OCCUPATIONAL THERAPY NOW

OCCUPATIONAL THERAPY NOW VOLUME 17.3

Table of Contents

CAOT • ACE

ISSN: 1481-5532 Canada Post agreement #40034418

CAOT PRESIDENT
Lori Cyr, OT(C)

CAOT EXECUTIVE DIRECTOR
Janet Craik, MSc, OT(C), OT Reg. (Ont.)

RETURN UNDELIVERABLE CANADIAN ADDRESSES TO:
CAOT – CTTC Building
3400 – 1125 Colonel By Drive
Ottawa, Ontario KIS 5R1 CAN
E-mail: publications@caot.ca

INDEXING
OT Now is indexed by ProQuest and OTDBase.

ADVERTISING
Phone: (613) 523-2268, ext. 232
E-mail: advertising@caot.ca

SUBSCRIPTIONS
Phone: (613) 523-2268, ext. 263
E-mail: subscriptions@caot.ca

Occupational Therapy Now is published six times a year (bimonthly beginning with January) by the Canadian Association of Occupational Therapists.

MANAGING EDITOR
Janna MacLachlan, OT Reg. (Ont.)
Tel. (613) 523-2268 ext. 266, Fax (613) 523-2552, email: otnow@caot.ca

TRANSLATION
De Shakespeare à Molière, Services de traduction

DESIGN & LAYOUT
JAR Creative

COPY EDITOR
Claire Hurd

What's new

Changes in columns and new *OT Now* topic structure

Over the last year, the *OT Now* Editorial Board has done a close review of the column offerings in this practice magazine, reviewing aspects such as submission rates and relevance of topics. The result is a shift to a model that will present all articles in one of four regular columns that will appear in each issue:

1. CAOT: Your Career Partner for Life – presenting CAOT news and initiatives
2. Knowledge to Practice – a "go-to" location for accessible information offering knowledge and skills to support your practice
3. Shared Perspectives - a venue for learning through the experiences of practitioners, students and consumers
4. Impacting Lives, Communities and Systems – a place to find examples of occupational therapists working for change in collaboration with clients and/or the profession. Themes are likely to include advocacy, leadership, justice, change agency, etc.

What we had previously referred to as columns and column editors will now be known as topics and topic editors. A few changes to the line-up have been made and new topics will be introduced in the July issue. To view the current topic roster and find contacts for topic editors, go to: http://www.caot.ca/default.asp?pageid=271

Occupational Therapy Now call for papers

September 2015 – Occupational therapists as agents of change: Improving the lives of Canadians

- Special call for brief reports of 300-500 words
- Submission deadline: June 1, 2015
- To view the full call for papers, go to: http://www.caot.ca/default.asp?ChangeID=25&pageID=7

The goal of this special issue of *OT Now* is to provide a broad audience with information about occupational therapy solutions for change – on both macro and micro levels. The issue will focus on occupational therapy approaches relating to six topics of national interest:

1. Military personnel (focusing on mental health)
2. Issues facing Aboriginal Canadians
3. End-of-life care
4. Access to pediatric services
5. Poverty
6. Caregiver support

CAOT Product Recognition Program

CAOT now formally recognizes products relevant to the practice of occupational therapy in Canada through a Product Recognition Program. Through this program, the association approves products with a seal of recognition, and end-users can use this as a basis for which to make decisions on products that will allow them to engage in everyday occupations.

The first product to receive recognition from CAOT is the Stander Handybar, a device that provides people with better hand support while transferring in and out of a vehicle. To view the Product Recognition Report for the Handybar and to learn more about this product, go to: http://www.caot.ca/default.asp?pageid=2177

OT Finder: Helping people find the occupational therapy services they need

Are you a practitioner? A researcher? A speaker or educator? A manager? Or professor? OT Finder helps you to be found by people looking for specific occupational therapy services. Become a part of the OT Finder community and help raise the profile and accessibility of occupational therapy.

OT Finder will be the best resource for finding and contacting an occupational therapist in Canada. CAOT has provided the link to all stakeholder groups, members of provincial and federal governments, as well as all major health-care associations.

Let OT Finder help you be found by clients and all people looking for occupational therapy services in Canada. Explore the new OT Finder at: http://www.caot.ca/default.asp?pageid=3622

Charting new ground: Interprofessional approaches to dysphagia management

Are you an experienced clinician seeking to advance your knowledge and skills in dysphagia assessment and management, as well as your expertise in working with an interprofessional team? If so, plan to be in Toronto from October 4 - 6, 2015.

The Canadian Association of Occupational Therapists (CAOT), Dietitians of Canada (DC) and Speech-Language and Audiology Canada (SAC) have developed a two-day workshop designed to engage clinicians from different disciplines to hone and advance their clinical skills as part of the interprofessional dysphagia care team. The program is intended delve into dysphagia practice in a way that may take you out of your comfort zone, challenge your assumptions and help you realize the power and benefits of interprofessional practice.

We have assembled an outstanding panel of speakers with internationally recognized expertise in the fields of speech-language pathology, occupational therapy, physiotherapy, nutrition and interprofessional practice. Adding depth to the program are our special guest speakers with extensive knowledge in medicine, bioethics, respiratory therapy and dental care.

Early bird rates are available until September 7, 2015.

For detailed program information and to register, go to: http://www.caot.ca/default.asp?pageid=1461 or contact: education@caot.ca

CAOT 2014-2015 Midyear Report

Janet Craik, CAOT Executive Director, and Lori Cyr, CAOT President

Over the course of this membership year, the Canadian Association of Occupational Therapists (CAOT) has kept its focus clear. CAOT is proud to be your career partner for life - to support you as you advance excellence in occupational therapy. We want to ensure that we provide resources, products and services that are beneficial to and valued by our members. Every year we strive to find new and innovative ways to create strategic partnerships, build alliances and foster a quality workforce through strengthening our evidence base and implementing standards for education and practice. The aim is to ensure quality occupational therapy services are delivered to meet the occupational needs of Canadians.

CAOT governance and human resources

October 1, 2014, marked a change in the leadership of CAOT's Board of Directors. We thanked Past President Paulette Guitard for her outstanding support and leadership in the past two years and welcomed Lori Cyr as the new CAOT President. On October 6, 2014, CAOT held a National Occupational Therapy Month event in Ottawa, where we welcomed occupational therapists, occupational therapy students and members of the public to our first CAOT Inspirational Talk. This event, entitled *Enabling the community of occupational therapy*, provided the opportunity to celebrate our wonderful profession, network with peers and be inspired by guest speakers. Lori Cyr delivered her inaugural presidential address and shared her vision for the association and the profession. A busload of occupational therapy students from the Université de Montréal joined in the event and a subset of these students shared reasons for choosing the profession and their vision for the future of occupational therapy. The final inspirational speech was delivered by former federal cabinet minister Jack Murta on how a life of service is a life worth living. As a part of this event, CAOT launched its YouTube channel (https://www.youtube.com/channel/UCkV1G8zJxmN8pEnXRwAVKeg) and made the speeches available to all.

Following the appointment of our new President, the CAOT Board of Directors appointed Janet Craik as CAOT's Executive Director. Janet stated, "I am proud to serve you in this position and look forward to building on my personal vision that someday people will understand that occupation is a determinant of health."

To better serve the needs of the association and our membership, a number of staffing changes have occurred at the CAOT National Office:

- Dr. Julie Lapointe joined us permanently as the Director of Professional Practice.
- Havelin Anand accepted the new role of Director of Government Affairs and Policy.
- Chantal Houde and Molly Gray joined us permanently as Membership Services Representatives.
- Caleb Ficner was promoted to Membership Services Coordinator.
- Ryan McGovern was promoted to Exam Services and Accreditation Coordinator.

CAOT staff is on hand to serve members. If you have comments, feedback or ideas on how we can better serve you, please get in touch by using the contacts listed in the staff directory at: www.caot.ca

In January 2015, CAOT launched a member outreach program called *CAOT Knowledge Exchange*. This program provides a space for the CAOT President and senior staff to meet CAOT members in their communities to discuss professional development activities, lobby and advocacy efforts, and other member benefits. To date, we have held three of these events in Metro Vancouver and one in Toronto. We are hoping to be able to meet CAOT members in their communities on a regular basis for this informal knowledge exchange. It provides us a better way to meet your needs and address your concerns. If you are interested in having us come to you, please let us know.

Membership services

CAOT now calls its new members to welcome them to the association as well as to provide an overview of the products and services that membership offers. We also contact lapsed members and are pleased to mention that a large majority of lapsed members simply forgot and have since renewed their commitment to CAOT. We would like to thank all of our members for their ongoing support for their professional association. Together we can be a strong voice to promote and shape this profession.

CAOT redesigned the online member profile platform that allows you to retrieve your insurance certificate number, review and update the information on your file and reset your

password. A new member satisfaction survey was developed with a focus on the needs of members and ensures that your voice is heard.

CAOT developed a Retired Occupational Therapists Network, which provides an opportunity for retired therapists to connect and have a voice in matters that concern occupational therapists who have retired or are thinking of retiring. A dedicated webpage was created in October 2014 to provide specific tools and resources to meet the needs of our retired members: https://www.caot.ca/default.asp?pageid=2340

CAOT introduced a new Occupational Therapy Student Committee to foster the future of the profession. This committee networks, engages and connects with occupational therapy students across the country to ensure that CAOT provides them with resources to support their academic and professional career. We have developed a blog to be the central hub for all CAOT student activities. CAOT continues to offer presentations to students on the role of the professional association and the tools and resources it offers.

The number of CAOT's corporate associates continues to grow. These companies are proud to show their support for occupational therapy in Canada, and share our vision and values to promote and advance all aspects of occupational therapy. CAOT has also introduced a Product Recognition Program. Through this program, the association approves products with a seal of recognition, and end-users can use this as a basis for which to make decisions relating to products that will allow them to engage in everyday occupations. Applications for product recognition will undergo a product review by a panel of selected reviewers. All reviews will be evidence-informed and produce a final report with detailed information and final recommendations.

CAOT is continually enhancing member services and providing value for its members. In partnering with BMS Group and the Healthcare Professionals Insurance Alliance (HPIA), CAOT has invested significantly to provide occupational therapists with insurance coverage that is one of the most cost-effective and comprehensive available, specialized resources and best-in-class legal defence. CAOT has optimized the professional liability insurance program and has become the primary source for the protection, advice and practice risk needs of Canadian occupational therapists. Last spring, CAOT and BMS Group published the second issue of *Risk Proof: The Risk Management Magazine for the Canadian Association of Occupational Therapists*, which provides information on managing risk in your practice.

CAOT partnered with GoodLife Fitness to provide you with a 55% savings on a GoodLife Fitness Membership. Mirroring our membership calendar, GoodLife offers access to more than 320 GoodLife Fitness Clubs across Canada and Energie Cardio in Quebec. Most of these gyms are open 24 hours per day, seven days per week, and are coed or for women only. GoodLife is proud to offer fitness services that make you comfortable and meet your needs.

CAOT enhanced its Members and Associate Assistance Program (MAAP) by providing Arive MAAP Services, which include counselling on legal issues, financial issues, family challenges, work-related difficulties, dependency concerns, child and elder care resource support, and nutritional counselling. MAAP also includes Acumin® Business Assistance Plan (ABAP), a support for small businesses that can't afford to have a team of specialists on hand to help deal with unexpected problems requiring an expert opinion. ABAP fills gaps for business owners by providing advice on topics ranging from legal and financial matters to human resources.

Learning services

Continuing professional education is essential for the personal and professional development of occupational therapists and for advancement of the profession of occupational therapy. CAOT assists occupational therapists to access and acquire current, relevant and evidence-based knowledge and skills.

CAOT offers Lunch and Learn webinars and Water Cooler Talk webinars each month. To better serve your needs, we developed new and affordable Lunch & Learn webinar pricing and bundle packages for individuals and groups. We are proud to say we have over 40 webinars planned for the coming year. A new offering this year is Management Mondays, which is a free new webinar series that will help you navigate through key business issues found in private practice.

CAOT is offering a wide range of workshops across the country this year. Topics include:

- Dementia: Its Challenges and Opportunities
- Ergonomics for Occupational Therapists: Conducting Back Injury Interventions in the Workplace, and Ergonomics for Occupational Therapists: Upper Limb Musculoskeletal Disorder Interventions in the Workplace
- Charting New Grounds – Interprofessional Approaches to Dysphagia Management. Developed by Dieticians of Canada, Speech-Language and Audiology Canada, and CAOT, this is an intensive learning program that advances knowledge and skills in dysphagia assessment and management, and supports collaborative interprofessional practice.

CAOT has partnered with SAGE since 2012 to publish the *Canadian Journal of Occupational Therapy (CJOT)*. CAOT is continually impressed by the quality of service and commitment that SAGE offers. Recently SAGE has instructed HighWire Press to remove all cover sheets from PDF articles on the SAGE Journals platform, including *CJOT*. This decision was made following feedback from Google that the cover sheets compromise the discoverability of the PDFs. SAGE is also reporting that a number of articles published in *CJOT* are amongst the most tweeted in SAGE Health Research social media platforms.

CAOT introduced an eBook rental service that allows members to rent a book for a 120-day period. This, along with our eBook purchase offerings, has extended the reach of Canadian occupational therapy research and resources worldwide, and has been seen as a great value to our members and international colleagues. The New OT Starter Kit was among CAOT's bestsellers this year and assists occupational

therapists and students to access a cost effective kit that includes *Enabling Occupation, Enabling Occupation II* and the fifth edition of the *Canadian Occupational Performance Measure (COPM)* with 100 *COPM* assessment forms.

