has not been substantiated empirically (Townsend et al., 2003). Measuring the beliefs can be achieved through questionnaire

development and a robust procedure for doing so exists (Frances et al, 2004).

Further applications of the TPB

The TPB can be utilized to enrich our understanding of clinician behaviour, for example, integrating electronic documentation into our work routines, increasing our use of standardized measures as a routine aspect of practice, and participating in a research study that requires us to change our care delivery. At least 56 studies between 1996 and 2008 have been conducted using the TPB explicitly for changing service provider behaviour in health contexts (Colquhoun, Letts, Law, MacDermid, & Missiuna, 2010). The majority of these studies (46 of 56) were conducted using a TPB questionnaire designed to measure all of the TPB beliefs and intention in order to determine which of the beliefs were more correlated to changing behaviour. One such study investigated the intention of rehabilitation professionals to include children's relatives in their care (Webster, 2007). This correlational study found that both attitude and PBC were highly correlated with the intention to enact this behaviour. This result could provide direction for programs aimed at increasing this behaviour.

The TPB was developed for investigating the behaviour of individuals (Ajzen, 1991) and is felt to be less useful when organizational and social factors are critical. It is believed, however, that many of the demographic factors that affect behaviour change are mediated through the three beliefs (Ajzen, 1991), and it is possible that this could include organizational and social factors. If this were substantiated through empirical studies, it would greatly widen the application of the theory.

Conclusion

While explicit procedures to effectively incorporate the TPB constructs into intervention planning need to be further developed and studied, the inclusion of theories of behaviour change like the TPB would be a valuable contribution to occupational therapy clinical reasoning. Understanding a richer set of beliefs related to behaviour change would facilitate our initial programming to change behaviour as well as provide direction for times when behaviour change presents as a challenge.

References

Ajzen, I. (1991). The Theory of Planned Behaviour. *Organizational Behavior and Human Decision Processes, 50*, 179-211.

Bonetti, D., Pitts, N. B., Eccles, M., Grimshaw, J., Johnston, M., Steen, N., et al. (2006). Applying psychological theory to evidence-based clinical practice: Identifying factors predictive of taking intra-oral radiographs. *Social Science & Medicine, 63*, 1889-1899.

Callaghan, B G., Johnston, M., & Condie, M E. (2004). Using the Theory of Planned Behaviour to develop an assessment of attitudes and beliefs towards prosthetic use in amputees. *Disability and Rehabilitation, 26*, 924-930.

Colquhoun, H. L., Letts, L. J., Law, M. C., Macdermid, J.C., & Missiuna, C. A. (2010). A scoping review of the use of theory in studies of knowledge translation. *Canadian Journal of Occupational Therapy. 77*, 270-279. doi: 10.2182/cjot.2010.77.5.3

Eccles, M., Grimshaw, J., Walker, A., Johnston, M., & Pitts, N. (2005). Changing the behavior of healthcare professionals: The use of theory in promoting the uptake of research findings. *Journal of Clinical Epidemiology, 58*, 107-112.

Francis, J. J., Eccles, M. P., Johnston, M., Walker, A., Grimshaw, J., Foy, R., et al. (2004). *Constructing questionnaires based on the Theory of Planned Behaviour. Report to ReBEQI: Research Based Education and Quality Improvement.* Callaghan, NSW: Centre for Health Services Research, University of Newcastle.

Hardeman, W., Johnston, M., Johnston, D. W., Bonetti, D., Wareham, N. J., & Kinmonth, A. L. (2002). Application of the Theory of Planned in Behaviour change interventions: A systematic review. *Psychology and Health, 17*, 123-158.

Kelley, K., & Abraham, C. (2004). RCT of a theory-based intervention promoting healthy eating and physical activity amongst out-patients older than 65 years. *Social Science and Medicine, 59*, 787-797.

Perkins, M. B., Jensen, P. S., Jaccard, J., Gollwitzer, P., Oettingen, G., Pappadopulos, E., et al. (2007). Applying theory-driven approaches to understanding and modifying clinicians' behavior: What do we know? *Psychiatric Services, 58*, 342-348.

