OCCUPATIONAL THERAPY NOW

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DESIGN & LAYOUT
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Everyday Stories

A pair of practitioners team up to investigate workplace safety

Andrea Dyrkacz and Lonita Mak

Andrea's story

Education: I decided that I wanted to be an occupational therapist in grade two. I watched a movie *(Reach for the Sky, 1956)* about Douglas Bader who lost both legs in an accident but became a World War II flying ace. The role of occupational therapy in his rehabilitation was briefly profiled and seemed really interesting and practical. My decision was finalized when I read *Willard and Spackman's Principles of Occupational Therapy* in grade six. However, I didn't actually meet an occupational therapist until I enrolled in the Bachelor of Medical Rehabilitation program at the University of Manitoba in 1978! I subsequently earned a Master of Divinity Degree from the University of Toronto. My thesis focused on Syrian mystical prayer and its influence on Russian religious and political history. Although my graduate work was not nearly as practical as my occupational therapy degree, it did help make me unbeatable in Trivial Pursuit.

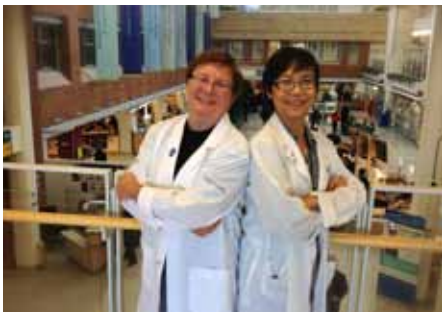

Photo by Linda Ngan.

Career path: I have worked in many areas of adult occupational therapy, from intensive care to the community. Occupational therapy has allowed me to be creative in my career choices, from managing volunteers in an AIDS hospice before antiretroviral drugs, to collaboratively developing an augmentative and alternative communication clinic, and now, combining clinical practice with interprofessional research and education. I am a member of the University Health Network (UHN) Krembil Neurosciences Program in Toronto, and find each day is unique and full of unanticipated challenges. I've also had the opportunity to be involved in a variety of CAOT initiatives, and have particularly enjoyed projects that seek to assist internationally educated occupational therapists (IEOTs) into Canadian practice, and the intellectual challenge of developing case studies and questions for the National Occupational Therapy Certification Examination (NOTCE). It has been wonderful to meet so many other occupational therapists from across Canada while volunteering for CAOT!

The most important thing I've learned: Intellectual curiosity is paramount. There are so many interesting problems to explore! Working closely with colleagues from other disciplines has been terrifically stimulating and has made me more aware of my particular world view as an occupational therapist.
Greatest influence: Archie Cooper! Her fearless, 'can do' attitude informed my practice.

Lonita's story

Education: After graduating from Form 7 in Hong Kong (essentially equivalent to a Canadian grade 12 or 13), I enrolled in the Professional Diploma Program in Occupational Therapy at the Hong Kong Polytechnic University. It was a structured three-year program that combined all of the essential academic subjects and a number of clinical placements. I obtained a BScOT in 1993 from the University of Toronto through their degree completion program.

Career path: I worked in a General Hospital in Hong Kong for four years, rotating through a variety of practice areas - burns, geriatrics, general medicine, spinal cord injury, stroke, orthopaedics and hands. These work experiences helped me to identify the area that I enjoy most: hand rehabilitation. I like the fast pace and the challenges, and I can integrate my interest in crafts into this specialized area of practice. I have also volunteered for CAOT, and was able to contribute my experience as an IEOT to developing case studies and questions for the NOTCE. Being involved in this process allowed me to see how different perspectives from both local and internationally trained occupational therapists can be seamlessly combined.

As a young and adventurous occupational therapist, I took advantage of the opportunity to travel and decided to immigrate to Canada after writing and passing the National Occupational Therapy Certification Examination. Although I initially moved to Vancouver, I was very fortunate to eventually obtain a position in the Hand and Upper Extremity Program at Toronto's University Health Network. In this program, I have had the opportunity to work with a dynamic group of hand surgeons, occupational therapists and physiotherapists. I completed hand therapy certification in 1998, which allowed me to expand my practice in hand rehabilitation through the use of non-traditional occupational therapy modalities.

Hobbies and interests: My interests are quite diverse. I enjoy walking, reading, craftwork (particularly pottery) and travelling. Most recently, I travelled throughout Asia and especially enjoyed Thailand.

Greatest influences on my occupational therapy practice: Although it might sound like a cliché, I believe that everyone I have encountered in my career has influenced me – my classmates, colleagues and clients. They have shaped me as an occupational therapist and as a person.

Coming together to investigate workplace safety

It started with a sore thumb - not an uncommon malady for a practitioner in a hand therapy clinic. Being an evidence-based occupational therapist, Lonita Mak turned to the literature to find out how other occupational therapists experienced work-related injuries. Her literature review was very short, as there was virtually no literature! What little existed simply made the assumption that occupational therapists had the same injury patterns as physiotherapists and nurses.

Knowing that occupational therapy was not the same as physiotherapy and nursing, Lonita approached her colleague at UHN's Toronto Western Hospital, Andrea Dyrkacz. After discussing our respective histories of workplace injury, we began a four-year, long-term and intense relationship, seeking to learn how Canadian occupational therapists are injured at work. Although not trained formally as researchers, the very act of engaging in a formal study seemed the equivalent of several graduate courses.

Armed with a UHN Allied Health Research Grant, and in conjunction with Carol Heck, a UHN allied health research associate, we surveyed English-speaking members of CAOT and received 600 completed and very detailed surveys. Indeed, results showed that occupational therapists were unique in their injury patterns, and that being a Canadian occupational therapist was a defining factor in many of the injuries.

After analyzing the binders full of data, we prepared for initial dissemination of the results. The first opportunities were at UHN's Allied Health Research Day and subsequently, at the 2010 CAOT Conference. Many occupational therapists shared their personal experiences of injury and asked what could be done individually and collectively to reduce the incidence of work-related injuries in Canadian occupational therapy practice.

While preparing a paper for submission to the *Canadian Journal of Occupational Therapy*, a request was made by the CAOT Board of Directors to submit a proposal for a Professional Issue Forum at the 2012 Conference in Quebec City. This invitation was exciting, as it offered an extended opportunity for discussion by CAOT members and other stakeholders related to the issue of work-related injuries in Canadian occupational therapy practice. We were frankly amazed that our simple research study was recognized by CAOT and had the potential to practically and positively improve the workplaces of Canadian occupational therapists.

After the completion of the study, our level of awareness regarding hazards in the workplace was heightened, and we had a new impetus to create change. The results of the survey helped inform our actions and have directed the prioritization of safety initiatives in our workplaces.

There have also been increased opportunities to join together with co-workers across various disciplines to recognize safety issues and advocate for change. For instance, policies have been revised related to the professional maintenance of equipment used at Toronto Western Hospital, such as scissors for splinting and wheelchairs used with patients. Ergonomically-appropriate furniture has been purchased for clinical areas, and additional bariatric lifting equipment has been obtained to ensure all practitioners can safely manage patient handling. Wheelchair seating systems have been replaced to reduce the risk of transmission of infectious agents. Practitioners and managers have tangibly and enthusiastically supported initiatives to improve patient and practitioner safety – a particularly gratifying outcome of that one sore thumb.

What have we learned?

- To effectively create change, it must be evidence-based. If the evidence does not exist, there is an opportunity to create that evidence.
- Nothing valuable can be done quickly. Every sustained change requires persistence and patience. You must be willing to be in it for the long haul.
- Change requires many active participants – there are allies everywhere that share similar problems and concerns and who can join to make any effort more powerful.

Editor's note: For more information about Andrea and Lonita's work on workplace safety, see the following references:

Brennan, M. , Dyrkacz, A., Mak, L., Stewart-Pyne, A., & Craik, J. (2012). CAOT Professional Issue Forum: Workplace safety and injury prevention in occupational therapy practice in Canada. *Occupational Therapy Now, 14* (4), 14-15.

Dyrkacz, A., & Mak, L. (2012). *Workplace safety and injury prevention in occupational therapy practice in Canada: Professional Issue Forum 2012 Report.* Retrieved from http://www.caot.ca/default.asp?pageid=4231

Dyrkacz, A. P., Mak, L.Y. M., & Heck, C.S. (2012). Work-related injuries in Canadian occupational therapy practice. *Canadian Journal of Occupational Therapy, 79,* 237-247.

OT Now encourages readers to share stories that inspire, describe successes, or highlight a unique contribution they have made. Send Everyday Story suggestions to: otnow@caot.ca

What's new

Resources to inform your practice:

- Free open access for CAOT members to the *Canadian Journal of Occupational Therapy, Occupational Therapy Now, American Journal of Occupational Therapy, Australian Occupational Therapy Journal, British Journal of Occupational Therapy, Hong Kong Journal of Occupational Therapy, Journal of Occupational Science, New Zealand Journal of Occupational Therapy, and Open Journal of Occupational Therapy.* To access these publications, go to: www.caot.ca > CAOT Members > Professional Development > Periodicals and Publications (http://www.caot.ca//default.asp?pageid=82).

- CAOT's OT Education Finder: www.caot.ca > Occupational Therapists >Professional Development > OT Education Finder (http://www.caot.ca/caot_cpe_search.asp?pageid=1391). This database contains a variety of resources from many providers that will assist occupational therapists to meet their continuing professional development and education needs. These resources include courses, workshops, books, journals, grant and scholarship information, coaching/mentoring services and more.

- CAOT's Information Gateway: www.caot.ca > CAOT Members > Professional Development > Information Gateway (http://www.caot.ca//default.asp?pageid=281). Information Gateway provides you with valuable tools and resources to help you with your pursuit for evidence-based occupational therapy.

- CAOT members receive a 25% discount on CAOT publications and a 20% discount on all books from Wiley-Blackwell. For details, go to: www.caot.ca > CAOT Members > Professional Development > Periodicals and Publications (http://www.caot.ca//default.asp?pageid=82).

Elder Abuse Initiative team recruiting trainers

CAOT has received funding from Human Resources and Skills Development Canada to provide interdisciplinary train-the-trainer workshops on managing situations of elder abuse. Seventy-five trainers are being sought. For more information about the initiative and the application process, go to: http://www.caot.ca/elderabuse The application deadline is June 1, 2013.

Rachel Thibeault appointed to the Order of Canada!

Rachel Thibeault, PhD, OT(C), has been appointed Officer of the Order of Canada by His Excellency the Right Honorable David Johnston, Governor General of Canada. She is receiving the honour in recognition of her work expanding the boundaries of occupational therapy and advocating on behalf of people with disabilities.

