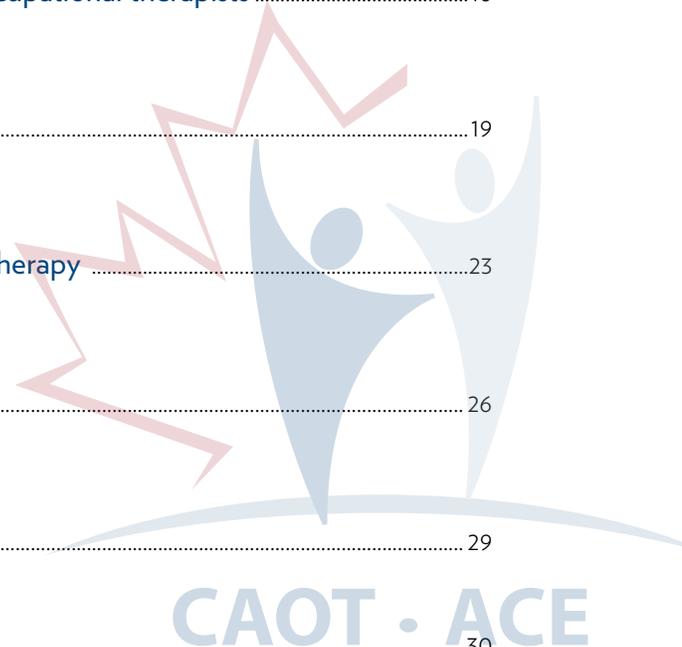


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Everyday Stories . . . profiles of your CAOT colleagues

Ivan Bachynsky, OT(C), OTR, OT Reg.(NB)

Education

I have two Bachelor of Science degrees, one in biology and biotechnology from Carleton University in Ottawa, Ontario (1991), and my second in occupational therapy from Queens University in Kingston, Ontario (1995).

Career path as an occupational therapist

Following graduation, I worked for Easter Seals in Connecticut, USA providing occupational therapy in schools. I then worked in various schools in New York, Montana and Connecticut; all of which were wonderful experiences. I was married in 1999 and returned to Canada and settled in Rothesay (near Saint John), New Brunswick where I presently work for the New Brunswick Extramural Program (EMP) in the Horizon Health Network. The EMP (known by many as the 'hospital without walls') provides comprehensive home and community health care services to New Brunswickers. When I started with EMP I was the first local dedicated school-based occupational therapist.

As part of a small but dedicated School Rehabilitation Team (occupational therapy, speech-language pathology, physical therapy and rehabilitation assistants), I have had the amazing opportunity to work with a group of highly innovative and dedicated individuals who are willing to embrace change in pursuit of best practice for the children with whom we work. The management of our team has been very supportive of innovative practice and hosting or promoting continuing education despite limitations of money, human resources, large caseloads and long wait-lists. With this support we have been able to provide occupational therapy services in flexible and adaptive ways including;

- in-class collaborative work with teachers,
- in-services for teachers and teaching assistants,
- multi-class student OT Boom Bonanza assemblies,
- Circus and Comic Book Cursive camps,
- direct hands-on therapy,
- involvement in student-serviced teams, and
- practice and school-based service work groups.

Other roles

One of my most exciting occupational therapy roles has been as an instructor for ABC BOOM/ABC BOUM Multisensory Approach to Handwriting (www.abcboom.net). Natasha Rouleau, an occupational therapist from Ergothérapie de la maison à l'école in Montreal, Quebec (www.edme.org), developed this practical, fun and easy method to teach handwriting that is used daily by therapists and teachers.

Since the program has been adopted at many local schools, the school staff has gained handwriting teaching tools that have resulted in a large reduction of occupational therapy handwriting referrals. I have had the opportunity to teach this course/method to hundreds of teachers and occupational therapy peers.

Family life

My wife Jennifer is also an occupational therapist and we have three wonderful boys aged 8, 6, and 2. We participate in many activities as a family especially skiing, biking, snowshoeing and lots of outdoor play.

Hobbies/interests

In my spare time I teach indoor cycling classes, train for and participate in triathlons, play water polo and am on my Church's parish council.

Greatest tools in my occupational therapy bag of tricks

ABC BOOM, School AMPS, Snakey, Bal-A-Vis-X

Greatest influences to my occupational therapy practice

Anne Fisher, Umea University, Sweden; Terry Krupa, Queens University, Kingston, Ontario; Stanley Greenspan, Interdisciplinary Council on Developmental and Learning Disorders (www.ICDL.com); and Natasha Rouleau, Université du Montreal and Ergothérapie de la maison à l'école, Montreal, Quebec (www.edme.org).

Ivan may be reached at otkids@nbnet.nb.ca.



What's new



Accreditation

- CAOT and the Physiotherapy Education Accreditation Canada (PEAC) have partnered and developed an occupational therapist assistants' and physiotherapist assistants' education accreditation programs (OTA&PTA EAP) in Canada.
- Funded by Health Canada, through a joint initiative of six Canadian accreditation agencies including CAOT, Canadian guidelines for inter-professional health education (AIPHE Guidelines) have been developed. These guidelines provide a framework to promote and advance inter-professional collaboration.

Discount on Wiley-Blackwell Publications!

- Enjoy a new very special discount for CAOT members. Receive 20% off ALL books from Wiley-Blackwell by entering the code COT11 at the checkout. Go to <http://ca.wiley.com> to browse the extensive selection of occupational therapy and health sciences titles. For more information, contact the customer services team at 1-800-567-4797.

New CAOT video available for viewing

Go to careercreate.com and search for 'CAOT' to view this informative and upbeat video on CAOT and the benefits of membership.

What's online



Legacy Website

- In honor of its 85th anniversary, CAOT has launched a commemorative legacy website (www.otlegacy.ca). The website takes a look back at how occupational therapy has evolved over the years. We encourage you to contact us should you have any ideas of what else should be added to this historically significant site. We are looking for old photos, oral histories, regional stories or articles relating to the history of occupational therapy. For more information, please contact Lisa Sheehan at legacy@caot.ca.

Practice Resources

- Revised CAOT Position Statement: *Tele-Occupational Therapy and e-Occupational Therapy* (2011).
- CAOT's online store has had a facelift. Check it out at www.caot.ca > online store.
- The CAOT Information Gateway (www.caot.ca > members > professional development > information gateway) is for CAOT members and it provides you with valuable tools and resources to help you in your pursuit of evidence-based occupational therapy.

Accreditation

- The Caseload Management Planning Tool (CMPT) is now available (www.caot.ca > about caot > advocacy > our initiatives > caseload management tool project).

OTepp

- The Occupational Therapy Self-Assessment Tool is available online (access.nsc.ca). The tool outlines the knowledge, skills and competencies necessary for successful occupational therapy practice in Canada and was developed for internationally educated occupational therapists (IEOTs).
- A series of *Day in the life of an OT* videos are being produced. They help IEOTs and other members of the public gain insight into the practice of occupational therapy in Canada. The videos will be available on the IEOT web portal and the CAOT web site..



Canadian Association of Occupational Therapists 2010-2011 Midyear Report

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

Celebrations are underway across Canada to mark the 85th anniversary of the Canadian Association of Occupational Therapists (CAOT). Our anniversary year began with the gift of a commemorative pin to individual members to recognize occupational therapists who met the requirements to join our Association and support the national voice for occupational therapists in Canada. Our celebrations continue with anniversary events in locations across the country where we welcome new members to the Association. We encourage you to wear your pin with pride and participate in our anniversary celebrations. We have much to celebrate.

This anniversary year brings the implementation of a new strategic plan for the Association. The strategic plan was developed with the input of members to work towards our vision that occupational therapy is valued and accessible across Canada. The plan highlights the importance of enhanced visibility, political advocacy, and research and scholarship in our mission to advance excellence in occupational therapy. Key activities undertaken to date this year that address our new strategic priorities are summarized below. For information on any of the described activities, please feel free to contact me at cvonzweck@caot.ca.

Advance political advocacy

- Completion of an annual environmental scan to understand issues that impact advocacy and business strategies
- Submission to the pre-budget consultation undertaken by the House of Commons Standing Committee of Finance (see <http://www.caot.ca/pdfs/budget2011.pdf> for content)
- Hosting of a successful lobby day on Parliament Hill and presentation to the Parliamentary Health Committee to promote messages of our pre-budget consultation submission
- Meetings with key politicians and representatives of the Department of National Defence to promote the role of occupational therapists with the military and veterans
- Participation in a veterans affairs conference on Operational Stress Injuries
- Participation on a research roundtable on military and veterans' health
- Meetings with key decision makers dealing with the renewal of the benefit plan offered to the public service to promote inclusion of occupational therapy coverage

- Preparation and distribution of an *Occupational Therapy Solutions* manual to the public service and unions
- Meetings to lobby for extended health care coverage of occupational therapy services
- Representation of occupational therapy on national coalitions and task forces (see <http://www.caot.ca//default.asp?pageid=2374>)
- Participation in key events attended by politicians including the Health Research Caucus, Champions for Mental Health dinner, Mental Health Roundtable, National Children's Day breakfast
- Announcement by Mr. Robert Oliphant (Don Valley West, Lib.) in the House of Commons regarding occupational therapy month (see http://www.facebook.com/note.php?note_id=162862077079612)
- Establishment of an MP/OT grassroots campaign to involve members in advocacy activities (see <http://www.caot.ca/default.asp?pageid=3954>)
- Provision of support to provincial occupational therapy organizations in Saskatchewan and British Columbia to increase entry level education seats for occupational therapists
- Development of an election kit to assist members with advocacy activities for the federal election

Ensure visibility of occupational therapy

- Introduction of social media to provide a new forum of communication using Facebook and Twitter (see <http://www.facebook.com/CAOT.ca?v=wall>)
- Launching of a new website design, including a media room with our latest media updates and an occupational therapy speaker's bureau
- Creation of the occupationaltherapylegacy.ca web site as an 85th anniversary project to celebrate the history of occupational therapy in Canada
- Development and distribution of a series of six posters to all members that profile the role of occupational therapists
- Development of short videos to highlight the work of occupational therapists with a variety of client populations
- Placement of advertisements in national newspapers and the Hill Times to promote the work of occupational therapists
- Hosting National OT Month with resources and ideas to promote occupational therapy, including the

OT Month student challenge “gOT Spirit”. View the winning entry from the University of Alberta at <http://www.edmontonjournal.com/Flash/3633846/story.html?tab=VID#ixzz129brwzSD%20>

- Publication of new position statements on the topics of *Occupational Therapy and Cultural Safety*; *Occupational Therapy and Aboriginal Health*; and *Client Safety and Occupational Therapy*
- Introduction of new caseload management guidelines for occupational therapy (see <http://www.caot.ca//default.asp?pageid=2331>)
- Continued support and utilization of the health human resource database for occupational therapists to promote a workforce that meets the health needs of the people of Canada (see <http://www.caot.ca/otnow/Nov10ENG/Workforce%20capacity.pdf>)
- Leading the National Occupational Therapy Examination and Practice Preparation Project in partnership with McMaster University to promote workforce integration of internationally educated occupational therapists (see <http://www.otepp.ca>)
- Implementation of a new blueprint for the national certification examination
- Development of a new online trial occupational therapy examination for pilot testing in spring 2011
- Approval of a new self-study guide for academic accreditation of university occupational therapy programs
- Hosting of a strategic planning session for the academic credentialing council
- Providing presentations on the work of CAOT on the *Older Driver Blueprint* at local, national and international conferences, including the National Mobility Equipment Dealers Association in Quebec City
- Development of guidelines to educate occupational therapists regarding elder abuse prevention and intervention for introduction in 2012

