OCCUPATIONAL THERAPY NOW

OCCUPATIONAL THERAPY NOW VOLUME 18.2

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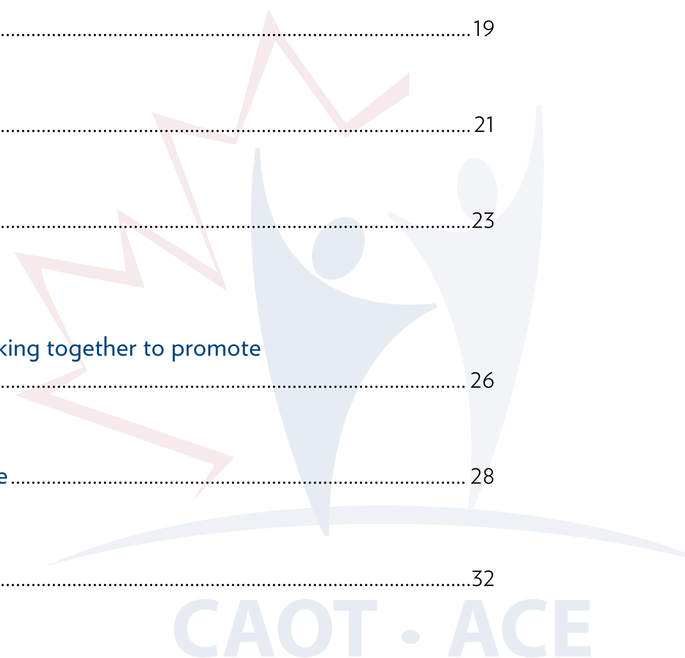

Cover photo credit: Mike Kwan
Photo submitted by: Gina Fernandez, OT
Gina writes: "This picture depicts how occupational therapy interventions can be effective and allow individuals to return to work following a repetitive strain injury. Carita Ho, a designer from Vancouver, BC, was able to continue her artistic work as a result of occupational therapy interventions. Often, designers must work long hours under grueling conditions to finish projects before show deadlines. In order for Carita to meet these demands, manage pain and prevent further injury, an occupational therapist was consulted. Interventions included adjusting Carita's workstation, recommending a splint and providing a home exercise and stretching program. As a result, Carita's career as a designer is still going strong!"

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Canadian Association of Occupational Therapists
100-34 Colonnade Drive,
Ottawa, Ontario K2E 7J6
Canada
E-mail: publications@caot.ca

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

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DESIGN & LAYOUT
JAR Creative

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All *OT Now* Editorial Board members and Topic Editors are CAOT members in good standing.

What's new

OT Now corporate associate page

CAOT corporate associates are valued members of our community and so we are proud to have them contribute to *OT Now*. In this issue, you will find our first corporate associate page, authored by Jim Closs from Stannah, explaining the different considerations in choosing a stairway lift. We, at CAOT, believe that members will appreciate the opportunity to hear from all those involved in supporting the work that we do.

News from *OT Now*

OT Now call for papers: Recovery-oriented psychosocial rehabilitation practice

The September 2016 issue of *OT Now* aims to provide a broad audience with information on the contribution occupational therapists make in recovery-oriented psychosocial rehabilitation. Submission deadline: April 1, 2016. To view the call for papers, go to: http://www.caot.ca/default.asp?ChangeID=25&pageID=7

Call for cover images

OT Now welcomes readers to submit photos and artwork for publication on its covers. We are looking for dynamic images that depict occupation or occupational therapy in Canada. Images must be at least 300 dpi and in portrait orientation. Send your images to: otnow@caot.ca

Thank you to _OT Now_ volunteers

Thank you to the following CAOT members who have completed their volunteer terms with *OT Now*:

- Christina Lamontagne – topic editor, Student Perspectives
- Laura Hartman – topic editor, Student Perspectives
- Sandra Bressler – topic editor, International Connections
- Sumaira Mazhar – entry-to-practice student representative, Editorial Board

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

CJOT: Evidence for your practice

OT Now has created a new regular space for knowledge translation, specifically of articles from the *Canadian Journal of Occupational Therapy (CJOT)*. It allows for research to be profiled in both publications, with a focus on practice implications in *OT Now*. *CJOT* authors are invited to participate. For more information, contact the topic editor, Briana Zur, at: briana.zur@outlook.com

New! Lunch & Learn Archive packages

CAOT is now offering packages of 5, 10 and 15 Lunch & Learn Archives! With the package of 15 Lunch & Learn Archives, each recorded webinar and associated handouts is only $25. There are over 100 Lunch & Learn Archives to choose from. To learn more, please visit: http://www.caot.ca/default.asp?pageid=4205

2015 gOTspirit winner

Every year, the occupational therapy students at the University of Alberta challenge students across Canada to see who can display occupational therapy pride through the "gOT Spirit Challenge." The winner of this year's gOT Spirit video challenge is Dalhousie University! Congratulations to the students of Dalhousie University for their enthusiastic rap promoting the role occupational therapists can play in enabling the occupations of all people. 2015 gOT Spirit videos can be viewed at: http://gotspiritchallenge2015.wikia.com/wiki/Special:Videos

COTF Scholarship Competition results

Barb Worth Emergent Leader Award ($5,000):

Paige Reeves, University of Alberta

COTF / Invacare Master's Scholarship ($2,000):

Stephanie Zubrinski – Resilience Education to Create Educator and Student Success (RECESS)

COTF Master's Scholarship (3 x $1,500):

Shawna Cronin – Impact of interdisciplinary teams in primary care on health outcomes of individuals with chronic disease

Samuel Turcotte – Représentations de l'approche centrée sur les forces: Une étude exploratoire auprès de clientèles d'un centre de réadaptation.

Alexandria Simms – Understanding rehabilitation needs from the perspectives of adults living with HIV in rural Manitoba

COTF Doctoral Scholarship (4 x $3,000):

Laura Bulk – Being blind in a sighted world

Flora To-Miles – The health-promoting potential of creative and social activities: An exploratory study of adults with and without inflammatory arthritis

Lina Tam-Seto – The development of an e-learning module for occupational therapists working with military-connected families affected by operational stress injuries

Caryne Torkia – Development and feasibility of Go-Win-Go:

an intervention to address community mobility for individuals post-stroke

Thelma Cardwell Scholarship ($2,000):
Theresa Sullivan – Learning to Reason-Think on their Feet: Exploring how occupational therapists learn to professionally reason in their first five years of practice

Goldwin Howland Scholarship ($2,000):
Joanne Park – The effectiveness of motivational interviewing as an interventional tool for improving return to work outcomes for injured workers

Congratulations to the winners and thanks to the COTF Research and Scholarship Review Committee for all of their hard work! The members for the 2013-2015 term were:

- Debra Cameron, chair
- Brenda Beagan
- Carolina Bottari
- Johanne Higgins
- Kim Larouche
- Leanne Leclair
- Bill Miller
- Susanne Murphy

A special thank you to Brenda Beagan, Carolina Bottari, Johanne Higgins and Leanne Leclair, who will not be continuing with the committee. COTF welcomes Emily Etcheverry and Aliki Thomas to the 2016-2018 Review Committee and looks forward to their contributions.

Your foundation
Remember that COTF is your foundation. It is the only foundation that exclusively funds occupational therapists, and specifically CAOT members. Please remember to donate to COTF: www.cotfcanada.org

Workforce trends in occupational therapy

Havelin Anand and Alison Douglas

Throughout 2016, *Occupational Therapy Now* is presenting an article series to celebrate the 90th anniversary of the Canadian Association of Occupational Therapists (CAOT). In January, the history of the association was profiled; the July issue will look at the future of occupational therapy. In this article, we focus on the present, considering current workforce and professional issues in Canada.

Occupational therapy workforce

According to the Canadian Institute for Health Information (CIHI; 2015), there were approximately 15,977 registered occupational therapists in Canada in 2014. The overall supply of registered occupational therapists in Canada is growing every year; the supply has increased by more than 13% since 2011. CIHI has informed CAOT that between 2010 and 2014, the occupational therapist workforce per 100,000 Canadians increased from 36 to 42, while the physiotherapist workforce per 100,000 Canadians increased from 52 to 57 in the same time period.

Employment status, practice settings and roles

According to the 2014 statistics, occupational therapists enjoyed a 93.5% employment rate. Of those employed, 74.7% were permanent employees, 13.5% were self-employed and 11.3% were employed on a temporary or casual basis. In 2014, 45.3% of occupational therapists worked in a hospital setting while 44.6% worked in communities or in private practice. Therapists work with health-care providers and other professionals in a variety of settings, including long-term care facilities, community support services, family health teams, hospitals, homes, schools and academic institutions. Occupational therapists also work with organizations such as government departments (as policy analysts), as well as in private industry and community agencies, to develop and administer programs and services. In 2014, 83.7% reported their position as being that of a "direct service provider," while more than 8.1% described their role as that of a manager/leader/coordinator (CIHI, 2015).

Workforce characteristics

The average age of occupational therapists continues to increase. The proportion of occupational therapists in the workforce who are younger than 30 years increased between 2010 and 2014 from 17.4% to 18.3%. The proportion of those 60 years and older grew slightly from 3.3% to 3.7%. Since 2010, the proportion of female occupational therapists in Canada has remained stable at around 91%, with a slight decrease from 91.8% in 2010 to 91.3% in 2014 (CIHI, 2015).

Distribution of workforce in Canada

The distribution of occupational therapists across provinces in 2014 can be seen in Table 1.

Table 1. *Distribution of occupational therapists across provinces and territories (CIHI, 2015)*

Jurisdiction	Number of occupational therapists	Percentage of occupational therapists
Newfoundland	187	1.2%
Prince Edward Island	50	0.3%
Nova Scotia	443	2.9%
New Brunswick	323	2.1%
Quebec	4,219	*28%*
Ontario	5,008	32.2%
Manitoba	630	4.2%
Saskatchewan	339	2.2%
Alberta	1,859	12.3%
British Columbia	1,977	13.1%
Territories	38	0.3%
Canada	15,977	100%

Demand for occupational therapy services

The demand for occupational therapy services in Canada is strong. According to the 2014 National Physician Survey of some 60,000 practicing physicians, undertaken by the College of Family Physicians, the Royal College of Physicians and Surgeons and the Canadian Medical Association, over 70% of physicians were unhappy about difficulties in securing appointments for patients with publicly funded occupational therapists (National Physician Survey, 2015).

Over the last few years, the number of occupational therapists in the workforce has increased (CIHI, 2015). Job growth stems from the treatment needs of older adults and community health needs in general. Employment prospects for occupational therapists are good in light of the following factors: Canada's aging demographic (in 2015, for the first time, the percentage of Canada's population that was over the age of 65 was greater than the percentage of individuals 14 and under—16.1% compared to 16%), longer life expectancy and higher survival rates from accidents and injuries (Chen, 2015).

Canada's aging population is also contributing to other conditions. According to the Alzheimer's Society of Canada (2015), 1.4 million or 14.9% of Canadians 65 and older are living with Alzheimer's disease or some other form of dementia. Occupational therapy interventions will be needed to assist with supporting the physical, cognitive and functional abilities of clients with dementia.

