OCCUPATIONAL THERAPY NOW

OCCUPATIONAL THERAPY NOW VOLUME 18.3

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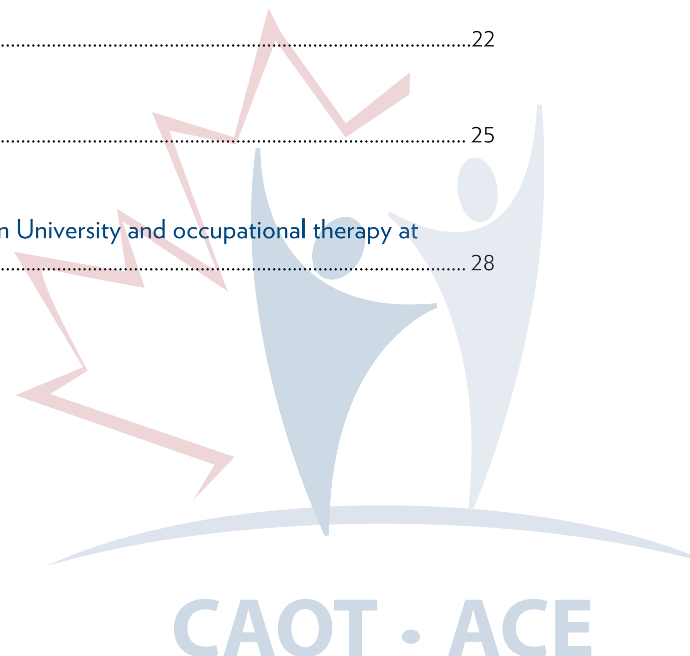

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Cary says: "The picture makes me think very much of the spirit of adventure many occupational therapists bring to their careers - carrying our profession's unique suitcase of tools (some old standbys and, of course, we can find space in the case to pack in new ones). We are always ready for new challenges and opportunities."

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

What's new

Announcing CAOT-QC!

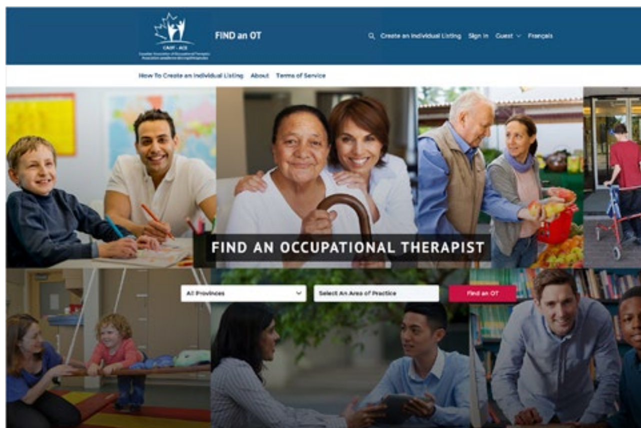
We have good news to share! On behalf of the CAOT Board of Directors, we would like to announce that, as of October 1, 2016, CAOT will establish a membership chapter in the province of Quebec. The Quebec chapter, called CAOT-QC, will provide Quebec members with official representation to their provincial government, a new partner in the pursuit of occupational therapy excellence in Quebec, more focus on their provincial needs and concerns, more forums and more resources.

Have you created your listing yet?

A new platform to help Canadians search for an occupational therapist is here! FIND an OT is a new member-exclusive benefit open to eligable CAOT members. This new search tool has several features, including:

- Easy-to-use online searchable format
- An interactive map
- Multiple search parameters, including areas of practice, city and contact information
- Options of adding a logo, photo, brief biography and social media links
- Four listing options to meet the varied needs of occupational therapists, including a *FREE* basic listing

CAOT will be promoting the new FIND an OT search tool to external stakeholders, referral sources and community partners, so be sure to create your listing today.



Learn more at: www.caot.ca/findanOT

OT Now news

NEW *OT Now* call for papers on private practice

OT Now is seeking submissions about private practice for a theme issue to be published in March 2017. Go to www.caot.ca/default.asp?ChangeID=25&pageID=7 to view the full call for papers.

Welcome to new *OT Now* volunteers

A warm welcome is extended to new *OT Now*'s newest topic editors and editorial board member:

- Sarah Hobbs and Sarah Villiger – Student Perspectives topic editors
- Erin Moerman – Occupational Therapist Assistants and Support Personnel topic editor
- Tarra Carter – Editorial board entry-to-practice student representative

We look forward to working with these new members of the *OT Now* team!

Publishing research and program evaluation

At *OT Now*, we often receive questions about what kind of data and project results can be published. *OT Now* does not publish original research results; however, we are happy to publish articles that describe the practice implications of a research project that has been published elsewhere. We are also happy to publish articles describing program evaluation or quality improvement projects, and these may include basic descriptive data. To learn more, please consult the *OT Now* author guidelines at: http://www.caot.ca/default.asp?pageid=91

Supporting the Canadian Occupational Therapy Foundation (COTF)

Donations can be made online, by phone or by mail. www.cotfcanada.org

You can also support COTF by purchasing a necklace through: https://www.hilarydruxman.com/product/53n1-ot/

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Supporting occupational therapists in their publishing initiatives

Julie Lapointe, Danielle Stevens and Janet Craik

Since 1926, the Canadian Association of Occupational Therapists (CAOT) has published resources to support and develop excellence in the practice of occupational therapy. As the sole publishing house dedicated exclusively to occupational therapy in Canada, its goal is to publish and disseminate evidence-based and highly relevant resources for practitioners (e.g., reference manuals, practice guides, reflection tools). The intent of this article is to illustrate how CAOT's publishing department supports occupational therapists in their publishing projects. This support process takes inspiration from the eight action points of the Canadian Practice Process Framework (CPPF), "a process framework for evidence-based, client-centred occupational enablement" (Craik, Davis, & Polatajko, 2013, p. 232). For this short article, only the first four action points of the CPPF process will be described.

A publication proposal is the communication tool used to *initiate* and establish contact with prospective authors. One completed, this proposal is typically 3 to 10 pages in length and is accompanied by a sample chapter, as well as information on the authors' expertise. A member of the CAOT team is assigned as the "case manager" for the project. This person meets with the authors and takes care to *set the stage,* providing them with information on the process and steps to follow.

The *assess and evaluate* action of the publishing proposal is then activated through a decision support table. This table is used to compile the strengths (which support the decision to move forward) and the weaknesses or risks inherent to the proposal in the context of the occupational therapy publications market. This type of tool has proven its usefulness in supporting the reflection and decision process (Stacey et al., 2014). The decision support table also describes the authors' level of expertise and experience relative to the topic. The anticipated challenges, development options and environmental factors are identified for the project. This table is completed by the case manager, and the authors contribute by suggesting elements to consider or clarify. Also, in order to improve the quality and performance of its environmental scan, CAOT calls upon a business development manager. This person performs a market analysis, comments on the viability of the publication and develops a business and promotion plan.

Once completed, the publication proposal and table are submitted to a CAOT advisory committee, which makes a final decision—to move forward or not with the publication project. Indeed, this committee is responsible for choosing publication proposals wisely in order to make optimal use of financial resources originating in a large part from membership fees. When the decision is to move forward, the work plan is agreed upon and implemented.

The next stage, *agreeing on objectives and plan*, includes not only reviewing the publication contents and performing quality assurance checks, but also reaching an agreement on the publishing contract and timelines, making sure that the presentation structure strikes a good balance, choosing the most relevant references, requesting copyright permission for images, dealing with feedback from the reviewers and planning the national and international promotion and dissemination steps. Throughout this process, the authors are invited to play an active role. The authors are the experts on the content of their work and the CAOT team, through its experience, makes sure to guide them and allow them to reach their highest level of excellence by adopting a customized and client-centred approach.

In conclusion, it is important to emphasize that the production of a publication requires considerable work, including an initial assessment and a rigorous and diligent follow-up. However, occupational therapy publications can generate multiple positive impacts and are a premier means of advancing our profession. CAOT is proud to enact its mission to "advance excellence in occupational therapy" by supporting authors. Readers interested in contributing to CAOT publications and learning services are invited to consult the "Be Involved with CAOT" webpage for more information: http://www.caot.ca/default.asp?pageid=1247

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May is Speech and Hearing Month

Each year, Speech-Language and Audiology Canada (SAC) dedicates the month of May to raising public awareness about communication disorders and the professionals who can help. Throughout this month, we work with more than 6,300 SAC members and associates — speech-language pathologists, audiologists and communication health assistants — to highlight the importance of communication health.

