OCCUPATIONAL THERAPY NOW

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Everyday Stories
Life Rolls On in Nova Scotia

Paula Green

Just over 10 years ago, early in my career as an occupational therapist, I was working with clients with spinal cord injuries at the Nova Scotia Rehabilitation Center in Halifax, Nova Scotia. Many of the clients I worked with presented with new traumatic injuries. They were young and had been very active, and I saw them struggling with thoughts about how they would move on from this life-changing injury, wondering how they would return to the fun and exciting activities that previously helped to define who they were as individuals. I went searching online for examples of people that my clients could identify with who had done just that. In my search I came across Jesse Billauer, the executive director and chief executive officer of a non-profit organization called "Life Rolls On" based in California.

In 1996, competitive surfer Jesse Billauer sustained a C6 complete spinal cord injury while surfing at his local break at Zuma Beach in California. Now living with quadriplegia, Jesse left the hospital motivated to surf again and wanting to help others follow their passions. He founded Life Rolls On, an organization that "is dedicated to improving the quality of life for young people affected by spinal cord injury and utilizes action sports as a platform to inspire infinite possibilities despite paralysis" (Life Rolls On, 2014). Watching videos of Jesse surfing on an adapted surf board in amazing breaks all over the world proved to be a fantastic motivator and inspiration for my clients.

At that time in my career, I didn't identify myself as a surfer. A few years later I would be practicing as an occupational therapist at Bondi Beach, Australia, where I would meet my future husband (an avid surfer). We later settled on the beautiful Eastern Shore of Nova Scotia. Surfing became one of my greatest hobbies, and the beach became a way of life for my family - where we lived and played on a daily basis. I returned to working with clients with spinal cord injuries at the Nova Scotia Rehabilitation Centre and I began to realize that many of my clients who experienced mobility impairments could not access the beaches that were so much a part of my world. Nova Scotia proclaims to be "Canada's Ocean Playground" and yet our beaches are virtually inaccessible to so many people. Returning to the "Life Rolls On" website, my dream of bringing an adaptive surfing event to Nova Scotia was born. I made an application to bring the organization's signature program, "They Will Surf Again," to Nova Scotia and to my amazement they said yes! Our event on September 20, 2014, became the first ever Canadian and international event for Life Rolls On.

Reflections and lessons learned

Following the initial excitement of being officially placed on the 2014 Life Rolls On - Get On Board Tour came a feeling of being overwhelmed. I asked myself, would people with mobility impairments in Nova Scotia actually want to learn to surf in the North Atlantic Ocean? How would we get them on the beach? How would we raise enough funds to make the beach accessible and purchase the necessary adaptive equipment to support participants on the beach and in the water? It was Jesse who gave me the confidence that I needed to plow ahead. In his relaxed, calming voice he told me that he believed we could make this happen - and because he believed it so whole heartedly, so did I. Each time I felt doubt, a new idea, resource or individual presented itself and brought us a step closer to our goal. I rekindled an old friendship with a schoolmate from childhood who offered a wealth of knowledge in public relations, marketing and communications. She was married to a recreation therapist and avid surfer who possessed the skills and contacts we needed to bring together the local surfing and health professional communities to support the event. Together with our newly formed board of directors, made up of enthusiastic volunteers who were all passionate about surfing, and with the support of corporate sponsors, provincial grants and our fundraising efforts, we raised close to $50, 000 in less than one year.

Through the funds raised and with the support of the Government of Nova Scotia and the Surf Association of Nova Scotia, a significant accessibility upgrade was completed on a local surfing beach, Martinique Beach Provincial Park. The upgrade included a new accessible restroom and change

Scott Jones, a local Life Rolls On participant.

room, a new ramp leading to the beach, and improvements to accessible parking, pathways and a picnic area. Additionally, a beach wheelchair, a beach mat (which allows a regular wheelchair to roll freely over soft sand) and two adapted surfboards were purchased. The funds that were raised also allowed for Jesse Billauer and a small support team to travel from California to Nova Scotia to help run the adapted surfing event, which included 24 participants and more than 100 volunteers.

This was more than just a day of surfing. It was about creating an ongoing legacy of beach access and adapted surfing in Nova Scotia. It was also about joining together people who may not have otherwise met: the surfing community, health professionals and people with mobility impairments. It was about demonstrating that anything is possible with the right supports, the power of positivity and by working together.

The smiles on the faces of the participants, volunteers and spectators from the event day said it all. For some, it had been more than 20 years since they had been in the water or on the beach. The magic we created was exhilarating and contagious, and the buzz from the event continued long after the park was closed for the season. The Life Rolls On team has committed to coming back to Nova Scotia again in 2015, and we know that next year's event will be even bigger and better.

In the words of Paul Vienneau, one of the Life Rolls On Martinique Beach participants, "I love that this was not just surfing for the disabled. This was surfing, period. Thanks to Jesse and the Life Rolls On team for seeing surfing again as an answer to you'll never walk again."

For more information about Life Rolls On, please join the Facebook group at: https://www.facebook.com/LifeRollsOnMartinique or email: lromartinique@gmail.com

To view a Global television interview with Paula and participant Scott Jones, go to: http://globalnews.ca/video/1567980/martinique-beach-hosts-they-will-surf-again

To view CTV News footage from the event, go to: http://atlantic.ctvnews.ca/video?clipId=446031

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Karen Goldenberg appointed to the Order of Canada!

Karen Goldenberg has been named a Member of the Order of Canada "for her role in advancing research and practice in occupational therapy, and for her leadership of social service organizations" (The Governor General of Canada, 2014). Congratulations to Karen for this well-deserved honour!

Karen's career has been diverse and made lasting impacts within and outside the profession of occupational therapy. As a leader, entrepreneur and occupational therapist, Karen has made contributions in the areas of prenatal health, mental health and community health-care services, among others. Her many roles have spanned direct service provision, education, administration, research and legislation development. Karen helped to found both Community Occupational Therapy Associates (Canada's first community-based not-for-profit occupational therapy organization) and the Canadian Occupational Therapy Foundation (Ortal, Davis, & Trentham, 2009).

To learn more about Karen Goldenberg's many contributions, read the oral history written by Aya Ortal, Jane Davis and Barry Trentham, posted on the OT Legacy website: http://www.otlegacy.ca/past/documents/Goldenberg.pdf

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What's new

CAOT YouTube channel

CAOT now has a YouTube channel: http://www.youtube.com/channel/UCkV1G8zJxmN8pEnXRwAVKeg Visit this site regularly to view updates on CAOT Board meetings, key information about professional development and highlights from CAOT events.

Thank you to *OT Now* volunteers

Thank you to the following CAOT members who have completed their terms as column editors for *Occupational Therapy Now* :

- Laura Bradley - Enhancing Practice: Children and Youth
- Sue Baptiste – OT Then
- Christel Seeberger and Jonathan Rivero - Private Practice Insights
- Lili Liu and Masako Miyazaki – E-Health and Occupational Therapy (and previously, Tele-Occupational Therapy)

Thank you for your dedication and for lending your expertise to CAOT's practice magazine. It has been a great pleasure working with all of you!

New CAOT workshop

Dementia: Its Challenges and Opportunities. Preparing Ourselves for the Future.

This new two-day interactive CAOT workshop will provide occupational therapists and other health professionals with current knowledge and essential skills to enhance their practice with older adults who have dementia or who may be in the early stages of cognitive decline. It will be offered in Toronto in January, in Saskatoon in March and in Halifax in April, 2015. For more information or to register, please visit: www.caot.ca/education/

Janet Craik appointed as CAOT Executive Director

On behalf of CAOT, President Lori Cyr is pleased to announce the appointment of Janet Craik as Executive Director of CAOT, effective November 3, 2014. As Executive Director, Janet will be responsible for the successful leadership of the Association and will represent CAOT nationally and internationally on occupational therapy and health-related issues.

Janet has over 25 years of professional experience in occupational therapy within the practice, education, research and association sectors. Since 2005, Janet has had the pleasure of working at CAOT with an increasing leadership role in the association. Throughout her professional career she has been motivated by a deep commitment to the profession and has sought positions where she could contribute to moving the profession forward.

"I view having the opportunity to lead CAOT as a tremendous occasion to contribute to the continued growth of the association and to collaborate with other practice, policy and education leaders within and outside the profession to support occupational therapists and to enhance and promote the occupational therapy practice." – Janet Craik

The CAOT Board of Directors would like to thank Janet for her contribution as Interim Executive Director over the last year and wish her every success in advancing excellence in occupational therapy.

Follow Janet's ED Talks blog at: https://caotedtalks.wordpress.com/

Canadian Occupational Therapy Foundation news

COTF's Research Grant Competition deadline is February 28, 2015. New grants are being offered! To apply online, visit: www.cotfcanada.org

ENHANCING PRACTICE:
MENTAL HEALTH

COLUMN EDITOR: REGINA CASEY

Exploring mindfulness meditation in occupational therapy: An introduction to basic practice

Nina Elliott

Stress is pervasive in health care and the toll can be seen amongst health-care recipients and staff alike. Examples from the literature include a study showing that 75-90% of visits to primary care professionals had a stress related component (American Psychological Association, 2004, as cited in Mitrovic, Fish de Pena, Frassetto, & Mellin, 2011), and another that reports nearly 50% of occupational therapists identified as stressed or very stressed (Wilkins, 2007, as cited in McCorquodale, 2013). Stressed health-care workers report subsequent impairments in all domains of life, including decreased job satisfaction, impaired cognitive functions (e.g., attention, decision making), interpersonal challenges and reduced ability to convey empathy and engage with clients (Stew, 2011). A stressed workforce not only feels poorly; they also take more sick days, are at greater risk of clinical errors, compassion fatigue and practitioner burnout (McCabe-Ruff & MacKenzie, 2009; Stew, 2011). One possible solution is to introduce therapists to the practice of mindfulness meditation. Mindfulness has demonstrated itself to have professional utility as a stress management tool and as a self-care practice that has the potential to modulate the stress response (Gura, 2010). Canadian therapists are taking notice of the role of mindfulness in occupational therapy, as is evidenced by the presence of articles on the topic in *Occupational Therapy Now* (e.g., McCorquodale, 2013) and the *Canadian Journal of Occupational Therapy* (e.g., Reid, 2013). While their inclusion is promising, these articles lack practicalities such as why mindfulness is relevant to all therapists and how to incorporate it into one's life and self-care routine. This article aims to fill in some of these gaps and offer practitioners an introduction to the basics of mindfulness.

Benefits of mindfulness

The benefits of integrating mindfulness into practice are far reaching within both personal and professional domains; mindfulness has been found to have positive effects on social skills, feelings of compassion towards the self and others, self-management, somatic awareness (Reid, 2013) and mental flexibility (Thompson, 2009).

Studies suggest that mindfulness training amongst health-care professionals not only improves the quality of care they deliver but also results in an increase in quality of life and general health (Gura, 2010). Mindfulness based stress reduction is considered one of the most well researched stress reduction interventions (Gura, 2010) and uptake by health-care professionals themselves is considered the most effective way to disseminate the benefits through the health system (McCabe-Ruff & MacKenzie, 2009). While mindfulness is an effective, widely applicable stress management tool, it is also infinitely portable, personalizable and affordable. Despite these facts, it seems that outside of mental health practices, mindfulness and stress reduction training are rare, thus suggesting that stress management may be an often neglected element of health care.