Established in 1967, the Order of Canada is our country's highest honour for lifetime achievement. For more information on the list of recipients, with short citations, go to: http://www.gg.ca/document.aspx?id=14904

Dr. Thibeault, a professor at the University of Ottawa, has completed participatory action research and community-based rehabilitation projects in the Canadian arctic, South East Asia, Central America, Europe, Africa and the Middle East. Frequently focusing on psychosocial care and community development in some of the world's most vulnerable, marginalized or traumatized communities, she epitomizes dedication to social justice and humanity.

Congratulations, Dr. Thibeault!

Canadian Association of Occupational Therapists 2012-2013 Midyear Report

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

Our mandate as the Canadian Association of Occupational Therapists (CAOT) is to promote excellence in occupational therapy. Our role is multi-faceted, addressing a broad array of factors and working with many partners that share our professional interests and goals. The summary below outlines the many strategies and activities underway that together help us to move forward our agenda to ensure occupational therapy is valued and accessible to the people of Canada.

Recruitment and retention

We have remained very active on a number of new initiatives to recruit and engage involvement in CAOT. For example, our new graduate 'membership bundle' has resulted in a spike in first-year members. This bundle allows new graduates to purchase a first-year membership, professional liability insurance and access to our new Trial Occupational Therapy Examination Manual (TOTEM) at a low reduced price. The manual contains a series of sample practice exam questions with answers and rationale that are designed to enable preparation for writing the National Occupational Therapy Certification Examination (NOTCE). The Manual also includes access to the Trial Occupational Therapy Exam (TOTE). The TOTE is a two-hour, web-based practice exam that reflects the content areas of the NOTCE.

The initiation of CAOT-BC led to a large increase in membership in the province of British Columbia. At the request of the British Columbia Society of Occupational Therapists with their closure in 2011, CAOT-BC assumed responsibility for provincial representation of occupational therapists in British Columbia. Services now offered by CAOT-BC complement but do not duplicate work of the Association at the national level. Recent activities include advocacy within the province related to issues such as dysphagia management, older driver safety and provincial auto insurance programs. A number of initiatives also have been undertaken to increase awareness of the profession in the province, including presence at a large health and wellness show in the Lower Mainland. The growing membership in CAOT-BC in our second year of operation attests to support for our work in British Columbia.

What I like about CAOT-BC

"Subscribing to the blog [http://caot-bc.blogspot.ca/] has been a great reminder of the breadth of occupational therapy. Reading member profiles reminds me of the great people who have chosen this profession and helps me see what our grads are up to...Brief updates on CAOT-BC representation and advocacy efforts reminds me that membership supports our collective voice on a range of practice issues...it's been wonderful to see the 'phoenix rising' as our new provincial association celebrates its first birthday."

- Dr. Catherine Backman

"I am thrilled with CAOT-BC for a number of reasons: the connectivity with CAOT is a win-win situation for me; the weekly blog updates - they are so informative, quick and easy to read and make me feel so connected to the issues within BC. Finally, the CAOT-BC managing director is responsive to the constituents, is holistic in her approach and working extremely hard on our behalf. Well done, CAOT-BC."

- Donna Drynan

" What I like about CAOT-BC:
- Alignment of professional support activities required in British Columbia with national experience, initiatives, infrastructure and support.
- Selection of the right person for the job! Evidence that the provincial director has a clear vision for practice support, supported by the provincial advisory group.

- CAOT-BC has rapidly developed an extensive communication strategy that appears to be impacting more and more occupational therapists and related stakeholders.
- Focus on professional development and support rather than the health of the professional association.

Can you tell...I like CAOT-BC a lot!"
- Caroline Ehmann

Member services

The provision of quality, innovative and valued services is important to our members. CAOT offers a broad array of tools and resources that assist members with their everyday practice. As an example, in spring 2013 we introduced Momentum, our new online mentorship module to assist occupational therapists to foster their professional growth through a guided reflective process. Momentum consists of four synchronous online sessions that explore the concepts of mentorship and provide an opportunity for members to be matched with a suitable mentor. A reflective workbook on mentorship is used to foster dialogue and encourage mutual evaluation of the expectations and efficacy of the relationship.

CAOT will also begin to offer the Occupational Therapy Exam Module (OTEM) this spring. This new resource complements the Trial Occupational Therapy Examination Manual to assist candidates to prepare for the NOTCE through online group discussion of practice questions facilitated by an experienced occupational therapist. Momentum and OTEM, as well as the new Trial Occupational Therapy Examination Manual, were developed and piloted by CAOT in partnership with McMaster University with internationally educated occupational therapists (IEOTs) as part of the Occupational Therapy Examination and Practice Preparation project (OTepp).

Other services offered for the first time in the past months include online access to the *American Journal of Occupational Therapy (AJOT)*. We are very happy to add *AJOT* to the many journals already offered as a benefit of CAOT membership. We also began our partnership with SAGE for the publication of our own journal, the *Canadian Journal of Occupational Therapy (CJOT)*. This partnership brings many benefits, including access to Highwire Press to obtain toll-free access to references cited in *CJOT* articles.

Following completion of a successful project funded by Human Resources and Skills Development Canada (HRSDC) for development and introduction of guidelines regarding prevention and management of elder abuse, CAOT received an additional grant to promote our work with an interdisciplinary audience. CAOT also received new HRSDC funding to translate our series of information booklets regarding older driver safety into Chinese (simplified and traditional), Italian and Punjabi for our diverse Canadian population. This information communicates the impact of normal aging and prevalent health conditions on safe driving and provides useful tips based on scientific evidence of high-risk situations and risk-reducing strategies.

A new model for professional liability insurance

In the fall of 2012, CAOT entered into a new type of agreement with our partners for offering low cost, comprehensive professional liability insurance. The insurance program offered by CAOT now has a 'group funded retention structure' that is similar to plans offered by larger health professional associations, such as for medicine, nursing and physiotherapy. While the program continues to guarantee all insurance limits and liability and policy coverage in the event of a claim, a portion of each insurance premium paid by members is allocated to support our group-funded deductible. This deductible fund ensures that monies are in place to cover legal and ancillary expenses if a claim is made against a member, as well as confirms clients receive appropriate and timely compensation for valid claims. However, with this model, instead of all profits being retained by the insurer, the insurance program offered by CAOT receives any funds with the deductible not used in the settlement of claims. As such funds become available in future years, we have opportunity to use these monies to enhance risk management materials and education for members, as well as potentially offer expanded insurance options. Our new model allows us to offer a program specific for our members to optimally protect their practice and their clients. Feedback from members can be used to determine future coverage options.

Bylaw revisions

With requirements to become compliant with new federal legislation governing not-for-profit organizations in Canada by the fall of 2014, changes are necessary in the relationship of current non-voting members with CAOT. Because the new legislation requires that all members have voting rights within not-for-profit organizations, we propose that current non-voting member categories of CAOT be given new status as associates, with no changes in services provided by the Association. Such non-voting member categories include any groups who do not meet the criteria for individual membership in CAOT, for example students and support workers. CAOT will continue to highly value the involvement of these groups and will actively recruit and engage their participation as associates. At the 2013 annual general meeting (AGM), members will be asked to vote on bylaw amendments that reflect these changes. We held forums across the country in the fall of 2012 to discuss the need for such changes and received overwhelming support for our proposal.

Public awareness

A number of initiatives were undertaken by CAOT in the fall of 2012 to promote awareness and access to occupational therapy. Billboard advertisements promoting our theme, "Because of occupational therapy... I can...," were posted in major cities across Canada. The winning entry of the 2012 gOT Spirit student campaign, submitted by talented students from the University of British Columbia, built on our theme by developing a creative and inspiring video. Check out their winning entry, "Because of OT...I can," at:

http://osot.ubc.ca/spotlight/ot-month-is-here-we-got-spirit/ We thank all students from across Canada who participated in the gOT Spirit campaign with a variety of innovative entries. Other CAOT members got involved in efforts to promote occupational therapy by posting "Ask for it" posters and bumper stickers that were supplied by the Association, and by using social media to share photos of our billboard advertisements.

CAOT was pleased to participate in the annual general meetings of provincial occupational therapy organizations across Canada in October of 2012. At many of these events we presented our joint citation awards to non-occupational therapists that have demonstrated significant support for the profession. The statements of our award recipients at many of these events serve as strong testimonials for the value of the services provided by occupational therapists.

Advocacy

To heighten awareness of occupational therapy prior to a CAOT Day on Parliament Hill in November 2012, our billboard advertisements were placed on the sides of city buses in Ottawa and in The Hill Times, the parliamentary newspaper. CAOT staff and board directors met with a number of members of Parliament on our "Day on the Hill." We received favourable support for our messages in our pre-budget submission to the finance committee regarding the role of occupational therapy to assist with labour market transitions for an aging workforce. We also promoted the role of occupational therapists in areas of health care that are under the jurisdiction of the federal government, including with the military and veterans, and in corrections. Our advocacy on these issues continued with sponsorship and hosting of a booth and presentation at the 2012 Military and Veteran's Health Research Conference, and with meetings with high-ranking officials from the Office of the Minister of National Defense and the Department of National Defense. Our work on the role of occupational therapy in corrections will continue with the hosting of a professional issue forum on this topic at the upcoming 2013 CAOT Conference in Victoria, British Columbia. A second professional issue forum at the conference will explore third party payers for occupational therapy services in Canada.

Standards

The latest version of the *Profile of Practice of Occupational Therapists in Canada* was published in fall 2012 and includes new and updated descriptive information regarding the practice of occupational therapy in Canada. This vital information is required for career development, and health human resource management and planning. It addresses issues such as the occupational therapy practice context, scope of practice, advanced competencies and career mobility.

Several new position statements were also published addressing topics such as elder abuse and pain management. A joint statement on the use of the occupational therapist title was developed with the Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO), the Association of Canadian Occupational Therapy University Programs (ACOTUP) and the Canadian Occupational Therapy Foundation (COTF). CAOT continues to work with ACOTRO, ACOTUP and COTF as members of the Occupational Therapy Council of Canada (OTCC) to work towards a common vision for the occupational therapy profession in Canada. A planning meeting was held in early 2013 to further the work of the visioning session held at the 2012 OTCC Forum. A leadership development session will be held at the 2013 Forum, followed by discussions on advanced practice in occupational therapy.

The second edition of *Enabling Occupation II* will be released in 2013 in English and French.

Work continued on the development of an accreditation process for occupational therapist assistant and physiotherapist assistant education programs. Following an initial pilot of the academic accreditation standards, the CAOT Board of Directors approved revised accreditation standards for a further pilot period of two years, ending September 30, 2014.

The OTepp project was able to extend existing funding to cover operational costs for another offering of the core curriculum for IEOTs. A shared tuition model is being trialed to promote future sustainability of the program. Proposals have also been submitted to seek out new funding for potential new expanded offerings for IEOTs in the future.