SAC's 2016 Speech and Hearing Month initiatives include reaching out to children's hospitals across the country, a social media campaign and promoting the value of communication health to politicians and the media. We have also created new posters, information sheets and activity sheets to add to our collection of resources. To access our free online resources and learn more about Speech and Hearing Month, visit: www.maymonth.ca

Communication health professionals do more than you think

Speech-language pathologists and audiologists work with people of all ages to identify, assess and treat a wide range of communication disorders. Speech-language pathologists work with individuals with speech, language, voice, swallowing and feeding disorders, and audiologists work with individuals with hearing loss, auditory processing disorders, tinnitus, other auditory disorders and balance disorders. In addition to working in clinical settings, speech-language pathologists and audiologists work in research, education, advocacy, counselling, policy development and health administration. Communication health assistants support both professions.

Speech-language pathologists and audiologists often work on interprofessional teams, collaborating with other professionals, including occupational therapists. Occupational therapists and speech-language pathologists have long valued the effectiveness of co-treating clients of all ages in hospitals, long-term care facilities, schools and other settings. Speech-language pathologists and occupational therapists also frequently collaborate to recommend, design and implement augmentative and alternative communication devices. Similarly, occupational therapists and audiologists often collaborate on patient/client care, particularly for those withvestibular disorders.

As an occupational therapist, you probably have experience working with a communication health professional or someone who has a communication disorder. We'd love to post your story on the Speech and Hearing Month website to demonstrate the power of human communication. Please share your experience with us by contacting Felicity Feinman, SAC's communications assistant, at: felicity@sac-oac.ca. Submissions of any length are welcome.

Editor's note: Within the Canadian health-care system there has been increasing need for working and learning strategies that promote interprofessional collaboration (IPC). CAOT is committed to advancing IPC and is pleased to promote the important work of our colleagues, encouraging dialogue about how IPC can improve client care.

ADULTS

TOPIC EDITOR: PATRICIA DICKSON

Workplace disability prevention considerations: A primer for occupational therapists

Alicia McDougall and Behdin Nowrouzi-Kia

Workplace injuries and work-related disabilities are serious issues in Canada. In 2013, over 241,000 Canadians experienced workplace-related injuries or diseases that resulted in a loss of productive work time (Association of Workers' Compensation Boards of Canada [AWCBC], 2013). These workplace injuries and disabilities directly cost the Canadian economy $9.7 billion in 2008. When both direct and indirect costs were factored in, workplace injuries were estimated to cost more than $19 billion annually as of 2010 (Gilks & Logan, 2010). Workplace disability therefore affects Canadians both directly and indirectly.

Disability management is defined as deliberate and coordinated efforts to prevent injuries and disabilities, create accommodations to help maintain employment after the onset of an injury or disability, and support recovery through treatment and early intervention. Disability management is a collaborative undertaking involving employees, employers and agencies providing disability services (Canadian Association of Occupational Therapists [CAOT], 2011). Workplace Disability Prevention (WDP) is an approach or model involving interventions implemented during the primary prevention stage or the subacute phase of a disease, and its use supports carrying out interventions early, therefore preventing disease or disability (e.g., during the subacute phase of low back pain to prevent chronicity; Bell et al., 1995; Loisel et al., 2001; van Oostrom et al., 2009). As discussed in this article, occupational therapists are in a position to play a central role in disability management, education and prevention as they relate to injuries and disabilities in the workplace.

The holistic approach of occupational therapy

The understanding occupational therapists have of the relationship between individuals, their environment and their occupations provides a unique perspective that is useful in the disability management process (CAOT, 2011). The holistic approach of occupational therapy not only takes into consideration the physical aspects of health in the workplace, but also considers the mental, emotional, cognitive, cultural, social and idiosyncratic aspects (CAOT, 2015; Thibault, Loisel, Durand, Catchlove, & Sullivan, 2008). In the literature, it has been found that taking a comprehensive approach to workplace disability and its prevention results in improved health outcomes (CAOT, 2015; Carragee, Alamin, Miller, & Carragee, 2005; Sullivan & Stanish, 2003; Thibault et al., 2008; Tjulin, MacEachen, & Ekberg, 2010). Evidence has shown that disability in the workplace encompasses more than physical components and is impacted by personal characteristics (e.g., psychosocial) and environmental features (e.g., workspace, compensation systems; Carragee et al., 2005; Loisel et al., 2001; Sullivan & Stanish, 2003; Thibault et al., 2008; Tjulin et al., 2010).

Psychosocial factors

The literature has shown that considering psychosocial factors (e.g., job satisfaction, decision-making capacity) in workplace disability management increases positive results and outcomes for clients and employers alike (CAOT, 2015; Carragee et al., 2005; Loisel et al., 2001; Sullivan & Stanish, 2003; Thibault et al., 2008; Tjulin et al., 2010). One study on low back pain found that taking into account psychosocial variables in combination with physical variables better predicted long-term low back pain, while physical variables alone had only weak associations with long-term low back pain and disability. The study also found that psychosocial variables strongly predicted instances of long- and short-term disability leave and health-care visits for low back pain (Carragee et al., 2005). Taking advantage of the predictive value of psychosocial factors could contribute to the development of appropriate treatments and intervention strategies and thus the reduction of total lost work time.

One study on return to work found that workplace-based interventions should extend beyond the technical and task-oriented accommodations typically involved with returning to work and also consider the social context in which these interventions take place (Tjulin et al., 2010). The authors suggested that the return-to-work process is a socially constructed event in which social interactions and relations are changing (Tjulin et al., 2010). The findings suggested that early social contact with work colleagues during the pre-return phase eliminated feelings of invisibility and uncertainty for the injured or sick employee; this contact also provided an opportunity to open communication about how and when return to work would take place. Early contact also resulted in shorter durations of sick leave (Tjulin, et al., 2010). The study also found that interventions in the post-return phase typically included jobs and tasks that were modified to eliminate the impact or presence of physical components of the worker's disability, but the social and psychological impact of the transition were not taken into account. Therefore, employing a more holistic approach to the return-to-work process could produce smoother transitions, fewer feelings of uncertainty and shorter durations of sick leave (Tjulin et al., 2010). Occupational therapists have the potential to play an integral role in this approach through educating employers and employees alike about the benefits of early contact. Furthermore, by getting involved in the earlier stages of the return-to-work process, occupational

therapists can help with the planning and development of return-to-work programming that keeps all stakeholders informed, thus opening lines of communication, facilitating early social contact and eliminating feelings of uncertainty.

Psychosocial factors are also important considerations in the area of pain management, since pain management is an integral element of the return-to-work process. One study found that interventions that target pain intensity, pain catastrophizing and fear could be effective means of reducing pain behaviours (e.g. wincing, guarding, verbal expressions of pain; Thibault et al., 2008). It has been found that interventions that address and reduce the psychological factors associated with pain could have a significant impact on the success of rehabilitation (Thibault et al., 2008). A similar study found that although psychological and social factors are addressed by many tertiary care pain management programs, the importance of these factors has been underacknowledged in primary and secondary prevention programs (Sullivan & Stanish, 2003). The authors noted that, thus far, pain has been predominantly conceptualized as physical, and psychological interventions have not been considered essential (Sullivan & Stanish, 2003). They suggest that psychologically-based activity mobilization programs (incorporating cognitive restructuring and reappraisal of activity participation as it relates to pain) could have significant benefits if incorporated into pain management and prevention programs (Sullivan & Stanish, 2003).

Workplace Disability Prevention (WDP)

An investigation by Loisel and colleagues (2001) discussed a shift of paradigm from workplace disability and disease treatment to WDP, which could help decrease the number of cases of chronic pain in workers. The WDP model shifts the focus from secondary and tertiary prevention (which aim to ameliorate or decrease the impact of injury or disease that has already occurred) to primary prevention (which aims to prevent injury or disease before it occurs; Bell et al., 1995; CAOT, 2015). Studies have shown that using the WDP approach of treating clients "through patient reassurance and interventions linked to the workplace," rather than the medical model of chronic pain treatment, can successfully prevent the development of progressive, prolonged or chronic disabilities (Loisel et al., 2001, p. 352).