A demographic shift caused by an aging population has also contributed to a mounting epidemic of vision loss in Canada. The prevalence of vision loss in Canada is expected to increase by nearly 30% in the next decade (CNIB, n.d.). According to CNIB (n.d.), another key factor in the vision loss epidemic is the steady rise in rates of diabetes, which has led to an increase in cases of diabetic retinopathy. CNIB reports that 75% of all vision loss can be prevented or treated if detected early. This situation presents opportunities for occupational therapists in areas such as:

- active engagement in preventive interventions that encourage clients to make simple lifestyle changes, such as "wearing ultraviolet-protective sunglasses all year round, taking vitamins, quitting smoking, exercising regularly, controlling diabetes and maintaining a healthy diet high in omega 3 fatty acids and dark leafy greens" (CNIB, n.d., para. 12)
- home redesign (using principles of universal design) that improves quality of life of older adults and facilitates aging in place—research indicates that occupational therapy interventions such as home adaptations have resulted in a reduction in daily home care services (Rexe, McGibbon Lammi, & von Zweck, 2013)
- assistance to clients with low vision with selecting and learning to use assistive technology, such as screen magnification or reading software, to facilitate occupational performance in meaningful activities that require reading

Baby boomers in Canada, who are rapidly becoming older adults, are unique because of their increased participation in the labour force and engagement in volunteer activities. They are more active and remaining healthier than earlier generations. The majority want to stay at home for as long as possible (Institute for Research on Public Policy, 2015). They are interested in maintaining their quality of life and independence.

In light of these factors, and given that occupational therapists are involved in enabling the occupations of people facing physical, psychological and social concerns, the prospects for occupational therapists look promising.

British Columbia's workforce: A special case

Occupational therapists are in high demand throughout the province of British Columbia, but the number of new graduates in the field is insufficient to meet demand (WorkBC, n.d.). This is particularly true for underserved populations of British Columbia, including northern, remote and Indigenous communities (Canadian Association of Occupational Therapists – British Columbia [CAOT-BC], 2015). Over 96% of the British Columbia occupational therapy workforce is employed in urban areas, leaving less than 4% that work in rural or remote areas (CAOT-BC, 2015), a distribution that does not match Statistics Canada's (2011) estimate that 14% of British Columbians live in rural communities. Educating occupational therapists in British Columbia to meet unique geographical, social and health needs outside of urban centres is paramount to improving health outcomes in the province and reducing disparity in access to health services.

The occupational therapist workforce in British Columbia grew from 1,696 occupational therapists in 2010 to 1,977 in 2014 (CIHI, 2015). The ratio of occupational therapists per 100,000 persons showed an increase from 38 in 2010 to 43 in 2014. This supply is less than in some other provinces, including Alberta (45 per 100,000 persons), Manitoba (49 per 100,000), New Brunswick (43 per 100,000), Nova Scotia (47 per 100,000) and Quebec (51 per 100,000; CIHI, 2015).

Registration

Registration for practice is granted by individual provincial regulatory bodies in Canada. Each regulatory body determines entry-to-practice criteria for its respective jurisdiction (Association of Canadian Occupational Therapy Regulatory Bodies [ACOTRO], 2015). Currently, in most provinces except Quebec, registrants are required by the regulatory bodies to have completed a university level program in occupational therapy in Canada and pass the National Occupational Therapy Certification Exam (NOTCE). If a registrant has not obtained occupational therapy education from a Canadian program, she or he may be required to undergo further screening and testing prior to writing the NOTCE (ACOTRO, 2015). This screening is completed by ACOTRO through their Substantial Equivalency Assessment System (SEAS) program (ACOTRO, 2015).

Attending a program that has obtained accreditation status (CAOT, 2015) provides assurance of the quality of the program as determined by an accreditation oversight council called the Academic Credentialing Council (ACC). It is important for those interested in practicing occupational

therapy in Canada to ascertain the regulatory requirements to practice in their jurisdiction.

Conclusion

In light of Canada's demography, occupational therapist workforce characteristics and the need to reduce unnecessary health-care expenditures while offering Canadians opportunities for care and interventions in a variety of settings, the future looks promising for occupational therapists. The profession of occupational therapy is entering an exciting time. Its landscape is ever changing, affected by advances in technology, policy emphasis on primary health care and self-management of chronic conditions, and the advancement of advocacy for occupational therapists to fulfill roles previously considered non-traditional. Occupational therapists are encouraged to promote the strength of evidence for occupational therapy interventions. This requires that the profession has leaders involved in the development of Canadian policy, to ensure Canadians have universal access to occupational therapy services that result in improved and cost-effective health and well-being outcomes.

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About the authors

Havelin Anand is director of government affairs and policy at CAOT. She may be reached at: hanand@caot.ca

Alison Douglas is director of standards at CAOT. She may be reached at: adouglas@caot.ca

Highlights: The October 2015 Occupational Therapy Month at CAOT

Havelin Anand, Giovanna Boniface, Janet Craik, Suzanne Maurice Kay and Julie Lapointe

Since 2004, October has been celebrated as Occupational Therapy Month (OT Month) in Canada (Klump, 2005).[1] The Canadian Association of Occupational Therapists (CAOT) and its staff believe that October is time to rejoice! It is a time to raise awareness about our unique contribution to people's health and well-being. This short article highlights some of the activities and successes of CAOT's October 2015 OT Month campaign. We hope this sharing of experience will spark interest in and commitment to participating in and implementing OT Month activities in 2016 so we can together achieve our vision—ensuring that occupational therapy is valued and accessible across Canada.

Inspirational Talks: 2nd rendez-vous

This half-day event held in Ottawa included a knowledge mobilization session, a networking activity and four keynote speakers. Transportation was offered from Kingston and Montreal to facilitate CAOT members joining us for this fun and thought-provoking lineup of activities. A jazz guitarist performed during the networking activity, adding to the already uplifted group spirit and cheerful atmosphere. Students from McGill University, Queen's University and the University of Ottawa contributed to the success of this event in many ways. The student-volunteer crew was involved in promotion, decoration and registration, and all students embraced this opportunity to build their professional identities. With a total of 74 CAOT members participating in this event, the Inspirational Talks is certainly an activity we look forward to expanding in years to come. You can watch some of the speakers on our YouTube channel at: https://www.youtube.com/watch?v=my8BMZQdTcA and https://www.youtube.com/watch?v=TrtXfOffvOM

Networking at the 2015 CAOT Inspirational Talks

Social media: #31dayOTchallenge

The #31dayOTchallenge was launched as a social media activity to raise awareness and promote occupational therapy during OT Month. The challenge was a simple request that Canadian occupational therapists speak to one person per day about occupational therapy during the 31 days of OT Month. Although the challenge was initially intended for Canadian occupational therapists, the campaign quickly went global and attracted contributions from 16 countries. With over 7500 messages posted on Twitter and Facebook during the month of October, the #31dayOTchallenge resulted in over 10 million social media impressions! In addition, the #31dayOTchallenge hashtag was consistently among the top two trending topics in health care on Twitter throughout the month (as measured by the Symplur Healthcare Hashtag Project: http://www.symplur.com/healthcare-hashtags). A post-challenge evaluation has been completed, indicating overwhelming support for CAOT to continue with this activity on an annual basis. Thank you to everyone who participated, and stay tuned for the next campaign during October 2016.

CAOT National Office: Open house

CAOT members and stakeholders joined staff in celebrating the official opening of the association's new home at 34 Colonnade Road in Ottawa on October 15, 2015. This new facility offers bright office spaces as well as a spacious boardroom equipped with the latest audio-visual technology for meetings and events. President Lori Cyr and executive director Janet Craik performed the official ribbon-cutting ceremony and kicked off the grand opening of our new home. Staff members took great pride in providing guided tours of the office and seized the opportunity to showcase some of the association's work and special projects. Attendees could appreciate what CAOT has to offer to the profession and its members, ask questions, and socialize with the executive and staff, as well as with some of the individuals who helped make the new location a reality. We look forward to

1 Prior to 2004, just a week had been set aside each year to celebrate occupational therapy.

opening our doors again next year and we hope that you will join us in sharing the enthusiasm and the commitment of CAOT's entire national office team!

CAOT-BC: Provincial activities

For the second year in a row, the Government of British Columbia proclaimed October to be Occupational Therapy Month. CAOT-BC was involved in 17 activities throughout the month, making it the busiest one on record for the chapter. Activities included provincial government engagement, consumer-focused exhibits, student presentations, a presentation to a large group of pharmacists, attendance at intraprofessional events and a celebration honouring CAOT-BC award recipients. As part of a public awareness campaign, CAOT-BC initiated meetings with five government ministers and received positive responses from each. We were granted a special honour following our meeting with the Minister of Health, when the Honourable Terry Lake tweeted "Nice to meet with @Caot_bc in #kamloops today. OT's big part of future health care in #BC." We would like to extend our gratitude to all of the volunteers who supported CAOT-BC activities during OT month—our success was possible because of your dedication and commitment.

Left to right: Giovanna Boniface, CAOT-BC managing director; the Honourable Terry Lake, British Columbia's minister of health; Catherine Backman, professor in the Department of Occupational Science and Occupational Therapy at the University of British Columbia.

Election: Playbook

In preparation for the October 19, 2015, federal election, CAOT developed the *Election Playbook 2015* to support occupational therapists in their advocacy efforts. This tool comprised a sample advocacy letter, potential questions and answers that could be used to discuss occupational therapy with candidates and a number of tweets occupational therapists could post. CAOT also delivered a Water Cooler Talk webinar on October 1, 2015, to present the *Playbook*. It was found to be "an invaluable resource" by CAOT members and garnered almost 600 page views over the month. After the election, CAOT posted Post Federal Election Resources (2015), consisting of a letter template that can be used to send congratulatory messages to the newly elected federal Members of Parliament.

Conclusion

OT Month is a time to celebrate and a time to promote the important work that we do. This dedicated month is a great opportunity to advocate for a just and inclusive society and position occupational therapy as a vital profession within health and social care systems. CAOT encourages all of its members to engage in OT Month activities with pride, in the recognition that working toward a world where people can engage in the occupations they need to do and want to do makes the world a better place.

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CAOT president Lori Cyr and executive director Janet Craik officially open the new CAOT National Office during the open house event.

About the authors

Havelin Anand is the director of government affairs and policy at CAOT. She can be reached at: hanand@caot.ca. **Giovanna Boniface** is the managing director of CAOT-BC. She can be reached at: gboniface@caot.ca. **Janet Craik** is the executive director at CAOT. She can be reached at: jcraik@caot.ca. **Suzanne Maurice Kay** is the human resources manager at CAOT. She can be reached at: skay@caot.ca. **Julie Lapointe** is the director of professional practice at CAOT. She can be reached at: jlapointe@caot.ca

Making strides for occupational therapist assistants

Tony Wang, Adrienne Yarrow and Elizabeth Steggles

In the spring of 2015, we (Tony and Adrienne) engaged in an intraprofessional, non-clinical, role-emerging fieldwork placement under the supervision of Elizabeth Steggles, who was then the director of standards at the Canadian Association of Occupational Therapists (CAOT). Tony was a first-year student occupational therapist at McMaster University, while Adrienne was a second-year student in the Occupational Therapist Assistant/Physiotherapist Assistant (OTA/PTA) Program at Mohawk College. Our goal was to assist CAOT to identify and introduce broader supports for the occupational therapist assistant (OTA) and support personnel community. This article describes our experience and what we learned.