Townsend, M. S., Contento, I. R., Nitzke, S., McClelland, J. W., Keenan, D. P., & Brown, G. (2003). Using a theory-driven approach to design a professional development workshop. *Journal of Nutrition Education and Behavior, 35*, 312-318.

Webster, G., & Daisley, A. (2007). Including children in family-focused acquired brain injury rehabilitation: A national survey of rehabilitation staff practice. *Clinical Rehabilitation, 21*, 1097-1108.

Exploring 'use of title' for occupational therapists in Canada

Julie Putman, Janet Craik and Claudia von Zweck

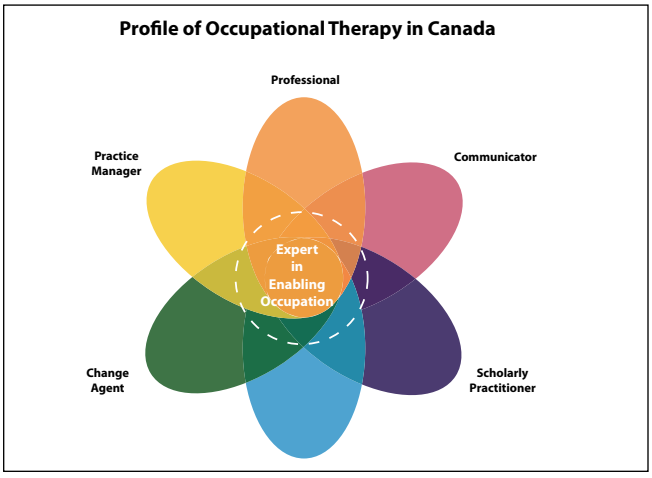
The Canadian Institute of Health Information's (CIHI) report *Occupational Therapists in Canada*, 2008, reveals a stark trend related to the use of title in the profession of occupational therapy. There is a significant decline of registered occupational therapists beyond the age of 38 years old. This suggests that occupational therapists in Canada are leaving the workforce, or at least dropping their professional title, prior to the average age of retirement. This trend associated with the older cohort of occupational therapists has raised concern among national occupational therapy organizations. At this time there is limited literature written on the use of title among occupational therapists. The lack of documentation related to the understanding of the use of title in occupational therapy, and observed attrition rate in the profession, has prompted national occupational therapy organizations to explore the issue. The purpose of this paper is to raise awareness of the use of title anomaly in Canada, promote understanding of key issues identified by stakeholders in the profession, and stimulate discussion on potential solutions to address this situation.

Defining occupational therapy

One problem occupational therapists in Canada face throughout their career is a lack of understanding from others about their profession and its scope of practice. Conceptual tools are available to address the age old question, 'What is occupational therapy?' In the latest set of occupational therapy guidelines occupational therapy was 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" (Townsend & Polatajko, 2007 p.2). Furthermore, the guidelines state that, "clients of occupational therapy may be individuals, families, groups, communities, organizations, or populations" (Townsend & Polatajko, 2007, p. 365). It is evident from this definition that the scope of occupational therapy practice in Canada is very broad. Practice encompasses both direct and indirect services with a variety of clients in many practice settings; enabling occupation for individual and social change.

In 2007, CAOT developed the Profile of Occupational Therapy Practice in Canada, providing stakeholders in occupational therapy a vision for practice and model for excellence. The profile reflects the broad definition of occupational therapy practice in Canada while it maintains the role of experts in enabling occupation at the core of the model (Canadian Association of Occupational Therapists [CAOT], 2007). Figure 1 illustrates the central role of the expert in enabling occupation surrounded by six supporting roles that comprise occupational therapy practice: communicator, collaborator, practice manager, change agent, scholarly practitioner, and professional.

Figure 1: Profile of Occupational Therapy Practice in Canada (CAOT, 2007)



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This model reflects current evidence in the areas of competency as outlined by regulatory organizations in Canada, and is aligned with theoretical professional directions for occupational therapy practice in Canada (CAOT, 2007) . The model also encompasses the broad skill sets required to fulfill the various occupational therapy positions recognized by CAOT membership, including direct service provider, manager, professional leader/coordinator, educator and researcher. The breadth of this model implies that occupational therapists in Canada can fulfill many roles as an occupational therapist.