The WDP approach to workplace injury and disability fits with the holistic approach of occupational therapy and also takes into consideration the psychosocial factors associated with successful interventions. CAOT has presented a concerted effort to better reflect the importance of taking into account physical, psychosocial, cultural and environmental components during workplace health interventions (CAOT, 2015). CAOT has created a list of initiatives it intends to pursue related to this topic that include: providing information to occupational therapists about ways to promote workplace health and primary prevention, expanding evidence-based practice by supporting effectiveness studies, and promoting collaboration with workplace disability stakeholders to advance occupational therapy services and contribute to the elimination of workplace disability (CAOT, 2015).

To learn more about workplace health and well-being resources, check out CAOT's resource page on this topic (http://www.caot.ca/default.asp?pageid=4265), as well as the related position statement (http://www.caot.ca/default.asp?pageid=1137).

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The authors wish to thank Ms. Janet Craik and Dr. Julie Lapointe for their productive discussion regarding this topic.

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CJOT: EVIDENCE FOR YOUR PRACTICE.

TOPIC EDITOR: BRIANA ZUR

A new opportunity for knowledge translation. CJOT: Evidence for your practice

Briana Zur

Welcome to the inaugural article in the new topic, CJOT: Evidence for your practice, which is creating a space to discuss practice implications of articles published in the *Canadian Journal of Occupational Therapy (CJOT).* There are many references over the years emphasizing a need for clinical scholarship and evidence-based practice (Thomas & Law, 2013; Law & Baum, 1998). "For an evidence-based practice approach to be implemented effectively and successfully, information from research reports must be adopted and utilized by the targeted users—occupational therapy practitioners who intend to use research evidence to support practice" (Sudsawad, 2005, p 351).

Evidence-based practice (EBP) expects practitioners to access, appraise and integrate research literature with clinical expertise and clients' values (Bennett & Townsend, 2006). Research has demonstrated that therapists support the importance and principles of EBP, but challenges to implementation include such issues as lack of time and appraisal skills, heavy workloads and a perception that there is a lack of evidence (McClusky, 2003, 2004). Law and Baum (1998) found that one of the barriers to evidence-based practice is the perception of occupational therapists that they lack skills in interpreting research evidence, implying that the translation of research findings into practice can be difficult to understand and interpret. Barrett and Paterson (2009) found in their focus group study that "participants described frustration and fears about their skills and abilities to search and critically appraise the literature accurately" (p. 9). Although many researchers now endeavor to translate their findings into implications for practice, this may not be something practitioners are yet comfortable with.

In the December 2015 *CJOT* issue editorial, editor-in-chief Helene Polatajko and Christie Welch wrote "each of us is, ultimately, the gatekeeper for our own knowledge uptake and translation into practice. Accordingly, each of us needs to be self-reflective; each of us needs to examine the factors we bring to bear in considering the emerging evidence so we can best enable our clients' occupation!" (p. 269).

The purpose of this new *Occupational Therapy Now (OT Now)* topic is to create a regular space for knowledge translation of evidence published in *CJOT*. It allows for research to be profiled and published in both publications. We invite authors and readers of *CJOT*, including students, to contribute. Topics can be presented as a full *OT Now* article with a focus on practice implications of a recent *CJOT* article or as a compilation discussing several *CJOT* articles with practice relevance. Short reports of 500 or 1000 words are welcomed, as well as longer articles up to about 2000 words. Please refer to *OT Now* author guidelines for further details on writing for *OT Now*: http://www.caot.ca/default.asp?ChangeID=114&pageID=91. Go ahead! Contact me and let's discuss your ideas.

To start off this topic, on the next page I have profiled a recent article by Brenda L. Beagan in the December 2015 issue of *CJOT*.

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Author: Brenda L. Beagan

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This *OT Now* article profiles Beagan's scoping study as presented in *CJOT*, which was conducted in response to calls for increased discussion about the implications of occupational therapists' approaches to practicing within cultural differences and other forms of diversity, emphasizing the importance of social and power relations between client and therapist. Her paper reviews and critically synthesizes the occupational therapy literature concerning culture and diversity published between 2007 and 2014. Four differing approaches and their implications are discussed: cultural competence, cultural relevance, cultural safety and cultural humility.

The article focuses on how diversity extends beyond ethnicity. The author highlights how diversity means attention not only to difference but also to how this creates power relations and inequities among certain groups. Beagan writes "in every occupational therapy encounter, both therapist and client are always thoroughly immersed in their own social and cultural contexts, which may differ by gender, class, ethnicity, and so on" (p. 273). Beagan reminds of us of the World Federation of Occupational Therapists' (2006) commitment to enabling all people to participate to their fullest potential in order to engage in everyday life.

In the articles reviewed by Beagan, cultural competence was found to focus on the development of awareness, knowledge and skills. Awareness is about acknowledging our own cultural values, biases and attitudes, and how those of our clients' may be different from our own. Knowledge involves learning about other cultures, particularly in relation to health, illness and disability. Skills for cultural competence often include effective communication and the use of culturally appropriate occupations.

Culturally relevant occupational therapy, as Beagan describes, is an approach to occupational therapy that creates a space for cultural differences. It recognizes the cultural biases and assumptions operating within occupational therapy as a profession. This perspective may promote a shift away from an exclusive focus on ethnicity toward considering other aspects of sociocultural diversity.

Beagan explains how cultural safety has been discussed mostly in the context of Aboriginal health. Cultural safety moves beyond sensitivity and developing an awareness of cultural difference to analyzing power imbalances and their lasting implications. It emphasizes the social, economic and political contexts that may shape our current social realities.

As Beagan describes, cultural humility and critical reflexivity require a commitment to ongoing and honest self-evaluation by examining how one may be contributing to patterns of intentional or unintentional marginalization based on ethnicity, race, class, ability, gender and sexual identity. Beagan cites Hammell (2013) who writes "cultural humility challenges occupational therapists to recognize the ways in which their own perspectives may differ from those of others and to acknowledge the advantages that derive from their own professional and social positions" (p. 228).

Beagan found that some principles appear common to all of the approaches to culture and diversity in occupational therapy, including self-awareness, knowledge about other sociocultural groups and respect for others. There is an excellent comparison of the four approaches in Table 3 (p. 279) within the *CJOT* article that includes answers to such questions as "how is the issue or problem understood?" and "how is better practice to happen?"

Beagan expresses alarm at how little attention there is in the occupational therapy literature to the aspects of social diversity beyond ethnicity. She says, "there is very little published in occupational therapy on poverty or other aspects of social class, racism or ethnocentrism, gender or gender identity, sexual orientation, religion or the effects of ableism" (p. 278).

About the author

Briana Zur, PhD., OT Reg. (Ont.), is an occupational therapist who entered and completed her doctoral studies driven by questions she encountered in her clinical practice. She is currently in private practice and is a designated capacity assessor under the *Ontario Substitute Decisions Act,* 1992, in Waterloo, Ontario. She may be reached at: briana.zur@outlook.com

In conclusion, Beagan asserts that although cultural competence seems to be well-known across professions, she believes that it does not address the issue of power relations and aspects beyond ethnicity. She acknowledges that awareness of cultural relevance contributes by adding important insight into the ways cultural assumptions are considered in the theoretical frameworks within occupational therapy. She considers that when using a cultural safety approach to diversity, the power structures based in social, economic and political issues are often confused as cultural difference. Beagan asserts that "though new in occupational therapy, cultural humility and critical reflexivity offer considerable promise in their attention to structured power relations, application beyond ethnicity, and insistence that the 'problem' of diversity is not individual in scope but is always an instantiation of historical and current structural relations" (p. 278).

Implications for practice

Beagan reminds us that with cultural humility we often feel increasingly aware of how little we know, and that we should learn to live with uncertainty, rather than being focused on demonstrating confidence and competence related to culture in our practice. This requires is us to think outside the box as we adapt our practices, assessments and interventions. Critical reflexivity requires us to examine how we maintain or transform social structures and power relations in our everyday interactions with our clients and our colleagues. By focusing our attention to these often neglected elements, we can clarify and enhance our understanding of how diversity can extend beyond ethnicity. One of Beagan's key messages is that with their focus on social power relations, the approaches of cultural safety and cultural humility with critical reflexivity appear to be most valuable for occupational therapy.