Following the introduction of voluntary accreditation of Canadian OTA/PTA education programs in 2012, CAOT recognized the need for a review of the resources offered to OTAs and other occupational therapy support personnel. To this end, CAOT membership categories were revised in the fall of 2015 to reflect recognition of graduates of accredited OTA/PTA programs. There is also a plan to implement many of the suggestions that we identified in our placement.

Approach

During our placement, we worked under remote supervision and in collaboration with the staff of CAOT Membership Services and Learning Services. Together, we developed a project plan that included: engagement with the OTA community (students, practitioners and educators) by means of focus groups and an online survey to determine what resources were wanted, review of the CAOT website content that relates to OTAs and support personnel, presentation of our findings to CAOT staff and consultation on suggested changes, production of a final report, initial review and update of the *CAOT Position Statement: Support Personnel in Occupational Therapy Services* (2011) and preparation of this article for *Occupational Therapy Now* to share our findings and experiences.

Project findings

- Few student OTAs and working OTAs are members of CAOT, despite the fact that student membership is free.
- Occupational therapists and other health professionals have a lack of awareness of the scope of OTA practice. This appears to lead to a significant disconnect between occupational therapists and OTAs.
- Many OTAs reported that they are not always used appropriately or provided with adequate opportunities to use their skills.
- OTAs and support personnel expressed a desire for more networking opportunities.
- There is a need for a dedicated job posting resource for OTAs and support personnel.
- Additional professional development resources, specific to the needs of OTAs and support personnel, would be advantageous.
- Educators, especially in Ontario, have difficulty providing OTA fieldwork opportunities. This is a particular challenge for those programs that need to meet accreditation requirements.
- Recruitment of OTA fieldwork placement sites and preceptors relies heavily on educators' own personal networks.
- Educators use CAOT position statements, its support personnel video and publications, but OTA practitioners rarely use CAOT resources.
- OTA/PTA textbooks with Canadian content are needed.
- OTAs have the skills to complete interventions that are sometimes delegated to personal support workers (PSWs), who require additional instruction in order to perform the task appropriately. Conversely, OTAs are sometimes expected to carry out tasks outside of their scope of practice and more appropriately addressed by PSWs.
- There is a need to advocate for the role of OTAs in broader settings, especially in the community, including tasks such as setting up and demonstrating equipment or assistive devices and assisting with activities of daily living.
- The *CAOT Position Statement: Support Personnel in Occupational Therapy Services* (2011) and the *Practice Profile for Support Personnel in Occupational Therapy* (2009) require revision to reflect the changes presented as a result of accreditation.

Suggestions

The following suggestions, based on our project findings, were made to CAOT:

1. Update the OTA/support personnel section on the CAOT website to include:
   - Job postings
   - Resources, for example, OTA/PTA program accreditation information and professional development opportunities
2. Provide professional development opportunities

3. Create a networking forum
4. Promote greater understanding of the role of OTAs and support personnel among occupational therapists and other health-care providers
5. Advocate for the role of OTAs in community practice and other sectors
6. Promote the benefits of being an OTA preceptor and providing fieldwork placements
7. Publish OTA textbooks with Canadian content
8. Initiate an OTA student representative committee
9. Implement an OTA award of distinction
10. Introduce an OTA stream at the annual CAOT Conference
11. Review and update the relevant practice profile and position statement
12. Include an OTA column in *Occupational Therapy Now* dedicated to OTAs and support personnel

Reflection

The placement provided a non-traditional learning opportunity and, in an interview style, we would like to share our reflections of the experience.

Did you develop new skills?
Adrienne: I developed strong collaboration skills and gained a clear understanding of occupational therapist and assistant roles in a very practical way. I learned that knowing both the OTA and occupational therapist roles and competencies is crucial in order to clarify the significant contribution that OTAs make to occupational therapy interventions. I was also able to develop my project management skills by recording and tracking all our activities.

Tony: I read materials that I may not have come across otherwise, for example, the *CAOT Position Statement: Support Personnel in Occupational Therapy Services (2011)* and the *Support Personnel E-Learning Module* presented by the College of Occupational Therapists of Ontario and the College of Physiotherapists of Ontario (n.d.). These documents helped me to understand the role and scope of practice of OTAs and, in particular, the seven competencies of support personnel. Working with my OTA student colleague helped me to develop skills in intraprofessional collaboration. Running focus groups and contributing to this article have also helped improve my verbal and written communication skills.

What did you learn about CAOT from the experience?
Adrienne and Tony: We learned that CAOT provides support for the practice of occupational therapy and we gained an understanding of how a national association works. As we identified potential resources for OTAs, we were pleased that the staff of CAOT acknowledged and planned to implement many of our suggestions.

Were you able to contribute to the OTA community through this experience?
Adrienne: Yes! I feel I have supported my community and contributed to its development by connecting with colleagues in order to identify their needs. I will also continue to volunteer with CAOT and assist in implementing initiatives that support OTA practice.

Tony: When I graduate, I will have a better understanding of the OTA role and scope of practice that will foster collaboration and benefit my clients. In addition, I have contributed to the updating of the *CAOT Position Statement: Support Personnel in Occupational Therapy Services* (2011) and facilitated the development of additional resources for OTAs.

Did you find any drawbacks to the fieldwork placement experience?
Adrienne and Tony: Occupational therapy and OTA placements are on different schedules, so it was difficult to plan the joint placement. As it was, we only shared four weeks together, rather than a full eight weeks, which would have allowed us to accomplish more. Also, in an ideal world, the student occupational therapist would be participating in a final placement rather than a first-year one, so that more foundational knowledge could have been developed first. We recommend greater collaboration between occupational therapy and OTA programs in order to facilitate this kind of valuable intraprofessional learning experience.

Adrienne and Tony

About the authors

Tony Wang is a second-year student occupational therapist at McMaster University. He may be contacted at: nuow@mcmaster.ca

Adrienne Yarrow graduated from the Occupational Therapist Assistant/Physiotherapist Assistant (OTA/PTA) Program at Mohawk College and is working as a rehabilitation assistant at Hotel Dieu Shaver Rehabilitation Centre. Adrienne may be contacted at: amyyarrow@live.com

At the time of the fieldwork placement described in this article, **Elizabeth Steggles** was transitioning into retirement from her position as director of standards at CAOT. She may be reached at: elizabethsteggles@rogers.com

Were you able to take advantage of each other's strengths?
Adrienne: Tony's research background was a great asset to the project, especially his ability to locate information from academic articles.

Tony: The project required us to coordinate with different parties, so we had to communicate well in order to stay on task. Adrienne's organizational skills were particularly helpful. The cooperative working environment enabled us to identify each other's skills in order to assign tasks appropriately.

What impact did speaking to the OTA community have on you?
Adrienne: I realized that I was in the same situation as the OTAs I was trying to help—that is, there are limited resources available for the OTA community. It also promoted a greater understanding of how I can contribute more myself, and I learned the value of expanding the depth and breadth of my experience.

Tony: I now realize that there is disconnect between occupational therapists and OTAs in terms of intraprofessional collaboration. This has motivated me to advocate for the OTA community to my fellow student occupational therapists and helped me to develop my own skills in working effectively with OTAs.

What advice would you give to others experiencing a similar opportunity?
Adrienne and Tony: It is imperative that occupational therapists and OTAs have a good understanding of each other's scope of practice and each other's strengths and abilities. Only then is it possible to determine each person's role in developing a project plan together.

Did you learn something new about each other's roles?
Adrienne: I learned that the occupational therapy profession is quite vast and offers many unexplored career avenues for OTAs. There is opportunity for occupational therapists to advocate for OTAs in order to enhance the delivery of occupational therapy services.

Tony: I gained perspective regarding the OTA scope of practice and the different roles of OTAs that may contribute to assisting clients in their occupational performance. Their skills are a definite asset to any health-care team.

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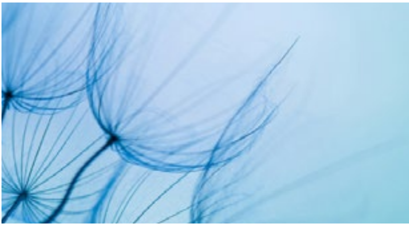
MENTAL HEALTH



Occupational therapy for people with military-related post-traumatic stress disorder: A call for action in Canada

Erin Rivers and Sara Saunders

Post-traumatic stress disorder (PTSD) is a complex, life-altering mental health condition that can cause significant occupational dysfunction and decrease quality of life (Lopez, 2011). Individuals with PTSD have been exposed to one or more traumatic events and experience symptoms relating to cognition, mood, behaviour, arousal, reactivity and re-experiencing of the event, often causing significant distress and functional impairment (American Psychological Association, 2013). PTSD can be a chronic condition, and can affect all aspects of the lives of those diagnosed with it, as well as their families and communities (Lopez, 2011; Dekel & Monson, 2010).

In military populations, PTSD may arise following traumatic events such as combat, imprisonment and loss of comrades (Richardson, Elhai, & Sareen, 2011). The conflict in Afghanistan resulted in an estimated one in five service members who returned from combat being diagnosed with PTSD (Dekel & Monson, 2010) and an increase in PTSD-related suicide (Paré, 2013). Additionally, the combined prevalence of PTSD and depression among current Canadian Forces (CF) service members is estimated to be 15%, with a lifetime prevalence estimated to be greater than 30%. The prevalence of chronic PTSD is even greater among veterans than among service members (Paré, 2013). These estimations may be lower than the actual occurrence, as a result of under-reporting due to stigma and negative CF implications, such as losing one's post (Paré, 2013; Government of Canada, 2015).

Despite the significant number of military personnel and veterans being impacted by PTSD, mental health support options, whether provided by non-military resources (civilian clinics) or military resources (CF or Veterans Affairs Canada [VAC] services), are not ideal. Civilian mental health programs can be costly, and may not be appropriate given the unique backgrounds, schedules and concerns of those with military-related PTSD (Elliot, 2010). Yet, navigating internal military mental health resources can also be challenging. Service members may face a number of barriers within the CF and VAC, including lengthy paperwork, unclear treatment qualifications and requirements, work constraints, difficulty accessing disability pensions and mental health services, and return to combat (Cudmore, 2013; Stewart, 2014). Additional barriers to service access can include stigmatizing societal attitudes and beliefs, as well as limitations related to PTSD symptoms (Paré, 2013).