Foster evidence-informed occupational therapy through research and scholarship

- Continued contribution of approximately 3% of membership revenues plus in-kind support to the Canadian Occupational Therapy Foundation to fund organizational operating expenses
- Validation and presentation of a chronic disease agenda for occupational therapy
- Promotion of occupation-based research as a priority for research funding organizations (e.g., through participation in the strategic planning consultation for the Canadian Institutes for Health Research)
- Hosting of a strategic planning session for the Canadian Journal of Occupational Therapy (CJOT)
- Promoting accessibility of information published in CAOT periodicals. The CJOT ranked in the top 100 out of more than 13,530 titles for number of full-text downloads on IngentaConnect in 2010
- Creating knowledge exchange regarding concepts from *Enabling Occupation II* through free member water cooler

presentations and development of a new interactive program for introduction in 2011

- Publishing special editions of CAOT periodicals on the topics of older driver safety, community mobility, chronic disease management and the 85th anniversary of the Association
- Implementation of online submission software for the CJOT
- Expanding member access to free and/or discounted research journals and publications. In addition to free access to a number of international journals, CAOT members now receive discounts on products published by Wiley-Blackwell.

Enable occupational therapy practice

- Ongoing evaluation of available CAOT products and services to support members in practice. The results of our latest survey indicate continued high levels of satisfaction, particularly with our publications, professional liability insurance and continuing education opportunities.
- Introduction of Lunch & Learn webinar presentations in 2010 to provide easy access to continuing education on a wide variety of topics. See <http://www.caot.ca/default.asp?pageid=3911> for the 2011 schedule. Also introduced in 2010, Water Cooler Sessions provide free webinar presentations for members regarding CAOT presentations and initiatives. 2011 topics include the new caseload management tool, the role and use of support personnel in occupational therapy, elder abuse guidelines and safeguarding your practice from liability litigation (<http://www.caot.ca/default.asp?pageid=3969>)
- Development of new publications, including revised editions of *Spirituality and Occupational Therapy* and *Living with Alzheimer's and Related Dementias*.
- Introduction of e-book formats for CAOT publications
- Hosting of a consensus meeting to develop an index of occupational therapy terms in French and English for quality and consistency in translations of CAOT products and services
- Hosting of online practice communities for members on a variety of topics including mental health, sensory processing, aboriginal health and rural practice (see <http://www.caot.ca//default.asp?pageid=2035>)
- Planning for the June Conference 2011 in Saskatoon, Occupation under the living skies in conjunction with the Saskatchewan Society of Occupational Therapists and the Canadian Society of Occupational Science. Keynote speakers include Steven Lewis, Karen Whalley Hammell and Senator Pamela Wallen. Professional issue forums will address the topics of cancer survivorship and pain management.
- Preparation for the 2011 annual general meeting that will be held in conjunction with Conference 2011. Members will be asked to vote on significant bylaw changes (see <http://www.caot.ca/pdfs/Proposed%20Changes.pdf>). Join us for the AGM in person or online.



COLUMN EDITOR: SANDRA HOBSON

Applying an innovative model of interprofessional team practice: The view from occupational therapy

Anne Medlock, Elaine McKee, Jenna Feinstein, Stephanie H. Bell and C. Shawn Tracy

The increasing number of older Canadians with multiple chronic conditions presents a challenge for occupational therapists, as well as other healthcare providers (HCPs). Optimal management of these older persons is not currently known (Dyer et al., 2003). Furthermore, best practice for educating future HCPs, including occupational therapists, in providing care to this population is also currently underdetermined (Uphur & Tracy, 2008). The recent focus on interprofessional teams demonstrates a growing recognition that the skills of many HCPs working together in collaboration might well be what is required to deliver the best care to the elderly population with complex needs (Gage, 1997). Acknowledging the value of interprofessional teams, occupational therapy training programs now expect trainees to gain knowledge of the roles of other HCPs. The IMPACT clinic (Interprofessional Model of Practice for Aging and Complex Treatments) was designed and developed to meet both these challenges: improved primary care to elderly clients with multiple chronic conditions and enhanced interprofessional training for those who will be providing this care.

The IMPACT model

The IMPACT model was developed and implemented in the Department of Family and Community Medicine at Sunnybrook Health Sciences Centre, in Toronto, Ontario, which provides primary care to a large and varied practice

population with many elderly patients. The model was collaboratively created by clinicians, educators, and researchers; the main objective was to develop and evaluate an interprofessional teaching clinic specifically designed for community-dwelling seniors with complex healthcare needs. A number of key strategic partnerships were formed including several local community health care and social care agencies. The IMPACT team includes family physicians, family physician residents, a community nurse, a pharmacist, an occupational therapist, a community social worker, a physiotherapist, and a dietitian (see Figure 1). Members of the team volunteered to join the IMPACT clinic and were seconded from their regular practices for one day per week (on average). Importantly, the IMPACT model specified that each individual member of the team assumed three unique roles: 1) as clinician: providing clinical care for patients/families in

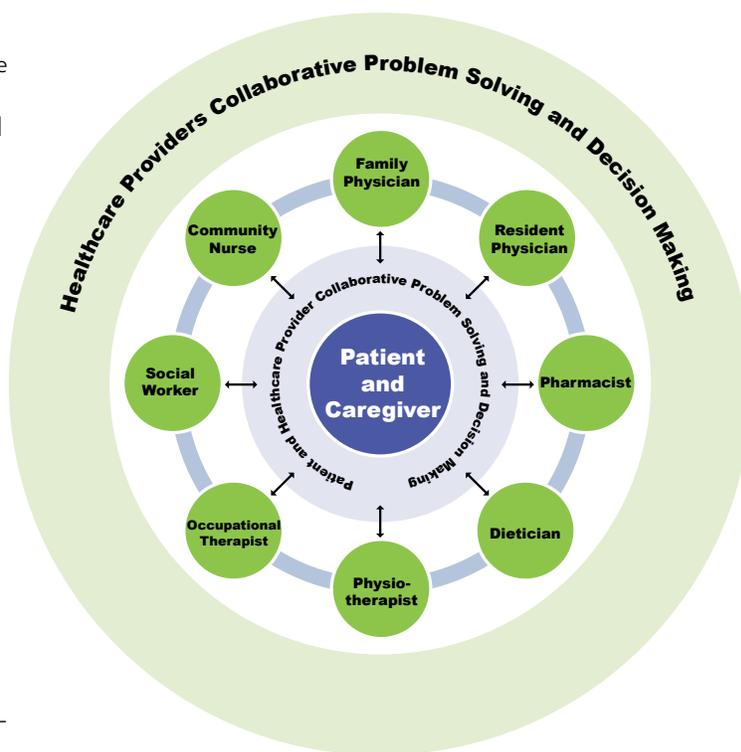


Figure 1. The IMPACT model of interprofessional care for complex elderly patients.

the weekly interprofessional clinic; 2) as educator: providing information, guidance, and support both to new trainees and practicing clinicians; and 3) as co-creator: contributing to the on-going refinement and evaluation of the interprofessional practice model. As such, the IMPACT model evolved over time through an open, collegial process based on collaboration and team-work.

Patients are referred to the IMPACT clinic by their regular family physician. The eligibility criteria included being 65 years of age or older; three or more chronic diseases requiring monitoring and treatment (or two chronic diseases when one

is frequently unstable); five or more long-term medications; a minimum of one functional ADL limitation; and not home-bound or institutionalized. Patients are scheduled for an extended appointment (1.5 to 2 hours) during which a diverse range of medical, functional, and psychosocial issues are explored. Patients seen in the IMPACT clinic typically are being followed by a large number of specialists and are often subject to multiple referrals for assessment and diagnostic tests. Due to the patient's complex history and the time required to adequately address the issues, the traditional family practice model with 15 to 20 minute appointments does not serve these patients well. Likewise, the traditional model is not ideal from the perspective of healthcare providers either. Indeed, an interprofessional team approach would appear better suited to optimize the care provided to complex older patients.

The IMPACT clinic begins with a 20-minute quality of life interview performed by a medical resident, while the rest of the team observes on a closed circuit television. This model allows for instantaneous real-time information sharing amongst the members of the team. As the initial interview unfolds, the



IMPACT team members physiotherapist Jennifer Wakefield (left), occupational therapist Anne Medlock (centre), and community nurse Susan Riddle (right) confer while observing patient interaction with family physician Lisa Del Giudice and pharmacist Jana Bajcar (inset).

team confers and documents the interview. The quality of life interview is similar to an occupational therapy assessment in that a holistic framework is employed. A gentle guided negotiating approach with the patient sets the stage, allowing the first layer of patient/family concerns to be uncovered. This information is utilized by the team in order to provide a satisfying patient-centred experience. Many patients express surprise at having this dedicated time to talk about themselves and their health concerns. It was not uncommon for patients and/or families to bring up issues that had not previously surfaced and were therefore not in the patient chart.

During the course of the visit, there are three formal discussion periods during which the team sets negotiated patient-centred priorities, establishes the order of assessments, and develops strategies. Informal discussions in smaller groups take place throughout the visit. Once the visit plan is in place, additional members of the team perform further assessments, as indicated by the patient's needs. Once these assessments are completed, the team re-assembles to create

an interprofessional care plan in collaboration with the patient and, when possible, the patient's family. At the end of the visit, the team devises a follow-up plan of care for the family physician who resumes on-going care for the patient. A strength of this model of care is that it is highly interactive. The full team shares information, ideas, and insights in real time with the patient and family. This allows the team to build on each others' individual assessments and to problem solve in collaboration with the patient and family. An additional advantage for the patient and family is that by having access to all the various HCPs at a single visit, they are able to avoid multiple sequential referrals and visits to individual HCPs.

The experience of the occupational therapist on the IMPACT team

The role of the occupational therapist on the IMPACT team centres on the comprehensive analysis of patient vulnerability in the physical/functional, cognitive, and perceptual/sensory domains (Canadian Association of Occupational Therapists [CAOT], 1997). Further, the occupational therapist evaluates the impact of these domains on the patient's self-care routines, safety at home and in the community, and leisure/productive activities. Creative solutions towards safety, function, and quality of life are sought in a collaborative manner with the patient and family caregivers. For instance, discussions of 'meaningful daily activity' routinely involved the team's social worker in brainstorming sessions with the patient and family. Negotiating goals with the patient and family is instrumental for each team member in order to arrive at functional outcomes that could help restore a sense of 'equilibrium' for the patient and family (Moats, 2007). Information is shared and heard by all members of the team so that the patient does not experience repetition, which is a common complaint of patients and families regarding the traditional model of care. Over three years, the IMPACT model has been refined to optimize the positive dynamic of team function and collaborative decision-making. A high degree of satisfaction among IMPACT team members was indicated by performance scores on the Dimensions of Teamwork Survey (Ryan, 2010). The two occupational therapists who participated in the IMPACT clinic found the model to be an enriched learning environment; a deeper understanding of other HCPs roles was gained and often new knowledge was incorporated into occupational therapy practice outside the clinic. Likewise, other members of the IMPACT team learned about the occupational therapy role from watching and modeling their assessment and development of a comprehensive plan. The other team members learned how to ask certain questions that aided in their own and the entire team's assessment.