You can read Beagan's article in its entirety by going to the *CJOT* website via the CAOT website: http://www.caot.ca/default.asp?ChangeID=91&pageID=83

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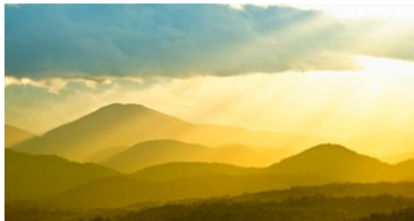
PRACTICE MANAGEMENT AND PROFESSIONAL SKILLS



TOPIC EDITOR: TIZIANA BONTEMPO

Collaborative activation: How occupational therapy and music therapy can work together to promote health

SarahRose Black and Catherine Dirks

The beginnings of collaboration

Since the summer of 2012 and the initiation of a new music therapy program at the Princess Margaret Cancer Centre in Toronto, Ontario, the authors, as two allied health team members, have been considering where their fields converge and the broader implications of those convergences. As members of many of the same health-care teams within the hospital, we, a music therapist and an occupational therapist, have begun to recognize our connections as practitioners working toward very similar goals through different media. This article features some of our collaborative experiences within oncology and palliative care and a description of what has emerged as a result of our collaborations. Together, we have spent countless hours in post-session discussions identifying what we now view as a new joint approach, which we have named "collaborative activation," for envisioning the joint experiences and mutual goals toward which we work.

Background

In our daily practice, we are required to do seemingly different tasks with our clients. As an occupational therapist, Catherine engages people in activities of daily living while assessing their abilities, so as to make recommendations about their needs and facilitate their participation. A psychotherapeutic aspect of intervention comes into play when Catherine offers relaxation therapy and emotional support, often indicated when clients are given an opportunity to reflect on the various factors affecting their daily lives. As a music therapist, SarahRose offers live music as a tool to help clients manage pain and other symptoms; process emotions and express thoughts, feelings and concerns in both verbal and nonverbal (musical) ways; create original songwriting projects as legacies for their loved ones and transition more comfortably as they face end of life. While we use different media, we noticed that many of our goals for our clients had shared intentions and objectives. We first connected when Catherine suggested live music as an alternative to recorded music during relaxation therapy for one of our mutual clients. The client responded well, which encouraged us to consider further collaboration and prompted ongoing discussions about why our collaboration was effective. These interactions sparked a variety of ideas for continued interdisciplinary interventions.

Catherine began referring some of her clients to SarahRose as she developed a deeper understanding of the role of music therapy with in-patient clients in an acute care hospital. SarahRose began to see the formation of a therapeutic relationship, a concept which she had studied at length during her music therapy training, as the basis of Catherine's role as an occupational therapist. As our professional relationship grew and our joint sessions continued, we saw that broad concepts such as therapeutic relationship, quality of life, meaning and spirituality formed the basis of practice in both of our fields. Despite differences in our tools, our foundations were very similar. These similarities led us to creating an approach within which to frame the way we work collaboratively with clients and with each other toward common goals, and this has since inspired ideas for further partnership. This approach has been contextualized as collaborative activation, a term which we feel embodies the convergence of our practices.

A new joint approach

When we sat down to discuss how we could situate and understand our mutuality as well as our divergences as practitioners, we began to notice that our commonalities existed on several levels: practical, relational and transcendent. Each level affects the others and each includes features shared between occupational therapy and music therapy. Within each level, there are also disparities, as naturally there are a variety of differences between the two fields; however, in this article, we will solely feature the intersections and commonalities.

The practical level

When examining our clinical work on a practical level, we noted that engaging clients in activity is the common thread. The practical level of our work involves the interventions we use with our clients; we both engage clients in occupations, including activities of daily living, activities involving psychosocial processing, and meaningful quality of life activities such as legacy songwriting. In music therapy, clients may engage in inter-active listening (Black, 2013), an activity that involves the client listening to music while the therapist plays or sings. Following the live music, the therapist and client may discuss images, thoughts, feelings and body sensations (Ahonen-Eerikainen, 2007). In occupational therapy, the therapist may guide the client through a meditation, after which the client and therapist may discuss strategies for incorporating meditation into anxiety management. Though our therapeutic activities are different in many ways, engaging clients in practical interventions is a common thread.

The relational level
Out of the practical level comes the relational level, at which trust and empowerment emerge through relationship building and contribute to facilitating health and well-being at any age and stage of life. There is a plethora of research that suggests that client-centeredness and a strong therapeutic relationship are important predictors of effective rehabilitation outcomes in occupational therapy (Law, 1998; Finlay, 2004) and effective treatment in music therapy (Hadley, 2002; Austin, 2008). We both practice with client-centredness and consider the development of a therapeutic relationship as the foundation of our clinical work. This relational component sets the foundation for a deeper and arguably more spiritual connection between practitioner and client in both occupational and music therapy interventions.

The transcendent level
From the relational level, the transcendent level emerges, in which a pathway to an individual's spirit develops and is fostered, nurtured and supported by the therapist's practical and relational engagement. There is a variety of research that supports the transcendent and notably spiritual nature of a strong therapeutic relationship (Egan & Delaat, 1994; Egan & Swedersky, 2003). Unruh, Versnel, and Kerr (2002) found that definitions of spirituality in occupational therapy literature include secular themes such as "meaning and purpose in life…and transcendence or connectedness unrelated to belief in a higher being" (p. 10). Indeed, it is this very transcendence, tying in directly with a client's perceived meaning and purpose in life, that we both feel we connect with in our roles as occupational therapists and music therapists.

Our vision
The summation of these three levels of clinical work results in "collaborative activation," an umbrella term to describe the different levels of mutuality that both occupational therapists and music therapists may experience as they partner with clients and each other in their practices. Through formally identifying and naming the common goals and actions of our professions as collaborative activation, we create opportunities to learn from each other's practice, and ultimately create new and innovative opportunities to enhance client care within our palliative care setting.

Although our professions have notable differences, it has become increasingly clear to us that the foundations of our work carry within them profound similarities that underlie the philosophical frameworks within which we practice. We envision further collaboration in practical settings, such as joint relaxation therapy sessions and ongoing mutual referrals, as well as theoretical collaboration in further development of our collaborative activation approach. Our vision is that occupational therapists and music therapists across various health-care facilities will explore collaborative practices and engage with each other for the overall improvement of interprofessional practice and client care.

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OCCUPATIONAL THERAPIST ASSISTANTS AND SUPPORT PERSONNEL

TOPIC EDITOR: ERIN MOERMAN

Reflections on preparing for educational accreditation as a private career college

Danielle N. Naumann

For many professions, accreditation is about ensuring a program standard in order to minimize the variation in levels of learner and graduate competencies between education centres. As articulated by the Occupational Therapist Assistant & Physiotherapist Assistant Education Accreditation Program (OTA & PTA EAP; 2013), "accreditation is both a process and a condition [. . .] The process involves an integrated system of continuous assessment, evaluation, and improvement to comply with specified standards. The condition or state of being accredited provides a credential for the educational institution, students, and the public, affirming that a program has accepted and is fulfilling its commitment to educational quality" (p. 4).

Accreditation is the process in which certification of competency, authority or credibility is presented. In the case of occupational therapist assistants in Canada, an accredited program needs to offer a minimum standard of education, determined by a rigorous independent peer-reviewed examination (OTA & PTA EAP, 2013). The variability in legislation and learner expectations between public and private educational institutions, however, increases the complexity of this process for private career colleges. In this article I reflect on the process of accreditation for occupational therapist assistant and physiotherapist assistant (OTA/PTA) education programs as it relates to private career colleges, and my experience with a private career college. The student profiles in the text box on the next page represent the diversity of private career college students and illustrate how several factors, including accreditation, impact their studies.

What is a career college, and how is it different from a publicly funded college?

A recent environmental scan conducted by the author revealed that there are about 420 registered private career colleges in the province of Ontario alone; of these, 29 offer OTA/PTA diploma programs. Private career colleges tend to be very small, with the majority of schools serving 200 or fewer students on an annual basis. Unlike publicly funded colleges, they operate as a private business within a competitive market, but, as with publicly funded colleges, are subject to strict appraisal from external bodies; programs of study must be government-approved following a third-party review. Increasingly, many programs must also meet the accreditation standards set by professional regulatory bodies.