With a substantial number of service members and veterans affected by PTSD, and concerns related to their care, occupational therapists have much to offer in addressing the needs of these individuals. Therefore, the aim of this paper is to illustrate the occupational challenges faced by service members and veterans living with PTSD, and to highlight some ways occupational therapists can help foster recovery and resilience among this population.

The role of occupational therapy

During the First and Second World Wars, early occupational therapists, referred to as "ward occupation aides," treated soldiers with physical and mental impairments (Canadian Association of Occupational Therapists [CAOT], 2012). To this day, occupational therapists continue to have a unique perspective that allows them to grasp the complexity of the issues faced by service members and veterans (CAOT, 2012). Occupational therapists consider the person, their environment and their occupation, as well as the interactions between these elements (Law et al., 1996), and PTSD impacts all of these spheres. Therefore, occupational therapists are in a unique position to identify facilitators and barriers to occupational performance and design evidence-based and client-centred interventions to support service members with PTSD and their families.

The impact of PTSD on occupation

The effects of PTSD can be observed in all areas of the lives of service members and veterans, impacting both their relationships and their occupations. In terms of relationships, social isolation is often experienced by people with PTSD because they may have difficulty forming and maintaining positive, meaningful relationships with family members and those in their broader communities (Plach & Sells, 2013). Their relationships with family members can be further complicated by symptoms of PTSD, leading to poor conflict management and problem solving, as well as the manifestation of aggressive behaviour when family members are perceived as a threat (Dekel & Monson, 2010). These effects can be compounded by misunderstandings of the disorder, leading to further mistreatment or isolation of service members from their families (Lopez, 2011). People with PTSD may also lose their connections to other people within their communities due to emotional detachment, in addition to avoidance of and disinterest in various activities and places (Dekel & Monson, 2010). Societal stigma and lack of understanding of PTSD further complicate community engagement (Plach & Sells, 2013).

The symptoms of PTSD can have many detrimental effects on occupation. Many people experience difficulties fulfilling occupational roles due to the impacts on relationships, as described above, as well as due to grief and elevated stress related to symptom

progression, medical leave or loss of military identity through service discharge (Paré, 2013; CAOT, 2012). Occupations can be further impacted by sleep disturbances and insomnia related to nightmares, flashbacks and work stress, significantly worsening daytime function and quality of life (Plach & Sells, 2013; Blount, Cigrang, Foa, Ford, & Peterson, 2014). Self-harming behaviours related to substance abuse can also be seen in this population (Plach & Sells, 2013; Paré, 2013; Robinette, Burker, Najera, & Radomski, 2012), and adversely impact occupations that support health and well-being. Individuals with PTSD may have difficulty driving due to panic attacks, fear avoidance and flashbacks, and may have maladaptive driving behaviours, including speeding and disregarding the rules of the road (Lopez, 2011; Plach & Sells, 2013; CAOT, 2012). Many service members with PTSD experience trouble with self-care following return from deployment, possibly due to physical injury, discharge or a sudden change in structure, coupled with changes in mood and volition (Plach & Sells, 2013). All of these issues can make returning to, finding and keeping employment, or excelling at school, extremely difficult (Plach & Sells, 2013; Lopez, 2011). Finally, it has been found that service members with PTSD may decrease engagement in healthful leisure pursuits due to blunted affect, reduced capacity for enjoyment and a diminished positive future outlook (Robinette et al., 2012). When these factors are all viewed together, it is possible to see the impact PTSD can have on a person's occupational identity, defined as the complex sense of who one is and seeks to become as an occupational being (Kielhofner, 2008).

Occupational therapy intervention

Occupational therapists can address the impact of military-related PTSD through: 1) interventions with individual service members, veterans and their families, 2) collaborating with interprofessional teams, 3) special initiatives such as those involving therapy animals and peer involvement, and 4) involvement in policy creation and research.

Individual and family interventions

When working with individuals with PTSD, occupational therapists can provide trauma-informed care by maintaining an understanding of trauma and the clients' need for physical and emotional safety throughout the intervention. The therapist must respect and seek to understand the clients' experiences of trauma and the effects these experiences have on the clients' daily lives (Kitchen & Hosegood, 2015). This can involve working to help service members accept support (Robinette et al., 2012) while providing education and support to them and their families. Once rapport and trust have been established, occupational therapists can teach self-management skills for PTSD symptoms, including goal setting, selecting and scheduling meaningful occupations, sleep hygiene, relaxation techniques and stress reduction methods. Such new skills can foster resilience and occupational performance while promoting gradual resumption of participation in self-care, social, productive and leisure occupations, further facilitating the re-emergence of an occupational identity (Robinette et al., 2012; Lopez, 2011).

To further support client goals, occupational therapists can collaborate with psychologists and counsellors to implement PTSD-specific motivational and psychotherapy interventions (Lopez, 2011). These have been shown to enhance optimism and commitment to change while reducing some PTSD symptoms underlying occupational dysfunction (Richardson et al., 2011). For current and former service members with PTSD, these interventions are best orchestrated in a highly structured manner to mirror familiar regimented military routine (Blount et al., 2014).

For those service members who are working, occupational therapists can advocate for intensive daily outpatient sessions to be integrated with reduced military duties, allowing for a focus on recovery with plenty of opportunities to generalize learning. Occupational therapy sessions may consist of daily goal setting, role-play or virtual reality scenarios, structured use of imagery, exposure to previously distressing stimuli and situations, the introduction of occupational adaptations and assistive technology, and feedback and coaching sessions (Robinette et al., 2012; Blount et al., 2014). These interventions are aimed to ultimately facilitate a service member's smooth and efficient return to and maintenance of regular work duties (CAOT, 2014). Additionally, vocational support and driving training have been shown to effectively assist veterans with PTSD to recover and increase their resilience (Richardson et al., 2011; CAOT, 2012). Where there is interest, occupational therapists can also support and encourage client involvement in altruistic work, which supports healing for trauma survivors, empowering them to act as agents of positive change (Silver, 2007).

Family-based interventions involving home visits, interviews and standardized assessments enable occupational therapists to become familiar with service members' social resources and any relationship concerns (Lopez, 2011). Occupational therapists can encourage service members to reach out for positive social support, a crucial protective factor implicated in resilience and recovery (Lopez, 2011).

Community interprofessional teams

Specialty interprofessional teams can circulate regularly within the CF community, interacting with members of the military community and building rapport, as well as increasing the accessibility of mental health care, all while also improving the team's cultural competency (Robinette et al., 2012). Cultural competency is an important concept for members of such teams to understand, given the uniqueness of military culture. Practicing cultural competence involves increasing one's awareness, attitudes, knowledge and skills in order to work equitably and effectively with populations whose members have a different cultural background than one's own (CAOT, 2009).

Therapy animals and peer involvement

Occupational therapists can link service members and other stakeholders to PTSD support services to increase resilience and

About the authors

Erin Rivers, CSEP-CEP, is a recent graduate of the occupational therapy program at McGill University. She may be reached at: erin.rivers@mail.mcgill.ca **Sara Saunders, PhD, OT(C),** is an assistant professor (professional) and associate director of the occupational therapy program at McGill University. She may be reached at: sara.saunders@mcgill.ca

social support (Lopez, 2011). For example, psychiatric service dogs have been found to provide physiological, psychological and social benefits to CF veterans (Gillet & Weldrick, 2014). The use of therapy animals may improve acceptance of mental health teams within the CF, as this may enhance engagement, feelings of security and motivation among service members and veterans (Robinette et al., 2012).

Occupational therapists may also help to coordinate peer programming, which involves integrating service members and veterans who are successfully self-managing PTSD into activity programming and education. Peer programming has been found to increase participants' receptivity and motivation, as well as to improve their perceptions of PTSD as being understandable and manageable (Paré, 2013; Lopez, 2011).

Policy and research support

Unfortunately, despite occupational therapy's roots in the military, occupational therapists are not currently well represented within the CF, which has led CAOT to lobby for an increase in occupational therapy representation (CAOT, 2014). In addition to these efforts, occupational therapists can work with the CF, VAC and other governmental bodies to research the unique occupational needs of CF members and veterans, as well as the most effective PTSD interventions and relevant protective factors. Research can explore causes of occupational injustices related to mental health stigma, poor continuity of care and service access issues, among other topics. Occupational therapists can also advocate for the development of preventive education and practices, mental health screening, policy improvements such as workplace mental health protection (CAOT, 2014) and training to develop military cultural competency in health-care providers (Stewart, 2012).

Conclusion

Military-related PTSD affects a substantial number of CF members and veterans (Paré, 2013). It can have a significant negative impact on occupational identity, roles and performance, and can lead to decreased well-being and quality of life (Plach & Sells, 2013; Robinette et al., 2012). As discussed in this article, the needs of Canadian service members and veterans with PTSD are not adequately being met. Occupational therapists are well positioned to make an important impact in the treatment of PTSD through the use of client-centered, holistic interventions that enable occupational identity, roles and performance, as well as recovery and resilience.

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Editor's note: To read more about the role of occupational therapy with military and veteran populations, check out pages 23-26 in the September 2015 issue of *Occupational Therapy Now,* found at: http://www.caot.ca/default.asp?pageid=394

OLDER ADULTS

TOPIC EDITOR: SANDRA HOBSON

The home and its symbolic importance in the receipt of home care services

(Hedy) Anna Walsh

Government emphasis on community-based care (Williams, 2006) has created a need for health-care providers to acknowledge the unique characteristics and symbolic meanings of the home environment where home care services are being received (Gitlin, 2003). The purpose of this article is to highlight the importance and symbolic meaning of the home environment for older adults in receipt of home care services.

"Aging in place" policy

Budgetary cuts to health-care programs in Canada have led to the introduction of "aging in place" policies in most provinces, encouraging older adults to remain in their homes and receive home care services. Embedded in this policy shift is the government's mandate to reduce health-care expenditures (Keefe, Knight, Martin-Matthews, & Légaré, 2011), because home care costs are perceived to be lower than those of hospital or institutional care (Legault, 2011). Although home care programs vary in design and delivery across provinces (Health Council of Canada, 2012), they typically include an array of professional services, such as nursing care, social work, occupational therapy, physiotherapy, speech therapy, dietitian services, respite care, and personal support services to assist with dressing, feeding, bathing and personal care (Romanow, 2002).

Occupational therapists are involved in the referral and follow-up processes of home care service delivery and well equipped to contribute to the multitude of health-care and social issues that affect older adults living in the community (Kasperski, Power, & VanderBent, 2005). In addition to their roles as advocates for individual clients, occupational therapists have the potential to guide policy development in the expansion of home care services (Egan & Kadushin, 1999), to optimize the experiences of older adults living at home (Gantert, McWilliam, Ward-Griffin, & Allen, 2008).

Canada's older adult population

According to the Canadian 2011 Census of Population, there were approximately 5 million (4,945,000) older adults aged 65 and over in Canada, of whom 92.1% resided in private households or dwellings, while 7.9% lived in residences for older adults or health-care and related facilities (Statistics Canada, 2015). Among older adults aged 90 years and over, 28.7% lived alone, 12.2% lived as a couple and 15.7% lived with people other than their spouses, for a total of 56.5% living in private households. The remaining 43.5% resided in collectives such as long-term care homes or residences for older adults (Statistics Canada, 2015). It is logical, therefore, to presume that a large number of older Canadians may receive home care services.