Conclusion

The success of our efforts as an association is dependent upon active and involved members. CAOT is us, and the work of the Association is our work; we all have a role in ensuring the quality and strength of our profession. Engagement of members within the Association is a significant priority. Together, occupational therapists in Canada can have a strong and powerful voice.

For more information on the above activities or regarding other initiatives of CAOT, please contact Claudia von Zweck at: cvonzweck@caot.ca

Equine-assisted therapy: Is it safe for our clients?

Jill E. Ball, Chad G. Ball and Andrew W. Kirkpatrick

COLUMN EDITOR: PATRICIA DICKSON

Introduction

Occupational therapists strive to enable occupation. We search for interventions that engage individuals in a holistic manner as they progress toward client-centered goals. Horseback riding can be a viable therapeutic activity used by occupational therapists with clients. Equine-assisted therapy (EAT), which is broadly defined as the use of horse-related activities for clients with physical, mental, cognitive, social and behavioral problems, has documented benefits (Gewurtz & Eccles, 2003). While the rewards of EAT for both clients and therapists are becoming evident, there are potential injury risks as well. Horseback riding in both the general population as well as in experienced riders is repeatedly identified as a high-risk activity that may result in significant injury.

When using horses in a therapeutic setting, there is a heightened responsibility to consider the associated safety profile of the intervention. The objectives of this article are to: (1) summarize the history of equine-related therapy, (2) describe the populations that may benefit from this form of therapy, (3) outline the potential therapeutic benefits of EAT, (4) explore the safety of horseback riding in the general population and (5) specifically explore the safety of EAT for our clients.

The history of equine-assisted therapy

The healing capacity of horses was first documented in the fifth century BC when injured Greek and Roman soldiers were placed back on their steeds to promote recovery (Benda, McGibbon, & Grant, 2003; MacKinnon, Noh, Laliberte, Lariviere, & Allan, 1995). On a more modern note, the concept of using horses as part of the therapeutic team began in 1952 when Liz Hartel of Denmark won a dressage-riding medal at the Helsinki Olympics after being diagnosed with poliomyelitis. After her victory she claimed horseback riding had helped in her physical recovery (Casady & Nichols-Larsen, 2004). National organizations, including the Professional Association of Therapeutic Horsemanship International (PATH Intl.) (formerly known as the North American Riding for the Handicapped Association [NARHA]) and the Canadian Therapeutic Riding Association (CanTRA), have subsequently become instrumental in this intriguing form of therapy. These organizations foster therapeutic equine activities and provide standardized training and certification for instructors who teach riding to children and adults with disabilities (http://www.cantra.ca; http://www.pathintl.org). Both PATH Intl. and CanTRA continue to grow, with PATH Intl. reporting more than 800 member centers in North America serving over 42,000 individuals with disabilities through equine-assisted therapy programs (PATH Intl., 2013).

Populations benefiting from EAT

The literature describes the benefits of therapeutic riding for clients with various conditions including cerebral palsy (Frank, McCloskey, & Dole, 2011; Zadnikar & Kastrin, 2011), developmental disabilities (Borioni, et al., 2012; Winchester, Kendall, Peters, Sears, & Winkley, 2002), multiple sclerosis (Bronson, Brewerton, Ong, Palanca, & Sullivan, 2010), mitochondrial disease (Millhouse-Flourie, 2004), autism spectrum disorder (Kern et al., 2011), sensory processing or modulation disorders (Candler, 2003), Down syndrome (Champagne & Dugas, 2010) and cerebrovascular accidents (Beinotti, Correia, Chirstofoletti, & Borges, 2010). Although the majority of publications describe therapeutic riding for children, supporting literature describe participants ranging from three to 84 years old, suggesting that clients of all ages, with a variety of abilities, may benefit from therapeutic riding.

Therapeutic benefits of EAT

The therapeutic benefits achieved by EAT primarily address three aspects of the person: physical, social/emotional and sensory processing. Occupational therapists engaged in EAT may consider these as components of occupational performance (Townsend & Polatajko, 2007). The physical benefits include improvements in gross motor abilities (Winchester et al., 2002),

balance (Kwon et al., 2011) and postural control (Zadnikar & Kastrin, 2011), as well as decreased back pain and improved body awareness (Hakanson, Moller, Lindstrom, & Mattsson, 2009).

The social and emotional benefits from EAT include care translation, socialization, conversation, self-esteem promotion, companionship, and affection stimulation (Rothe et al., 2005). Broad benefits such as an enhanced quality of life, emotional well-being, and improved social integration have also been observed in clients (Millhouse-Flourie, 2004; Champagne & Dugas, 2010).

Sensory processing is defined by A. J. Ayres as the ability to organize and integrate sensory information from the environment (1974). Meregillano (2004) explains that EAT offers a controlled environment where clients are not taught horse riding skills, but are instead provided with circumstances where their sensory processing can be targeted. The specific secondary benefits achieved through improved sensory processing include decreased sensory defensiveness, improved self-regulation, and increased attention, coordination, motor planning, communication, responsiveness, self-concept and self-esteem (Gewurtz & Eccles, 2003; Candler, 2003).

The available research primarily discusses benefits at a component level for the individual (physical, social/emotional, and sensory processing). As occupational therapists can target components of the person as part of an intervention plan to enable occupation, there are many occupational benefits that can come from EAT, although they aren't all specifically described in the literature. For example, the benefit of improved balance could help some individuals working toward their goal of independence and safety for activities of daily living. Furthermore, participation in horseback riding could also be recognized as a meaningful occupation in and of itself.

Safety considerations for horseback riding

Horseback riding can be a fun and relaxing form of recreation. However, there are inherent risks and safety precautions that must be considered. Jagodzinski and Muri (2005) outlined the severity of horse-related injuries specific to children in a recent review. Compared to other childhood injuries, equestrian-related trauma was more severe than all-terrain vehicle, bicycle and passenger motor vehicle crash injury.

Two studies (Ball, Ball, Kirkpatrick, & Mulloy, 2007; Ball, Ball, Mulloy, Datta, & Kirkpatrick, 2009) described the injury patterns associated with equestrian activities for adult trauma patients. Most injuries were caused by riders falling from a horse (60%), or being crushed (16%), kicked (8%), or stepped on (4%) by the animal. Patient injuries included chest (54%), head (48%), abdominal (22%) and extremity (17%) locations. As a result, the authors suggest that chest injuries have been previously underappreciated and therefore support the use of safety vests, in addition to helmets, in all injury prevention programs. Furthermore, Jagodzinski and Muri (2005) noted that hoof-kick injuries to children who were around but not actively riding horses represented 30% of pediatric equestrian injuries. Consequently, they encourage children to wear helmets when they are on or near a horse.

Is EAT safe for our clients?

While the benefits of EAT appear numerous, it is crucial to determine if the therapeutic advantages outweigh the potential risk for injury in this type of therapy. Although no specific risks have been published in the literature, national organizations promoting therapeutic riding address associated risks in several different ways. First, they have identified a list of participant contraindications based on rider abilities. NARHA established contraindications and precautions for clients that focus on disabilities or behaviours that may limit a one's ability to participate safely. These disabilities include, but are not limited to, uncontrollable seizures, pathologic fractures, complete quadriplegia, exacerbation of multiple sclerosis, and medication dosages causing physical states that are inappropriate for riding (NARHA, 1992). Secondly, NARHA provides and regulates instructor training, quality and certification. Finally, national organizations also provide facility accreditation to sites that support safe therapeutic riding experiences for clients.

Although contraindications to participation are infrequently identified within the rehabilitation literature, numerous environmental supports have been identified including side walkers, back riders, certified instructors, professional horse handlers and well-trained horses (Millhouse-Flourie, 2004; Rothe et al., 2005; Meregillano, 2004).

Conclusion

Current evidence describes the effectiveness of EAT with various client populations, as well as the potential therapeutic benefits of this modality at a component level. Improvements in physical, social/emotional, and sensory processing performance components achieved through EAT may contribute to a client's goals in enabling occupation. While there is a paucity of data on the safety of EAT, the safety profile of horseback riding can be extrapolated from examinations of the incidence and injury patterns of riders from the general population. Based on this data, significant consideration must be given to using both helmets and chest protection vests with our clients. In conclusion, therapists need to consider the safety of EAT for their clients. Future studies that explore horse-related injuries specific to EAT programs would be beneficial.

About the authors

Jill Ball, BPE, BHScOT, is an occupational therapist practising school-based occupational therapy in Calgary. She can be reached at: ball.jill@gmail.com

Dr. Chad Ball, MD, MSc, FRCSC, FACS, is an assistant professor at the University of Calgary. He currently practices hepatobiliary, pancreas, trauma and acute care surgery at the Foothills Medical Centre in Calgary.

Dr. Andrew Kirkpatrick, MD, MSc, FRCSC, FACS, is a professor in both the Departments of Surgery and Critical Care Medicine at the Foothills Medical Centre of the University of Calgary, and is Medical Director of Regional Trauma Services.

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Access to experiential learning: Key to transition to professional practice

Sue Baptiste and Pat McMahon

Introduction

Canada has 14 educational programs that prepare graduates at the master's level for entering occupational therapy practice. The human resource need for occupational therapists vacillates, but at any point in time, there are many vacancies across the country. As health systems change and roles emerge, this situation is unlikely to be rectified quickly, if ever. Two sources of an untapped workforce are internationally educated occupational therapists (IEOTs) and Canadian occupational therapy graduates who have been absent from practice and wish to return. For both of these groups, resources and support are needed to facilitate a successful transition to professional practice.

Context

Over the past decade, there has been increasing and frequent media attention that has exposed chronic underemployment of foreign-trained professionals and linked it to Canadian labour market shortages. Discussions have been shared in the media related to the barriers and serious problems experienced by new Canadians in making inroads to become established in their new country. This applies clearly to IEOTs who are attempting to enter professional practice in Canada. An educational program was developed to address these barriers. Early steps included an informal facilitated process, face-to-face, that helped participants to become prepared for taking the National Occupational Therapy Certification Exam (NOTCE). This became more enriched once funding was received. A short program was developed for internationally educated occupational therapists and physiotherapists working with mentors to prepare for their respective national certification exams and to consider issues related to entering the workforce. Outcomes of this micro-project created the foundation for a larger project which has been in existence since 2008, evolving from an Ontario-centred process to one that is now national in scope. Research was proposed, funded and undertaken by a group of occupational therapy investigators to explore the problems faced by IEOTs and to develop educational and networking resources to meet individual needs. Funding was received through the Government of Canada's Foreign Credential Recognition Program and the Ontario Ministry of Citizenship and Immigration. The curriculum of the Occupational Therapy Examination and Practice Preparation project (OTepp) reflects: the foundations of Canadian occupational therapy practice; is guided by the *Profile of Practice of Occupational Therapists in Canada* (CAOT, 2007, 2012) and the *Essential Competencies of Practice for Occupational Therapists in Canada* (ACOTRO, 2003, 2011); is built on principles of self-directed, problem-based learning; and can be accessed face-to-face or through distance learning (online in real time or through archived sessions). To date, participants have spanned the globe as well as from coast to coast in Canada. In addition, through the project process, the needs of re-entry candidates from the Canadian occupational therapy workforce became apparent and these individuals are now being included as participants. Details of this project and its curriculum will be reported elsewhere and have been presented at conferences. This paper will focus upon the philosophy, experiences and learning gained from the practicum experiences, which are essential components of the OTepp core curriculum.