Private career colleges focus on vocational training, with an emphasis on providing small and diverse groups of students with many of the essential employability and vocational skills required to successfully obtain employment in a vocation (Pizarro Milian & Hicks, 2014). While annual tuition tends to be higher than at publicly funded colleges, programs offered through private career colleges are often much shorter and more intensive. A shortened program length enables mature students who do not have the flexibility to take two years off work in order to attend a program to be successful and pursue their career of choice. Students and the provincial ministries expect private career college programming to be fast-tracked in order to qualify for funding support from key student sponsors (e.g., Ontario's Second Career program).

Students at private career colleges are more likely than other college students to:

- Be over the age of 25
- Support dependent children
- Be immigrants to Canada
- Speak English as a second language
- Represent a visible minority (Pizarro Milian & Hicks, 2014)

Accreditation of OTA/PTA programs

In 2009, a movement began toward requiring OTA/PTA programs to meet a consistent standard of education, spearheaded by the OTA & PTA EAP (Davidson, 2015). Starting from the ground up, the OTA & PTA EAP advocated for a minimal standard of education for occupational therapist assistants, in line with the competencies listed in the *Practice Profile of Support Personnel in Occupational Therapy* (Canadian Association of Occupational Therapists [CAOT], 2009). The accreditation process for Canadian OTA/PTA academic programs is designed to support educational institutions throughout the process. There is a range in the amount of adaptation a program must undergo in order to meet accreditation requirements, given that OTA/PTA programs currently exist at varying types of institutions:

- The majority of assistants are graduates of publicly funded college programs (also known as community colleges).
- Some assistants receive their diploma from a university (e.g., Capilano University, BC).
- Many graduates receive their education through private career colleges, which operate under different provincial government guidelines.

Accreditation expectations

Accreditation standards are explicitly outlined on the OTA & PTA EAP website (2012), and criteria include expectations around the educational program:

1. Meeting the expectations of the government and health-care environment
2. Drawing from the expertise of qualified faculty
3. Appropriately preparing students with the skills they require in order to meet competencies
4. Engaging in self-assessment, planning and improvement
5. Accurately representing itself to the public
6. Representing OTA and PTA competencies in the curriculum

Education sites are required to pursue accreditation *candidacy* (a status that can be held for a maximum of six years) prior to accreditation by meeting a minimum set of requirements in the above areas as they prepare for full accreditation. It is important to note that the status of accreditation candidacy does not mean that the program will achieve full accreditation.

Challenges for private career colleges seeking accreditation

Traditional private career college OTA/PTA diploma programs face unique challenges to successfully meeting the accreditation standards set forth by the OTA & PTA EAP. Colleges who have received candidacy status and are seeking full accreditation are embracing these challenges through collaboration and program accommodation, trialling innovative approaches to curriculum design and educational intervention. Foremost is the challenge inherent in the "for-profit" business model foundational to private career colleges. Successful educational environments require a team-based, collaborative approach, and funding may not be allotted in order to support the time that this requires. In my experience, the lack of a cohesive approach between the core program staff and the administration was readily apparent to accreditation reviewers. While an interprofessional faculty is essential for a dual program like OTA/PTA, it may be challenging to attract professional faculty with competitive remuneration packages, due to the funding structure, for-profit nature of the institution and small class sizes. Additionally, coordination of clinicians' teaching schedules is often a challenge. Private career colleges are pressured to offer students fast-paced, intensive programming in order to reduce their amount of time outside of the workforce, but this cannot compromise the competencies of graduates. Moreover, senior administrators need to be cautious about the risk of being perceived as a "diploma mill," and should demonstrate to their faculty and the accreditation team that goals for profit do not influence endorsement of student competency.

OTA/PTA programs that have traditionally been offered at private career colleges therefore need to undergo significant change in order to meet the criteria to apply for accreditation candidacy and meet full accreditation expectations, while still meeting the diverse needs of their target population of learners. While there are some barriers, the emerging representation of private career colleges on the accreditation candidacy list suggests that innovative thinking can overcome them.

Preparing for accreditation: My experience

In the private career college environment, it has been my observation that it is common for core curriculum to remain constant throughout the time that the college offers the program. This is largely due to the for-profit expectations of a business venture, and is the first hurdle that must be overcome in order to pursue accreditation candidacy. In the absence of an external review for accreditation, the cost associated with regular updates of the curriculum may not be supported by senior business administration. Faculty may not be compensated for preparation and curriculum development time; however, the ministry requirement for experienced clinicians as faculty means that methods of instruction, teaching philosophy and learning objectives represented in the classroom naturally reflect changes to rehabilitation professions and trends in health and health care.

Within my previous role as program coordinator for a private career college, I faced many challenges related to the currency of the OTA/PTA curriculum. The curriculum that was being taught at the time that my position began was 14 years old and had

Profiles of students at a private career college

These fictionalized student profiles are descriptive of the range of learners who seek training from a private career college in order to prepare for a career in assisting occupational therapists.

Tyler is a 47-year-old man who has worked at a manufacturing plant in southeast Ontario for 21 years. Four months ago, Tyler was laid off from his job and has been offered funding to support second career training. Tyler sees this change as an opportunity to pursue meaningful employment as an OTA/PTA; however, he is unsure how to navigate and appraise the educational options available to him. Some job postings specifically require that applicants graduate from a two-year OTA/PTA program, while others require a certificate from an "accredited" program. A local program at a little-known private career college offers the diploma in 10 months, but it is not accredited and seems very costly. At his age, Tyler is reluctant to spend two years in college. He has a family to support, university tuition to pay for his children and is a very self-directed learner. He chooses to attend the private career college and graduates at the top of his class.

Annie has an undergraduate degree in women's studies but wants to be accepted into an occupational therapy program. She is taking the OTA/PTA program at a local private career college in order to have a more competitive application to graduate occupational therapy studies. She chose this program simply because of its condensed length. She completes the program, and after working for six months as an OTA, she is accepted into an occupational therapy education program.

Joy is an immigrant with a learning disability who dreams of becoming an OTA. She knows that she requires a great deal of one-on-one instruction and learns best through experiential learning. She has chosen to attend a small private career college because it explicitly offers class sizes of 10 students or fewer. While she struggles throughout the program, she graduates and is hired by her occupational therapist supervisor from a fieldwork placement.

undergone only minimal change to reflect evolving competencies for both occupational therapy and physiotherapy professions. As a researcher with experience in curriculum design and familiarity with adult learning principles, I was well positioned to implement changes in the curriculum. I worked with an expert advisory committee of peers in occupational therapy, physiotherapy and speech-language pathology, as well as OTA/PTAs and members of other professions in order to thoughtfully design a model curriculum that reflected the OTA/PTA competencies detailed in national competency profile documents (CAOT, 2009; Physiotherapy Education Accreditation Canada [PEAC], 2012). I recruited a diverse faculty of 10 clinicians (representing occupational therapy, physiotherapy, chiropractic, mental health, kinesiology, gerontology, linguistics, OTA and PTA), and we required students to use the national competency profiles to guide learning outcomes for the courses in the program. Faculty and students transitioned from a traditional didactic teaching approach to adopt a student-centred, collaborative and interdisciplinary experiential learning paradigm that was responsive to the needs of diverse learners within the private career college environment.

At the initial stage of applying for accreditation candidacy, the radical changes that I proposed within the curriculum had not yet been officially implemented. Because several students had already signed up for the 10-month program, senior administration was reluctant to implement changes that would lengthen the program. While placement hours could be added in order to meet the accreditation standards' minimum requirement of 500 placement hours, the entire program needed to be completed within 44 weeks of study. The initial application that I submitted for accreditation candidacy was, therefore, unsuccessful, for a number of reasons related to the curriculum and program design. Feedback from the accreditation team confirmed that 10 months is not a sufficient amount of time for students to obtain essential knowledge, develop skills and reflect on their performance in order to demonstrate appropriate levels of competency in each role. It was recommended that the application be resubmitted featuring the proposed new curriculum instead.