Occupational therapists are well poised to address this gap as mindfulness can be used both personally and therapeutically. People with almost any condition that involves suffering or has a stress-related component can benefit from the practice of mindfulness; persistent pain (Stroh-Gingrich, 2012), psoriasis, anxiety, depression, cancer, substance abuse (Kabat-Zinn, 1990), disordered eating (Smalley & Winston, 2010), traumatic experiences (McCabe-Ruff & MacKenzie, 2009) and acquired brain injury (Bedard et al., 2005) are amongst the conditions for which a link between mindfulness and improved well-being has been demonstrated. Mindfulness also provides a means to empower clients towards self-management, personal responsibility and healthy lifestyle modification (Kabat-Zinn, 1990; Reid, 2013; Thompson, 2009). It is widely acknowledged that mindfulness meditation is best received when delivered by an educator with their own meditative practice, thus, an established personal practice is recommended prior to introduction in a clinical setting (Gura, 2010).

Mindfulness 101

Mindfulness is a state of consciousness that involves attending to one's moment to moment experience; it involves paying attention in a purposeful, present and non-judgmental way (Reid, 2013). The aim is present moment awareness without strong attachment to thoughts, beliefs and emotions (McCabe-Ruff & MacKenzie, 2009). The ultimate goal is a constant state of mindfulness and in that pursuit one may practice both formally and informally. Formal mindfulness practice involves a daily session, sitting with eyes closed, either following the breath or having an experience of open awareness for 45 minutes or longer. These formal sessions cultivate attention to the present moment experience of the mind and body and allow repetitive practice in not reacting to whatever arises. Informal practice involves paying detailed attention to the experience of the mind and body throughout the day. Below are three commonly used simple exercises to introduce the concept of mindfulness:

Mindful breathing: Sit comfortably in an upright and stable posture with your eyes closed or with a lowered gaze. Focus on the physical sensations associated with breathing (Smalley & Winston, 2010). There is no need to control the breath; simply be aware of the natural and normal process taking place. Be conscious of the temperature of air entering and exiting your nostrils, and the sensation of the air hitting your upper lip as you breathe out. Take note of the sensations in your chest as your lungs fill and then deflate. Rest your hands on your abdomen and cultivate awareness of the sensation of them rising and falling with the breath. Make an effort to follow your breath as it enters your nostrils, throat and lungs, and visualize it moving through your entire body. Be aware of the precise moment that your breath turns around from an inhalation to an exhalation, and from an exhalation to an inhalation. Try to keep your mind focused on this seemingly simple task for 10 breaths (Smalley & Winston, 2010). When your mind wanders, as it will, simply bring it back to the breath without frustration or irritation with yourself (Kabat-Zinn, 1990). With practice, you will be able to maintain the awareness of breath for longer and longer periods; strive for 20-30 minute periods, once or twice a day (Meleo-Meyer & Smith, 2014).

Mindful eating: Sit comfortably and take a moment to settle into your seat. The goal of this exercise is to experience eating as if you've never experienced eating or come across the object to be eaten before. Place three raisins in front of you and consider their color, shape and smell before bringing just one to your lips. Upon putting the object in your mouth, be conscious of its texture, temperature and flavor. Be aware of the thoughts, sensations and emotions that arise during this exercise (Smalley & Winston, 2010), for example, judgments based on your preference for raisins or thoughts associated with the exercise itself. Whatever distractions arise, let them pass without getting involved in the content or emotion (Kabat-Zinn, 1990). Take a bite and consider how your experience changes as a result. Be aware of all the movements and sensations involved in chewing. Also be aware of the salivary response and notice the changing textural experience. Chew the object slowly and try to maintain awareness during the whole exercise. Attempt to make a conscious decision to swallow. Pace yourself. Eat each object in this slow, thoughtful manner. Reflect on how you typically eat raisins. Try the same exercise with a cup of tea. Reflect on how you typically approach eating an entire meal (Kabat-Zinn, 1990; Smalley & Winston, 2010).

Mindful walking meditation: This exercise will allow you to explore the sensations of walking and breathing. Aim to walk in a circle somewhere you won't be observed, for example, your living room. To begin, stand tall, take three slow, mindful breaths and take note of the all the sensations that allow you to know you are standing upright. Take a slow step and think about how the experience changes for you with the intention and then the movements. Choose a pace that allows to you be maximally mindful (Kabat-Zinn, 1990). Focus on the sensations within your feet, be aware of where your foot contacts the ground and how this changes with your stride. Acknowledge the sensations present in your ankles, knees, hips, chest, head and upper body; notice the sensation of clothing on your skin and how the earth feels beneath you. Continue walking slowly while remaining alert to all the bodily sensations, including the breath, thoughts that arise and the emotional experience. If you are outdoors, expand your awareness to include your environment (i.e., the feeling of the wind, sun, ground surface and incline, as well as sounds). Maintain awareness of all the sensations involved with mindful walking. Your mind will wander; the exercise is in continually bringing your attention and awareness back to the present moment experience of mindful walking. Do this as often as you can (Meleo-Meyer & Smith, 2014).

Additional strategies for daily mindfulness

- Strive to be mindful on a daily basis. One minute of mindfulness is better than none at all.
- Take three mindful breaths, for example, each time you visit the bathroom, look in the mirror, start your car, check your email or answer the phone. Develop your own "mindfulness moments."
- Be aware of the bodily experience when you are feeling rushed, overwhelmed or fatigued. Take note of your patterns and areas of tension during these times and make an effort to check in with these areas regularly.
- Notice your thought patterns when you are tired, irritated, stressed or hungry and take note of your emotional landscape during these times.
- Notice your bodily experience when you are relaxed, happy, comfortable or at ease.
- Slow down. Avoid rushing.

The STOP technique is an easy way to bring mindfulness to any point in your day when you notice *mindlessness*. It is intended to take only five seconds and includes four steps (Smalley & Winston, 2010):

1. Stop
2. Take a breath
3. Observe
4. Proceed

The exercise is initiated by simply recalling the technique and stopping your current action, and then taking a breath. Observing

About the author

Nina Elliott is the only occupational therapist within a 100 km radius of Twillingate, Newfoundland, where she lives and works. She works at Notre Dame Bay Memorial Health Center in acute, long-term and restorative care, and also fulfills the role of restorative care program coordinator. She gained an interest in stress reduction and mindfulness while working in acquired brain injury rehabilitation in Ontario and England. Nina has since completed a number of mindfulness courses as well as a 10-day silent meditation retreat and aims to pursue mindfulness-based stress reduction teacher training. She is an outdoor enthusiast, yoga instructor and avid yarnbomber who can be reached at: naelliott@gmail.com

requires plugging into the body to observe anything that is there to be observed. This may be poor posture or nagging back pain, an emotional experience of anger or a sense of feeling rushed. Whatever the experience, observe it and then proceed. Acknowledging your present moment experience, whatever it is, is powerful in that it grounds you in your lived experience and cultivates an acceptance of what is.

Conclusion

Given occupational therapists' holistic approach to health and well-being, mindfulness is a natural, yet underused ally despite documented results in many practice areas. Having a personal mindfulness meditative practice would help occupational therapists manage their own experiences of stress and enable them to begin knowledge translation activities with their clients regarding mindfulness benefits and techniques.

Recommended resources

If you are interested in furthering your study of mindfulness, here are some suggestions of helpful resources:

1. Watch informative videos by searching for "mindfulness" on YouTube (www.youtube.com).
2. Read mindfulness meditation blogs.
3. Explore free meditation "apps," such as:
   - Stop, Breathe & Think - Includes basic meditation exercises of varying length, including mindfulness meditation, loving-kindness and body scan. (http://stopbreathethink.org/)
   - Mindfulness Training App by Sounds True

   Includes teachings from well-known mindfulness instructors, including Jon Kabat-Zinn. Includes additional talks on the science of mindfulness, neuroplasticity and happiness (available through itunes.com).
4. Enroll in a meditation or hatha yoga class in your community.
5. Subscribe to *Mindful* magazine, published in Halifax (http://www.mindful.org/mindful-magazine).
6. Attend a mindfulness professional development workshop. Opportunities are being offered in most major Canadian cities. Alternatively, www.soundstrue.com offers an eight-week Mindfulness Based Stress Reduction program.
7. Explore books about mindfulness, such as:
   - Hanson, R. (2009). *Buddah's Brain: The Practical Neuroscience of Love, Happiness and Wisdom*. Oakland, CA: New Harbinger Publications.
   - Kabat-Zinn, J. (2013). *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain and Illness* (Rev. ed.). New York, NY: Bantam Dell.
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COLUMN EDITOR: PATRICIA DICKSON

The Alberta Algorithm: Driving occupational therapy practice

Cherie Henderson, Cynthia Johnson, Debra Froese, Christine Gregoire-Gau, Hilary Irvine and Ryan Sommer

Occupational therapists are experts at facilitating participation in valued occupations in all areas of daily activity, promoting satisfaction and independence for clients. Few activities are as closely associated with perceived independence as driving a motor vehicle. Driving is a complex, multi-faceted instrumental activity of daily living (IADL) and can be a challenging area of practice for occupational therapists. Its implications for clients, families and the general public are serious, especially if assessment and intervention are not performed by knowledgeable professionals. The Canadian Association of Occupational Therapists (CAOT; 2009) promotes occupational therapists' involvement in driver evaluation, stating: "An understanding of the relationship among the person, occupation, and the environment uniquely positions occupational therapists to provide client-centred driver rehabilitation programs with a focus on engagement and community participation" ("Driver rehabilitation services," para. 8). Occupational therapists must strive to provide services that reflect current best practices, responsibly use resources and are consistent with their individual level of competence.

In 2011, occupational therapists in Alberta formed a provincial working group to examine roles, best practices and the possibility for standardization in the field of driver screening, assessment and intervention. Over the next two years, a number of tools and supports were developed, including an algorithm that uses a