Interprofessional education in occupational therapy

According to the Centre for the Advancement of Interprofessional Education (2002), "[i]nterprofessional education occurs when two or more professions learn with, from, and about each other to improve collaboration and

the quality of care” (Definitions, para. 1). By including student occupational therapists in the IMPACT clinic, these future practitioners were able to observe first-hand how occupational therapists interact and collaborate with other HCPs as members of an interprofessional team. This is in line with the interprofessional education (IPE) goal to enhance health professional students’ knowledge, skills, and attitudes needed for collaborative practice (University of Toronto Centre for Interprofessional Education, 2008).

The IMPACT clinic is a unique and ideal environment to learn about interprofessionalism. It provides students an opportunity to observe the practice of many different professionals and to discuss the different roles and watch the team members interact with and assess patients. Students are included in the discussion process and encouraged to actively participate in the clinic. It was observed that the different HCPs used their knowledge to build on others’ ideas in order to provide best patient care. By contributing to this interactive process, students may best understand interprofessional collaboration. This active participation allows students to see strategic value and understand the different perspectives behind decisions being made. The occupational therapy student role on the IMPACT team allows them to perform an occupational therapy assessment and participate in other HCP assessments. As IPE initiatives continue to advance, it will be important to develop more formal opportunities for occupational therapy students to participate in enhanced learning environments (Lyle, 2008), such as the IMPACT clinic.

Conclusion and key messages

The fast-growing number of frail and at-risk seniors living in the community demands new and innovative models of care. Interprofessional primary care teams are a promising approach to meet this present challenge; however, interprofessional models require further exploration and testing by healthcare providers, educators, and researchers. A formal mixed-methods evaluation of the IMPACT clinic is currently underway, including a retrospective chart audit and qualitative interviews of patients and family members. The IMPACT clinic represents a new practice model in which occupational therapy has made significant contributions, both in the development of the care model and in the education and training of future HCPs, including future occupational therapists. Occupational therapists

possess the requisite skills and training to be valuable members of interprofessional primary care teams. Indeed, occupational therapists are very well placed to advocate, collaborate, and participate in the development of novel approaches and more creative and effective models of care for individuals at risk.

Acknowledgements

The authors would like to thank each of the members of the IMPACT team (past and present) for their contributions to this project. A special thanks to Dr. Leslie Nickell for helpful comments and suggestions on an earlier draft of this paper. Funding for the IMPACT project was provided by HealthForceOntario (a joint initiative of the Ontario Ministry of Health and Long-Term Care and the Ontario Ministry of Training, Colleges and Universities).

Note from the Editor

Watch for a case scenario of a client’s journey through the IMPACT clinic to be in the November/December, 2011 issue of OT Now.

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Introducing a space for dialogue: Aboriginal Peoples Health and Occupational Therapy in Canada

Alison Gerlach and Janet Jull

COLUMN EDITORS: ALISON GERLACH AND JANET JULL

The intent of this new column, Aboriginal Peoples Health & Occupational Therapy in Canada, is to promote the visibility and discourse of our profession with issues relating to Aboriginal health in Canada. As such, it is an early but important first step in creating space within the Canadian occupational therapy profession to reflect on and question our relationships and relevance in relation to diverse Aboriginal peoples living in urban, rural and remote communities. The intent of this bi-annual column is to present and reflect on the experiences and perspectives of occupational therapists working with Aboriginal peoples, Aboriginal consumers of occupational therapy and Aboriginal colleagues and stakeholders from across Canada.

Background

In June 2008 Prime Minister Harper made an historical official apology to all the Aboriginal peoples of Canada for the intergenerational damage inflicted upon many as a result of the residential schools. On the same day in Whitehorse, Madeleine Dion Stout, an Aboriginal scholar was giving the opening address to the annual Canadian Association of Occupational Therapists (CAOT) conference, and in media interviews spoke of the potential for a new relationship between occupational therapists and Aboriginal peoples. Madeleine described the apology as *'a step forward, we've broken the mold and thrown it away today. Now we're onto a new project that is more inclusive, that is more respectful, that is hopefully more reciprocal'* (Yukon News, June 13, 2008).

In your clinical practice...

Do you have Aboriginal clients, colleagues or organizations that you work with?

Do you know if any of your clients identify with the name of their Nation, Band, tribe or clan?

Do you wonder how occupational therapy fits within Indigenous worldviews on health and well-being?

... If you answered 'yes' to any of these questions, then this column will be of value to you.

A significant and recurring theme at the CAOT professional issue forum "First Nations, Métis and Inuit Peoples Health and Community Development" was the invisibility of occupational therapy in Aboriginal peoples' health care services at local, provincial and national levels (Gerlach, 2008). A representative from Health Canada, which funds services for Aboriginal peoples living on reserve, noted that in all of his travels he was unaware of 'First Nations' knowledge about what an occupational therapist does' (Gerlach, 2008). In order to engage in the national dialogue with our partners in Aboriginal communities, we need to make visible the topic of occupational therapy and Aboriginal health.

The Aboriginal Peoples

Canada has the second largest proportion of Aboriginal Peoples of any country in the world, with over 1 million people representing almost 4% of the Canadian population (Statistics Canada, 2008). It is also the fastest growing population. Within Nations, Bands and tribes, there is great diversity and no one 'pan-Aboriginal' worldview. There are over 600 First Nations communities, each with distinct cultural beliefs and practices, languages and dialects, arts, and music. In this column we use the term 'Aboriginal health' to specifically refer to the health issues and status of Aboriginal peoples, as documented in the literature (Estey et al., 2008), which recognizes that there are significant health disparities between Aboriginal peoples and the general Canadian population as a result of a complex interplay of political, socio-economic and historical factors. A fundamental concept of Aboriginal health is an understanding that the current health, social and occupational status of Aboriginal peoples in Canada continues to be impacted by the processes of colonization. There is some evidence to suggest that the ongoing health disparities experienced by many Aboriginal peoples is due in part to the lack of meaning and thus accessibility of health services that are based on western health care knowledge, practices and policies. Occupational therapists work with Aboriginal individuals and communities, however a study of Canadian health policies including those for Aboriginal peoples revealed gaps in access to health programs including occupational therapy services (Pierre, Pollack & Fafard, 2007). CAOT supports the need to increase the number of both Aboriginal and non-Aboriginal health care providers in Aboriginal

communities on reserves and to improve health care for urban Aboriginal populations (CAOT, 2008).

As defined by the Canadian Constitution, the term 'Aboriginal Peoples' refers to First Nations, Métis and Inuit populations. Despite a shared history of colonization, each Aboriginal community has its own unique cultural, political, and linguistic history (Adelson, 2005). First Nations is a widely used term to replace the word 'Indian', and many Aboriginal people identify with the name of their Nation.

The OT Now column

This column proposes to provide a starting point to explore the cultural assumptions and biases of our professional knowledge and practice in relation to diverse Aboriginal clients and communities. It is also hoped that through reading this column therapists will be inspired to share their stories, experiences and perspectives, resulting in suggestions for further dialogue concerning occupational therapy and Aboriginal health in Canada.

As co-editors of this column, it is important to clarify that we are not Aboriginal and we are not experts on Aboriginal health. We are writing from a place of privilege as occupational therapists who share an interest and commitment to promoting a broad and inclusive discourse in Canada on our professional being and doing in the context of Aboriginal peoples' health and well-being. We welcome your stories, insights, knowledge and questions as we begin to make more visible the role of occupational therapy with the Aboriginal peoples, communities and stakeholders from across Canada.

About the column editors

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If you would like more information about the column, or have a submission, please contact either Alison or Janet.

A Network for Occupational Therapists and Aboriginal Peoples Health

was launched in January 2011

The newly formed members of this Network are from across Canada and are providing occupational therapy services in a diverse range of health care settings with Aboriginal children, adults and elders. It is anticipated that this Network will contribute towards making more space within our discourse for Aboriginal knowledge, voices, relationships and dialogue at the community, provincial/territory, national and international level.

Information on this Network, and the occupational therapy representative for your province/territory is available through the CAOT website, or by contacting the Network Chair Alison Gerlach at ag.consulting@telus.net

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CONTINUING EDUCATION WORKSHOP LISTING:

The Árnadóttir OT-ADL Neurobehavioral Evaluation: The A-ONE Certification

Presented by: University of Toronto, Department of Occupational Science and Occupational Therapy, Continuing Education and Professional Development Committee
Instructor: Glen Gillen EdD, OTR, FAOTA

Dates: June 1-5, 2011

Location: Toronto, Canada

Course Contact: hebert.debbie@torontorehab.on.ca

Website: <http://www.glengillen.com/A-One.htm> and
http://www.ot.utoronto.ca/news/cont_ed/index.asp



COLUMN EDITORS: CHRISTEL SEEBERGER
AND JON RIVERO

An update from the Occupational Therapy Practices Committee

Stephen Kuyltjes

The Occupational Therapy Practices Committee (OTPC) works with the Canadian Association of Occupational Therapists (CAOT) national office to develop marketing and communication materials, disseminate information to target audiences, and create networking opportunities for occupational therapists working in private practice that advance the strategic priorities of the CAOT.

Social media presentation

In 2010, four OTPC members along with one very helpful student presented a successful extended session, entitled Social Media Possibilities, at the National CAOT Conference in Halifax Nova Scotia. Our congratulations and thanks go out to Christel Seeberger, Janet Craik, Jane Simmons, Marion Hutton, and Robyn deForest. Also, thank you to the other committee members who contributed to the session but could not be in Halifax.

The session was well attended by about 37 participants who received an informative overview that included the pros and cons of social media sites, potential uses of social media, and professional practice implications of using social media. The types of social media that were discussed included: Facebook, Twitter, Linked-In, My Space, and blogging. Statistics from a CAOT membership survey were reviewed and interestingly, of the 434 CAOT respondents, 58% were aware of, or used, Facebook, 43% use social networking for personal use and 40% did not use any social networking. In the Fall of 2010, CAOT launched a Facebook page and a Twitter account to reach more members.

Registration with the Federal Public Service

Directory

The OTPC committee has had at least one member successfully register with the Federal Public Service Directory.

Occupational therapists can register to be considered as a supplier to the federal government and become added to a list that is referred to when there is an opportunity to bid on government tenders.

