OCCUPATIONAL THERAPY NOW

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Table of Contents

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Everyday Stories

Recognizing excellence in practice education: An exchange with a lifelong mentor

Caroline Storr and Clara Carpintero

The School of Physical and Occupational Therapy at McGill University has recently created a faculty lecturer appointment in conjunction with the Faculty of Medicine to confer a title worthy of recognition on dedicated occupational therapy fieldwork educators. The appointment is forward-looking; the preceptor must intend to supervise at least five occupational therapy students during their fieldwork rotations over a three year interval and engage in at least one other teaching and learning activity each year. In the 18 months since the inauguration of this appointment, 11 occupational therapy practitioners have been recognized, giving them faculty benefits, including such perks as full library access.

One of our inaugural appointees is Clara Carpintero, who has supervised at least 46 occupational therapy students over the course of her occupational therapy career. She is a frequent guest lecturer on topics related to pediatrics, global health and community practice. As well, she was a volunteer for our new mini-interview admissions process and an invited speaker for our Name Tag Ceremony, an event that marks occupational therapy students' transition from classroom learning to student professional practice learning. In her talk at the May 2012 Name Tag Ceremony, she stated:

> Today, I have been given the wonderful opportunity to share with you something that I consider the most valuable activity of my professional life: lifelong learning, or, as I like to think of it, 'the three Ls.' 'LifeLong Learning' is, in my experience, a vital and necessary element to keep your career 'healthy and well,' as it will continue to enhance your growth and expertise in evidence-based practice. ... I mentioned earlier that part of lifelong learning in my career had to do with the opportunity to learn. What better opportunity for ongoing learning than being associated with the university and, furthermore, having the opportunity to exchange with a diverse new generation of students. This is the reason why I am here today. Teaching, mentoring and working with students, supervising students in their fieldwork rotations and research projects, sharing my knowledge with students, and learning from students have been key elements in my lifelong learning experience. Students bring new ideas and new challenges to the practicing therapist and educator. Students have novel ways of approaching familiar activities. Students enrich my clinical reasoning. I often tell the students I supervise, "This is a 50/50 situation; we should both give and take from this experience. If it is not like that, it is wasted opportunity for both parties." And, as I get older, I realize that I cannot waste any opportunities.

Clara received her occupational therapy degree (B.Sc.) from Universidad Nacional de Colombia in Bogota, Colombia. She received her graduate degree (M.Ed. Psychology) from McGill University. Clara has worked for 44 years as an occupational therapist in the field of pediatrics and 10 years as a university instructor training aboriginal teachers in the area of inclusive education. She began her occupational therapy career in Colombia, where she worked for eight years before immigrating to Canada with the assistance of the Canadian Association of Occupational Therapists. Her first job here was at the Montreal Children's Hospital (Alexandra Pavilion), where she worked for four years before moving to her present job at Summit School, a private special needs school subsidized in the public interest, located in Ville St. Laurent. She has been the director of occupational therapy at Summit School for the past 20 years.

During her time there, she has championed welcoming occupational therapy students to Summit School, in addition to collaborating with McGill University in role-emerging learning projects in diverse practice settings with mixed caseloads, such as summer camps and rehabilitation centers. She has also supervised international fieldwork electives in countries such as Colombia, French Polynesia and Guatemala. In addition to sharing her expertise with occupational therapy students from McGill University, she has also supervised students from McMaster University, Université de Montréal and University of Ottawa. For diversity, she has also supervised an art therapy student from Concordia University.

When McGill University approached practitioners looking for involvement in occupational therapy student research projects within the new professional master's program, Clara was one of the first to jump in. She considered it a great opportunity to discover evidence-based answers to questions faced in daily practice. Clara has co-supervised three projects, in collaboration with faculty supervisors, on the topics of sensory processing in children with intellectual disability, the impact of sensory diets on classroom behaviors, and leisure activities in children with mild to moderate intellectual deficiency. She encouraged her teams to brainstorm practice questions. This involvement offered her another enriching angle of experience - working with the students' professors at the university, consolidating her evidence-based practice.

Interview

Clara has always considered it a priority and an honor to share her passion about mentoring occupational therapy students in fieldwork practicums. The following questions and answers help to illuminate her dedication to lifelong learning through mentoring.

Q: What inspired you to take your first student?
A: There was no initial choice. I was told I had to take students as part of my work responsibilities at the hospital. I was very apprehensive; I was new to the job and I had to take a student! The experience turned out to be very positive; we were both learning! The student was just great for my first experience; she was very motivated. She faced challenges (like me), but she was willing to face them (like me!).

When I changed jobs, I was already aware of the benefits of having students. I knew it was demanding, but I also knew that it was very enriching. Furthermore, I became aware how much I enjoy sharing my experiences and expertise with students and problem solving with them.

Q: How do you balance excellence with your administrative duties, your caseload and teaching students? What would be your top three tips?
A: This is hard, but I would prioritize them as follows. Firstly, I recommend modeling and mentoring as the main tools to help students gradually acquire independence. I consider modeling the most important tool to orient the student to the setting and role. It provides the student with the foundation she or he needs to build the confidence and the skills to meet the practicum objectives. Once the student is immersed in her or his role, mentoring provides the student with the support and guidance to master the competencies required.

Secondly, delegate. Use the expertise around you, including your colleagues and other professionals, to support and expand the mentoring. Share your caseload with the student. Thirdly, expect the student to be as active as you are in the learning exchange process, what I call the 50/50 situation.

Q: Can you summarize your teaching and mentoring philosophy?
A: 50/50. Give and take. Don't be afraid to let the student know what you are learning as well, when the student brings new ideas, new learning, etc. I don't have to know everything.

Q: What advice would you give to new therapists contemplating fieldwork teaching?
A: Despite the initial work it requires, it is an enriching and rewarding experience. My main advice is to make the experience enjoyable for the student and for you. Motivation can be contagious and it certainly fosters learning.

The 50/50 formula has been rewarding and effective for me. I let the students know that we are both giving and taking during the practicum. No matter how many years of experience you have, do not be afraid of letting the students know that you learn from them as well.

Q: If you were starting out as an occupational therapist today, would you do anything differently?
A: This is a hard question, as it is difficult to see myself as a new graduate after 44 years of experience! I like the road I have travelled, so I would say no!

Left to right: Jenne Saunders, OT; Samantha Leibovitch, OT student; Sophie Durocher-Noel, OT; Elizabeth Wynands, OT; Clara Carpintero, OT; Deborah Pinsky, OT.

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What's new

Special *OT Now* on Occupational Therapy and Primary Health Care OUT NOW!

The September Primary Health Care theme issue of *Occupational Therapy Now* is online with free public access. The intention of this special issue is to provide a broad audience, including occupational therapists, health professionals, clients, policy makers and other stakeholders with information on the range of roles occupational therapists hold in primary health care. Please share this link widely: http://www.caot.ca/default.asp?pageid=3876 Do you have ideas about which stakeholders should receive a hard copy of this issue? Send suggestions to: otnow@caot.ca

New CAOT practice network: Occupational therapy within the military and Veterans Affairs Canada Network (MAVAN)

MAVAN's goal is to encourage and support the appropriate use of occupational therapy services within the Canadian Armed Forces and Veterans Affairs Canada, especially in areas of primary health care, and physical and mental health services. Visit the network's webpage to learn more: http://www.caot.ca/default.asp?pageid=280

CAOT at WFOT Congress 2014

CAOT is very pleased that its work is being recognized and will be presented at the 16th World Federation of Occupational Therapists (WFOT) Congress, to be held in June 2014 in Yokohama, Japan. CAOT will be presenting on the following initiatives:

- Development of an interprofessional knowledge translation project on elder abuse
- Meeting the demands from the field of health-care publishing: A Canadian perspective
- A national strategy led by occupational therapists to enhance older driver safety
- CarFit: Lessons on international collaborations to enhance community engagement and promote public safety and injury prevention initiatives
- The evolution of occupational therapy representation in British Columbia: Challenges and innovations
- Adopting the LEADS Framework to a leadership special interest group in British Columbia

Visit http://www.wfot.org/wfot2014/ to view the full conference program.

New position statement

The Occupational Therapy Professional Alliance of Canada (PAC), the Canadian Occupational Therapy Foundation (COTF), the Association of Canadian Occupational Therapy University Programs (ACOTUP), the Canadian Association of Occupational Therapists (CAOT) and the Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO) have written a joint position statement titled *Professional identity, individual responsibility and public accountability through the use of title in occupational therapy.* View it at: http://www.caot.ca/default.asp?pageid=4

CarFit

CAOT is involved in the Canadian chapter of CarFit, an educational program that offers older adults the opportunity to check how well their personal vehicles 'fit' them. For more information, go to: http://www.car-fit.org/ Watch for details to be released soon about a CarFit post-conference workshop at the 2014 CAOT Conference in Fredericton in May.

Canadian Occupational Therapy Foundation News

- Deadline for the COTF Research Grant is February 28, 2014. Remember to check the website for up-to-date information: www.cotfcanada.org
- COTF is launching a *new* Clinical Research Grant and a co-partnered award with the Ordre des Ergothérapeutes de Quebec. In both cases, clinicians and researchers will be working together. This is a first for COTF!
- COTF would like to welcome three new board members: Jeff Boniface, Barbara Code and Anick Sauvageau.
- COTF would like to thank three departing board members for their time and dedication: Nancy Reynolds, Jacqueline Rousseau and Huguette Picard.

OT Now call for papers: Occupational Therapy and Universal Design

Each year, the September issue of *OT Now* is a consumer 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.

Celebrating 15 years of *Occupational Therapy Now*: The past and future of your Canadian practice magazine

Janna MacLachlan, Managing Editor, *Occupational Therapy Now*

This issue of *Occupational Therapy Now (OT Now)* marks 15 years since the Canadian Association of Occupational Therapists (CAOT) first published its practice magazine. At this milestone, it seems an opportune time to recall how the publication evolved and to share recent developments about where it is headed.

The evolution of a practice magazine

OT Now, as many will recall, replaced *The National*, which was CAOT's newsletter publication. *The National* began after members at the 1973 CAOT Conference expressed a need for a newsletter to compliment the then quarterly *Canadian Journal of Occupational Therapy (CJOT)*. The first issue, in April 1974, was comprised of four stapled pages in French and English that included an editorial; listings of meetings, conferences and professional development opportunities; listings of recent interesting journal articles; and a book review. The first editors, operating out of the University of Alberta, expressed a hope in the editorial to receive submissions "of perhaps a lighter nature than is suitable for our learned *Journal*!" (Allbon & Rowland, 1974). From there, *The National* grew over the years to include not only more pages, but also more practice content, including the development of practice columns and special issues. This content was so popular that the decision was made to create a new publication focused on just this.

In January 1999, the first issue of *Occupational Therapy Now* launched in print and online. *OT Now* continued to share CAOT news and resources as the newsletter had, but now primarily published practice articles that were reviewed and supported by a team of column editors with a variety of practice area expertise. Over the years, column topics have changed with the times and reader interests. Theme issues have developed to include an annual practice theme issue aimed at occupational therapists and an annual open-access consumer theme issue aimed at occupational therapists, consumers and stakeholders. In the annual CAOT membership renewal surveys, *OT Now* is consistently rated as a top member benefit. There is much to be proud of, but also many opportunities to consider.