The OTepp practicum experience

Participants enrolled in the Core Curriculum Module of OTepp must complete academic courses successfully to be granted access to the supervised practicum, the final course. Initially, there was a short and a long practicum experience, the first being more observational than engaged. Currently, the practica have been amalgamated into a longer experience consisting of 300 hours, which is completed preferably on a full-time schedule, or at a minimum of 20 hours per week, to optimize learning. Performance expectations align with an entry-to-practice level of competency. Several pre-practicum tasks are completed including: police check, tuberculosis testing, and demonstration of immunity to measles, mumps, rubella, and varicella zoster. Participant/preceptor matching is conducted based on geographic location and area of practice. Preceptors receive an orientation and support is available throughout the practicum from the course faculty.

It has been challenging to recruit placements for OTepp participants for a range of reasons. Most notably and understandably was the absence of professional liability and workplace safety insurance that was required of traditional learners by practicum sites. In 2010, the OTepp Core Curriculum Module was granted certificate status from the McMaster University Senate. This accomplishment eliminated the insurance dilemma and added credibility to the OTepp brand.

Despite having resolved the insurance issue, it continued to be difficult to recruit practica for OTepp participants. Potential sites reported being pressed already for resources due to existing fieldwork commitments for local and other Canadian occupational therapy students, as well as limited staffing ratios and changing conditions in the workplace during organizational transitions. At no time was there an intention to be in competition with colleagues at educational institutions. OTepp keenly appreciated the challenges associated with managers and practitioners meeting the demand for fieldwork for domestic students, and often explored creative strategies with sites to engage preceptors. This resulted in discovering unique supervision models and ways to involve part-time therapists as preceptors.

Since 2008, partnerships had been forged with many sites across the country to meet the needs for practica. Sites reported various motives for offering support, reflecting recognition of a recruitment opportunity and a sense of professional responsibility. Many preceptors stated that they valued having an opportunity to assist a colleague to return to practice, to learn about occupational therapy in another culture or to welcome a newcomer to Canada, sometimes being either a first or second generation Canadian themselves.

IEOTs overwhelmingly reported an increase in confidence once immersed in the opportunities of the supervised practicum. Previous experience was validated and when mingled with new practice exposure, helped to uncover gaps in knowledge and skills on which to focus new and future learning. Becoming part of the local occupational therapy community helped to spark feelings of hope and decrease feelings of isolation. Access to supported, experiential learning enabled some IEOTs from diverse cultural backgrounds to begin the process of acculturation to Canadian occupational therapy practice standards – a process vital to successful integration (Kolb & Kolb, 2005).

From the onset of the project, the OTepp investigators and project team have been conscious of adding new expectations and professional responsibilities to already extended resources when recruiting practica for internationally educated or re-entry colleagues. Many OTepp participants have expressed that one of the biggest barriers to transitioning to practice is the lack of access to a supervised practicum opportunity to acquire currency hours. The Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO) is involved currently in an extensive project to address provincial differences and streamline through a harmonization process (see http://acotro-acore.org/ for more information).

Some IEOTs and re-entry colleagues have access to networks that facilitate opportunities during the transition to practice. Others lack these vital networks and resources and find integration a daunting process. It is vitally important for the diversity and enrichment of the occupational therapy profession to welcome and support internationally educated and re-entry colleagues to find a path to (re)integration to professional work in Canada (Baptiste, n.d.).

Future considerations

From the experiences of the past five years, the OTepp team has been involved in developing many partnerships and participating in multiple initiatives that have resulted in some easing of the pressures on IEOTs, but by no means is the work complete. There would appear to be three major foci that relate closely to the preparation of IEOTs and re-entry occupational therapists that would inform the importance of direct experiential learning. The first is to uncover, explore and gain an enhanced understanding of the real experiences of people trying to re-enter practice from the perspectives of new Canadians as well as those who have been away from the profession for an extended period. The second is the parallel need to understand the experience of employers while recruiting, investing in and retaining IEOTs. Matters of cultural 'fit' go both ways - from the new to the established and from the established to the new. Finally, there is a clear need for innovative approaches to supporting all learners through the transition to professional practice. The work related to enabling IEOTs has opened the way to recognize the complexities of becoming a professional for anyone, be they comfortable within the professional and work culture or not.

The central importance of practicum exposure to occupational therapy work settings for IEOTs, and occupational therapists returning to practice should be maximized and can never be overstated. The ability to integrate into a workplace is paramount in embracing a professional self that recognizes personal worth, skill, learning needs and values.

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For country-wide information about occupational therapy job postings, outlooks, wages and other resources, go to:
http://www.workingincanada.gc.ca/home-eng.do?lang=eng
http://www23.hrsdc.gc.ca/.4cc.5p.1t.3onsummaryd.2tail%40-eng.jsp?tid=49%20

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SENSE OF DOING

COLUMN EDITOR: SHANON PHELAN

Mindfulness in the life of an occupational therapist: The 'being' behind the 'doing'

Lisa McCorquodale

Oh, I've had my moments, and if I had to do it over again, I'd have more of them. In fact, I'd try to have nothing else. Just moments, one after another, instead of living so many years ahead of each day (Kabot-Zinn, 2005, p. 17).

Occupations are a synthesis of doing, being, becoming and belonging (Yerxa, 2009). Being has been defined as the meditative or contemplative self, and represents the here and now of occupations (Wilcock, 1998). I consider 'being' the assemblage of feelings, emotions and thoughts that make up the essence of the present moment. Collins (2001) suggests that occupational therapists are uniquely poised to consider the complexity of inner lives (being) and the extent to which these inner states impact on the occupational process (doing).

Mindfulness is a practice that helps people deeply explore their being. It is characterized by an awareness of and enhanced attention to the constant stream of lived experience (Varela, Thompson, & Rosch, 1992). Mindfulness is the opposite of multitasking and mindlessness. Being mindful increases engagement with the present moment and allows for a clearer understanding of how thoughts, feelings and emotions influence health and quality of life. Mindfulness is most often cultivated through meditation practices, and may also be cultivated informally (e.g., through yoga, tai chi, walking, body scans, and mindful eating) (Kabot-Zinn, 2005). Empirical research and publications in the field have proliferated in the past few decades (Black, 2012). Researchers have found that mindful practices lead to structural and functional changes in the brain, resulting in, among other things, more sophisticated attention skills and improved well-being (Holzel et al., 2011; Siegel, 2007). Mindfulness has been researched in fields as diverse as professional sports, law, business leadership, and parenting (Black, 2012). The practice has also been formalized for use with clinical populations (Kabot-Zinn, 2005; Segal, Williams, & Teasdale, 2002). Interestingly, some researchers have suggested that mindfulness may be more effective than medications in managing some chronic diseases (Baker, Costa, & Nygaard, 2012).

Mindfulness and professional actions

In this paper I discuss ways in which mindfulness, a practice focused on 'being', has the potential to nurture the 'doing' of occupational therapy. To structure this paper, I use Noffke's (1997, 2009) seminal work regarding professional practice and draw upon my personal experiences to exemplify. Noffke offers three dimensions of professional action or 'doing': the professional, the personal, and the political (see Table 1). These dimensions represent the different actions occupational therapists may undertake in practice, and each are discussed in the following sections.

Table 1. Dimensions of professional action adapted from Noffke (1997, 2009)

Dimension	Related actions
Professional	Professional development, including the production of a knowledge base which may enhance professional quality and professional status.
Personal	'Self-studies', seeking answers to questions about individual problems in professional practice.
Political	Enhanced democracy and social equality.

Professional

Mindfulness helps practitioners gain access to tacit intuitive knowledge, a form of knowledge critical to the development of expertise (Benner, Tanner, & Chesla, 1996). Tacit knowledge represents that which is hard to put into words, suggesting we know more than we can say (Polanyi, 1983). In practice, it appears as if expert practitioners, drawing on tacit and intuitive knowledge, simply know the best course of action in professional life. Because this form of knowledge can be hard to put into words, it may be overlooked. Intuitive knowledge, found primarily in the subcortical regions of the brain, comes from internal data typically left at the non-conscious level (Epstein, Siegel, & Silberman, 2008). The intuitive act is passive; all one can do is create the conditions to allow the knowledge to surface (Depraz, Varela, & Vermersch, 2003). The assumption is, with mindfulness training, practitioners can access and use this information (Epstein, 1999).

I offer an example from my own practice experience to exemplify the power of using intuition. Several years ago, I worked at a long-term care facility with a gentleman who, as the result of a stroke, was combative, non-verbal, and lacked physical control of his body. After months of working with him, I was beginning to understand his rhythms and patterns. One

particular morning his actions held a different reverberation for me. Staff members were convinced that he was displaying more 'behaviour' and would be better managed at a chronic care facility, a one-hour drive from his family. I sensed that something was different about him, but could not put my finger on it. I spoke at length with the medical staff, urging them to rule out other causes for his change. Unfortunately, this gentleman ended up having a tumour on his pancreas that was causing his 'behaviour', but thankfully he was not transferred to another facility before this was discovered. In this example, I was able to rely on intuitive judgments revealed through attunement to my client.

Personal

There is a call for increasing attention to the self-care habits of those in health-care professions (Irving, Dobkin, & Jeeson, 2009). Mindfulness may serve as a self-care tool for practitioners. In a recent study, 47% of occupational therapists identified themselves as stressed or very stressed at work (Wilkins, 2007). Unfortunately, cynicism and burn out often accompany stress (Gupta, Paterson, Lysaght, & von Zweck, 2012). While the purpose of mindfulness is not to induce relaxation, the practice has been shown to circumvent stress reactions by lowering blood pressure and stress hormone levels, and foster the adoption of healthy lifestyle choices (McCabe Ruff & MacKenzie, 2009).