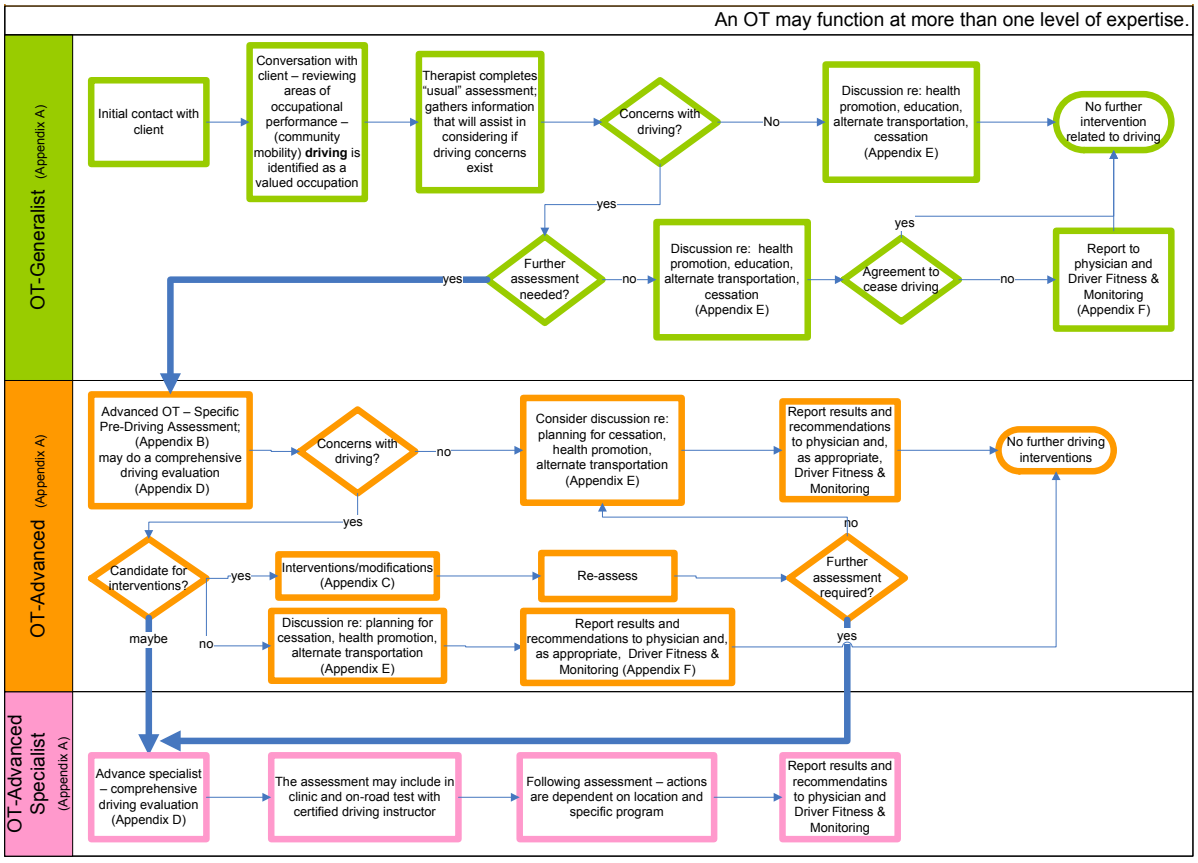

Figure 1. **Alberta Health Services Occupational Therapy Process Enabling Safe Participation in Driving.**

three-tiered system of levels to describe expertise: generalist, advanced and advanced specialist (Davis, 2003; Korner-Bitensky, Toal-Sullivan, & von Zweck, 2007). The algorithm and support documents have been developed from current knowledge in best practices and are consistent with CAOT's recommendations for occupational therapy and driver rehabilitation (Korner-Bitensky et al., 2007; CAOT, 2009; Dickerson, Reistetter, Schold Davis, & Monahan, 2011; Vrkljan, McGrath, & Letts, 2011). The three tiers of the algorithm are not mutually exclusive, nor do they have specific training requirements. It is up to each practitioner to ascertain and practice within their own knowledge, skills and abilities. This article will describe each level of the algorithm using case examples and demonstrate how it assists occupational therapists in addressing driving in their everyday practice environments.

OT-Generalist

"OT-Generalists" (see Figure 1) work in a variety of settings and have expertise in health promotion, facilitating community mobility and screening those at risk of unsafe driving (Korner-Bitensky et al., 2007). When concerns exist regarding a client's driving ability, referral to an "Advanced" or "Advanced-Specialist" occupational therapist may be warranted. In other cases, such as for clients with severe cognitive impairments, the OT-Generalist can recommend driving cessation based on her or his expertise in assessing safety in complex IADLs. Ideally, driving cessation should be approached with the client, family and health-care team, including physicians. In most provinces, physicians are responsible for reporting driving concerns to licensing bodies, however, CAOT advocates also empowering occupational therapists to make this report if they feel it is required (Korner-Bitensky et al., 2007). Mandatory physician reporting does not exist in Alberta but all occupational therapists should be knowledgeable of their provincial context and regulations regarding licensing, reporting driving concerns and professional college guidelines.

In situations in which driving cessation is not warranted, the OT-Generalist may consider broaching the subject of eventual retirement from driving, for example, with older drivers or those with progressive conditions. Advance planning and preparation can help clients maintain a sense of autonomy if they must give up driving at some point (Gustafsson et al., 2011).

Case study: Mr. J is a 78-year-old gentleman with diabetes, a previous stroke and mild cognitive impairment. He was recently discharged from hospital after being admitted due to a fall, and he is returning to his home where he lives alone. Prior to hospitalization, he was independent with basic activities of daily living (BADLs), had some supports for IADLs and was driving within his community. He has been referred to an occupational therapist for a home assessment.

Scenario 1: The assessment reveals no changes in functional status. Mr. J has adequate physical, sensory and cognitive skills for complex IADLs, such as meal preparation. The occupational therapist provides resources on safe driving and initiates discussion regarding the possibility of eventual cessation.

Scenario 2: The occupational therapist has significant concerns about Mr. J's function. His cognition is severely impaired on standardized and functional testing and he requires cueing for most BADLs. On his right side, coordination and vision are poor. Discussions with his family reveal several "close calls" behind the wheel. The occupational therapist informs Mr. J that she has concerns about his driving safety and the potential for harm to himself or others. He does not agree with these statements, and she informs him that she will speak with his physician and one of them will report these concerns to the licensing body. The licensing body will then contact Mr. J and let him know the next steps - possibly a medical assessment by a physician, the surrendering of his license or a comprehensive driving assessment. She offers resources on community transportation options.

Scenario 3: The occupational therapist finds Mr. J manages well with BADLs but has a few concerns about his driving. His daughter completes most IADLs for him, he has limited right arm function and he is only driving within his neighbourhood because it makes him nervous. The occupational therapist feels that a referral to an OT-Advanced Specialist will give him the opportunity to trial adaptive equipment and have his on-road performance evaluated. She makes the referral and asks that he refrain from driving until the evaluation.

OT-Advanced

The "OT-Advanced" (see Figure 1) uses standardized pre-road and/or on-road assessments to assess physical, cognitive, visual-perceptual and behavioural aspects of safe driving (Korner-Bitensky et al., 2007). At times, the OT-Generalist may perform the role of an OT-Advanced when conducting assessments with the specific goal of relating results to driving. This occupational therapist may have the competence to recommend interventions or modifications to facilitate driving and may or may not perform on-road tests, depending on the service area and resources.

Case study: Ms. W is a 24-year-old woman with an incomplete spinal cord injury at the T7 level. During in-patient rehabilitation, she has been working with an occupational therapist on independence with activities of daily living (ADLs), wheelchair mobility and discharge planning.

Scenario 1: Ms. W has progressed well, strengthening her intact muscle groups and achieving independent transfers

About the authors

The authors were all members of the Alberta Health Services Occupational Therapy Driving Working Group. In addition to the authors, the working group has included: **Todd Farrell, Amy Lau, Nicole Thompson, Gary Spiess and Brenda Wilson**. For more information regarding the group's work please contact: practice.consultation@albertahealthservices.ca

and good trunk stability. She has no deficits in cognition, arm strength or judgment. Her occupational therapist recommends vehicle modifications (hand controls/ spinner knob). Upon discharge, Ms. W has the equipment installed in her car and practices on a friend's farm. When she feels comfortable, she completes a road test and regains her license.

Scenario 2: At completion of in-patient rehabilitation, Ms. W has reduced trunk control and does not have enough arm strength to turn a steering wheel or push down on hand controls. She and her occupational therapist discuss the options of continuing to work on her deficits in outpatient rehab and returning for re-evaluation at a later date, or making a referral to an OT Advanced-Specialist for evaluation and retraining with high-tech modifications (e.g., electronic gas and brake, low-effort steering). Based on her potential for improvement and the cost of high-tech modifications, they decide to re-evaluate her status in six months.

OT-Advanced Specialist

"OT-Advanced Specialists" (see Figure 1) have highly specialized skills in assessment, complex problem solving, the use of assistive technology and vehicle modifications, and proficiency in driver training and retraining (Korner-Bitensky et al., 2007). They often have advanced training with postgraduate or driving rehabilitation specialist certification. They complete comprehensive driving evaluations (CDE), usually in conjunction with a certified driving instructor. While CDE is considered the gold standard for driving evaluation, access can be limited, and responsible use of health-care resources should help guide referrals.

Case study: Mr. Y is a 17-year-old man with right hemiplegic cerebral palsy. His physician referred him to his local driver evaluation program to evaluate his potential for driving. The OT-Advanced Specialist and driving instructor complete a CDE and feel Mr. Y has the ability to learn to drive with adapted equipment. He tries driving with his right foot, but due to incoordination, hand controls are recommended. After completing classroom driver education, Mr. Y returns to the program to complete on-road lessons with the driving instructor and successfully passes his road test.

These examples illustrate how the algorithm can be used by occupational therapists to effectively address the IADL of driving. The algorithm includes several appendices intended to provide additional support for screening, education, assessment and intervention related to driving.

Every occupational therapist can and should play a role in addressing concerns related to driving when it is one of a client's valued occupations. We believe the tools developed by the Alberta Health Services Occupational Therapy Driving Working Group can be used to develop occupational therapists' knowledge, skills and abilities, building capacity to enable clients' safe participation in driving. These tools have been developed for the Alberta context, and user groups may (with referencing) adapt as appropriate to meet their own contextual needs. When doing this, occupational therapists should be familiar with their provincial legislation, particularly the requirements for reporting of driving concerns, sharing of health information with licensing bodies, and what titles can be used in describing the occupational therapist role. The Alberta Health Services working group will continue to develop resources to build capacity at all three levels of occupational therapists' involvement, advocate for the development of more professionals at the advanced and advanced specialist levels, and further disseminate their tools to reach stakeholders at local and national levels.

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OT THEN

COLUMN EDITOR: SUE BAPTISTE

Once upon a time...The story of one of Canada's first private occupational therapy practices

Margaret Tompson

I found myself launched into private practice because I had the temerity to request a part-time job. It was the early 1970s in Saskatoon, and when my request for shifting from full-time to part-time work was refused, I found myself saying that in that case I would quit and go into private practice. This shocked my department head who told me that was impossible, as occupational therapists did not do that kind of thing. My response was short and to the point: "Just watch me."

That was the start of one of the first private practices in Canada. The other emerging private practice at that time, a group of five therapists, went on to become virtually a household name in Ontario: Community Occupational Therapy Associates (COTA). My own company served its purpose, to break the monopoly on employment, but never grew beyond a one-person practice. As I look back forty years, I have some fond memories of that period of my career.

Start-up

I was lucky to have a supportive husband, and in those days families could survive on one income. I remember the flurry of activities in the early days: obtaining a home business licence, deciding on a name (Consultative Occupational Therapy Services), registering the company with the city and the province, and buying malpractice insurance. Nobody had heard of occupational therapy, so every person I had to deal with needed an explanation of the kind of business I was starting. On one occasion, the city even sprung a surprise home inspection on me. I don't know what they were expecting to find, but certainly not a young mother with two toddlers.