Research on home environments

Ongoing policy commitments to provide home care services have greatly expanded the need to consider the home environment from different perspectives (Gitlin, 2003). The aim of home care services is to maximize the health and safety of older adults to enable them to remain independent in their homes (Demiris, Oliver, & Courtney, 2006). Previous research has emphasized the temporal properties of the home (e.g., housing needs and living arrangements), safety in the prevention of falls (Lang, Edwards, & Fleiszer, 2008), and adaptive devices, as well as home-based interventions to enhance individuals' abilities to engage in activities of daily living (Golant, 2003) and moderate underlying physical barriers that limit access to the home (Iwarsson, Nygren, Oswald, Wahl, & Tomsone, 2006). However, despite its importance as the site where services are received, the "home" and its symbolic importance (Gitlin, 2003) has been a rather neglected area of concern (Martin-Matthews, 2007). Sufficient information pertaining to the symbolic use and meaning of space (Gitlin, 2003) is lacking (Aronson, 2004).

Furthermore, there seems to be both a temptation and a tendency in the literature to apply common principles to every home setting. Current studies of the home environment centre more on environmental barriers, rather than on its importance as the place where social relations and practices are expressed (Aronson, 2004; Gitlin, 2003). The home environment is rarely represented as a complex setting in which cultural norms are preserved. Health-care providers are required to develop positive therapeutic relationships with clients (Preto & Mitchell, 2004) that respect home spaces and their cultural and symbolic significance (Kuo & Torres-Gil, 2001), while simultaneously maintaining professional boundaries.

Concerns about delivering services in the home environment

Examination of the home environment relative to other

health-care environments has led to the conclusion that the home environment is, in fact, very different. Concerns about the home environment relate to its ability to allow for the safe provision of complex medical services, as it is an environment designed for daily living, rather than for the provision of home care services (Porter, 2005). There is no regulation of private family homes where home care services are received and these dwellings are individually maintained with respect to their distinct individual structure and composition (Gitlin, 2003). Unlike hospital environments, which are regulated to optimize the health and safety of both care professionals and clients, home environments are not, and are often ill-equipped for the provision of health care (Gitlin, 2003).

Privacy matters (Porter, 2005) and the personal representation of space are also extremely relevant in the home environment, where assistance with bathing and dressing and other services are provided. In this context, the home environment is not only a place where individuals reside and receive services, but it is also intricately connected to the individual's personal identity, privacy, cultural beliefs and overall sense of security (Preto & Mitchell, 2004). Home care clients identify the home setting as a unique environment, which, unlike the hospital setting, is not for public use. Its cultural and symbolic meanings (Gitlin, 2003) require home care providers to be sensitive to and respectful of private areas (Woodward, Hutchison, & Abelson, 2001).

Attachment to the home

The attachment to the home emerges as an important aspect in the provision of care, due to its symbolic meaning and the fact that it serves as an extension of an individual's identity. The association of "home" within the community, and its relationships to an individual's sense of belonging, reveal the home to be more than just a place of residence (Leith, 2006). As people age, the home becomes a reminder of a multitude of experiences that have been shared with others. Apart from familiarity and access to community resources, the preference to "age in place" is often attributed to a physical location and the right "fit" between the environment and the individual's physical and psychological abilities (Cook, Martin, Yearns, & Damhorst, 2007).

The meanings attached to personal space should be considered in the development of strategies that enable older adults to successfully "age in place" and maximize their quality of life (Gitlin, 2003). In the contemporary climate of health-care reform, issues related to the home environment and individual experiences in receiving care are critical to understand (Romanow, 2002). Articulating their importance in the provision of care could lead to safer home care practices, increased client engagement and potentially more cost-efficient care (Anderson, Tang, & Blue, 2007).

Recommendations

1. Occupational therapists are encouraged to develop strategies to ensure that the meaning of "home" and its symbolic and cultural representations, which are highly personal to each client (Preto & Mitchell, 2004), are incorporated into intervention plans.
2. Ongoing educational opportunities for student occupational therapists and practitioners should highlight individual clients' experiences and feelings related to the geographical space called "home" (Leith, 2006).
3. Occupational therapists need to define professional boundaries and consider individuals' privacy and control over their living space (Martin-Matthews, 2007).
4. Strategies for engaging with clients in the home should reflect how older adults belonging to differing ethnocultural groups negotiate their home spaces and the associated cultural and symbolic significance of their home environments (Kuo & Torres-Gil, 2001).
5. More research is required related to the uniqueness of the home environment, in which private and intimate spheres of individual space affect older adults and their experiences in the receipt of home care services (Martin-Matthews, 2007).

Conclusion

The home environment differs from public facilities such as hospitals, long-term care facilities, or clinics (Martin-Matthews, 2007), whereby provision of medicalized care in a client's home must account for an individual's property and preferences for care (Sharkey & Lefebre, 2008). Although past studies have expanded analysis of the home environment from different perspectives, its unique symbolic importance is often overlooked (Gitlin, 2003).

In addition to the importance of considering the physical barriers of the home that may limit the access of older adults (Iwarsson et al., 2006), individual meanings in the receipt of home care services must be better understood (Kitchen, Williams, Pong, & Wilson, 2011). It is hoped that this article will spur interest in incorporating into home care services an understanding of the importance of home spaces and their associated symbolic representations (Martin-Matthews, 2007).

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About the author

(Hedy) Anna Walsh, PhD, MHSc., CHE, LLB/J.D., BScOT, is an occupational therapist, lawyer and health administrator, currently working as an adjudicator for the Toronto Licensing Tribunal and as a public member for the Council of the Ontario College of Social Workers and Social Service Workers. She may be reached at: hedy.walsh@utoronto.ca

E-HEALTH AND ASSISTIVE TECHNOLOGY

TOPIC EDITOR: PAM MCCASKILL

Finding one's voice thanks to technology

Danielle MacDougall

The ability to communicate is arguably one of the most important and innate components of our being. Throughout my occupational therapy educational program, I have learned the importance of reading my clients' communication, whether physical, through body language, or verbal, through words. Communication enables therapists to support clients in ways most meaningful to them, because we cannot possibly be client-centered if we don't understand the needs of those we work with. Luckily, adaptive technology is available to support the independence of clients who are unable to speak, by helping them to express their needs, communicate with the world and participate in occupations requiring communication.

In this article I will share Penny Kitchen's story. Beginning as Penny's aide and now as her friend, I have witnessed first-hand her difficulty communicating her needs and wishes without the production of speech. For Penny, the ability to express herself has been a challenging and never-ending journey. Communication is an integral part of who she is, necessary for maintaining her many relationships, community responsibilities, self-care wishes and leisure activities. Although one could argue that communication is equally important for everyone, for Penny it is even more so, as she is physically reliant on an aide and needs to provide direction for assistance with her basic activities of daily living.

Due to a complication at birth, Penny has spastic athetoid cerebral palsy. Although this impairment prevents her from using spoken language, it has not stopped her from having an active and engaging social as well as civic life. In addition to being a dedicated daughter, sister and aunt, Penny is a respected and active community member, avid volunteer, entrepreneur, university graduate, devoted church member and nationally competing boccia athlete.

The road to independent communication was neither easy nor quick for Penny. The first and most natural method of communication for her was to use facial gestures and body language. At the age of seven, she used a head pointer with a spell board to communicate, along with a typewriter. These allowed her to write letters, complete lessons and do art. At 13, Penny and her family developed a way to communicate by using eye movements, with the assistance of an interpreter. This system involves asking closed-ended questions with Penny looking up for yes and down for no. Additionally, Penny spells out words or sentences using a method in which the alphabet is broken into three sections. These methods may appear basic, low-tech, limited and full of barriers, yet they have been Penny's primary and most consistent means of communicating since her teen years.

At 16, Penny got her first high-tech augmentative and alternative communication (AAC) device: Handy Voice, or as Penny calls it, "the talking shoebox." Since then, Penny has used six other communication devices and, with this support, completed a bachelor of commerce degree at Saint Mary's University. Penny's AAC devices have changed as her communication skills, needs and role expectations have changed. The latest "game changer" in the realm of adaptive communication technology has made it easier for Penny to converse with her family, friends and community members, as well as to use technology independently.

Penny says that AAC aids have made a "huge impact" on her life and her newfound independence would not be possible without her latest communication device: the Accent 1200 with NuEye eye gaze technology. Penny chose this device in the summer of 2013 because it not only offers eye gaze control as a method of access, allowing her to type words and sentences to produce audible speech, but compared to other devices, it runs more smoothly without freezing. Moreover, it gives her control over her environment as it works as a remote control for her television, light switches and radio. Additionally, this new device has made it possible for Penny do things she has never done before, like sing "Happy Birthday" and Christmas carols or read the speeches she writes and delivers at conferences nationwide. This device enables Penny to live a more inclusive life in the community. Furthermore, because the device works as a computer, Penny can answer emails, play games, surf the web, run a business and design greeting cards, all with the movement of her eyes. As well, Penny expects that her new device will

About the author

Danielle MacDougall graduated from Dalhousie University in Halifax, Nova Scotia, in 2015 and is currently practicing as a school-based occupational therapist in northern Alberta. She may be reached at: danielle.macdougall@dal.ca

help her gain autonomy in other aspects of her life, such as communicating with health-care professionals. However, even with the newest and coolest gadgets, there are still limitations and a substantial learning curve. Though the new device uses sophisticated eye gaze technology and is faster than older technology, it still requires practice for Penny to keep up with the pace of a conversation. Each letter needs to be stared at and then input, so it is both energy and time consuming to write words, let alone entire sentences or paragraphs. Although the Accent 1200 seemed like the ideal device for Penny, there were still many barriers to obtaining such a highly specialized piece of technology, most notably the hefty price tag. At $25,000, this device was definitely an investment, and Penny is quick to thank the community for helping her afford it. A combination of Penny's, her family's and her friends' unrelenting advocacy coupled with Penny's inclusive, enthusiastic and active community lifestyle positively contributed to the fundraising success. Penny's latest device was funded entirely by donations from her church and other organizations, which again highlights her strong relationships and engagement in her community.

Low- and high-tech devices have played a vital role in Penny's life, helping her to converse with loved ones, gain an education, play boccia and be involved in the community. Since Penny has only had her latest device for a couple of years, she is still learning and fine-tuning her skills. Despite the time lag when using her device to communicate, Penny maintains that having an AAC device is absolutely a necessity for people like her who live independently. "Independence" is a word we often talk about in occupational therapy. As practitioners, we can help support the occupational goals of our clients with communication impairments by advocating for adaptive communication technology and working collaboratively with speech-language pathologists (SLPs). In order to be client-centred, we need to be able to communicate with our clients and understand their needs, because as we know, not being able to speak is not the same has having nothing to say.

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Penny using her newest ACC device.