Mindfulness has taught me to really take notice of daily events, rather than be lost in worries, or plan for the future, or ruminate about the past. I find myself noticing many seemingly mundane, but nevertheless life-affirming events; small things like birds chirping when I head out the door, or a beam of sunlight hitting my desk. Mindfulness has also enhanced my body awareness. For many years I lived with chronic neck and back pain after a car accident. Mindful body awareness attuned me to how feelings (e.g., stress or thinking intently) automatically led to tension and clenching in my upper body. Now I am able to sense tension in my shoulders, notice what I am feeling, and realize mental states do not have to express themselves in my shoulders!

Political

Mindfulness may support actions that enhance social justice and equality. Mindfulness heightens a practitioner's ability to be open and non-judgmental to emotions as they arise in practice. Doing so may offer occupational therapists the opportunity to notice areas of practice that were previously hidden. For example, practices and habits that restrict the occupational potential of clients may be perceived. Occupational therapy is a profession founded in the belief that a person, embedded within a context, is an occupational being in cognitive, affective, physical, and spiritual ways (Townsend & Polatajko, 2007). In the area of practice I have spent the majority of my career, brain injury rehabilitation, physical and cognitive sequelae are adequately addressed, but spiritual and affective sequelae are poorly understood and often ignored. This becomes ironic when considering that occupational therapy started in Canada as a psychosocial profession with the purpose of healing the minds of injured soldiers at the turn of the 20th century (Ikiugu, 2010). Interestingly only 10% of registrants with the College of Occupational Therapists of Ontario (2012) identify mental health as an area of practice. There is a growing body of literature that argues occupational therapy, in keeping with its origins, should incorporate psychosocial issues into all areas of practice and specialization (Ikiugu, 2010).

"Mindfulness helps practitioners gain access to tacit intuitive knowledge, a form of knowledge critical to the development of expertise"

I wonder if therapists shy away from areas of practice because they do not feel competent. I am not suggesting people should practice in areas where they do not have a basic level of competence, but ignoring parts of practice because of fear may be harmful for both practitioners and clients. An example from my own practice highlights the power of paying attention to thoughts, feelings and emotions. In the early part of my career I was reticent to work with clients who had concurrent mental health and substance misuse issues in addition to a brain injury. I erroneously believed I could not help someone with a brain injury until they sought treatment for mental health challenges. Today, it is abundantly clear that concurrent issues must be treated in parallel rather than sequentially (Government of Ontario, 2009). In hindsight, I can see the reason I did not want to address the issues was my own discomfort and lack of competence. With a formal mindfulness practice, I may have been attuned to my discomfort and sought the necessary education, rather than unintentionally perpetuate the stigma people with mental illness often face.

Conclusion

Mindfulness has become an indispensable practice for both my personal and professional lives. Insights gained during mindfulness awareness about 'being' can have ethical undertones for professional practice, and can also lead to a more satisfying personal and professional sense of 'doing'.

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Reflections on a role-emerging fieldwork placement using a collaborative model of supervision

Nicole A. Thomson and Laura Thompson

Introduction

It is well established that fieldwork placements are a fundamental component of education for occupational therapy students (Overton, Clark, & Thomas, 2009). Broadening scopes of practice and the restructuring of health-care delivery to the community have resulted in more occupational therapists being employed by industry, government and community agencies. One significant change in the profession in the last decade is the number and frequency of role-emerging placements, which are now reasonably common (Cooper & Raine, 2009; Fieldhouse & Fedden, 2009).

Role-emerging placements are fieldwork experiences in settings with no established occupational therapy service. Student supervision is typically provided collaboratively by an 'off-site' occupational therapist and an 'on-site' interprofessional mentor. Although there is extensive research exploring traditional fieldwork placements, there is a shortage of literature on non-traditional fieldwork opportunities including role-emerging placements (Overton et al., 2009). The limited body of literature that does exist has primarily focused on the student perspective, with very little published from the viewpoint of the preceptor (Thomas et al., 2007).

The purpose of this paper is to share the reflective experiences of engaging in a role-emerging placement from both the preceptor and student perspectives. Reflections are based on the authors' participation in this type of placement at a community organization in Toronto, Ontario, in 2009. The agency offered early childhood consultation to promote the inclusion of children in daycare settings. This was the students' final fieldwork placement and the preceptor's first time supervising a role-emerging placement.

Collaborative model of student supervision

A collaborative model of student supervision was used in this role-emerging placement, with one occupational therapist supervising four students simultaneously (Flood, Haslam, & Hocking, 2010). The placement was structured around principles of adult learning whereby students learned from and with each other in a self-directed way. Supervision was shared, with interprofessional mentorship provided by on-site staff of varying non-occupational therapy professions. This strategy is supported by Marshall and Gordon (2010), who suggest that interprofessional mentorship complements uni-professional mentorship of students in fieldwork placements.

Preceptor reflections: Strategies and techniques for successful learning

As a preceptor, I (Nicole) would like to share my experiences by highlighting the strategies and techniques that enabled a successful learning experience as described by Sullivan and Finlayson (2000).

Several strategies were employed in the role-emerging placement including: individual on-site observations at the childcare facilities, individual meetings with students, reflective journals, and structured off-site weekly group meetings at the university. Weekly group meetings proved to be one of the most important strategies for collaborative learning among the students. The meetings were structured in a way that allowed for dialogue on key practice topics, as well as in-depth case reviews and discussion of common themes from reflective journal entries.

Throughout the role-emerging placement, it became evident that several techniques were imperative to ensuring a successful experience. Clear instructions and continuous review of expectations were essential for establishing defined boundaries around practice. Acting as a facilitator and moderator was particularly important during group meetings. Pre-planned learning objectives were set before each meeting, and students were led through structured discussions in order to reach their objectives.

Attentive listening and deferred feedback were integral preceptor techniques, essential in providing students the opportunity to collaboratively work through case reviews, further developing their clinical reasoning skills. In contrast to more traditional placements where feedback is often immediate, deferred feedback was used, often in the form of guided reflective discussion with the group outside of the practice environment. This provided increased opportunities for students to engage in collaborative problem-solving and reflective analysis.

The strategies and techniques described above fostered a safe and collaborative learning environment. Reflecting on this experience, it is clear that there are several benefits of supervising a role-emerging placement using the collaborative model for student supervision. The first is a sense of fulfillment: I had the opportunity to foster students learning together as they transitioned from students to autonomous entry-level professionals. In addition, I was exposed to and learned about new areas of practice, thus enhancing my own practice and professional knowledge. This experience also

provided the opportunity to continue to develop and refine my teaching, coaching, mentoring and facilitation skills.

In spite of the overwhelming benefits of supervising a role-emerging placement, it is also important to consider and discuss the concerns and challenges. The most evident relates to issues of accountability and liability for the supervising therapist. In most jurisdictions in Canada, supervising therapists assume professional responsibility and accountability for the occupational therapy services that are provided by students. This could potentially be worrisome to preceptors who are providing off-site supervision. As a preceptor, this meant balancing the need to provide an authentic learning experience and the development of professional autonomy with the appropriate level of supervision.

In order to mitigate some of the risks, students were expected to share their clinical reasoning using genuine cases in structured weekly meetings. This provided an opportunity for collaborative discussion among the students to problem-solve and develop consensus regarding appropriate assessment and intervention plans. Additionally, and perhaps more importantly, I believe that the most significant factor in minimizing the risk associated with accountability was the establishment of a trusting relationship. It was imperative to develop a safe environment whereby students felt comfortable to discuss their questions, concerns, and intervention plans honestly. Despite the concerns of providing off-site supervision, with the appropriate strategies and techniques, the risks can be managed allowing for a rich experience for all parties involved.

Student reflections: Acquisition of core competencies

As the second author, I (Laura) would like to share my reflections from the perspective of a now-practising therapist looking back on the student experience of acquiring the core competencies that I needed to reach entry-level (as defined by Bossers, Miller, Polatajko, and Hartley, 2007). Although key requisite skills develop in all types of fieldwork settings, I believe that the collaborative model of supervision used during this role-emerging placement, as well as the strategies and techniques employed by the preceptor, allowed for the consolidation of these skills in a unique way which continues to impact my practice.

The development of my clinical reasoning and communication skills were strongly enhanced by several factors. Clear communication, especially related to articulating the thought processes guiding my clinical decision making, was essential for building a trusting relationship with the preceptor and promoting accountability. The deferred feedback techniques and the reflective journaling exercises offered rich opportunities for self-reflection. My individual reflections were subsequently enhanced through collaborative discussions with the other students, facilitated by the preceptor during group meetings. I clearly remember several 'aha moments' that resulted from thoughtful discussions with peers who were facing similar practice issues!

The refinement of my professional interaction skills was strongly influenced by the interprofessional nature of the role-emerging placement. I was challenged to clearly define and then confidently articulate the occupational therapy role in a practice environment where therapy services do not typically exist. At the same time, I was simultaneously learning from and demonstrating my appreciation for the expertise of the other professionals.

Over the course of the placement, there was an abundance of opportunities to build on professional development and performance management skills. This was strongly influenced by the self-directed nature of the experience. The coaching style used by the preceptor helped empower me to take charge of my own learning process, and the relative autonomy allowed me to practise managing my own schedule and workload.

Opportunities to develop technical practice knowledge seemed less apparent at the beginning of placement. Unlike my previous fieldwork experiences, this role-emerging placement did not allow me to observe my preceptor's technical skills before gradually taking on more responsibility. This required high levels of resourcefulness in learning hands-on skills through referring to evidence-based resources, engaging in role play with peers, and quickly building confidence to apply skills with clients. From the student perspective, the process of acquiring technical competencies proved to be one of the most challenging, yet, in the end, most rewarding aspects of engaging in the role-emerging placement.

Looking back on the process, I feel that the way in which the core competencies were fostered during this fieldwork experience continues to impact my practice today. More specifically, my early experiences of interprofessional mentorship, close interaction with peers, and working in a self-directed manner have had a direct positive impact on my performance in my current role on a collaborative interdisciplinary team.

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Conclusion

Our reflections demonstrate the significant benefits of engaging in role-emerging placements for preceptors and students. These placements require a definite level of comfort on the part of the preceptor regarding accountability issues and associated risks, and a high level of comfort on the part of the student with the relative level of autonomy required. Our experiences highlight specific strategies and techniques, which are grounded in a collaborative model of student supervision, that help foster a successful learning experience for both the preceptor and the students.

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Medication adherence technologies and older adults

Katie Woo and Lili Liu

COLUMN EDITORS:
LILI LIU AND MASAKO MIYAZAKI

In general terms, the World Health Organization (2003) defines medication adherence as "the extent to which a person's behaviour taking medications, following a recommended diet and/or executing lifestyle change corresponds with the agreed recommendations of a health care provider" (p. 17). When looking at the characteristics of the average older adult, one study found that 81 % of older adults have at least one chronic condition, with 33 % of this group having three or more chronic conditions (Gilmour & Park, 2006). To treat these chronic conditions, a 2010 Canadian Institute for Health Information (CIHI) report found that older adults consumed more than 40 % of the total amount of prescription drugs in Canada and yet represented only 13 % of the total Canadian population. A majority of older adults were also prescribed multiple medications, with 62 % using five or more drugs and 21 % using ten or more drugs (CIHI, 2010).