Defining 'use of title' in occupational therapy

The title 'occupational therapist' or 'OT' is protected by legislation and its use is granted through a process of registration with a provincial regulatory college of occupational therapy. Title protection is used to help the public readily identify those individuals who are registered with the College and are subsequently accountable for the delivery of occupational therapy service that meets the established standards of the profession.

'Use of title' can also be understood as a professional responsibility to retain the occupational therapist title throughout the career span to promote recognition and accountability of the work of occupational therapists, regardless of practice setting or job title. Individuals as well as occupational therapy organizations and other stakeholders such as employers, governments and policy makers have a responsibility to take action to promote appropriate use of title among those educated as occupational therapists. Promoting appropriate use of title fosters and maintains the integrity of the profession of occupational therapy as an accountable, evidence-based and client-centred profession (von Zweck, personal communication, May 26, 2010).

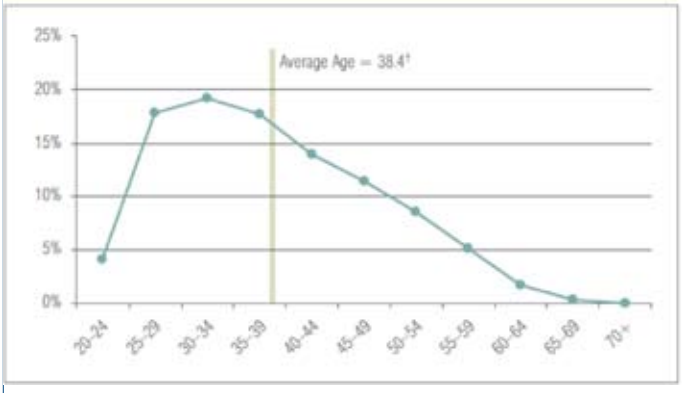
Occupational therapy workforce trends and concerns

Despite the broad scope of practice defined by the occupational therapy profession and the professional responsibility to retain title, retention and continued use of title among occupational therapists in Canada is a long-standing concern for many stakeholders, including CAOT and the regulatory organizations across Canada (CAOT, 2009). It is evident from CIHI (2009) statisitics that many experienced occupational therapists continue to drop their title as their career evolves.

To contextualize the issue of 'use of title' in occupational therapy, one must first consider overall occupational therapy workforce trends in Canada. In 2008, there were over 12 000 practising occupational therapists in Canada. This number denotes an increase of 6.8% practising occupational therapists since 2006, translating to an average of 38 occupational therapists per 100 000 people (CIHI, 2009). It was noted that comparatively, occupational therapists were among the lowest per capita rates of regulated health professionals in Canada, and in comparison to other countries Canada had a low utilization of occupational therapy services (CIHI, 2009).

A closer look at the demographics of occupational therapists in Canada offers greater insight into the issue of 'use of the title' among Canadian occupational therapists. Figure 2 illustrates the age distribution of active occupational therapy registrants in Canada.

Figure 2: Occupational Therapist Workforce by Five-Year Age Groups and Average Age (CIHI, 2009). Figure reproduced with permission from CIHI.



It can be noted from this figure that the age distribution of active occupational therapists in Canada is skewed towards younger registrants. A significant decline of registrants beyond the age of 38 years is evident from the figure. In comparison to other health care professionals, occupational therapists in Canada comprise a young profession. In 2008, 71% of occupational therapists were under the age of 45 years. Comparatively 59% of physiotherapists, 54% of pharmacists, 41% of nurses, and only 30% doctors practising in Canada were under the age of 45 (CIHI, 2009).

The noted discrepancy of age distribution across health care professionals has contributed to a demand for occupational therapy in Canada that exceeds supply. The young age profile of the occupational therapy workforce means a loss of experienced professionals and potential leaders in occupational therapy due to early workforce attrition.