Marketing

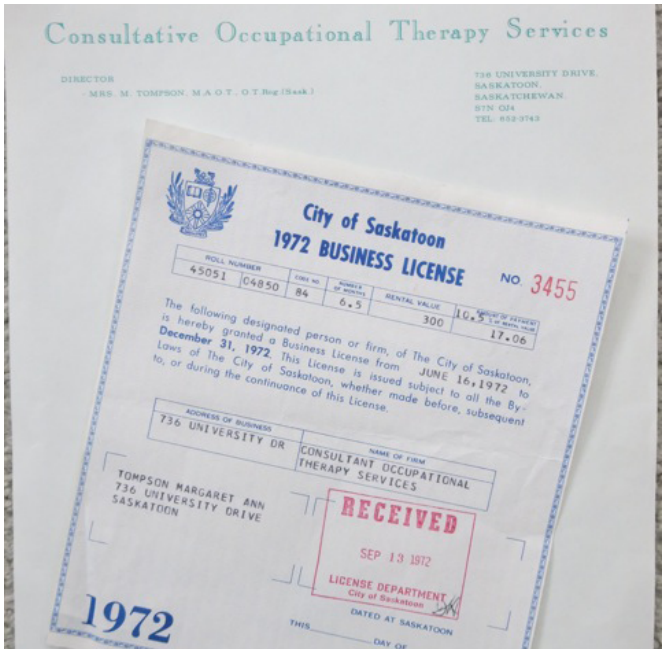
My first step was to have professional stationary designed. I had letterhead printed with a green strip across the bottom to mimic the occupational therapy charting paper from the hospital. I had referral pads made up because in those days, occupational therapists in Saskatchewan could only work if there was a doctor's referral. Now I was all set. I sent a letter to all the city physicians describing my services and enclosed a referral pad. Then I sat and waited, and waited and waited. I was really naïve in assuming this approach would be effective. Physicians were too busy to respond and further, more probably, had little interest in exploring the use of occupational therapy.

Eventually, I managed to get one or two physicians interested. I also made some contacts in nursing homes. Referrals from physicians were easier to obtain for residents in nursing homes. After staff identified a resident in need, I would have a casual chat with them, get a preliminary idea of what was needed, and then send a letter to their physician. This letter outlined how I felt I might be of assistance and asked them to sign a copy of the letter (which was enclosed with a stamped and addressed envelope) to approve my assessment and treatment of the resident. This strategy worked well and I would follow up my visit with a report. Unfortunately, my reports had to be far more detailed and lengthy than a traditional report as I needed to use each one as my opportunity to educate physicians about the value of occupational therapy.

"To be or not to be" a physical therapist

The "to be" part of this memory relates to the kind offer by the director of a physical therapy department to employ me using funding for part of one of her "physical therapy" positions on a contract basis. The clinic administrator agreed, as did the government officials, who knew I was not actually a physical therapist. All involved agreed it was the best way to implement a pilot study on the role of occupational therapy within a family practice. Patients were hand-picked by the director as she was anxious to prove the cost-effectiveness of occupational therapy services. One patient in particular stood out during the pilot process. He was a plumber who had injured his thumb and kept reinjuring it and having to stop work. A one-hour intervention and a simple working splint ensured he returned to work and kept working. As a result of the pilot project, the clinic decided to create a new position for an occupational therapist, which was funded as such.

The "not to be" a physical therapist incident came about during my efforts to have my company listed in the Yellow Pages of the local telephone book. I was told that I would be listed under "physical therapy." When I protested, I was informed that there was no category for occupational therapy and this was the best they could do. As I was getting no where with the telephone company, I contacted the physical therapy regulatory body and they assured me they would take action if my company was listed in the Yellow Pages under physical therapy. I then contacted the telephone company and told them that I would have no choice, if prosecuted by the physical therapists, but to sue the phone company for misrepresentation.



The author's 1972 business licence and her business stationary.

My stance on this issue resulted in a phone call from the telephone company's head office in Ontario to obtain further clarification on the situation. The official explained to me that they could not create a category just for one person. He was amazed to learn that there was more than one occupational therapist in Canada and that, in fact, there were several thousand. Again, an explanation had to be made about our role in the community. And if my memory serves me well, the call went on for almost an hour because the caller was so intrigued about this group of health-care professionals that he was not aware even existed. Thus was born the occupational therapy category in the Yellow Pages of the telephone book.

Professional fees

Being one of the first to start a private practice in occupational therapy made the creation of the fee schedule problematic. I ended up with three levels of payment. The top level was what I should be paid and was the fee schedule I charged nursing homes, government departments or any other third party. The second level was for individuals who were paying out of their own pocket. It covered my costs but not much more. Finally, there were the individuals, usually older adults, who would press a couple of dollar notes in my hand and ask me if that was enough. Fortunately, these latter cases were few and far between, and I guess were my own form of pro bono work.

Have case, will travel

My practice was very self-contained, to the point that I could throw it all into one suitcase: splinting supplies, hot-air gun, cognitive assessments, some basic assistive devices and whatever else I needed for a home visit. It came in handy having my resources in one place when I went on vacation; I just passed the suitcase on to whoever was covering for me.

Differences between institutional and private practice

One of the most startling discoveries I made was the way my approach to delivering occupational therapy services changed from the way I previously practiced when I was on salary, working within an institution. I became very aware that individuals were paying for my time, so I tried to be as cost-effective in my approach as possible, whilst continuing to provide an effective and quality service. I aimed to complete my interventions within approximately three visits. If it looked as though it would take longer, then I tried to get the patient into the public system where they could receive free occupational therapy. I remember one situation where a patient initially refused to switch. She was convinced I was the only person who could satisfactorily create her tiny finger splints. The matter was only resolved to the satisfaction of the patient when I accompanied her into the local occupational therapy department and demonstrated the creation of these splints to the therapist who was going to take over her care.

Another unexpected offshoot of going into the world of private practice was the assumption by my colleagues that I was now wealthy; after all, I was charging a fee that was roughly double their hourly salary. I managed to correct this erroneous impression by pointing out that my billing was based on patient contact time. I reminded them of the numerous activities that took place when the patient was not present. I also started making reference to myself as a "freelancer" rather than a private practitioner, which seemed more acceptable.

Finally, I came to appreciate how much easier it was for an occupational therapist to have a profile when working in the community. In the hospital, I was but one of many health-care professionals. However, in the community it was very different. Many times I was the only health-care professional, besides the family physician, seeing an individual. They remembered me, and talked about my services to their family and friends. It was great public relations for the profession. However, being one of the few people to see the patient did have its drawbacks. It made me very conscious of the responsibility of spotting any problems, because if I missed something, there was no other team member to notice my error.

Final thoughts

I never made much money from my private practice but I learned much and gained a great deal of satisfaction from having the opportunity to practice independently outside the constraints of an institution. I was also able to demonstrate the value of occupational therapy services, which led to the achievement of my original goal: the development of additional occupational therapy departments, thus expanding the employment opportunities for occupational therapists in Saskatoon and ending the 1970s sole employer monopoly.

About the author

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COLUMN EDITORS: HEIDI CRAMM AND HEATHER COLQUHOUN

Moving constraint-induced movement therapy and bimanual therapy into practice

Sophie Lam-Damji, Linda Fay, Julia Lockhart and Sue Hoffman

Children with hemiplegic cerebral palsy (CP) present with weakness, poor selective motor control, spasticity, sensory impairments and disuse of the impaired limb. Research involving constraint-induced movement therapy (CIMT) and bimanual intensive therapy (BIM) has shown improvements in upper extremity function in children with hemiplegic CP (Novak et al., 2013). In a systematic review, Novak (2013) used the Oxford Levels of Evidence and the Evidence Alert Traffic Light and found CIMT and BIM were "green light" interventions with high levels of evidence supporting their use for children with hemiplegic CP. CIMT focuses on unilateral hand function and is a therapy involving restraint of the unaffected limb with concurrent provision of repetitive intensive practice of the impaired limb to improve spontaneous use (Gordon, 2011). BIM focuses on bilateral hand function and was introduced by Gordon (2011) to address the limitations of CIMT while maintaining intensive training of the impaired limb.

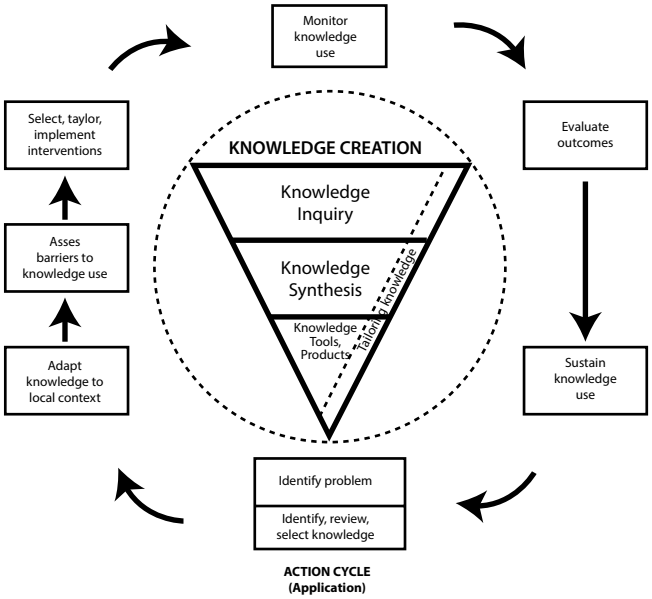

Figure 1. **The knowledge-to-action process. Reprinted from "Lost in knowledge translation: Time for a map?" by Graham et al., Journal of Continuing Education in the Health Professions, Vol. 26, pp. 13-24.**

Translating evidence into practice can be challenging, prompting researchers to identify the evidence to practice gap (Grohl & Grimshaw, 2003). This paper describes how Holland Bloorview Kids Rehabilitation Hospital (HBKR) and the Children's Developmental Rehabilitation Program (CDRP) used the Knowledge To Action (KTA) framework (Graham et al., 2006) to implement these therapies into practice. The KTA framework (see Figure 1) describes the relationship between knowledge creation (the inner circle) and the activities required for knowledge application (the outer action cycle) (Canadian Institutes of Health Research, 2014).

Knowledge creation

In this step, we focused on knowledge synthesis by synthesizing the best available evidence for use in practice. Critical review of the literature and evidence was pursued. CIMT was originally used in the adult stroke population to overcome learned non-use of the impaired limb (Taub, 1994). Children with hemiplegic CP also ignore the impaired limb in daily life, as using the unimpaired limb is more efficient and effective. DeLuca, Case-Smith, Stevenson, and Ramey (2012) described this phenomenon as developmental disregard. CIMT was later adopted for children with hemiplegic CP, and both the type of restraint and intensity of CIMT were modified to make this approach more child-friendly (Charles, Wolf, Schneider, & Gordon, 2006; Eliasson, Krumlinde-Sundholm, Shaw, & Wang, 2005). Studies comparing CIMT and BIM found that children receiving CIMT do better on unilateral tasks, while children receiving BIM do better on bilateral tasks. Recently, a combined serial approach of CIMT and BIM has been recommended (Dong et al., 2013).

Action cycle

The action cycle describes the process of knowledge implementation and includes seven phases (Graham et al., 2006).

Identify the problem.

Both centres (HBKR and CDRP) were receiving requests from families for CIMT. To be client-centred and employ best evidence in practice, a decision was made to engage in a process of integrating these therapies.

Adapt knowledge to local context.
Given the evidence and the local context, the occupational therapists examined the available resources and considered the time required to create, deliver and sustain CIMT and BIM (including staff, space and materials), as well as the experience and skills of present staff and the relevance of these therapies to the local client population.

Assess barriers to knowledge use.
Barriers to implementing CIMT included how to implement practical aspects of CIMT (e.g., how to restrain the unaffected limb and how to provide developmentally appropriate programs for children of different ages).

From a family and client perspective, barriers to participating in these programs included client frustration, safety, commitment (e.g., wearing the restraint, attending assessment visits, implementing home programs) and the timeliness of the intensive therapy (including its potential interference with school).

Select, tailor and implement intervention.
To decrease the knowledge-to-practice gap, the development of CIMT as an emerging best practice was presented by an occupational therapist to the senior management team at HBKR. The physician director and the occupational therapist submitted an article reviewing the evidence to CanChild Centre for Childhood Disability Research, a research and educational centre located at McMaster University in Hamilton, Ontario (Lam-Damji & Fehlings, 2006).