CAOT understands there is a need for timely and innovative professional continuing education. We have successfully offered Momentum (Online Mentoring Module) in early 2015. Momentum consists of four webinars that allow individuals/mentees to explore the concepts of mentorship, coaching, networking and partnering. The webinars provide an opportunity for a mentee to be matched with a mentor based on similar values, interests and professional paths.

CAOT developed and offered the Career Readiness Online Module (CROMe), consisting of reflective exercises, small group discussions and mock interviews. Through this, CROMe participants develop an understanding of the current work environment and are assisted to prepare for the job market. CROMe consists of a pre-requisite, self-study culture activity and four interactive webinars facilitated by an experienced occupational therapist.

Examination and accreditation services

CAOT protects the public interest with the National Occupational Therapy Certification Examination (NOTCE), which assesses the written application of academic knowledge and professional behaviour of individuals entering the occupational therapy profession in Canada. CAOT offers the NOTCE every July and November. The NOTCE was administered with 592 candidates in November 2014.

As of October 1, 2014, exam candidates will have a total of three opportunities to successfully pass the NOTCE. Candidates who have already attempted the NOTCE prior to October 1, 2014, will have three more opportunities to write the exam. If a candidate does not succeed in passing the NOTCE after three attempts, the candidate will no longer be eligible to write this examination. Research supports the rationale behind this policy and demonstrates that three attempts allow candidates a fair opportunity to pass the NOTCE, while limiting the number of false positives that are likely to occur after three attempts.

As of May 1, 2015, occupational therapists who have completed their occupational therapy education outside of Canada (including Canadians who travelled outside Canada for their occupational therapy education) and want to register to practice anywhere in Canada (except Quebec) must first apply to the Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO) to complete a new assessment process called the Substantial Equivalency Assessment System (SEAS) before registering to write the NOTCE. SEAS is an assessment process to determine the extent to which an internationally educated occupational therapist's educational qualifications and competencies are equivalent to those of a Canadian-educated occupational therapist.

CAOT plays a key role in developing standards and quality assurance mechanisms. It is the sole agency in Canada with the mandate for the accreditation of occupational therapy education programs. CAOT's Academic Accrediting Council (ACC) introduced two new policies:

1. The Substantive Change(s) to a CAOT Accredited Entry-level Occupational Therapy Education Program policy discusses parameters for programs undergoing significant changes.
2. The Satellite Program policy refers to satellite programs that are added to accredited Canadian entry-level occupational therapy education programs.

CAOT has been working with Physiotherapy Accreditation Canada to accredit college programs for occupational therapist assistants and physiotherapist assistants. There are currently 10 accredited programs and 22 programs with candidacy status (see http://otapta.ca/ for more details).

CAOT-BC

The CAOT-British Columbia chapter (CAOT-BC) continues to engage the occupational therapy community by representing the professional interests of occupational therapists in many forums, including the BC Workforce Collaborative, Insurance Corporation of British Columbia, SafeCare BC, BC Care Providers Association Annual Conference, WorksafeBC, Health Sciences Association of British Columbia Professional Associations Meeting, and as a member of Honourable Hedy Fry's Veterans Affairs Advisory Committee.

CAOT-BC is a member of Honourable Hedy Fry's Veterans Affairs Advisory Committee.

In January 2015, CAOT-BC released the CAOT-BC Occupational Therapy Private Practice Directory 2015. The purpose of the directory is to help British Columbians locate an occupational therapist by geography or by area of practice. CAOT-BC continued to build on the success of special interest group activities with the new Measurement and CommunitOT groups. To learn more about CAOT-BC activities, go to: www.caot.ca/caot-bc/

Government affairs and policy

CAOT recently published the *Joint Position Statement on Diversity* and Professional Issue Forum reports on *Suicide Prevention and the Role of Occupational Therapy* and *Interprofessional Education and Collaboration*.

In the past year, CAOT engaged social media like never before. Social media is increasingly becoming an important tool in the promotion and advocacy of occupational therapy in Canada and the world. As well as introducing our YouTube channel, Google+ and Instagram accounts, we have established six blogs, including three relating to specific areas of practice: Occupational Therapy within the Military and Veterans Affairs Canada, Occupational Therapists Working in Dementia Care, and Occupational Therapists and Sensory Processing. The goal of these blogs is to provide timely and interesting information on the work and practice of occupational therapists in these specific areas. The CAOT ED Talks blog provides a timely communication vehicle to share current CAOT news, activities and events that are undertaken by the Executive Director on behalf of the association. Additionally, we have established a Student Network blog and a CarFit Canada blog. See www.caot.ca/socialmedia for more details on the specific blogs or to follow CAOT on various social media platforms.

CAOT has built on its advocacy and promotional campaign, and continues to develop monthly resources to help occupational therapists engage in a meaningful dialogue with clients, stakeholders, decision makers and other health-care providers on a variety of practice topics. See resource collections at: http://www.caot.ca/default.asp?pageid=1512

Using CAOT advocacy resources, the Board of Directors has been actively engaging in meetings with members of Parliament (MPs) from across the country and from various political parties, discussing and advocating for the role of occupational therapy in providing solutions for an aging Canada. Our board members and senior staff have been extremely successful during these meetings and are currently scheduling new meetings with other MPs.

CAOT has been very successful this year with advocacy and representation activities. Highlights include:

- Janet Craik attended the Advisory Panel on Healthcare Innovation for a discussion about the future role of the federal government in health care with Rona Ambrose, the federal minister of health.
- Janet Craik was appointed the chair of the Group of 7 Health Professions (G7) for the next two years. The G7 is a group of national health-care professional associations who formed a partnership to work collaboratively on health initiatives with a view to broadening policy initiatives beyond traditional health-care providers.
- CAOT made a presentation at the "Seniors Roundtable," hosted by the Liberal Party of Canada. The presentation emphasized the importance of occupational therapists in primary care teams and the return on investment of including occupational therapists in health and health-care delivery.
- CAOT supported Bill M-456, calling on the federal government to develop a Pan Canadian End of Life Palliative Care Strategy. The association and occupational therapists were recognized by the New Democratic Party of Canada for their aid with this bill.
- CAOT participated in a number of Health Action Lobby (HEAL) activities, which culminated in the public release of a consensus document that calls for federal leadership, titled *Accelerating Innovation and Improving Health System Performance*.

We continue to plan and develop new opportunities to discuss the role and benefits of occupational therapy throughout 2015.

Moving forward for 2015

With all of this accomplished, we still have so many interesting activities and initiatives ahead of us:

- Conference 2015 has the theme, "Occupational justice: Rising to the challenge." Occupational therapists have developed an understanding of the importance of addressing injustices to enable people's full participation in occupations that are meaningful and enriching. Join us in Winnipeg to share your knowledge and strategies for rising to the challenge of enhancing occupational justice in our communities. The conference will be co-hosted by the Manitoba Society of Occupational Therapists and will be held in Winnipeg, Manitoba, on May 27-30, 2015.
- CAOT is planning an expansion of the CarFit program across the country, including the introduction of AutoAjuste, the new French component to this program that will be launched in late spring in Montreal. CAOT hosted an MP reception on March 31, 2015, in the parliamentary dining room to discuss the role of occupational therapy in the federal jurisdiction and promote the CarFit program as a great education and public service event. Conservative MP Peter Braid sponsored CAOT for this event. CAOT will also be reviewing and renewing the Older Driver Safety Website in the coming year.
- Accessing extended health insurance for clients is often a priority for occupational therapists. Watch for CAOT to provide you with new resources and a new campaign to encourage insurance providers to include occupational therapy services as part of their standard coverage.
- CAOT will soon move the National Office to its new location in Ottawa. Photos and video of the new office will be shared with members. This move represents the first step in celebrating our association's 90th anniversary (which will happen in 2016).

CAOT has been fortunate to have seen growth over the years in terms of membership and service offerings. We believe that CAOT is well positioned with good governance and management practices to foster continuous growth for the profession for years to come.

For more information on the activities above or regarding other initiatives of CAOT, please contact Janet Craik at: jcraik@caot.ca

What you always wanted to know about the National Occupational Therapy Certification Examination but were afraid to ask

Chris Beauchamp, Ryan McGovern and Elizabeth Steggles

The purpose of the National Occupational Therapy Certification Examination (NOTCE) is to protect public interest by assessing the written application of academic knowledge and professional behaviour of individuals entering the occupational therapy profession in Canada. In all provinces except Quebec, passing the NOTCE is a requirement to practice as an occupational therapist, but what is the NOTCE? How is it developed and how do we know it measures what it is supposed to? In this article we shall try to answer some common questions and demystify the process.

Who is responsible for the NOTCE?

The Canadian Association of Occupational Therapists (CAOT) is responsible for the development and delivery of the NOTCE. A number of people contribute. CAOT has a team that includes the Director of Standards and the Exam Services Coordinator who oversee the daily operations. It is the volunteer members of the Certification Examination Committee (CEC), however, who construct, with the help of the NOTCE Blueprint (see Figure 1), and validate the entire exam, along with NOTCE's preparation materials. The CEC meets after every exam to review the exam's performance and finalize and approve the next exam in line. Additional meetings are held for maintenance of the exam questions and other NOTCE initiatives. Furthermore, occupational therapists from across the country who reflect a broad range of practice expertise are recruited to write the "cases" and "items" (questions) for the multiple choice exam. CAOT also recruits the services of an "exam provider." The exam provider is a company that specializes in testing and statistics, and provides other national exams. The role of the exam provider is to ensure that the NOTCE is valid, reliable and fair, and adheres to best practices in high stakes assessment. Finally, NOTCE site coordinators and invigilators are recruited for each exam site across Canada and one site in Australia to ensure that the exam is secure and that the writers' needs are met.

Who writes the NOTCE and what should they expect?

Every year, approximately 800 candidates write the NOTCE in July or November. The majority of the candidates are new graduates from Canadian entry-level occupational therapy university programs. Around 20% of the writers are internationally educated occupational therapists (IEOTs). Other candidates include occupational therapists who are re-entering the workforce after a lengthy absence.

Recent domestic graduates are eligible to write the NOTCE by showing proof that they have successfully obtained a professional master's degree in occupational therapy from a CAOT-accredited entry-level occupational therapy university program. As of May 1, 2015, IEOTs must establish their eligibility to write the NOTCE with the Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO). IEOTs will need to pass an assessment process called the Substantial Equivalency Assessment System (SEAS). Visit www.acotro-acore.org for more information.

The NOTCE consists of 200 multiple choice questions. Candidates have four hours (with a break) to complete the examination. Special accommodations are granted based on requests and supporting documents. As of October 1, 2014, the NOTCE may only be attempted a total of three times. Every exam has a lead invigilator, called a "site coordinator." The site coordinator is responsible for setting up the exam room and managing other invigilators as needed. All site coordinators and invigilators are given an honorarium for their efforts. For more information about the NOTCE, please visit: www.caot.ca/exam

Currently, the cost of writing the NOTCE is $555.00 and the fees cover:

- Exam sites
- Honoraria for site coordinators and invigilators
- Examination production (including computer storage, item selection and printing)
- Marking and reporting results
- National Office administration costs
- Cost of research activities involving the ongoing evaluation of the reliability and validity of the examination
- Exam services provider
- Item generation workshops
- NOTCE resources and preparation materials
- Certification Examination Committee activities

How is the exam bank maintained?

Exam questions on the NOTCE are selected from a large pool of questions. This pool of questions, known as an "item bank" contains questions written by content experts from across Canada. Questions are also reviewed periodically by a nationally-representative group of qualified content experts who ensure that the questions are consistent with current best practices and are fair to candidates taking the NOTCE.

Do exam questions have more than one correct answer, and how is the correct answer determined?

A multiple-choice question is constructed so that only someone who has mastered the subject matter will select the correct answer; to that person, only one option will appear to be the correct answer. To someone who lacks a firm grasp of the subject matter, all options may look plausible.

Each question on the NOTCE is supported by at least one reference. Most of these references have been published within the past five years. The purpose of the references is to indicate that the correct answer within each question has authoritative support from experts in the field. Every attempt is made to use references that are up-to-date, accessible and accepted.

Enabling Occupation Matrix

Enabling Occupation			
Practice Process	Professional Knowledge		
	Client (7) 20-25%	Environment (8) 20-25%	Occupation (9) 20-25%
Initiate therapeutic relationship (1) 5-7%	7.1	8.1	9.1
Assessment (2) 15-17%	7.2	8.2	9.2
Planning (3) 15-17%	7.3	8.3	9.3
Implementation (4) 15-17%	7.4	8.4	9.4
Evaluating Outcome (5) 10-12%	7.5	8.5	9.5

Figure 1. **NOTCE Blueprint. The percentages indicate the proportion each content area is represented on the exam. For further explanation of the blueprint, please refer to the NOTCE Resource Manual at:** http://www.caot.ca/default.asp?pageid=4165

Does each question have equal weight on the exam?

Each exam question has the same value. Individual scores on the NOTCE are based on the number of questions that were answered correctly.

Are there any questions that you must answer correctly to pass the NOTCE?

The answer to this question is "no." There are no critical questions that a candidate must answer correctly to receive a passing score on the NOTCE.

How is the pass mark for the NOTCE set?

The pass mark is set in reference to the content and the difficulty of the test questions. The pass mark is NOT set using a norm-referenced approach such as "bell curving." The pass mark is set by a panel of content experts from across Canada. These content experts work closely with entry-level practitioners, and include educators, experienced practitioners and administrators. The pass mark is set at a level that represents the performance expected of a competent entry-level occupational therapist.

