OCCUPATIONAL THERAPY NOW

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Everyday Stories

The challenges and advantages of being an occupational therapist with a physical disability

Patti Plett

I am an occupational therapist who has a physical disability. On a regular basis, people are surprised to learn that I am an occupational therapist when they meet me – and then tell me it's very fitting when they get to know me better. Having a disability and being an occupational therapist has both its challenges and its advantages. In fact, I have found having a disability can be a great therapeutic tool.

My background

I have geroderma osteodysplastica, a rare condition mainly affecting my bones. As a result, I've experienced many fractures and only learned to walk at five years of age. Even then, I never developed a proper gait, so I tire easily and have difficulty walking due to fatigue and poor balance. Today, I use a wheelchair or scooter on a regular basis. In my free time, I enjoy taking photos, getting out into nature, canoeing or kayaking, blogging, drumming and playing piano. Prior to becoming an occupational therapist, I worked in a variety of settings, including offices, research labs and teaching music lessons. I also volunteered with international students for several years. My life experiences as a person with a disability gave me the skill set to advocate for my own needs. My experiences also exposed me to many different cultures and built an interest in getting to know people from different backgrounds. My understanding of independence was shaped strongly by my move to Australia where I lived on my own for the first time with no family supports and had to hire someone to help out with household tasks.

Over time, I gained a strong interest in helping individuals experiencing marginalization. This interest was solidified during an international internship in Australia where I worked in an Alzheimer's disease research lab and volunteered with a group that prepared meals for people living in poverty. Instead of just serving the food, we ate with our guests and got to know them. In addition, my friends in Australia were active social justice advocates.

Career path

My decision to become an occupational therapist was based on my interest in mental health, social justice, counselling, research and music. Occupational therapy seemed like a profession that was flexible enough to bring all my interests into a career that would be meaningful. My experiences as a client receiving occupational therapy also fueled my interest in the profession. I graduated with a master's degree in occupational therapy from the University of Manitoba in 2005. My first clinical position was as a sole practitioner at an inner city agency in Calgary, working primarily with people who are homeless. My role included group facilitation, program planning, counselling, case management, assessments and advocating for clients. In 2010, I began doing private practice work on a part-time basis, with a focus on providing services to veterans with mental illness and providing individual consultations for individuals seeking funding and specialized equipment. I later began to offer adapted music lessons for individuals with learning disabilities, attention deficits and a variety of physical impairments. I continue to live in Calgary and split my time between working on an in-patient psychiatry unit, providing private practice services and teaching in the Rehabilitation Therapy Assistant program at The Southern Alberta Institute of Technology. My career experiences have also included volunteering with the Canadian Association of Occupational Therapists (CAOT) and presenting at the 2008 CAOT Conference in Whitehorse.

The challenges

The field of occupational therapy is hard to enter as a person with physical limitations. This was the most surprising find for me. I expected medical professionals, and occupational therapists in particular, to welcome individuals with disabilities. However, securing employment upon graduation was a struggle. Instead of being able to share my strengths, I had to fight at each interview to focus on these rather than my physical limitations. I openly discuss my limitations but I wanted a chance to share how having a disability can be a strength and how I am a fully trained occupational therapist with a variety of strengths. An occupational therapist does not need to be able to do lifts and transfers or be able to walk, but it seemed hard to convince employers of this. The good news is that occupational therapy is a broad profession and there are jobs for people with physical limitations.

Facilities are often not wheelchair friendly. Nursing stations, charting rooms and hospital units are not often set up for individuals with mobility impairments. However, for the most part, staff want to make things work and are willing to make accommodations, and I am thankful for this.

Clients and medical professionals alike perceive me to be the client when first meeting me. On my first day of work at one of my jobs, I went to meet a new client. One of the staff members called me off, telling me to get out of the client's room and to grab my breakfast tray instead. Other times, I've had staff members rush over to me to help me out, looking very concerned, when I did not need assistance at all. When clients perceive me to be the client, they sometimes have difficulty seeing me as the therapist and are overly friendly with me, perceiving me to be 'one of them.'

Job choices are somewhat limited. Many occupational therapy positions require the physical ability to lift and be a stable balance support for clients. Mental health has been a good field for me as, generally, physical limitations are not a factor. In some community-based work, accessibility is an issue. I choose to focus on the fact that occupational therapy is a diverse profession and there is potential for out-of-the-box options for people with varying ability levels.

The advantages

'One of us.' This is a double-edged sword. As noted above, some clients have difficulty initially seeing me as a professional. However, when they do, I often hear feedback that they believe I have gone through struggles making me more human and approachable, and seemingly, more understanding. In some situations, I have an understanding of a somewhat similar lived experience and am able to knowingly empathize. My lived experience with marginalization has also brought passion for working with marginalized individuals and those fighting to get what they need. My experiences can be used as a therapeutic tool.

Life experience is a great teacher. I have personally gone through the experience of moving through 'the system,' as clients so often refer to it, and have learned how to navigate it in an efficient manner. I've been my own occupational therapist all my life, solving problems and developing out-of-the-box solutions that make life work for me. My experiences have taught me what to say, how to advocate and to be open minded in exploring solutions for clients.

A healthy understanding of independence. I have a fiercely independent and determined spirit. Initially, accepting help was a struggle for me. It has humbled me and I have learned that I can be independent even though I need some help. Being dependent on others enables me to do what I want to do and need to do. It is natural to need help; indeed, we are part of a larger community, each with something to give – and receive. I am independent, but also a valuable member of a larger community. This is an important understanding to pass on to others.

Key lessons from my experiences:

- The occupational therapy profession is so diverse, lending itself well to individuals with disabilities.
- Challenges exist for individuals with disabilities to enter the profession. When hiring individuals with disabilities, remember to focus on the strengths of the individual. Keep an open mind and put on your occupational therapy hat to problem-solve potential barriers.
- There is a need to advocate for accessibility within the workplace.
- People with disabilities have unique strengths that benefit the therapeutic process for clients.
- Enabling occupation does not always mean enabling total independence.

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

What's new

Seeking successful advocacy stories

We are looking for your successful advocacy stories to publish in OT Weekly and *OT Now*. Your story may have impacted one person, a whole community, your employer or a funder. Whatever your story is, we'd like to hear from you. Our aim is to share your ideas, actions and enthusiasm in order to inspire and be inspired. Using the template in this issue's article on advocacy (Step up! Speak out! Act now!, page 11), please submit your story to Elizabeth Steggles at: esteggles@caot.ca If you have an idea but are unsure of its suitability, Elizabeth will be pleased to chat with you.

CAOT advocacy resources

CAOT has introduced a number of materials that will help with your advocacy initiatives. The calendar that was sent to CAOT members for National Occupational Therapy Month includes vignettes that demonstrate occupational therapy practice. Additional paper copies of the calendar are available for purchase, but it can also be found online in digital format along with companion fact sheets, screen savers and a customizable e-card. New resources will be added each month. The online resources are free and we encourage you to share them with as many people as possible: clients, families, referrers, physicians, colleagues, insurers, politicians, administrators, etc. They are yours to use as you see fit and to help you advocate for your own practice and for the profession of occupational therapy.

New at www.caot.ca

- Revised elder abuse training tools available in French and English at: www.caot.ca/elderabuse
- New e-books in CAOT's online store: http://www.caot.ca/default.asp?pageid=1042
- New position statements at: http://www.caot.ca/default.asp?pageid=4
    - Occupational Therapy in Primary Care
    - Enabling Health Literacy in Occupational Therapy
    - Professional identity, individual responsibility and public accountability through the use of title in occupational therapy

CAOT Fellowship Award winner

CAOT is pleased to announce that Christine Guptill is the 2013-2014 CAOT Fellowship Award winner! Christine holds concurrent bachelor's degrees in oboe performance and biology from Western University. She completed a master's degree in occupational therapy at Western Michigan University in 2000, and a PhD in rehabilitation sciences at Western University in 2010. She recently completed a post-doctoral fellowship funded by the Canadian Institutes of Health Research (CIHR) at McMaster University, and will soon complete a CIHR training program in Work Disability Prevention. Her research focuses on the health and participation of musicians, for which she received the 2011 Performing Arts Medicine Association Young Investigator Award. Christine joined the CAOT team as a research fellow on September 2, 2013, for a 12-month term. She will be working on a number of priority initiatives, including issues related to occupational therapy human resources.

New clinical research grant

Did you know that the Canadian Occupational Therapy Foundation (COTF) will be offering a clinical research grant for the first time in the 2014 Research Grant Competition? For more information, visit COTF's web site at: www.cotfcanada.org

Call for Papers: Occupational Therapy and Universal Design

Each year, the September issue of *OT Now* is an advocacy issue that aims to provide a broad audience with information on the range of roles occupational therapists hold in a particular area of practice. This year we are seeking submissions about the role of occupational therapists in universal design. Submissions are due by April 1, 2014. To view the call for papers, go to http://www.caot.ca/default.asp?ChangeID=25&pageID=7 or contact otnow@caot.ca for more details.

Thank you to *OT Now* volunteers

The *OT Now* Editorial Board is pleased to welcome Patricia Dickson (column editor representative), Tamara Germani (post-professional student representative) and Heather Gillespie (clinician representative). Thank you to departing members, Melissa Croskery and Aliki Thomas – your contributions have been invaluable!

Thank you also to departing column editors, Josée Séguin and Roselle Adler (In Touch with Assistive Technology), and Mary Stergiou-Kita (Practice Scenarios). It has been a great pleasure working with you!

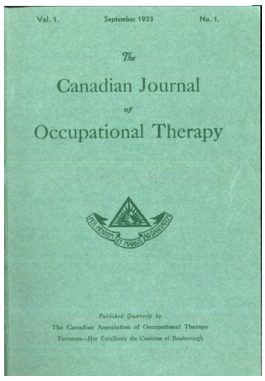
CAOT members awarded Queen Elizabeth II Diamond Jubilee Medals

The Diamond Jubilee Medal was created in 2012 to mark the 60th anniversary of Her Majesty Queen Elizabeth II's accession to the throne, and serves to honour significant contributions and achievements by Canadians.
Dr. Bernadette Nedelec, associate professor and director of the occupational therapy program at McGill University, was awarded a Diamond Jubilee Medal in recognition of her contributions to the field of rehabilitation for people who sustained burn injuries. Dr. Christine Guptill was awarded a medal for her work as a founding member of the health advisory team at National Youth Orchestra Canada. Congratulations to Dr. Nedelec and Dr. Guptil!