The 2013-2018 *Occupational Therapy Now* Strategic Plan

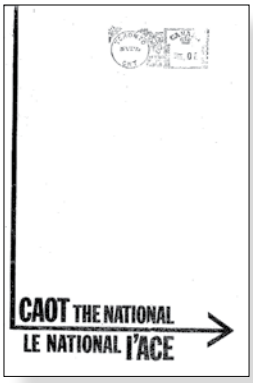
In April 2013, the *OT Now* editorial board met in Ottawa to discuss future directions of the publication and to create a five-year strategic plan. Discussions were informed by surveys completed by readers, article reviewers, authors and the editorial board members themselves.

In the survey results, readers told us they appreciate *OT Now* content that is practical and relevant to practice. They like content that keeps them up to date with what is happening in the profession, particularly in Canadian practice. There was also positive feedback about the length of *OT Now* articles and the fact that they feel accessible – the right size for a busy practitioner to consume. Readers highlighted that they especially appreciate articles that address case studies, knowledge translation, the role of occupation in practice, new or interesting resources, service models, practical tips and summaries of current research. Authors, column editors and guest reviewers generally provided us with positive feedback about their experience of working with *OT Now*, and had suggestions for how we could improve our review process and submission guidelines.

The conversation at the strategic planning day was spirited and full of ideas and possibilities for *OT Now's* future. The outcome of these discussions was an updated mission, vision, value statements and list of strategic priorities.

Mission statement

Provide a vehicle for the dissemination and exchange of information in order to advance occupational therapy.



From the August 1975 cover of *The National*.

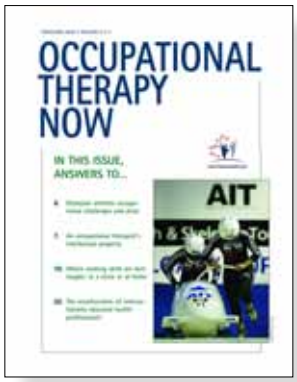
Vision

Occupational Therapy Now will be a recognized, comprehensive resource for pushing boundaries and inspiring visions of possibilities for the occupational therapy landscape of health, well-being and justice.

Value statements

CAOT values integrity, accountability, respect, equity,

***OT Now*, January 1999.**



***OT Now*, May 2006.**

innovation and transparency. In addition, *Occupational Therapy Now* values:

- high quality, evidence-informed, practical, accessible, timely and interesting content regarding occupational enablement;
- discussion and shared experience;
- leadership and advocacy;
- processes that are fair, transparent and timely;
- relevance to Canadian practice, potentially with a global reach;
- knowledge mobilization, exchange and translation;
- multi-level collaborations within and beyond the health arena locally and globally;
- inclusivity of all stakeholder groups.

Strategic priorities:

1. Enhance the knowledge mobilization, exchange and translation capacity of *OT Now*.
2. Inspire visions of possibilities for occupational therapy.
3. Expand the reach of *OT Now* and the engagement of all its stakeholders.
4. Enhance multi-level collaborations within and beyond the health arena locally and globally.
5. Clarify the status of *OT Now* within the continuum of CAOT resources and the broader health, wellness and resources landscape.
6. Enhance continuous quality improvement processes.

***OT Now*, September 2013.**

We are thankful for the many ideas that were suggested through the surveys and the strategic planning day and, in working towards our new strategic priorities, we have begun to work on putting some into action. These include updating our submission and review processes, ensuring equitable processes for French and English submissions, presenting a theme issue in March on occupational therapy's contributions to addressing social issues, and providing a 'how to write for *OT Now*' conference workshop and Water Cooler Talk. We plan to continue presenting practical, applicable, accessible content that is of interest and use to readers. We plan to continue emphasizing a mentoring style of article evaluation to encourage and support inexperienced authors as well as experienced ones.

As Mary Clark said in her editorial of the last issue of *The National, OT Now* is "your practice magazine – written, edited and debated by Canadian occupational therapists who make the time to put their thoughts and practices on paper, challenge what they read, and in the long run, improve the overall practice of occupational therapy in Canada" (1998, p. 2). Fifteen years later, these words remain true. What are you up to that might be of interest to colleagues across the country? Or to consumers, stakeholders and the public? What do you want *OT Now* to be? What can *OT Now* do for you? My inbox is always open: otnow@caot.ca

Thank you to all the readers, authors, editorial board members, column editors, our translation and production team, and CAOT for the ongoing support that continues to nourish this publication.

All 15 years of *OT Now* issues are available online for CAOT members at: http://www.caot.ca//default.asp?ChangeID=94&pageID=88

References

Allbon, L. G., & Rowland, E. F. (1974). Editorial. *The National, 1*(1), p. 1.

Clark Green, M. (1998). Editorial: A comfortable end. *The National, 15*(6), p. 2.

COLUMN EDITORS: HEIDI CRAMM AND HEATHER COLQUHOUN

How one research committee is tackling research capacity in occupational therapy

Dayna Greenspoon, Andrea Dyrkacz, Vicky Cheung, Alison Lake, Trudy Langendoen, Lonita Mak, Candy Pleasance and Kauser Tarbhai

Development of an occupational therapy research committee

University Health Network (UHN), one of Canada's largest academic health-care networks, consists of three acute care hospitals and five rehabilitation centres. Together, they strive to transform patient care, research and education locally and globally (UHN, 2012). Occupational therapists and occupational therapist assistants at UHN strive to use evidence-based practice as one means to achieve this goal. After all, the Canadian Association of Occupational Therapists includes scholarly practice as a core role of occupational therapists; scholarly practitioners "critically evaluate information to support client, service, and practice decisions" (2012, p. 10) and "support the use of best evidence, and the distribution and translation of new knowledge into … practice" (2012, p. 12). This includes the creation of evidence through participation in research.

As part of scholarly practice, knowledge translation is "… a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system" (Canadian Institutes of Health Research, 2012). Health-care professionals, consumers, researchers and policy-makers look to knowledge translation to help bridge the gap between knowledge and practice (Newton & Scott-Findlay, 2007). If done well, it should encompass the entire research enterprise, from the development of a research question to the incorporation of knowledge into practice (Metzler & Metz, 2010). It also includes activities designed to increase the degree to which occupational therapists use research as an integral component of practice and the degree to which they are involved in the conduct of research.

The recent merge of the University Health Network and Toronto Rehab into one institution to provide care across the continuum has provided an opportunity to look at what is required to assist practitioners to move scholarly practice forward in the spirit of collaborative practice. Approximately 120 occupational therapists and occupational therapist assistants at UHN work across varied practice contexts. This diversity creates challenges in collaboration, and in both using and conducting research. The Occupational Therapy Research Committee was created to address these challenges. The goal of the committee is to help overcome challenges to knowledge translation at UHN by implementing initiatives that enhance research competence. In this article, we will discuss how the committee went about creating a plan to achieve this goal.

Barriers and facilitators to practicing occupational therapists engaging in research activities

In order to enhance occupational therapists' use of research in everyday practice and encourage more occupational therapists to become involved in conducting research, specific personal and organizational barriers must be identified. Metcalfe et al. (2001) examined attitudes towards research and perceived barriers to implementing research in practice among four allied health disciplines: speech and language pathology, occupational therapy, physiotherapy and clinical nutrition. The Occupational Therapy Research Committee at UHN developed a short questionnaire using the survey developed by Metcalfe et al. (2001) as a guide to examine UHN occupational therapists and assistants' attitudes, barriers and facilitators to using and conducting research. An electronic survey was developed and emailed to all occupational therapy staff at UHN. The survey consisted of 16 questions that were open- and closed-ended in nature. The survey was open for one week with a reminder sent midweek to encourage timely responses. Responses from open-ended questions were summarized based on a consensus of the entire committee.

The University Health Network Occupational Therapy Research Committee.
Front Row: Trudy Langendoen, Candy Pleasance, Dayna Greenspoon.
Back Row: Lonita Mak, Kauser Tarbhai, Andrea Dyrkacz, Vicky Cheung.
Missing: Carly Charach.

Survey findings

Attitudes regarding research

The survey had a 57.5% response rate. Research was indicated as "important for professional practice" by 96.7% of respondents. Of the survey respondents, 73.13% reported at least some proficiency with searching, reading and evaluating literature. While 65.2% percent reported having some level of participation in research activities, 71.6% of the respondents indicated that they had limited or no experience with conducting independent research. Figure 1 highlights the survey respondents' self-evaluations of their research proficiencies. Despite limited experience, respondents expressed an interest in locating, reading and conducting research, emphasizing that there is an interest in improving their skills in these areas and the need to identify and address specific perceived research-related barriers.

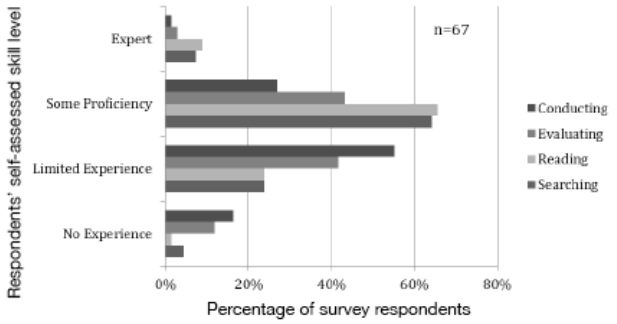


Figure 1. **Occupational therapist and occupational therapist assistant rankings of personal research skills.**

Perceived barriers

Practitioners were asked to identify barriers to using and conducting research across UHN. Figure 2 illustrates the various barriers to using and conducting research that were identified by respondents. 'Time' was identified as the most significant barrier. Respondents described the challenge of managing caseload demands with a lack of protected time to pursue research. One occupational therapist stated, "It is very challenging to see patients and chart. Adding research would be amazing, but my caseload is overwhelming as it is." Employment status was cited as a barrier, as those employed on casual, temporary or part-time bases are challenged to engage in research if they not available on a consistent or ongoing manner.

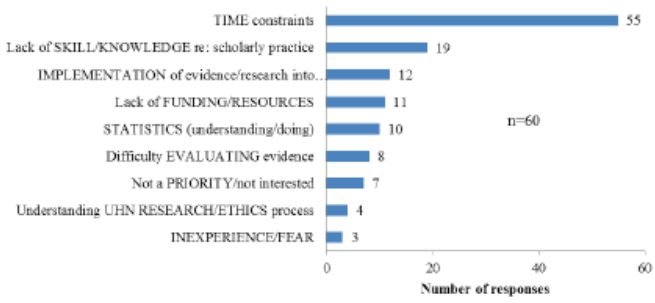


Figure 2. **Barriers to the implementation of evidence and research into practice at UHN.**

Lack of knowledge and skills related to research was the second most frequently identified barrier. Many indicated that they had fewer than five years of practice experience. Figure 3 shows the diverse range of years of practice experience within the profession at UHN. One respondent indicated that the learning curve for an entry-level practitioner is significant; the development of clinical skills is necessarily prioritized over research engagement and development of research skills.