The panel of content experts reviews each exam question and produces difficulty ratings based on a common understanding of a competent entry-level occupational therapist. In addition to these ratings, a variety of relevant data (for example, information on the preparation of new graduates, results data from previously administered exams) are carefully considered to ensure that the pass mark that candidates must achieve on the exam is valid and fair. Based on this information, an appropriate pass mark is set.

For each sitting of the NOTCE, the pass mark is the same across writing centres and across provinces and territories. The pass mark is also the same for English and French versions of the NOTCE.

What resources does CAOT offer to support those who take the NOTCE?

CAOT offers a number of resources to assist those who plan to take the NOTCE. The "Resource Manual" provides further details about the NOTCE, including an explanation of the blueprint and some sample questions. The "Procedures Manual" provides more general information, including information on registration, administration and accommodations. The 2012 *Profile of Practice of Occupational Therapists in Canada* reflects current evidence in the areas of competency and Canadian occupational therapy practice. All three resources are available free of charge on the CAOT website: https://www.caot.ca/default.asp?pageid=424

Further resources include the Trial Occupational Therapy Exam Manual (TOTEM) and the Trial Occupational Therapy Exam (TOTE). The TOTEM contains 100 practice questions

About the authors

Chris Beauchamp, PhD, Vice-President, Business Enterprise Growth & Strategic Projects, joined Assessment Strategies Inc. in 2004 and has held the positions of Senior Consultant, Testing & Measurement, and Manager, Business Development.

Ryan McGovern joined CAOT in 2011 and is the Exam Services and Accreditation Coordinator. He can be reached at: rmcgovern@caot.ca

Elizabeth Steggles joined CAOT in 2010. Latterly, she was the Director of Standards until her retirement in April of 2015.

with answers and rationales that are reflective of the NOTCE. This paperless, web-based resource introduces the format of the NOTCE and the type of questions that may be encountered when writing the NOTCE.

In addition, the TOTEM includes a one-time access to the TOTE. TOTE is a paperless, web-based resource and is intended to be used as a measure of readiness for the NOTCE. It is an online exam consisting of 100 questions, with a two-hour time limit. Once the 100 questions are completed, a summary score is provided. The TOTEM and TOTE are available in a "ready to work" bundle that also covers first year membership with CAOT and professional liability insurance. Details are available at: https://www.caot.ca/default.asp?pageid=4247

Finally, CAOT offers the Occupational Therapy Exam Module (OTEM). OTEM offers exam candidates the opportunity to work through and discuss the rationale and reasoning behind a series of NOTCE practice questions through a facilitated discussion with an experienced occupational therapist. Small groups meet online once a week for six weeks to discuss case scenarios, reviewing more than 125 questions over the course of the module. Each small group is facilitated by a registered occupational therapist who is knowledgeable about the content and the clinical reasoning required to successfully answer the practice questions. Details are available at: https://www.caot.ca/default.asp?pageid=4238

Conclusion

In this article, the National Occupational Therapy Certification Examination has been described in order to provide insight into its purpose, who is required to take it, how it is developed and maintained, and what resources are offered by CAOT to assist candidates. If you have further questions please contact Ryan McGovern, Exam Services and Accreditation Coordinator at: rmcgovern@caot.ca

Editor's note: CAOT is pleased to have Dr. Alison Douglas join the staff as the Director of Standards, a role she began on May 4, 2015.

Be involved in CAOT Learning Services

Christina Lamontagne, Julie Lapointe and Janet Craik

As an occupational therapist, teaching and mentoring others is a foundational competency (Friedland, 2011). Occupational therapists commonly provide education to their clients in order to facilitate occupational performance (e.g., DeCleene et al., 2013) and support engagement in meaningful occupations (Townsend & Polatajko, 2013). Client education is important for occupational therapists to fulfill their roles of "expert in enabling occupation," "communicator," "change agent" and "scholarly practitioner" (Canadian Association of Occupational Therapists [CAOT], 2012). The educator role is also enacted when acting as a preceptor to students or as a mentor to other professionals.

Considering the above, educators and mentors have a prominent role in improving the occupational performance of others by imparting knowledge. Evidence has shown that enabling others through mentorship provides a drive to ensure currency, overcome some knowledge gaps and find ways to better explain clinical reasoning (Craik & Rappolt, 2006). In short, teaching others about a skill set or a practice area that you have developed over the years is enriching and a great way to contribute to the advancement of the profession.

"teaching others about a skill set or a practice area that you have developed over the years is enriching and a great way to contribute to the advancement of the profession."

This article is an invitation to challenge yourself to become the best occupational therapist you can be by sharing your expertise with others and learning from this experience. It provides an overview of the opportunities with CAOT and how CAOT can support you to become a presenter, an author or a mentor. CAOT is committed to enabling you in this journey.

A guided tour of CAOT Learning Services

CAOT's mission is to advance excellence in occupational therapy. CAOT Learning Services strive to advance excellence by providing access to evidence-informed knowledge, as well as to opportunities to reflect on current practices and to learn hands-on skills in varied areas of practice. There are opportunities for you to be involved in a variety of CAOT Learning Services formats, including:

- Momentum: This online program matches mentees (typically new graduates, internationally educated occupational therapists and occupational therapists in a career transition) with mentors in order to work on professional goals. These goals may relate to developing clinical reasoning, sharing knowledge or resources, applying the information into practice and developing interpersonal skills for the workplace (such as conflict management or time management). Being a mentor with Momentum is well-suited for experienced occupational therapists who strive for one-on-one coaching relationships to advance the future of occupational therapy in Canada.
- Conference: Taking place over four days plus pre- and post-conference workshops, the CAOT conference is held annually and is a stimulating opportunity to share, meet and be inspired by the Canadian occupational therapy community. This venue is relevant for researchers, clinicians, decision-makers, educators and students to exchange about their work in brief presentations and obtain feedback.
- Lunch & Learn webinars: These presentations (45 minutes long with 15 minutes of questions and interaction with the audience) provide an opportunity for presenters to inform the occupational therapy community about a variety of emergent and specialized topics of interest in order to diffuse knowledge and share resources. These webinars are ideal for presenters who wish to communicate evidence and discuss concrete applications through lived experience and/or case studies.
- Workshops: Typically one or two days in length, workshops are held at various locations throughout Canada in order to facilitate the development of competency in a specific area of practice. This format is ideal for an occupational therapist who wants to teach hands-on skills and enhance clinical reasoning through the use of in-person interactions and various teaching modalities.
- Periodicals:
  - *Occupational Therapy Now (OT Now)*: This practice magazine includes shorter articles to share information and stories that facilitate everyday practice for occupational therapists. *OT Now* is an ideal venue for practitioners and students who wish to share current and emerging practice experiences, ideas and

resources, as well as academics who wish to present practice implications of their research work.
    - *Canadian Journal of Occupational Therapy (CJOT)*: This peer-reviewed scientific journal includes full-length articles reporting results of studies with quantitative or qualitative methodologies. Benefiting from international recognition, *CJOT* is the ideal venue for occupational therapy researchers to share the results of their work.
- Publications: Textbooks and workbooks are ideal vehicles for occupational therapists who have garnered in-depth knowledge and experience in an area of practice. This medium allows for the diffusion of such extensive work by demonstrating examples of how to apply evidence, advanced interventions and models of care into practice.

CAOT welcomes all ideas that would advise its offering of professional development services. A CAOT staff member takes the time to meet with you to discuss ideas and explain the concrete steps to realize your project. We are committed to guiding you through the process with clear expectations, such as the deadlines, and be available to answer any questions. In most cases (with the exception of the periodicals), you will need to submit a written proposal or an outline of your idea, which will be reviewed by the CAOT Learning Services Advisory Team. We provide feedback and support throughout the entire process, coherent with our mission to advance excellence in occupational therapy in Canada.

To learn more about CAOT Learning Services, including how to send us a proposal, as well as other opportunities to be involved with CAOT, consult: www.caot.ca/beinvolved

References

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

Craik, J., & Rappolt, S. (2006). Enhancing research utilization capacity through multifaceted professional development. *American Journal of Occupational Therapy, 60*, 155–164. doi:10.5014/ajot.60.2.155

DeCleene, K. E., Ridgway, A.J., Bednarski, J., Breeden, L., Mosier, G. G., Sachs, D., & Stephenson, D. (2013). Therapists as educators: The importance of client education in occupational therapy. *Open Journal of Occupational Therapy, 1*(4), Article 5. doi: 10.15453/2168-6408.1050

Friedland, J. (2011). *Restoring the Spirit: The Beginnings of Occupational Therapy in Canada, 1890-1930*. Ottawa, ON: CAOT Publications ACE.

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

About the authors

Christina Lamontagne is the professional development coordinator at CAOT. She can be reached at: clamontagne@caot.ca

Julie Lapointe is the director of professional practice at CAOT. She can be reached at: jlapointe@caot.ca

Janet Craik is the executive director at CAOT. She can be reached at: jcraik@caot.ca

CHILDREN AND YOUTH

TOPIC EDITOR: GAIL TEACHMAN

Partnering for Change: Embedding universal design for learning into school-based occupational therapy

Cheryl Missiuna, Nancy Pollock, Wenonah Campbell, Leah Dix, Sandra Sahagian Whalen and Debra Stewart

In this article, we describe an innovative model of occupational therapy service delivery initially developed for children with developmental coordination disorder that uses principles of universal design for learning to change physical, social and learning environments in schools. The idea of universal design first emerged in the field of architecture, in which it has long been recognized that designing buildings to be fully accessible at the outset is more equitable, more efficient and less costly than retrofitting them later (Center for Applied Special Technology, 2015). Over time, such principles were expanded to apply to other features of the physical environment, including curb cuts, automatic doors, closed-captioned television and audible street signals, just to name a few. Although these features were initially designed to ensure access for individuals with disabilities, we now recognize that everyone benefits from these environmental enhancements.

In educational settings, the analogous movement is termed "universal design for learning" (UDL) and refers to an approach to curriculum design and instruction that promotes inclusion by planning for variation in learners from the start rather than relying on materials and tools that are accessible to only some students (Klinger, Campbell, & Knight, 2009). Thus, UDL places the onus on educators and health professionals to use flexible strategies and tools that can be customized to meet the needs of learners who differ widely in their physical, cognitive, behavioural and communicative abilities (Meyer, Rose, & Gordon, 2014). In so doing, it enhances the capacity of all students to fully engage in educational curriculum. While UDL does not necessarily remove the need for individual accommodations and remediation for students with disabilities, we suggest that it does lessen the extent to which that level of support will be required (Missiuna et al., 2012a).

Developmental coordination disorder (DCD) is a specific motor disability that affects about 5% of all children (American Psychiatric Association [APA], 2013) — that is, over 400,000 children across Canada. DCD significantly impacts a child's ability to complete everyday motor-based academic and self-care tasks such as printing, using scissors, lacing up shoes, brushing teeth, opening a knapsack, climbing stairs or riding a bicycle. DCD is a chronic health condition that also decreases children's participation in leisure and social activities, and its persistence into adolescence and adulthood eventually affects pre-vocational activities and vocational choices (APA, 2013). While present very early in children's lives, the difficulties of children with DCD become most apparent when they enter kindergarten and encounter new motor challenges and increased requirements for independence (Forsyth et al., 2007). Without appropriate support at school, children with DCD, their families and their educators struggle and become frustrated (Missiuna, Moll, King, King, & Law, 2007). Secondary academic, mental health and physical health issues develop, which make children's needs more complex and difficult to cope with over the long term (Cairney, Veldhuizen, & Szatmari, 2010).

In Ontario and other jurisdictions across Canada, intervention for children with DCD is typically provided by occupational therapists in school settings, who conduct individual assessments followed by one-on-one intervention targeting children's underlying motor impairment (Bayona, McDougall, Tucker, Nichols, & Mandich, 2006). This most often involves withdrawal of the child from the classroom. Extensive research has shown that impairment-focused interventions are ineffectual with children with DCD and are an unrealistic focus for school-based rehabilitation (Rodger, 2010). Moreover, even if children with DCD are identified and referred for service, long waitlists mean that many children do not access the health services they need to succeed and participate at school (Deloitte, 2010).

Poor child outcomes, concerns about waitlists and frustration with the current system of health service provision prompted the establishment of a partnership between researchers at *CanChild* Centre for Childhood Disability Research at McMaster University and a decision-maker from a Community Care Access Centre, part of the agency that funds school-based occupational therapy services in Ontario. The team recognized that system-level change was needed and partnered to develop an innovative model of school-based service delivery for children with DCD that was evidence-based and used principles of universal design. This evidence-informed service delivery model is called Partnering for Change (P4C) because it emphasizes the partnership of the occupational therapist with educators and parents to change the everyday environment, and life, of a child. The Partnership focuses on building Capacity through Collaboration and Coaching in Context (Missiuna et al., 2012a).