Understanding 'use of title' in Canadian occupational therapy

A deeper understanding of the issue of the use of title in Canada required input from the stakeholders involved. A Leadership Forum involving organizational stakeholders was therefore held with the Professional Alliance of Canada (PAC), the Canadian Occupational Therapy Foundation (COTF), the Association of Canadian Occupational University Programs (ACOTUP), CAOT and the Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO) in the spring of 2010.

Retention issues identified in a 2009 CAOT Professional Issues forum on the Canadian occupational therapy workforce were used to inform the Leadership Forum. In addition, the ACOTRO representative coordinated an informal survey on the use of title to provide some real life examples of the issues around 'use of title'. Regulatory bodies sent out the survey to select individuals across the country working primarily in positions outside the realm of direct service provision.

While the survey addressed many issues related to the use of title, this paper will only report on influences of participants' decision to retain or drop title. Three key issues that influence Canadian occupational therapists' decision to maintain or drop title were drawn from survey themes

Table 1. Three key themes that influence Canadian occupational therapists' decision to hold/drop title.

Theme	Example survey response
1. Participants' perception that the roles they fulfill fit into the definition and scope of occupational therapy practice.	"Absolutely. Being involved outside the clinical role or the occupational therapy field does not mean that my brain stopped functioning as an occupational therapist. Being in a manager's role and keeping the occupational therapist title gives a positive image of the profession." "I continue to struggle with aligning my work within the scope of occupational therapy practice. My decision to maintain my College registration is driven by 1) a requirement that the incumbent in this position be a member of a regulated health profession and 2) acknowledging the need for public accountability which can be extracted through registration with the college."
2. Participants' values, sense of identity, and pride in belonging to the professional group.	"My occupational therapist designation is a part of who I am and it is very important to me. My knowledge and expertise as an occupational therapist colours what I do every day and gives me a strong functional basis that makes me a unique member of my work team. I do not intend to leave my profession until I retire!" "I have felt, at times, a lack of support, vision and understanding from occupational therapy 'leaders' in my immediate contact, when trying to develop a new role."
3. Participants' desire to maintain flexibility in their career to keep future opportunities open.	"I have seen the profession grow in credibility and numerous occupational therapists now practice in the medical legal field. The title is very useful as lawyers have come to understand what we can offer. I have been able to sustain a healthy practice in this field so I would not want to give up the usefulness of my title. I could not be qualified by a judge as an occupational therapist if I were not registered." "There are limited opportunities for career progression and leadership roles within occupational therapy. For example, we have not developed advanced practice roles in the way that nurses have. As such, I have had to look outside traditional clinical work to advance my career goals."

Forum to understand the 'use of title' by occupational therapists in Canada.

Survey participants also indicated that they felt professional and regulatory organizations have a responsibility to support individuals to stay in the profession, through advocacy, education and development of a mechanism to increase flexibility between various professional roles. The three themes from the surveys (Table 1) were confirmed by participants at the Leadership Forum.

Members of the Forum were asked to discuss potential solutions to promote retention of Canadian occupational therapists throughout their career span. The participants indicated that collaboration is necessary to effectively address the issue of the use of title in Canada. It was felt that a difference can be made by; (1) promoting awareness of the issue; (2) communicating a clear definition of occupational therapy and its scope of practice; and (3) the promotion of the diversity of occupational therapy within and outside of the professional community. In addition, an individual from each of the organizations present was designated to sit on a committee to develop a position statement on the use of title in occupational therapy in Canada. Fundamentally, it comes

down to a need to strengthen the profession and promote its sustainability so that practicing occupational therapists in Canada can feel supported to "be proud, be daring and be the change" (Law, Polatajko, Townsend, 2010) as they forge new and innovative career paths.

References

Canadian Association of Occupational Therapists (2007). *Profile of occupational therapy practice in Canada.* Ottawa, ON: CAOT Publications ACE. Retrieved from http://www.caot.ca/pdfs/otprofile.pdf.

Canadian Association of Occupational Therapists. (2009). *Report on the professional issue forum on: workforce retention in occupational therapy.* Ottawa, ON: CAOT Publications ACE. Retrieved from http://www.caot.ca/default.asp?pageid=3903.