STUDENT PERSPECTIVES

TOPIC EDITORS: LAURA HARTMAN AND CHRISTINA LAMONTAGNE

The community: Enabling grounds for occupational therapy students

Dominique Leclerc, Noémi Cantin and Nancy Baril

During my occupational therapy studies, I noticed that, along with my student colleagues at the Université du Québec à Trois-Rivières (UQTR), I have a profound desire to help people. We are a group of young adults who are committed and sensitive to the needs of people around us. For most of us, the desire to be helpful dates back much farther than the start of our post-secondary studies. Indeed, several factors may inspire the choice to study occupational therapy, but an interest in helping and guiding vulnerable people seems to be a frequently occurring influence on this decision (Craik, Gissane, Douthwaite, & Philip, 2001).

Throughout our studies, our knowledge as well as our professional and personal skills have expanded to complement this desire to help. The academic curriculum, which aims to develop our understanding and skills in relation to the different roles we will be playing as occupational therapists, focuses on students' knowledge, know-how and self-management skills so that we can enable people to engage in occupations. Now that my journey as a student is coming to an end, however, I realize that the acquisition of those competencies was greatly influenced by my practical experiences, positive or negative, outside the university walls, notably during my fieldwork placements, but more specifically through my community involvement as a volunteer. Thus, I believe that knowledge gained in an academic context benefits from being integrated into practice as early and as often as possible. Just as the saying goes, "it takes a village to raise a child," one could also say that "it takes a community to raise an occupational therapist."

The community: A village

In the present societal and economic context, it would be idealistic to believe that health and social services succeed in responding to all community members' needs. Quite often, it is community organizations that try to fill service gaps in response to the perceived needs of their members. However, current funding does not always allow these organizations to perform their missions (Coalition des tables régionales d'organismes communautaires & Table des regroupements provinciaux d'organismes communautaires et bénévoles, 2012).

In order to support community organizations and foster the development of the communities they serve, UQTR developed a "community-based intervention project" course titled Projet d'intervention communautaire (PICOM). This course enables the development of partnerships between students and community organizations in order to meet the tangible action needs of the latter and the learning needs of the former. During the second year of my occupational therapy program, I took this course with three fellow students. We contacted Anna et la mer, a community organization that offers services throughout Quebec to children who have a loved one with a mental health condition, a population sometimes forgotten by health and social services (Sanders & Szymanski, 2013). After exploring several avenues, we chose to create a workshop for students in grades 3 and 4 on the topic of mental health promotion, which we presented in a few schools. Even though the project is now done, Anna et la mer can continue to offer the workshop. In response to an expressed need, we took the opportunity to collaborate with this organization and contribute our personal and professional skills.

We can posit that numerous organizations and members of the community have needs that student occupational therapists would be able to meet with their knowledge of the dynamic interaction between person, environment and occupation. The goal of student involvement would not be the performance of occupational therapy interventions by those who do not yet hold the title of occupational therapist, as that would be unethical and illegal. Rather, student occupational therapists should ask themselves which community needs they could help to meet, given the knowledge and skills they have developed and are continuing to develop. This volunteer involvement, whether donating time, effort or knowledge, could prove advantageous for members of the community. Examples of potential beneficiaries might include a group of older adults in a long-term care facility who could benefit from a few hours of help per week to engage in a meaningful activity, a community organization offering parent-child early stimulation groups that is short on volunteers, or adults with a mental health condition participating in activities organized by a local day program who enjoy the opportunity to interact with students in professional programs.

The community: A village rich in learning

If student occupational therapists can bring value to their communities, would the community not be one of the most accessible sources of opportunities that students can use to improve their skills and put their academic learning into practice? In the academic curriculum, the development of professional identity and practical skills generally occurs during fieldwork placements. However, placements are time-limited experiences, and as the prospect of starting one's first job as an occupational therapist can seem stressful for many students, it could be interesting to consider volunteering and community involvement as an experience that positively reinforces feelings of proficiency and self-efficacy. Moreover, with some mentoring, experiences in the community can help student

occupational therapists to develop their practice reasoning skills and their ability to work with individuals from different age groups; they can experience building rapport with clients and discover existing community resources (Hoppes and Hellman, 2007).

Incidentally, beyond the development of professional skills, the literature provides a wealth of studies exploring the motivations of people to engage in volunteer work or community service (e.g., Clary et al., 1998; Dwyer, Bono, Snyder, Nov, & Berson, 2013). For instance, some may choose to engage in such activities for personal reasons (e.g., to improve personal well-being), for professional reasons (e.g., to make contacts or get promoted at work) or for the sake of the work itself. Specifically, it has been demonstrated that students primarily undertake community involvement activities for altruistic reasons, as well as to gain work experience and to further their knowledge (Brewis et al., 2010; Smith et al., 2010).

Opportunities for engagement in the community are numerous and may take various forms in order to respond to the different needs and personal motivations of students. Thus, a student may choose to volunteer outside the university or to become involved in the community through engagement in a structured program designed to promote learning through community service, such as the PICOM project at UQTR.

Sharing between the community and occupational therapy students: Learning through community service

Student occupational therapists generally have a positive attitude toward community involvement, are sensitive to their communities needs and feel that they have the necessary abilities to meet those needs (Hoppes & Hellman, 2007). However, some authors have asserted that the perceived pressures of academic workload and lack of free time contribute to the fact that many students hesitate to get involved as volunteers, despite being interested in doing so (Brewis, Russel, & Holdsworth, 2010).

Taking these perceptions into account, partnerships between occupational therapy programs and community organizations, as part of a structured approach to learning, represent an interesting avenue to encourage students to get involved in their communities, despite their academic workload. Such an approach has the potential to promote a realistic image of community involvement and to support students in the integration of this new occupation in their daily lives. Through such programs, students and teachers have experienced meaningful and empowering learning opportunities that allowed them to meet students' learning needs while meeting the needs of the community and actualizing occupational therapy's values (including engagement, participation, learning through experience; Hansen et al., 2007). This evidence could encourage students to take a first step toward community involvement, which could be the beginning of engagement in a new meaningful occupation that will endure long after graduation.

As for me, my various volunteering experiences allowed me to develop the interpersonal skills required to interact with a variety of clients and stakeholders, to put my knowledge into action, to engage in helping relationships, and to develop my collaboration and communication skills, all while contributing to innovative projects and increasing my sense of competence and level of confidence. In retrospect, it is obvious that these experiences have also left a mark on my career path and my occupational therapy practice, principally affecting my view of the exceptional potential of community involvement and the relevance of developing similar projects in clinical environments.

Conclusion

By participating in volunteering and community involvement activities, which can enhance their sense of competence, support their interest in helping others and offer the community a response to certain needs, student occupational therapists become exposed to a rich experience that not only empowers them as future professionals but also empowers the members of the community in which they live and learn. This exchange provides meaning through the balance it creates.

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About the authors

Dominique Leclerc, MSc, erg., was a student in the occupational therapy program of the Université du Québec à Trois-Rivières (UQTR) at the time of writing this article. She is now a school occupational therapist at the Centre François-Michelle in Montreal, Quebec. She may be reached at: dleclerc@francois-michelle.qc.ca. **Noémi Cantin, PhD, erg.,** is a full-time professor in the occupational therapy department of UQTR. **Nancy Baril, erg., MSc,** is a clinical professor in the occupational therapy department of UQTR.

Chronic pain: Finding solutions with clients as partners

Susan Yee, Kahla Wellum and Kristen Wilson

One in five Canadian adults experiences health issues involving chronic pain, placing a heavy burden on the health-care system (Moulin, Clark, Speechley, & Morley-Forster, 2002; Schopflocher, Taenzer, & Jovey, 2011). The experience of chronic pain and associated pain behaviours may result in a downward spiral of disengagement and decreased ability to participate in daily occupations (see Figures 1 and 2). In fact, more than 50% of Canadians receiving care at pain clinics have severe levels of depression, and almost 35% have thought about suicide (Choiniere et al., 2010).

Occupational therapists practicing in mental health are well-suited to working with individuals living with chronic pain because they can employ a biopsychosocial perspective, which is beneficial for understanding the complexities of chronic pain. Organizations of pain specialists recommend a comprehensive approach to pain. The Canadian Pain Coalition in collaboration with the Canadian Pain Society (Stinson & Montgomery, n.d.) and Pain BC (n.d.) provide extensive free information, including resources that address non-pharmacological interventions. Unfortunately, many health-care providers are not aware of these resources and focus mainly on medication and physical modalities. Non-pharmacological approaches include mindfulness meditation (Zeidan, Grant, Brown, McHaffie, & Coghill, 2012) and somatic education such as the Feldenkrais Method® (Hillier & Worley, 2015). This article will share various perspectives on chronic pain management, informed by an occupational therapist's professional experience, a project completed by her students, as well as lessons learned from clients and the community.

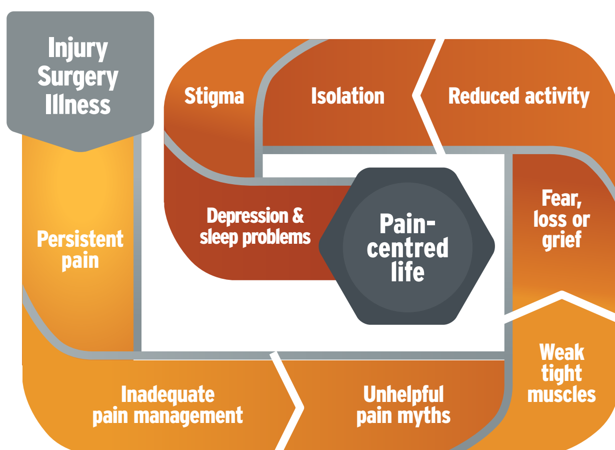

Figure 1. **The pain spiral. Reprinted with permission from Pain BC.**

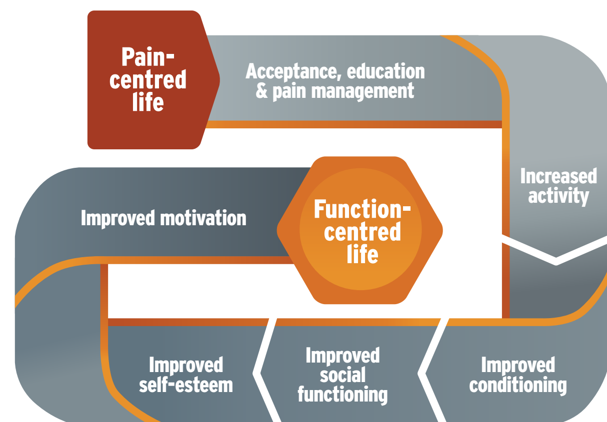

Figure 2. **Breaking the pain spiral. Reprinted with permission from Pain BC.**

Working with clients living with chronic pain

Many referrals that I (first author) receive are from clients with chronic pain, mental health concerns and/or addiction issues. These clients report limited relief from traditional treatment options such as physiotherapy, massage therapy and medications. They are unable to work, which leads to financial crises, poor sleep and high stress. Society often stigmatizes people with chronic pain, promoting notions that they are malingering or exaggerating their problems. In addition, my clients are also often shamed for having a mental health or addiction problem.