Designing a model OTA/PTA curriculum

In preparation for future application for accreditation, I worked with the expert advisory committee in order to design the OTA/PTA curriculum described above to meet the expectations of the OTA & PTA EAP and the needs of a diverse target audience of learners. The resultant model curriculum is based on an extensive qualitative analysis of existing educational programs and community and student feedback; it explicitly features the OTA and PTA competencies outlined in national competency profiles (CAOT, 2009; PEAC, 2012). Drawing on feedback from the accreditation committee, I proposed lengthening the program to span 16 months and offering students three separate and distinct semesters with both coursework and fieldwork education, representing (a) community development/rehabilitation experience, (b) occupational therapy support experience, and (c) physiotherapy support experience. In OTA/PTA education, an interprofessional faculty is essential, and the expertise of instructors should be supplemented by interactions with clinicians, vendors and clients from the community whenever possible (by hosting elective in-services in the learning space). As an interprofessional team, faculty at private career colleges should work with learners to create the unique learning environment that they require in order to become reflective, client-centred, informed and competent assistants for Canadian occupational therapists and physiotherapists.

Conclusion: A valuable resource to occupational therapy practice

Despite the obstacles described in this article, there are a number of private career colleges that are rising to the challenge of implementing innovative problem solving and collaboration in order to lead the transformation of OTA/PTA education in these institutions. As a therapist who supervises many OTA/PTAs in community practice, I have found that, as mature learners, graduates from private career colleges often have a great deal of lived experience that can enhance their ability to support rehabilitation professionals and clients alike. Making accreditation possible for students in private career colleges ensures that the group of learners served by these institutions enjoy the same employment opportunities following graduation as public colleges, as employers increasingly seek graduates from accredited programs.

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About the author

Danielle N. Naumann, OT Reg. (Ont.), is an occupational therapist in private practice and a PhD candidate at Queen's University. She previously held a position as program coordinator for an occupational therapist assistant and physiotherapist assistant (OTA/PTA) diploma program at a private career college, and has subsequently designed a model OTA/PTA curriculum for use in private career colleges. Educators interested in more information about this model curriculum can contact Danielle at: danielle.naumann@queensu.ca

PRIVATE PRACTICE INSIGHTS

TOPIC EDITOR: FLORA TO-MILES

Juggling different hats in private practice

Adeena Wisenthal

Occupational therapists practice with a client centered holistic approach (Canadian Association of Occupational Therapists, 2012; Townsend & Polatajko, 2013; Wilkins, Pollock, Rochon, & Law, 2001). Our professional orientation requires us to wear different metaphorical "hats," reflecting the diverse roles we assume in our practices.

The breadth of our varied roles is captured in the Canadian Model of Client-Centered Enablement (CMCE; Townsend, Polatajko, Craik, & Davis, 2007) which asserts that enablement is a core competency of occupational therapy. This model includes a spectrum of enablement skills, illustrating their interwoven nature and reflecting the range of roles that occupational therapists play in day-to-day practice. For example, we are collaborators when we work together with clients to determine their occupational goals, we are educators when we teach pacing techniques or how to use a particular piece of technology and we are consultants when we are sought after for our expertise on return-to-work planning and workplace accommodations.

In addition to fundamental occupational therapy skills, a practitioner working in private practice requires knowledge and skills pertaining to the establishment of the practice and to its ongoing management and success. In this article, I present some tips related to the various roles we assume in private practice based on my experience. These may assist occupational therapists who contemplate starting a private practice.

As a small business owner, the private practice practitioner needs to handle the challenges of running a small business, which include setting its overall vision and strategy, ensuring its viability and implementing effective marketing for customer recruitment and retention. This requires business acumen, knowledge of accounting and tax concepts, as well as marketing and technical skills. Personal sustenance skills (e.g., stress management, time management) mitigate the stressors associated with running a small business. While knowledge pertaining to college requirements and processes as well as regulations related to the collection of client information is necessary for every occupational therapist, this is particularly crucial for the private practice practitioner who is solely responsible for adherence to college regulations. The cumulative skills required for a private practice practitioner are summarized in Figure 1.

The following are some examples of the skills required of a private practice occupational therapist based on my 15 years in private practice:

1. *Business acumen:* Coming to understand the business world is a significant undertaking and can involve a steep learning curve for many. Business acumen can include understanding how a business works in terms of profitability and cash flow, developing a marketing orientation and having the ability to strategize and see the "big picture." Basic business literacy is needed to establish a viable business model with a clear mission and goals to address the needs of all stakeholders. This is ultimately reflected in a sound business plan that demonstrates the potential profitability of occupational therapy services aimed at assisting clients in their rehabilitation journeys.

   A business mentor can be extremely valuable in helping an occupational therapist lay the foundation for a successful business. There are also resources available through the Canadian Association of Occupational Therapists (CAOT) to help support occupational therapists in private practice. These include position statements, private practice networks and publications

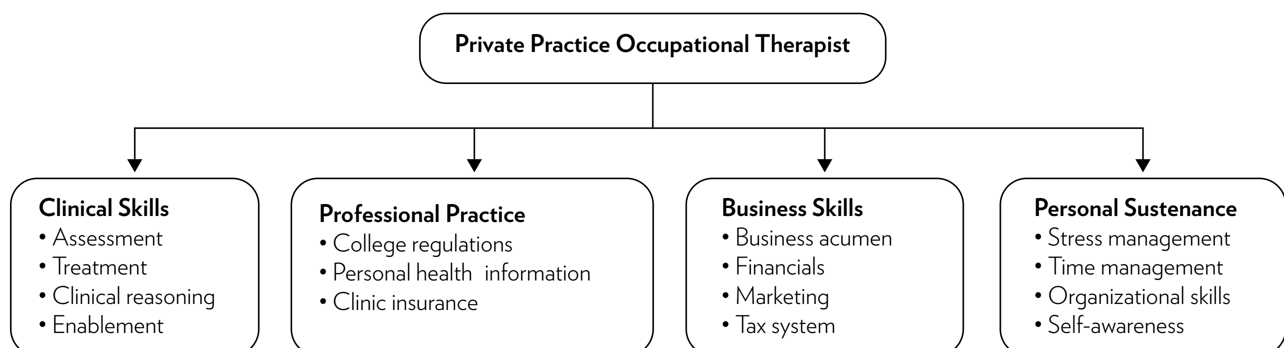

Figure 1. **Cumulative skills necessary for private practice occupational therapists.**

(e.g., Seeberger, 2013). Fee structure is an important consideration when setting up a private practice. As therapists, we want to help our clients, but we also need to ensure that our businesses are viable and that we are fairly compensated. Information regarding how some therapists structure their fees is available through CAOT (Simmons, 2013; CAOT-BC, 2015). The government of Canada also offers resources for small business entrepreneurs through publications, workshops and mentorship programs (see www.canadasmallbusiness.ca; www.canadaone.com).

The federal government provides information on how to do business with the government (see www.wd.gc.ca) and how to sell to the government (see www.canadabusiness.ca), as well as offering the opportunity to bid on Canadian public tenders through MERX, Canada's leading electronic tendering service (see www.merx.com).

Individual provinces offer opportunities for small businesses and entrepreneurship. It is wise to familiarize oneself with these based on the province in which one is working and setting up a private practice. As well, local chambers of commerce and business networking groups (e.g., www.womensbusinessnetwork.ca) can offer support and direction, inspirational speakers and networking events, and timely and relevant information on the local economy.

2. *Accounting fundamentals:* An occupational therapist in private practice needs to have an understanding of basic accounting principles in order to ensure that appropriate financial and record keeping structures are in place. Drawing on the expertise of a professional accountant can ensure that one's private practice is adopting a sound financial system (with ongoing review of fee structures for business viability) as well as a thorough accounting recording system to track financial transactions (e.g., billings, expenses). Accounting systems can range from ad hoc spreadsheets, to accounting packages, to clinic-specific management software integrating scheduling, billing and various other aspects of client file management.

3. *Tax system literacy:* Basic knowledge of the Canadian tax system is important in order to make sound business and financial decisions throughout the year. Being aware of major tax benefits and exemptions, understanding sales taxes and attaining general financial literacy have implications for running a rewarding practice. Many books are available on this subject and the Canada Revenue Agency (www.cra-arc.gc.ca) is also a valuable resource. Again, an accountant (or other tax professional) can assist the therapist in this area.