Extended health insurance lobby

OTPC was previously involved in the extended health insurance lobby that has now been assumed by CAOT due to the extensive work required to pursue this further. At this point it seems that the funding agencies (insurers) are looking for a sign of demand from consumers (health care users). Therefore, CAOT is promoting occupational therapy as a household name with a publicity slogan "OT solutions that work" with a view to public education and identifying the demand for services.

The committee

OTPC is composed of CAOT members representing different areas of private practice such as disability management, medical-legal consultants, children's services, and long-term disability services. We welcome new member interest from private practice CAOT members practicing in provinces not currently represented including British Columbia, Saskatchewan, Manitoba, Ontario and Prince Edward Island.

To find out more about the OTPC or for private practice resources, please visit www.caot.ca > members > professional development > network exchange > occupational therapists working in private practice

About the author

Stephen Kuyltjes received his Bachelor of Science in occupational therapy from the University of Alberta in 1988 and has been the owner of Rehab Works in Calgary Alberta, operating in the medical legal assessment area for the past 12 years. Stephen is the Chairperson of the OTPC and may be contacted at rehab-works@shaw.ca.

SENSE OF DOING



COLUMN EDITORS: HELENE J. POLATAJKO
AND JANE A. DAVIS

Students as advocates for occupation-based practice

Rachel Stack and Donna Barker

As advancements in occupational science continue to inform our profession, we are realizing more completely the centrality of occupation to the health and well-being of people and the vital role of the occupational therapist in enabling occupation. The scope and practice of occupational therapy has evolved “from the provision of diversional activity, through the use of therapeutic activity, to enablement through meaningful occupation” (Polatajko et al., 2007, p. 15). The position statement on *Occupations and Health* (CAOT, 2009) provides recommendations for occupational therapists that include raising awareness of the health benefits of occupational engagement, advocating for policies and funding that ensure access to occupational therapy services, and establishing a practice environment that is “client-centred, occupation-based and is grounded in enablement foundation principles...” (p. 24). Canadian occupational therapists strive to provide clients with the optimum occupation-based care; however, with high caseloads, strict funding formulas, and prescribed roles and expectations, occupational therapy within some practice settings may actually remain more impairment-based.

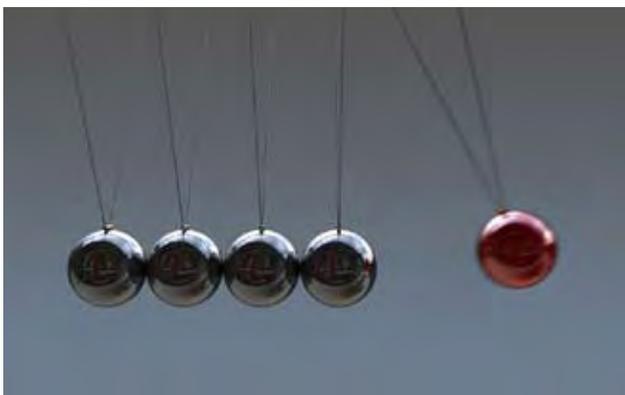
The principle of occupation-based practice is central to many entry-level occupational therapy curricula, including the clinical education aspects of the curricula. Students,

armed with the information that occupation is the core domain of concern of the profession and enablement its core competency, enthusiastically enter fieldwork placements, anxious to translate their learning into practice. However, the practice setting is not always set up to facilitate this translation. In this article we want to consider how students can assist in the national initiative of enabling all persons to have the opportunities and resources to engage in meaningful occupations for their health and well-being, using two case scenarios as examples. These case scenarios, although simplified, are based on experiences of students as communicated to us as fieldwork coordinators, though all names have been changed. These case scenarios are offered here not only to illustrate the challenges of infusing occupation faced in some practice settings, but, more importantly, to illustrate how preceptors and students can work together to enhance occupation-based practice.

Scenario #1: Caleb and Mrs. Jones in the outpatient orthopedic clinic

Caleb, a student occupational therapist, is very excited about his six-week, year one, fieldwork placement in an outpatient orthopedic setting. He is eager to apply what he has learned about occupational enablement in the classroom to the clients in this clinical setting.

Two weeks into the placement Caleb is amazed at the knowledge and skills of his preceptor, Beth, and how she handles the fast pace and complicated clinical situations that they see each day. He is pleased to put his musculoskeletal and splinting knowledge and skills to use, but he has questions about the lack of occupation-based assessments and outcome measures used in the clinic and the nature of Beth’s documentation, which is essentially impairment-based and does not reflect the concepts of occupation in an explicit way.



About the author

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One client in particular is on Caleb's mind: recently widowed, 80-year-old Mrs. Jones, lives alone and, due to a fall, sustained a Colles' fracture six weeks ago. Earlier in the day, Beth, in her 45 minutes with Mrs. Jones, took a quick history, assessed strength, range of motion, and sensation, and fabricated a splint. While the splint was being made, Mrs. Jones mentioned to Caleb that she was 'feeling down', was lonely, and found the days long with little to occupy her time.

At the end of the day, Caleb asks Beth whether, at Mrs. Jones' follow-up visit, he could administer the Canadian Occupational Performance Measure (COPM) (Law et al., 2005) and spend time talking with Mrs. Jones to obtain a better understanding of her issues and then formulate a treatment program for her. Beth acknowledges that occupational therapy could do much more for Mrs. Jones, but explains that taking the time to address these issues with Mrs. Jones would mean that another client would not get treatment in a timely manner, due to a large waiting list and the expectations of the interdisciplinary team.

Beth and Caleb discuss what optimum assessment and treatment of Mrs. Jones' occupational performance issues might entail, how that might benefit Mrs. Jones, and what the consequences might be for her not having these needs addressed. They decide that when Mrs. Jones returns for her follow-up visit, in addition to the check-up of her wrist, Caleb will talk with her about the benefits of increased involvement with an occupational therapist and include information about referrals to both public and privately-funded occupational therapy services, which might be covered by an extended health plan.

Caleb decides to do his fieldwork project on the research evidence supporting the benefits of occupational therapy services in addressing occupational performance issues in the older adult population. Beth thinks that she might be able to use this information to advocate for further occupational therapy services within her institution. Beth also decides to submit a student research project idea to the university concerning infusing occupation into the outpatient orthopedic occupational therapy services at the clinic.

Scenario #2: Leslie at the off-site community centre

Leslie, a student occupational therapist, is very excited about her final placement where she will be working with children with autism in a community centre. This role-emerging placement involves an off-site occupational therapist preceptor model as there is currently no occupational therapist on staff at the centre.

On the first day of placement, Leslie meets with both the off-site occupational therapist, Ben, and the on-site activity coordinator, Carl, to begin her orientation to the centre and discuss expectations of the placement. Leslie has learned

that the After School Program was developed for children 9-12 years of age. The children are expected to participate in a structured pre-set activity program from 4-7pm which includes a gross motor sport activity, dinner, and a fine motor craft activity. Within the first week, Leslie observes that the children participating in the After School Program appear to be disinterested and display increased behavioural issues when participating in the pre-determined structured group activities.

Leslie feels that she needs some direction regarding where and how to begin to infuse meaningful occupation within the After School Program. With Ben's approval, Leslie decides to use the COPM (Law et al., 2005) to assist with identification of occupational performance needs and goals with the children and parents at the centre. The results indicate that many of the children have self-care and leisure performance issues, such as brushing teeth, tying shoes, and turn taking during games, which are not being addressed in the program.

Leslie meets with the on-site supervisor, Carl, during her first week of placement. Leslie asks whether the children and parents had input into the types of activities that are available during the After School Program. Leslie understands

the importance of being client-centred and providing clients with meaningful group occupations through her review of the article by Heidenbrecht and Monardo (2007). Carl explains that he had developed the activity calendar based on a general understanding of the developmental conditions of the children at the centre, without input from the parents and children, as it would be challenging to address individual needs of children within the group activities. Leslie conveys to Carl that the main domain of concern for her is enabling meaningful occupations for the children; she believes that health and well-being is strongly influenced by having choice and control in everyday occupations, and also when people's occupations give meaning and purpose to their life (CAOT, 2009).

Leslie meets with Ben the following week and explains that she would like to develop group activities based on the clients' COPM assessment and the identified occupational performance issues. Leslie reveals that several children, along with their parents, identified being able to brush teeth independently as a goal. As per Ben's suggestion, Leslie engages, educates and coaches individual children, within a group of children, to brush their teeth after dinner. In observing the group, Carl is amazed at the interest and cooperation level of the children. Over the course of Leslie's placement, several children reach their goal of successfully brushing their teeth. Leslie states that although it was challenging to go into an environment unfamiliar with the occupational therapy role, it was very rewarding to be able to facilitate changes within the program so that client's occupational performance issues were addressed, ultimately engaging clients in meaningful occupations.

“student occupational therapists are equipped with current knowledge and research evidence around occupational science and occupational therapy models and frameworks that can assist in enhancing services to clients.”

Reflections

It is our experience as fieldwork coordinators that, as these scenarios demonstrate, student occupational therapists are equipped with current knowledge and research evidence around occupational science and occupational therapy models and frameworks that can assist in enhancing services to clients. Students can provide the enthusiasm, research evidence, extra man-power, and support to find creative ways to advocate for all persons to have the opportunities and resources to engage in occupations to promote health and well-being (CAOT, 2009).

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Occupational therapy services becoming more integral in the Canadian Forces

Cheryl Evans, CAOT Communications Coordinator

As a member of the Canadian Association of Occupational Therapists (CAOT), Megan Rocquin, has a lot to celebrate in light of recent improvements to the Mobility Assistance policy within the Department of National Defence (DND). Ms. Rocquin is employed as the Occupational Therapist Advisor to Client Services within the Joint Personnel Support Unit (JPSU) Headquarters in Ottawa.

The JPSU provides standardized, high quality, consistent care and administrative support during all phases of recovery, rehabilitation, and reintegration for return to active service or transition to civilian life following release for all injured and ill Canadian Forces (CF) members, former members, their families and the families of the deceased.

"The CF currently has a very broad and open policy that covers these services, which is great on one hand but on the other leaves it open to interpretation," said Ms. Rocquin. "To make sure we close all the gaps, our first step was to determine the intent of the policy."

Ms. Rocquin specializes in the JPSU support service specific to home and vehicle adaptations as well as home assistance. She devotes most of her time developing sound policies for these three important services to ensure high level of care is delivered to CF members and their families. To ensure the proper implementation of these policies, Ms. Rocquin conducted research to obtain a full appreciation and understanding of how different Workers' Compensation Boards (WCB) compensate injured workers. She also used every opportunity to promote the benefits of occupational therapy to ill and injured CF members by incorporating occupational therapy insights and terminology while conducting her research and developing policies.

Through her research and recommendations, Ms. Rocquin's team was successful in clarifying the policy to include adaptations to newly constructed residences, when existing homes were not modifiable, and securing the appropriate funding.

Ms. Rocquin credits much of her success to the assistance and dedication of the CAOT. "CAOT was there for me every step of the way and provided me tremendous support" said Ms. Rocquin. "One of the biggest accomplishments was the push for a client-centered process versus a one solution fits all approach."