Letters

CAOT congratulates the *Canadian Journal of Occupational Therapy*

The Canadian Association of Occupational Therapists is proud to highlight the 80-year contribution of the *Canadian Journal of Occupational Therapy (CJOT)*. Our journal represents the longest running occupational therapy journal in the world. CAOT published the first issue of *CJOT* in September 1933.



The cover of the first *CJOT* in 1933.

From its humble beginning in 1933, with articles including "A Brief History of Occupational Therapy" and "Occupational Therapy in Europe," *CJOT* has been a stable beacon in the development of occupational therapy in Canada and around the world.

CAOT is proud to recognize *CJOT's* 80th anniversary. This year is also significant as the full *CJOT* library, from Volume 1, Number 1, to the current issue are now available online. The new *CJOT* platform continues to be innovative and dynamic, offering a direct-to-email table of contents of every new issue.

CAOT would also like to congratulate all of the editors over *CJOT's* 80-year history:

May 2011-present - Helene. J. Polatajko
2006-May 2011 - Marcia Finlayson
2002-2006 - Fern Swedlove
June 1983-2001 - Geraldine Moore
October 1981-April 1982 - Annette Rudy
Winter 1976-June 1980 - Alice Lehrer
Summer 1974-Fall 1976 - Rosalie Kupfer-Hallstuch
December 1971-Spring 1974 - Sheila Majoribanks
1963-September 1971 - Joan W. Crosby
1961-1962 - D.W. Hillhouse
1959-1960 - W.M. Irvine
December 1954-1958 - Pat Fisher
June & September 1954 - R. Ross
June 1952-March 1954 - J.D. Robinson
1949-1952 - Elizabeth (Pierce) Robinson
1938-1948 - R.M. Franks
1936-1938 – K.I. McMurrich (co-editor)
1933-1937 - T.G. Heaton

We encourage you to take a few minutes to look back at older issues of *CJOT* and see what we have all been doing for our profession together.

Congratulations *CJOT*!
Paulette Guitard, CAOT President

Editor's note: Go to http://www.caot.ca//default.asp?ChangeID=91&pageID=83 to connect to and explore the new *CJOT* platform and sign up for *CJOT* email alerts.

Desiderantes meliorem patriam: A conversation with Order of Canada recipient, Rachel Thibeault

Nicolas McCarthy, CAOT Communications Officer

Desiderantes meliorem patriam. "They desire a better country" is the motto that is found on the Order of Canada. "They desire a better country" is such a tall order to fill. Such hope, such desire and such a motto to live up to.

In December 2012, one of our own lived up to this motto. Dr. Rachel Thibeault was made an officer of the Order of Canada, recognizing her "lifetime of achievement and merit of a high degree, especially in service to Canada or to humanity at large" (The Governor General of Canada, 2013, para. 3). She received this prestigious award "for expanding the boundaries of occupational therapy and advocacy on behalf of people with disabilities" (The Governor General of Canada, 2012). The appointment was made by His Excellency the Right Honorable David Johnston, Governor General of Canada.

Perhaps for Dr. Thibeault, desiderantes meliorem patriam is still too small a motto for her; perhaps her Order of Canada should have read, *desiderantes meliorem mundi:* "they desire a better world." To celebrate Dr. Thibeault's award and to share her accomplishments, CAOT Communications Officer, Nicolas McCarthy, sat down for an interview with Dr. Thibeault. The following article offers excerpts from this interview combined with biographical snapshots from Dr. Thibeault's career.

Rachel Thibeault received a B.Sc. in Health Sciences (occupational therapy) from Université Laval, a M.Sc. (psychology) from Acadia University, and a PhD (community psychology) from the Université de Montréal. She also did post-doctoral studies at the University of Southern California (Los Angeles) and at the University of Århus (Denmark).

Q. What made you pursue occupational therapy as your profession?

I was always very good and interested in science and was looking for a profession that connected me to human values and clients. Science tends to be disconnected from those it's looking to help. I decided to shadow health-care professionals, like a doctor, a nurse and finally came to a clinical occupational therapist. I discovered that [occupational therapist] clinicians treated clients differently. They look at the human aspect of the client. The occupational therapist I shadowed looked at the client in a holistic manner. I discovered that they worked closely with their clients and helped them in a manner that was completely different from other health-care professionals.

Dr. Thibeault's work as a clinician took her from acute mental health settings and physical rehabilitation centers in Ontario, Quebec and Nova Scotia to community-based services in the Canadian Arctic. From 1990 to 1992, she was the director of occupational therapy at the Stanton Territorial Hospital in Yellowknife and special advisor to the Northwest Territories government on physical and mental health rehabilitation programs for aboriginal populations.

A professor in the occupational therapy program at the University of Ottawa since 1992, Dr. Thibeault specializes in community-based rehabilitation (CBR), participatory action research (PAR), psychosocial care, peer support and issues of meaning and social justice in health care. The World Health Organization defines CBR as a "strategy that empowers persons with disabilities to access and benefit from education, employment, health and social services. CBR is implemented through the combined efforts of people with disabilities, their families, organizations and communities, relevant government and non-government health, education, vocational, social and other services" (2013, para. 1). PAR allows for the examination of issues from the perspectives of those most impacted by those issues; the aim is to produce social change (Trentham & Cockburn, 2005).

Dr. Thibeault's career has been one marked by achievement. In 2001, she received the highest honour of the Canadian Association of Occupational Therapists, the Muriel Driver Memorial Lectureship, for her outstanding contribution to occupational therapy in Canada.

Q. For your Muriel Driver Lecture, you chose to speak about the incredible life and career of Anne Lang-Étienne. What would you say her impact was on you as an occupational therapist?

Because the language barrier was difficult to cross in Anne's time, I figured that my Muriel Driver Lecture would be a great opportunity to provide the non-francophone world a look into this dynamic and avant-garde thinker. I believed Anne brought our attention to the great European thinkers and Eastern philosophers and concepts like phenomenology. Anne understood the importance of the study of the structures of subjective experience and consciousness. Anne would tell us to look at the person's experience. It was my opportunity to bridge the gap and introduce Anne to the anglophone occupational therapy world.

Q. What ideals do you think occupational therapists should embrace from Anne?
Anne really taught me to think outside the box. Never try to make a situation fit the mould, since it never will. Anne would often tell us that growth doesn't happen in the comfort zone. Typical of her French character, Anne would challenge us, push us out of our comfort zone. My relationship with Anne grew from a mentorship to a friendship.

Dr. Thibeault has been dedicated to some of the most vulnerable communities in Canada and the world. Her main practice interests in occupational therapy have been in mental health (specifically post-traumatic stress disorder [PTSD]) and CBR. Within Canada, she has worked from rural Nova Scotia to the far North helping to develop CBR services.

Q. Why did you decide to dedicate your career specifically to vulnerable communities?
It's strange how that came about. I was completely immersed and saturated in academia. I was doing a second post-doc at the University of Southern California (Los Angeles) and just found what I was doing so removed. I wanted to return to the core values that interested me in occupational therapy. I took a position in Yellowknife and found myself working with aboriginal communities.

I was shocked by the state of health and health care in these communities. I was witness to communities robbed of their traditional occupations and culture. The system really creates a structure of disempowerment. It was a complete shock for me thinking this was still in Canada. (It still remains some of the worst conditions I have ever seen in the world.) I began working with the local communities and looked at CBR as a way forward to offer better service and build a path together.

Q. How did your work in Canada's far North influence your career path?
The far North helped me understand both community-based rehabilitation and participatory action research. I was trying these methods that were then outside regular academia and frowned upon. I discovered that I was just one member of the team and the local community needed to lead the project. Twenty years ago this was a radical thing. We would tell people what they needed to do and not really listen to what they wanted to do. This was our western arrogance, thinking we knew better than the local communities.

I learned to start from the recognition of my own ignorance. I don't know these people, their lives, their experiences and what they want to do. How could I come in and tell them what they need to do?

I remember in Ethiopia, I began to work with 40 women with leprosy, most of them with few fingers. I spoke to them and asked what they wanted to do in terms of income-generating activities, what kind of project they wanted. They said needlepoint. At first I thought this was impossible. So I asked them how they planned to do their needlepoint. The women grabbed hard vegetables and stuck needles in them and began to do needle point, beautiful and artistic designs. They had been doing this work for years, as a therapy to overcome their social exclusion, with no market or financial gains in mind. The people in their region did not want to buy items from people with leprosy, so we needed to expand to a larger market. The project was successful; these women became economic engines for their entire community. I eventually asked them why they had kept doing this artwork for years in the absence of a viable market. They explained that in their country they are seen as the symbol of ugliness, they get spat on and mistreated, marginalized, and as a result, they needed to create beauty to feed their souls. I was moved.

Dr. Thibeault has worked in Africa, Asia and South America with diverse and marginalized groups, including victims of war, people with disabilities and chronic and stigmatized diseases such as leprosy and AIDS.

Q. When did you first decide to go abroad? What was the decision process like? How did you choose your first project?
I really did not make the decision; it was really an implementation agency that had me go. One of my first projects was with bush wives in Sierra Leone. These women, more girls, were taken by soldiers and rebels as children, drugged, sexually abused, raped repeatedly and as consequence they contracted HIV. They were seen as a burden on society. We worked together and began building micro-businesses. These businesses expanded and became an economic force in the community.

I began to see CBR as more of a social movement. The ultimate goal is, after all, to change the mentalities or turn the tables on disability and vulnerable populations. We enabled these women's empowerment and helped them become an economic engine, a job provider. Around this time, I had left Yellowknife following Anne [Lang-Étienne]'s request that I replace her at the occupational therapy program in Ottawa as she feared it was going to close down. I returned to academia and was lucky enough to continue my work in CBR.

Dr. Thibeault's main means of transportation when working in Cameroon. Photo by Daniel Buckles.

Q. What was your reaction when you first left Canada to go abroad? What impressions did you have of entering that country?

Going overseas was not difficult, but coming back proved harder. I would leave a war zone and its life-threatening issues to find myself in university meetings about the type of stationary we should favour or the use of commas and semicolons in APA-style documents[1]. This contrast triggered intense frustration. I just wanted to go back and work with the child soldiers; I wanted to make a difference and have the leeway to do so. Research on CBR does not fit well within the rigid confines of traditional academic structure, amongst them ethical guidelines often designed with affluent societies in mind. CBR is fluid and changes as the local community's needs change, a fact that is hard to reconcile with cast-in-stone proposals.