To overcome the above noted barriers, occupational therapists engaged in self-directed learning by reviewing the literature, attending journal club meetings with the physician director and management, and attending focus groups and local and international conferences to increase knowledge of CIMT and BIM. At HBKR, the occupational therapists presented on CIMT and BIM to staff, fellows and colleagues to share information and increase awareness of these evidence-informed therapies. A business plan was developed and presented to management detailing required resources and costs. To overcome client-reported barriers, developmentally appropriate programs and a variety of protocols were established.

At CDRP, the occupational therapists also reviewed the literature and attended focus groups and conferences. However, being a considerably smaller centre, the occupational therapists only needed to discuss their ideas directly with the medical director prior to formalizing their protocols.

Integrating CIMT and BIM into practice.
Individual programming: For the individual CIMT and BIM programs, resources presently required include occupational therapists, orthotists and occupational therapy assistants (OTAs). The OTA implements the CIMT and BIM programs under the guidance of the occupational therapist. The client attends once-weekly sessions with the OTA over a 12-week period, working on activities to target unilateral motor control, strength, speed and efficiency, as well as bimanual hand skills. Selection of the restraint is based on factors such as safety, comfort, climate, fabrics and hygiene (Eliasson et al., 2014). Other factors include the client's upper limb motor control, mobility and balance, ease of frustration and participation level, and the client's environment(s). Each client chooses between wearing a removable restraint for two to four hours during the day over several weeks or a non-removable restraint for three weeks. Home programs are provided. Children are followed to determine the need for repeated CIMT. Individual CIMT and BIM programs are now available throughout the year at both facilities.

Summer camp: For camps, resources include occupational therapists, OTAs, volunteers, social workers, music therapists, dance therapists, magicians and aquatic lifeguards. Social workers provide client and parent support, and disability awareness intervention. Participants attend the camp for four hours per day. For one week before camp, the participants wear a non-removable cast. This cast is bivalved on the first day of camp and made into a removable restraint. The removable restraint is worn for three hours daily for the first week of camp, which has a focus on the development of unilateral skills. For the second week of camp, the children wear the removable restraint for one hour daily and the focus is on integrating the unilateral skills into bimanual activities. Camp activities are developed using the model of motor learning and are embedded within an activity-based framework. As the participants progress through the camp, the activities are graded using task analysis, while ensuring a "just right" challenge. Camps are offered annually in the summer.

Assessments for both individual and camp programming are completed before the intervention and again one week and six months after the intervention. These include assessment of motor impairment (e.g., the Quality of Upper Extremity Skills Test [DeMatteo et al., 1993; Thorley, Lannin, Cusick, Novak, & Boyd, 2012], the AQCUIREc Motor Activity Log [DeLuca, Echols, & Ramey, 2007] and the Jebsen-Taylor Hand Function Test [Sears & Chung, 2010]), and assessment of participation (e.g., the Assisting Hand Assessment [Krumlinde-Sundholm, Holmefur, Kottorp, & Eliasson, 2007], the Canadian Occupational Performance Measure [Law et al., 1990] or the Children's Hand Use Evaluation Questionnaire [Sköld, Hermansson, Krumlinde-Sundholm, & Eliasson, 2011]). More recently at HBKR, assessments have also included a sensory evaluation (e.g., Semmes Weinstein Filament Test, Two Point Discrimination Test, Stereognosis [Auld, Ware, Boyd, Moseley, & Johnston, 2012]).

Monitor knowledge use.
Occupational therapists continue to review current evidence and participate in education opportunities. Findings have been disseminated at various local, national and international conferences and focus groups about best practices. Requests are received from centres that are members of the Ontario Association of Children's Rehabilitation Services to consult on how to start a CIMT and BIM program and to share our resources.

Evaluate outcomes.
Findings from standardized assessments help to inform practice. Positive trends have been noted in upper extremity skill development with improvements in daily activities following CIMT/BIM interventions that persist to six months after the intervention. Client and caregiver questionnaires are also used to

gather camp feedback. Feedback received indicates that families would welcome more CIMT and BIM camps and would like the camps to be longer than four hours per day with sessions longer than two weeks.

Sustain knowledge use.
At HBKR, a Constraint and Bimanual Therapy Handbook for home programming will soon become available on the HBKR website for easy access and sharing with community partners. The creation of this handbook has helped to continue to develop occupational therapists' skills in these therapies and it is hoped the handbook will build capacity in the system. Occupational therapists from both sites continue to collaborate with the Bloorview Research Institute to further investigate the efficacy of CIMT and BIM.

Conclusion

The KTA framework has been a useful tool to help implement CIMT and BIM into practice in a way that is evidence-based, meets the needs of our clients and enables the occupational therapists to systematically evaluate the evolving evidence to ensure these therapies continue to be based on best evidence. The KTA framework will be continue to be a useful tool for the occupational therapists to apply to other evidence-based treatments in narrowing the gap from knowledge to practice.

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ENHANCING PRACTICE: OLDER ADULTS

COLUMN EDITOR: SANDRA HOBSON

Pushing spokes for older folks: Two novel approaches for improving manual wheelchair use among older adults

Ed Giesbrecht, Krista L. Best and William C. Miller

Wheelchairs and older adults

The wheelchair is among the most recognizable forms of assistive technology, and arguably the most important. Over 60% of Canadian wheelchair users are older adults, a demographic expected to double by the year 2050 (Statistics Canada, 2008). Obtaining a wheelchair involves considerable cost to both the consumer and health-care system; the purchase price and process of assessment and procurement can easily exceed $10,000. Acquisition alone does not ensure independent nor safe use of the device. Almost 60% of older wheelchair users in Canada require assistance from others for basic mobility (Shields, 2004). Mobility dependence can lead to reduced participation, loss of social connectedness, increased caregiver burden and abandonment or disuse of mobility devices (Finlayson & van Denend, 2003; Turner Goins et al., 2014). Moreover, improper wheelchair use can lead to collisions, tips and falls, particularly among older adults, who comprise nearly 70% of emergency room visits related to a wheelchair accident (Xiang, Chany, & Smith, 2006).

Factors contributing to compromised use

A variety of systemic and social factors combine to disadvantage older wheelchair users. Stereotypes associated with wheelchair acquisition in later life suggest older adults lack the potential to be active users and are perceived to be less capable of learning new skills. Older adults often internalize these stigmatizing social perceptions, as wheelchair self-efficacy is negatively associated with aging and they have lower expectations for their own capacity to use a wheelchair (Sakakibara, Miller, Souza, Nikolova, & Best, 2013). The World Health Organization (WHO) recognizes training as a critical element for optimal wheelchair use (WHO, 2008), a position well supported by evidence. Wheelchair skills training should ideally comprise 10-12 sessions with an expert practitioner. Higher capacity for function may be attained post-discharge from hospital, in the community (Best, Kirby, Smith, & MacLeod, 2005). However, limitations on health-care resources lead to shorter hospital stays and competing priorities. Consequently, few wheelchair users receive advanced mobility training, and a decline in rehabilitation services means community-based therapists have little time to learn and use specialized skill sets, such as wheelchair training.

Innovation for wheelchair skills training

Given that rehabilitation resources are unlikely to increase in the current funding environment, developing alternative training strategies is critical. Two novel approaches to wheeled mobility education have recently been developed by researchers at the University of British Columbia and the University of Manitoba. Conceptual principles from andragogy (adult learning; Knowles, 1980) and social cognitive (self-efficacy) theory (Bandura, 1997) were used to specifically target the learning needs of older adults, encourage the uptake of assistive technology and promote adherence and investment in the training process.

Enhancing Participation In the Community by improving Wheelchair Skills: EPIC WheelS

EPIC WheelS is a one-month individualized home training program that uses a tablet computer to teach wheelchair skills to older adults. Experienced older adult manual wheelchair users, as well as caregivers and prescribing practitioners, were engaged throughout the development and evolution of the EPIC WheelS program. An occupational therapist with wheelchair skills expertise conducts two one-hour one-on-one training sessions, during which they assess learning needs and goals, and then provide instruction in both skill performance and use of the tablet-based home program. Trainees use a 10-inch tablet computer, mounted on a rigid platform with a simple thigh strap for in-wheelchair use. This unique configuration allows trainees to view demonstrations and training activities *while* they are wheeling, and they can practice in virtually any environment in their community, promoting improved generalization of skills. For example, participants can "ride a rollercoaster" on the tablet screen to practice weight shifting for skills such as wheeling up inclines and across side slopes.

The EPIC WheelS home program is menu-driven and interactive, using a touch screen interface. Training material is multi-modal, with illustrations and videos, allowing detailed step-by-step guidance and slow-motion demonstrations that use age-appropriate older adult models. Practice activities can be clearly illustrated and include imitative, function-based and interactive game-related activities. Training activities are graded in their complexity and degree of challenge. To reinforce participation, a "progress" icon provides daily updates on the number of minutes practiced per week. During the four-week study period, a dedicated EPIC WheelS tablet is provided on loan at no cost, as well as a

mobile Internet device to enable voice message exchange between each trainee and his or her occupational therapist, and to upload tablet data to a secure website. The therapist can monitor training activity and progress online, make changes to the treatment plan and communicate with the trainee by voice mail, all at his or her own convenience. Important others (i.e., family members, friends or caregivers) are invited to participate in the training sessions, during which they may be taught strategies and spotting techniques so they can make the home program more interactive and reinforce the principles of EPIC WheelS.

Delivering home-based rehabilitation interventions among older adults has been effective for improving a variety of outcomes, including strength (Layne et al., 2008), physical activity (Jette et al., 1998), self-care (Gill et al., 2002) and exercise (Campbell et al., 1997). The low demands for travel and direct contact, in addition to the scheduling flexibility for both the occupational therapist and the trainee, make this a more cost-effective alternative than traditional outpatient therapy. A monitored wheelchair skills home program that is effective and efficient for older adults also has potential for application to other groups, for example, those living in rural and remote locations with limited access to rehabilitation.

Wheelchair training Self-efficacy enhanced for Use: WheelSeeU

WheelSeeU is a community-based program administered by an older adult who is an experienced manual wheelchair user. Participants take part in the intervention in dyads, but complete customized training based on individualized goals. To promote adherence, provide perspective and encourage safe practice outside of the intervention, participants are encouraged to bring an "important other" to the training sessions. The peer trainer assists participants to generate meaningful wheelchair mobility goals, and then applies problem-solving methods similar to those used in self-management programs to achieve each goal. The four components of social cognitive theory, which include vicarious experience, performance mastery, verbal persuasion and reinterpretation of physiological responses (Bandura, 1997), are used to promote training and learning.

Vicarious experience is observing success in comparable peers and is established through two means. First, through a peer mentor who facilitates the intervention, participants learn skills by watching an experienced wheelchair user. Second, working in pairs, participants learn by watching similar others go through a process of trial and error while working toward successful performances. Observing a peer succeed strengthens belief in one's own ability to succeed (Bandura, 1997). Performance mastery is learning to perform a specific skill and is the most robust source of self-efficacy. To ensure mastery of meaningful wheelchair skills, training focuses on participant-identified goals. Verbal persuasion arises from credible communication and feedback targeted to guide the learner through the task and motivate optimal effort. This is provided by the peer trainer, other participants and important others. Participants are taught to reinterpret physiological responses by learning strategies to identify and then address issues, such as stress and anxiety reactions associated with challenging situations, through role-playing, discussion and situational vignettes. Peer-led programs have been used effectively for increasing self-efficacy and health-related behaviours in various clinical settings, for the treatment of conditions such as arthritis and diabetes, as well as for cardiac rehabilitation and exercise promotion. High retention rates and perceived benefits of peer-led programs have also been demonstrated to positively influence long-term program adherence among older adults (Dorgo, King, Bader, & Limon, 2011).