I started to use the Feldenkrais Method®, current research on pain and psychosocial principles to enable my clients to engage in meaningful activities. I have found the following to be the most beneficial activities for clients: creating a positive support system, setting a practice of gratitude (e.g., recording three things for which you're grateful every day), appreciating the importance of laughter and joy, developing the ability to give back to society, learning about chronic pain, practicing relaxation techniques to address poor sleep, and having hope.

An excellent book, *Explain Pain* (2nd ed.) by Butler and Moseley (2013), illustrates the relationship between activity level and pain experienced. According to the authors, there is most often either gradual decline into chronicity when a person with pain is fearful of movement, or a person ignores pain and keeps doing activities until the pain is unbearable. I see the latter in many of my clients whose lifestyles prior to major illness involved ignoring their bodies, living very fast-paced lives, having inadequate sleep, and placing self-care as a

low priority.

I find the Transtheoretical Model and its stages of change (Prochaska, Norcross, & DiClemente, 1994) useful in determining which treatment to use. This biopsychosocial model conceptualizes six different stages one passes through when attempting to change a behaviour. When clients are in the precontemplation stage, I have observed that many have difficulty accepting their diagnoses. I discuss with them how this attitude does not allow for opportunities to address and reduce the pain. In contemplation, clients have accepted that they have chronic pain and depression and want to attend a self-management program, but have reasons why they cannot attend. I help clients make connections between their current activity level and their perceptions of their quality of life. I support client motivation by giving reasons to learn positive coping strategies. In the preparation stage, clients have the schedule for the self-management group but are anxious. I explain the group format and encourage individuals to commit to attending the group. In the action stage, clients have attended a couple of group sessions and have read the handouts but are still having much pain. I acknowledge that new behaviours are stressful and note the positive steps being made. In the maintenance stage, clients have increased activity levels, are more social and have less pain. I support clients in their wellness plans to ensure a balance of rest and activity.

Educating the community about chronic pain

Two student occupational therapists (co-authors of this article) completed a community development placement at my agency. They completed a project intended to provide education about the connections between chronic pain, mental health and addiction. The education was targeted at both community members living with chronic pain and community service providers from whom individuals with chronic pain often seek support. The students aimed to educate participants about available local resources and to clarify the services offered at our agency. The students approached a local chronic pain group that I run and asked its members which community resources have been useful in their journey with chronic pain. With this information, the students planned and delivered the information sessions, to which all stakeholders were invited.

The students approached health-care providers, including doctors, chiropractors, pharmacists, naturopaths, massage therapists and physiotherapists, as well as pain clinics, local community agencies (e.g., legal aid offices, spiritual leaders, school boards) and local employers. This broad group of professionals, identified as resources by the chronic pain group, was important to involve because each individual with chronic pain uses a unique combination of services to cope (Pain BC, n.d.). The students held three information sessions at various times and locations in the county. Across three sessions, 35 people attended; 10 were health-care professionals and 25 were individuals living with chronic pain.

The mission of the agency and the students' project align with Rothman's (2007) "capacity-centered development" approach to community development. This approach, with an overriding goal of education, focuses on empowering people and communities to problem solve and act successfully on their own behalf (Rothman, 2007). Leadership and cohesion are cultivated within the group, and a variety of strengths, talents and strategies are used to develop capacity (Rothman, 2007). For example, the primary stakeholders with chronic pain conveyed to the students whom to approach in the community for participation in the sessions.

In executing the project, the students attempted to involve as many local resources as possible. For each information session, they solicited local shops to provide food and beverage donations. They also had primary stakeholders in leadership roles to help facilitate the logistics of the events. They hoped that, through all stakeholders being invited to the information sessions, a strong, transparent network, inclusive of a wide spectrum of people in the community, would develop. They hoped that strengthening the network among professionals would better enable all to appropriately help people with chronic pain. Acknowledging and using the strengths, resources, talents and strategies provided by the clients at the agency allowed these individuals to be part of the development and execution of the project. They became invested and encouraged that they could help make change, which aligns with the agency's mission. Although the information sessions had limited participation, foundational relationships between our agency and other community agencies were established. Strengthening networks and collaboration among health-care providers supports the integration of our health-care system, which often operates in silos (Drummond, 2012). The community professionals who participated in the information sessions expressed interest in attending more information sessions on topics such as post-traumatic stress disorder, and running further sessions is a potential next step.

Reflecting on the importance of peer support and community networks

To provide my clients with lasting positive change, I meet my clients where they are in their change journey (pre-contemplation, contemplation, preparation, action or maintenance stages) to provide the appropriate intervention (Prochaska, Norcross, & DiClemente, 1994). I acknowledge that behavioural changes must be gradual to be long-lasting;

About the authors

Susan Yee, MScOT, OT Reg. (Ont.), has been an occupational therapist for 18 years and works in a rural community addiction and mental health agency. **Kahla Wellum, MScOT,** and **Kristen Wilson, MScOT,** are recent graduates of Queen's University. Susan may be contacted at: syeekingston1@sympatico.ca

hence, intervention has to be long-term. Working in a health-care system that is short on funds, I facilitate two chronic pain groups along with providing regular individual appointments. Through the provision of groups, clients receive more services and have peer support, which helps empower them. Following intervention, during the reassessment of individualized goals (including formal, informal and group feedback), clients tell me they feel in control of their pain, their quality of life has improved and their pain has subsided. When they are more physically active, their depression is reduced or alleviated. Openly talking about chronic pain and mental health helps to decrease stigma.

In my experience, building a supportive, diverse group of people who can help individuals throughout their journey with chronic pain is crucial. To do so, family members, friends and service providers must be informed of the challenges and stigma people experience. The project discussed here had this objective. Empowering individuals living with pain and aligning the community to better understand them has healing power in itself. Having individuals with chronic pain be the driving force behind the information sessions (through identifying the key stakeholders in the community), along with contributing their talents and time, enabled them to take some control of their situation.

For more information about pain management, readers are encouraged to refer to:

- *CAOT Position Statement: Pain Management and Occupational Therapy:* https://www.caot.ca/position%20statements/Pain%20management%20and%20occupational%20therapy%20position%20statement%20.pdf
- *Occupational Therapy Now* special issue on pain; September 2012: http://www.caot.ca/default.asp?pageid=1310
- *Pain Management and Occupational Therapy Professional Issue Forum Report and Recommendations:* https://www.caot.ca/pdfs/PIF/Pain%20PIF%20Report.pdf

Reflecting on hope for the future. Photo credit: Kahla Wellum

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Occupational therapy and the Administrative Justice Support Network: Working together to promote occupational justice through social inclusion

Katherine Stewart

The profession of occupational therapy holds that a relationship exists between occupation and health, well-being, and justice (Townsend & Polatajko, 2013). In their 2004 article, Townsend and Wilcock suggested that addressing occupational injustice is, in part, one of the reasons for the profession's existence, and that occupational injustice is an issue often implicitly faced by occupational therapists. Perhaps the most explicit link between occupational therapy and occupational justice lies in the profession's aim to promote social inclusion through the client-centred enablement of occupation (Townsend & Wilcock, 2004). While the construct of occupational justice is not often explicitly addressed outside of the profession, there are certainly many organizations whose aims address social inclusion. The Administrative Justice Support Network (AJSN) is one such organization. Having completed a role-emerging fieldwork placement with the AJSN in the summer of 2014 as part of the Master of Science in Occupational Therapy (MScOT) program at the University of Toronto, I will draw upon my experiences to illustrate the strong fit that exists between the aims of this organization and those of the occupational therapy profession, and how working with such organizations can promote occupational justice.

A student occupational therapist's experiences with the AJSN

Created within Community Living Ontario, the AJSN aims to support individuals with disabilities (defined in the broadest sense of the term) and their families to appeal exclusionary administrative decisions made by provincial or local authorities (e.g., school boards, hospitals). In the first phase of its development, the AJSN created a plain-language website (ajsn.communitylivingontario.ca) providing information on eight administrative tribunals commonly accessed by individuals with disabilities and their families. At the time of my placement, the AJSN was engaged in the second phase of its development: the creation of a province-wide mentorship program. It was hoped that this approach to support through mentorship would connect individuals and families with previous experience in undertaking an appeal with individuals and families at the outset of an appeal process.

As a student occupational therapist with the AJSN, my role was to support the organization in the development of its mentorship program. For example, I gathered information from potential mentors about their past experiences with the appeal process, to better understand and anticipate the mentorship needs of individuals and families just beginning to undertake an appeal. However, my role at the AJSN may be viewed as situated within a broader role: to enable individuals with disabilities and their families to feel empowered to successfully navigate the tribunal system to advocate for access to resources that would allow for participation in meaningful occupations. This broader role included the exploration of issues of occupational justice through supporting social inclusion for individuals with disabilities and their families.

Social inclusion within occupational therapy and the AJSN

At the heart of occupational justice lies social inclusion. Social inclusion may be understood to involve the ability to participate in one's community and have these contributions be acknowledged. Social inclusion also relates to access to the resources and opportunities that enable community participation (Ogilvie & Eggleton, 2013). In this way, social inclusion may be understood to be a strategy through which occupational justice can be achieved. An occupational justice framework views the ability to participate in valued occupations as a right (Polatajko et al., 2013). Individuals with disabilities living in the community represent a population at risk for experiencing a lack of social inclusion as a result of inadequate access to opportunities or resources for occupational participation. Occupational therapists are well positioned to minimize this risk through advocating for the just distribution of supports and services that enable clients to participate in meaningful occupation.

Just as social inclusion lies at the heart of occupational justice, so too does it lie at the heart of the goals espoused by the AJSN. The AJSN was created in response to the challenges that many individuals with disabilities experience when accessing the resources and supports necessary to live well in the community. The allocation of benefits and supports is more likely to occur through a bureaucratic process for individuals with disabilities than it is for other members of society (World Health Organization, 2011). Often, individuals and families are unaware of their right to appeal decisions made by administrative boards, should they disagree with these decisions. For those who are aware of their right to appeal administrative decisions, the appeal process can be

unfamiliar, intimidating and unwieldy. The AJSN supports individuals and families through this process, and is ultimately concerned with advocating for the just distribution of supports and services that enable individuals with disabilities to participate in community life.

Occupational justice through social inclusion

It is clear that the occupational therapy profession is concerned with occupational justice, which may be facilitated through the promotion of social inclusion. Similarly, it is clear that AJSN's work to promote social inclusion through equitable access to resources and services does support occupational participation. It is precisely this focus on social inclusion that allows for such goodness of fit between the AJSN and the occupational therapy profession. In reflecting on my role as a student occupational therapist, and considering both occupational therapy and the AJSN's concerns with social inclusion, it seems logical that issues of occupational justice could be addressed by occupational therapists working with the AJSN. The occupational injustice that often occurs when a society dictates the manner in which individuals "should" participate has consequences for their health and empowerment. When participation is restricted, as is frequently the case for individuals with disabilities, occupational injustice persists (Townsend & Wilcock, 2004). Through partnerships with the AJSN, developing supports intended to enable individuals with disabilities and their families to feel empowered to exert choice and control over the occupations in which they participate, occupational injustices may be combatted through social inclusion.