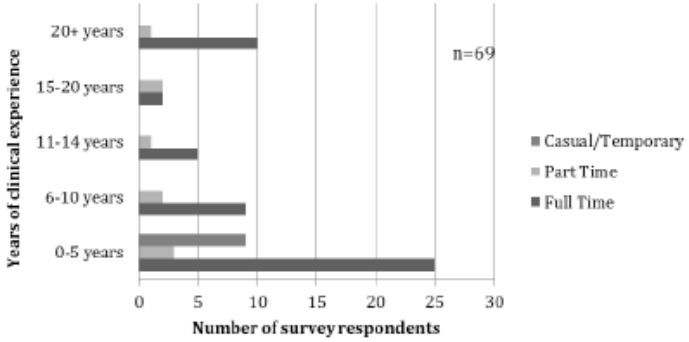


Figure 3. **Years of practice experience and employment status of survey respondents.**

Fifty-seven percent of respondents reported having participated in research as a degree requirement. Although research-related knowledge and skills were gained through this experience, it was not deemed sufficient by respondents to provide the competence needed to design and implement independent research. Respondents also identified difficulties with statistics as a significant barrier to using and conducting research. Other identified obstacles to knowledge translation were institutional in nature, such as a lack of access to funding and mentorship, or were related to a lack of skill evaluating evidence and implementing research findings.

Perceived facilitators

Therapists were asked to identify perceived facilitators for research and scholarly activity at UHN. Again, the majority indicated that protected research time and acquiring help with balancing caseload and research demands would enable participation in research-related activities. Also suggested were opportunities for active learning focused on specific research skills (e.g., literature reviews, critical appraisals of evidence and statistics). Other recommendations included research mentorship, increased access to resources and funding, journal clubs, the creation of a guide to UHN research processes and opportunities to collaborate with colleagues.

What the literature tells us about improving research capacity

The perceived barriers to knowledge translation identified by occupational therapy staff at UHN were consistent with those identified in interprofessional literature, including insufficient time, difficulty understanding statistics and conflicting results reported in the evidence (Metcalfe et al., 2001; Grol & Grimshaw 2003; Metzler & Metz, 2010). Studies indicate interventions to overcome barriers related to knowledge translation that are active, multi-faceted and

interpersonal (e.g., educational outreach opportunities, interactive continuing education seminars and problem-based learning groups) are more likely to be effective in changing the research behaviours of health professionals than passive, single-dissemination strategies (e.g., articles, websites, newsletters and information bulletins). Although less effective in changing research behaviours, passive dissemination strategies may be useful in increasing general knowledge regarding particular topics and issues, and are also less expensive to implement (Grimshaw et al., 2001; Grol & Grimshaw, 2003; Metzler & Metz, 2010).

Where do we go from here?

Since its inception in early 2012, the goal of the UHN Occupational Therapy Research Committee has been to create and sustain a culture of research. The first event sponsored by the committee was a research symposium as part of UHN Occupational Therapy Month celebrations. The sharing of recent research activities by UHN occupational therapists and assistants with intra- and interprofessional colleagues encouraged knowledge translation through dialogue and discussion of the practice applications of research findings. We aim to conduct this research symposium each year.

In response to the survey, initiatives are being undertaken to promote and address identified barriers to knowledge translation. Both active and passive dissemination strategies will be used in order to address the gap between research and practice. These include plans to:

- Identify occupational therapy staff members who are acknowledged as scholarly practitioners with research-related skills to develop a pool of peer educators and mentors.
- Establish a research-specific mentorship program to provide opportunities for those interested in participating in research to collaborate with more experienced practitioners who can provide practical research guidance.
- Create a step-by-step guide to undertake research at UHN, from literature review to publication, including the process of research ethics approval.
- Develop a 'research school,' consisting of regular, sequenced sessions led by peers to provide practical guidance on topics related to the use and creation of evidence. Using didactic and small group problem-based approaches, participants will develop skills to enhance abilities in evaluation and use of evidence, in undertaking research, and in presentation and publication.
- Pursue opportunities to develop and share research resources, engage in education and participate in collaborative research with other members of the interprofessional team. For example, a 'research school,' in conjunction with UHN's spiritual care department is being developed to provide a structured process to enhance research skills. The hope is that this partnership will create opportunities to engage in joint research endeavors.

Occupational therapists and assistants at UHN have a significant history of engaging in evidence-based practice and research. The creation of an occupational therapy-specific research committee has led to the development of a road map to shape research education and mentorship for the next decade.

References

Canadian Institutes for Health Research. (2012). *About knowledge translation*. Retrieved from http://www.cihr-irsc.gc.ca/e/29418.html

Canadian Association of Occupational Therapists. (2012). *Profile of practice of occupational therapists in Canada: 2012*. Retrieved from http://www.caot.ca/pdfs/2012otprofile.pdf

Grimshaw, J. M., Shirran, L., Thomas, R., Mowatt, G., Fraser, C., Bero, L., . . . O'Brien, M. A. (2001). Changing provider behavior: An overview of systematic reviews of interventions. *Medical Care, 39*(8), II-2 - II-45.

Grol, R., & Grimshaw, J. (2003). From best evidence to best practice: Effective implementation of change in patients' care. *The Lancet, 362*, 1225-1230. doi:10.1016/S0140-6736(03)14546-1

Metcalfe, C., Lewin, R., Wisher, S., Perry, S., Bannigan, K., & Klaber Moffett, J. (2001). Barriers to implementing the evidence base in four NHS therapies: Dietitians, occupational therapists, physiotherapists, speech and language therapists. *Physiotherapy, 87*(8), 433-441.

Metzler, M. J., & Metz, G. A. (2010). Translating knowledge to practice: An occupational therapy perspective. *Australian Occupational Therapy Journal, 57*, 373-379. doi: 10.1111/j.1440-1630.2010.00873.x

Newton, M. S., & Scott-Findlay, S. (2007). Taking stock of current societal, political and academic stakeholders in the Canadian healthcare knowledge translation agenda. *Implementation Science, 2*(32), 1-6. doi:10.1186/1748-5908-2-32

University Health Network. (2012). *UHN: About UHN*. Retrieved from http://www.uhn.ca/about_uhn/index.asp

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Students creating innovative occupational therapy roles through integration of academic and fieldwork curricula

Shelley Vaisberg, Andrea Duncan, Tara Laing, Biraj Khosla, Rachel Stack and Donna Barker

Role-emerging fieldwork placements provide opportunities for students to work within organizations that have not yet employed occupational therapists; that is, these organizations have not been exposed to the possible valuable contributions of our profession (Bossers, Cook, Polatajko, & Laine, 1997; Cooper & Raine, 2009). Supervision of students within these unique placements is provided by an off-site registered occupational therapist with expertise in a related practice area, and an on-site professional within the organization. The on-site preceptor works together with the student and the off-site preceptor to uncover areas where occupational therapy services would be beneficial as well as to plan the logistics for introducing these services. Aside from providing students with unique practice experiences, the goal of this type of placement is to highlight the value of occupational therapy with the hope of creating a permanent occupational therapy role within these organizations. Typically, these placements have been organized by the academic fieldwork coordinators and occur within community non-profit organizations. In the last couple of years, occupational therapy students at the University of Toronto have been invited to submit proposals for role-emerging placements by applying the skills and concepts learned through their project work within a year-one practice course that emphasized new and emerging roles for occupational therapists. Students' enthusiasm for, and creativity in, establishing these roles has contributed to the project's overall success, as illustrated below in Shelley Vaisberg's account of her experiences as a student on such a role-emerging placement.

Supporting practice innovation through student-initiated fieldwork experiences

I began to recognize the value of role-emerging placements because of their demand for creativity and innovation, and I was excited that these experiences were offered by my program. At the beginning of my second year in the occupational therapy program, I became interested in collaborating with an industrial designer who had created an educational toy company, Twenty One Toys Inc. This company designs toys to teach 21st century skills: creativity, collaborative learning, innovation and problem solving (Twenty One Toys, 2013). As I learned more about the designer's flagship toy, Connexions, I began to appreciate the varied possible applications for toys within occupational therapy practice. Occupational therapists value play as a means for children to develop a wide range of skills in adaptive functioning, such as emotional regulation, coping and problem solving (Rodger & Ziviani, 1999). In adults, play provides the opportunity to create and explore novel behaviours as well as solidify and consolidate new ones (Vandenberg & Kielhofner, 1982). Over the next few months, the company founder and I explored the idea of developing a rehabilitation market for Twenty One Toys.

When the University of Toronto fieldwork coordinators offered students the opportunity to design a role-emerging placement, I submitted a proposal along with a business plan. After many planning sessions, I focused the scope of the placement in two areas: one, on running a trial of the Connexions toy with one client population and, two, on creating a business contract with the industrial designer to formally define our working relationship. I decided to explore the use of this toy in a mental health setting.

Connexions is comprised of two sets of abstract three-dimensional puzzle pieces. One player starts with a shape built from two to five pieces and must tell another player how to recreate that shape with an identical set. The challenge is that both players are blindfolded. In the mental health setting,

Shelley Vaisberg, playing with the Connexions toy.

the toy was used to address socialization skills necessary for successful functioning in daily life: self-discipline, cooperation, concentration, competition, socio-flexibility, leadership, followership, emotional control, tolerance and problem solving. Through this exercise and a debriefing session thereafter, players would have the opportunity to create, explore, solidify and consolidate behaviors to enable them to enhance occupational performance and function successfully in daily life.

My placement experience at Twenty One Toys was unique among other role-emerging fieldwork placements offered at the university because I had two occupational therapy off-site preceptors. One had clinical experience in mental health and one had business expertise. The university assisted me with identifying occupational therapists within the community who would be interested in this project and connected me with the appropriate contacts to negotiate the details of the project.

Designing this placement was a challenging task as I had to translate my big vision of developing a rehabilitation market for the toy into a manageable reality. This task required determining the rationale, purpose, objectives, resources and implementation plan for an eight-week timeline. I had never completed a placement in mental health, and the proposal demanded a great deal of research to rationalize the use of this tool in a mental health setting. I had difficulty determining the structure and timeline of the placement because I did not know how much time I needed to introduce the tool to the occupational therapists and clients, to have them implement the tool and to receive their feedback. Most of the information in my proposal was based on a monitor and modify strategy.

On the first day of my placement, the preceptors and I decided that I would spend two days per week practicing clinical skills with my mental health occupational therapist preceptor at a mental health hospital and three days per week at the Centre for Social Innovation (CSI), where I would work alongside the founder of Twenty One Toys. CSI serves Toronto's community of social entrepreneurs by providing a common workspace to socially-charged projects. It enables entrepreneurs to work, meet and connect as a community. Every year, CSI offers an initiative titled *Youth Agents of Change Program*, whereby space and support are provided to young people with a promising social venture. I was accepted to this program with a vision to develop health-care market applications for new and existing toys and to develop tools to address the needs of vulnerable populations (for example, individuals with mental health issues, and physical and cognitive disabilities). At CSI, I worked independently and checked in with my off-site occupational therapy preceptors on a weekly basis.

The fieldwork implementation plan had three phases. In the first phase, I gathered information by obtaining feedback on the clinical utility of the tool from occupational therapists. The first two weeks of placement were designed to orient me to, and clarify the expectations of, my placement and for organizing the initial in-services and focus groups. I quickly realized that my initial proposal objectives were too broad, so I developed more specific learning objectives by the end of my second week. Had the specific learning objectives been developed prior to beginning my placement, I would have been better prepared to start the project immediately. As it was, I felt that I lost some time in those first two weeks. Once the specific learning objectives were determined, I felt comfortable moving forward.

In the second phase, I focused on product development by designing the instruction manual for using the tool with a mental health population (based on the information received in the first phase). In the third phase, I reviewed the first draft of the manual with occupational therapists and gathered feedback. While the tool received positive feedback in practice, it became clear that further research was required to determine the effectiveness of the instruction manual and an appropriate cost structure.