Summary

EPIC WheelS and WheelSeeU provide novel and innovative approaches for addressing the wheeled mobility concerns of an aging population. EPIC WheelS provides the unique advantages of privacy, convenience and control for the trainee in a familiar and authentic learning context while reducing the time, effort and expense of travel for both the trainee and the occupational therapist. WheelSeeU provides the notable advantage of peer trainers, who tend to be more empathic and respectful compared to practitioners, especially among older adults (Bratter & Freeman, 1990). It can also be administered in pairs or a group, increasing efficiency and fostering a sense of community among participants (Webel, Okonsky, Trompeta, & Holzemer, 2010). WheelSeeU may be sustainable through partnerships with existing community-based peer mentor programs. The feasibility and effectiveness of these programs are currently being evaluated in two clinical trials. Improvement in wheelchair skill capacity is the primary outcome of interest, but we are also evaluating improvement in wheelchair safety, self-efficacy and community mobility. Together, EPIC WheelS and WheelSeeU may provide innovative solutions for wheelchair training, addressing the social, systemic and economic barriers to increased independence and fuller participation in the

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community for older adult wheelchair users. For more information on these studies, please visit our website: http://millerresearch.osot.ubc.ca/research/participate/

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ENHANCING PRACTICE:
OLDER ADULTS

COLUMN EDITOR: SANDRA HOBSON

Budget restraint in health-care services and its effects on Canada's older immigrants

(Hedy) Anna Walsh

Budget restraint in health-care services (Forget, Deber, Roos, & Walld, 2005) has increasingly challenged occupational therapists and other health-care providers in the delivery of services for Canada's diverse multicultural populations (Wisensale, 2006). These reforms have resulted in earlier hospital discharges, more community-based care and greater pressure on families to provide informal and private care for older relatives (Baranek, Williams, & Deber, 1999).

The majority of individuals over the age of 75 continue to live independently in the community, however, there are those who require assistance with their activities of daily living, such as bathing, dressing and eating, as well as with their instrumental activities of daily living, such as shopping, banking and transportation (Wisensale, 2006). Health-care providers may expect ethnocultural groups to provide informal support for such activities, stemming from assumptions about close family relationships, cultural traditions revering older adults, and individuals' innate caregiving skills, leading to inaccurate predictions of older adults' needs for formal home care services (Brotman, 2002). Although reciprocal relationships of caregiving are embedded in many cultural traditions, information pertaining to family loyalty and attitudes of obligation and commitment remain poorly understood among health-care providers (Tomlinson & Åstedt-Kurki, 2008). This article is intended to stimulate discussion among occupational therapists about the effects of budget restraint on the caregiving and occupational engagement needs of Canada's older immigrants.

Canada's caregiving challenges

Older adult immigrants make up a significant number of Canadians. International migration has been the main source of Canada's population growth since the early 1990s (Statistics Canada, 2013). Within the foreign-born population, 18% are aged 65 or older, compared to 11% of those born in Canada (Wu & Hart, 2002).

Budgetary restraint within Canada's health-care programs has led to the "aging in place" strategy, encouraging older adults to remain in their homes and rely on sources of public, private and informal care (Lai, 2004). Its positive effect of encouraging people to continue residing in their own homes has, however, led to an increased reliance on families to provide care, as many older adults are unable to afford private care (Dorazio-Migliore, Migliore, & Anderson, 2005).

Increased budget reductions have prioritized spending on acute medical care, which has led to difficulties for older adults in accessing much-needed medical support for chronic ailments (Simms, 2003) and in receiving services such as cooking, cleaning, socialization, transportation and personal care, which have been deemed non-medical services (Simms, 2003). Competing demands created by complex health-care needs exacerbate the problem of limited entitlement to such services. Additionally, linguistic and cultural considerations are often not prioritized. These factors can result in visits by health-care providers being time-pressured (Fiscella & Epstein, 2008).

Cultural patterns of caregiving

Historically, responsibility for long-term care in Western cultures was largely viewed as the family's responsibility. This has since changed as a result of expectations having shifted, in part as a result of women's involvement in the paid workforce and their unavailability to provide full-time care. Another contributor to this shift may be individualism, which emphasizes the need for self-determination, autonomy and privacy. This often conflicts with the values of familism, which prioritize the importance of the family in the provision of care (Montgomery, 1999). For example, prescribed use of adaptive aids, such as grab bars to ensure client safety in the bathroom, may conflict with a family's values and preference to do without them (Benoit & Hallgrímsdóttir, 2008).

Patterns of caregiving are largely influenced by factors such as cultural traditions, beliefs, the length of time spent in a new country, education level and economic factors (Jones, Zhang, Jaceldo-Siegl, & Meleis, 2002). Culture has been defined as values, beliefs, norms and practices that are transmitted and shared among individuals (Jirwe, Gerrish, & Emami, 2006). Although cultural traditions of caregiving are often passed on from one generation to another (Won Min, 2005), variations may occur as a result of "acculturation," so cultural differences in a new country may emerge. Acculturation is defined as "those phenomena which will result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original culture patterns of either or both groups" (Rohmann, Piontkowski, & Van Randenborgh, 2008, pp. 337-338).

Health-care workers' expectations for caregiving are not only informed by personal interpretations of cultural meanings and values, but may also be affected by the government's emphasis upon cost containment of health-care services — the promotion of early discharges from hospital and more reliance on sources of private and

informal care are being fostered. For example, cultural values that encourage family members to assist their loved ones with self-care in hospital may be negatively viewed by hospital personnel who have been encouraging the person to build independence; such assistance may be seen as a potential delay to the discharge process. Such issues risk perpetuating the cultural divide between family and health-care providers. Interpretations of culture must, therefore, be also understood as they relate to Canada's restructuring of health-care services, in which the political objective of cost containment prioritizes more self-sufficiency and early discharges, with corresponding less reliance on the public health-care system (Anderson, Tang, & Blue, 2007).

Recommendations

The result of the situation described above is that older adult immigrants in Canada may be assumed to have greater family support than is actually the case and have a more difficult time accessing publicly funded support services. In other words, social and institutional environments may not sufficiently support many older adults' basic occupational engagement at home. Therefore, occupational therapists need to consider the effects of health-care reforms as they influence older adults and their access to resources and how this impacts intergenerational support systems (Joubert & Bradshaw, 2006). In order to address this issue, occupational therapists may:

1. Encourage older adults and their family members to freely express their caregiving needs as they relate to their access to formal, informal and private care. Consider the potential effects of acculturation on patterns of caregiving, such that realistic caregiving expectations of older adults and their family members are clarified, rather than assumed.
2. Recommend public home care services based on realistic appraisals of available informal and private support.
3. Encourage the development of more research evidence to guide practitioners in better understanding the role of the family in the provision of care for older relatives.
4. Advocate for increased time for the provision of culturally competent care and for addressing the complex health-care needs of older adults.

Conclusion

Occupational therapists play an important role in enabling Canada's older immigrants to participate in daily occupations in their own homes and assisting them and their families to access health, social and economic resources. The continuing emphasis on cost containment in public services poses challenges to this role (Padilla, 2007). Occupational therapists' ability to adequately respond to the caregiving needs of older adult immigrants is contingent upon a thorough understanding of the effects of budgetary restraint on health-care services and of the role of the family in the provision of care.

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ENHANCING PRACTICE:
MENTAL HEALTH

COLUMN EDITOR: REGINA CASEY

Spirituality in the forensic mental health system: A student perspective

Natalie A. Hunt and Meghan J. Harris

In Canada, occupational therapy practice is often guided by the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Polatajko, Townsend, & Craik, 2007). A central concept of the CMOP-E is spirituality, yet despite its significance within the model, occupational therapists struggle to "name, frame, and utilize spirituality in practice" (Smith, 2012, p. 78). This paper aims to discuss spirituality in terms of the authors' unique student experience while on placement in a forensic mental health setting. It will address a theory-practice gap that seems to exist in the current clinical practice of occupational therapy and will provide some insights into ways in which therapists may begin to reflect on spirituality and incorporate it into their own practice.

According to the occupational therapy literature, spirituality does not appear to be well understood and no universally applicable definition of the concept exists (Koenig, 2009; Wilding, May, & Muir-Cochrane, 2005; Egan & Swedersky, 2003). Kaye and Raghaven (2002) present one professionally relevant definition of spirituality: "the central way of life which guides people's conduct and . . . the essence of an individual's existence that integrates and transcends the physical, emotional, intellectual, volitional and social dimensions" (p. 231). Perhaps more explicitly, spirituality may be defined as living and being human, while finding meaning and purpose in life and everyday activities (Bassett, Lloyd, & Tse, 2008; Egan & Swedersky, 2003). In keeping with the CMOP-E, clinical practice is typically informed by considering the physical, cognitive, affective and environmental influences on occupational performance (Polatajko et al., 2007). Additionally, however, it is important not to overlook the role that spirituality may play, for example, in the recovery process for individuals who live with mental illness. In the mental health context, Chidarikire (2012) speaks to this theme, noting, "spirituality and religiousness have been identified as key in the process of recovery from severe mental disorders . . . through providing meaning and hope in suffering" (p. 289).

As students completing placements at the Southwest Centre for Forensic Mental Health Care in St. Thomas, Ontario, we had the opportunity to observe the powerful role that spirituality can play in supporting client recovery from severe and persistent mental illness. In this institution, individuals are supported within the forensic mental health system after they have come into conflict with the justice system while, at the same time, being affected by severe and persistent mental illness. An interdisciplinary approach to facilitating recovery was used based on a psychosocial rehabilitation (PSR) approach (Psychosocial Rehabilitation/Réadaptation Psychosociale [PSR/RPS] Canada, 2009).

PSR/RSP Canada's core principles and values speak to the relevance of spirituality, noting that practice should "strive to help individuals improve the quality of all aspects of their lives, including social, occupational, education, residential, intellectual, spiritual and financial" (PSR/RPS, 2014, para. 11). Accordingly, at the Southwest Centre for Forensic Mental Health Care, spiritual care and spirituality take on a vital role in the service delivery paradigm (St. Joseph's Health Care London, 2013).

In this setting, clients frequently voice their experiences of significant role loss or participation changes. Often these losses include the loss of family, friends, jobs, homes and the capacity to participate in meaningful occupations (Reilly, 1969; Batten, 2012). Renowned mental health advocate and former mental health consumer Patricia Deegan (1995) speaks to this theme:

> "Prior to becoming active participants in our own recovery process, many of us find ourselves in a time of great apathy and indifference. It is a time of having a hardened heart. Of not caring anymore [sic]. It is a time when we feel ourselves to be among the living dead: alone, abandoned, and adrift on a dead and silent sea without course or bearing" (p. 93).

By supporting participation in meaningful occupation, practitioners at the Southwest Centre for Forensic Mental Health Care partner with each client in his or her unique recovery journey. This type of approach enables clients to consider challenging spiritual questions, such as "Who can I become, and why should I say yes to life?" (Deegan, 1995, p. 92).