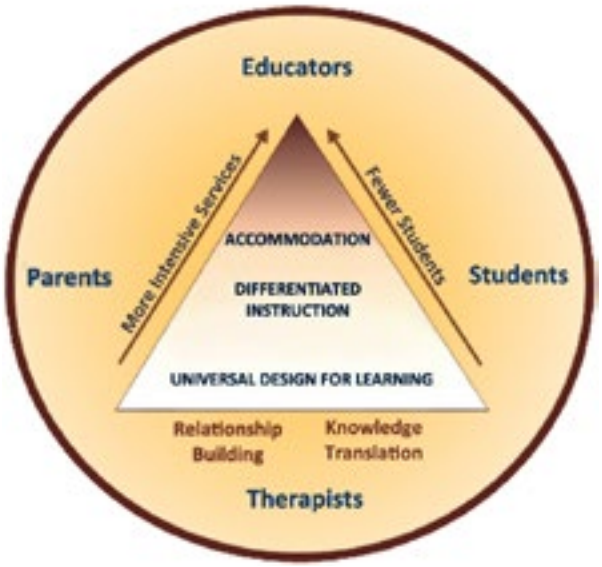


***Figure 1*. Partnering for Change Model. ©Missiuna, Pollock, Campbell, Levac, & Whalen, *CanChild*, McMaster University, 2011. Please note: This figure is used with permission of the authors.**

The figure reflects the partnership that is needed between occupational therapists, parents and educators to create inclusive school environments that will facilitate successful participation, not just for children with DCD, but for all students. Indeed, early results from our current research indicate that the P4C model may be appropriate for students with a range of occupational performance issues and diagnoses, a possibility that we plan to explore in our future research (Camden et al., 2015). Working from a foundation that focuses on relationship building and the sharing of knowledge, occupational therapists and educators collaboratively design environments that foster skill development in children of all abilities. Classrooms and curricula are addressed with regard to increasing the engagement of all children in the learning experience. Educators learn how to differentiate instruction for children who are experiencing motor challenges and accommodate for students who need to participate in a different way. The school is the target of intervention, allowing therapists to impact the greatest numbers of children through informal discussions and problem-solving with educators. Experiential "lunch and learn" sessions are provided to address issues or questions raised in discussion. In this model, all collaboration and intervention occurs in the context of the school environment—classrooms, hallways, gymnasiums and playgrounds are viewed from the perspective of UDL. Some illustrative examples of occupational therapy interventions and their UDL outcomes are presented in Table 1.

Following a one-year pilot project, the P4C service delivery model was evaluated in a demonstration project that involved eight occupational therapists working one day a week in each of 11 schools (Missiuna et al., 2012a). Questionnaires administered before and after the project, together with interviews the next fall, showed that this model of service delivery was viewed as highly successful from the perspective of educators, parents, school board administrators and the health-care system (Missiuna et al., 2012b). Occupational therapists reported that delivering UDL services that impacted entire schools was very rewarding: services were perceived as more equitable, supportive and accessible to all children, not just to the few who had been referred to school health support services (Campbell et al., 2012). The Ontario Ministry of Health and Long-Term Care funded *CanChild* to conduct a research project examining the implementation of the P4C service as delivered by 15 occupational therapists in 40 schools across three school boards, including evaluation of outcomes for children, families and schools. A grant from the Ontario Ministry of Education enables data collection to continue to the end of the 2014-15 school year.

Table 1
Examples of Embedding Universal Design for Learning in School-Based Occupational Therapy.

ILLUSTRATIVE EXAMPLES OF EMBEDDING UDL IN SCHOOL-BASED OCCUPATIONAL THERAPY		
Therapist's observation	**Therapist's actions**	**Outcomes**
Many students in junior and senior kindergarten were struggling to learn scissor use.	• Develops scissor kit for each class that includes alternative scissors (spring-loaded, loop, etc.) • Presents lesson on scissor use to whole kindergarten classes to model different learning strategies for educators • Delivers "lunch and learn" session at request of educators to review development of scissor skills and to demonstrate rationale for selecting tools	Parent council provides funds so each kindergarten classroom has a scissor kit with which the students can try different styles in order to promote their skill development and their success in cutting.
Outdoor kindergarten play space offered limited opportunity for skill development (asphalt, no apparatus due to safety concerns).	• Recommends painting curving lines and hopscotch squares, adding tricycles, fabric strips, foam balls, sidewalk chalk and bean bags to play area	Children with varied motor abilities are able to be included and skill development could occur without fear of injury.
The Daily Physical Activity (DPA) routine was the same for the entire school (junior kindergarten to Grade 5), but many of the skills included were not developmentally appropriate for the younger students (e.g., grapevine).	• Collaborates with the Grade 5 students responsible for developing and teaching the DPA routine to the kindergarten students by creating a list of developmentally appropriate skills and movements for the junior and senior kindergarten students to do during their fitness time • Observes Grade 5 students and provides feedback	Many more junior and senior kindergarten children are able to participate in the DPA routines and get the fitness benefit of these activities.
Some children in primary grades were having difficulty with independence in dressing and managing lunch containers.	• Develops parent guides in consultation with primary teachers and lunchroom supervisors to identify optimal types of clothing choices, backpacks and lunch materials to foster independence	Many children in primary grades are supported in managing their self-care routines with greater independence.

With their knowledge of the interaction among person, environment and occupation, and their skills in occupational analysis, occupational therapists are ideally positioned to implement UDL strategies across school settings. By broadening the scope of the role of the occupational therapist beyond the individually referred student, environmental changes can be made that build capacity within schools, so that all students can participate and learn to the best of their ability.

Acknowledgements

P4C would like to thank the Ontario Ministry of Health and Long Term Care for funding this two-year study led by *CanChild* and Cathy Hecimovich, CEO of the Central West Community Care Access Centre, and the Ontario Ministry of Education for enabling further evaluation of P4C.

Recommended resources

Videos about UDL:

- Center for Applied Special Technology. (2010). *UDL at a glance* [Video]. Retrieved from https://www.youtube.com/watch?v=bDvKnY0g6e4
- Rose, Todd. (2012). *Variability Matters* [Video]. Retrieved from https://www.youtube.com/watch?v=8WClnVjCEVM

Online UDL resources:

- Center for Applied Special Technology. (2015a). *CAST: Home*. Retrieved from http://www.cast.org/
- Center for Applied Special Technology. (2015b). *National Center on Universal Design for Learning*. Retrieved from http://www.udlcenter.org/

Online workshops about DCD:

- CanChild Centre for Childhood Disability Research. (2015). *Workshops about DCD*. Retrieved from http://dcd.canchild.ca/en/dcdresources/workshops.asp

References

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Washington, DC: American Psychiatric Association.

Bayona, C. L., McDougall, J., Tucker, M. A., Nichols, M., & Mandich, A. (2006). School-based occupational therapy for children with fine motor difficulties: Evaluating functional outcomes and fidelity of services. *Physical & Occupational Therapy in Pediatrics, 26*(3), 89–110. doi: 10.1080/J006v26n03_07

Cairney, J., Veldhuizen, S., & Szatmari, P. (2010). Motor coordination and emotional-behavioural problems in children. *Current Opinion in Psychiatry, 23*, 324–329. doi:10.1097/YCO.0b013e32833aa0aa

Camden, C., Campbell, W., Stewart, D., Hecimovich, C., Dix, L., Floyd, K., … Missiuna, C. (2015, accepted). *Implementing the "Partnering for Change" service delivery model: What do stakeholders say?* Presentation at the 11th International Conference on Developmental Coordination Disorder (DCD 11), Toulouse, France.

Campbell, W., Missiuna, C., Rivard, L., & Pollock, N. (2012). "Support for everyone": Experiences of occupational therapists delivering a new model of school-based services. *Canadian Journal of Occupational Therapy, 79*, 51–59. doi: 10.2182/cjot.2012.79.1.7

Center for Applied Special Technology. (2015). *About Universal Design for Learning*. Retrieved from http://www.cast.org/our-work/about-udl.html#.VS7AXpPqXaI

Deloitte. (2010). *Review of school health support services: Final report*. Retrieved from Ontario Ministry of Health and Long Term Care website: http://www.health.gov.on.ca/en/public/contact/ccac/docs/deloitte_shss_review_report.pdf

Forsyth, K., Howden, S., Maciver, D., Owen, C., Shepherd, C., & Rush, R. (2007). *Developmental co-ordination disorder: A review of evidence and models of practice employed by allied health professionals in Scotland - Summary of key findings*. Edinburgh, Scotland: NHS Quality Improvement Scotland.

Klinger, L., Campbell, W. N., & Knight, J. (2009). Universal design for learning: A novel perspective on school-based occupational therapy services. *Occupational Therapy Now, 11*(6), 9–12.

Meyer, A., Rose, D. H., & Gordon, D. (2014). *Universal design for learning: Theory and practice*. Retrieved from http://udltheorypractice.cast.org/

Missiuna, C., Moll, S., King, S., King, G., & Law, M. (2007). A trajectory of troubles: Parents' impressions of the impact of developmental coordination disorder. *Physical & Occupational Therapy in Pediatrics, 27*, 81–101. doi:10.1080/J006v27n01_06

Missiuna, C., Pollock, N., Levac, D., Campbell, W., Sahagian Whalen, S., Bennett, S., . . . Russell, D. (2012a). Partnering for Change: An innovative school-based occupational therapy service delivery model for children with developmental coordination disorder. *Canadian Journal of Occupational Therapy, 79*, 41–50. doi: 10.2182/cjot.2012.79.1.6

Missiuna, C., Pollock, N., Campbell, W., Bennett, S., Hecimovich, C., Gaines, R., . . . Molinaro, E. (2012b). Use of the Medical Research Council Framework to develop a complex intervention in pediatric occupational therapy: Assessing feasibility. *Research in Developmental Disabilities, 33*, 1443–1452. doi:10.1016/j.ridd.2012.03.018

Rodger, S. (2010). Becoming more occupation-centred when working with children. In S. Rodger (Ed.), *Occupation centred practice in children: A practical guide for occupational therapists* (pp. 21–44). Oxford, England: Wiley-Blackwell.

About the authors

Cheryl Missiuna, PhD, OT Reg. (Ont.), is a professor in the School of Rehabilitation Science and a scientist with *CanChild* Centre for Childhood Disability Research, both at McMaster University. She can be reached at: missiuna@mcmaster.ca

Nancy Pollock, MSc, OT Reg. (Ont.), is an associate clinical professor in the School of Rehabilitation Science and a scientist with *CanChild,* both at McMaster University. She is also a managing associate at REACH Therapy Services.

Wenonah Campbell, PhD, is an assistant professor in the School of Rehabilitation Science and a scientist with *CanChild,* both at McMaster University.

Leah Dix, MSc, OT Reg. (Ont.), is an assistant clinical professor in the School of Rehabilitation Science and a project coordinator for the Partnering for Change project at *CanChild*, both at McMaster University.

Sandra Sahagian Whalen, MHSc, OT Reg. (Ont.), is the peer mentor for the Partnering for Change project and a managing associate with REACH Therapy Services.

Debra Stewart, MSc, OT Reg. (Ont.), is an associate professor in the School of Rehabilitation Science and a scientist with *CanChild,* both at McMaster University. She is also a managing associate with REACH Therapy Services.

Student accommodations in occupational therapy university programs: Requirements, present environment and trends

Jill Stier, Donna Barker and Margaret Anne Campbell-Rempel

There are an increasing number of students with disabilities enrolled in universities across Canada (Cooper et al., 2012; Harrison & Wolforth, 2012). Universities commonly provide accommodations to enable participation for students with acquired brain injuries, attention deficit disorders with or without concurrent hyperactivity, learning disabilities, systemic and chronic medical conditions, hearing and vision deficits, mobility impairments and psychiatric illnesses (University of Toronto, n.d.). Individuals of all abilities are to be provided with opportunities to fully participate (e.g., Accessibility for Ontarians with Disabilities Act, 2005) in all academic endeavors, but students may express concerns about their abilities to fully participate in their academic programs and thus may require accommodations. University programs are working diligently to support students with disabilities and provide them with equitable learning opportunities.

The term "accommodation" refers to the reduction of barriers and the inclusion of individualized arrangements to ensure that students can fully participate in their program (Cooper et al., 2012). Canadian and provincial/territorial laws provide the framework for university requirements, which should guide decisions and actions within university programs regarding the provision of accommodations (Barnett, Nicol, & Walker, 2012; Cooper et al., 2012). A reasonable accommodation within university academic programs is described as "one that would address an inequality toward a person with a disability without offering that individual an unfair advantage over other students" (Cooper et al., 2012, p. 7). A reasonable accommodation must not result in the compromise of a *bona fide* academic requirement nor create undue hardship for the university. Students must still acquire and demonstrate the required knowledge, mastery of essential skills or other necessary academic requirements of a program of study, although this may be done in an alternative way. The goal of reasonable accommodation is not to lower the bar, but rather to provide a different and equitable approach that permits students with disabilities to access learning and assessment opportunities (Cooper et al., 2012).

In order to facilitate the equitable inclusion of students with documented disabilities, it is critical that Canadian occupational therapy programs recognize their ethical, moral and legal responsibility to ensure their students have access to reasonable accommodations. As the trends related to accommodations in Canadian occupational therapy programs were unclear, questions arose regarding the percentage of students who require accommodations for disability-related issues, the types of accommodations required, and what factors help or hinder a program's ability to provide accommodations. As well, it was unknown which documents guide programs' decisions regarding the implementation of student accommodations. This article will share how the Association of Canadian Occupational Therapy University Programs (ACOTUP) sought to answer these questions.

Study design and instrument development

A perceived increase in the number of occupational therapy students requesting accommodations and a desire to set the stage for increased national discussion led the Education Committee of ACOTUP to conduct a survey of Canadian occupational therapy university programs in December 2012. Specifically, the Education Committee wanted to survey occupational therapy programs with regard to: a) trends related to the proportion of students receiving accommodations, b) common procedures used to implement both academic and fieldwork accommodations and c) successes and challenges encountered related to the provision of student accommodations. The University of Toronto research ethics board granted ethics exempt status for this project, recognizing it as a quality improvement project.