Throughout these three phases, I was also developing a marketing strategy for this tool. While these phases were initially outlined in the placement proposal, the specific learning objectives I created in week two clarified the details of the phases. These latter two phases ran smoothly as my preceptors provided continual guidance and feedback.

Lessons learned

Although there were many challenges along the way, this learning experience was exceptional. I learned that it is important to be open-minded and flexible due to the amount of uncertainty that exists when developing a new business venture. The placement was overwhelming at times, raising multiple complex questions. The high level of complexity taught me the importance of assessing all possible solutions to select the most appropriate one for the task at hand. I received a tremendous amount of support from my preceptors to help me overcome these challenges.

As innovative role-emerging placements become more prominent in occupational therapy programs, it is useful to learn from this experience. For students and universities considering this student-initiated type of role-emerging placement, I recommend a few key elements for a successful placement:

1. **Start early.** Establishing plans, preceptors and learning objectives early allows students to hit the ground running on their first day of placement. When recruiting preceptors, prepare and present a detailed proposal to ensure you recruit a preceptor with a skill set that complements the project.
2. **Plan for less.** Once you have determined all the goals for placement, cut them in half. Setting realistic goals will give students the opportunity to achieve them all with a high level of quality.
3. **Provide a variety of resources.** Ensure students have a team of preceptors who can provide them with varied expertise to address the needs of the project.
4. **Provide support.** Whether electronic, written or face-to-face support, ensure students have someone they can access for questions, concerns, ideas and encouragement.

The beauty of designing a role-emerging placement is that one can experiment with setting up a practice in a safe space, with access to abundant resources, support and guidance. As a result of this experience, I am now working part-time for Twenty One Toys as the Rehab and Health Care Advisor. This placement provided me with the opportunity to plan ahead in this challenging job market and develop my own occupational therapy position within this innovative company after graduation.

References

Bossers, A., Cook, J., Polatajko, H., & Laine, C. (1997). Understanding the role-emerging fieldwork placement. *Canadian Journal of Occupational Therapy, 64*, 70–81.

Cooper, R., & Raine, R. (2009). Role-emerging placements are an essential risk for the development of the occupational therapy profession: The debate. *British Journal of Occupational Therapy, 72*, 416.

Rodger, S., & Ziviani, J. (1999). Play-based occupational therapy. *International Journal of Disability, Development, and Education, 46*, 337–365.

Twenty One Toys. (2013). *About*. Retrieved November 3, 2013, from http://twentyonetoys.com/about/

Vandenberg, B., & Kielhofner, G. (1982). Play in evolution, culture, and individual adaptation: Implications for therapy. *American Journal of Occupational Therapy, 36*(1), 20–35.

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STUDENT PERSPECTIVES

COLUMN EDITORS: LAURA HARTMAN AND CHRISTINA LAMONTAGNE

Different perspectives, common goal: A student's experience in collaborative care

Shauna Eisen

Last fall, as I was settling into my final year as an occupational therapy student at Queen's University, I was introduced to a unique opportunity for interprofessional learning: the Health Care Team Challenge™. While the enthusiasm of past participants and event organizers made me eager to volunteer, I had no idea how the year-long journey would shape the way I viewed interprofessional collaboration, and ultimately my role as an occupational therapist. In this article, I hope to express the importance of early exposure to interprofessional collaboration through educational programs, and to shed light on the benefits of effective, ongoing interprofessional collaboration for occupational therapists, other health-care professionals and their clients.

Interprofessional events encourage health-care students to look at their profession as an important part of a health-care team (Cameron et al., 2009). To promote collaborative care and the development of future health-care team members, the Office of Interprofessional Education and Practice (OIPEP) at Queen's University runs several interprofessional events throughout the academic year. One of the main events that brings together Faculty of Health Sciences students is the annual Health Care Team Challenge™. This event, now in its fifth year at Queen's University, was designed to challenge students within the Faculty of Health Sciences to collaborate in developing client-centered, creative and effective care plans for a fictitious client developed by OIPEP and community partners.

For the teams of students, the event was the culmination of many weeks of meetings, planning and discussions, as each team of randomly-assigned students prepared to present a care plan for this year's patient, 'Lucy.' Every week for four weeks, I met with my team who consisted of upper-level physiotherapy, medical, clinical psychology and nursing students. To assess and plan an intervention for our 'client,' Lucy, a 77-year old female who presented with various concerns, such as coronary artery disease, celiac disease, and degenerative disc disease, we brainstormed, compiled resources, clarified roles and discussed professional reasoning. On the day of the official challenge, three teams presented their care plans to an audience of fellow students, health-care professionals, academic leaders and community members. Our team won the regional competition and went on to compete at the national Health Care Team Challenge™ in Vancouver in June 2013. My reflection on the experience has led to many important lessons for myself, as well as hopes for my future interprofessional practice.

Through participating in this unique interprofessional event, my teammates and I were able to recognize and appreciate the challenges as well as the rewards of working together. While conflicting schedules, differing professional jargon and unfamiliar scopes of practice were among the many obstacles we faced as a team, gaining understanding and genuine respect for each other's professional roles were some of the rewards. Our discussions of role clarification, term definitions, treatment priorities and professional competencies helped us navigate around obstacles to facilitate a smoother group process. Keys to effective communication included allowing opportunities for each member to express his or her perspectives and knowledge, using common language and defining necessary terms, as well as identifying each member's personal and professional skills relevant to the case. This commitment to clear communication allowed us to maximize our potential as a group to determine the best care for our client. While these methods were effective in the context of this challenge, they also provided us with helpful information, better communication skills, and valuable experiences in interprofessional conflict management that will be truly relevant to our future roles on health-care teams.

As team member Adam Heenan (clinical psychology) stated, "I was amazed at how stereotypes were quickly replaced with well-earned respect after discussing cases with the members of my team." Once initial conflicts and barriers were addressed, newfound understanding contributed to holistic, efficient and client-centered care. Team member Peng You (medicine) commented, "Having to work together to manage a case helped me appreciate the various resources each profession is able to contribute." As well, our faculty mentor, Catherine Donnelly (occupational therapy), was "inspired to see the depth of learning and collaboration that occurred as the team immersed themselves in developing Lucy's care plan."

Through recognizing and accessing the personal and professional skills of the other members, as well as our combined abilities, we were able to increase our collective proficiency in developing the most comprehensive plans for our client. Our team strengths included our consideration

Members of the winning team at the Queen's University Faculty of Health Sciences Office of Interprofessional Education and Practice Health Care Team Challenge™ 2012. Left to right: Adam Heenan (psychology), Katrina Parent (nursing), Catherine Donnelly (faculty mentor), Kristen Riley (physiotherapy), Shauna Eisen (occupational therapy), Peng You (medicine) and Cody Li (medicine).

of our client's mental health, our ability to communicate effectively through use of technology, and our ability to access relevant community resources. At the end of the challenge, our final care plan for Lucy included fall prevention education, collaborative medication management, pain management and encouraging constant family involvement. Through continued communication and collective problem-solving, our team not only realized the depth and value of each of our distinct roles, but most importantly, we realized that many of our professional competencies and views towards client health were similar.

While many interprofessional events encourage learning about the roles of other health-care professionals, this unique experience of working together as a team over an extended period of time allowed us to take our first real look into the professional dynamics that may exist in any health-care setting. In light of the positive response this event received from participants and audience members, I believe incorporating long-term team work opportunities, friendly competition, and care plan presentations into future interprofessional events would be highly valuable. Through expanding on current interprofessional education programs with these same components, many other students from other institutions can experience the sense of teamwork, mutual respect and understanding of intra- and interprofessional roles. These opportunities can encourage the development of professional collaboration skills - valuable, transferable skills that can later be applied in workplaces across Canada.

As an emerging occupational therapist, I think it is important to recognize the value of collaborative care early in one's professional training. I have now seen how mutual support, respect and understanding can enable a team to work at its best. Team member, Katrina Parent (nursing) was inspired to "... be even more of an advocate for my patients and to play an active role in the workplace to ensure interprofessional collaboration."

I believe occupational therapy students and practicing professionals can play an important leadership role in promoting interprofessional collaboration. We can do this by seeking opportunities for relevant professional development, by committing ourselves to engage in scope of practice clarification with colleagues, and by actively discussing and exploring the unique strengths that professional health-care teams can offer clients. Through the Health Care Team Challenge™, I was able to see how each member of a health-care team offers a unique perspective based on their scope of practice and experiences, and how it is that when each of these perspectives is recognized and appreciated by the entire team, that the common goal of providing the best possible client care can be achieved.

For more information about the Health Care Team Challenge™, go to:
http://healthsci.queensu.ca/education/oipep/ipe_curriculum/health_care_team_challenge_hctc_

Suggested resources for learning more about interprofessional practice:

- Canadian Interprofessional Health Collaborative: http://www.cihc.ca/
- Canadian Interprofessional Health Leadership Collaborative: http://cihlc.ca/
- Donnelly, C., Brenchley, C., Crawford, C., & Letts, L. (2013). The integration of occupational therapy into primary care: A multiple case study design. *BMC Family Practice, 14*:60.

References

Cameron, A., Rennie, S., DiProspero, L., Langlois, S., Wagner, S., Potvin, M., . . . Reeves, S. (2009). Findings from and evaluation of an interprofessional education experience for 1000 first-year health sciences students. *Journal of Allied Health, 38*(4), 220-226.

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GUEST COLUMN EDITOR:
SUSAN BAPTISTE

Human and animal interactions in occupational therapy

Claire Dumont

Human beings have always formed strong ties with the animal world. Whether it be to feed, clothe or protect ourselves, to help us with our work, for transportation or play, to keep us company or simply to cheer us up, animals are part of human occupations. The study of animals has helped researchers advance our knowledge, particularly in such fields as anatomy, physiology and psychology. Animals are also used in testing the efficacy of treatments, with growing recognition of the beneficial role they can play in human health. In Quebec, for example, the Mira Foundation trains guide dogs for people with low vision, mobility assistance dogs, service dogs for children with autism and rehabilitation dogs (MIRA, 2013a; 2013b). The Quebec government classifies assistance dogs as technical aids and pays their annual maintenance costs (Government of Quebec, 2013). This article reviews current scientific knowledge about the benefits of human-animal interactions with a view to recognizing potential uses in occupational therapy. Secondly, it proposes some theoretical considerations aimed at exploring how the animal model (i.e., considering the animal world, their characteristics and issues) might contribute to occupational therapy interventions and research. The article is based on a literature review as well as consultations with animal experts, including veterinarians, animal behaviourists and specialists in animal-assisted therapy.