4. *Marketing skills:* As therapists, we focus on our clients and their needs in order to help them reach their goals. In private practice, however, we also need to promote ourselves in order to market our practices and build our businesses. While the private practice occupational therapist does not have to be a marketing professional, acquiring some comfort in the world of marketing is of definite benefit. We need to become at ease with self-promotion through recognizing our value as therapists and promoting the value of our practice. Embracing marketing strategies and marketing tools facilitates the process of attracting clients and building a successful private practice. There is a plethora of resources available, including books, online material, workshops, software tools, business coaches and marketing consultants (e.g., www.julietaustin.com). A professionally designed website is a necessity once a practice's identity and marketing approach are established. Social media can also play a role in promoting the practice.

5. *Technology skills:* Today, most occupational therapists have at least basic computer skills. More in-depth technological knowledge, however, may be helpful for an occupational therapist running a private practice. Knowledge of clinic management software can assist with client bookings, billings, payment tracking and overall record keeping. The individual therapist will need to sift through the myriad record keeping software that is available and determine what is the "best fit" based on needs and ease of use. A more advanced knowledge of technology may be especially necessary if the private practice therapist uses technology as a part of service provision to clients. The services of an information technology (IT) specialist should be sought, as required, to assist with IT setup, troubleshooting, or other technology-related needs in order to ensure a practice runs smoothly.

6. *Time management:* We frequently urge our clients to adopt time management strategies to help them balance many conflicting demands. These strategies are more important than ever when running a private occupational therapy practice. Not only do we need to provide direct services to our clients, but we also need to take care of business decisions, respond to various stakeholders, determine marketing strategies, consider purchases, write reports and respond to other communication requests. Juggling various demands and responsibilities can be stressful, necessitating good time management and organizational skills. Using a paper-based or electronic agenda is critical, and writing notes is a helpful memory aid. Set aside time for answering phone messages and

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emails; do not spend your day dealing with interruptions as they arise. Schedule 15-30 minutes first thing in the morning to plan your day and schedule 15-30 minutes at the end of the day for wrapping up, returning messages and planning the next day. Be aware that one cannot ever have everything done. Accept this and recognize that you are doing a great job.

7. *Stress management:* Beyond using their clinical skills and business skills and giving expression to their entrepreneurial spirit, private practice occupational therapists need to take the time to take care of themselves. The key to juggling the many demands of a private practice occupational therapist is employing effective stress management strategies. This includes nurturing ourselves through healthy outlets that can provide respite from the demands we face, re-energizing us and helping us gain perspective and be more effective in our therapist roles. Engaging in physical activity and the arts can be part of our self-care. Family, friends and colleagues also make up the support system that can help us manage our stress.

8. *Self-awareness:* Acknowledging our strengths and limitations is part of self-awareness. Self-awareness is crucial in private practice, because while we may be very competent clinicians, we may indeed have some shortcomings when it comes to running a small business or private practice. Accepting our limitations propels us to seek ways to address whatever gaps we may have in our knowledge bases or skill sets. As already noted, resources can include a business mentor or an accountant, as well as books and relevant training workshops.

9. *Professional regulations:* Each province's regulatory college exists to protect the public interest and provides professional guidelines and regulations that every occupational therapist must follow in order to ensure they are competent, ethical and accountable. There is a wealth of resource material available from each of these colleges which can include information regarding informed consent, record keeping and ethical dilemmas. Private practice therapists need to stay informed of professional regulations and policies. We are responsible for our own oversight, which is crucial for our practice as individual occupational therapists as well as our private practices as businesses.

   Furthermore, if the private practice operates under a trade name then the entity needs its own clinic professional liability insurance over and above the individual insurance for each practitioner. This is distinct from general liability insurance applicable to all businesses.

10. *Personal health information:* Private practice occupational therapists need to be aware of federal rules and regulations applied to businesses pertaining to the collection, use and disclosure of personal information as outlined in The Personal Information Protection and Electronic Documents Act (PIPEDA). Many provinces also have their own privacy laws, similar to the federal law, that all health professionals are required to follow.

While it may seem daunting, the rewards of a private practice outweigh inherent challenges. Working as a private practice occupational therapist provides autonomy and self-direction, which can be extremely satisfying. The personal investment in a private practice is well worth the effort for occupational therapists with entrepreneurial spirit.

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INTERNATIONAL CONNECTIONS

TOPIC EDITOR: ANDREW FREEMAN

A fieldwork placement at Amar Seva Sangam: A "just-right" experience in community-based program development

Jana Abdulrahman

In 2014, I had the pleasure of completing a fieldwork placement in a picturesque 30-acre property surrounded by the Western Ghats mountain range. Nestled in the heart of rural Ayikudi in southern India, the campus of Amar Seva Sangam (ASSA) is lively and unique. Aromas of jasmine and incense fill the humid air, and clouds float along the majestic peaks. Resounding Hindu mantras pierce the silence early in the morning and intertwine with ASSA's quiet prayer for equality, carried in the hearts of its people. The atmosphere is innately inspiring, for ASSA aims to empower people with physical and mental health challenges—as individuals and as a collective—to be active agents of change who can guide the population of South India toward becoming a more inclusive society. A self-proclaimed "valley for the disabled," the establishment is full of colourful buildings that bustle with people of diverse abilities who work together to make in-house rehabilitation and community outreach services available to the rural villages of Tirunelveli district (Krishna, 2003). In 2013-2014 alone, ASSA provided services to over 800 villages, influencing the lives of more than 14,000 individuals living with disability (ASSA, 2014). ASSA aspires to play the role of an "enabling agent" for equality in society (ASSA, 2014, p.7.), a role that greatly mirrors that of the occupational therapist in "enabling a just and inclusive society," as described by Townsend and Polatajko (2013, p. 380). This orientation makes ASSA a highly appropriate context in which to do role-emerging occupational therapy work. Indeed, ASSA offers a tremendously valuable experience for therapists and students interested in improving their program development skills in the context of rural, community-based fieldwork. The aim of this article is to discuss this program development opportunity by sharing a specific project that I worked on during my fieldwork experience.

Overall placement structure

Two of my peers (another student occupational therapist and a student physiotherapist) and I ventured to Ayikudi feeling excited and uncertain. Our uncertainty was primarily due to our anticipation of the challenges typically associated with community-based placements (CBP) and role-emerging placements. Gat and Ratzon (2014) described CBPs as "unique, valuable and challenging practice experiences for students and educators" (p. e48) because students work—individually and collaboratively—through the complexities inherent in the process of delineating and implementing occupational therapy programs. As well, our project felt challenging because the role-emerging nature of the placement meant that we worked with an off-site supervisor to establish a program that met the needs of the community (Thew, Hargreaves, & Cronin-Davis, 2008). Our occupational therapist supervisor—who provided virtual support from Ottawa—encouraged us to adopt a knowledge translation approach that focused on meeting facility-wide needs in a sustainable manner. After consulting with leaders at ASSA, three major projects subsequently emerged: (1) a two-day workshop to inform staff and clients on the spinal cord injury unit about pressure sore prevention and intervention, (2) a one-day workshop to show caregivers and teachers how to provide supportive positioning using readily available materials for children living with cerebral palsy and (3) a six-week program to educate elementary school teachers about designing classroom sensory-related interventions for children with developmental disabilities. The focus of this article will be on the third project.

Program development: Initial stages

Prior to the start of the placement, teachers at Sangamam School (on site at ASSA) had become increasingly concerned about the poor academic performance of their students. Children who attend this school are 5-12 years of age and are living with autism spectrum disorders and/or developmental delays. The teachers had learned from previous volunteers that academic performance may be impacted by problems with sensory processing. They did not, however, understand how these problems affected academic performance, or how to mitigate their effects. My supervisor and ASSA's head physiotherapist identified this as an area of potential growth, which was imperative to the development process because introducing a program that is meaningful to the target population is critical to ensuring its sustainability (Scaffa, 2001).

Next, in the process of assessing stakeholder needs, preliminary discussions with my supervisor emphasized the importance of considering time constraints, limited resources, cultural differences and language barriers. Because the placement was only eight weeks long, and because the students did not speak English, we determined that working with them on an individual basis would not be effective. Instead, we decided that it would be more sustainable to offer teachers an educational program that would empower them to autonomously address their students' basic sensory needs long after the end of the placement.