An online survey was developed by an expert working group composed of ACOTUP members with experience and expertise in the area of student accommodations. Feedback from the pilot study informed a subsequent revision of the survey. The survey consisted of 14 questions, including both open and closed response options. Participants were asked to identify the types of student disabilities seen, the number of students requiring accommodations, the types of accommodations requested and the factors affecting implementation of these accommodations in a typical academic year. Examples of open-ended questions asked how programs used available essential skills documents to inform the accommodations process, while another requested suggestions regarding how Canadian occupational therapy programs could assist each other in the provision of student accommodations.

The survey request was sent to the chairs of the 14 Canadian occupational therapy programs. To provide a cross-sectional convenience sample, instructions asked that one survey be completed for each program by individuals who were most familiar with student accommodations within their respective programs. Participants were given three weeks to complete the survey with one reminder given prior to the deadline. Data were obtained from all 14 Canadian universities offering occupational therapy programs.

Data from the completed surveys were analyzed using descriptive statistics. Consensus was used by the working group to summarize common themes from the open-ended questions. The total number of occupational therapy students in any given academic year (including all cohorts), as reported by programs, ranged from 48 to 480 students for a total of 2494 students.

Present environment

All of the programs reported having students who required accommodations in a typical academic year and, depending on the program, the number ranged from one to 12 students. Across all programs, a total of 95 students were reported to require one or more accommodations.

Students are not required to disclose reasons for accommodations to faculty members. However, the survey did ask programs to indicate the number of students that they were aware of who fit within each disability category. The number of universities reporting that they had students within disability categories that required accommodations are as follows: mental health issues (n=13), learning disabilities or attention deficit hyperactivity disorder (n=11), systemic/chronic medical conditions (n=11), temporary injuries (n=9), mobility deficits (n=5), brain injury/concussion (n=4), hearing loss (n=3), visual impairments (n=1) and autism spectrum disorders (n=0). The most common was mental health issues, with a minimum of 40 students requiring related accommodations; 43% of programs reported that five or more students had mental health issues requiring accommodations. The total number of students provided with accommodations in a typical academic year across all Canadian occupational therapy programs was distributed as follows: mental health issues (n=64), learning disabilities or attention deficit hyperactivity disorder (n =34), systemic/chronic medical conditions (n=32), temporary injuries (n=24), mobility deficits (n=10), brain injury/concussion (n=8), hearing loss (n=6), visual impairments (n=2), autism spectrum disorders (n=0).

Table 1 shows the frequency and variety of different types of accommodations put in place by programs in a typical academic year. If a student had multiple accommodations, participants were instructed to include them in each applicable category.

Trends

Participants were asked to compare the frequency of required accommodations in the 2010/2011 academic year to the five years previous. Depending on the specific accommodation, one to three programs indicated that they have seen a decrease in some required accommodations (e.g., provision of an alternative format for printed materials). However, the majority of programs have seen an increase in required accommodations, including: alternative test and exam arrangements, note-taking services, sign language interpreters, provision of adaptive equipment and assistive devices, leaves of absence, acceptance of occasional absences from class or fieldwork due to appointments, altered fieldwork schedules and altered academic coursework or scheduling. Programs most frequently reported increases in accommodations for altered academic course work (62% of programs), alternative test and examination arrangements (57% of programs) and leaves of absence (54% of programs).

Table 1
Number and Percentage of Programs Indicating the Numbers and Types of Student Accommodations in a Typical Year (n=14)

Type of accommodation	Programs with 1-2 students per year	Programs with 3-4 students per year	Programs with 5 or more students per year
Alternative test and examination arrangements	5(36%)	4(29%)	5(36%)
Leave of absence	7(50%)	4(29%)	1(7%)
Altered fieldwork schedule	9(64%)	1(7%)	1(7%)
Occasional absence from classes or fieldwork due to appointments	4(29%)	1(7%)	6(43%)
Altered academic course work (e.g., assignment due date extension)	1(7%)	3(21%)	5(36%)
Note-taking services	6(43%)	1(7%)	0
Adaptive equipment and assistive devices	5(36%)	2(14%)	0
Altered academic schedule (e.g., part-time courses or fieldwork)	3(21%)	1(7%)	0
Specialized fieldwork placement to allow for graduated acquisition of competencies	3(21%)	0	1(7%)
Sign language interpreters	1(7%)	0	0

All occupational therapy programs reported that they were able to put required accommodations in place for students. Almost all programs were able to provide altered academic coursework/assignment extensions (n=13) and, to a lesser degree, adaptive equipment and assistive devices (n=10). Many programs indicated that they were always able to provide an altered fieldwork schedule (n=8), whereas other programs indicated that they were unable to provide this accommodation due to resource issues other than costs (n=1) or the requirement to uphold either professional standards (n=2) or academic standards (n=2). Some programs responded that they were always able to provide an altered academic schedule, such as part-time academic or fieldwork courses (n=6), however, other programs indicated that they were unable to provide this accommodation (n=4) due to the requirement to uphold academic standards or due to cost or other resource issues. Some programs (n=3) responded that they were always able to provide specialized fieldwork placements that allowed for graduated acquisition of competencies. However, many programs were unable to do this because of professional standards (n=4), academic standards (n=3), client safety (n=1) or other resource issues (n=1).

There were a variety of factors that affected a program's ability to provide student accommodations. Those having minimal or no effect on the provision of student accommodations included financial (92%), human (77%) and time costs (70%). Factors having moderate or great effects on a program's ability to provide accommodations included upholding academic standards (46%),

upholding professional standards (46%) and fulfilling fieldwork-specific objectives (54%).

All programs indicated that they had the following resources to assist with identification and implementation of student accommodations: university counseling services, university test/exam services to adjudicate extended exam writing, other university support services for needs such as facilitation of student time management skills and effective study habits, and fieldwork site resources or contacts. Most of the programs (n=13) indicated that students had access to university writing support services as well as advocacy from university accessibility services. Many programs (n=11) have department faculty and/or staff who help to facilitate accommodations, and half of the programs (n=7) had faculty advisors assigned to each student.

University programs used a number of documents to guide their student accommodations policies and processes. All programs (n=14) follow their own university policies. Other documents used include those related to provincial legislation (n=9), federal legislation (n=8), occupational therapy essential skills and competencies documents (n=8) and program- or department-specific curriculum documents (n=8). One of the programs used a "tips and strategies" document that it provides to students who require an accommodation.

Perceived future barriers to providing accommodations

Many participants had comments regarding the provision of accommodations, including concerns about increased workload, cost, resources and the overall ability to maintain the academic standards of the program. One participant reported, "We make student accommodations a priority at the expense of getting other tasks accomplished in the department. [Doing so] doesn't affect our ability to provide the accommodations but our workload increases."

Discussion

The number of students requiring accommodations is increasing across programs. It can be challenging to support students and provide accessible learning opportunities. Although the implementation of accommodation requests is managed in a variety of ways across Canadian occupational therapy programs, it appears that the programs are aware of and guided by federal and provincial laws and codes as well as university policies. Programs are able to provide many different accommodations and there are a variety of resources available to help identify and implement those accommodations. However, concerns have been raised about implementation, including those regarding a program's ability to uphold professional and academic standards, a lack of available resources, financial and time costs, as well as the fulfillment of fieldwork-specific objectives. The provision of student accommodations in fieldwork is particularly challenging due to factors that are beyond the university's control. These fieldwork-specific factors include appropriate placement availability, time factors and the ability of facilities and preceptors to provide the necessary student accommodations due to perceived quality and risk issues related to client care. Despite these challenges, programs are committed to providing reasonable accommodations.

What do we need to do now?

Participants were asked if there was a way that programs could assist each other in the provision of student accommodations. Suggestions included the following: development of a "national essential skills document to guide the provision of accommodations," development of a national strategy to deal with accommodations, provision of dedicated staff who are assigned to address accommodation issues and creation of opportunities to share success stories among educators and administrators, especially regarding complex cases. ACOTUP is keen to facilitate the sharing of information about the provision of student accommodations through member communications.

With our understanding of the interaction between the person, environment and occupation, occupational therapy university programs are well positioned to work together and lead the country to develop helpful strategies that will ensure the provision and implementation of accommodations for students with disabilities. In doing so, occupational therapists can facilitate the equitable inclusion of all students with respect to learning.

References

Barnett, L., Nicol, J., & Walker, J. (2012). *An examination of the duty to accommodate in the Canadian human rights context*. Retrieved from http://www.parl.gc.ca/content/lop/researchpublications/2012-01-e.pdf

Cooper, J., Coyston, S., Crooks, D., Gabbert, M., Juliano, G., Leclair, L., . . . Whitmore, M. (2012). *Report of the ad hoc committee of senate executive to examine accommodation of students with disabilities and governance procedures related to academic requirements.* Retrieved from http://umanitoba.ca/student/saa/accessibility/media/Cooper_Commission_Report_Feb_2012.pdf

Harrison, A. G., & Wolforth, J. (2012). Findings from a pan-Canadian survey of disability services providers in postsecondary education. *International Journal of Disability, Community and Rehabilitation, 11*(1). Retrieved from http://www.ijdcr.ca/VOL11_01/articles/harrison.shtml

Accessibility for Ontarians with Disabilities Act, *Statutes of Ontario.* (2005, c. 11). Retrieved from http://www.ontario.ca/laws/statute/05a11

University of Toronto. (n.d.). *Accessibility services statement.* Retrieved from http://www.accessibility.utoronto.ca

About the authors

Jill Stier, MA, BMR(OT), OT Reg. (Ont.), is an assistant professor and graduate coordinator in the Department of Occupational Science and Occupational Therapy at the University of Toronto. She can be reached at: jill.stier@utoronto.ca

Donna Barker, MSc, BSc(OT), OT Reg. (Ont.), is the director of clinical education in the Department of Occupational Science and Occupational Therapy at the University of Toronto.

Margaret Anne Campbell-Rempel, BMR(OT), OT Reg. (MB), is the academic fieldwork coordinator in the Department of Occupational Therapy at the University of Manitoba.

SENSE OF DOING

TOPIC EDITOR: SHANON PHELAN

Mindfulness in practice: Developing an occupational therapy niche

Randy McVeigh

Mindfulness, a meditative practice associated with reduced anxiety and depression (Khoury et al., 2013), and more effective emotional regulation (Davis & Hayes, 2011), has become increasingly popular, both in popular culture and the health-care world. A strong theoretical case has been made that mindfulness has a place within occupational therapy (Reid, 2011; Elliot, 2011) and that occupational therapists are in a unique position to connect the "being" that mindfulness honours with the "doing" of people's occupations (McCorquodale, 2013). There is, however, a degree of abstraction in the discussion of the theory of mindfulness. How can practitioners actually implement it in practice? A number of challenges are posed to its real-world application. I will address two in this paper: the challenge of integrating mindfulness in a uniquely occupational way and the difficulty of helping clients adhere to a mindfulness routine. I am an occupational therapist who has practiced mindfulness in my personal life for seven years, and I have reflected on my experience within the occupational therapy context to generate the suggestions I share here.

Mindful occupation

The first challenge to consider is how mindfulness can be integrated into practice in an occupational way. Some have argued that mindfulness is important to occupation. Reid (2008) suggests mindfulness can lead to occupational presence, a state of consciousness of being aware of oneself, "engaged in occupation in place" (p. 43), and that this can influence well-being. McCorquodale (2013) highlights the benefits of a mindfulness practice by occupational therapists when used as a way to access intuitive knowledge about their clients. Elliot (2011) notes that mindfulness is itself an occupation. But, what might mindfulness look like in practical terms for a practitioner?

Mindfulness has been defined in many ways in the fields of psychology and occupational science, as well as by Buddhist writers in popular literature. Brown and colleagues (2007) describe it as a mental state of "present-oriented consciousness" (p. 214). The Buddhist teacher Thich Nhat Hanh describes it as "the capacity to shine the light of awareness onto what's going on here and now" (2011, p. 20). I describe mindfulness simply as the practice of presence, where presence is an awareness of the events in our stream of consciousness, whether they be emerging thoughts, sensing our physical environment, or feelings such as happiness, tiredness or boredom. When we are present, we notice these events of consciousness with awareness, rather than being 'caught up' in them.

As a student of occupational therapy, I have found that occupations can be carried out with varying degrees of presence. Consider two different ways of driving. One driver, after a busy day at work, puts her brain on "autopilot," turns on the radio and "zones out" as she drives her familiar route home from work. She arrives home with no problems. A second driver decides to turn off his radio and spend the 20-minute drive paying attention to the fine details of the car bumping over gravel on the road, the sound of the engine gearing up and the complex events of the road. The second driver has been engaged in mindful driving. McCorquodale (2013) notes that mindfulness is the opposite of mindlessness. Similarly, mindful driving can be experienced as the opposite of mindless driving. Rather than zoning out, the mindful driver has "zoned in" to the occupation. He has spent 20 minutes building on his capacity to relax and respond effectively to stressful events (Davis & Hayes, 2011), and his experience of the occupation is likely enhanced because he has been focussed wholly on it.

Formal mindfulness meditation usually begins with sitting quietly and paying attention to one's breath (Kabat-Zinn, 1990). We may want to introduce clients to such sitting meditations in order to build a foundation for the practice. As occupational therapists, however, we can go beyond this and incorporate mindfulness training into occupation. Making breakfast, washing dishes, eating a meal or going for a walk can all be done more or less mindfully (Nhat Hanh, 2011). I suggest that our profession's niche in mindfulness should be built around helping clients to identify occupations during which they would benefit from greater presence and which they can use as formal meditation practices.