Ms. Rocquin was then tasked to co-write a full set of instructions outlining how to complete a home or vehicle adaptation and the considerations for home assistance benefits under the CF policy. Her goal is to write clear instructions that will help simplify the process and ensure CF members, and their families, receive services in a shorter amount of time and the same level of services are offered to all CF members and their families.

"I believe the profession of occupational therapy has a lot to offer the CF and will help ensure they are able to serve their members to the best of their ability," said Ms. Rocquin. "I would encourage any occupational therapist who has the opportunity to work with the CF in the future, to do so!"

In recognition of Ms. Rocquin's significant work with the CF, CAOT selected Megan to lay a wreath on behalf of CAOT at the 2010 Remembrance Day ceremony at the National War Memorial in Ottawa.



COLUMN EDITOR: REGINA CASEY

Occupational perspectives in mental health

Regina Casey

Welcome to the new column Enhancing Practice: Mental Health. A sincere thank you to CAOT, the OT Now Editorial Board, and Brenda McGibbon Lammi for creating this opportunity to learn and advance occupational therapy practice and research in mental health.

In 2004, Krupa and Clark said: “[t]hese are exciting and challenging times for occupational therapists working in the field of mental health” (Krupa & Clark, 2004, p. 69). Fast forward to 2011, and, in many ways, we experience a similar sense of excitement and challenge in advancing such agendas as developing recovery-oriented services, facilitating social inclusion and stigma reduction, and advocating for occupational justice; important areas for occupational therapy and mental health. The Mental Health Commission of Canada (MHCC) in 2007, created a framework/structure to guide improvements in mental health services. An exciting range of projects has already emerged, including the publication of a Canadian mental health strategy, *Toward Recovery and Well-being* (MHCC, 2009), a framework for working with children and adolescents, the Evergreen Project (Kutcher & McLuckie, 2010), and other projects such as the Opening Minds anti-stigma campaign, and the At Home/Chez Soi homelessness initiative. Many of you are making equally important advances in your daily practice (in a variety of roles) with clients and their families.

Moving forward, there will be many opportunities for us to contribute in leadership and direct care roles, advancing an occupational perspective in mental health practice, policy,

and research. As we launch this new column, we want to hear about your successes, passions, and key learnings; these will equip us to embrace the challenges ahead and lead the way to better mental health with and for our clients.

If you would like more information or have a submission, please contact the column editor Regina Casey at regina.casey@gmail.com.

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A CAOT Network for Occupational Therapists working in Mental Health and Addictions was launched in 2010. Information on this Network is available for CAOT members on the website (www.caot.ca>>Professional Development>> Network Exchange).

Toward recovery-oriented mental health care: Next steps for occupational therapists

Catherine White, Regina Casey and Shu-Ping Chen

A recovery-oriented approach to the development, provision, and evaluation of mental health services has gained national and international attention as the predominant paradigm, and is acknowledged as such by the Mental Health Commission of Canada (Kirby, Howlett, & Chodos, 2009). Recovery is facilitated by enabling people with mental illness to build on strengths and strive toward their potential as it relates to living, learning, socializing and working (Anthony,

2002), even though symptoms may persist. Occupational therapists have long acknowledged the influence of the recovery approach in mental health practice and the resulting opportunities for improved client outcomes (Krupa & Clark, 2004). Defined as “...a journey of healing that builds on individual, family, cultural and community strengths, and enables people living with mental health problems and illnesses to lead meaningful lives in the community, despite any

limitations imposed by their condition” (Kirby, et al., 2009, p. 8), recovery clearly shares its philosophy of client-centred care and meaningful community participation with occupational therapy.

Mental health services in Canada are in the early stages of adopting the recovery philosophy and there are ongoing challenges associated with moving the agenda forward (Piat et al., 2008). Some guidelines for recovery-oriented services are emerging (Farkas, Gagne, Anthony, & Chamberlin, 2005), but efforts at knowledge translation have been frustrated by a lack of leadership, limited partnerships between knowledge producers and knowledge users, and the emergence of a wide range of knowledge products that are not sensitive to the varying contexts in which the knowledge is to be applied. The result is inconsistent applications of recovery-oriented services across the country.

Informal discussions related to these topics resulted in the three authors sharing how we hoped to critically conceptualize recovery, and perhaps shape the process through our doctoral work. We had the opportunity to share our views, and collaborate with others with similar goals in an extended discussion with over thirty participants at the CAOT national conference in 2010. The results, which produced more questions than answers, are shared here.

Extended discussion

As the presenters at the extended discussion, we shared the challenges of integrating recovery principles in various settings:

1. Acknowledging that appropriate housing is a significant contributor to recovery, author Cathy White’s study, “Enabling recovery in a custodial group home for individuals with mental illness: A case study” explores the culture of a group home, and analyzes its compatibility with a recovery vision.
2. Author Shu-Ping Chen’s research is focusing on in-patient mental health services, and the inherent tensions of the setting that make it challenging to integrate a recovery focus. Her study, “Recovery-oriented services in in-patient settings” will culminate in an education program, highlighting the staff competencies necessary in this setting.
3. Author Regina Casey analyzed the recovery focus in some innovative community-based settings. Her presentation, “Three programs from Vancouver, BC that integrate recovery and occupational therapy” explored recovery in the context of; a) Spontaneous Human Combustion, theatre classes held in partnership

with occupational therapists and community court staff, b) Success Stories, a series of DVDs featuring the experiences of mental health consumers on eleven topics such as quitting smoking, housing, and returning to school/college, and c) ConKer, a program to engage persons with mental illness in the research process.

The presenters shared their enthusiasm for the new recovery-oriented occupational therapy practice tool, Action over Inertia (Krupa et al., 2010) and the presentations highlighted challenges and facilitators to recovery and laid the groundwork for small-group discussions based on three questions (summaries of which are shared here with permission from the participants):

1) Are recovery principles integrated at your practice setting?

Most participants indicated that they did integrate the recovery approach in their practice settings with mixed success. For example, some participants said they were “doing it” (although specifics were not clear), and “staff and clients are pleased with the outcome.” A noteworthy concern was “roll back,” the loss of initial significant success in integrating recovery caused by a lack of systems-level leadership and the strong and sometimes contradictory influence of the medical model. One group identified recovery as a “more effective way to connect with and enable clients,” supporting therapists to be more client-centred and better able to focus on health promoting activities. Overall, the recovery approach was seen as positive and something for occupational therapists to strive toward in the provision of mental health services.

2a) If yes, what key factors influenced this transition?

Unanimously “stakeholder involvement” (including clients, families, staff and management) in all aspects of the change was cited as the key to success. Participants embraced recovery as having a “similar underlying philosophy” to occupational therapy, which eased its implementation. Some workshop participants had organized a retreat to vision the change and identify how their mission/mandate would need to be different. One group was able to “consult with Boston University [renowned leaders in psychosocial rehabilitation] who took on the responsibility for implementation.” Both “top down” and “bottom up” approaches were mentioned. Some participants began to listen to clients who were unhappy with their service and others had the idea as a team and began

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with a literature search on the topic. Importantly, participants cautioned that it could take a long time to effect change (one group cited a modest five years), but much depends on leadership. Goal attainment provided an impetus for change and offered a tool for evaluation.

2b) If no, what challenges/barriers exist?

“Resistance to change and lack of leadership or ‘buy-in’ from management” were difficult challenges to overcome, with “managers sometimes agreeing to change but not following through”. “Misconceptions about what is recovery” by staff and clients adds to the challenge. Different philosophical approaches amongst team members (medical versus rehabilitative) remains an issue with no consideration of how to bring these approaches together. “Developing recovery-oriented services in in-patient settings” is seen as profoundly challenging, often due to the clash of philosophies, such as safety versus risk-taking. “Time constraints” were seen as a barrier to the delivery of recovery-oriented services, and service providers are not commonly afforded the time to overhaul programs. Finally, participants warned about assumptions as they stated that “a lot of what we said we were doing, in reality we were not doing.” They concluded that recovery “has to be an attitude of the heart.”

3) As we move forward, what suggestions do you have for building the structure to pool our efforts?

Participants highlighted the need for leadership and pooled resources. There is a need to be aware of what others have done, such as the transformation of services at the Centre for Addictions and Mental Health (CAMH) that accompanied the introduction of recovery-oriented electronic documentation (Clark & Paterson, 2008). In addition, it was identified that “technology remains underutilized as a means of connecting like-minded occupational therapists”.

We have much to do in the areas of gaining conceptual clarity, bringing clinical questions forward, forming reciprocal partnerships to enhance knowledge translation and sharing practice successes as a cautionary note was offered: “It is all assumptions, as little about recovery is proven.” A concern about losing many occupational therapy mental health positions in the United States was also expressed as “occupational therapists fear loss of identity due to impending overlap with our role - we need to embrace the challenge and lead.” This call to leadership was acknowledged as the means to integrate occupational therapy into recovery-oriented services.

Conclusions

In April 2005, Karen Rebeiro-Gruhl posed the question: “The recovery paradigm: Should occupational therapists be interested?” (Rebeiro Gruhl, 2005, p. 96). Clearly, we are indeed interested and ready to take on the challenges that lie ahead. New approaches are often slowly adopted into practice. Occupational therapists can play a key role in moving recovery-oriented care forward by pooling resources, using

technology and integrating consumer views, but we urgently need to collaborate to maximize possibilities. In an effort to take some initial steps in moving forward a CAOT network, Occupational Therapy and Mental Health (OTMHN) has been formed, please contact Liz Taylor (liz.taylor@ualberta.ca), OTMHN chairperson, for information.

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COLUMN EDITORS: JOSÉE SÉGUIN AND
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iDevices and occupational therapy

Heidi Cramm, Josée Séguin and Roselle Adler

iDevices have gained immense popularity in mainstream culture over the past few years. It is no wonder; this technology enhances productivity at home, work and school, it expands social networks, and offers a multitude of recreational opportunities. It is evident that iDevices can be important therapeutic tools to use in occupational therapy. For example, use of iDevices has been described as a “life changer” for individuals with autism and the adults who support them, mitigating anxiety and frustration while supporting communication, transitions, and participation (Bascaramurty, 2010).

While such innovations can enable occupations in previously unthinkable ways, keeping up with the advancements of this technology can be challenging and overwhelming in daily practice. Some may not consider this technology in their practice due to time constraints and/or lack of funding. This article is intended to share current knowledge on iDevices so that occupational therapists will have options and strategies to explore this exciting technology with clients and their families.

Key Terms

iDevices is an unofficial, general term that refers to any portable electronic devices marketed by Apple such as iPhone, iPod and iPad (pcmag.org).

App – refers to a software application that can be loaded onto a portable device such as an iDevice.

iTunes is an application used to play and organize digital music and video files. This application is also the interface to manage apps on iDevices.

Wi-Fi provides wireless Internet access using wireless router signals.

3G provides wireless Internet using the mobile broadband access to laptops, phones and iDevices. In order to connect using 3G technology, the user needs to be in cell phone coverage area and pay a monthly fee.