With so many medications and schedules to juggle, it's not surprising that many older adults experience non-adherent episodes, whether intentional or not. These can include dose-taking errors (e.g., dose omissions, dose duplication) or dose-timing errors (i.e., failure to take medications within the pre-defined dosing interval) (Claxton, Cramer, & Pierce, 2001). Why is this important? Medication-taking behaviors are an instrumental activity of daily living and chronic non-adherence often leads to sub-optimal clinical outcomes and can lead to loss of independence.

Currently, as occupational therapists, we work alongside our multidisciplinary team to recommend dosettes, blister packs or medication assistance programs through our local home care services. However, these systems do have limitations. For example, many frail older adults have difficulty punching out the pills from blister packs, resulting in missed or dropped pills. Dosettes are often filled by the older adult themselves and can be loaded incorrectly or be unmonitored for long periods of time. Medication adherence programs, which provide phone calls or visits to older adults to assist with adherence, are effective but are challenged with workforce shortages. With this in mind and the proliferation of technology in most aspects of our lives, do better products currently exist on the market to help older adults? How much do we, as occupational therapists, know about these products?

Medication adherence technologies (MATs) are a new category of products with an electronic component. Simply put, they are electronic pillboxes or dispensers. The main benefit promoted by the companies that manufacture these products is their ability to provide electronic reminders and collect precise information on the timing of when medications are taken. They use microprocessors to record the timing of medication compartment openings to provide real-time data over a pre-determined length of time. Certain products offer the additional feature of regularly uploading data to a central database, either via phone or internet. This feature is typically targeted at caregivers who do not live with the older adult, and allows them to check in online to see if medications are taken on time. This type of remote monitoring also has the ability to provide caregiver notifications via text or email if the pill-taking data strays beyond pre-defined parameters. Theoretically, data collected over an extended period of time can give caregivers and health-care providers insight into reoccurring patterns of medication non-adherence. MATs may also have the ability to provide information to assist the older adult with decision making and improve medication adherence beyond what a non-electronic aid could provide. Examples of MATs on the market include the Philips Medication Dispensing Service, which is available in Canada (http://www.managemypills.com/content/);

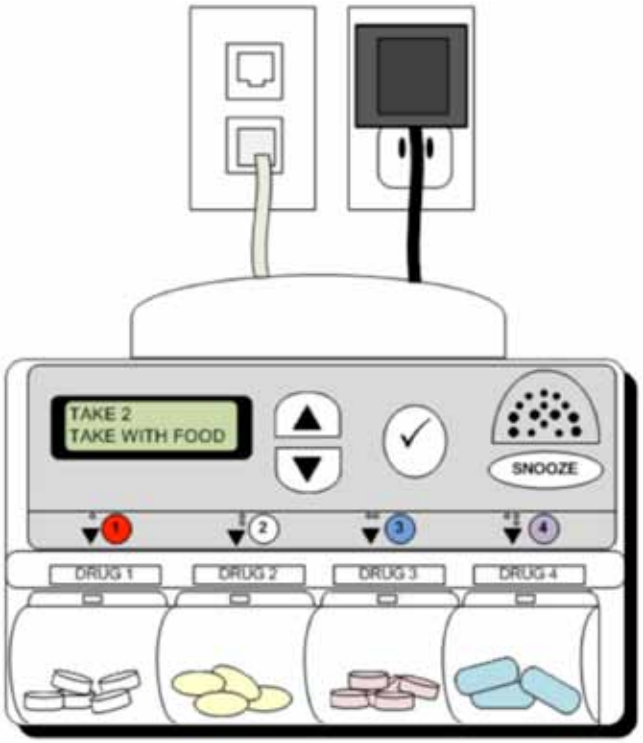

Figure 1. Small compartments may require older adults to tip the device over to access pills.

MedSignals, available in Canada (http://www.vitalsignals.ca/medsignals.html); and Glow Caps, available in the United States (http://www.vitality.net/glowcaps.html).

We completed a study in the summer of 2011 that examined the usability of MATs to improve medication adherence among older adults (Woo, 2012). A MAT survey and a product trial were used to understand the perspectives of health-care providers and older adults. The survey was distributed to health-care providers in Edmonton and surrounding areas. It received 210 responses with a 25% response rate and the results showed a low level of awareness of MATs. However, 94 % of respondents felt MATs could be beneficial. We conducted a usability trial of a commercial MAT product with two older adults at the Glenrose Rehabilitation Hospital in Edmonton. We examined the use of the technology in a home-like space over a two-day period and data was collected on the product's ability to track medication adherence, as well as the participants' ease of use and general satisfaction with the product. Overall, the study highlighted specific design limitations for use by older adults.

However, the electronic health (e-Health) industry is constantly evolving with new and improved products entering the marketplace. The results of our study led us to develop the following practical tips to help occupational therapists assess if a MAT product is right for a client:

1. **Price:** What does the price include? Products with remote monitoring technologies can charge a monthly monitoring fee as an add-on feature. Ensure the older adult or caregiver is aware of this cost and willing to invest in this monthly expense. Devices such as the Medi-Mate Pill Box, with a timer and audio reminder, can cost as low as $35.00 to $60.00. The Philips Dispensing Service costs between $845.00 to $895.00 with no monthly fees, however, there are replacement costs for medication cups. This device may also be rented.
2. **Drug capacity:** Are there enough compartments in the product to store all of the older adult's medication? Is the compartment or dispenser slot large enough for the older adult to remove the medications without needing to tip the product over (see Figure 1)?
3. **Design aesthetic:** Does the product look similar to their current system? A product which resembles a dosette may be easier for technology adoption and user training if the older adult is currently using a dosette at home.
4. **Alerts:** What types of alerts does the product offer? Audible, visual (e.g., blinking lights, LCD screen) or tactile alerts (e.g., vibration)? And how far can the older adult be from the product to see or hear the reminders? Is the frequency of the audible alert hearing aid compatible?
5. **Durability:** How durable is the product? Can the product withstand long-term use if it's dropped or exposed to liquids? Can it be disinfected?
6. **Connectivity:** What type of connectivity is required for remote monitoring? MATs require some method of connecting to their centralized server, which can be via analog phone line or 3G network. With the popularity of digital all-in-one cable and phone packages, double-check to see if the older adult still has an analog phone line at home. MATs available for purchase online from international vendors may require 3G connectivity with a specific mobile carrier that is not available in Canada (e.g., AT&T).
7. **Remote monitoring features:** What is considered a 'missed dose' or episode of non-adherence? Does an extra lid opening create a false positive and report that a pill was taken twice?
8. **Power supply:** In the event of a power outage, is there a battery back-up for the power supply? Is there a power indicator on the product?
9. **Technical support:** Does the company provide assistance with programming and in-home technical support? What are their hours of operation and warranties?
10. **The biggest tip:** Technology is only effective if it matches the capacity of the people who use it. Ensure that the older adult is actively engaged in the product selection process and that caregivers are aware that no technology can be a stand-alone device. All MATs still require human support to provide ongoing monitoring to ensure the product is doing exactly what it's programmed to provide and to interpret the data collected by the device.

Occupational therapists and students can view MATs as assistive devices and help clients choose the devices that best fit with their functional abilities and social support. Researchers can collaborate with other disciplines to improve designs of MATs, and examine the effectiveness of such technologies on medication adherence and occupational performance.

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Preparing occupational therapy students for professional practice

Michèle Hébert, Jean-Pascal Beaudoin, Marie Grandisson, Georges Al-Azourri, Rachel Thibeault, Manon Tremblay, Jacinthe Savard and Paulette Guitard

Introduction

The mission of any allied-health professional program is to train reflexive practitioners (Argyris & Schön, 1999) who are able to provide quality services to people who have or are at risk of having difficulties in performing occupations (Green, Lertvilai, & Bribriesco, 2001). During the transition towards an entry-level master's curriculum, educational programs had to be transformed. The program at the University of Ottawa adopted a teaching approach based on competency development. In order to maintain dialogue and understanding among practitioners, professors and students, we are presenting our thoughts on the pedagogical choices made while transforming our program, with a focus on the concepts of competency, evidence-based practice, occupational enablement, professional identity and values.

Competencies

A competency is a system of conceptual and procedural knowledge organized into schemas that, within certain situations, allow a person to identify a problem or task and then an effective action (Gillet, 1991). These schemas express complex action-oriented knowledge that mobilizes the individual's internal and external resources (Allal, 2002; Le Bortef, 2002; Tardif, 2003). Ongoing development is required during training and in professional practice due to the complexity of competencies.

In the occupational therapy program at the University of Ottawa, our Curriculum Framework incorporates the entire set of competencies that students must develop. It is reviewed regularly by professors and provides a full description of the program, including the:

- list of competencies to be developed by students, that is, the professional competencies from the *Profile of Occupational Therapy Practice in Canada* (Canadian Association of Occupational Therapists [CAOT], 2007) and the university competencies set out by the Ontario Council on Graduate Studies (OCGS) (OCGS, 2005);
- breakdown of competencies into knowledge, skills, attitudes, learning skills and action-oriented professional knowledge;
- transfer of these types of knowledge into learning goals based on the expected level of development: novice, intermediate and advanced;
- linkage between these goals and courses and fieldwork placements. One goal is usually linked to three courses (one for each level of learning) and at least one fieldwork placement, to discipline-specific content, and to key authors for each type and each level of knowledge;
- teaching approaches and evaluation methods congruent with the chosen learning approach.