Q. Would you mind sharing your first impressions of Africa, Asia and South American? What struck you?

First impressions? It really depends on where you are going. I would first suggest going with a clean slate. It can be quite different. You can visit a Bantu village in Africa where they are quite rich or a Bagyéli village where poverty is highly visible. As I mentioned before, acknowledge your ignorance, embrace the fact that you know nothing and start at the grassroots. I've worked with many international agencies and they would host large meetings at five-star hotels, which would discourage the vulnerable people from attending. I first go to the vulnerable communities and work with them instead of for them.

Dr. Thibeault has helped establish community re-integration programs and small businesses with many people. Her work has included skill development and vocational and managerial training programs with victims of war in Laos, Lebanon, Nicaragua, Ethiopia and Sierra Leone. She has also worked with people living in economically deprived areas of Los Angeles, California, where violence is a feature of daily life.

Q. What are some of the biggest challenges you have faced while working with communities to achieve their goals?

The big picture challenges are always funding and research proposals. Funding agencies and ethics review boards demand a very precise description of all activities that will be carried [out] in the field before you can even talk to your local partner communities. There is no room for the initial – and essential - exploration and consultation with local communities to determine together what the focus will be.

At the community level, learning to navigate the local power structure, the ethnic, religious rivalries and the post-colonial culture can be hard. You always begin with developing a local team that includes both people living with disabilities and local people of influence.

Q. What have you learned from working in communities with high rates of PTSD?

Typical of community-centered practice, you do what I would call a community COPM [Canadian Occupational Performance Measure]. You ensure that you put the community in the driver's seat. I've learned that this approach works best. Client-centered is key. Other health-care professions are slow to embrace this philosophy. I truly believe in the basic occupational therapy skills: listen and be client-centered and don't be afraid to say you don't know.

Q. How important has your role as an advocate been in your work?

If I play the role of the leader, of the advocate, people with disabilities sometimes tend to assume that the eventual gains in rights or resources are linked to my status as a person without a visible disability. It has a disempowering effect. The best thing to do is to encourage the growth of advocacy skills in people. We follow the independent living movement motto: "Nothing about us without us."

Q. What advice would you give an occupational therapist who wants to pursue this type of work in social justice and help the more marginalized communities across the world?

Be ready to be outside the comfort zone. In social justice work, you are working against the system [that is] looking to keep the vulnerable population where they are. You end up upsetting the balance and can trigger backlash. It can be quite trying.

The best way to mitigate this backlash is to make sure you have a proper strategy that will not make the vulnerable community more vulnerable once it becomes successful. Any micro-business should be inclusive and ensure that it's seen as a benefit to the entire community. In certain places, where women were engaging in a micro-business, there was a backlash and an increase in violence against women in the region. To curb this, we encouraged the women to hire a third of their new employees outside their vulnerable community and include some men.

It's also important to approach any project in a collaborative manner, connecting the local communities to all relevant stakeholders to create a sustainable organization.

Q. How do you stay positive when faced with these challenges?

Early on in my career, I abandoned the notion of trying to save the world. Instead I get up in the morning and look to touch the lives of people around me.

In addition to working with international communities, Dr. Thibeault has also helped the community of occupational therapists in Canada to recognize the connection between social justice and meaningful occupations, a key concept in the profession.

Dr. Thibeault embraces issues that are important to Canadians and people around the globe. She researched and designed a university-level training programme for

[1]'APA style' refers to the publication formatting guidelines of the American Psychological Association.

community-based rehabilitation agents and coordinators in French-speaking West Africa. She negotiated the approval of eight separate national ministries of health in Africa with funding from the European Union. In Canada, she has been approached by the Operational Stress Injury Social Support Program, Canadian Armed Forces, to help support service personnel returning from active service who may need mental health support and services designed for addressing PTSD.

Q. What did it mean to you to be nominated and then awarded the Order of Canada?

It's meant two things to me. I saw it as an endorsement and validation of CBR and participatory action research. It felt like the culmination of a long journey and it was nice to see these strategies recognized. Despite the resistance over the years, I felt it was a vindication or validation for the vulnerable populations with whom I worked.

But then again, I did not feel that it [the award] was mine to accept. I worked with vulnerable communities and people who risked imprisonment, deportation and even death to champion and advocate for themselves. I felt like I was only there to be part of their team. I have been humbled to meet people from these vulnerable communities I served. These are the people who showed real courage. In truth, I face minimal risks while they put their lives on the line. It is thus highly ironic that of all people involved, I end up receiving the award. I felt it was a shame that awards can only be given to one individual, because I always have a voice inside me that says I did not achieve this, we did.

Desiderantes meliorem mundi - they desire a better world, words exemplified by Dr. Rachel Thibeault. As quoted by Dr. Thibeault in her Muriel Driver Memorial Lecture, "To live is to be open to each moment's richness, and thus our own richness. We interrupt our superficial agitation...to delve into existence" (Lang-Étienne, 1983, p.179).

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Step up! Speak out! Act now!

Elizabeth Steggles and Mary Clark

"Each of us has the ability to choose, on a daily basis. We can drift with the tides and see where they can take us or we can rise every morning and say 'I choose to make a difference for good.'"
- John Manley, former deputy prime minister of Canada (as cited in Mayne, 2012, p. 1).

Occupational therapists from the Vancouver Coastal Health Region meet annually for a one-day education research retreat called Building Bridges. This year it took place in February and the authors were pleased to contribute to the overarching theme of 'advocacy.' Elizabeth and Mary addressed the 'what,' 'why' and 'how' of advocacy and participants engaged in reflection about their own past, present and future advocacy initiatives. This article provides an overview of Elizabeth and Mary's presentations and extends an invitation to submit your advocacy success stories to be published in a new section of OT Weekly (the Canadian Association of Occupational Therapists [CAOT] weekly e-newsletter).

A search for definitions of advocacy often leads to notions of political lobbying, but this is only one aspect. One definition found on the Internet reads, "Advocacy means actively supporting something or someone (an idea, action, or person) and attempting to persuade others of the importance of that cause" (Center for International Private Enterprise, 2013, p. 2). This definition goes beyond political lobbying but ignores the fact that advocacy is more than persuading people; it is also about taking action to affect positive change.

We have all advocated at one time or another; it is the nature of occupational therapy. As you read this article, you are encouraged to reflect on the advocacy initiatives in which you have been involved. Was it for clients (occupational therapists are good at this), yourself, or an organization perhaps? What worked well and what didn't? What would you do differently next time? Take the time to chat with someone and exchange experiences as you mull over these thoughts.

Why do we advocate?

On the face of it, it seems that it is 'the right thing to do' and we feel good when we facilitate change for the better, but let's go a little deeper. Occupational therapists consider themselves to be professional. This is a complex notion that includes such attributes as being knowledgeable, demonstrating respect for others, communicating effectively, taking responsibility, being self-directed, and having personal integrity. These qualities are reflected in the *Essential Competencies of Practice for Occupational Therapists in Canada* (Association of Canadian Occupational Therapy Regulatory Organizations, 2012). Unit seven of this document states that an occupational therapist "manages [his or her] own practice and advocates within systems" (p. 21). We are required to go beyond our personal daily 'doing' of practice in an ethical manner. We are required to advocate. Similarly, the *Profile of Practice of Occupational Therapists in Canada* (CAOT, 2012) describes one of the roles of occupational therapists is that of 'change agent,' stating, "occupational therapists advocate on behalf of, and with clients, working toward positive change to improve programs, services, and society..." (p. 3).

One of the key findings of the Occupational Therapy examination and practice preparation (OTepp) program[1] is that internationally educated occupational therapists (IEOTs) who demonstrate professional behaviours are more successful in their transition to Canadian occupational therapy practice. It would be a logical conclusion that domestically trained occupational therapists who demonstrate professional behaviours will also be more successful in their practice.

Robinson, Tanchuck, and Sullivan (2012), conducted a qualitative study that explored faculty and students' perspectives on the concept of professionalism. One faculty member reflected:

> If you are that kind of individual who is always curious about the position of the other .... or wondering how do I influence this space, how do I influence what goes on for other people, well, like, you're on the [professionalism] journey (p. 281).

In her Muriel Driver Memorial Lecture at the 2012 CAOT Conference in Quebec City, Dr. Juliette Cooper (2012) stated:

> To maintain and advance its status as a profession, occupational therapy must ensure that its central tenet—occupation—is understood and valued by the general public. We will need to focus more on our external dynamic to develop effective communication strategies that can be applied at individual, provincial, and national levels (p. 207).

A myopic, insular view as we engage in our day-to-day practice is limiting. If we reach out and demonstrate our value,

[1]The OTepp program is a joint venture of CAOT and the School of Rehabilitation Science at McMaster University. The aim of the program is to assist IEOTs to transition to occupational therapy practice in Canada.

as individuals and as a profession, the potential for recognition and respect by the community at large grows tremendously. When we remind ourselves that advocacy is part of our professional responsibility and daily practice, it becomes natural to take action.

Having considered why we advocate, let us think about what we advocate for. It may be something local, such as ensuring a client has a piece of equipment, or it may be something with broader implications, such as advocating for extended health benefit coverage for occupational therapy services. We may advocate for a single client or a group of clients. We may advocate for our colleagues, an organization or the profession as a whole. Regardless of the 'cause,' the approach is the same and here is a suggested road map. As with all routes, we sometimes take wrong turns or realize there is a better way in future. The route outlined here is a suggested guide, a place to start.

A. Identify or clarify the 'cause.'
B. Record the story (a narrative) about the issue.
C. Define the purpose of your advocacy efforts. What is the 'ask'?
D. Get the facts.
E. Find allies and build alliances.
F. Decide on tactics, what you need to do.
G. Make sure you target the right people. (This often changes as you move forward.)
H. Make a detailed plan and write it down.
I. Get input on the plan and tactics.
J. TAKE ACTION!
K. Review your plan and progress; change your approach if needed, but KEEP GOING.

Step up and speak out!

Creating and delivering messages that appeal to those who are in positions of influence is one of the most challenging parts of advocacy. Passion can grab attention, but to sustain the engagement and bring others on board takes more than charisma and charm. Your commitment has to be communicated.

Planned and carefully crafted communication can build and sustain momentum, garner support and advance the cause. Overly planned and slick communication can backfire and feel insincere. The trick is to be nimble and very mindful of the reactions to your communication. Adjust quickly to appeal to your target audience, and watch your new and powerful alliances grow. Staying with messages only you understand will slow adoption of your ideas, so become an agile translator or be prepared for the polite brush off.