Choosing the appropriate tools for clients

iDevice features

An occupational therapist should first assess each client’s occupational performance needs and priorities, and their social and physical environment to clarify if an iDevice might be appropriate. When considering an iDevice, the occupational therapist must consider which apps might support performance and practical issues such as upfront and ongoing costs, environmental support to maintain and secure the device, Internet access, and accessibility features.

Most iDevices can be purchased with a range of memory capacity, case, charger, microphone, and camera connection kit for under \$1000 (CDN). It is ideal to purchase one iDevice per client as the device is highly personalized and it is challenging to maintain generalization. If a client is ambulatory and doesn’t have a physical disability that limits their ability to use the device or a visual impairment, then the portability of the iPod touch is optimal. Moreover, if a client has a more involved disability with physical and visual needs, then the iPad might be a better choice given its larger size and built-in accessibility features (Sailers, 2010).

Occupational therapists can assess the client’s performance to determine which accessibility option will suit each client. Added features such as switch controls, mounting devices, and speakers can be acquired to optimize access. Hardware-based options for switches can be purchased to help the client physically access the iDevices (e.g., Spacerkraft’s iPod switcher, RJ Cooper’s big iPod remote, & Technical Solutions’ iscanmp3). Switch interfaces can be used in conjunction with apps designed for switch use such as RJ Cooper’s iPad switch. Changing the programming within the devices to ease the interface operations can also be done using apps like Gesture Player and Leech Tunes (Buchanan, 2010). Apple provides a website of the accessible features for all of their devices including voice-over, braille, zoom, and closed captioning (<http://www.apple.com/accessibility>).

A stylus is a computer accessory that acts as a writing implement for iDevices and other platforms and they come in a variety of shapes and sizes. Options are available to help bypass typical finger access with a pen stylus, finger stylus, tech gloves and/or mouth stick. There are also a variety of options available from homemade to higher end products to

improve accessibility. Some examples are Boxwave Stylus, Acade Stylus, Pogo Stylus, Techtouch Glove and Aglove. The differences between the products are the style, length, grasp, thickness and number of uses. For example, the Hard Candy iPad Stylus and Ballpoint Pen Combo has a pen at one end and a stylus at the other. As well, possibilities for mounts are varied and are widely available for any consumer; options include desk, car, cabinet, headrest, and table mount attachments.

Integrating apps in occupational therapy

Apps can be incorporated into an intervention plan for clients in rehabilitation, long-term care, community, home and

mental health settings, to name a few. Apps can be suitable for a range of clientele from pediatrics to geriatrics. By no means exhaustive, Table 1 identifies some key occupational performance issues and some examples of apps that could be incorporated into an intervention plan. Some apps may support more than one occupational performance issue; for example, a visual schedule may support both organization and self-regulation. Some apps have a web-based interface meaning that information can be managed using a full-sized keyboard and computer monitor. Most apps can be installed on all iDevices, with five installations permitted per app purchase. Data can be automatically updated across devices for some of the apps. Others allow the user to invite others

Table 1. iDevice apps for occupational performance issues.

Type of Performance Issue	If the client needs, wants, or is expected to	Consider apps such as	With this app, the client can
SOCIAL & LEISURE	socially engage with others	favourite card or board game (Uno, Yahtzee, Scrabble, cribbage, Monopoly, etc.)	play against others in real time (with Internet connection)
	engage in leisure occupations	iBooks, activity books (Sudoku, wordsearch, crosswords, etc.), puzzles (jigsaw, tiles).	turn the pages of a book, move puzzle pieces into position, or complete activity books
	develop social interaction and independent living skills	Everyday Social Skills, Model Me Going Places, Stories2Learn, Everyday Skills, Living Safely	watch a video instruction and/or social story book of common social interaction skills
COMMUNICATION & LEARNING	communicate with others in text	Assistive Chat, Type n Talk, Easy Speak, iSayIt, Locabulary,	enter text for the app to read aloud; access favorite expressions
	communicate in American sign language	ASL signs, iSign, Sign 4 Me	look up signs for common words and phrases
	communicate with others using symbols	iConverse, Proloquo2Go, AACSpeechBuddy, iComm	tap on a symbol to express needs or thoughts
	communicate in Braille	iBraille, Braille Pro	translate English to Braille
	participate and listen to a conversation	soundAMP R	soften loud sounds, or amplify soft and medium sounds
	convert text to speech	Read 2 Me; Web Reader	read any text file or Google document; read web pages
	write notes or e-mails	Dragon Dictation; TextExpander	dictate a note/email to be converted to text (Dragon Dictation); expand abbreviations to full words/phrases (TextExpander)
ORGANIZATION	remember tasks/errands to complete	Cozi, 2DO, RTM, EgretList, To Do's, Awesome Note, PictureScheduler; myHomework	receive by e-mail weekly schedule reminders of specific tasks; create to-do lists; track homework and assignments
	manage time	Time Manager, Eternity Time Log	run timers on activities to verify how/where time is spent

HEALTH MANAGEMENT	remember personal health information	MyMedical	integrate all medical information
	remember when to take medications	MedAlert	set up medication schedule and set reminder alarm on the device to alert of schedule
	track specific health information	Health Tracker	track BMI, blood pressure, and blood sugars; view graph of progress, and e-mail reports
	track a personal or therapeutic goal	Goal Tracker, GoalsKeeper	track progress towards a goal
	track a behavior	BehaviorTrackerPro	track ABC data, frequency, and duration
	make personal and health information accessible in case of an emergency	Close Call	save information as iDevice wallpaper
HOME MANAGEMENT	meal plan	MealBoard, MiMeals	enter recipes and ingredients which can then be migrated to a shopping list
	grocery shop	Grocery Gadget, Shopping Digit-Eyes	set up reusable grocery lists; scan a barcode with the camera and hear a description of the item
	budget	HomeBudget, Budget Tool	plan and track budget
	pay bills	Bill Reminder	receive reminders of when bills are due; track bills
	control items in the environment	Mobile Mouse, Remote, environmental control unit interfaces (most manufacturers have an app)	use iDevice to control computer or iTunes; operate environment control system
SELF REGULATION	practice relaxation strategies	Serenity, Relax, WhiteNoise	access relaxation sounds
	manage transitions	Time Timer, Take Turn Timer	program visual timer to verify time remaining until transition
	develop or follow a routine	iPrompts, Visules, First Then Visual Schedule	be prompted by audio and/or visual for schedule items

into a group so that app data can be shared which can be very convenient for activities such as shopping. Basically, the right app depends on the particular client and the nature of the occupational performance issue.

Where can apps be purchased?

Apps are available in the App Store, which can be found on the Internet under iTunes, the software that allows the user to manage iDevices. According the Apple website, there are over 300,000 apps in the App Store, with more approved on a daily basis (Jan. 23, 2011). With that many apps, it is easy for both occupational therapists and clients to feel overwhelmed. Apps can be found for just about anything by browsing through the App Store categories or by searching the App Store using terms that may be in the app title. Websites like atmac.org, www.spectronicsinoz.com/article/iphoneipad-apps-for-aac and slpsharing.com/app-resources/help have many apps that would be of interest to occupational therapists. Once the app has been selected, it can be purchased using and Apple ID and password, which is all you need if it is free.



If there is a fee, the app may be purchased with a credit card or by redeeming an iTunes gift card. Referring to the Getting Started Guide on the Apple website is helpful to navigate through the system. Apps can be downloaded onto a computer and then transferred onto an iDevice, or downloaded directly onto an iDevice.

To use Wi-Fi, the iDevice needs to be within range of a wireless router or network and the user must have password access if trying to connect to a secure network. Although an iPod or iPad can be used regardless of access to wireless Internet, some apps need to be connected to the Internet via Wi-Fi or a cellular network to function. An iPhone or iPad can be used with 3G through a monthly expense data plan to allow for Internet connection to run certain apps and to text message.

Apps are for occupational therapists too!

Apps can assist occupational therapists optimize their efforts when they are away from their computers. Having access to electronic education or resource information can be simplified through use of a secure document storage and share folder app like DropBox, which allows the user to invite others to share folders. This can limit the need to print or carry paper resources. A global positioning system (GPS) and map apps can also assist with travel to clients' homes or schools. Recording expenses and mileage for tax purposes can also be tracked with apps.

Challenges of iDevices

Despite their potential, iDevices are not a panacea. For example, clients who have difficulty controlling the rate and fluidity of hand movements may find it difficult to consistently use an accurate sweeping finger motion to access the apps. Furthermore, apps have their own keyboard settings and it would be difficult to integrate all of them for accessibility. Word processing adaptations can be limited when compared to the possibilities of a personal computer. Although the cost of an iDevice can be a fraction of traditional communication devices, monthly data plan fees may be difficult for clients to afford. Becoming comfortable with using iTunes to download, sync, and organize your apps can also feel overwhelming to many who are not familiar with this computer program.

Occupational therapists should also be aware that not all apps are created equal. Some apps do not allow for customization of settings. Some are set up in ways that can feel counter-intuitive or visually cluttered. Others require the input of basic information for the initial set-up which may be time-consuming and frustrating to the user.

Like any form of assistive technology, there are challenges associated with clients accepting a new device. iDevices are an

innovation that is popular across many populations and may serve to decrease the experience of stigma often associated with the use of an assistive device. Nevertheless, there is a fair amount of upfront learning to know how to navigate and customize the iDevices and clients may struggle to troubleshoot the technological glitches that will likely occur.

Conclusion

Not only have iDevices begun to offer occupational therapists new opportunities to enable the occupations of themselves and their clients, but Google and Android versions are quickly being developed. Becoming literate with iDevices is essential if occupational therapists are to offer informed and effective 'interventions' to clients and families. Given the explosive growth of these devices and their apps, no occupational therapist can keep abreast of all the apps that are flooding into the App Store every day. It will become increasingly important to identify and become connected with people who would be the 'go-to' people within our communities, drawing on the knowledge of clients and professionals alike. Within our occupational therapy community, we can work to this end by sharing or seeking information about the new technology and their applications. As readers, you also play a role in this knowledge translation. If you would like to share your experiences and/or research initiatives, please send us an email and tell us about your challenges and successes.

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Technology can enhance the lives of many of our clients, though, for most of us, keeping current on technology can be overwhelming when added to already full workloads. Sharing information between occupational therapists, to build on our individual practices and expand our knowledge, is essential if we are going to keep up with everything that is available to us and for our clients. With this in mind, the column editors for *In Touch with Assistive Technology* and CAOT are developing a web page for you to share apps that you are finding useful with your clients.

For more information, or to add to the resource page, please contact either Roselle Adler at radler@octc.ca or Josée Séguin at jseguin@octc.ca.

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COLUMN EDITOR: PATRICIA DICKSON

More than raised toilet seats: Holistic orthopedic occupational therapy

Michael Ivany

Background

Gina (pseudonym) reported that she managed well for many years living independently with rheumatoid arthritis. That changed when Gina fell from her step stool. When she regained consciousness, she dragged herself to the telephone and got help. After surgery to fix her fractured hip, Gina refused to get up on the standing hoist with physiotherapy staff stating she felt like she almost fell on the machine and was not going to risk the pain of another fall. How would an orthopedic occupational therapist address her fear? Can a raised toilet seat really be used as a motivational tool?