Current scientific knowledge

Several literature reviews provide an overview of scientific knowledge about the effects of human-animal interactions (Barker & Wolen, 2008; Endenburg & van Lith, 2010; Giaquinto & Valentini, 2009; O'Haire, 2009; Palley, O'Rourke, & Niemi, 2010). The Delta Society website has a list of research publications that document the use of different animals (dogs, horses, dolphins, etc.) for therapeutic purposes (Delta Society, 2013). A broad range of applications are cited for animal-assisted therapy with all age groups in all types of health-care institutions, and for a variety of conditions, including dementia, schizophrenia, depression, personality disorders, cancer, heart problems, HIV/AIDS and sexual abuse. Observed effects include decreases in depression, anxiety, isolation, agitation, apathy and pain, and improvement in mood and social interactions. Animals can stimulate physical activity, thereby assisting with rehabilitation programs (Barker & Wolen, 2008; Giaquinto & Valentini, 2009) and reducing mortality after heart surgery (Palley et al., 2010). Other clearly demonstrated beneficial effects of human-animal interactions involve child development in the areas of social, cognitive, emotional and language development. Consequently, occupational performance might improve in activities including, but not limited to, school performance, leisure activities and personal independence, particularly in children with developmental delay, behaviour problems or autism (Barker & Wolen, 2008; Endenburg & van Lith, 2010; Sams, Fortney, & Willenbring, 2006; Viau et al., 2010). According to several studies, using animals in treatment helps reduce health-care costs, owing to such benefits as shorter intervention times, improvements in psychological well-being and better social support (O'Haire 2009). Animals are non-judgmental; they accept us with all our differences and limitations and want to be with us, as long as we give them what they need. Attachments to animals can become just as close as attachments to other humans (O'Haire, 2009). According to Vasen and Massei (2006), social reintegration programs in mental health services benefit from the therapeutic effect of human-animal interactions in the community, particularly related to socialization. Focusing more specifically on occupational therapy, Zimolag and Krupa (2009) describe the benefits of companion animals for persons with mental health problems. One of the authors' recommendations is that occupations related to pet ownership be given greater consideration in occupational therapy. Having a companion animal alters a person's daily routine. Caring for an animal can represent a significant occupation that enables the pet owner to take on responsibilities, boosting self-esteem and social integration (Zimolag & Krupa, 2009). Bonding with an animal can give meaning to life, and the animal can become a life companion.

Nevertheless, some authors underscore the weak points of many of the studies examined, including descriptive approaches, small sample sizes and methodological weaknesses, and point out the need for more robust studies. They suggest avenues of research to help understand the psychological effects of being with animals and to develop better knowledge of the mechanisms of human-animal interactions (Barker & Wolen, 2008; Endenburg and van Lith, 2010; Giaquinto & Valentini, 2009; O'Haire, 2009; Palley et al., 2010).

The human model and the animal model

In this section, a comparison is drawn between the knowledge applied by occupational therapists and by animal specialists. Consideration is given to whether the animal model might be applied in the study of occupation, as it is in other disciplines (e.g., medicine's use of laboratory animals and psychology's studies of animal behaviour), while taking into account that there are limitations to the extent to which animal models can be related to human occupations.

The Canadian Model of Occupational Performance and Engagement (CMOP-E) (Townsend & Polatajko, 2013) groups human occupations into three categories: self-care, productivity and leisure. Animals' main occupations share many commonalities with human occupations, such as: seeking food, eating, maintaining hygiene, obtaining protection, defending territory, reproducing, building or arranging appropriate shelter, playing, teaching their young, engaging in species-appropriate social activities, resting and sleeping (ETHO-Logique, 2013; Cyrulnik, 2013).

Several individual or personal factors can disrupt human and animal occupations alike. Genetic predispositions, for example, can influence occupations (e.g., cancer, diseases of the liver, heart or kidneys, behavioural problems, cognitive difficulties related to aging, etc.). Treatments and technical aids that are used in human medicine may also be used for animals. These include, for example, wheelchairs for cats or dogs and access ramps that enable elderly dogs to get up onto a sofa.

The occupations of all living beings (human or animal) can also be disrupted by environmental factors, particularly when the natural habitat is altered by disasters, climate change or pollution (Blakeney & Marshall, 2009; Pereira, 2008). The impact of occupational deprivation while living in a restrictive environment has been studied and described for human beings, such as prisoners and refugees (Bryant, Craik, & McKay, 2004; Cockburn, 2005; Farnworth & Muñoz, 2009; Provident & Joyce-Gaguzis, 2005; Whiteford, 2005), and for animals. In fact, according to animal specialists, animals that live in environments created by humans (such as houses, zoos and farms) may actually experience occupational deprivation – they no longer have to seek their own food or defend their territory, they do not reproduce, and their social lives are dictated by human social patterns rather than their own (M.-P. Rainville, personal communication, February 12, 2011). Many have trouble adapting and some even develop aberrant behaviours or stereotypies (i.e., purposeless and unregulated repetitive behavioural patterns), which veterinarians sometimes consider an obsessive-compulsive disorder (OCD) (Overall & Dunham, 2002). Examples of animals engaging in such behaviour include parrots that pluck out their feathers or horses that continuously repeat the same back-and-forth movement (Gaultier, Boureau, Pageat, & Falawee, 2005). This situation can be ameliorated by providing an environment that matches the natural living conditions of the species. For example, a stallion in the wild is in charge of watching over and protecting his herd. He can be effective because his eyes are set on each side of his head, giving him 360-degree vision. If he is kept in a place where he sees nothing but walls on each side, he may develop OCD. According to a veterinarian who specializes in horses (K. Rodier, personal communication, February 12, 2011), restoring a 360-degree field of vision to the horse can mitigate this type of problem. Another type of intervention is known as enrichment for animals living in captivity, where animals are able to perform activities that resemble what they would do in the wild, like search for food or play with toys (Bouchard, 2008). Environmental enrichment is also used to improve daily life and prevent problems among incarcerated people and refugees (Farnworth & Muñoz, 2009) and to keep employees motivated (by enriching their tasks with greater responsibility, additional challenges, more autonomy, etc.) (Herzberg, 1971; Ryan, Lynch, Vansteenkiste, & Deci, 2011). The management or adaptation of the environment therefore enables occupation for both humans and animals.

The environment must permit occupations to be performed. An occupational therapist can contribute to environmental adaptation, for example, by improving physical accessibility for people with impaired mobility or vision. Adaptations can also be conceived for the needs of cognitive and sensory function, such as in the case of people with autism for whom the management of certain environmental factors can enable occupational performance (Mottron, 2004). The environment must also meet the needs of the person. Humans are social beings who need to be physically and cognitively active, need parental care to develop, and opportunities for essential occupations must be provided in the environment. There has been a significant increase in the prevalence of neurodevelopmental disorders, like autism, in children (Blaxill, 2004; Taylor, Jick, & Maclaughlin, 2013). Could expertise in the field of occupational therapy contribute to identifying problematic elements in our environments and suggesting

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favorable environments, possibly inspired by an ethological approach (Cyrulnik, 2013)? Could animal models provide paths to understanding which environments are the most favorable for humans, according to their particular attributes? In occupational therapy, could we deepen our models to include the environmental conditions and occupations that are favorable to humans in different stages of life?

The theoretical basis for interventions

Interventions with humans and animals are grounded in several behavioural theories. Classical or operant conditioning is considered a widespread behavioural theory applied to animals. Modern approaches use this theory by combining a treat (earned reward) and the sound of a whistle or clicker; this technique is called teaching with acoustical guidance (TAG). The animal associates the sound with a message that acts as positive reinforcement – that is, a clear, simple message given at the right time that has a direct effect on the amygdala, rather than a complex message that must be understood and interpreted. Using a sound as reinforcement is effective and does not pose any risk to animals (Bouchard, 2008). TAG is also used in human training – for example, with athletes, dancers and gymnasts. The audio signal tells the individual when he or she has made the right movement, adopted the correct position, etc. (Stokes, Luiselli, Reed, & Fleming, 2010; TAGteach International, 2013). This approach is also used with people with autism or who have a developmental delay (Persicke, Jackson, & Adams, 2013; TAGteach International, 2013).

Other popular theories applied in work with humans are also sometimes used with animals, according to an animal behaviour specialist (J. Bouchard, personal communication, March 15, 2011). Elements of psychodynamics can be used when trying to understand what gives pleasure to an animal within a training framework. Identifying what gives pleasure can help identify what rewards can be used. In the theory of transactional analysis, Berne (1977) distinguished three types of ego states: the parent, the adult and the child. This theory can help the owner of an animal to understand the ties that bind it in regards to these three states, and possibly adjust their type of relation (parental, adult or child) if it is a source of difficulty.

Theories of motivation can also be used with both humans and animals. Maslow (1954) classified the hierarchy of human needs into five levels that constituted the foundation of motivations: 1) physiological, 2) safety, 3) social participation (belonging to a group), 4) self-esteem and 5) self-actualization. Living beings are born intrinsically motivated to satisfy their physiological needs first, and then the other needs in the order of level on the hierarchy. Knowing that the needs of animals are situated on the first two or three levels of the pyramid can help us to understand the motivations behind their behaviour in our interactions with them. The theory of intrinsic and extrinsic motivation is another theory of motivation (Ryan & Deci, 2000). Motivation is intrinsic when an action is prompted by the interest and pleasure derived from performing it – for example, eating when you are hungry, sleeping when you are tired, or engaging in a leisure activity or game that you enjoy. When motivation is extrinsic, the action is prompted by an outside factor, such as punishment, reward, social pressure or approval. Overuse of extrinsic motivation can weaken and even eliminate intrinsic motivation, at which point the action is performed solely to obtain a reward. This theory is used in the fields of health care (e.g., motivating patients to adopt certain behaviours), education and labour (e.g., motivating students and employees) (Gagné & Deci, 2005; Ryan, Lynch, Vansteenkiste, & Deci, 2011). According to an animal behaviour specialist (J. Bouchard, personal communication, March, 15, 2011), successful experiments have shown that its application can eliminate certain OCD behaviours among animals.

In summary, there are areas of overlap between animal and human models, with some theories and interventions applying to both groups, at least in part. Occupational therapists may be able to enrich current practice using human-animal interactions that have demonstrated effectiveness. These may range from occupations related to caring for a pet, to therapeutic interventions using an animal, such as a guide dog, to intervention models that are effective for both animals and humans. The animal model and the use of interactions with animals could be appropriate for interventions and research in occupational therapy, as they have been in other disciplines.

References

Barker, S. B., & Wolen, A.R. (2008). The benefits of human-companion animal interaction: A review. *Journal of Veterinary Medical Education, 35*, 487-95.

Berne, E. (1977). *Analyse transactionnelle et psychothérapie*. Paris : Petite Bibliothèque Payot.

Blakeney, A. B., & Marshall, A. (2009). Water quality, health, and human occupations. *American Journal of Occupational Therapy, 63*, 46-57.

Blaxill, M. F. (2004). What's going on? The question of time trends in autism. *Public Health Report, 119*(6), 536-51.

Bouchard, J. (2008). *Devenez le meilleur ami de votre chien*. Montreal, QC : Les Éditions de l'Homme.

Bryant, W., Craik, C., & McKay, E. A. (2004). Living in a glasshouse: Exploring occupational alienation. *Canadian Journal of Occupational Therapy, 71*, 282-289.

Cyrulnik, B. (2013). *Éthologie humaine*. Retrieved from http://australie.uco.fr/~cbourles/Ethology/Couretho/Etho_hum.htm

Cockburn, L. (2005). Canadian occupational therapists' contributions to prisoners of war in World War II. *Canadian Journal of Occupational Therapy, 72*, 183-188.

Delta Society. (2013). *Pet Partners, Touching Lives, Improving Health, Improving lives through positive human-animal interaction.* Retrieved from http://www.petpartners.org/aaa-and-aat-resources

ÉTHO-Logique. (2013). *Petite biographie éthologique*. Retrieved from http://www.ethologie.info/Etho-logique/Biblio.htm

Endenburg, N., & van Lith, H. A. (2010). The influence of animals on the development of children. *The Veterinary Journal, 190*, 208-214.