At the Southwest Centre for Forensic Mental Health Care, clinical spiritual care is guided by the Reverend Stephen Yeo, a certified Pastoral Care Specialist with the Canadian Association for Spiritual Care. Indeed, all occupational therapists and interdisciplinary team members are encouraged to collectively support the unique spiritual needs of each client (St. Joseph's Health Care London, 2013). In this context, the concept of spirituality ensures a focus on each client's personal narrative, unique spiritual journey and broad existential experience. By employing a specialized approach in concert with an interdisciplinary approach to spiritual intervention, clients are consistently supported to find and make meaning in their unique lived experience. On a practical level, they are encouraged to explore their personal narratives, to embrace the whole of their own story and to discover, or at

least consider, their potential future role participation. At the facility, clients are encouraged to use their spirituality as a source of strength and hope within their own unique recovery journey. In this light, "spirituality assists the individuals to accept the changes the illness has brought . . . [and] it serves as a powerful source of strength, determination and resilience in the face of adversity" (Bassett, Lloyd, & Tse, 2008, p. 256).

The Reverend Stephen Yeo highlights four fundamental and universal spiritual themes that he explores when working with clients in this setting, which include: hope and hopelessness, connectedness and disconnectedness, meaning and meaninglessness, and identity (personal communication, December 9, 2013). During our placement, former mental health consumer and award-winning mental health author and advocate Brett Batten shared his lived experience in the forensic mental health-care setting both in person and through phone conversations, identifying how these fundamental spiritual themes impacted his recovery from mental illness. Brett stated that throughout his journey with mental illness he felt darkness and hopelessness; however, in exploring his spirituality, he began a process of finding meaning in his circumstances. Brett recounted his experience of mental illness as one of isolation and loneliness, but with time he was able to use spirituality as a tool to connect with others. He voiced the perception that he is still re-forming elements of his identity and that this process of exploring new meaning in occupations and roles was guided by his spirituality (personal communication, December 9, 2013).

Lessons learned

What made our student experience in forensic mental health different from previous fieldwork placements was the centrality, constancy and thematic influence of spirituality, informing both client narratives and the care paradigm. The work to which we were exposed in this setting embodies the central nature of spirituality outlined by the CMOP-E on a practical level (Polatajko et al., 2007). Spirituality is the most crucial tenet guiding the respectful provision of care at The Southwest Centre for Forensic Mental Health Care (St. Joseph's Health Care London, 2013). It constantly informs staff and client interactions, as well as client choice, autonomy and occupational participation. Clients are encouraged to explore their spirituality, are regularly engaged in dialogue discussing their personal and spiritual narratives, and are given opportunities to engage in various spiritual practices. These include, but are not limited to, facilitated spirituality groups, meditation, labyrinth walking, prayer, music and interfaith services, as well as services supported by a specific faith community. This approach enables clients, such as Brett Batten, to be supported to live with dignity in the face of serious and persistent mental illness and travel the often uncertain path that is associated with interaction with the justice system.

Employing reflective practice (Kinsella, 2001) helped us to appreciate how this placement experience has challenged us to explore and redefine our own spiritual narratives. Our initial assumptions and beliefs regarding spirituality are markedly changed, and the influence it can have on both a personal and professional level is evident to us. Initially we saw spirituality as a complex concept that would be difficult to discuss with individuals and to regularly incorporate into our practice. From our placement experience we have come to see that spirituality, while complex, can be incorporated into practice in many simple ways while still having a profound impact on an individual's recovery and healing processes. Through conversations with clients and supervisors, as well as through participation in experiential learning, we have grown in our knowledge and capacity to practically incorporate spirituality into client-centered care.

Theory-practice gap

In the profession of occupational therapy, a gap exists between theory and practice pertaining to spirituality (Morris, 2013). Within the literature, it has been debated that occupational therapy practice may be less than fully client-centered if clinicians fail to recognize the spirit (Rebeiro, 2001). While occupational therapists acknowledge the important role that spirituality plays in their own personal lives and in the lives of their clients, many report they do not have the skills to delve into spiritual issues in their practice and fear offending their clients (Egan & Swedersky, 2003). It is also noted that therapists may need time to become more confident in their abilities to handle common treatment protocols and understand diagnoses before their ability to take spiritual considerations into account can develop and mature (Egan & Swedersky, 2003). We encourage occupational therapy practitioners and students to begin to reflect on spirituality and how it informs their personal and professional narratives. What are your strengths and weaknesses regarding spirituality? How do you define spirituality? What are the spiritual practices in which you engage? What are your assumptions or beliefs regarding spirituality? Therapists should be careful not to work outside of their expertise or comfort level (Rosenfeld, 2001); however, by beginning to reflect on these types of questions, clinicians may become more aware of how spirituality is at work in their own personal lives and how they may be able to incorporate it into a practice context.

Conclusion

The role of spirituality in occupational therapy contributes markedly to the practice of client-centered care. Our fieldwork experience was a catalyst that made us acknowledge the theory-practice gap regarding spirituality in occupational therapy practice. While therapists may recognize that spirituality lies at the center of the CMOP-E (Polatajko et al., 2007), it appears that the implications of this centrality are not well understood or readily incorporated into client care. The Reverend Stephen Yeo suggests that clinicians do not need to be experts in clinical spiritual care, nor do they need to find answers for their clients' existential questions. Rather, occupational therapists can address spirituality in practice by recognizing that all individuals are spiritual beings, by confirming and validating their clients' lived experiences, and by helping them to work toward meaningful occupational roles. He emphasizes that "we all search for meaning and hope; we all seek to belong; we all have our existential questions" (personal communication, December 9, 2013). It is our hope that occupational therapists begin to explore their own spirituality and that of their clients, and consider ways to help narrow the theory-practice gap.

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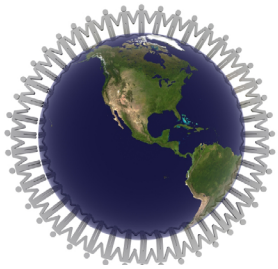

COLUMN EDITOR: SANDRA BRESSLER

Identity in our ever-evolving world: Occupational therapy on a macro level

Emma Scammell

In 2014, I completed an internship at UNICEF Headquarters within the Data and Analytics Section in the Division of Data, Research and Policy, working on child disability projects as my final student fieldwork placement. The University of Toronto offers role-emerging final fieldwork placements in settings where there is no established occupational therapy service. I was fortunate to be presented with this opportunity after applying for a summer internship with UNICEF Headquarters, as well as connecting with my fieldwork supervisor in advance. In this article, I reflect on my experiences as an occupational therapy student in this environment, specifically how my occupational therapy skills were applied at the macro (or population) level.

I was uncertain – yet excited – as I walked into UNICEF Headquarters in New York City on the first day of my placement. Up to this point I had no experience in the field of international development or working with a children's rights organization. I entered with many questions: Had my occupational therapy education prepared me for this position? What will child disability data and analytic initiatives entail? How will I introduce myself as a student occupational therapist on this non-traditional placement?

Within a few hours of meeting the team and beginning work, I realized that my occupational therapy education had provided me with an identity, and a way of thinking and problem solving that was congruent with UNICEF's vision and mission. UNICEF's mission, as mandated by the United Nations General Assembly, is "to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential" (UNICEF, 2003, para. 1). This mission is congruent with that of occupational therapy, as it is a belief in the profession that an occupationally just world allows for all individuals to have access to engagement in occupation (Townsend & Whiteford, 2005).

While at UNICEF, the need and urgency for a new way of viewing childhood disability around the world was impressed upon me. The team working on child disability projects in the Data and Analytics Section was advocating for a rights-based conceptualization of disability, where the rights of all persons with and without disabilities are met. Disability is often only understood from a biomedical approach around the world, focusing on the impairment rather than the individual's full participation in society, and subsequently the rights of many children with disabilities are not being met. For instance, children with disabilities have been shown to attend school less frequently than their typically developing peers (Filmer, 2005).

Over the course of my master's program, models such as the Canadian Model of Occupational Performance and Engagement (CMOP-E; Polatajko, Townsend, & Craik, 2007) helped guide my thinking. But how could these models be applied at UNICEF, outside of a clinical setting and on such a macro level where the client is considered to be all children globally? Furthermore, in my occupational therapy program, I had learned about childhood development, how to break down activities and how to incorporate elements of the environment into my clinical reasoning. In this new setting, how could this knowledge help me look beyond my local surroundings to my global community? I soon discovered that my identity and capabilities should not have been my focus while entering UNICEF. I should have instead been asking myself: How will I apply the depth of knowledge that I've learned in my occupational therapy program to this organization? And how will this enhance child disability data and analytics projects with UNICEF?

Throughout the first few weeks of my placement, I began to see the application of my occupational therapy skill set to the three main projects I was involved in. First, I updated an existing database on child disability, compiling all available published census and survey data on child disability internationally, along with corresponding questions and definitions of disability. Through this work, I was able to fully grasp the number of children living with disabilities around the world that are not accounted for. The need for higher quality data collection

Emma Scammell at UNICEF.

was evident, as it would influence programs and resources for these children. It was on this project that I applied my master's research skills to the work of UNICEF. My occupational therapy education had indeed prepared me for data and analytic work on the macro level.

I then helped with a set of guidelines that will be disseminated to educate stakeholders who are measuring child disability in low- and middle-income countries. I was able to compile resources and references to enhance knowledge on models of disability, child development, clinical assessments, and data collection and analysis procedures. Throughout the work on these guidelines, it was evident that the authors of the resources spoke with much of the same function- and activity-based language as occupational therapists. I was confident, as I had just learned much of the same content related to child development and models of disability through the University of Toronto occupational therapy curriculum. Again, I felt that my education had well equipped me to compile resources and references related to these guidelines.

Finally, I helped translate these guidelines into a week-long workshop to be presented around the world in the coming years to key stakeholders. I applied my knowledge translation skills as I disseminated information to knowledge users through presentations, paying close attention to details within the guidelines. I was able to apply engaging teaching modalities to these presentations, encouraging critical thinking and deeper learning. By creating workshop material that would encourage ethical and accurate data collection of children living with disabilities, I was enabling these stakeholders' engagement in the data collection process. I took from the many engaging teaching modalities I had witnessed throughout my master's classes and applied them here.

What became clear to me while working on these projects was the need for stakeholders (e.g., policy-makers and statisticians) to reframe their thinking in terms of how function and participation are conceptualized. While updating the child disability database, there seemed to be a direct link between function- and participation-based questions and statistics showing a higher number of reported children living with disabilities. This link was also clear to UNICEF, and fit well with the framework chosen to guide their child disability data collection: the *International Classification of Functioning, Disability and Health: Children and Youth* (ICF-CY; World Health Organization, 2007). The ICF-CY is congruent with the CMOP-E (Stamm, Cieza, Machold, Smolen, & Stucki, 2006), as it highlights how participation and activity engagement are influenced by contextual factors, such as those relating to the environment and person (e.g., demographics). The CMOP-E situates engagement in meaningful occupation in the same way: as an interaction between the environmental contexts, the occupation itself, and unique person-specific factors (Polatajko et al., 2007). Throughout my time with UNICEF, I felt that I was speaking the same language as the team. Because of this, I did not feel that my identity as a budding occupational therapist had to be masked or changed. I felt completely at ease knowing that my skills fit the profile of one working on projects to quantify how many children live with disabilities around the world.