Most occupational therapists have met a patient like Gina who demonstrates the complexity that our work involves. From my experience on orthopedic inpatient units in Canada and New Zealand, orthopedic occupational therapists are not always using the breadth of their skill set to regularly address all of the needs of the patient, including mental health needs. Orthopedic occupational therapists are in a position to provide greater quality of care by addressing, in addition to physical function, the mental health of the patient. This comprehensive

approach will not only facilitate a safe discharge, but may also lead to decreased hospital length of stay. This paper provides evidence to support an increase in the breadth of practice of occupational therapists working in orthopedics and optimal occupational enablement and describes the comprehensive roles of occupational therapists, practice leaders, patients and their families to ensure all needs are met.

Evidence

Orthopedic medicine is a fast-paced work environment with high patient turnover. Occupational therapists focus on assessment, brief intervention, equipment recommendation, and/or activity adaptation. This primary focus on self-care activities is justifiable (Edwards, Baptiste, Stratford, & Law, 2007). Research, however, has identified that this narrow focus may be insufficient as up to 65 percent of patients do not recover their pre-fracture ambulatory status within a year after hip fracture (Young & Resnick, 2009). In addition, impairments in motor skills, activities of daily living and instrumental activities of daily living post-hip fracture have been well documented (Edwards, et al., 2007). Poor mental health has also been linked to poor functional recovery from a hip replacement (Kirk-Sanchez, 2004; Edwards et al., 2007; Young, Brant, German, Kenzora, & Magaziner, 1997). It has been shown that gains made in rehabilitation may be negated if mental health is left unaddressed (Petrella et al., 2000). A study of patients post-hip fracture showed comparable or improved outcomes for individuals with depression, amotivation, or up to a moderate cognitive impairment who received appropriate treatment when compared with the general population (Lenze, 2007). In addition, research indicates that mental health interventions can reduce length of stay after hip fractures by two days and decrease overall costs (Holmes et al., 2010). Alternately, hospital stays are known to increase after hip fracture in association with depression, dementia and delirium (Holmes et al., 2010). This evidence suggests a holistic role for occupational therapy that includes mental health interventions should be considered on orthopedic units to maximize functional outcomes and decrease length of stay.

Poor detection of mental health problems is a preliminary obstacle (Gustafson et al., 1991); it is a common misconception that mental health problems in older patients are an issue for



mental health services (Holmes et al., 2010). Occupational therapists are prepared and in a position to address basic mental health needs. This role may also be particularly useful in cases of anticipated delayed discharge. Anecdotal reports by Glasby, Littlechild and Pryce (2004) identified that the most complex cases of delayed discharge involved older individuals with mental health problems. Occupational therapists have both the practical and theoretical knowledge base and the mandate to identify and address mental health needs and/or to refer to an appropriate resource.

Operationalizing occupational therapy treatment of mental health interventions is difficult for many therapists, practice leaders, clients and family members. The following are suggestions of actions for occupational therapists, practice leaders, occupational therapy colleagues, patients and their families that could be taken to meet the comprehensive needs of orthopedic inpatients.

Practice implications

Orthopedic occupational therapists can:

- Provide information about mental illness, anxiety, stress, or anger management. Assess the need for more intensive or specialized mental health support and make referrals as appropriate.
- Identify activities that will improve self-esteem, motivation, and coping skills. Train individuals in relaxation techniques (visualization, progressive muscle relaxation, or deep breathing) or assign this task to support personnel.
- Support patients in setting goals or assign this task to support personnel.
- Assist patients in identifying fears of falling, perceived barriers to wellness, and moods associated with these barriers. Set-up safe environments for reality testing (through simulation, role-plays, etc.) to distinguish between actual and perceived barriers. Track patients' mental attitude and identify thoughts that promote their sense of self-efficacy (Allegrante, MacKenzie, Robbins & Cornell, 1991). Patients with hip fractures identified that their own mental attitude facilitated their recovery (Young & Resnick, 2009).
- Include family or friends, upon patient request, in rehabilitation programming to support the patient. Patients identified verbal encouragement received from family and friends contributed to their optimistic attitude towards rehabilitation (Young & Resnick, 2009).
- Identify individuals who may have poor levels of social support or difficulty accessing social support due to injury. Patients with hip fractures identified that they wanted more spiritual or social support to facilitate recovery (Young & Resnick, 2009). Identify situations where caregivers are providing too much physical support which can limit long term functional recovery (Kirk-Sanchez, 2004).
- Talk to other occupational therapists in orthopedics about the holistic nature of their practice.
- Record the amount of time spent addressing mental health components and report to managers when there is insufficient time to address mental health concerns with a patient. Ask managers to track the length of stay of these individuals.

Occupational therapy managers and unit managers can:

- Support orthopedic occupational therapists in professional development to address mental health needs.
- Facilitate peer consultation with occupational therapists with more mental health experience.
- Challenge orthopedic occupational therapists during performance appraisals to provide case examples of holistic practice.
- Support occupational therapists in defining their role as practitioners that treat mental health components. Role confusion and competing priorities negatively influences communication on orthopedic units (Atwal, 2002).

Occupational therapists working in other areas can:

- Be available to support and consult with peers; use this article to start a discussion.
- Facilitate in-services on the identification of mental health needs, brief mental health interventions, and when to make a referral. Use specific case examples of patients that could be admitted to an orthopedic unit.
- Share commonly used tools or forms that would relate to mental health interventions.

Patients and their families can:

- Identify past mental health needs and current concerns to their occupational therapist.
- Talk to an occupational therapist early about addressing feelings of hopelessness, disorganization, or difficulty with setting realistic goals.
- Talk to occupational therapy managers and unit managers if concerns were not addressed adequately.

Conclusion

Occupational therapists assimilate an array of information and create a client narrative, identifying past, current and future performance issues (Mattingly & Flemming, 1994). While it may be an obstacle when trying to describe our role in under thirty seconds, our strength is in our breadth. In orthopedic settings, occupational therapists need to be supported to employ elements within our scope of practice and integrate mental health interventions into routine clinical practice.

Orthopedic occupational therapists are poised to address mental health issues to decrease patient length of stay, facilitate a safe and comprehensive discharge from hospital, and provide a greater quality of care. Mental health issues are not being sufficiently addressed on orthopedic units. It is the role of occupational therapists working in orthopedics, orthopedic unit managers, occupational therapy program managers, and patients and their family members to make sure that mental health concerns are addressed sufficiently in an orthopedic setting. Individuals like Gina may require more support than the average patient; however, a raised toilet seat could open the door to a discussion regarding some of the concerns, fears and losses that Gina feels she needs to address before moving forward with her rehabilitation.

While raising toilet seats is an important part of our role, it is equally important that we rely on our breadth and target the components that significantly affect occupational disengagement. When orthopedic patients have increased sense of self-efficacy, have been referred onto appropriate mental health supports, and have felt like their mental health needs were adequately explored; only then will family members and patients know that their health concerns have been sufficiently addressed.

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COLUMN EDITOR: SANDRA HOBSON

Low vision and older adults: The role of occupational therapy

Colleen McGrath

Vision is necessary to engage in daily life. With the aging Canadian population, the rate of low vision conditions is increasing. Most occupational therapists that work with older adults, and not just those working in low vision rehabilitation, will encounter older clients with low vision. As such, occupational therapists need to understand the effect low vision has on occupational engagement in order to provide optimal client care. This article intends to provide occupational therapists with an overview of low vision, discusses the effect of low vision on occupation, proposes assessment tools that can be used in low vision rehabilitation, and provides treatment methods to enhance participation in occupation.

Demographic overview

The Canadian population is aging; seniors now constitute the fastest growing segment of the population in Canada (Health Canada, 2002). There is a particularly strong relationship between aging and vision loss (Horowitz, 2004). Vision impairment is one of the most common age-related physical impairments among adults older than 65 years of age (Horowitz, 2004). In fact, the fastest growing low vision group are older seniors (Elliott et al., 1997) and the majority of low vision clients are elderly persons between the age of 75 to 84 years old (Elliott et al., 1997). Given these population trends, it is important for all occupational therapists, and not just those who work specifically in low vision rehabilitation, to understand the impact of low vision on occupational engagement and be able to provide adaptations to enhance participation and safety.



Defining low vision and the impact on occupational engagement

Unlike typical vision changes associated with aging, low vision is defined as a “degree of visual impairment that cannot be corrected by eyeglasses or surgery and that interferes with daily functioning” (Laliberte-Rudman & Durdle, 2008, p. 106). The most common age-related low vision disorders include macular degeneration, glaucoma, and diabetic retinopathy (Horowitz, 2004). Low vision conditions are typically gradual in onset and result in decreased visual acuity, decreased depth perception, and poor visual accommodation (Tolman, Robert, Hill, Kleinschmidt, & Gregg, 2005). Low vision often restricts participation in meaningful occupations such as activities of daily living, instrumental activities of daily living, leisure, work, and social participation (Girdler, Packer, & Boldy, 2008). When individuals do not possess the necessary vision to engage in daily activities, they may experience feelings of isolation, functional dependence, depression, and loneliness (Kleinschmidt, 1996). In fact, low vision can profoundly affect the physical, social, and emotional well-being of older adults (Markowitz, 2006).

The role of occupational therapy

Occupational therapists who work with any older adult population will encounter, at some point in time, a client experiencing low vision. Unfortunately low vision is a commonly under-treated condition because health professionals, older adults, and their families too often accept low vision as an inevitable part of the aging process. When this occurs, the older adult does not receive the rehabilitation services required to address the functional consequences of low vision (Horowitz, 2004). With their specialized knowledge of occupation and expertise in task analysis, occupational therapists already have the unique skills required to work with older adults with low vision.

Low vision assessments

In order to understand how low vision is affecting occupational performance, a clinical assessment is required. There are a variety of standardized assessments that an occupational therapist working in low vision rehabilitation may use to assess

a client. This article, however, will focus exclusively on how an occupational therapist, who is not working in low vision rehabilitation, can integrate an evaluation of low vision into their typical assessment process.

Client interview: The client interview is where the occupational therapist can gain an understanding of the client's vision history, significant medical conditions, and pre-morbid occupational performance history. At this stage, it is also important for the occupational therapist to understand the current goals of the client.

An evaluation of the environment: It is important for the occupational therapist to assess the specific environment(s) where various occupations will be performed. The occupational therapist may consider evaluating the placement of furniture and appliances, lighting, glare pattern, and contrast in the visual environment.

An evaluation of occupational performance: Clinical observation is a key step to identifying the occupational performance challenges experienced by a client with low vision. The occupational therapist should observe the client in a variety of occupations, including those which the client needs to do, wants to do, or is expected to do. By observing the client engage in various occupations, the occupational therapist can establish where the client is experiencing barriers to performance. The occupational therapist may, for example, consider assessing the following areas:

- Self care. Observe your client applying makeup, applying toothpaste, eating, managing medications, and selecting clothing.
- Meal preparation. Observe your client cooking, cutting, pouring liquids, measuring, reading recipes, reading food labels, setting appliance dials, and setting timers.
- Home management. Observe your client grocery shopping, cleaning, ironing, maintaining the yard, and completing household repairs.
- Money management. Observe your client addressing envelopes, maintaining a checkbook, reading bills, and writing a cheque.