First, clarify the purpose of your communication. Ask yourself: "How will it advance the cause?" or, "Which tactic in my advocacy plan will it support?"

Write it out...

"The purpose of my communication today with X is ..."

Never lose track of the overall purpose of your advocacy efforts.

Second, identify your target audiences and analyze their information needs and preferences. What do they need? What do they think they need? What moves them? Are they interested in facts and outcomes, or status and limelight? The more you know your audience, the better you can craft messages that they will hear, and even more importantly, act upon.

Third, develop messages that appeal intellectually and emotionally. Speak the language of your decision-maker. The tone and style of your message has to appeal to their values, motives and emotions. If they are all business, be all business. If they like stories, tell them stories. If they are not chatty, get to the point immediately.

Fourth, build messages that communicate the value of your cause to your target audience. Stay away from features and strike hard with value propositions. The value is most likely something that allows them to meet their goals, which can be personal or organizational, or a goal for their community or society at large. Be clear why they should support your cause, how your approach is unique, and what the benefits are to them.

Write it out...

"If [audience/decision-maker A] supports [our cause] it will benefit/help them accomplish [insert the outcome they want and the values they support.]"

Fifth, ask others for input. Preferably, talk to those who are decision-makers or who have been – who know what outcomes matter and are of value. Don't be precious – re-work your messages with input from others.

Sixth, build on your messages and pace them out. This prevents overwhelming your audience. Also note the 'today' underlined in the first step regarding the purpose of your communication. A first communication may be just to introduce yourself. The next time you introduce the cause. Then it's the solution, etc. Plant the seed one day. Keep it watered. Watch it grow. Then help your audience put it on their lapel! Demonstrate how it can help them meet their goals, which, if aligned, accomplish that 'win-win' situation.

Seventh, repeat and be consistent. Brand the cause in their minds. They may not be able to act right away, but if your cause is occupying mental real estate in their minds, they'll think of you when the time is right.

Eighth, build relationships and don't burn bridges. Be a magnet. Be someone they want on their team. Deliver on what you promise. When they give you a chance, meet their expectations. Even better – exceed them!

Ninth, celebrate the gains and results. Advocacy can be a long process, so it's important to celebrate the process as well as the outcome.

Act now!

Really? Yes! If advocacy is something you have never considered before, join a cause; get involved with a CAOT project. Find an advocacy buddy to help get you going. If you have a success story, share it! What may seem like everyday practice in one corner of the country is novel in another. And we can help you with this. Starting in January 2014, OT Weekly will feature short Advocacy Success Stories like the one found below. They are quick to write but can have a powerful impact elsewhere. For more information or to discuss your advocacy initiative, contact Elizabeth Steggles at: esteggles@caot.ca

Template for Advocacy Success Stories

Advocacy issue: Environmental Control Equipment (ECE) clinic unable to respond quickly enough to needs of people with ALS. People died before needs met.

Initiative: Set up an equipment loan pool.

Approach:

- Planned loan pool with rehabilitation technician colleague.
- Developed business plan that included finding $20,000 for capital costs.
- Pool to be housed and administered by ECE clinic.
- ALS Society approached to carry ongoing costs. Agreed.
- ALS clinic to refer in timely manner. Agreed.
- Hospital foundation raised $20,000. N.B. Staff champion had uncle with ALS.

Outcome: ECE loan pool implemented. Clients with ALS receive ECE within one week of referral.

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IN TOUCH WITH ASSISTIVE TECHNOLOGY

COLUMN EDITORS: JOSÉE SÉGUIN AND ROSELLE ADLER

Mobile technologies and individuals with an autism spectrum disorder: A list of applications and reflections on their use

Claire Dumont

Occupations can evolve over time, particularly as new technologies become available. Tablet computers, smart phones and other mobile devices enable people to engage in various occupations, kinds of learning, fine motor skill activities, movements involved in using a device, and cognitive or perceptual stimulation activities. Together with an Internet connection, a computer keyboard, a global positioning system (GPS), a gyroscope, a clock, a calendar, a microphone, a speaker, a camera and a video recorder, it is possible to imagine a whole host of uses that combine one or more of these possibilities. The purpose of this article is to share information on the applications ("apps") available for use on these devices, particularly for individuals with an autism spectrum disorder (ASD).

Creating a list of applications that can be used in occupational therapy

As part of their work as research assistants, some occupational therapy students at the Université du Québec à Trois-Rivières explored various tablet and smart phone applications that might prove useful in occupational therapy. Key words entered into common Internet search engines, as well as the iTunes and Google Play libraries, were used to find promising applications from among the hundreds of thousands available. The applications identified were tested by the students and those that were selected were placed into various categories, including independent living (agenda, reminders, task assistants, etc.), motor skills (coordination, writing, colouring, etc.), cognitive and perceptive skills (association, memory, color, shapes, etc.), educational tools (letters, numbers, reading, mathematics, etc.), learning (time, music, etc.) and autism. A full list of applications was created with entries containing a hyperlink, a brief description and an evaluation by the students who tested them (Dumont, Bellemare, Durand, Leclerc, & Brûlé, 2013). The creation of this repertoire was made possible in part by funding from the Government of Quebec (Fonds de la recherche - société et culture). The list has been updated during the summer of 2013 and is available on the author's website at the Université du Québec à Trois-Rivières (www.uqtr.ca/Claire.Dumont). The website also provides a description of criteria used in the selection of the applications included in the repertoire, other application repertoires, and a list of educational or professional application provider websites.

The use of information technologies for persons with an ASD

One of the innovative aspects of tablets and smart phones is that they offer opportunities to compensate for certain cognitive disorders through applications such as agendas, reminders, task assistants and schedule assistants, with hints or instructions in written, oral or picture form to assist the user in following rules or instructions, or keeping to a schedule (VanBergeijk, Klin, & Volkmar, 2008). One group that seems to derive the greatest benefit from this type of technology is people with an ASD. An Internet search helped identify lists of the best applications for persons with an ASD (e.g., iAutism (2011) and Jeremy Brown's list (2011)), in addition to advice on the subject from parents and journalists. One website even calls the iPad a "miracle" for persons with an ASD (Des Roches, 2010). Certain scientific findings substantiate these comments and testimonials.

According to the central coherence theory, persons with an ASD have difficulty processing an overall situation or its meaning (Mottron, 2004). On the other hand, they are believed to have a heightened capacity for systematization (el Kaliouby, Picard, & Baron-Cohen, 2006). Individuals with an ASD often focus their attention on non-social stimuli and do not maintain eye contact with others, and are thus unaware of a great deal of social interaction. They can also have limited but intense interests (VanBergeijk, Klin, & Volkmar, 2008). These characteristics lend themselves well to the use of information technology in daily occupations, because these tools seem to mesh well with the interests and skills of a person with an ASD. The paragraphs below present the results of studies that explain how technologies can help enable individuals with an ASD.

Prior to 2004, studies generally concluded that people with an ASD had executive function deficits compared to typically developed people (Hill, 2004a; Hill, 2004b). However, subsequent research has shown different results. One reason for that is the altered format of some testing. For example, computer-based versions of tests such as the *Tower of London* and the *Tower of Hanoi* have been used in studies done since 2004. The results no longer show any deficit in the planning aspect of executive function evaluated by these tests (Kenworthy, Yerys, Anthony, & Wallace, 2008). Instead, better results are achieved when the examiner is replaced by a computer, suggesting that it is the relational aspect that presents difficulties for the people being tested. Moreover, one recent study illustrates the benefits of using a digital avatar to

communicate with persons with an ASD (Hopkins et al., 2011), while another shows that they can understand irony when the situation is presented on a computer (Glenwright & Agbayewa, 2012). These studies provide further evidence that information technologies may be useful tools for promoting learning and occupational performance when working with this client group.

A computer helps focus the attention of persons with an ASD, reduces stress during learning, and allows learners to set their own pace, repeat tasks as often as necessary, and receive hints (Hetzroni & Tannous, 2004). It is a predictable tool – one that the user can control, unlike an interaction with a person. Different computer applications have had positive effects on learning vocabulary, reading and other skills (Pennington, 2010; Travers et al., 2011; Whalen et al., 2010), on communication (Flores et al., 2012), and on certain social skills, particularly through video modeling (Ayres, Maguire, & McClimon, 2009; Ramdoss et al., 2012; Reichow & Volkmar, 2010). Several of the authors cited above also mention that children with an ASD particularly enjoy working with computers and that this enhances their learning. According to one study (Shane & Albert, 2008), children with an ASD are attracted to visual media displayed on a screen and demonstrate several skills in activating and watching content that interests them. Mobile technologies are also socially acceptable and can help boost self-esteem. Moreover, certain applications such as task assistants and schedule assistants can be configured for the specific needs of individuals and thus enable them to live more independent lives (Pigot, Lussier-Desrochers, Bauchet, Giroux, & Lachapelle, 2008).

Conclusion

Clinical experience, user opinion and scientific findings support the use of information technologies for persons with an ASD. Mobile technologies and their many applications offer unique opportunities and new developments can be expected in the coming years. Occupational therapists can consider including these tools in their work and they should be on the lookout for new technologies that can benefit their clients.

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KT & OT

COLUMN EDITORS: HEIDI CRAMM AND HEATHER COLQUHOUN

Developing a knowledge translation strategy in occupational therapy

Catherine White, Heather Colquhoun, Heidi Cramm and Shalini Lal

Effective knowledge translation (KT) across health professions has become increasingly important, creating the need within occupational therapy to discuss how the profession will develop its KT capacity. Through our interactions, we, the authors, shared an interest in the importance of KT for occupational therapists. Realizing that KT often happens in a somewhat haphazard and inconsistent manner, and that occupational therapy is in many ways a unique health profession, this networking concluded the need for discussion around building KT capacity in occupational therapy. Thus, we convened a round table discussion wherein a diverse group of over fifty participants at the 2012 Canadian Association of Occupational Therapists Conference described current challenges and opportunities related to effective KT in occupational therapy. This paper highlights key points raised during this discussion. We conclude the paper with suggestions for moving forward with a strategy that considers the individual as well as practice and systems-level contexts.

An increasingly important element across health research, practice and policy, knowledge translation is defined as "a dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge to improve health, provide more effective health services and products and strengthen the health care system" (Canadian Institutes of Health Research, n.d., para. 1). If KT is to be "dynamic and iterative," widespread communication and increased collaboration between knowledge producers and users, typically separated by mandate and funding structures, is needed to ensure that knowledge products are relevant, meaningful and sensitive to context. Furthermore, as a research-emergent profession that values practitioner and client-derived knowledge in addition to empirical knowledge, a KT strategy consistent with our theories, models and approaches to practice is required (Cramm, White, & Krupa, 2013).