Canadian Institute of Health Information. (2009). *Occupational Therapists in Canada,* 2008. Ottawa, ON: CIHI. Retrieved from http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_2570_E&cw_topic=25 70&cw_rel=AR_1809_E#full.

Canadian Institute of Health Information.(2009). [Linear graph illustration of occupational therapist workforce by age group and average]. *Occupational Therapists in Canada,* 2008. Ottawa, ON: CIHI. Retrieved from http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_2570_E&cw_topic=25 70&cw_rel=AR_1809_E#full.

Law, M., Polatajko, H., Townsend, E., (2010). From 'C' to 'C' to 'C': CAOT conference 2010 keynote talk. *Occupational Therapy Now, 12*(4), 5-7.

Townsend, E. & Polatajko, H., (2008). *Enabling occupations II: advancing an occupational therapy vision for health, well-being & justice through occupation.* Ottawa: CAOT Publications ACE.

Proposed changes to the CAOT bylaws

Claudia von Zweck, PhD, OT(C), CAOT Executive Director

CAOT members will be asked to vote on several changes to CAOT bylaws at the annual general meeting in Saskatoon on June 18, 2011. Proposed revisions relate to two areas of Association concern:

1. Criteria for individual membership in CAOT:

Bylaw revisions are proposed to offer alternatives to the requirement that all individual members must successfully complete the CAOT certification examination. The current requirement serves as a barrier for some occupational therapists wishing to seek individual membership with CAOT, particularly in the provinces of Quebec and Saskatchewan. Graduates of Canadian occupational therapy educational programs working in Quebec are not required to have successfully completed the certification examination in order to register with the provincial regulatory organization. In Saskatchewan the requirement to successfully complete the certification examination to register with the regulatory organization was only recently legislated in March of 2010. Many occupational therapists therefore practice in Saskatchewan and Quebec that have not previously passed the certification examination.

The proposed revisions to the bylaws continue to reserve individual membership for occupational therapists that have met Canadian standards for the profession by requiring successful examination completion and/or unconditional registration with a Canadian regulatory organization, in addition to the other current criteria. These current criteria include:

- graduation from either an occupational therapy educational program in Canada that has been granted Academic Accreditation or an occupational therapy educational program outside Canada and recognized by WFOT;
- Canadian citizenship or established primary residency in Canada.

2. Management of off-cycle vacancies in Board positions:

Bylaw changes are proposed to establish a by-election process to manage vacancies that occur before the end of the pre-established term of office of the WFOT Delegate or President. The recent adoption of online voting by CAOT facilitates the use of by-elections to provide members with a democratic and more timely process to manage off-cycle vacancies. The bylaws as currently stated allow use of by-elections for all Board positions except the WFOT Delegate and President. Current provisions in the bylaws prohibit use of by-elections for the two latter positions by stating that the Board of Directors will appoint a representative until an election is held during the annual election cycle to replace the WFOT Delegate or President (in years there is no President-Elect). If the bylaw changes are approved, the CAOT Board will implement a new policy regarding the use of by-elections for Board positions.

More information regarding the proposed bylaw changes is posted on the CAOT website at http://www.caot.ca/pdfs/Proposed%20Changes.pdf. I encourage you to contact me at cvonzweck@caot.ca if you have feedback regarding these proposed revisions. Alternatively, CAOT President Sue Baptiste and I plan to visit cities across Canada to celebrate the 85th anniversary of CAOT. We welcome the opportunity to discuss these proposed changes at your request during our visits. A listing of the dates and times of our visits are listed at http://app.fluidsurveys.com/surveys/caot-s/pinning-ceremonies/.

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ENHANCING PRACTICE: PEDIATRICS

Thinking outside the toy box

Laura Bradley

COLUMN EDITOR: LAURA BRADLEY

"The time has come, the walrus said, to talk of many things"
~Lewis Carroll

Welcome to the new *Occupational Therapy Now* pediatric column where our time has come, indeed! Perhaps to talk of shoes and ships and sealing wax, however, more likely to discuss shape sorters, sensory integration and printing strategies for the children and families that we serve. This column is offered as a place to discuss issues in clinical practice, disseminate new research information and communicate with your professional peers on a national level.