Forming a mindfulness habit

The benefits of mindfulness accrue with practice (Kabat-Zinn, 2003). However, keeping up a practice can be difficult. Many people who are excited by the idea of mindfulness have difficulty maintaining a consistent practice. How then can we expect a client who is just dipping their toes into the waters of mindfulness for the first time to maintain a consistent practice? I believe assisting people to incorporate mindfulness into their daily lives should be a key part of the occupational therapy role in mindfulness. As the "doing" profession, we as occupational therapists assist in the incorporation of abstract ideas into real world practice, which we know is complex

and messy. It is our responsibility to understand clients' deeper motivations; we can harness our understanding of those motivations to promote an effective mindfulness habit in clients.

Occupational therapists can help people to identify reasons for meditating. People generally form habits when they can connect their behaviours to a tangible payoff (Duhigg, 2012). We can help clients identify ways they could benefit from continuing to meditate long after our intervention sessions are finished. Such benefits can include an increased sense of peace in the world, improved ability to manage pain (Kabat-Zinn, 1982) and enriched self-awareness during activities (Reid, 2008). We draw directly on our client-centred practice philosophy when we customize the education we offer to the unique needs of the individual.

Occupational therapists can also help clients to find the mindfulness practice that is right for them. I believe that the best way to ensure the continuity of a practice is to fit the practice to the lifestyle, rather than the other way around. As practitioners, we can assist clients to find a practice that they will actually want to commit to. For example, some people simply don't like sitting still. For such individuals, more kinetic meditations, such as walking meditations, may be a better option. Some people may not be interested in mindful eating, but may be willing to spend ten minutes washing dishes mindfully following a meal.

Occupational therapists can help clients develop a mindfulness plan that is practical and realistic. Research about habit formation of health behaviours suggests that a common obstacle to developing habits is unrealistic plans (Aarts et al., 1997). Many mindfulness practitioners recommend meditating for at least 20 minues each day, and a client may even agree to this. However, if he or she doesn't realistically have the time or motivation to do it regularly, the practice will not be sustained. During busy periods, I have managed to maintain a mindfulness routine in my life by meditating for as little as five minutes each morning. While shorter than the ideal amount of time (Kabat-Zinn, 1990), this has maintained the continuity of my habit. We can encourage clients to use similar strategies. In order to best position clients to maintain a mindfulness habit, we can let go of ideals and focus on the pragmatic factors that will allow clients to maintain that habit. This way, we can ensure that practicing mindfulness is something clients look forward to doing.

Finally, occupational therapists can encourage clients to be non-judgemental with themselves in relation to their mindfulness practice. Clients might be inclined to drop mindfulness when they believe they are not "good" at meditating, that they can't "stop their thoughts." But this is unnecessary. In my experience, I have found I was able to stick to mindfulness because I didn't worry about being good at it. Human minds are uncooperative and race automatically through their own inner monologues. Even as an experienced meditator, I frequently get lost in thought. Each time I remember my intention to meditate and reorient myself to the present moment, I consider this to be the act of participating in meditation. This is the practice of gaining awareness of the wanderings of our minds and recapturing focus. No matter how many times clients realize they are lost in thought, rather than berating themselves for this, they can congratulate themselves for finding focus again.

Conclusion

With the widespread appeal and growing recognition of the benefits of mindfulness today, it is appropriate that many health professionals are introducing the practice to clients. Occupational therapists can claim our own niche in this area by focusing on bringing mindfulness into occupations and helping our clients to develop the habit of mindfulness. In this way, we can draw on the fundamental client-centred values of our profession as we extend mindfulness into our practice.

References

Aarts, H., Paulussen, T., & Schaalma, H. (1997). Physical exercise habit: On the conceptualization and formation of habitual health behaviours. *Health Education Research, 12*, 363–374. doi:10.1093/her/12.3.363

Brown, K. W., Ryan, R. M., & Creswell, J. D. (2007). Mindfulness: Theoretical foundations and evidence for its salutary effects. *Psychological Inquiry, 18*, 211–237. doi: 10.1080/10478400701598298

Davis, D. M., & Hayes, J. A. (2011). What are the benefits of mindfulness? A practice review of psychotherapy-related research. *Psychotherapy, 48*, 198–208. doi: 10.1037/a0022062.

Duhigg, C. (2012). *The power of habit: Why we do what we do in life and business.* Toronto, ON: Anchor Canada.

Elliot, M. L. (2011). Being mindful about mindfulness: An invitation to extend occupational engagement into the growing mindfulness discourse. *Journal of Occupational Science, 18*, 366–376. doi:10.1080/14427591.2011.610777

Kabat-Zinn, J. (1982). An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: Theoretical considerations and preliminary results. *General Hospital Psychiatry, 4*, 33–47. doi: 10.1016/0163-8343(82)90026-3

Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain and illness.* New York, NY: Bantam Dell.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present and future. *Clinical psychology: Science and practice, 10*, 144–156. doi: 10.1093/clipsy.bpg016

Khoury, B., Lecomte, T., Fortin, G., Masse, M., Therien, P., Bouchard, V., . . . Hofmann, S. G. (2013). Mindfulness-based therapy: A comprehensive meta-analysis. *Clinical Psychology Review, 33*, 763–771. doi:10.1016/j.cpr.2013.05.005

McCorquodale, L. (2013). Mindfulness in the life of an occupational therapist: The 'being' behind the 'doing.' *Occupational Therapy Now, 15*(3), 14–16.

Nhat Hanh, T. (2011). *Peace is every breath: A practice for our busy lives.* New York, NY: HarperCollins.

Reid, D. (2008). Exploring the relationship between occupational presence, occupational engagement, and people's well-being. *Journal of Occupational Science, 15*, 43–47. doi: 10.1080/14427591.2008.9686606

Reid, D. (2011). Mindfulness and flow in occupational engagement: Presence in doing. *Canadian Journal of Occupational Therapy, 78*, 50–56. doi:10.2182/cjot.2011.78.1.7

About the author

Randy McVeigh, OT, is an occupational therapist in community rehabilitation and return to work in Vancouver, BC. He graduated with his MScOT in 2014 from Western University, where he developed the connections between his mindfulness practice and occupational therapy principles during a mindfulness course led by Dr. Elizabeth Anne Kinsella. He can be reached at: randy.mcveigh@gmail.com

Reflections on vulnerability and self-awareness

Chad Bauld

"The sufferer who frustrates a keen therapist by failing to improve is always in danger of meeting primitive human behaviour disguised as treatment." - Dr. T. F. Main (1957, p. 129)

Many of us find ourselves drawn to work in the world of health care for similar reasons. We want to help others in need. We want to work with people who will benefit from our assistance. As therapists, all is well in our world when we encounter clients who, through their smooth recovery and "compliance," reinforce our views of ourselves as effective, competent helpers. We feel good about ourselves when it appears our efforts are paying off.

Inevitably, however, we run into clients who, for various reasons, do not recover in ways that fit our view of what constitutes "normal." Perhaps we work with clients who do not seem to recover at all. Or, we meet individuals who we deem to be "non-compliant," perhaps because they reject our occupational therapy services or there is a personality clash. Through offering personal examples and reflections from my own practice over the years, in this article I will describe the importance of self-awareness and reflective practice as a means to understanding and recognizing vulnerability in ourselves and our clients, vulnerabilities that can divide client and therapist rather than unify them.

Difficulties have arisen for me as an occupational therapist when I have failed to examine, consider or re-evaluate my own personal and professional values, beliefs and intentions. Anger, frustration, irritation and client-therapist tension have surfaced when, upon reflection, I've realized that the client in front of me has not "behaved" in a way that reinforces my view of myself as "competent helper." At those times, I have lost sight of the professional value of putting client needs in front of my own.

At times I have been quick to forget that it is primarily my responsibility to develop and foster rapport. Vulnerability affects many of our clients, a vulnerability that concerns power and lack of power. As Gill (2006) states, "many people with long-term impairments confront society's power over their lives each day as they struggle with abridged choices and blocked access to resources" (p. 183). Being unwell (mentally, spiritually, physically or otherwise) may make a person feel vulnerable. To the extent that a person may have adopted or internalized ageist notions favouring youth, being an older adult may heighten vulnerability. Disability in general is often accompanied by vulnerability insofar as many of our clients carry histories of rejection and discrimination, and may arrive at our door with a subconscious expectation that we, too, will reject or judge them (Krupa, 2008). This expectation may manifest as behaviours or attitudes that prove challenging for us to accept, including significant validation-seeking, low motivation and learned helplessness. Again, it is primarily our responsibility to foresee and counteract this expectation of rejection. In her 2008 Muriel Driver Memorial Lecture, Terry Krupa explains this best. She is speaking from a mental health perspective; however, I feel her points are very much relevant to all domains of health care. She says:

These [therapist-client] relationships will be delivered with an understanding that individuals will bring the culmination of their historical experiences with stigma into the relationship. Subsequently they are vulnerable to responding to even neutral social interactions with a biased expectation for discrimination, and the enabling relationship is thus vulnerable to compromise. This possibility suggests that to be truly enabling, therapists need to explicitly and proactively integrate approaches that will offset these experiences through acceptance and respect, thus creating a "counterculture" to rejection in their relationships and in their working environments. (p. 202)

The client who frustrates us in his or her "failure" to improve provides us a real gift. We are offered immense opportunities for personal growth in these situations if we can step back and reflect on the truest sources of our frustrations. Perhaps my need to impose fall-prevention interventions, for example, on a person who is not concerned about falls is giving rise to my frustration. Perhaps I am misdirecting stress about a fast-approaching discharge date at my client who appears to not be progressing quickly enough. Perhaps my client is an unfortunate witness to the moral distress I might unknowingly be feeling

About the author

Chad Bauld is an occupational therapist and graduated from the Dalhousie University occupational therapy program in 1999. Along with his wife, daughters and dogs, he has recently returned to Nova Scotia following four years of living, working and playing in Whitehorse, Yukon. He currently resides in the beautiful Annapolis Valley region of Nova Scotia and works at King's Regional Rehabilitation Centre. He can be reached at: cbauld2@gmail.com

through working in a system that is often focused on objective outcomes rather than relationships or client priorities. Perhaps it has become safer and easier for me to label Mrs. Jones "difficult" rather than to confront the insecurity I might be feeling about her honest rejection of my service, or about her triggering subconscious memories of a difficult personal relationship. Is my need to enable success and functional gain in line with the reality of what is unfolding with this particular client?

Perhaps I have unintentionally internalized common health-care stereotypes about certain client populations that are now impacting my ability to see Mr. Smith as an individual, an individual with diabetes and a recent amputation, who, despite years of patterned behaviour, "should" be able to stop smoking and completely revamp his diet during an eight-week rehabilitation centre stay. Perhaps I am becoming frustrated with a particular client because I see and judge in her patterns of personal behaviour and choice that research shows directly contribute to her being ill. Perhaps I have not taken the time to reflect upon the fact that what presents as personal choice is actually very complex and socially situated. This is particularly true when examining the lives and "personal choices" of our most vulnerable citizens (Shah, 2008). The decision to smoke or not is clearly personal. But what are the multitude of biological, psychological and social influences that combine to shape what is "personal?" Are the factors involved in the decision about whether or not to smoke comparable when considering, for example, a wealthy African Nova Scotian heterosexual woman in her early forties and a poor Caucasian homosexual man in his sixties living with a long-term mental illness? I am continually reminding myself that I must not hold the behaviours and choices of others up against a one-size-fits-all "template for healthy living" that simply does not fit for most people.

The personal and professional benefits of reflective practice are many and include increasing our awareness of our biases, as Westberg (2001) explains:

Reflection can enable learners to identify unexamined assumptions and biases that can interfere with learning and patient care. All of us have assumptions and biases, which can lead to distorted impressions and faulty conclusions. A student [or therapist] who thinks that most addicts are street people might miss the fact that his well-groomed, wealthy patient has an addiction. (p. 5)

What has been particularly helpful to me is advice I have received about taking an attitude of gentleness towards myself when facing relational difficulties with clients. Such an attitude allows me to retain a sense of humour and a lightness of spirit as I go about my days learning, changing, uncovering and rediscovering personal and professional beliefs and values. Mindfulness practice also plays an enormous role as a practical method for fostering awareness of both my own vulnerability as well as that of the clients with whom I work. Research evidence has shown "that therapists who practice mindfulness are better able to pause before reacting, accept their emotions, and have increased awareness of patients' non-verbal signals" (Christopher et al., as cited in Baldini, Parker, Nelson, & Siegel, 2014, p. 221). I am proud of an evolving self-awareness and self-understanding that has increasingly helped me to stand back and see my beliefs and ideals at a distance. This distance, this emotional separation, provides a foundation from which I can attempt to make decisions about whether to accept, reject or adjust my beliefs and ideals to better provide care for myself and my clients. This distance provides the conditions to more clearly see and understand how values and beliefs differ within society, between professions, amongst our clients and colleagues, and also between friends and family members.

As therapists working with people whose age, gender identity, social status and differing abilities expose them to varying degrees of stigma, our awareness of personal biases and client vulnerabilities can be significantly heightened through a commitment to reflective practices. This sharpened awareness can only serve to improve our client-therapist relationships as we begin to better understand the impact that vulnerability can have on our clients' abilities and willingness to engage with us.