Low vision interventions

An occupational therapist who is working with a client with low vision will typically work alongside an ophthalmologist and a low vision optometrist, a social worker, and a low vision rehabilitation therapist (Scheiman et al., 2007). Occupational therapy interventions for older adults with low vision are commonly focused on compensatory strategies such as the provision of assistive devices as well as education and environmental modifications.

About the author

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Assistive devices: The provision of assistive devices helps to support the older adult's engagement in everyday tasks. These assistive devices range from low to high technology. It is important for occupational therapists to be comfortable with the types of low vision assistive devices available. The Canadian National Institute for the Blind (CNIB) (<http://www.cnib.ca/en/>) offers a product catalogue and online store where occupational therapists and their clients can view various assistive devices. Examples of adaptive technology include:

- Closed circuit television (CCTV). The CCTV is a magnifying system that uses a camera to project a magnified image onto a television screen or computer monitor. Individuals may use this device to magnify the text found on a bill they need to pay.
- Daisy playback device. The Daisy playback device plays audio files such as books or magazines for individuals with low vision.
- PenFriend talking labeler. The PenFriend is held over a pre-recorded label, and it plays back the message for any label (clothes, food, CDs).
- Hand held magnifying glass. The handheld magnifying glass is portable and provides different levels of text magnification. This device is useful for a variety of day to day tasks and can also be purchased with a light if added illumination is required.
- Medication dosette. A large print pill box with the letters of the week raised would allow an older adult to remain independent in medication management.

Education and referral: The occupational therapist may provide education for both the individual with low vision and the family. A referral to an agency or organization may also be required. The occupational therapist may:

- Refer the client to an organization such as the CNIB for individual and/or group counseling services that provide support to people as they adjust to low vision.
- Provide life skills training to help manage the essentials of daily living, with an emphasis on maintaining independence.
- Provide education and training on the use of the assistive devices and provide instruction regarding home modifications.

Environmental modifications: Low vision is an uncorrectable condition, and as such, modification to the physical environment and to routine patterns is often required to facilitate safe and independent engagement. Examples of environmental modifications or routine adjustments that an occupational therapist working with an older adult with low vision might consider include:

- Increase the amount of light available and/or the use of task lighting to decrease glare.

- Mount extension-arm magnifying mirrors on the walls.
- Keep walkways clear of clutter, cords, and/or throw rugs to minimize the risk of falls.
- Use contrasting coloured tape or paint to mark the edge of counters, sinks, bathtub, toilet seat, light switches, and stair treads.
- Modify the colours in the home to provide contrast.
- Stabilize furniture and appliances in natural traffic patterns.
- Develop and adhere to routines and patterns that increase efficiency of the task.
- Label containers, boxes, and drawers with raised letters, tactile labels, or labels in sharply contrasting colours.
- Develop a routine location for leaving important items (keys, wallet, purse, etc.)
- Mark the stove, oven, washing machine, dryers, microwave, and other appliances with adaptive markings to make controls more visible.

Conclusions

As the Canadian population ages and the number of older adults being diagnosed with low vision conditions increases, so too will the demands for occupational therapists that are knowledgeable in the field of low vision. Low vision is often accompanied by a myriad of other health conditions. As such, all occupational therapists working with an older adult population must be familiar with low vision conditions, how

to assess and treat low vision, and the effect of low vision on occupational performance in order to best assist their clients.

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A Hot Topic resource sheet on Low Vision is available to CAOT members on the website (www.caot.ca>>Professional Development>>Publications & Periodics>>Hot Topics). These resource sheets are compiled by experts and provide a list of references (journals, books, assessments, etc..) on specific topics.



COLUMN EDITOR: SANDRA BRESSLER

Sue Baptiste, CAOT Alternate Delegate to WFOT and I, as the CAOT Delegate to WFOT, had the privilege of attending the 29th WFOT Council meeting and the 15th WFOT Congress in Santiago, Chile in April, 2010.

Highlights of the 29th WFOT Council meeting

The name for the 'WFOT International Day', which occurred on October 27th, 2010 during Occupational Therapy month, was changed to 'World Occupational Therapy Day' at the Council meeting. World Occupational Therapy Day included a very exciting 24 hour webinar with presentations from all over the world, which WFOT members could attend at no cost.

The Council meeting also included discussion about policies on approval for and monitoring of occupational therapy educational programs. A motion was passed to develop a master plan to review and evaluate the existing organizational policies and procedures and to develop strategies to address the findings considering global higher education forces in the context of the diversity of member organizations.

The following Position Statements were approved at the Council meeting and can be found on the WFOT website (www.wfot.org):

- Client-centerdness in Occupational Therapy Position Statement
- Position Statement on Diversity and Culture
- Position Statement on Professional Registration
- Position Statement on Consumer Interface with Occupational Therapy

Other items of interest from the Council meeting include:

1. Anne Carswell, Ph.D., FCAOT, OT(C), OT Reg.(NS), Associate Professor and Associate Director at the School of Occupational Therapy at Dalhousie University in Halifax, Nova Scotia, was elected for another two year term as Vice President of WFOT.
2. The title for the document *Definition of Occupational Therapy* that was developed by the WFOT International Advisory Group: Occupational Science was changed to the *Statement on Occupational Therapy*.
3. WFOT continues to lead disaster preparedness educational workshops and dissemination of information.

World Federation of Occupational Therapists (WFOT) Update

Sandra Bressler

15th WFOT Congress 2010, Chile

The Congress occurred immediately following the Council meeting. Over 2000 delegates attended this conference including more than 100 Canadian delegates. More information can be found on the WFOT website about Congress proceedings. The 16th WFOT Congress in 2014 will be held in Japan.

Educational programs

WFOT is in the process of updating the Educational Programs section on their website and only information about WFOT-approved entry level occupational therapy programs will be included. The new website will make the process of updating information about educational programs easier.

Human Resources Project 2010

In May 2010, WFOT launched the results from the Human Resources Project. Ninety-three percent of member organizations responded to the questionnaire that enabled WFOT to generate its second global demographic scan of the occupational therapy profession.

National Congress on education of rehabilitation therapists, China.

At the end of July, Nanjing Medical University's Professor Li Jianan and the Chinese Association of Rehabilitation Medicine (CARM) brought together the first National Congress on the education of rehabilitation therapists in China. About 1,000 participants from all over the country and key political representatives attended this prestigious event that was part of three conferences. Among the foreign experts invited were Kit Sinclair and Nils Erik Ness, from WFOT and Sue Baptiste, CAOT President. They each gave a presentation about aspects of occupational therapy and their particular interest in supporting the development of national curriculum guidelines for the education of occupational therapists in China.

Just as in the WFOT Council Meeting that was held in Ljubljana, Slovenia, the respect that WFOT countries and the Executive have for Canadian occupational therapists and the CAOT was obvious. The Canadian contribution to the international community of occupational therapists is very well known and highly regarded.

Update from the COTF



What it means to receive funding from COTF: In the words of Linna Tam, 2009 COTF Master's scholarship recipient:

"When I started my graduate degree, I knew that I could not relocate my life in order to do pursue this goal. During the course of my graduate studies, my husband and I decided to start a family, which we were thrilled about, however, it would add to the challenging of going to school and working at the same time. As it turned out, the bulk of my research study was completed while I was on maternity leave. The logistical challenges of not being able travel to conduct my research were present, however, the funding I received from COTF supported me in other means while doing my study. The funding allowed me to complete my research at a time when I was not working and while learning to become a mom. My research was on the experiences of occupational therapists while engaging in shared-decision making with adolescent clients diagnosed with mental health difficulties. The study I completed contributed to the existing body of knowledge of the occupational therapists working in this highly specialized field, which has been lacking in the literature. Funding through COTF allows therapists to pursue research that is needed in occupational therapy while continuing to fulfill other roles in their lives."

Without the support of COTF donors, it is clear that Linna would not have been able to juggle her busy schedule – graduate student, wife and new mother! Her testimonial is an example of how your donation dollars are used to help occupational therapists just like you. Your donations are very meaningful to recipients. Please continue to give so that more occupational therapists, like Linna, can continue in their studies and research. Thank you!

COTF at the 2011 CAOT Conference

Conference is quickly approaching! COTF will be holding three fundraising events in Saskatoon:

1. Silent Auction at the COTF Booth
2. Live Auction at the CAOT Social
3. Lunch with a Scholar, with Debbie Rudman as the Scholar

For the auctions, COTF is looking for in-kind donations from individuals, universities and provinces. Items, such as crafts, jewelry, regional items, and paintings always do well. An income tax receipt will be issued to donors who provide proof of value of the item donated. Please contact skamble@cotfcanada.org to receive a donor declaration form.

Debbie Rudman's presentation is entitled *Striving to do Research that Matters*. The relevance of critically informed qualitative research regarding the situated nature of occupation promises to be inspiring and informative. Remember that a portion of the ticket sales is a donation to COTF. Tickets are not sold on site for this event.

Apart from the fundraising events, please remember to attend COTF's AGM. It will be held on Saturday, June 18 immediately after CAOT's AGM.

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.



Sleep and Dementia: Evidence-based Resources for Non-pharmacological Sleep interventions for Persons with Dementia

February 2011

In the next 20 years, over one million Canadians are expected to have some form of dementia. Research shows that many of those people will also experience significant sleep disruption. This sleep disruption will interfere with all aspects of cognitive, social and physical function. Problem sleep is one of the most frequently cited reasons for institutionalization of older adults with dementia.

A large part of the problem is the prevalent belief that a poor sleep is a normal part of aging. As a result, people do not recognize that sleep problems are treatable and they do not seek help. Also, societal ageism, older adults' denial of sleep problems, coexisting disabilities related to alcohol misuse, depression, isolation, and poor healthcare provider awareness all contribute to the under-diagnosis and under-treatment of disordered sleep in older persons and specifically, in those individuals with dementia.

Our team of researchers in the Department of Occupational Therapy at the University of Alberta, recently completed a structured review of the evidence for non-pharmacological sleep interventions. We found that there is conclusive evidence for the non-pharmacological sleep interventions of bright-light therapy, increased daytime activity and passive body warming. We also found promising, but insufficient, evidence for a range of other sleep interventions.

Our research team, lead by Dr Cary Brown, developed a Knowledge Translation website (www.sleep-dementia-resources.ualberta.ca) to provide stakeholders with reliable, evidence-based information about the relationship between sleep and dementia, and to help them access resources for assessing and managing sleep problems in older adults with dementia. A full report of our review and downloadable patient education brochures on different non-pharmacological sleep interventions is also accessible on the website.

Our team's next project is a survey of healthcare providers to gain insight into current practice and perceived barriers related to recommending non-pharmacological sleep interventions for persons with dementia. If you would like to be part of this study, or would like more information- please contact Dr. Cary Brown, Associate Professor, University of Alberta (cary.brown@ualberta.ca)



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www.sleep-dementia-resources.ualberta.ca