It is my view that occupational therapists working with the AJSN have the ability to beautifully support Townsend and Wilcock's (2004) goal: "We want to bring to public awareness the injustices that persist when participation in occupations is barred, confined, restricted, segregated, prohibited, undeveloped, disrupted, alienated, marginalized, exploited, excluded or otherwise restricted" (p.77). Through their shared commitment to promoting social inclusion, occupational therapy and the AJSN are ideally suited to partner in addressing issues of occupational justice. Occupational therapists are capable of working toward occupational justice through social inclusion, and my placement experiences at the AJSN serve to illustrate just one example of this. The opportunity exists for occupational therapists in other organizations and practice settings to do the same, in the hope of raising the issue of occupational justice in practice in a more intentional manner, while also increasing public visibility of issues of occupational justice that continue to persist today.

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About the author

Katherine Stewart, BASc, MScOT, is a second-year doctoral student in the Rehabilitation Science Institute at the University of Toronto. At the time this article was written, Katherine was a student in the Master of Science in Occupational Therapy program at the University of Toronto. She may be reached at: ke.stewart@mail.utoronto.ca

OLDER ADULTS

TOPIC EDITOR: SANDRA HOBSON

Examining the impact of poverty on older adults' occupations and health care

(Hedy) Anna Walsh

It has been estimated that in 2031, life expectancy will reach 82 years for men and 86 years for women, and three percent of Canada's population will be 85 years or older (Andrews, 2008). Older adults are a diverse group that may include vulnerable individuals—the very old, and those with low incomes, poor social ties and a reduced capacity to be independent (Grundy, 2006). This article examines the impact that poverty can have on older adults' occupational performance and discusses what occupational therapists can do to meet the needs of this vulnerable population.

The disappearing middle class

Social determinants of health, including social, environmental and economic factors, have been shown to affect the health of individuals (Adler & Ostrove, 1999). Older adults are particularly vulnerable to economic challenges, especially as they relate to housing, community services and caregiving support (Warburton, Bartlett, & Rao, 2009). In the past several years, economic disparities have increased; an emphasis on international trade and investment (Epps & Flood, 2002) within a global market economy has led to increased income inequalities and a shrinking of the middle class (Foster & Wolfson, 2010; Lazonick, 2010). The result has been an increase in households in which multiple family members must work to make ends meet, affecting their availability to provide informal caregiving support to older family members, often needed to supplement the limited availability of publicly funded home care services (Markle-Reid et al., 2008). Older adults in Canada with limited income security face difficulty accessing many health services, because Canada's health-care insurance coverage, which places emphasis on acute care and does not cover all services in the community. As a result, many older adults with limited income experience difficulties in purchasing health and social services that are not covered by Canada's Health Act (Health Council of Canada, 2012).

Older adult populations impacted by poverty

Although Canada's poverty rate amongst older adults remains relatively low when compared to other industrialized countries, approximately 11.7% of older adults over the age of 65 have incomes below $20,000, with the majority being single and female (Bazel & Mintz, 2014). Older adults often rely on income from investments, pensions and government transfers, including Canada Pension Plan (CPP), Old Age Security (OAS), and Guaranteed Income Supplement (GIS). Older adults residing with family members tend to have a higher individual income level (Markle-Reid et al., 2008).

Racial and ethnic minorities (Simms, 2003) tend to occupy lower socioeconomic levels than non-minorities (Egede, 2006), experience poorer health-care outcomes (Newbold & Danforth, 2003) and suffer greater morbidity and mortality from chronic diseases compared to non-minorities (Egede, 2006). Studies have shown that many immigrant populations experience limited access to and use of health and social services (Lee & Bean, 2004). Poor access to services may be related to communication, and cultural and structural barriers, the latter of which may be tied to a limited ability to afford services. For instance, many older immigrants experience financial difficulties, resulting in an inability to finance private care to supplement the limited allocation of public home care services (Forget, Deber, Roos, & Walld, 2005).

The overall rationing of health-care services disproportionally impacts women, as their average income level is less than that of men (Forget et al., 2005). Poverty has been shown to greatly affect older women, as a result of their longer life expectancy compared with men (Fook, 2002), with the rate being higher among older disabled women and among older women who are living alone (Zahidi, 2012). Older women who had not been in the paid workforce are especially vulnerable, as a result of not having contributed to a work pension (Wisensale, 2005), and women who are retired and have lost a spouse are often prone to a reduction in their overall income (McDonald, Donahue, & Moore, 2000).

Poverty and its effects on health

Poverty has been associated with greater morbidity and mortality risks (Markle-Reid et al., 2008), including a higher risk for institutionalization in long-term care facilities compared to those with access to funds (Edwards & Mawani, 2006). Many older adults face income, housing and social welfare concerns in their retirement years (Smith & Ley, 2008), which are linked to higher morbidity and mortality risks (Andrews, 2008).

Aside from poor living conditions, poverty is psychologically difficult, impacting individual self-worth and creating uncertainties for survival. Population-based research has revealed lower self-esteem, due to the stigma of poverty, associated with society's negative attitude about maintaining a lower standard of living (Mickelson & Williams, 2008), and a

higher risk for depression and suicide among individuals who are unemployed or living in impoverished conditions (Patel, 2001).

Economic disparities have implications for occupational therapy practice. Differences in income levels affect access to health-care services (Bass-Haugen, 2009). Additionally, health status is worse as income gaps increase (Landry et al., 2006). Older adults have been greatly affected by the rationing of health care and social services (Baranek, Williams, & Deber, 1999). Budget cuts to health-care services have been aimed at encouraging Canadians to assume more individual responsibility for their health-seeking behaviour, resulting in the delisting of many previously public health-care services (Forget et al., 2005). For example, routine eye examinations by an optometrist or ophthalmologist, as well as outpatient physiotherapy services for individuals aged 20 to 64 are no longer covered in many jurisdictions (e.g., Ontario Ministry of Health and Long-Term Care, 2015). Additionally, non-medical services such as cooking, cleaning, socialization, transportation and personal care have been deemed a non-priority (Simms, 2003). Such budget reforms have also resulted in earlier hospital discharges and more policy emphasis on community-based and private care, to reduce the consumption of publically funded services (Forget et al., 2005).

Recommendations

Efforts are needed to ensure that occupational therapy clients have equitable access to services, regardless of income level. In the climate of health-care reform and cost containment, occupational therapists must be alert to older adults with limited income security and limited access to health and social services. Occupational therapy goals should be realistic and aimed at improving occupational engagement by promoting activity and social participation within an individual's financial means (Szanton et al., 2011). Specifically, occupational therapists are encouraged to:

1. tailor treatment options in accordance with individuals' financial ability to afford services (Soskolne, Halevy-Levin, & Cohen, 2007)
2. provide assistance in accessing funding (Soskolne et al., 2007)
3. educate older adults about available services within their financial means (Brown, 2002)
4. advocate for policies that reduce economic disparities to ensure equal access to care (Bass-Haugen, 2009) and improve overall health outcomes (Brown, 2002)
5. perform research related to income and occupational performance (Bass-Haugen, 2009) to better understand different population groups and develop strategies reflective of the aging process, gender, culture and socioeconomic status (Matsuoka, 1999).

Conclusion

The current rationing of health-care services has particularly affected older adults with limited income security. Occupational therapists need to be alert to their limited resources (Szanton et al., 2011) when outlining occupational goals. Interventions should be financially realistic to enable older adults' participation in meaningful occupations that support their health and well-being (Krupa, Fossey, Anthony, Brown, & Pitts, 2009).

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Editor's note: To read more about the role of occupational therapy in working with people living in poverty, check out pages 14-17 in the September 2015 issue of *Occupational Therapy Now*, found at: http://www.caot.ca/default.asp?pageid=394

For those attending the 2016 CAOT Conference in Banff, Alberta, please consider attending the Professional Issue Forum on Poverty and Homelessness, taking place at the Fairmont Banff Springs Hotel - New Brunswick Room, on Thursday, April 21, 8:30-11:30. If you are unable to attend Conference, watch for reports from the forum to appear in the July *Occupational Therapy Now* and on the CAOT website.

About the author

(Hedy) Anna Walsh, PhD, MHSc, CHE, LLB/J.D., BScOT, is an occupational therapist, lawyer and health administrator and is currently working as an adjudicator for the Toronto Licensing Tribunal and as a public member of the Council of the Ontario College of Social Workers and Social Service Workers. She may be reached at: hedy.walsh@utoronto.ca

Considerations when choosing a stairway lift

Jim Closs

Stairways: Safety or esthetics?

Stairs come in all shapes and sizes and although building codes have tried to keep some uniformity to the rise and run of stairs, builders and designers are often faced with space restrictions and the desire for aesthetics. This can compromise stair safety.

Pre-fabricated handrails and posts are often made to be a pleasing element of the décor rather than a safe and ergonomic solution. In such cases, the handrail or post can be ineffective (i.e., not properly positioned) and even dangerous as it has not been designed to actually hold the full weight of a person requiring support.

Client assessment and understanding the stairlift fitting process

A stairway lift is well-suited for a client who generally has the ability to ambulate on flat surfaces but is having difficulty in managing stairs. Conditions that affect strength, balance and endurance are generally those that can create a need to install a stairway lift. There are also scenarios where, because of budget and construction confinements, the stairway lift is chosen as a device to improve access for a wheelchair user. In these situations, it is important to address the safety of transfer, both at the bottom and the top of the stairs where any mishap could lead to serious injury. It is advised that a careful assessment be conducted by a health professional and that other alternatives be considered if there is a risk of injury.

Ergonomic design of the lift

All stairway lifts are not created equal. In fact, many are not designed with the human body in mind. People who require assistance need a chair that fits them. A user's balance, cognitive capacity and comfort should be considered when choosing the chair and the lift system. The chair should allow for a natural sitting position with armrests long enough to be used as a support when exiting the chair. The system controls should be intuitive and easy to operate.

Ensuring value

The key elements that the consumer needs to address with the vendor are quality, design, comfort and reliability, as well as its warranty and reputation. Consumers should ask questions such as: How long have they been in business? Who performs the installation and are they capable of providing after-sale service and maintenance?

Many clients neglect to consider the maintenance aspect when selecting a vendor. A stairway lift is a machine and it will need maintenance and service. Taking pre-emptive action and scheduling maintenance will ensure a lifetime of continuous use.

The stairway lift could become the next standard piece of equipment in North American homes as the population ages and the desire to age in place becomes the norm. When mobility needs become more common, then products and services become all that much better. As it is, a stairway lift is a very easy solution to a personal and logistical need.

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About the author

For almost 25 years, Jim Closs has been helping people go up and down stairs so they can live in the place they want. He may be reached at: jim_closs@stannah.com

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