Herzberg, F. (1971). *Le travail et la nature de l'homme*. Paris : Entreprise Moderne d'Edition.

Farnworth, L., & Muñoz, J. P. (2009). An occupational and rehabilitation perspective for institutional practice. *Psychiatric Rehabilitation Journal, 32*, 192-198.

Gagné, M., & Deci, E. L. (2005). Self-determination theory and work motivation. Journal of Organizational Behavior, 26, 331–362.

Gaultier, E., Boureau, V., Pageat, P., & Falawee, C. (2005). Les stéréotypies

chez le cheval: revue de littérature. Pratique vétérinaire équine, 37, 5-14.

Giaquinto, S., & Valentini, F. (2009). Is there a scientific basis for pet therapy? *Disability and Rehabilitation, 31*, 595-598.

Government of Québec. (2013). *Portail santé mieux-être: Programme de remboursement de frais relatifs à l'utilisation d'un chien d'assistance à la motricité.* Retrieved from http://sante.gouv.qc.ca/programmes-et-mesures-daide/programme-de-remboursement-de-frais-utilisation-chien-assistance-a-la-motricite/description/

MIRA. (2013a). *Qu'est-ce qu'un chien d'assistance?* Retrieved from http://www.mira.ca/fr/nos-services/7/chien-d-assistance-pour-personne-avec-handicap-moteur_26.html

MIRA. (2013b). *Nos services: chien d'assistance pour enfant présentant un TED.* Retrieved from http://www.mira.ca/fr/nos-services/7/chien-d-assistance-pour-enfant-presentant-un-ted_142.html

Maslow, A. (1954). *Motivation and personality.* New York: Harper.

Mottron, L. (2004). *L'autisme, une autre intelligence: diagnostic, cognition et support des personnes autistes sans déficience intellectuelle*. Sprimont, Belgique: Mardaga.

O'Haire, M. (2009). *The benefits of companion animals for human mental and physical health.* Centre for Companion Animal Health, University of Queensland, Brisbane.

Overall, K. L., & Dunham, A. E. (2002). Clinical features and outcome in dogs and cats with obsessive-compulsive disorder: 126 cases (1989-2000). *Journal of American Veterinary Medical Association, 221*, 1445-1452.

Palley, L. S., O'Rourke, P. P., & Niemi, S.M. (2010). Mainstreaming animal-assisted therapy. *Institute for Laboratory Animal Research Journal, 51*, 199-207.

Pereira, R. B. (2008). Population health needs beyond ratifying the Kyoto Protocol: A look at occupational deprivation. *Rural and Remote Health. 8*: 927.

Persicke, A., Jackson, M., & Adams, A. N. (2013). Brief report: an evaluation of TAGteach components to decrease toe-walking in a 4-year-old child with autism. *Journal of Autism and Developmental Disorder, 9*/2013. doi:10.1007/s10803-013-1934-4

Provident, I. M., & Joyce-Gaguzis, K. (2005). Creating an occupational therapy Level II fieldwork experience in a county jail setting. *American Journal of Occupational Therapy, 59*, 101-106.

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist, 55*, 68-78.

Ryan, R. M., Lynch, M. F., Vansteenkiste, M., & Deci, E.L. (2011). Motivation and autonomy in counseling, psychotherapy, and behavior change: A look at theory and practice. *The Counseling Psychologist, 39*, 193-260.

Sams, M. J., Fortney, E. V., & Willenbring, S. (2006). Occupational therapy incorporating animals for children with autism: A pilot investigation. *American Journal of Occupational Therapy, 60*, 68-74.

Stokes, J. V., Luiselli, J. K., Reed, D. D., & Fleming, R. K. (2010). Behavioral coaching to improve offensive pass-blocking skills of high school football athletes. *Journal of Applied Behavioral Analysis, 43*, 463-72. doi:10.1901/jaba.2010.43-463

TAGteach International. (2013). *What is TAGteach?* Retrieved from http://www.tagteach.com/What_is_TAGteach

Taylor, B., Jick, H., & Maclaughlin, D. (2013). Prevalence and incidence rates of autism in the UK: Time trend from 2004-2010 in children aged 8 years. *British Medical Journal Open, 3*(10):e003219. doi:10.1136/bmjopen-2013-003219

Townsend, E. A., & Polatajko, H. J. (2013). *Enabling occupation II: Advancing an Occupational Therapy Vision for Health, Well-being & Justice through Occupation* (2nd ed.). Ottawa, ON: CAOT Publications ACE.

Vasen, J., & Massei, H. (2006). [Adolescent social integration through the "Cuidar cuidando" program]. *Vertex, 17*, 432-439.

Viau, R., Arsenault-Lapierre, G., Fecteau, S., Champagne, N., Walker, C. D., & Lupien, S. (2010). Effect of service dogs on salivary cortisol secretion in autistic children. *Psychoneuroendocrinology, 35*, 1187-1193.

Whiteford, G. E. (2005). Understanding the occupational deprivation of refugees: A case study from Kosovo. *Canadian Journal of Occupational Therapy, 72*, 78-88.

Zimolag, U., & Krupa, T. (2009). Pet ownership as a meaningful community occupation for people with serious mental illness. *American Journal of Occupational Therapy, 63*, 126–137.

COLUMN EDITORS:
ALISON GERLACH AND JANET JULL

Turning the gaze inward: Relational practices with Aboriginal peoples informed by cultural safety

Alison Gerlach, Theresa Sullivan, Kaarina Valavaara and Cathy McNeil

As members of the Canadian Association of Occupational Therapists (CAOT) Occupational Therapy and Aboriginal Peoples Health (OTAPH) Network, we are committed to promoting cultural safety within our profession. To this end, the authors of this paper facilitated an extended discussion at the 2013 CAOT Conference in Victoria. This discussion was aimed at generating a greater awareness of, and dialogue on, relational practices with Aboriginal peoples informed by cultural safety. In this session, approximately 60 participants were asked to reflect on their practice and brainstorm what occupational therapists need to *continue, stop* and *start* doing in order to build relationships with Aboriginal peoples. Following a brief overview of cultural safety and the socio-historical context of Aboriginal peoples' health, this paper highlights two key themes that emerged through participants' brainstorming.

Cultural safety and Aboriginal peoples' health

In the late 1980s, Maori nursing scholar Irihapeti Ramsden in Aotearoa/New Zealand asserted that it was impossible to understand or reverse the poor physical and mental health of the Maori until the historical, socio-economic and political injustices faced by the Maori people were understood and addressed (Papps & Ramsden, 1996; Ramsden, 2005). Cultural safety has since been defined by the National Aboriginal Health Organization in Canada as: "what is felt or experienced by a patient when a health-care provider communicates with the patient in a respectful, inclusive way, empowers the patient in decision-making and builds a health-care relationship where the patient and provider work together as a team to ensure maximum effectiveness of care" (2008, p. 19). Understanding health from a cultural safety perspective shifts our focus from studying about 'difference' to understanding how power and oppression play out in health-care relationships and contexts (Gerlach, 2012).

The socio-historical context of Aboriginal peoples' health

In the extended discussion, we emphasized that Aboriginal peoples in Canada are extremely diverse in their languages, history, geography, cultural practices and their experiences of colonization. We also stressed that it is important to recognize that Aboriginal individuals, communities, Nations and health-care organizations are increasingly calling for, and exercising their human rights to, self-determination and self-governance over every aspect of their lives, including their health and health care.

From a cultural safety perspective, the pervasive health inequities that are experienced by many Aboriginal peoples in Canada are understood as being rooted in our colonial past and present. Whilst it was beyond the scope of the extended discussion (and this paper) to discuss how colonization can be manifested as health inequities for Aboriginal peoples, it is important to highlight that colonial policies, practices and discourses continue to create a disproportionate burden of adverse social determinants of health. Adverse social determinants, including racism, discrimination and chronic cycles of poverty are rooted in underlying structural inequities in contemporary Canadian society (Adelson, 2005; Reading & Wien, 2009; Smylie, 2009). It is also important to understand that negative and racist stereotypes and beliefs about Aboriginal peoples are enacted, albeit largely unknowingly, in health-care encounters and settings, and are increasingly recognised as a significant barrier to Aboriginal peoples' access to equitable health and health care (Browne, Varcoe, & Ford-Gilboe, 2011).

Turning the gaze inward

A recurring theme in the extended discussion was the recognition that occupational therapists need to seek out and engage in more learning opportunities in both academic and community settings in order to become more informed about Aboriginal history and the distinct health and health-care issues and concerns that continue to impact the health and well-being of diverse Aboriginal peoples. Aligned with the conceptual underpinnings of cultural safety, participants identified the importance of shifting power away from the 'expert occupational therapist' to create time and space to learn *with* and *from* Aboriginal peoples as genuine partners and allies.

About the authors

The authors are all occupational therapists with a background or interest in Aboriginal peoples' health and are members of the CAOT Aboriginal Peoples' Health Network. **Alison Gerlach, M.Sc. (OT), OT (C)**, may be contacted at: alison.gerlach@telus.net

Implicit in the decentering of power in relational practices from a cultural safety perspective is the need to shift our professional focus away from learning about cultural differences, and to turn the lens inward in order for occupational therapists to better understand how our taken for granted and largely unquestioned assumptions, beliefs and perspectives on health and health care may not be shared by some Aboriginal peoples. Turning the analytical gaze inward requires occupational therapists to critically reflect on the multiple ways in which our knowledge, theories and practices are "situated in Western spheres of shared experiences" (Iwama, 2007, p. 24). It is our responsibility – *not* our clients' – to adapt and transform our practices so that they may be experienced as culturally safe by *all* peoples, including those who may self-identify as being of Aboriginal ancestry. This requires that occupational therapists know how to adapt their practices in different social, economic and cultural contexts, and how to engage in ongoing reflective clinical reasoning. This is consistent with a strong and recurring message from participants in the extended discussion, who repeatedly voiced the need for occupational therapists to stop making assumptions and judgements, and stop perpetuating racial stereotypes about Aboriginal clients and communities. Participants clearly identified the need for occupational therapists to: stop defining health for our clients, stop interpreting clients' information 'our way,' stop looking at issues in isolation from community contexts, and stop using rigid models of service delivery.

(Re)building and developing strong relationships

As previously stated, woven through participants' comments was an implicit directive that as a profession, we need to move beyond learning *about* Aboriginal peoples to learning *from* Aboriginal peoples. We need to have ongoing partnerships in education, practice and research, and we need to engage with and learn from communities about how to provide occupational therapy so that it is accessible, meaningful and effective. From a cultural safety perspective, such partnerships require that occupational therapists have a clear understanding of how colonization in Canada has, and continues to be, enacted through relations of power between the state and Aboriginal peoples (Adelson, 2005).

A recognition and understanding of the historical and ongoing context of relations between Aboriginal peoples and the state is viewed as essential to, as one participant noted, "partnering in real ways" – so that Aboriginal individuals, communities, and health-care organizations can both learn about and inform occupational therapy and we can move towards providing services that can be experienced by Aboriginal individuals and communities as culturally safe.

Participants identified practical strategies that included: listening more, asking questions about what we can do differently and better, being an ally, learning from Elders, creating formal and informal educational opportunities, and building and developing relationships with Aboriginal community leaders and champions.