The round table discussion provided a starting point for such a strategy. Six tables of eight to ten participants were asked to reflect on the ways in which they convey and receive knowledge, with whom they exchange knowledge, how change is implemented in practice, and what would comprise an effective strategy for participation in knowledge translation. The results of the group discussions are summarized below.

Conveying and receiving knowledge

Occupational therapists indicated that they translate knowledge to a diverse group of people. Within their practice settings, this includes clients, colleagues, students, administrators, family members, caregivers and commercial vendors. Outside of the practice setting, they present at professional conferences and to community-based organizations. Depending on their role, some also present to research funding agencies, city planners, policy-makers or other non-clinical groups. Participants indicated that, in most of these relationships, the knowledge sharing is bi-directional. They may also receive information from other institutions, regulatory bodies, the media, government and culturally diverse groups.

In terms of providing information, occupational therapists indicated the need to be prepared with a succinct reply to the question, "what is an occupational therapist?" Participants referred to this as their 'elevator speech.' People who consult occupational therapists expect them to understand their unique needs, and to have solutions that can be shared in a partnership. They expect user-friendly language reflective of their values, and information provided in various formats, including face-to-face interaction and access to electronic or web-based resources. Therapists are expected to provide information that is clear, simple, accessible and applicable to varied contexts, and they expect the same when they are obtaining information.

Therapists acknowledged they are increasingly expected to provide cost-effective care that is evidence-based, and would like access to expert knowledge and the latest research to do so. They value input from students and clients, and want a greater role in formulating relevant research questions as well as access to mentorship in seeking answers in a timely fashion. They also expressed interest in knowing more about what is going on in other facilities.

Implementing change

While occupational therapists acknowledged the need for ongoing change in practice, they identified many challenges for achieving change. Three key issues were identified as the most crucial for change:

1. Format: Therapists value information that is clear, simple, accessible and applicable if it is to inform change. In particular, they appreciate occupational therapy-specific knowledge. The evidence itself needs a 'punch' if it is to gain attention. Participants indicated that new knowledge is sometimes introduced to a practice setting in the format of 'guidelines,' but even clear guidelines can be difficult to translate into the various practice settings, particularly when the guidelines are not specific to occupational therapy. In the examples provided by participants (specifically related to stroke and developmental coordination disorder), even when guidelines or compelling reports exist, there was a need for advocacy, tailoring messages and figuring out how the information relates to diverse practice settings. An example that gained significant attention was the ongoing challenge of incorporating the occupational therapy guidelines provided in the *Enabling Occupation II* text (Townsend & Polatajko, 2007) into practice. Even though efforts were made at conferences and through webinars, many people identified challenges with implementing these guidelines and suggested the need for an even more deliberate process to facilitate knowledge translation.

2. Leadership towards change: Leadership to enable the implementation of change was raised as a key need for successful knowledge translation. Participants indicated that a 'motivated champion for change' is needed to provide motivation and a sense of direction, to promote buy-in, to evaluate success and to ensure sustainability. Therapists identified a variety of ways they could individually demonstrate leadership toward change. In addition to being more involved in the formulation of relevant practice questions, participants want to be involved in the process of finding answers, but indicated a need for support in the form of time, money and access to appropriate resources to do so. Furthermore, therapists want avenues to validate the knowledge they generate from practice. Whether gleaned from client responses or from their own observations and experiences, therapists have lacked a structure to capture information from these valuable knowledge sources in a manner that affords credibility.

3. Our varied context: Some contexts more readily support the implementation of knowledge than others. Those in rural areas or in sole-charge practices questioned where support for change might come from. An ongoing challenge is the varied access to education or new knowledge, and the requisite time and processes to enable integrating the knowledge into practice. Therapists commonly attend educational events, but are challenged when they return to the practice setting with intentions to implement the new knowledge. Issues were raised, such as considering the fit of the knowledge with the organization's mandate, knowing how to tailor the information specifically to the context, and motivating staff who appear unwilling to change. A team-based culture that values learning and evidence-based practice was considered as an asset to facilitating change.

Towards a strategy

Moving forward, a variety of considerations will shape the development of a KT strategy for occupational therapists. On a backdrop of fiscal restraint, solutions need to be cost-effective and align with the priorities and mandates of the organizations in which one is embedded. Based on the round table discussions, a KT strategy for occupational therapists will need to consider the following:

1. The identification of 'champions for change' in the various practice contexts. Managers in particular are generally considered gatekeepers of time and money, and can create the necessary culture for a more integrated approach to the translation of knowledge and the transformation of practice.
2. Approaches to validate the knowledge generated from practice, whether gleaned from client responses or from therapists' own observations and experiences. Such knowledge is invaluable, but has typically lacked a mechanism for gaining credibility in the research world.
3. Support for a range of practice roles, partnerships and scholarly activities that support KT. Practice roles typically lack protected time for therapists to engage in or access research, and therapists and researchers typically have little interaction, thus, limiting their capacity to support one another's activities. Other roles, such as knowledge brokers, could help bridge the gap and facilitate the translation of knowledge to practice (for example, contextualizing and implementing practice guidelines).
4. Opportunities to develop 'communities of practice.' Communities of practice can bring together knowledge producers with knowledge users, offer mentorship opportunities, and provide a venue to share practice-based knowledge.

Therapists are increasingly expected to provide cost-effective care that is evidence-based, but while this mandate is clear, the ways in which this expectation is to be manifested in the many settings in which occupational therapists practice are not. Meanwhile, much important occupational therapy-relevant research has limited uptake.

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Although the group discussing this strategy was diverse, and represented both practitioner and academic perspectives, much of the discussion centred around enhancing the ability of individual occupational therapists to apply research to practice. Occupational therapists have described a comfort in interacting at the individual level. However, although they have expressed a desire to expand their "avenues of influence" (Restall & Ripat, 2008, p. 297), they often feel less prepared and have few, if any, opportunities to engage at the practice and systems levels. As a group, we are still 'thinking small'; without multi-level collaboration within and outside of the profession, occupational therapists will continue to limit their own capacity to embrace knowledge translation. Such collaboration will require occupational therapists to step forward into positions of power and influence, leadership to enact a deliberate approach to change, and the formation of sustainable partnerships that become a matter of course, not a special circumstance. It is time to take a reflective view of what we are doing and why we are doing it, and commit as individuals and as a group to move forward with developing a strategy that embraces knowledge translation and places us at the forefront of sustainable health care.

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PRACTICE SCENARIOS

COLUMN EDITOR: MARY STERGIOU KITA

Linguistic and cultural considerations in the provision of home care services

Hedy Anna Walsh

Case study

Mrs. Susanna C., age 87, is a widow with two children and seven grandchildren who live close to her. Although she emigrated from Italy to Toronto, Ontario, 52 years ago, she speaks and understands very little English. She has rheumatoid arthritis and complains of ongoing pain in her low back and in both lower extremities, and requires a walker to ambulate. You are her case manager at the local Community Care Access Centre (CCAC), the Ontario provincial home care agency. CCAC case managers have diverse professional backgrounds, such as occupational therapy, nursing, physiotherapy or social work, and are involved in the assessment, referral, allocation of home care workers and supervision of services for their clients. Mrs. C. is grateful to learn that you have arranged for her to receive home care assistance with her bathing and dressing. You, as an occupational therapist, understand her need for home care assistance with her activities of daily living (ADLs), as well as her need for modifications in her home environment for her physical safety. However, communicating with Mrs. C. proves to be difficult as a result of her inability to converse in English, and she in turn reports being fearful of receiving services as a result of linguistic barriers. When her personal support worker arrives, the worker reports that Mrs. C. appears to be frustrated and despite her reassurances, she cannot make Mrs. C. understand that she will be gentle when providing her with assistance. Mrs. C. asks the support worker to leave and denies the need for any services. What are your responsibilities as an occupational therapist in the role of case manager to ensure that the client receives the services and care that she requires to enable her occupational performance and functional independence in her home environment? How can you promote her interest and participation in receiving services? What recommendations can you offer so that she receives services that are appropriate for her needs? In this article, I argue for the importance of linguistic and cultural considerations in the delivery of home care services for Canada's older immigrant populations to enable their active participation in their treatment plan, and to enhance their independence and safety in their home environment. The Italian culture will be used as a case example, although the ideas presented could possibly apply to other cultural groups as well. In addition to supporting the enabling of occupation at the micro (client) level, the role of the occupational therapist as an advocate for policy reform from a macro-level perspective is considered.

Canada's aging immigrant population and home care services

Whereas, only 11% of Canada's non-immigrant population is 65 and older, 18% of Canada's immigrant population is in this age bracket (Wu & Hart, 2002). Canada is home to 1,445,335 Italian immigrants, who make up Canada's fifth largest ethnic group, following individuals of British, Irish, French and German origin (Statistics Canada, 2006). Values of the Italian culture include the importance of family, friends, the Italian language and for many, the Catholic religion. Historically, the family has been the primary source of support for older adults (Sturino, 1999). However, changes in caregiving practices as a result of declining fertility rates and women's increased involvement in the paid workforce have produced an increased demand for formal home care services (Wisensale, 2005).

Between 75-80% of home care users in Canada are currently over the age of 75 (Markle-Reid et al., 2006). These individuals frequently suffer from multiple health problems, live alone and experience financial difficulties (Markle-Reid et al., 2006). In Canada, an aging population along with budgetary cuts to health-care spending have led to an increased demand for formal home care services (Bonnet, Gobillon, & Laferrere, 2010). In addition, 'aging in place' policies for older adults have been introduced as a cost-efficient alternative to hospital and institutionalized care (Morrow, Armstrong, Galvin, Grinvalds, & Hankivsky, 2004).

While 8% of all Canadians rely on some type of formal personal care or support services, many immigrant groups experience difficulties procuring health-care services as a result of language and cultural barriers (Wray & Mortenson, 2011). Current home care models may often not be tailored to reflect the importance of cultural beliefs, attitudes and values, despite evidence that a cultural approach leads to safer medical practices, higher client participation rates, lower health inequities and more cost-efficient care (Anderson, Tang, & Blue, 2007). Home care programs that are reflective of cultural diversity are therefore needed to meet the specific needs of immigrant populations.

Occupational therapists are uniquely positioned to enable occupation through provision of effective home care services

while considering the importance of the home environment as it relates to the overall safety and well-being of clients. They can contribute to maximizing older adults' potential to 'age in place' in their own home (Horowitz, 2002).