References

Baldini, L. L., Parker, S. C., Nelson, B. W., and Siegel, D. J. (2014). The clinician as neuroarchitect: The importance of mindfulness and presence in clinical practice. *Clinical Social Work Journal, 42*, 218-227. doi: 10.1007/s10615-014-0476-3

Gill, C. J. (2006). Disability, constructed vulnerability, and socially conscious palliative care. *Journal of Palliative Care, 22*, 183-189.

Krupa, T. (2008). Part of the solution ... or part of the problem? Addressing the stigma of mental illness in our midst. Muriel Driver Memorial Lecture 2008. *Canadian Journal of Occupational Therapy, 75*, 198-205. doi:10.1177/000841740807500404

Main, T. F. (1957). The ailment. *British Journal of Medical Psychology, 30*, 129-145.

Shah, S. (2008). *Young Disabled People: Aspirations, Choices and Constraints*. Burlington, VT: Ashgate Publishing Company.

Westberg, J. (2001). *Fostering Reflection and Providing Feedback: Helping Others Learn from Experience*. New York, NY: Springer Publishing Company.

Editor's note: An earlier version of this article was originally published in the Summer 2009 *Nova Scotia Society of Occupational Therapists Newsletter.*

Positioning occupational therapists to do their best work: Reflections from the 2014 Occupational Therapy Canada Forum

Susan G. Rappolt, Andrew R. Freeman, Pascale Geoffroy, Jeff Boniface, Heather Cutcliffe and Paulette Guitard

Occupational Therapy Canada (OTC) is the collaboration of the leading national occupational therapy organizations, including the Association of Canadian Occupational Therapy Regulatory Organisations (ACOTRO), the Association of Canadian Occupational Therapy University Programs (ACOTUP), the Canadian Association of Occupational Therapists (CAOT) and the Canadian Occupational Therapy Foundation (COTF)[1]. OTC meets quarterly to discuss issues pertaining to the profession of occupational therapy that are of concern to all four organizations. One of these meetings is a day-long forum that also includes provincial leaders from the Professional Alliance of Canada (PAC). Here we report on the proceedings of the 2014 OTC Forum that took place in Fredericton, New Brunswick, on May 7, 2014, during which five representatives from each of the five organizations examined how to position occupational therapists in Canada to do their best work.

Topics and processes of the 2014 OTC Forum

Every year, one of the OTC's participating organizations coordinates the annual OTC Forum. In 2014, ACOTUP took the lead and invited a representative from ACOTRO, CAOT, COTF and PAC to form an inter-organizational planning committee. Rather than hire an external facilitator, the members of this planning committee quickly resolved to model national collaboration by facilitating the meeting in Fredericton themselves. The theme of the 2014 meeting was built upon the findings of the 2013 OTC meeting in Victoria, British Columbia, which focused on the educational, practice, regulatory, political and economic implications of occupational therapy competencies, proficiencies, advanced practice and specialization (Freeman et al., 2014). The planning committee's deliberations on that report revealed underlying questions needing OTC's further consideration: *How should occupational therapy's unique contribution within the Canadian context be strategically defined? That is, when is occupational therapy the BEST service? How do we strategically "brand" this contribution?*

Prior to meeting in Fredericton, each participant received the list of all participants, the 2013 OTC meeting report, a summary of each organization's mandate, and a discussion guide for the 2014 meeting. The discussion guide oriented participants to the meeting's three objectives: (1) identifying what is unique about occupational therapy, (2) defining a national vision and (3) outlining plans to realize the national vision. The planning committee also requested that the members of each organization prepare a brief overview of three key issues they would like other participants to understand about their organization's mandate and current challenges.

At the meeting, following each organization's overview of its key issues, an environmental scan of occupational therapy's unique contributions, population needs and occupational therapist workforce trends in Canada was provided. This high-level scan was based on a review of scientific evidence on the effectiveness of occupational therapy practices, demographics from the Statistics Canada *Survey on Disability* (2012), and the occupational therapy workforce data compiled from 2012 provincial occupational therapist registers by the Canadian Institute for Health Information (CIHI; 2013). From the Statistics Canada *Survey on Disability* (2012), we learned, among other facts, that of those Canadians reporting a disability, 81% reported using an assistive device and 48% indicated their disability was severe or very severe. Key findings regarding the Canadian occupational therapy workforce included evidence that the percentage of occupational therapists' time required for direct service had increased from 80% to 85% between 2006 and 2012, and that the percentage of occupational therapists identifying themselves as researchers decreased from 1% to 0.7% (CIHI, 2013). The intensification of the requirement for direct service and the relative decrease in research capacity were seen as disturbing trends.[2]

With these preliminary reports in mind, the remainder of the OTC annual meeting focused on addressing the group's three objectives. This part of the meeting was designed to have five interorganizational small groups deliberate on each of the three objectives concurrently, report on their findings, and then engage in an open forum to synthesize the small group reports into consensus statements. Representatives of each inter-organizational working group presented their findings orally and these findings were summarized on flip charts. Large group discussions and syntheses were similarly recorded. One OTC planning committee member took minutes of the entire day. All three sets of data were analyzed independently by the five members of the planning committee. The data were synthesized and categorized into the themes reported below.

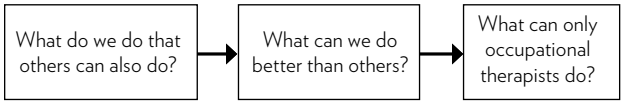
[1] For an account of the evolution of Occupational Therapy Canada, please see article by Freeman and Rappolt to appear in the July 2015 issue of *OT Now*.
[2] An expanded report on the three sets of data summarized for the 2014 OTC environmental scan and an examination of the pressures on the Canadian occupational therapy workforce, as well as the limitations of workforce data, will be reported elsewhere.

Background to the 2014 OTC Forum

The 2014 Forum orientation was a logical continuation of some of the reflections identified at the 2013 Forum (Freeman et al., 2014). The need for our profession to strategically define and brand its unique contribution within the Canadian context is linked to both our knowledge base and the social, political and economic contexts of our practices. In light of increased funding pressures on publicly-funded services and the profit interests of privatized services, there is increased pressure from service funders and employers to maximize the value returned for their funding. Those who fund services are inevitably obliged to ask the question: *Who can provide the best services for the best price?* Key elements implicit in positioning occupational therapists to do their best work include the need to strategically and collaboratively build toward the future.

Objective 1: What are occupational therapy's unique contributions (and who needs them most)?

In the discussion guide prepared by the planning committee, participants were asked to consider occupational therapy's contributions on a continuum:



Within their interorganizational working groups, participants were asked to respond to the following questions:

- *What can we do better than others and what can only occupational therapists do?*
- *Who needs the unique contributions of occupational therapy services the most?*

The interorganizational small working groups reported a total of 109 contributions unique to occupational therapists. These contributions were synthesized by participants in one large group into 27 categories, then further reduced to seven all-encompassing categories:

1. Holistic regard of the physical, mental, social and spiritual person
2. Contextualization of individual values, goals and attributes within social and physical environments
3. Integrated analyses of the "big picture" that facilitate predictions of long term outcomes
4. Ecologically valid assessments, and sound models and processes for interventions
5. Focus on occupation, including occupation both as motivation and function
6. Authentic client-centredness
7. Enablement of decreased dependence and increased self-management

The planning committee's further synthesis of the participants' findings suggested three foundational contributions of occupational therapy practices:

- Optimized occupational outcomes given personal attributes and environmental supports
- Ecologically valid assessments, effective models, processes and interventions
- Enablement of individual and social change

In addition to occupational therapy's unique contributions, participants noted occupational therapists' exceptional capacity to partner with other professions and emphasized the need to build greater human resource capacity in occupational therapy to address population needs for our services.

Objective 2: Achieving a common vision for occupational therapy across Canada

Participants working in their interorganizational small groups were asked to propose vision statements that used evidence-based, outcome-oriented plain language that could be easily understood by the public and incorporated the concepts of client-centredness, justice, wellness, economic value, access and sustainability to raise the public profile of the profession. Seventy-seven phrases and one graphic incorporating some of these elements were proposed, including:

Where people live, what people do
Innovative solutions to help you
You can do it when OT helps
The profession that makes life worth living
Do the things you want to do

Following deliberation by the full group, a provisional common vision for the profession of occupational therapy in Canada was proposed:
Evidence-based occupational therapy is understood, valued and utilized as the profession that makes life worth living.

Objective 3: Determining priority actions for Occupational Therapy Canada

During a facilitated discussion of priorities for occupational therapy in Canada, participants endorsed five key principles for the actions that ACOTRO, CAOT, PAC, COTF and ACOTUP will undertake collaboratively:

1. One voice: The profession of occupational therapy in Canada will present a unified message, endorsed by all member organizations, to the Canadian public, public policy-makers, corporate leaders and other professions.
2. Economic evidence: A top priority for the profession of occupational therapy in Canada is the demonstration of the economic value of the effectiveness of occupational therapy services for all ages and populations served by occupational therapists.
3. Human resource capacity: The number of occupational therapists per capita in Canada should be increased to be sufficient to provide the services we advocate to promote health and well-being for Canadians.
4. Evidence-based practice: Action plans for the profession of occupational therapy in Canada will be based on the best available evidence that is selected with respect to pressing Canadian needs and interpreted with respect to Canadian values to advance the occupational engagement, health, well-being and community integration of Canadians.

5. Commitment to OTC: The five participating organizations will continue to work collaboratively to achieve consensus on priority action plans and implementation strategies to facilitate Canadians' access to the timely provision of the occupational therapy services they need to improve their occupational engagement, health, well-being and community integration.

Prior to the articulation of the top priority actions for OTC, the participants agreed to three processes to streamline the use of OTC's collaborative resources, including: (1) accessing relatively untapped resources (e.g., consumers' voices, occupational therapy human resource and service utilization data); (2) maintaining collaborative and timely interorganizational working relationships; and (3) communicating strategically by refining our vision statement, strategic priorities and implementation approaches to guide our collective communication strategies.

OTC's four priority actions

1. Aligning occupational therapists' unique capacities with complex high need populations

The first discussion of the day included the question *"Who needs the unique contributions of occupational therapy services the most?"* Given our profession's very broad and largely open scope of practice, many health and social service providers can and do provide services that are similar to those provided by occupational therapists. Therefore, the crucial next step is to map occupational therapy's unique contributions to the needs of high priority populations so that the profession's resources can be allocated to have the maximum impact on occupational engagement, health and well-being in Canadian society.

2. Differentiating occupational therapy from other professions

The profession of occupational therapy derives much of its credibility from its theories, models and bodies of evidence. However, some of our most ecologically valid assessments and effective interventions appear to be as (deceptively) simple as making a cup of tea. Participants recognized that OTC must learn how to articulate the depth and breadth of occupational therapists' foundational competencies and complex therapeutic skills to more clearly differentiate our roles from those of our partnering professions. Every occupational therapist must be able to communicate the need for specific occupational therapy services and their anticipated outcomes in every circumstance in which services are being allocated, to ensure that patients and clients receive the most appropriate service at the right time.

3. Demonstrating outcomes and cost benefits

As both public servants and private practitioners, occupational therapists must account for their assessments, interventions and clinical and economic outcomes. Producing evidence of the effectiveness and cost benefits of occupational therapy services is a top priority.

4. Building leadership capacity

Strategic alliances are desperately needed among the relatively few occupational therapists with advanced research skills and the many occupational therapists who have identified clinical research priorities. In addition to building research capacity, the profession needs to become highly politicized. Explicit entry-level education and continuing professional development programs in leadership and advocacy could help occupational therapists and the profession as a whole realize our potential as change agents by encouraging partnering with economists and policy-makers.

Summary

The leaders of the profession's five main organizations in Canada who participated in the 2014 OTC Forum were energized by the agenda and deeply committed to working toward the alignment of our diverse profession's goals and priorities. Gaining a shared understanding of the five organizations' mandates and current activities was seen as an important step in the process of developing collective solutions together. Working in interorganizational small groups and then all together, the participants generated ideas and reached a consensus on a provisional vision statement and strategic priorities that transcend the individual organizations' mandates and challenges. During the meeting, participants were so highly committed to interorganizational collaboration that they rebelled against the planning committee's recommendation to consult within their own organizations.

The 2014 report on the annual OTC Forum was ratified by all participants and disseminated to the five organizations (OTC, 2014). In the coming year, OTC will finalize a common vision for the profession in Canada. Collaboratively, we will examine opportunities for aligning occupational therapists' unique capacities with populations who have complex health and social needs, and will seek partnerships in demonstrating practice and client outcomes and the cost benefits of occupational therapists' services. We are committed to working together to build human resource capacity in occupational therapy practices and research, and fostering leadership and advocacy within the profession in Canada.

About the authors

Susan G. Rappolt, PhD, OT Reg. (Ont.), is the chair of the Department of Occupational Science and Occupational Therapy at the University of Toronto. **Andrew R. Freeman, PhD, erg.,** is an associate professor in the occupational therapy program at Laval University. **Pascale Geoffroy, erg.,** is the president of the Association of Yukon Occupational Therapists. **Jeff Boniface, BPE, BHScOT, OT,** was on the board of directors of the Canadian Occupational Therapy Foundation. **Heather Cutcliffe, OT Reg. (PEI),** is the registrar of the Prince Edward Island Occupational Therapists Registration Board. **Paulette Guitard, PhD Erg. Aut. (Ont.), erg(c),** is the director of the occupational therapy program at the University of Ottawa and recently completed her term as president of the Canadian Association of Occupational Therapists.
For more information, please contact Susan Rappolt at: s.rappolt@utoronto.ca

Responses to this brief report and the full 2014 OTC report are welcome. Please send comments to s.rappolt@utoronto.ca

References

Canadian Institute for Health Information. (2013). *Occupational therapist workforce 2012*. Retrieved from https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC2433&lang=en

Freeman, A. R., Rappolt, S. G., Jarus, T., Collins, D., Salsman, G., & Paterson, M. (2014). Proficiency in occupational therapy practice: Reflections from the 2013 Occupational Therapy Canada Forum. *Occupational Therapy Now, 16*(3), 26-28.