This Curriculum Framework is the conceptual map of our program of studies (see excerpt in Figure 1). Designing the framework took considerable time, the participation of

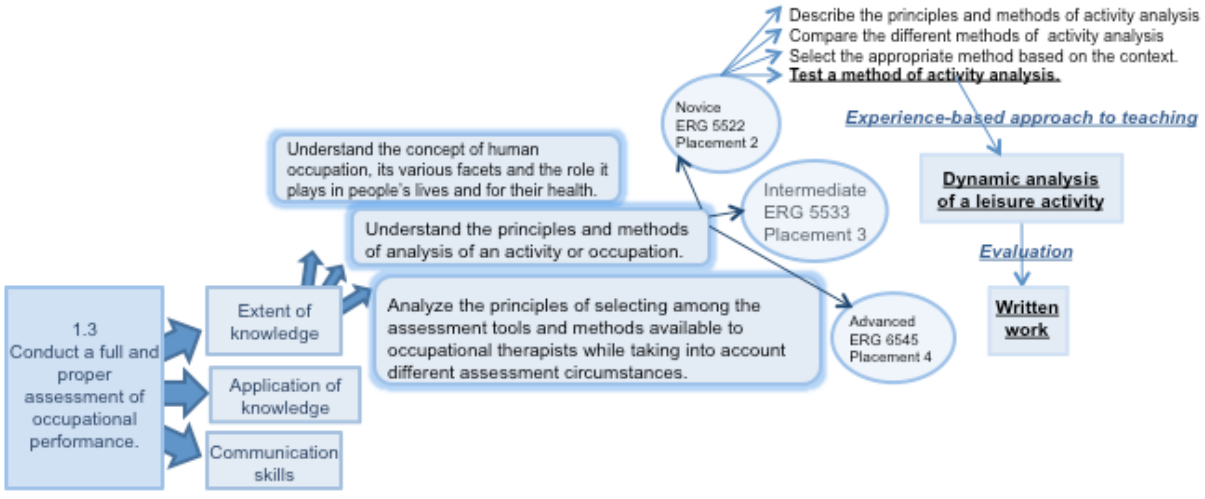

Figure 1. Excerpt from the Curriculum Framework of the University of Ottawa 's occupational therapy program.

all stakeholders, and was limited by the parameters of the competencies of the *Profile of Occupational Therapy Practice in Canada* (CAOT, 2007), as they are not all professional action-oriented knowledge. However, those difficulties were insignificant compared to its usefulness as a teaching and communication tool.

Evidence-based practice

The need for evidence-based practice was the key argument for moving occupational therapy training from undergraduate to graduate level (Green et al., 2001), as training should be more conductive to evidence-based practice by promoting the acquisition of high-level intellectual and critical thinking skills, better scientific writing skills, better use of scientific documentation, and greater confidence in the student's ability to apply research results to practice (Powell & Case-Smith, 2010; Vogel, Geelhoed, Grice, & Murphy, 2009). Stube and Jedlicka (2007) add that fieldwork placements and discussions about the use of evidence in practice enable students to develop critical thinking regarding evidence-based practice and the factors that hinder or facilitate its implementation. However, it is important to underline the nuance between evidence-based practice and practice based on scientific facts. The former is based on multiple sources of information (Kinsella & Whiteford, 2009; Reagon, Bellin, & Boniface, 2010), such as results of research, practitioner's expertise, resources, and information from the client, whereas the latter is based strictly on research results (Shaw & Shaw, 2011).

Payette (2000, p. 31) states that, "Practice has knowledge that science does not produce." The development of our program incorporated knowledge from several sources, such such as research results, practice expertise, available resources, and clients' perspectives. Students are encouraged to critically analyze all types of knowledge and the unique features of different practices in order to gain a good understanding of research results and the realities of occupational therapy practice. Students are asked to support experienced practitioners in their pursuit of evidence-based practice and practitioners are asked to share their expertise to help students develop their competencies. This results in a two-way mentorship that takes place mainly through courses taught by practitioner tutors using a problem-based learning approach (PBL) and through fieldwork placements. Moreover, to stress that fieldwork placements are as important as courses, we created a tool to monitor the development of competencies during fieldwork placements that is appropriate for settings in which students are learning to apply action-oriented knowledge (Beaudoin, Hébert, & Tremblay, 2007).

Professional identity

The development of a strong professional identity by students was considered paramount. The identity development process stems from a social dimension expressed by the identification with a disciplinary group, and from a psychological dimension related to the quality of the individual's emotional and cognitive bonds with other group members as well as with oneself (Riopel, 2006; Roux-Perez, 2004). Professional identity is built from professional values, beliefs and knowledge that, according to Dubar (2000), results from successive socialisations with surrounding social institutions leading to one's own socio-professional self-representations. Thus, each person develops their own personal way of thinking, experiencing, understanding and interpreting reality, as well as interacting with others and with the environment (Salgado & Ferreira, 2005). Kinn and Aas (2009) argue that the range of areas of practice in occupational therapy and their unique features render the acquisition of a professional identity in occupational therapy challenging, even though occupation does serve as the core element of a shared identity. Others propose that in occupational therapy there is a dichotomy between theory and practice, that is to say a gap between the client-centred approach and the biomedical approach that still dominates health service delivery in many settings (Clouston & Whitcombe, 2008) – and this has an impact on the identity-development process.

In our program, many learning activities focus on professional identity development. These include having students keep a professional portfolio like those required by regulatory bodies and organizing discussions with mentors identified by students. For example, in the first year of the implementation of our master's program, students had informal meetings with clients, Dr G. Kielhofner, Dr. R. Thibeault, a well-known practitioner in our region, and the University of Ottawa's Interprofessional Clinic team. These encounters modulated, enhanced and diversified students' socio-professional representations while anchoring them to occupational therapy fundamental concepts (Hébert et al., 2012).

Professional values

Few professors in occupational therapy programs have pedagogical training, although they are assigned teaching duties. Teaching, particularly at the graduate level, not only requires that professors provide content but also that they supervise and motivate students while serving as role models for their future practice (Harden & Crosby, 2000). The act of teaching should convey the concepts to be learned, the nature of those concepts, and strategies that will help students

About the authors

At the conception of this article, all the authors were associated with the University of Ottawa occupational therapy program: **Michèle Hébert, PhD; Rachel Thibeault, PhD; Jacinthe Savard, PhD; and Paulette Guitard, PhD**, as professors; **Jean-Pascal Beaudoin, M.P.A.**, as the academic fieldwork coordinator; **Marie Grandisson** as an occupational therapist and a candidate in the PhD program in Rehabilitation Sciences; **Georges Al-Azourri** as a master of health sciences candidate in occupational therapy, and **Manon Tremblay** as the director of the Consortium national de formation en santé. For more information, please contact Michèle Hébert at: michele.hebert@uottawa.ca

integrate them in order to apply them effectively in practice (Molenaar et al., 2009). Professors must be aware of the essential attitudes, skills and methods required to support students as they face increasingly demanding learning challenges, and of the level of scholarly activity expected at the graduate level (Townsend, 2011).

The teaching process remains a central preoccupation in our program. Its founder, Anne Lang-Étienne, suggested the use of experiential teaching grounded in students' experiences and professional values. We observed a strong association between the development of a solid student professional identity and respect for professional values with the transfer of professional values into the teaching approach by professors (Desbiens et al., 2012). As an example, a student-centred approach to teaching would help make a client-centred approach part of students' socio-professional representations. Numerous initiatives support our preoccupation with the act of teaching, namely workshops on university teaching, complex-problem-based learning, occupational therapy models and evidence-based practice. With these initiatives, professors realize the extent to which their presence in the classroom transmits a socio-professional message.

Customized training?

Teaching, like occupational therapy practice, requires informed choices. In addition to shaping the training and its scientific quality, these choices offer students mentorship and learning situations that build their socio-professional representations. Teaching approaches should therefore be congruent with the practice expected of our students and their application should result from pedagogical and disciplinary reflection with all stakeholders – students, professors and practitioners – in order to provide relevant training for our profession.

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The trouble with transfers: Thoughts on barriers and solutions to home lifting equipment from a student occupational therapist and equipment user

Natalie Sanborn

COLUMN EDITOR: SANDRA HOBSON

Lifting people is difficult. They are an awkward shape, there are no handles to hold and they can be heavy. While hospitals, long-term care homes, and other institutional settings have begun to come on board with the use of equipment for all transfers, this is not always the case for people who provide care in their own homes. Home caregivers may be used to completing transfers alone, without the use of equipment, and often in cramped and unsafe situations. Unfortunately, implementing lifting equipment to improve clients' safety is not always simple or without barriers to overcome.

As an occupational therapy student in my final fieldwork placement, I had the opportunity to engage in a residency with an equipment manufacturing company. In this residency I learned about transfers and lifting equipment for home environments and went into clients' homes to provide education about their options. Through this experience, I discovered many barriers to the implementation of home lifting equipment, everything from cost to home aesthetics.

In addition to my occupational therapy practice experiences with home lifting equipment, I am also a daily equipment user as my partner requires lift equipment for all transfers. I have a ceiling track and portable lift currently installed in my apartment. I have personally experienced many of the challenges that I've seen clients encounter and have come to gain a unique understanding of the 'trouble' with home transfers. This article describes some of the barriers to home lifting equipment that I have seen and proposes possible solutions. This information comes from personal experiences and interactions with clients, vendors and occupational therapists.

Barrier #1- "It's ugly and it will ruin my home!"

One of the main areas of concern I have observed among people when they are first introduced to home lifting equipment is aesthetics. Lifting equipment has not been designed to blend seamlessly into modern interior design. There are essentially three main types of lifting solutions, all of which come with their own home decor challenges. Although a floor lift is often the least useful of all the lift designs, it is often the most popular because it requires no installation. If you have a closet that is empty and large enough to accommodate the lift, you can tuck it away out of sight, but most homes do not allow for this. Free standing frame-based systems do not require any permanent modifications to the home, but they are large and cumbersome and will often become the focal point of any room in which they are placed. The third major type of lifting system involves the installation of a ceiling track with a portable or fixed mechanical lift. This set up is arguably the least obtrusive. The track itself often blends with the ceiling and is not immediately noticed by a visitor to the home. A major reason I have seen clients express disinterest in this system is that it involves a semi-permanent modification to their home.

Possible solutions

A strong solution to overcome this barrier is education. Occupational therapists who are going into clients' homes and recommending home lifting equipment should arm themselves with information about each type of lifting solution, its benefits and downfalls, and yes, how it looks. By doing this they can engage clients in a realistic discussion about what they might expect from their equipment. For example, although a floor lift may initially seem like the most desirable solution because it does not require installation, it is awkward, cumbersome, difficult to use, and often abandoned quickly by the user. Another piece of information to have is that the installation of a track in the ceiling may seem like a significant intrusion on the home environment, but if the ceiling is properly reinforced, it actually only requires three small holes that

Author, Natalie Sanborn, and her partner, Tim Rose, show off their home lifting solution.

can easily be puttied and painted over upon removal. Occupational therapists should take the time to review all the pros and cons of the different types of lifting solutions as well as the potential risks of having no equipment. Although some clients will never be willing to accept home lifting equipment, it is our responsibility to ensure that clients understand all of their options and the risks and benefits that go along with each one.

Another strategy is to provide manufacturing companies with the feedback you are hearing from clients. Although the companies that make equipment do a great job with safety testing, they do not always have access to feedback from the actual end user and might not consider how a piece of equipment will blend into a user's home decor and style. Companies are highly receptive to this feedback because it will lead to more sales for them, and occupational therapists can assist in making sure this feedback reaches the appropriate people.

Barrier #2- "My landlord won't allow it."