Cultural competence

Cultural competence refers to policies, behaviors and beliefs that reflect individual cultural needs. Cultural sensitivity refers to the ability to appreciate differences and similarities, and to acknowledge ethnocultural values, traditions, beliefs and behaviours of other populations (Schim, Doorenbos, & Borse, 2005). Cultural values and beliefs are linked to an individual's background, religion, family structure, language and attitudes about illness and health-care decisions (Egede, 2006). Thus, the delivery of culturally competent services is premised on the ability of the practitioner to acknowledge, respect and accept individual differences while being aware that these are situated within larger cultural contexts. In turn, the receipt of care is based on the care recipient's ability to trust providers and feel understood and respected (Maharaj, 2007). In addition to reducing cultural barriers to the provision of care, culturally competent services have been linked to increased interest in receiving services, and safer health-care practices and interventions for home care clients (Canadian Association of Occupational Therapists [CAOT], 2011; Majumdar, Browne, Roberts, & Carpio, 2004).

The following approach and theory may be particularly beneficial in guiding the delivery of culturally and linguistically relevant home care services: 1) client-centred practice and 2) the culturally congruent care theory. Client-centered practice considers the provision of individualized services and stresses the importance of clients' active participation in their care (Townsend & Polatajko, 2013). The culturally congruent care theory, developed by Leininger (1995), stresses the importance of the intersections of culture, language, history, gender and values with the provision of culturally based home care services. This approach and theory both acknowledge the importance of providing services that are congruent with individuals' own unique beliefs and values. They encourage consideration of the importance of cultural factors while transcending a former overreliance on Western cultural norms and the biomedical model's emphasis on disease or disability (Anderson et al., 2007). Occupational therapists should consider adopting principles from both the client-centred practice approach and the culturally congruent care theory to permit clients to be actively engaged in their interventions while having their linguistic and cultural needs accounted for. Strategies to adapt and modify the home environment for improved occupational performance are most successful when cultural and linguistic factors are considered, and collaboration is enabled between health-care providers, clients and families (Horowitz, 2002).

Practice implications

A rising proportion of older immigrant adults in Canada require the provision of culturally competent services (Beach, Saha, and Cooper, 2006). Future legislative and policy recommendations will need to address the importance of Canada's diverse cultural populations and the delivery of health-care services so they reflect complex differences in language, beliefs, traditions and values. Occupational therapists can play an important role in the health, economic and social integration of Canada's immigrants. This integration would be aided by the development of strategies aimed toward assisting clients and their families to have adequate access to much-needed health, social and economic resources.

On a micro level, occupational therapists are uniquely skilled to address the home environment as it relates to occupation-based enablement in the provision of home care services (Horowitz, 2002) and to outline modifications to maximize the safety and ability of older adults (Whitehead, Drummond, Walker, & Parry, 2013). Occupational therapists should consider their clients' cultural beliefs, values and practices, and reflect on the effect of social factors such as gender, culture and socioeconomic status in the provision of linguistically and culturally appropriate care (Trask, Hepp, Settles, & Shabo, 2009). This could include discussions with Mrs. C. about her family and the important role that they could play in facilitating care between care providers and herself, the cultural customs and traditions that she continues to practice and the services that she feels she requires most. On a macro level, opportunities to forge alliances with governments and other stakeholders should be advanced to advocate for and direct policy interventions regarding the provision of culturally and linguistically competent services (Campinha-Bacote, 2002). Lobbying for health-care reforms may include informing one's member of Parliament about the

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importance of cultural and linguistic factors in the delivery of home care services, as well as forging alliances with other health professional organizations to build capacity and concern for this issue (CAOT, 2008). For example, this could include advocating for policy reforms that require agencies to provide personal support workers who speak a client's language or have access to translation services to assist family and friends who could otherwise be required to provide translation assistance. Efforts should also be directed towards educating immigrants about how to access much-needed home care services (Segal & Mayadas, 2005). Lastly, researchers should examine the effectiveness of the delivery of culturally and linguistically informed interventions.

Conclusion

Occupational therapists have the ability to develop and advocate for home care policies in support of Canada's immigrant populations and to recognize the importance of health and illness practices that are embedded in cultural norms (Dorazio-migliore, Migliore, & Anderson, 2005). They are equipped with the skills to support client participation while taking into consideration the physical, psychological, spiritual, social, cultural, and political factors that influence health care outcomes and medical compliance rates (CAOT, 2008). This Practice Scenarios article aims to raise awareness about the importance of cultural and linguistic considerations as they relate to occupation-based enablement in the provision of home care services (Horowitz, 2002).

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ENHANCING PRACTICE:
RURAL PRACTICE

COLUMN EDITOR: ALISON SISSON

"Opportunity knocks, the north rocks": The occupational therapy fieldwork experience in northern Ontario

Amy Forget

Research from several countries, including Canada (Tran et al., 2008; Solomon, Salvatori, & Berry, 2001), the United States (Daniels, VanLeit, Skipper, Sanders, & Rhyne, 2007) and Australia (Eley, Synott, Baker, & Chater, 2012) illustrates the widespread difficulties with the recruitment and retention of rehabilitation professionals in rural and remote communities. As of August 2013, 15 communities in northern Ontario were listed as being underserviced and actively recruiting rehabilitation professionals (Ministry of Health and Long Term Care, 2013). The research clearly documents that one of the predictable factors for successful recruitment is the opportunity for students to experience a fieldwork placement in a rural or remote location (Daniels et al., 2007; Tran et al., 2008). In turn, the retention of health professionals has been shown to be strengthened by opportunities to act as preceptors for students on fieldwork placements (Solomon et al., 2001).

The Northern Studies Stream program of the Northern Ontario School of Medicine (NOSM) was developed in 1991 in partnership with McMaster University. This program provides opportunities for occupational therapy and physiotherapy students to experience both an educational and a fieldwork component of their program in northwestern Ontario. The Rehabilitation Studies program of NOSM was developed in 1996 to provide fieldwork placement opportunities throughout northern Ontario for occupational therapy, physiotherapy, speech-language pathology and audiology students attending all other Ontario universities. Both programs receive their funding through the Ministry of Health and Long Term Care (MOHLTC) for the following purposes: to coordinate rehabilitation student placements in northern Ontario, to recruit students for future employment in the north and to assist in the retention of established health professionals through the provision of teaching opportunities. This article will detail the features of the Rehabilitation Studies program from the perspective of the occupational therapy clinical education coordinator for northeastern Ontario, with specific emphasis on the strategies used to recruit students to practice in rural and remote locations.

My role in the Rehabilitation Studies program is to coordinate student occupational therapy placements in northeastern Ontario locations, including North Bay, Parry Sound, Huntsville, Sudbury, Timmins, Sault Ste. Marie, Temiskaming Shores and other smaller communities within an area of approximately 200,000 square kilometres. My colleagues at NOSM have complimentary roles to mine: an occupational therapy coordinator for placements in northwestern Ontario, and coordinators in both northeastern and northwestern Ontario for physiotherapy, speech-language pathology and audiology. Each academic year, financial provisions are available to support approximately 30-35 placements for occupational therapy students in northeastern Ontario. These placement opportunities are shared among the five Ontario universities that offer entry-level master's occupational therapy degree programs.

The organization of these placements begins with the fieldwork coordinators at each of these universities; their role plays a crucial part in the success of the Rehabilitation Studies program. Due to an often overwhelming demand for placements in the North, the fieldwork coordinators dialogue with occupational therapy students interested in a northern placement, vetting the applicants to ensure that they are appropriate candidates for recruitment to future employment in northern Ontario. Once the students have been selected to apply for a NOSM placement, they then apply online. The application allows the students to indicate three areas of geographical preference and three areas of practice preference for the fieldwork placement. The practice areas of choice are fairly general, allowing students to choose hospital or community locations in physical medicine, mental health, geriatrics or pediatrics.

Upon receiving these applications, my process of preceptor selection begins. The geographical location of preference is the focus of placement matching if a student born in northern Ontario has requested to return to his or her hometown. For the student with a specific practice area of interest, my placement matching focuses upon this practice interest, with less emphasis on geographical location. Significant consideration is also given to the known teaching preferences of preceptors to enhance their teaching opportunities. My experience has shown that preceptors may prefer a certain level of student, a specific time of year to precept, or other factors, including independent transportation or bilingualism.

Once a preceptor and student match is made, formal confirmations are sent with mutual contact information. The students are provided with travel funding assistance and accommodations if needed. NOSM maintains fully furnished apartments in our placement communities, which are conveniently located close to placement facilities or public transportation. Students need only pack personal belongings and perishables. Students have frequently indicated that the financial support for travel and our accommodations were very helpful when pursuing

Northern Ontario communities in which NOSM coordinates fieldwork placements. Map by Christopher Winn.

a placement in northern Ontario (NOSM, 2012).

Aside from the financial support, it is my experience that formal and informal opportunities for social, cultural and interprofessional networking are essential elements of a successful experience in a rural or remote fieldwork placement. Students returning to their hometowns have existing familial supports accessible to them; however, students not from the north may find their placement socially and culturally isolating. As well, if the preceptor is the student's only social contact, supporting the student outside of the placement location and time can be onerous for the preceptor. Thus, opportunities for social, cultural and interprofessional interactions are emphasized in northern Ontario placements to bridge this possible isolation. These types of opportunities can help support the students' interest in returning to practice in the north, as lifestyle and cultural opportunities are frequently cited as factors influencing recruitment (Daniels, et al., 2007; Tran et al., 2008; Solomon et al., 2001).

In geographical areas that are extremely remote, attempts are made to place two students in the same location, possibly in a 2:1 student to preceptor ratio. This arrangement allows for peer learning and support in a potentially isolated placement. For all locations, students are encouraged to travel to their placement location by car whenever possible, allowing them to travel within and outside of the immediate community during off-placement hours. In student confirmation emails, I often include a side note that provides the student with some information on the location in which he or she will be placed—a recreational activity or tourist site recommendation to encourage them to explore the amenities outside of the placement. Students are also linked to NOSM site administrative coordinators in their location. This coordinator can provide the student with more information on the location in which they are placed and any NOSM-related activities that may be occurring in that location while they are on placement.