Statistics Canada. (2012). *Canadian survey on disability*. Retrieved from http://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=3251

Building support networks: A review of one year of a forensic occupational therapy journal club

Michael Ivany

Working in a specialized area of occupational therapy can be isolating. While you may have colleagues nearby, the more specialized your field, the more unlikely it is that your colleagues can support you in clinical decision-making, application of theory to practice process and in program development. In addition, finding a group of like-minded colleagues to search for, evaluate and discuss the applications of research relevant to your field can be difficult. When I first started working in forensic mental health as the sole occupational therapist at my site, I noticed that the two previous occupational therapists had lasted less than a year. One of these therapists expressed the difficulty of working with staff from other disciplines who had a very different frame of reference. Forensic mental health combines elements of retribution with elements of rehabilitation, but my occupational therapy education program and fieldwork experiences focused solely on rehabilitation. Fortunately, there were occupational therapy scholars ahead of me who had paved the way and had already demonstrated that occupational therapists could make a difference in this area of practice. This was reinforcing but still insufficient support for the practice environment I found myself in.

In 2007, when I first checked the box on my registration form for the Canadian Association of Occupational Therapists to indicate I was working in forensic mental health, I thought that there must be others like me who believed that occupational therapy could make a significant difference in the field. I wondered if they may be feeling socially isolated or burnt out. To find out, I telephoned individual sites across Canada, asking if there was an occupational therapist at each and created a database of occupational therapists working in corrections and forensic mental health. I sent an email request to everyone in the database inquiring about their interest in participating in a journal club that would review relevant literature and discuss practice implications. Therapists from all sites contacted replied and said they would like to join such a group. The purpose of this article is to share the practice process used by the National Forensic Occupational Therapy Journal Club and to demonstrate how teleconference networks, like this one, can support practice development and offer peer support. The article will also provide an update on some of what is being discussed in the field by presenting an overview of the meetings that took place in 2013.

Journal club session structure

Every three months, a group of occupational therapists who work in hospital or corrections centers in forensic mental health meet to review and critique a journal article and then discuss how services relating to the article topic compare across Canada. Over thirty occupational therapists across 11 sites from Nova Scotia to British Columbia connect via videoconference or teleconference, with support from Crystal Dieleman, an occupational therapy professor at Dalhousie University. The articles are chosen based on an annual theme selected by the group and are searched for either by occupational therapists or by students on placement with one of the group members.

The meetings are 90 minutes long, and include a 45-minute critique of the article using the McMaster critical review guidelines (Law et al., 1998; Letts et al., 2007). These guidelines were selected based on their prominence in occupational therapy education programs across Canada as guides for critical appraisal of peer-reviewed articles. It has been helpful having a standard set of questions by which we all evaluate the quality of the article. In addition, the structure makes it easier to facilitate group meetings, as it essentially provides an agenda to follow. One site facilitates the article critique process. Each section of the guideline is presented by a different site, with others offering any additional comments. The remaining 45 minutes of the meeting are open for discussion questions that come from the critique, and differences in practice processes and policy across sites are highlighted and compared. Members also bring specific practice questions to the group.

A review of meetings in 2013

The theme chosen for 2013 was to explore how occupational therapists working in mental health promote social inclusion. The articles reviewed in 2013 by the National Forensic Occupational Therapy Journal Club are listed below with a

About the author

Michael Ivany started working as the only occupational therapist in forensic mental health in North Bay, Ontario, in 2007; now there are three. The National Forensic Occupational Therapy Journal Club was created as a support network for occupational therapists practicing in forensic mental health, whether in hospital or in the corrections system. For further information or to join, please contact: michael.ivany@nbrhc.on.ca

summary of the main points discussed at each meeting. These summaries demonstrate the results that can be obtained from short, focused sessions on professional development in a specialized practice area.

March

Article: Fitzgerald, M. (2011). An evaluation of the impact of a social inclusion programme on occupational functioning for forensic service users. *British Journal of Occupational Therapy, 74, 465-472.*

Description: This article described a program through which occupational therapists can help people access information and support to meet social inclusion goals.

Our discussion: Participants questioned whether group programming, which is seen as more efficient than individualized intervention, can be as effective as individualized intervention in maintaining gains in social inclusion. Some significant limitations of the study were discussed and members questioned the effectiveness of the intervention based on the outcome measure results presented. The group agreed that, in their experience, the majority of Canadian occupational therapists working in the criminal justice system do not use the *Model of Human Occupation Screening Tool* (Parkinson, Forsyth, & Kielhofner, 2006), which was used in this study. The group suggested more research is needed to identify if this tool offers more direction than others currently in use.

July

Article: Lindstedt, H., Grann, M., & Soderlund, A. (2011). Mentally disordered offenders' daily occupations after one year of forensic care. *Scandinavian Journal of Occupational Therapy, 18*, 302-311.

Description: The article focused on how individuals use their time one year after being discharged from forensic services.

Our discussion: Group members challenged the definition of social participation used by Lindstedt, Grann, & Soderlund (2011): "an ability to handle social situations with significant others in relation to self-maintenance, work/study/play, and leisure activities" (p.303). Ability is necessary but not sufficient for social participation; group members argued that meaning needs to be of primary focus. Members noted concerns regarding whether there is an increase in meaning or an increase in acceptance of one's situation over time. Members mentioned how follow-up one year post-discharge is rarely completed in forensic mental health in Canada. Discussion highlighted that in a forensic system, occupational engagement may be influenced by the pressure to engage in activities that are favourable in the view of the parole or review board. There are risks to discharging people to an environment and activities that are chosen primarily to help them get off of a parole or disposition order if they don't hold meaning for the person, as they may not be maintained.

September

Article: Mezey, G., & Eastman, N. (2009). Choice and social inclusion in forensic psychiatry: Acknowledging mixed messages and double think. *Journal of Forensic Psychiatry & Psychology, 20*, 503-508.

Description: This article discussed how individuals are given a choice of participation in activity, but those choices are influenced by the client's perception of how the staff will perceive their participation in the activity.

Our discussion: The discussion focused on activities that involve peers on in-patient units in paid and unpaid roles. Group members identified that many sites do not have paid full-time peer support workers, although some do. Self-stigma was discussed as a barrier and interventions targeting self-esteem and self-worth were highlighted, including speaking about mental illness, phototherapy projects and increased community participation. Conversation led to the individualized nature of social capital: different groups have social norms that treat certain people more favourably due to a perceived benefit, whether economic or otherwise (Portes, 1998). Participants discussed supporting people with legal options for increasing their social capital, where illegal activities may traditionally have been used by these individuals to increase their social capital.

December

Articles: Twinley, R. (2013). The dark side of occupation: A concept for consideration. *Australian Occupational Therapy Journal, 60*, 301-303.
Hammell, K. W. (2013). Client-centred occupational therapy in Canada: Refocusing on core values. *Canadian Journal of Occupational Therapy, 80*, 141-149.

Description: One article focused on the occupational therapist's approach to their views of occupations that may be labelled as 'dark occupations' and the other focused on challenging the application of a client-centered occupational therapy service.

Our discussion: The group discussed the challenges associated with applying client-centered principles to forensic occupational therapy practice. Being client centered is not so clear when the client's stated goal is to be discharged

immediately from a forensic unit or released from prison without intervention. The public is also a client/stakeholder and public protection is a portion of the mandate. A clear power imbalance impacts daily practice and life choices for the client; a team often decides what is permissible, considering anti-social and prosocial activity patterns. Strategies suggested by group members included allowing individuals to direct their care and set goals within the parameters outlined by the facility and program, as well as enabling the client to engage in activities that will facilitate the long-term goal of discharge or valued participation in the community.

Lessons learned

Working in a specialized practice area can often be isolating but it does not need to be. Therapists can come together virtually to support each other and to highlight research needs, which can then direct future research to inform practice. This journal club has directed both individual and student projects, and the group has already been used as a participant group for research projects both at a national and international level. Building or participating in a professional practice network journal club does not necessarily require much dedicated time from your caseload, and we have found that assigning the search for a journal club article as a student project is a good use of resources. This journal club forms an occupational therapist support network that allows for peer mentoring and reflection. Members have used the network to check how other sites are dealing with a specific issue or have worked through team challenges regarding controversial issues. As challenges within specialized practice areas such as forensic mental health often trend with political and cultural shifts, there is a strong likelihood that someone across Canada has been through or is considering a similar issue. Shared solution-making benefits practitioners and clients. Individual therapists have also identified that the support received in the journal club has been helpful in reducing professional isolation and enhancing their professional competence.

In short, this group is a resource that many occupational therapists find sufficiently valuable, five years later, that regular and novel attendance continues. The hope in writing this article is that occupational therapists who feel isolated in their work will realize that they are not alone and that a professional network can support them in developing not only their practice, but the practice of their peers and strengthen the profession as a whole.

References

Fitzgerald, M. (2011). An evaluation of the impact of a social inclusion programme on occupational functioning for forensic service users. *British Journal of Occupational Therapy, 74,* 465-472. doi: 10.4276/030802211X13182481841903

Hammell, K. W. (2013). Client-centred occupational therapy in Canada: Refocusing on core values. *Canadian Journal of Occupational Therapy, 80*, 141-149

Law, M., Stewart, D., Pollock, N., Letts, L., Bosch, J., & Westmorland, M. (1998). *Guidelines for Critical Review Form – Quantitative Studies*. Retrieved from http://www.srs-mcmaster.ca/Portals/20/pdf/ebp/quanreview.pdf

Letts, L., Wilkins, S., Law, M., Stewart, D., Bosch, J., & Westmorland, M. (2007). *Guidelines for Critical Review Form – Qualitative Studies (Version 2.0)*. Retrieved from http://www.srs-mcmaster.ca/Portals/20/pdf/ebp/qualreview_version2.0.pdf

Lindstedt, H., Grann, M., & Soderlund, A. (2011). Mentally disordered offenders' daily occupations after one year of forensic care. *Scandinavian Journal of Occupational Therapy, 18*, 302-311. doi:10.3109/11038128.2010.525720

Mezey, G., & Eastman, N. (2009). Choice and social inclusion in forensic psychiatry: Acknowledging mixed messages and double think. *Journal of Forensic Psychiatry & Psychology, 20*, 503-508. doi: 10.1080/14789940903178023

Parkinson, S., Forsyth, K., & Kielhofner, G. (2006). *Model of Human Occupation Screening Tool* (Version 2.0). Chicago, IL: University of Illinois at Chicago.

Portes, A. (1998). Social capital: Its origins and applications in modern sociology. *Annual Review of Sociology, 24*, 1-24.

Twinley, R. (2013). The dark side of occupation: A concept for consideration. *Australian Occupational Therapy Journal, 60*, 301-303. doi: 10.1111/1440-1630.12026

Update from the Canadian Occupational Therapy Foundation

CAOT Conference 2015

COTF would like to thank everyone who supports the Foundation at CAOT's annual Conference. Support includes those who donate in-kind items for the live and silent auctions, purchase items from the same, buy raffle tickets and mugs, and attend the COTF events, which this year include the COTF Session with Karen Goldenberg, the Lunch with a Scholar with Jacquie Ripat and the COTF Annual General Meeting.

New clinical research grant for 2016

Proceeds from the fundraising at Conference will go towards the Karen Goldenberg Leadership Impact in Research Grant, which will be launched during the 2016 COTF Research Grant Competition. This grant has been established to honour Karen Goldenberg, one of COTF's founding members and a 2014 recipient of the Order of Canada. This grant will be open only to clinicians; its purpose is to meet clinicians' need for research on issues directly related to their practice. The importance of leadership will be a major focus of the grant, and projects must also contain a plan for an analysis of the economic impact of the proposed research. Economic analysis of occupational therapy interventions is critical to determining the best outcomes for clients, systems of care and society at large. Karen will present a session at the 2015 CAOT Conference about the importance of leadership in research and how economic evaluation can be built into a grant proposal.

2015 COTF Scholarship Competition

The next COTF awards application deadline is October 1, 2015, for scholarships. Remember that all students showing leadership potential who are beginning their second year of school in the autumn should consider the Barb Worth Emergent Leader Award. Students must nominate themselves, but require two references. Please visit the website for more information: http://www.cotfcanada.org/index.php/en/scholarships

Canadian Occupational Therapy Foundation

Anne McDonald, Executive Assistant
Tel: 613-523-2268 ext. 226/ 1-800-434-2268 ext. 226
amcdonald@cotfcanada.org

Sangita Kamblé, MA, CAE, Executive Director
Tel: 613-523-2268 ext. 241/ 1-800-434-2268 ext. 241
skamble@cotfcanada.org

CTTC Bldg, 3401-1125 Colonel By Drive
Ottawa, ON K1S 5R1 Canada

Fax: 613-523-2552
Facebook: http://www.facebook.com/cotffce
Twitter: https://twitter.com/COTFFCE

COTF is the only organization that provides funding solely to occupational therapists who are CAOT members! Make a donation now! www.cotfcanada.org