Clients who rent their apartment or house often cite this as a barrier to installing home lift equipment, as it would require their landlord's permission.

Possible solutions

This is arguably the easiest barrier to overcome. Under the Ontario Human Rights Code, the duty to accommodate requires landlords to make reasonable accommodations for people with disabilities (Ontario Human Rights Commission, 2009). Individuals with disabilities and landlords are encouraged to work together to find solutions, and occupational therapists can help to facilitate this process. Occupational therapists should familiarize themselves with this legislation or its equivalent in their own province or territory. Occupational therapists can also prepare themselves to educate their clients about their rights and to advocate with them in order to exercise those rights and get the equipment that they need. In addition, occupational therapists should inform both clients and landlords about equipment options that do not require home modification, such as frames that are free standing or which are installed by bracing equipment with tension between the ceiling and floor.

Barrier #3- "It's too expensive."

Cost is frequently a major barrier in putting lifting equipment in the home. Home lifting solutions typically cost in the thousands of dollars. Although there may be some funding available through provincial or not-for-profit programs, it can be difficult to acquire and often will not cover the entire cost. For clients who are not happy about the idea of using a lift in the first place, the high cost can be an added deterrent. Other clients simply cannot afford the cost, no matter how much they want a lift.

Possible solutions

The solution here is neither straightforward nor easy. The first step is to learn as much as possible about the pricing of each option, all of the funding that is available, and the process for acquiring that funding. Sources of funding will vary depending on your client and location, but some options may include charitable organizations, service clubs, diagnosis-specific organizations (e.g., Muscular Dystrophy Association, etc.), government grants or programs (e.g., for veterans, aboriginal Canadians, etc.), private insurance, workers compensation or other local funding sources in your area. Creative fundraising strategies can also be used, such as online donation drives or fundraising events. Second hand equipment might also be a possibility, provided it is in safe operating condition. Occupational therapists working in clients' homes should not refrain from recommending equipment because of a lack of funding. Instead they should do what they can to assist clients to seek funding and participate in advocating to all potential funding sources about the need for this equipment. Although a lift might cost in the thousands of dollars, the alternative may be that the client ends up in long-term care or their caregiver injures themself. If these scenarios can be avoided by the simple addition of a mechanical lift, then surely it is not only the more client-centered option but also more cost-effective. Occupational therapists might also consider advocating for manufacturers or vendors of equipment to set up rental programs or create more affordable options. As front line workers, we are the ones who see the need for home lifting equipment on a daily basis, and are well positioned to help clients advocate.

The lift in my apartment is something we could not live without. I have experienced the barriers to acquiring equipment, including dealing with landlords and the confusing sea of funding forms and applications. Still, we were able to overcome all these barriers and I could not be happier with my home lifting solution. Occupational therapists work to find solutions to any of the occupational problems that clients encounter, and safe transfers in the home should be no exception. With a little bit of education and time, we can help to facilitate the adoption of home lifting equipment and advocate for its use. Doing so will not only contribute to clients' safety and independence, but may also allow them to stay longer in their own homes.

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About the author

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COLUMN EDITOR: SANDRA BRESSLER

World Federation of Occupational Therapists update

Sandra Bressler, CAOT Delegate to WFOT

Sue Baptiste, Alternate CAOT Delegate to the World Federation of Occupational Therapists (WFOT); Claudia von Zweck, CAOT Executive Director; and I, as CAOT Delegate to WFOT, had the privilege of attending the 30th WFOT Council Meeting in Taipei, Taiwan, March 26-30, 2012. We also attended a Focus Day preceding the meeting.

WFOT Focus Day

Focus Day is an initiative that began in 1994 and it has been used since that time to facilitate the change to WFOT's current management structure. It was agreed that the initiative should continue and be used to promote long-term planning and discussion amongst delegates to ensure that WFOT continues to meet the needs of its member associations and the occupational therapists they represent.

In the morning, delegates were divided into regional groups to provide an overview of the current challenges facing the profession in their respective countries. The pressing topics were the economic crisis in Greece and its impact on occupational therapy services there, and the challenges being faced by the Brazilian Association of Occupational Therapists regarding proposals to consider allowing physical therapists to undertake all or some of the role of occupational therapy. WFOT has worked closely with and has provided written support to both countries' associations regarding their specific challenges.

The second topic for discussion was a review of some aspects of the strategic plan for 2013-2018. The updated version will be available on the website (www.wfot.org) when it is completed.

Highlights of the 30th WFOT Council meeting

There were many items discussed at the Council meeting; the following are some highlights. Further information can be found on the WFOT website or by contacting me.

Disaster preparedness and response

WFOT has established working partnerships with other international organizations and there is a plan to develop an educational module to promote the role of occupational therapy in disaster preparedness and response. It will be available for purchase by universities.

Admission of new members

Associate membership was approved for Armenia, Romania, Trinidad and Tobago, and Tunisia. The Arabic Occupational Therapists Regional Group (AOTRG), which includes Kuwait, Palestine, United Arab Emirates, Jordan, Saudi Arabia and Lebanon, was approved as a regional member. WFOT now has 74 member organizations.

Thelma Cardwell Foundation Award for Research and Education

The Thelma Cardwell Foundation Award for Research and Education is intended to encourage research into developing aspects of occupational therapy. It was established in 1984 to honour Thelma Cardwell, a distinguished Canadian occupational therapist. She was the first CAOT President who was also an occupational therapist. Thelma helped to build WFOT and was Secretary/Treasurer for six years. In 1967 she was elected President.

There were six applicants for the award. Clare Hubbard of South Africa won the award for her work, "A study to explore the defining features of occupation-based practice in South Africa."

WFOT World Congress in Yokohama, Japan

The next WFOT World Congress will be held in conjunction with the 48th Japanese National Congress, June 18-21, 2014.

The Congress theme is Sharing Traditions, Creating Futures with the sub themes:

1. Disaster preparedness, response and recovery
2. Inter-professional collaboration and the role of occupational therapy
3. Wisdom: Learning from the past, tradition and the future
4. Innovations and challenges in occupational therapy
5. Education and research: Meeting the demands from the field
6. Evidence-based practice and quality of occupational therapy
7. The nature of human occupation
8. Community and occupational therapy

The call for abstracts closed on April 30, 2013. Early bird registration runs from January 2013 to March 2014.

World Health Organization
The Council met with with Alana Officer, World Health Organization (WHO) Disability and Rehabilitation Team Coordinator, to discuss the WHO Concept Paper on the Guidelines on Rehabilitation in Less Resourced Settings and the concept for the development of a generic curriculum for health and rehabilitation personnel about disability and human rights. With the first item, they plan to review the literature, conduct systematic reviews, and use human resource information and case studies to aid in the development of guidelines. The original plan was to focus on low and middle-income countries, but now high-income countries will also be included, particularly in light of economic changes globally.

Another topic of discussion was Creative Commons licensing, where copyrighted material is reused or adjusted to share intellectual material and acknowledge contributors.

Canadian occupational therapists may be interested in reading the WHO World report on disability (http://www.who.int/disabilities/world_report/2011/en/index.html), which was written with significant input from the Canadian occupational therapy community.

Promotion and Development
A new corporate logo and a revised website have been developed. WFOT is now also on Facebook (http://www.facebook.com/wfot.org).

World Occupational Therapy Day (October 27th) held successful events worldwide in 2012. Promotion strategies from different countries will be available online for others to use.

Standards and Quality
The Council approved the following positions statements and policies, which can be found on the WFOT website:

1. Competency/Maintaining Competency
2. Universal Design
3. Environmental Sustainability: Sustainable Practice within Occupational Therapy
4. Activities of Daily Living
5. Vocational Rehabilitation
6. Human Displacement
7. Occupational Science
8. International Advisory Groups

Education and Research
A motion was passed to raise the international entry-level to practice to a bachelor's degree. As a result of the project to support occupational therapy educators in mainland China, there was discussion about the development of an online education package for occupational therapy faculty members in emerging or new occupational therapy programs.

International Co-operation
WFOT is working in cooperation with individual occupational therapists to assist in the development of the profession in Ghana, Madagascar and Guatemala. A project is currently underway between a university in the United States and Ghana to establish an occupational therapy curriculum.

I presented an overview of the Global Accessibility Map, now called PLANAT, a project sponsored by the Rick Hansen Foundation (www.planat.com/). It is an easy-to-use online ratings tool for consumers to obtain and submit reviews from a mobility, sight or hearing perspective on the accessibility of buildings and public spaces in communities around the world. The presentation also included information about the role that WFOT and CAOT members can play in creating more inclusive communities at home, including the benefits to citizens and the community as a whole.

Elections
Election of the Executive Management Team and Program Coordinators occurred at this meeting and Canada has much to be proud of with the representation on this team.

Anne Carswell's term as Vice-President ended in June 2012 and she was presented with a WFOT Award of Merit.

The result of the elections were:
Executive Management Team

- President – Sharon Britnell, Canada
- Vice-President – Sue Baptiste, Canada
- Executive Director – Marilyn Pattison, Australia
- Vice-President Finance – Samantha Shann, United Kingdom

WFOT Program Co-ordinators

- Education and Research – Lyle Duque, Phillipines
- International Co-operation – Suchada Sakornsatian, Thailand
- Promotion and Development – Richard Ledgerd, United Kingdom
- Standards and Quality – Nils Erik Ness, Norway

If there are any questions or comments about this report and/or WFOT, please contact me at sbressler@shaw.ca or go to the WFOT website, www.wfot.org.

Update from the Canadian Occupational Therapy Foundation

CAOT Conference 2013

Support COTF:
COTF will be present and we want you to support your Foundation! How?

1. Live auction at the social event on Thursday, May 30 from 5:30 - 11:00 PM
2. Silent auction at the COTF booth (closes at noon on Friday, May 31)
3. Lunch with a Scholar – Lili Liu from the University of Alberta - Saturday, June 1 from 11:30-1:00

Other COTF events:

1. COTF Session, Case Study Research (facilitated by Gayle Restall, University of Manitoba) - Friday, May 31 from 10:00-11:00
2. COTF AGM - Saturday, June 1 from 1:00-1:30

COTF's 30th anniversary - May 17, 2013

May 17 marks COTF's 30th anniversary! Stay tuned for fun-filled fundraising events to celebrate this noteworthy milestone!

Phonathon 2013

COTF will be holding its second Phonathon during National Occupational Therapy Month. Funds from the event will be used to support an award for research investigating the cost effectiveness of occupational therapy. Just say "YES!" when we call you in October.

Social media

COTF is on Facebook (http://www.facebook.com/cotffce). Please 'Like' COTF if you have a Facebook page. Photos of award recipients are being posted on this page. You will be sure to recognize many faces over time! You can also follow COTF on Twitter (https://twitter.com/COTFFCE)!