Our housing arrangements often provide for social interaction and informal opportunities for interprofessional learning as these accommodations are also accessed by all other students on NOSM-supported clinical experiences. Thus, an occupational therapy student on a fieldwork placement in a rural or remote community may share his or her NOSM apartment with a student in physiotherapy, medicine, the physician assistant program, etc. Students are often also invited to participate in formal NOSM-supported interprofessional education activities outside of placement time. Typically these weekly evening sessions are preceded by a shared meal, again encouraging additional learning and social opportunities with other students.

My experience has also been that the communities and facilities in which students are placed frequently show students remarkable hospitality. Students have reported to me that potlucks were arranged to welcome or bid farewell to them; they have been invited to participate in outdoor recreational activities such as snowshoeing, skiing and ice-fishing by staff members at the facility at which they were placed; and that generally they felt welcomed by both the facility and the community. I imagine that these experiences certainly encourage students to consider practicing in a rural community upon graduation.

It appears that the opportunities for fieldwork placements through NOSM are yielding results and that our slogan in the Rehabilitation Studies and Northern Studies Stream programs, "Opportunity knocks, the north rocks!" is resonating with our students. In a recent study of occupational therapy and physiotherapy students who participated in a placement in northern Ontario through NOSM from 2002-2010, 33.9% of these students moved to a rural or remote region upon graduation (Winn, Tryssenaar, Chisholm, Hummelbrunner, & Kandler, 2012). Additional studies at NOSM are underway to further investigate factors affecting recruitment and retention, but thus far we know that students have cited our financial supports; the quality of clinical teaching; the unique learning opportunities afforded; and the social, cultural and lifestyle opportunities experienced on placement as influencing factors (NOSM, 2012). Thus, NOSM will continue to support students with strategies to encourage their feelings of connectedness to northern Ontario in order to successfully recruit future practitioners to our underserviced areas. Future directions for NOSM include providing students with mandatory pre-placement readings on the social, cultural and health-care indicators of northern Ontario and additional on-placement learning competencies to prepare students for future practice in underserviced areas.

About the author

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STUDENT PERSPECTIVES

COLUMN EDITORS: LAURA HARTMAN AND CHRISTINA LAMONTAGNE

Occupational therapy practice in public health: A fieldwork experience

Marjorie Désormeaux-Moreau

From the moment I began my training in occupational therapy, I knew that physical rehabilitation was not my preferred area of practice, and so, I contemplated my first fieldwork placement in physical health with some anxiety. When I was offered the opportunity to do a placement in preventive health and health promotion, I accepted it immediately. In fact, I felt lucky that I had managed to 'escape' that way! At the time, I could scarcely have imagined what excellent experience I would gain by working with the public health team at the Trois-Rivières Health and Social Services Centre (HSSC), and more precisely in the Fall Prevention Service.

Background

The Fall Prevention Service of the Trois-Rivières HSSC is responsible for two programs: the *Stand Up!* program and the *integrated dynamic balance program (programme intégré d'équilibre dynamique,* or *'P.I.E.D.'* in French). The team consists of an occupational therapist, a health promotion counsellor, a recruitment officer and an administrative agent.

The *Stand Up!* program (Nadeau, 2005) is geared towards people aged 50 and older. This program involves conducting awareness-raising workshops to reduce the risk of falls by teaching healthy life habits and safe behaviours. The workshops are led by volunteers who are themselves 50 years of age or older and who receive training and support from the occupational therapist in the Fall Prevention Service.

P.I.E.D. (Fauchard & Le Cren, 2009) was developed for people aged 65 and over who have fallen in the previous year or are concerned about their balance. The program has three components: one-hour group exercise sessions held twice per week, 30-minute exercise sessions done at home at least once per week and fall prevention information mini-sessions offered once per week.

Reflections on my experience

During the eight weeks of my internship, my activities included leading a *P.I.E.D.* group, attending team meetings and volunteer committee meetings, designing promotional posters and an informational placemat in the form of a game of snakes and ladders, and promoting the activities offered by the Fall Prevention Service.

It seemed to me that nothing in my occupational therapy training had prepared me for this type of work, as most of my tasks had more to do with communication and social marketing than skills I had learned so far in occupational therapy, and I had absolutely no knowledge in those areas. Fortunately, I was part of a dynamic team that supported me and provided guidance while also giving me the independence I needed to channel and develop my skills.

At first I was surprised to see how much importance the Fall Prevention Service attached to social activities. For example, shortly after I arrived, the Service offered coffee and dessert to the volunteers after a meeting for the *Stand Up!* program. Once the coffee had been served, the occupational therapist told me to take a piece of cake and go mingle with the volunteers. At the time, I felt that this was not a good use of my time, but since then I have come to understand the importance of snack and coffee breaks or gathering for dinner at a restaurant. I found these moments promote a climate of collaboration and a sense of belonging within the program, and also allow the team to acknowledge and reward volunteers' contributions and commitment.

Whereas my previous training had been in settings that struggled with endless wait-lists, I soon found that the situation in public health was quite different. Indeed, it was not uncommon for people who had expressed an interest in *P.I.E.D.* or the *Stand Up!* program to later decide not to join, or for people to register and then later drop out. While the demand for occupational therapy generally outstrips the supply in many practice settings, the Fall Prevention Service at the Trois-Rivières HSSC has to show enormous creativity in order to effectively reach its target clientele. Whereas in the past I had generally been greeted with open arms by my clients, at the Fall Prevention Service I had to constantly assert the relevance of my interventions.

I came to understand that in a public health setting, occupational therapists may have to reach out to their potential clients and inform them of the benefits of occupational therapy services. To do this, I visited community centers to present *P.I.E.D.* and *Stand Up!* to participants at socio-cultural activities and I ran a kiosk at events.

The benefits of engaging in occupational therapy services may be more obvious to certain client populations (e.g., those recovering from illness or injury), where occupational performance is clearly affected; people targeted by fall prevention programs may still be able to perform occupations

but not recognize their risk of falling, or understand how fall prevention education could improve their ability to perform their occupations more safely or effectively. The clientele of the programs that I engaged with often do not feel compelled to participate in health promotion activities, because at first glance, they do not see the potential benefits. That being the case, it is essential to meet the needs of the target clientele and provide services that demonstrate almost immediate benefits, not only to encourage them to sign up for the groups and workshops available but also to entice them to maintain attendance. It is essential to ensure that the target audience has an opportunity to receive the information that could be beneficial to their safety and well-being. It is therefore important to use the enablement skills of occupational therapy, especially those of advocating and educating (Townsend et al., 2013).

In recent years, the Ordre des ergothérapeutes du Québec (OEQ) and the Canadian Association of Occupational Therapists (CAOT) have highlighted the importance of health promotion and prevention in the *Référentiel de compétences lié à l'exercice de la profession d'ergothérapeute au Québec* (Competencies for occupational therapy practice in Quebec) (OEQ, 2010), the *Profile of Practice of Occupational Therapists in Canada* (CAOT, 2012) and the CAOT position statement on the role of occupational therapy in primary care (2013). Nevertheless, I felt that my occupational therapy training had not prepared me for public health practice. This is possibly because it is still marginal and underdeveloped in Quebec, despite the fact that as early as 1986, the *Ottawa Charter for Health Promotion* (World Health Organization, 1986) underlined the importance of retargeting health services to place greater emphasis on health promotion. Resources to support occupational therapy practice in public health may be found within the literature of occupational therapy and other disciplines (CAOT, 2013).

Lastly, I have to acknowledge that I gained much more than I ever would have expected from my eight-week internship at the Fall Prevention Service of the Trois-Rivières HSSC. The internship allowed me to question and think over my ideas about health-care services. I must admit it made me understand the challenge of recruiting clients in public health and reminded me of the importance of shaping my services in a way that meets the needs of clients. I now humbly recognize that the general public has enormous power when it comes to health care: the power to accept or refuse our help.

Acknowledgment

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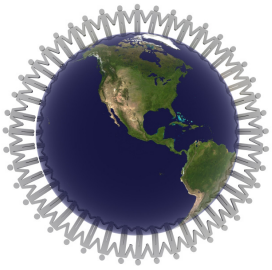
About the author

At the time of writing, **Marjorie Désormeaux-Moreau, erg., PhD (student),** was completing a fieldwork placement at the Fall Prevention Service of the Trois-Rivières Health and Social Services Centre. While on this placement, Marjorie wrote an article about winter fall prevention that was printed in the November 2012 issue of *Occupational Therapy Now*. She can be contacted at: desormma@uqtr.ca.



COLUMN EDITOR: SANDRA BRESSLER

Occupational therapy fieldwork adventures in India

Gina Fernandez

"Do you want to do an overseas fieldwork placement in India with me?" the woman sitting beside me in my University of British Columbia (UBC) Problem Based Learning Group asked. I looked over and saw Elizabeth, a quiet, studious student. I was surprised; Elizabeth and I had never socialized outside of our entry-level occupational therapy program, but we had always smiled when we crossed paths. In contrast, I was a loud, outgoing individual whose version of studying was of the last-minute variety. Due to our lack of commonalities, I found it surprising that she had inquired about completing an overseas placement with me. However, she piqued my curiosity and after chatting about this idea we agreed to pursue it together. We were both interested in an international placement because we had heard from previous students about the unique learning opportunities they provided. We had no idea of the extent to which our creativity would be put to the test on such a placement!

Elizabeth contacted the World Federation of Occupational Therapists and spoke to our UBC fieldwork coordinator. Within one month, Elizabeth had contacted a University in Southern India, Manipal University Hospital, which is a premiere Indian teaching facility in Karnataka state. An orthopaedic fieldwork placement was organized for Elizabeth, as was one in pediatrics for me.

On the plane, we discussed how we were confident that we knew our occupational therapy principles and anticipated scenarios in our placements. We decided that orthopaedic fieldwork placements always involve prescribing appropriate equipment for the bathroom after hip or knee surgery, and pediatric fieldwork placements definitely involve fun handwriting aids and unique adaptive technological devices, such as laptops. As one of the technological hubs of the world, we expected that a place like India would definitely have access to these tools. Further, we felt we had covered the language barrier, as we had our Hindi phrase book with us and had discovered prior to leaving Canada that English was one of India's national languages - we were set!

We decided that we would have to dress in a more conservative fashion in India, and so upon arrival, we embarked on a shopping expedition. We learned that the 'salwar kameez' is typical work attire, and consists of long pants, a long tunic and scarf. Initially, venturing out of the hotel was scary – the traffic was unimaginable: five lanes merging into two, rickshaws with six people inside, wild dogs roaming about, no crosswalks or signals, and people yelling to each other happily and not so happily, as they honked their horns to communicate turns and lane changes.