The extended discussion about cultural safety at the CAOT conference provided an opportunity for participants to be introduced to the basic tenets of this concept and to reflect on the implications for occupational therapy relationships and practices. We hope that this dialogue continues at all levels of our profession so that we can create a greater momentum towards strong and respectful relationships with Aboriginal individuals, communities and health-care organizations, and play a more active role in addressing health inequities that are preventable and unjust.

For further readings on cultural safety, please refer to the references below and to the OTAPH Network website: http://www.caot.ca//default.asp?pageid=3964

References

Adelson, N. (2005). The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health, 96*(Supplement 2), 45-61.

Browne, A. J., Varcoe, C., & Ford-Gilboe, M. (2011). *Equity-oriented primary health care interventions for marginalized populations: Addressing structural inequities and structural violence.* Unpublished research proposal. University of British Columbia, Vancouver, Canada.

Gerlach, A. J. (2012). A critical reflection on the concept of cultural safety. *Canadian Journal of Occupational Therapy, 79*(3), 151-158. doi: 10.2182/cjot.2012.79.3.4.

Iwama, M. (2007). Embracing diversity: Explaining the cultural dimensions of our occupational therapeutic selves. *New Zealand Journal of Occupational Therapy, 54*(2), 18-25.

National Aboriginal Health Organization. (2008). *Cultural competency and safety: A guide for health care administrators, providers and educators.* Retrieved from http://www.naho.ca/documents/naho/publications/culturalCompetency.pdf

Papps, E., & Ramsden, I. (1996). Cultural safety in nursing: The New Zealand experience. *International Journal for Quality in Health Care, 8*(5), 491-497.

Ramsden, I. (2005). Towards cultural safety. In D. Wepa (Ed.), *Cultural Safety in Aotearoa New Zealand* (pp. 2-20). Auckland: Pearson Education New Zealand.

Reading, C. L., & Wien, F. (2009). *Health Inequalities and Social Determinants of Aboriginal Peoples' Health.* Retrieved from http://www.nccah-ccnsa.ca/Publications/Lists/Publications/Attachments/46/Health Inequalities & Social Determinants of Aboriginal Peoples' Health (English).pdf

Smylie, J. (2009). The health of Aboriginal peoples. In D. Raphael (Ed.), *Social Determinants of Health* (2nd ed., pp. 280-301). Toronto: Canadian Scholars' Press Inc.

OT THEN

COLUMN EDITOR: SUSAN BAPTISTE

Elaine May: A profile of an occupational therapist and Order of Canada recipient

Keely Bujold

While working as an occupational therapist, Elaine May received the Order of Canada for opening a workshop that integrated people with psychiatric and physical disabilities back into society. Her hard work and compassion empowered the lives of many people at her workshop by giving them the skills they needed to be autonomous and to contribute to society.

Mrs. May, who is now 89 years old, graduated in 1945 from the University of Toronto. She worked as an occupational therapist in Toronto, Kingston and Montreal until the late 1970s, at locations including the Ste. Anne de Bellevue Queen Mary Veterans' Hospital, The Montreal General Hospital, The Pasteur Hospital, the Montreal Rehabilitation Institute and Recreation for the Handicapped.

In 1967, while working at Recreation for the Handicapped in Montreal, the McGill School of Social Work requested that a survey be done to find out how people with physical disabilities were able to live their lives in the community following rehabilitation. This survey found that there were many architectural barriers limiting access to community facilities. Furthermore, many people prioritized obtaining gainful employment over recreational activities. People wanted to be contributing members of society.

With private funding, Recreation for the Handicapped and the McGill School of social work collaborated to publish an accessibility book in time for the 1967 Montreal Universal and International Exposition (Expo 67). This book provided information about wheelchair accessible areas in Montreal. Unfortunately, it was not within the mandate of Recreation for the Handicapped to address employment issues. Therefore, Mrs. May explored the possibility of opening a workshop to reintegrate clients with a variety of disabilities into meaningful employment. After consulting with the MacKay Centre (a school for children with disabilities) and the Montreal Rehabilitation Institute, she applied for a summer Local Initiative Program employment grant from the federal government, which provided for a salary of $100 per week for three people. There weren't sufficient funds to rent a space for the workshop but a parent of a student at the MacKay Centre allowed her to use a small space in his warehouse, rent-free.

In 1972, Mrs. May opened the Montreal United Workshop Association (MUWA) as a non-profit organization. As there was no such facility in Montreal at the time, both French and English hospitals, as well as associations representing people with various disabilities, referred a total of 86 clients with physical and psychiatric health problems to the workshop in the first year it was in operation. The workshop brought together French and English associations, which typically operated separately from each other in the 1970s, in an important new cooperative way.

The Local Initiative Program grant wasn't enough money for them to be self-sufficient. Furthermore, not many health-care practitioners were eager to sign up for a salary of $100 per week, and so the workshop took on occupational therapy and physiotherapy students to help with the workload. To cut costs even further, the workshop began teaching clients to use public transportation, thereby saving the cost of hiring a bus at MUWA's expense. Every year, MUWA recieved greater numbers of referrals and needed more money. Fundraisers were held and the workshop slowly began to raise more and more awareness of their work until they were finally fully funded by the Quebec provincial government.

MUWA provided a sheltered workshop intended to increase normalization, social reintegration and employment. It offered opportunities in education, work training, job placement and transportation training. Two community benefits were listed in the MUWA pamphlet: "The Workshop recycles human potential, offering a chance for development in a warm, supportive environment. Families are released from constant daily care." As program coordinator, Mrs. May worked very hard to re-integrate her clients back into society, pairing clients together based on their personalities and strengths. The fact that 26 of the 86 initial referrals received successful job placements was impressive.

Sadly, due to health complications, Mrs. May was forced to resign after the workshop had been open for four years. Under new management, the workshop's mandate eventually changed to work solely with individuals with intellectual disabilities. In 1976, Mrs. May was awarded the Order of Canada for her work helping people to reintegrate as productive members of society.

For your contribution to improving the quality of life and the level of autonomy of people with disabilities, and for your contribution to occupational therapy, thank you, Elaine May!

Elaine May on the day she received the Order of Canada. To her right, her husband, William May, shakes hands with Governor General, Jules Léger, and his wife, Gabrielle Léger.

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References

The Governor General of Canada. (2009a). *Order of Canada: Mildred Helfand Ryerson, C.M.* Retrieved from http://archive.gg.ca/honours/search-recherche/honours-desc.asp?lang=e&TypeID=orc&id=2430

The Governor General of Canada. (2009b). *Order of Canada: Paulette Bourgeois, C.M., LL.D.* Retrieved from http://archive.gg.ca/honours/search-recherche/honours-desc.asp?lang=e&TypeID=orc&id=8542

The Governor General of Canada. (2012, December 30). *Appointments to the Order of Canada.* Retrieved from http://www.gg.ca/document.aspx?id=14904

Editor's note: According to our research, three other occupational therapists have been awarded the Order of Canada:

Mildred Ryerson – 1987 – for her work in the "social rehabilitation of ex-psychiatric patients, persons with physical handicaps and the unemployed through the teaching of professional-quality creative skills at craft workshops" (The Governor General of Canada, 2009a).

Paulette Bourgeois – 2003 – for her work as a children's book author and promoter of literacy. Her "insightful writing demonstrates her deep understanding of children" (The Governor General of Canada, 2009b).

Rachel Thibeault – 2012 - "for expanding the boundaries of occupational therapy and advocacy on behalf of people with disabilities" (The Governor General of Canada, 2012). See the November 2013 issue of *OT Now* for a profile of this Order of Canada recipient.

Do you know of other occupational therapists who have been awarded an Order of Canada? Let us know! Send additional names to otnow@caot.ca or legacy@caot.ca.

About the author

Keely Bujold graduated from the University of Ottawa in 2013. She is proud to be a granddaughter of Order of Canada recipient, Elaine May. She can be contacted at: KeelyBujold@gmail.com

COLUMN EDITOR:
PATRICIA DICKSON

The role of occupational therapy in university accessibility services

Sarah Ko

Most occupational therapists work in community agencies, nursing and residential care facilities, and hospitals (Service Canada, 2012). That said, some occupational therapists also engage in multiple roles, such as research, education or policy development (Canadian Association of Occupational Therapists, 2012). This article provides an example of how occupational therapists are equipped with the skills and knowledge to enter the field of accessibility services at the college and university levels. In my personal observation, most of these positions are filled by social workers and those with training in counselling, psychology or education. The aim of this article is to inspire and encourage fellow occupational therapist colleagues to explore new fields where occupational therapists have historically not had a significant presence. I will illustrate this by sharing my personal experience.

With the implementation of the Accessibility for Ontarians with Disabilities Act in 2005, the Ontario Government developed mandatory accessibility standards that aim to prevent and remove barriers for people with disabilities in key areas of daily living (Ontario Ministry of Community and Social Services, 2012). As a result, more emphasis is being placed on accessibility services at post-secondary institutions. The mandate of these accessibility departments is to maximize students' educational potential and learning experience by providing accommodations and support (National Educational Association of Disabled Students, 2013). When I first learned about these services, I knew right away that occupational therapists could provide valuable input to this field. The philosophies of these accessibility departments closely align with the values of occupational therapists in that we focus on enabling occupational performance and engagement by determining appropriate interventions through client-centered services. With diversity and client perspectives taken into account, services are holistic, flexible, context sensitive and take into consideration the changing conditions of the people, environment and occupations. According to the *Profile of Practice of Occupational Therapists in Canada*, we are experts in enabling occupation and carry six supporting roles, including communicator, collaborator, practice manager, change agent, scholarly practitioner and professional (Canadian Association of Occupational Therapists, 2012). These roles ideally situate occupational therapists to perform tasks within university accessibility services, such as working effectively on interprofessional teams as a collaborator, supporting diversity in communication as a communicator and participating in activities that contribute to the effectiveness of the organizations as a practice manager. I have found it difficult and frustrating that job descriptions for disability counsellor positions often only seek candidates with a social work, counselling or education background.

After two years of applying for disability counsellor jobs, I finally landed an interview at York University. It took me considerable effort to explain to the interview panel how occupational therapists are trained to perform assessments and how our strong observation skills and hands-on training prepare us well for this job. Finally, I was offered the position and was ecstatic to learn that the interview panel "made an exception" and "took a risk" in employing me. This was how my career in disability services at post-secondary institutions started. At times it was difficult, as I had to explain to colleagues and even clients how an occupational therapist could work outside of a hospital or community agency. Since then, I have moved on to my current role as a disability counsellor at the University of Toronto, again a role that was traditionally not held by an occupational therapist. I now provide case management, disability-related counselling and accommodation services for students with mental health conditions, and I proved my competence for the job with my occupational therapy background.

On a daily basis, I meet with different students who experience occupational barriers in navigating the school system due to mental health conditions. For example, students with social anxiety may not be able to interact with a financial aid advisor or complete group work due to their comfort levels, confidence and varying levels of social and communication skills. My role is to counsel, educate, enable and practice those skills with students to maximize their occupational engagement and performance so they

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can eventually interact with others in these contexts. For students with obsessive compulsive disorder, I work with them to identify the first signs and symptoms of an episode and determine how to respond appropriately. This involves identifying and locating community resources ahead of time, and putting together a contingency plan if the student is hospitalized for a period of time. I collaborate with the university physicians, psychiatrists and campus police in providing crisis interventions and counselling in cases where students have suicidal thoughts. I also develop return-to-school plans with students, their caregivers and health-care professionals from the community.