Approximately one quarter of the respondents of the annual membership renewal survey for the Canadian Association of Occupational Therapists (CAOT) in 2009-2010 work in the pediatric sector (CAOT, 2010). Pediatric occupational therapists identify themselves as working mainly in the populations of learning disabilities, neurological impairment, developmental delays and rehabilitation (Brown & Rodger, 2007). We can often be found debating the merits of specific toys and generally have a sticker (or two) on our badges or agendas. We can be seen evaluating and treating feeding disorders in the Neonatal Intensive Care Unit, providing alternative computer access to promote literacy, fostering the development of fine motor skills in toddlers with developmental disabilities, leading parent groups, or conducting research projects to understand the participation of children with special needs in daily activities. To our colleagues, we are a wealth of ideas and creativity; to our families, we are a source of information and understanding; to our children, we are cheerleaders; and to our profession, we are an integral part of promoting occupation in the early stages of life.

"The more that you read, the more things you will know. The more that you learn, the more places you'll go."
~ Dr. Seuss

As part of a regulated health profession, we are encouraged to reflect on our own practice and design our treatment interventions and goals using a combination of sound clinical judgment and recent evidence (CAOT, 2007). Evidence-based practice, knowledge translation, and the dissemination of experiences between clinicians are key sources of information in today's busy clinical environment (Lencucha, Kothari, & Rouse, 2007) and are essential to offering a solid service to our clients.

"My spelling is Wobbly. It's good spelling but it wobbles, and the letters get in the wrong places."
~Winnie the Pooh

This column invites its contributors to submit articles regarding recent clinical research or applications of theory, issues affecting pediatric practice, or other information influential to Canadian pediatric practitioners. Articles should be clear and concise and run no more than 1500 words using the American Psychological Association Style Guide for referencing. More information can be found on the CAOT website, including a CAOT Style Guide and Author's Package. Submissions are reviewed monthly and every effort is made to ensure articles are published in a timely fashion. We look forward to hearing from you. Should you require any additional information, please do not hesitate to contact Brenda McGibbon Lammi, Managing Editor (blammi@caot.ca) or myself, Laura Bradley, Column Editor (lbradley@octc.ca).

References

Brown, G., Rodger, S., Brown, B., & Rœver, C. (2007). A profile of Canadian Pediatric occupational therapy practice. *Occupational Therapy in Health Care, 21*(4), 39-69.

Canadian Association of Occupational Therapists (2010). *Membership Data Report*. Retrieved from http://www.caot.ca/pdfs/membership/Final%20Compiled%20Stats-2009.pdf.

Canadian Association of Occupational Therapists (2007). *Profile of Occupational Therapy in Canada*, 2007. Retrieved from: http://www.caot.ca/pdfs/otprofile.pdf.

Carroll, L. (1871). *Through the Looking Glass*. United Kingdom: Macmillan.

Geisel, T. (1978). *I Can Read With My Eyes Shut*. New York: Random House Inc.

Lencucha, R., Kothari, A., & Rouse, M. (2007). The issue is- Knowledge translation: A concept for occupational therapy? *The American Journal of Occupational Therapy, 61*, 593-596.

Milne, A.A. (1926). *Winnie-The-Pooh*. United Kingdom: Methuen & Co, Ltd.

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Update from the COTF

What it means to receive funding from COTF, in the words of a recipient Edith Ng:

"As an occupational therapist, I have always wanted to take part in intervention-based research. My goal has been to contribute to the practice of occupational therapists working in the area of brain injury. For my MSc study, I am piloting the use of the Internet to deliver an intervention approach with individuals with executive dysfunctions post-traumatic brain injury. The project is extremely meaningful and rewarding. Admittedly, however, the lack of income during my studies has created challenges. I am very grateful to COTF and its donors for their support. Thank you COTF for helping to advance research and practice in our field and for the opportunity to put your donations to work!"

Edith's testimonial is an example of how your donation dollars are used to help occupational therapists. Without your support, Edith would have continued to face challenges. Your donations are very meaningful to recipients. Please continue to give so that more occupational therapists like Edith can continue in their studies and research. Thank you!