The next day, armed with our traditional Indian outfits, we walked to the hospital. It was only a five minute walk but by the time we arrived, the 40 degree weather had us sweating. The other students were warm and welcoming, and eagerly showed us textbooks they were using for their occupational therapy curriculum – the same ones as ours! However, this was where the similarities ended...

Adapting to Indian occupational therapy practice

Elizabeth soon discovered that her 'orthopaedic' fieldwork placement was in fact a hand therapy placement. At first, she felt confident that she would excel at this placement, having already done a hand therapy placement in British Columbia. However, she soon realized that Indian hand splinting required different skills. To be specific, she was required to make splints out of aluminum instead of thermoplastic! There were no hydroculators of hot water to melt plastic for molding; rather, metal vices, drills, and other unfamiliar tools with which to build the splints. The other students and teachers explained that plastic splints would melt in India and the plastic materials were too expensive for locals to afford; therefore, metal was the splinting material of choice.

I discovered that although Hindi and English were the official languages of India, very few individuals in the southern states speak these languages; the locals had their own dialects. Therefore, I realized I had to become creative with my communication if I was to succeed in my fieldwork placement. Stick drawings and hand gestures became my preferred mode of communication with parents of children in the clinic.

There were no laptops, fancy wheelchairs or handwriting aids in the pediatric clinic. If a client needed an adaptive piece of equipment, there was no public funding from the government to pay for these, and as such, my 'letter of justification' writing skills were useless. Instead, I used creativity as I fashioned metal devices by hand.

One day, I remarked to Elizabeth how unfortunate it was that the Indian government did not provide care for children with disabilities when they reached adulthood, such as support workers or group home coordinators. One of the occupational therapy professors overheard me and explained that the principle of enabling individuals still existed in this country. To

A man with cognitive impairment engages in candle making as part of a vocational training program.

illustrate this, she arranged for Elizabeth and me to take a trip to a rural school. At this school, teens with various cognitive impairments were trained in vocational trades such as sewing or candle making, and upon graduation, were provided with jobs at nearby factories. As adults, these individuals managed to earn a living independently as a result of this education.

Over the next few weeks, Elizabeth and I began to develop skills in what we now refer to as the crux of occupational therapy – creatively using the resources around us to enable clients. We brainstormed how to use the materials we had around us for client centered rehabilitation with our adult and pediatric clients – sandboxes, wooden wheels, plastic pitchers of water...the list was endless! We learned how to use unfamiliar metal tools to build splints, positioning devices and anything else that clients needed while employing the universal principles of positioning that we had learned in our classes at UBC. We learned how the impact of injuries could be devastating. In one instance, a betel nut farmer had severed his extensor pollicis longus with a machete while he was cutting down the fruit. He was unable to work during the period of rehabilitation and this severely impacted his family, as they depended on his sole income and there was no worker's compensation insurance in this country to provide support in such circumstances. The farmer's injury required daily rehabilitation, and he worked with Elizabeth on gaining range and strength. By the end of the placement, he was back to scaling trees to harvest these popular nuts.

Lessons learned

We are extremely appreciative of the patience extended to us by the other students and professors as they taught us how to maneuver the health-care systems and use local equipment, while not looking down on us because we practiced differently. We were profoundly impressed by our Indian colleagues' skill, innovation, creativity and willingness to share their knowledge with us. On the plane ride home from this exciting country, Elizabeth and I were quiet as we reflected on our two months in India. We began to realize that adaptive devices and interventions did not necessarily need to include laptops or bathroom equipment. We realized that we could enable our clients using very little outside resources and that our creativity was our best asset as therapists. We knew that as new therapists we would be able to handle any situation, regardless of the physical resources available to us, if we relied on our creativity. Interestingly, while working in pediatrics and neurorehabilitation back in Canada, I have employed these principles when working with my clients.

In addition, for the first time, I began to understand the struggles that internationally-trained occupational therapists encounter when they arrive in Canada – not only do they have to adapt to another language, but they also have to learn to use different modalities and maneuver the health-care system. As such, my respect for these individuals has increased immensely. I made a personal vow to help occupational therapists succeed on their journey to certification in Canada, and as such, I dedicated time as a preceptor last year for the Occupational Therapy examination and practice preparation (OTepp) program for internationally trained occupational therapists wanting to practice in Canada. I will admit, part of it was due to curiosity – I knew that the practices from the participants' home countries would help broaden my own occupational therapy practice and I was excited to learn from them.

As for the friendship born out of this Indian adventure, I am glad that fate gave me the chance to interact with a classmate that is very different than me. We learned so much from each other during our time in India and encouraged each other to try new activities. The adventures of Gina and Elizabeth still continue, as we realized that our fantastic working relationship is beneficial to our occupational therapy practice. We continue to work side by side as pediatric occupational therapists in British Columbia when we're not embarking on new adventures, such as rock climbing!

About the author

Gina Fernandez's occupational therapy background includes palliative care and oncology, community mental health and elder care. Currently, she divides her time between acute care and pediatrics and working at an outpatient neurorehabilitation clinic. She performs and teaches Indian dance in her spare time throughout British Columbia. Gina can be contacted at: gina.ubc.ot@gmail.com

COLUMN EDITORS: CHRISTEL SEEBERGER AND JONATHAN RIVERO

Christel's five favorite free resources for running a private practice

Christel Seeberger

Free resources abound on the Internet, but a discerning eye is often needed. My top five favorite free resources are ones that I go to regularly and repeatedly. I thought *OT Now* readers might also find them worthy, so am sharing them here.

1. Free e-books about private practice

Clinic Server is a company that sells internet-based clinic management software to manage all aspects of a clinic, including scheduling, billing and client care. They have also published four free e-books about private practice with the leadership of Kelly Lawson, a New Brunswick occupational therapist who is their Director of Community. At http://clinicserver.com/free-resources/ you can find:

a. *Be a #smartclinician – 30 things every clinician should know*
b. *A HOW-TO Guide for Turning your Small Practice into a Big Success…*
c. *Patient and Staff Retention: A Prescription for Keeping People Happy and Motivated*
d. *Three Evidence-based Profit Drivers of the Most Successful Clinicians*

2. Buying from and selling services to the Government of Canada

As of June 1, 2013, suppliers must go to www.buyandsellgc.ca/tenders to find federal government tenders or check for amendments to any tender opportunities that they have been following on MERX prior to June 1. MERX was the previous Government of Canada tender site. Federal government contracts specifically for occupational therapists are listed here. The Office of Small and Medium Enterprises (OSME) offers free seminars on "Finding Opportunities on Buyandsell.gc.ca/tenders." You can register online for one of these at: https://buyandsell.gc.ca/event-calendar.

3. The Business Development Bank of Canada Twitter feed

Follow @BDC_News (the Twitter feed), or go to https://twitter.com/BDC_News for information from the Business Development Bank of Canada. This bilingual Twitter feed often links to articles on a wide range of topics that help small businesses.

4. The email newsletter from the Social Media Examiner

http://www.socialmediaexaminer.com/ is one of the few newsletters that I actually take the time to read. In my opinion, hands down, it's the best one-stop-shop for everything 'social media.' The daily newsletter explains how and why to use social media in business.

5. LinkedIn News

I follow mainstream business news blogs on my smart phone's LinkedIn News feed. It offers brief updates from the world of business in a mix of traditional media articles as well as blogosphere feeds. The general news feature can be accessed here: http://www.linkedin.com/today/

Do you have a favorite free private practice resource you would like to share? Tweet @caot_ace using the hashtag, #otprivatepractice, or head on over to CAOT's facebook page (https://www.facebook.com/CAOT.ca) where we will start a conversation.

Editor's note: CAOT members can access additional private practice resources at: http://www.caot.ca/default.asp?pageid=2039

About the author

Christel Seeberger has been an occupational therapist for over two decades. In 2002, she founded TOTAL ABILITY™, www.totalability.ca, where she has since led her team of occupational therapists to provide mobile, private occupational therapy services in Saint John, Fredericton and Moncton, New Brunswick, to children, adult and seniors. In 2012, Christel launched TOTAL ABILITY Solutions, www.totalabilitysolutions.com, to share downloadable, expert occupational therapy e-books she wrote of resources, advice and activities for parents, teachers, caregivers and other therapists. Christel may be reached at: contact@totalability.ca

Update from the Canadian Occupational Therapy Foundation

2013 Critical literature review grant

Rose Martini, Debra Cameron, Désirée Maltais, Mary Setgiou-Kita and Helene Polatajko

I, along with the rest of my research team, am honoured to receive the 2013 Canadian Occupational Therapy Foundation (COTF) award for the critical research review grant. We would like to thank COTF and the Foundation donors for their generous support. As health services move toward more evidence-based practice and there continues to be pressure to decrease costs of our finite health-care resources, it is imperative that practicing occupational therapists possess information on the best evidence from the intervention literature relative to both effectiveness and cost. The aim of our critical review is to examine the effectiveness and relative cost of interventions where the outcome is explicitly identified as enabling activity and participation for children with neurodevelopmental disorders (specifically: developmental coordination disorder, cerebral palsy, and autism spectrum disorder).

This critical review involves two facets: i) synthesize the intervention literature with respect to effectiveness in enabling participation and optimal occupational development and ii) determine the relative cost of these effective interventions. Pediatric occupational therapists use many different types of intervention approaches with their clients and it would be impossible to compare each individual intervention to the other. In the literature, two broad theoretical distinctions have been used to group intervention approaches: "bottom-up" (which has also been referred to as "processes-oriented" or "fix") and "top-down" (which has also been referred to as "task-oriented" or "function"). The first group of interventions explicitly aim to remediate deficits or delays and presume that these remediated processes are then integrated into the performance of daily activities without any specific training in these activities. The latter group of interventions are generally based on motor learning theory and focus specifically on activity performance. While the proponents of each approach have invariably argued that each approach is superior to the other, the actual evidence from reviews remains rather equivocal. These two broad theoretical distinctions will be used to group the myriad of published intervention studies to produce meaningful findings regarding their effectiveness for enabling occupation. A cost analysis will then be undertaken where the cost of the more effective interventions will be compared.

With this information, practitioners will be able to consider the use of various interventions not only with respect to their effectiveness for enabling their client's occupational development, but also from a relative cost perspective. As a recipient, this award will enable me to expand my research to the exploration of interventions from a cost perspective, train students in research processes, and foster new research collaborations. More importantly, it will allow us to provide practitioners with relevant information that will make a difference in their daily lives as occupational therapists, as well as the lives of their clients and families.

Canadian Occupational Therapy Foundation

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