Occupational therapy is broadening the application of its scope to new environments, and there is no need to alter our identity to fit into our ever-evolving world. We, as a profession, are well equipped to apply our skills to the extensive global context that is always in front of us. Be it positions with non-governmental organizations, or projects that enhance policy within local hospitals, occupational therapists have the skills to work on a macro level. In this internship setting, I felt that I was able to promote frameworks that examine participation and function, thus enabling engagement in occupation. With UNICEF, engagement in meaningful activity extends to all children, ensuring that the rights of all children are recognized.

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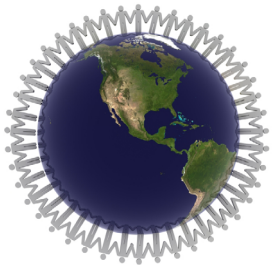

COLUMN EDITOR: SANDRA BRESSLER

World Federation of Occupational Therapists update

Sandra Bressler, CAOT Delegate to WFOT

This article highlights information from recent World Federation of Occupational Therapists (WFOT) events: Council Focus Day; WFOT Council Meeting held in Chiba, Japan; the 16th WFOT Congress, held in Yokohama, Japan; and World Occupational Therapy Day.

WFOT Council Focus Day

Lori Cyr (then CAOT President Elect) and I (CAOT Delegate to WFOT) attended Focus Day, held in Chiba the day before the WFOT Council Meeting. The purpose of the day was to promote long-term planning amongst the delegates and alternates to ensure that WFOT is meeting and continues to meet the needs of its member associations and the occupational therapists they represent. Discussion included an overview of the WFOT Human Resources Project, a review of the 2013-2018 Strategic Plan, and an overview of the outcomes and finalizing the process to complete the review of the Minimum Standards for Education of Occupational Therapists (MSEOT). There was also an opportunity to break into regional groups to discuss current trends in health in our countries.

For an interesting look at occupational therapy human resource numbers around the world, check out WFOT's interactive map at: https://mapsengine.google.com/map/viewer?mid=zzCP5B35cUvo.kH3G44H1hkoU

WFOT Council Meeting

Over 80 delegates and observers representing 48 countries attended the 31st WFOT Council Meeting held June 10-14, in Chiba, Japan. The council meeting included a full agenda of discussion, debate and decision making on issues of importance to WFOT and to occupational therapy at an international level.

The following new WFOT Position Statements were approved by the WFOT Council and can be found at: http://www.wfot.org/ResourceCentre.aspx

- Telehealth
- Human Displacement (revised)
- International Professionalism
- Recruiting Occupational Therapists from International Communities (revised)
- Recognition of Former Educational Status
- Global Health: Informing Occupational Therapy Practice
- Scope and Extension of Practice
- Specialization and Advanced Occupational Therapy Competencies
- Occupational Therapy in Disaster Preparedness and Response

Two associations, Bulgaria and Malawi, were approved for full membership to WFOT, and associate memberships were approved for Faroe Islands, Madagascar and Zambia.

The WFOT Thelma Cardwell Foundation Award was made to Dr Katherine Wimpenny, senior research fellow, senior occupational therapy lecturer, Coventry University, for the project titled: "Preparation for an uncertain world: International curriculum development for mental health occupational therapy practice preparation."

The Council elected a new Executive Management Team, with their terms of office in these positions commencing at the end of Congress:

- Marilyn Pattison – President
- Sue Baptiste – Vice President
- Samantha Shann – Vice President Finance
- Ritchard Ledgerd – Executive Director
- Sandra Bressler – Program Coordinator: Practice Development
- Sue Coppola – Program Coordinator: Research
- Lyle Duque – Program Coordinator: Education
- Athena Tsai – Program Coordinator: Standards and Quality

Paulette Guitard, Giovanna Boniface, Janet Craik and Lori Cyr at the CAOT booth at the 2014 WFOT Congress in Yokohama, Japan.

The 16th WFOT Congress

Over 6400 delegates from 72 countries attended the 2014 WFOT Congress, held in Yokohama, Japan, June 18-21, 2014. Many Canadian occupational therapists attended and presented. CAOT organized a dinner for Canadian registrants, which provided an informal opportunity for networking.

A highlight of the Congress was the inaugural WFOT Lecture, titled "Seizing the Future: Occupational therapy's readiness for the Global Health Stage," delivered by Sharon Brintnell, then president of WFOT. As the first recipient of the WFOT Lectureship Award, Sharon was recognized as an exemplar in her contributions to occupational therapy in the areas of teaching and research, curriculum development, publications and presentations, mentoring, and promotion of the profession and professional organizations.

The Emperor and Empress of Japan attended the official Congress Opening, which was a very proud moment for the Japanese hosts of Congress. The Imperial guests participated in the Opening Ceremony and then met with WFOT executives and delegates, and JAOT officials at a small function.

World Occupational Therapy Day

World Occupational Therapy Day is held annually on October 27 and is an opportunity to heighten the visibility of the profession's development work and to promote the activities of WFOT locally, nationally and internationally. The aim is that the WFOT World Occupational Therapy Day be integrated with other national celebrations and promotions of the mission and goals of occupational therapy. For more information, visit: http://www.wfot.org/AboutUs/WorldOTDay.aspx

COLUMN EDITORS: LAURA HARTMAN AND CHRISTINA LAMONTAGNE

Learning...in the most unusual places

Kristy Taylor and Catherine White

While attending Dalhousie University's School of Occupational Therapy, I expected to be learning in the classrooms and laboratories, but I had no idea I would be putting that learning to work in the school's administration office, nor at our local ski hill. Michelle Mahoney, an administrative assistant at the school, was born with a condition known as arthrogryposis. This neuromuscular condition causes significant muscle weakness and contractures, making flexion and extension of affected joints impossible. Although both wrists and one knee are affected, Michelle doesn't let that slow her down. She drives, plays piano and has a unique approach to "knuckle typing." I wondered if she could ski.

As a level two instructor with the Canadian Association of Disabled Skiing (CADS), I have seen a lot of people, who thought that taking to the slopes was out of reach for them, embrace the opportunity and give it a try. It is such a privilege to share my love for skiing and to see someone experience the thrill of sliding down the hill for the first time. This sensation gives them a real sense of freedom, I'm told.

One day I finally asked Michelle, "Have you ever thought of skiing?" At first she just looked at me and laughed. She said, "I really wanted to ski. I tried it once before and it wasn't good...it scared me." She clarified that she went with friends who didn't really know how to help her and who didn't realize the challenges she would face. For example, having to hike up the hill when she could not grip the rope tow was not a pleasant experience! I explained that there was an adaptive skiing program at a nearby resort that uses a range of different approaches to enable people with varying abilities to ski. Michelle was excited to give it a try.

Before heading to the slopes, I recruited some of my occupational therapy classmates who were interested in becoming volunteers with the program. It seemed like the perfect fit with our occupational therapy knowledge and provided an excellent learning opportunity for all of us. Skiing can be adapted so that people with different abilities and challenges can take part. As a CADS instructor, I have enabled people to ski with a range of physical or cognitive impairments, including those with cerebral palsy, visual impairments, Down syndrome, cerebellar ataxia, multiple sclerosis, autism, Angelman syndrome and many others. Building on the strengths and abilities of each person, we collaborate with them to choose the right equipment and the best approach for making skiing fun and safe.

The student volunteers were able to learn about the different types of equipment and approaches, and help the instructors to problem solve a solution for each skier. By pairing an instructor and a volunteer with a skier (rather than using two instructors), the program could double the number of people it could accommodate. My fellow classmates brought their "occupational therapy lens" with them and were able to collaborate with both skiers and instructors alike to support the program.

In preparation for Michelle's introduction to adaptive skiing, I started to observe her to see how she did things. I wanted to determine which movements she would be able to do, and where she might need support. Activity analysis and clinical reasoning in action! With the combination of the contractures in her wrists and her fixed knee, stand-up skiing was not likely to work. Michelle has trunk control, so I knew she would be able to make the turns by herself. After considering the options, I thought the sit-ski approach (a seated approach that relies on trunk control and upper body strength) would be best (see photo).

Kristy and Michelle on the ski hill.

Michelle arrived for her first ski day, excited with anticipation. Once at the hill, a volunteer and I got Michelle in the sit-ski and customized the padding to make sure she was supported and safe. For safety reasons, Michelle needed someone tethered to her to guide her down the hill; this was my job. With a couple of volunteers skiing behind us doing "traffic control," Michelle got to experience the feeling of skiing and started to learn how to turn. We zigzagged back and forth and made our way to the bottom. With the aid of the adapted equipment, the volunteers, and the ski hill staff, Michelle was able to get on and off the chair lift safely, and do it all again.

She loved it! "The first time down the hill, I was unbelievably overwhelmed. It was quite possibly the best day of my life," she said. "It is just such a feeling to come down that hill - it's just so much fun. I always hated winter before, but now I have something to look forward to, and it's all thanks to the students. They did that for me. I just cried that first day, and said thank you, thank you. It just means so much."

We've been back many times since then, and on her third time out, Michelle took a bit of a tumble. She scraped her face and laughed about it. "I'm proud to say 'I did this skiing.'" She loves that skiing is now a regular winter activity for *her*, and not just something everyone else does. "They figured it out for me. It's great."

My fellow CADS instructors have really appreciated what occupational therapy students bring to the ski hill, and we are all looking forward to the year ahead. They say that we are really good at problem solving, thinking of adaptations and making skiing work for each person. We know that everyone is different and we just try to use the strengths and abilities of each person to make it happen, to *enable occupation*. It's been a great hands-on learning experience, and as we continue in our occupational therapy program, hopefully we will have more and more to offer. It just goes to show, we can learn in the most unusual places.

To learn more about adaptive ski programs in Canada, visit the Canadian Association for Disabled Skiing website: http://disabledskiing.ca/

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Update from the Canadian Occupational Therapy Foundation

Deirdre Dawson is a monthly COTF donor. Here she shares her motivations for doing this.

Why Deirdre donates to COTF

I received my first scholarship for graduate school and one of my first research grants from COTF. At the time I was thrilled that there was an agency that was interested in occupational therapy and occupational science research. I am still thrilled about this! Scholarship in our profession is critical for building our science and our evidence. Canadian occupational therapy researchers are truly at the forefront worldwide and COTF is one reason for this. Donating to COTF is one way I support our profession and can "give back."

Why Deidre became a monthly COTF donor

I have switched many of my charitable donations to monthly rather than annual. It only makes sense to me – I depend on a reliable monthly income to make my financial decisions – I want COTF to have that same stability so that they can develop and grow without worrying about whether there will be enough in the coffers this month to pay the rent.

The benefits of being a monthly donor

There are two key benefits to me of being a monthly donor. When I made the switch to monthly support, a mental switch also happened – I started to feel like I really was supporting an organization I think is vital to our profession rather than being "on the fringe." I like this! On a more pragmatic note, it has made my life simpler. I've decided to support COTF – it happens through an automatic withdrawal, my monthly finances are more stable and I don't have to think about whether I'll send money with each request or mention – it's done!

More new awards for the 2015 Research Grant Competition:

1. COTF KT Translation Grant in the amount of $5,000 to support the translation of a publication in English or French.
2. Association of Yukon Occupational Therapists Research Grant in the amount of $3,000 to support rural or remote research.
3. McMaster University Legacy Award in the amount of $1,500 to honour two retired faculty members, Penny Salvatori and Mary Edwards, both passionate about clinical education, for research with a focus on perspectives and roles of occupational therapists as clinical educators.

Visit http://www.cotfcanada.org/index.php/research-grants to see all grants and to apply online.

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