2010-2011 COTF Board of Governors

Donna Klaiman (occupational therapist), Anne Peters (consumer of occupational therapy services) and Bas Van Lankvelt j(Chief Operating Officer of MediChair) joined the Board recently. COTF extends a warm welcome to them, as they join the other eight board members.

2011 COTF Awards Program Deadline:

Please note that the awards information can change from time to time. Therefore, please contact Sangita Kamblé or Anne McDonald for the most up to date information.

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. COTF is using e-mail when possible to communicate with donors in order to be respectful of the environment. Updates can be made by contacting amcdonald@cotfcanada.org or 1-800-434-2268 x226.

2011 CAOT Learning Services

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CAOT Lunch & Learn Webinar Series:

Cost: $50 for CAOT members or $75 for non-members, plus GST/HST. Time: Tuesdays 12:00pm – 1:00pm EST

Supporting safe driving: Tools for clinicians and consumers
Presenter: Brenda Vrkljan
Date: March 22, 2011 | Register by: March 15, 2011

Developmental assessments for young children: Selecting an appropriate tool
Presenter: Barbara Mazer
Date: April 5, 2011 | Register by: March 29, 2011

Handwriting interventions for school-aged children: A systematic review
Presenter: Mona Hoy
Date: April 19, 2011 | Register by: April 12, 2011

Action Over Inertia series
Presenters: Terry Krupa and Megan Edgelow
Dates: May 3, 10, 17, and 24, 2011 (4 sessions)
Register by: April 26, 2011
Early Bird Registration Fees (Until April 1, 2011)
CAOT member: $225.00 non-member: $338.00
Regular Fees (After April 1, 2011)
CAOT member: $275.00 non-member: $388.00

CAOT Water Cooler Talks:

Free and are exclusively for CAOT members. Time: Thursdays 12:00pm – 1:00pm EST.

Caseload Management Planning Tool (French)
Presenter: Christiane Des Lauriers
Date: March 31, 2011 | Register by: March 24, 2011

CAOT - Advancing occupational excellence in your career
Presenters: Janet Craik and Christina Hatchard
Date: April 14, 2011 | Register by: April 7, 2011

Internationally Educated Occupational Therapists (IEOT)-Employer Partnership: How to achieve common goals
Presenter: Marie-Christine Beshay
Date: April 28, 2011 | Register by: April 21, 2011

Please go to http://www.caot.ca/default.asp?pageid=3907 to register for a Lunch & Learn Webinar or for a Water Cooler Talk of your choice, or contact education@caot.ca for more information.

CAOT Learning Services Workshops:

Enabling Occupation through Universal Design and Home Modification
April 14th - 15th, 2011
Ottawa, ON - Canadian Housing and Mortgage Corporation
Presenter: Kathy Pringle, BSc(OT), OT Reg. (Ont.), Dipl.Arch. Tech.

Please visit http://www.caot.ca/default.asp?ChangeID=46&pageID=30 to register or for more information.

CAOT Endorsed Courses:

Myofascial Release Seminars:
Fascial - Pelvis Myofascial Release
Pediatric Myofascial Release
Myofascial Release I
Myofascial Release II
Myofascial Unwinding
Myofascial Mobilization
Cervical - Thoracic Myofascial Release

Various dates and locations

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4th International Conference on Fetal Alcohol Spectrum Disorder The Power of Knowledge: Integrating Research, Policy, and Promising Practice Around the World

March 2 – 5, 2011
The Westin Bayshore, Vancouver, BC

Our understanding of FASD is entering a period of rapid expansion and change, dramatically increasing our comprehension of the breadth and depth of the global impact of this lifelong disability. This 4th International conference will provide an advanced forum for emerging and cutting edge research, policy and practice that will assist governments, service systems, service providers, parents and caregivers, as we strive to address the complex issues of FASD. This new knowledge will be an impetus for critical action in supporting women, individuals, families, and communities around the world.

Contact: Katia Selezeneva ipad@interchange.ubc.ca or visit : http://www.interprofessional.ubc.ca/FASD.htm