The education that helped prepare me the most was my occupational therapy coursework in psycho-social determinants of health and my fieldwork placement at a community treatment centre where I provided group interventions and social skills training to clients with severe and persistent mental health conditions. Throughout my occupational therapy education, interprofessional education was helpful in allowing me to understand the different health-care roles and how to collaborate with psychiatrists, physiotherapists, psychologists, nurses and social workers. My education in physical determinants of health was also very useful since many students have comorbid disorders. My occupational therapy education prepared me well to work with diverse populations and in many capacities. I was also trained to analyze situations holistically, taking into account the person, environment (including cultural aspects) and occupations.

Additional training that was useful for the disability counsellor position includes courses in cognitive behavioural therapy, life coaching, Applied Suicide Intervention Skills Training (LivingWorks Education, 2013), motivational interviewing, violence threat assessment and Critical Incident Group Debriefing (Crisis and Trauma Resources Institute Inc., n.d.), just to name a few.

The most challenging aspects of the job are when clients refuse referrals, over-use resources or are not agreeable to intervention recommendations. I also have to be mindful of students' cultural beliefs and understand the stigma associated with accessing mental health resources. Additionally, it is often difficult for students to navigate the health-care system, especially during distress.

The best aspects of this role as a disability counsellor are that I can use my practice reasoning and problem solving skills to the fullest when determining safe, creative and elaborate remediation plans and accommodations for students. It can be challenging but it is also very rewarding to be able to enable young adults to maximize their occupational performance and engagement potential and live meaningful lives while pursuing their academic aspirations and goals.

I can't help but wonder why only a few occupational therapists have taken on disability counsellor roles. Out of all the counsellors that I have met over the years in Ontario, I only know of a handful who are occupational therapists. Could it be that the public is not familiar with the nature of work and scope of occupational therapy practice? Are therapists not applying for these positions? And is it possible that occupational therapists apply for these positions but are often not selected for interviews?

Occupational therapists have a lot of professional skills to offer in many areas, such as human rights, equity and diversity, accessibility coordination, crisis management and assistive technology, due to the wide spectrum of competencies that occupational therapists develop over the course of our education. I am not only encouraging my fellow colleagues to explore new work opportunities at post-secondary institutions; I would also like us to think about how we can challenge and change the public's perception of what occupational therapy is, where occupational therapists work and what skill sets we can bring to non-traditional occupational therapy fields, so that our professional contributions are accessible to the community at large.

Over the years, I experienced resistance along the way as I was entering this new territory. However, I firmly believe that with persistence, public education and demonstration of our knowledge and transferrable skills, we can surely create more opportunities for ourselves. Most importantly, in taking up new roles in the community, we can stimulate curiosity and generate consensus among the public that occupational therapists can enable occupation in many environments. After all, aren't we, as occupational therapists, encouraged to use our creativity to think outside the box?

References

Canadian Association of Occupational Therapists. (2012). *Profile of Practice of Occupational Therapists in Canada: 2012*. Retrieved from http://www.caot.ca/pdfs/2012otprofile.pdf.

Crisis and Trauma Resources Institute Inc. (n.d.). *Critical Incident Group Debriefing – Issues and Considerations*. Retrieved from http://www.ctrinstitute.com/int/ctriticalarticle.pdf

LivingWorks Education. (2013). *ASIST*. Retrieved from http://www.livingworks.net/programs/asist/

National Educational Association of Disabled Students. (2013). *Enhancing Accessibility in Post-Secondary Education Institutions*. Retrieved from http://www.neads.ca/en/norc/eag/policies.php

Ontario Ministry of Community and Social Services. (2012). *Publications: About the Accessibility for Ontarians with Disabilities Act, 2005*. Retrieved from http://www.mcss.gov.on.ca/en/mcss/publications/accessibility/aoda2005.aspx.

Service Canada. (2012). *Analytical text 3143 – Occupational Therapists*. Retrieved from http://www.servicecanada.gc.ca/eng/qc/job_futures/statistics/3143.shtml

STUDENT PERSPECTIVES

New occupational therapists: Learning to define ourselves

COLUMN EDITORS: LAURA HARTMAN AND CHRISTINA LAMONTAGNE

Laura Klaponski

One of the traditions of the master of occupational therapy program at McGill University is the annual Name Tag Ceremony. This ceremony aims to acknowledge students' transition from classroom education to applied practice skills as they enter their first fieldwork placements. As part of the ceremony, a class representative is chosen to speak about stepping into this new role as student practitioners. Laura Klaponski was a student in McGill's master of occupational therapy program from 2011 to 2013. In this article she shares some excerpts and reflections from her speech at the 2012 Name Tag Ceremony event.

Remember that moment before walking into your first fieldwork placement as an occupational therapy student? Those anxious and excited feelings? The nervous energy? The hopeful expectations rising in your chest? You acknowledge your heart rate is slightly over the recommended beats per minute and your breath comes quicker. You think to yourself, should I begin some pursed-lip breathing?

Whether it be your first day in your fieldwork placement or your first day on the job as a new graduate, there are always those first uncertain moments that symbolize an accumulation of hundreds of smaller stepping stones that have gotten you there. Think back to the beginning of your occupational therapy program. The very first task in one of my occupational therapy classes was to write out a definition of what occupational therapy is – what do you say to a client? – a family member? – a friend? – someone you meet at a party or at the local campus pub? "What is occupational therapy?" It seems like an easy task until you attempt to break down and define our profession in one sentence.

The issue is that, to me, occupational therapy doesn't have a single definition. It depends on the context in which the conversation is being held, on the person you are talking to, on the environment you are in and the role that person lives and needs help with. It depends on building a partnership with that person so that they don't simply understand what occupational therapy is, they experience it.

And now we come to a point in our education when our definition of occupational therapy jumps from theory to practice. We have learned a completely new 'language' during our studies. From the MOHO to the CMOP-E, the CPPF, 'the Kawa,' the PEO and the CMCE[1]. We know how to get from problem lists to long-term goals to short-term goals, etc. We can recite the four 'P's' of energy conservation while creating a 'Google Doc' and Skyping with our project group members at any hour of the day.

But have we actually thought about what comes next? Actually walking into a room wearing your student name tag, greeting 'Frank,' the nightclub bouncer with a Boxer's fracture, looking him in the eye and being responsible for contributing to his health and well-being? Are we really ready?

Occupational therapy students are a group of diverse individuals. Each one of us is unique with a myriad of personal life stories and experiences, bringing our own flavour to the practice of occupational therapy. The theory and skills - the 'language' - that our professors have taught us have created a group of like-minded individuals who believe that health is not the absence of disease or disability, it's the presence of well-being; we believe in client-centered practice; we believe in looking for scientific evidence before recommending a therapeutic activity; we believe in interprofessional collaboration; we believe that we are advocates for those with disabilities when they need a voice. Clients are counting on us to think through their cases with knowledge, theory and wisdom. We will be providing our clients with the tools and knowledge to change their own lives.

I know I'll be learning even more along the way. I'm not afraid to receive feedback on what I did right and wrong, so that next time, I get it 'more right.' I am ready to step out of my comfort zone, act confidently and own the role of occupational therapist. Yes, that is self-efficacy. I am ready to figure out what my definition of occupational therapy really is.

I urge my fellow occupational therapy students and new graduates to take what we have learned so far and apply it to

[1]Abbreviation explanations. MOHO: Model of Human Occupation (Kielhofner, 2002), CMOP-E: Canadian Model of Occupational Performance and Engagement (Townsend & Polatajko, 2013), CPPF: Canadian Practice Process Framework (Townsend & Polatajko, 2013), 'the Kawa': Kawa Model (Iwama, 2006), PEO: The Person-Environment-Occupation Model (Law et al., 1996), CMCE: Canadian Model of Client-Centered Enablement (Townsend, Polatajko, Craik, & Davis, 2013).

our own lives. We can lead by example. I propose the five 'P's' of surviving our first fieldwork placement, and even our first jobs as new graduates. We all know the first four: planning, prioritizing, pacing and posture.

- *Plan* - We can plan out our days in our fieldwork placements to achieve occupational balance that includes not only our work but our own self-care and leisure.
- *Pace* – We can pace ourselves, so that we create our own tempo and rhythm within our respective settings.
- *Prioritize* - We can prioritize our tasks to best attend to our clients' needs, our supervisors' expectations and our own learning outcomes.
- *Posture* - We will remember our posture and proper body mechanics so that we don't attend our 25-year reunion reporting symptoms of lower back pain.

Finally, I'd like to propose a fifth 'P' – peer support. Let's share our experiences, support each other and learn together. To this year's class of occupational therapy students– let's show what we can do; we will shine with the excellence of our work.

References

Iwama, M. (2006). *The Kawa model: Culturally relevant occupational therapy.* Edinburgh, Scotland: Churchill Livingstone Elsevier.

Kielhofner, G. (Ed.). (2002). *A model of human occupation: Theory and application* (3rd ed.). Baltimore, MD: Lippincott, Williams & Wilkins.

Law, M., Cooper, B., Strong, S., Stewart, D., Rigby, P., & Letts, L. (1996). The Person-Environment-Occupation Model: A transactive approach to occupational performance. *Canadian Journal of Occupational Therapy, 63*, 9-23.

Townsend, E. A., & Polatajko, H. J. (2013). *Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-being & Justice through Occupation* (2nd ed.). Ottawa, ON: CAOT Publications ACE.

Townsend, E. A., Polatajko, H. J., Craik, J., & Davis, J. (2013). Canadian Model of Client-Centred Enablement. In E. A. Townsend & H. J. Polatajko (Eds.), *Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-being & Justice through Occupation* (2nd ed.), p. 110. Ottawa, ON: CAOT Publications ACE.

About the author

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Update from the Canadian Occupational Therapy Foundation

New COTF award

COTF is launching a Clinical Research Grant for the very first time! It will be awarded to a CAOT member who is undertaking research on a question directly related to clinical practice in occupational therapy. The applicant team must include an occupational therapist in direct client service delivery and an occupational therapist with demonstrated research experience. The research proposal must include a plan for an analysis of the economic benefit that could result from the study. The amount of the award is $5,000. The application deadline is February 28, 2014.

COTF's 2014 strategic plan initiatives

COTF has approved the following strategic goals and supporting activities:

1. Increase the dollar amount of donations by 27%.
   - Increase the number of monthly donors.
   - Establish new fundraising activities targeted at CAOT members.
   - Encourage the Occupational Therapy Professional Alliance of Canada (PAC) to challenge each professional society to donate to the annual auctions at the CAOT Conference.
   - Encourage universities to challenge each other to donate to the auctions at the CAOT Conference.

2. Increase the number of CAOT members who donate to 25%.
   - Identify the research needs of CAOT members.
   - Review the COTF awards to ensure that they meet the needs of the profession and public, and use data from surveys to support the awards program review.

3. Increase the visibility of COTF by working with CAOT, whose role includes raising the awareness of the profession.
   - List donors and supporters on COTF website.
   - Feature donors in various media.
   - Inform students in each university program of COTF and its mission, as per the work that is being undertaken with the Association of Canadian Occupational Therapy University Programs (ACOTUP).
   - Increase partnerships with CAOT to promote COTF and its activities.

Social media strategy

Visit COTF on Facebook to keep up to date on COTF news!
https://www.facebook.com/cotffce?fref=ts

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COTF is the only organization that solely funds occupational therapists!