Program development: Connecting stakeholders and establishing goals

Working in an international role-emerging CBP was particularly enjoyable because of its dynamic nature. In addition to sharpening critical thinking skills, creating community-wide solutions allows students to exercise collaboration, consultation, leadership and management skills, as well as practice being mindful of the cultural needs of a group (Gat & Ratzon, 2014; Thew et al., 2008). Advancing a high quality program required building alliances among stakeholders and resources, including ASSA staff, who communicated their needs and inspired program goals; a McGill University professor, who helped formulate the intervention by drawing on her clinical experience and relating current evidence to practice; and my supervisor, who used her expertise in rural and remote practice to propose strategies that facilitated maximal use of limited resources and promoted program sustainability. My role was to organize on-campus and virtual meetings that connected and engaged stakeholders and resources, which eventually generated an agreed-upon, culturally relevant program to realistically address Sangamam School's needs. Program objectives included familiarizing teachers with the basic principles of sensory modulation and developing their ability to: (1) observe and identify signs of non-optimal modulation affecting students'—as well as teachers'— performance in the classroom, (2) determine sensory activities appropriate for use in the classroom, (3) recognize classroom environmental elements contributing to modulation problems and (4) pinpoint beneficial environmental modifications for optimal student and teacher performance. The ultimate goal was to cultivate teachers' skillfulness in these areas so they could apply this new knowledge long after the fieldwork placement had ended.

Program development: Introducing and adapting the Alert Program®

Williams & Shellenberger's (1996) Alert Program® (AP) explains sensory modulation concepts by relating levels of alertness to the speed of a car engine: "low," "high" and "just right." Teachers can use the program to learn how to identify strategies that change or maintain students' levels of alertness. Occupational therapists commonly use the AP with students with sensory processing problems (Hui, 2014), as the literature has revealed that it is effective in improving sensory processing skills, self-regulation, behavioural management and executive functioning (e.g., Cobb, Fitzgerald, & Lanigan-O'Keefe, 2014; Wells, Chasnoff, Schmidt, Telford, & Schwartz, 2012). Although the majority of the evidence for the AP originates from the United States, the program's benefits have also been demonstrated with Canadian, English, Irish, Australian and Maltese populations (TherapyWorks, Inc., 2015), suggesting that it is applicable across various—albeit largely Western—cultures. To align the AP better with the culture and context of South India, examples of South Indian activities and environments were used in explanations of sensory processing principles. This teaching strategy was augmented by discussions that encouraged teachers to reflect on their daily routines and how different activities and settings affected their levels of alertness. One teacher, for example, was surprised to discover that listening to Hindu prayers at the temple helped regulate her "engine" level in the morning. Another teacher noted a high "engine" level after riding her scooter to work, zipping through the busy, narrow streets. She began considering ways to modulate this level before entering the classroom.

Considering that English is these teachers' second language, the program was simplified so as to avoid overwhelming them with theoretical principles and unfamiliar vocabulary. While all senses were examined in initial teaching sessions and when analyzing student observations, in-class activities and interventions were designed with a focus on targeting primarily the proprioceptive system. Our intent was that, over time, future student occupational therapist cohorts would work with the teachers on designing interventions that revolved around the other senses—one at a time—with each successive year. Teachers were encouraged to think of whole-body proprioceptive activities (e.g., pushing against the wall, moving books, etc.) when planning interventions, because it was felt that they would cater best to the varying sensory needs of a large group of students. These kinds of activities can have calming and alerting effects, and are unlikely to overload the nervous system (Williams & Shellenberger, 1996). Regarding sustainable environmental strategies, teachers were given the opportunity to implement modifications that they felt would balance auditory and visual stimuli in the classrooms. Cluttered classrooms were cleared, blackboard frames were covered with red tape, and "quiet corners" decorated with calming colours, pillows and blankets, were created in each classroom. The school was also provided with vendor information for obtaining headphones to add to the quiet corners.

Due to language barriers, and to help teachers better understand the nature of sensory strategies used in occupational therapy, they were invited to engage in activities that facilitated experiential learning—a recursive process of "experiencing, reflecting, thinking and acting" (Kolb & Kolb, 2015, p. 194). Reflective exercises were used to foster teachers' understanding of how their own behaviours and activity choices represented their varying preferences and reactions to sensory input. This helped clarify the relationship between sensory processing profiles and unconscious self-regulating behaviors. Experiential learning was promoted further through random visits that were made throughout the day to ask teachers to identify their "engine levels" by noticing bodily sensations, current behaviours and environmental elements. Additionally, program classes, run after teachers' working hours, would typically begin with a proprioceptive group activity. This was intended to optimize teachers' learning by addressing their often-reported "low" engine levels, and to facilitate teachers' appreciation of what it might be like for their students who need sensory modulation to be able to focus in class.

Other program activities focused on strengthening teachers' reasoning skills related to sensory processing, through active practice. During two activities, teachers were asked to vocalize (in real time) changes to students' engine levels as evidenced by their behaviours. Discussion sessions followed, to facilitate reflection and allow the teachers to articulate their reasoning. Finally, teachers were challenged to independently tailor sensory strategies for three of their students. This step was designed to

offer teachers a chance to exercise their developing skills, and, together with the constructive feedback that followed, cultivate teachers' sense of competency in tailoring and implementing strategies independently.

Eliciting experiential learning was emphasized in our program plan, not only because it has been shown to promote students' confidence in their therapeutic skills, decision-making abilities and autonomy (Smith, Emmett, & Woods, 2008), but also to promote sustainability. Our hope was that by allowing teachers to directly experience the effects of simple sensory strategies, teachers would gain confidence in their use and become intrinsically motivated to continue using them after we had left. Indeed, anticipation of positive outcomes has been shown to improve teachers' perceptions about the acceptability of an intervention program, and program acceptability has been identified as one of the four "essential ingredients" that characterize sustainable classroom-based programs (Han & Weiss, 2005, p. 672). Other elements we considered included ensuring compatibility of the program with teachers' own beliefs, cultivating teachers' self-efficacy and preventing burnout (Han & Weiss, 2005). Because the school was short staffed, the adaptations mentioned above aimed at making the program manageable so as to avert teacher burnout and discouragement.

Final reflections

CBPs develop student occupational therapists' ability to develop community-based occupational therapy programs (Gat & Ratzon, 2014). This skill development and the role-emerging nature of my experience in India certainly prepared me for the job in which I am currently working. My transition into my position in Merritt, BC, also necessitated defining an occupational therapy role to meet the community's needs. This process was easier than it might have been otherwise because I had a strong foundation in role-emerging, community-based practice. Although training with virtual supervision can be intimidating, it also facilitates the development of a strong professional identity (Wood, 2005), and it improves students' cultural competence and perceptions of personal responsibility (Gat & Ratzon, 2014). My time at ASSA nurtured my resilience and ability to adapt to atypical settings, making it a pivotal milestone in my professional journey.

Update on ASSA

As of 2016, ASSA now collaborates with seven Canadian universities that send students for fieldwork placements throughout the academic year. Canadian occupational therapists now travel to ASSA to provide volunteer occupational therapy services and to supervise students in person. To learn more about ASSA and its volunteer program, contact Dinesh Krishna at: dkrish6@gmail.com

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The power of occupational engagement: Norm's story

Rhona Anderson and Heidi Reznick

In 2007, new Canadian practice guidelines were published in which the Canadian Model of Occupational Performance (CMOP) was broadened to include the construct of occupational engagement. In the Canadian Model of Occupational Performance and Engagement (CMOP-E; Polatajko, Townsend, & Craik, 2007), engagement is viewed as a more inclusive term than performance alone, and Polatajko and colleagues highlight the definition of *engage* as all that one does "to involve oneself or become occupied" (Houghton Mifflin Company, 2014, as cited in Polatajko et al., 2013). The CMOP-E promotes the recognition that an individual does not necessarily have to perform an occupation to be engaged in that occupation, thereby capturing an expansive perspective on occupation. Nine years have passed and, anecdotally, there appears to be limited understanding of this newer model, particularly of the concept of occupational engagement, and an inadequate appreciation of the possibilities that this model can offer practice. The objective of this article is to describe how the CMOP-E can be used to guide occupational therapy practice in a rehabilitation setting using a case example.

Norm's story

Norm (a pseudonym) was a 48-year-old man living in a multi-storey home with his extended family when he sustained an acquired brain injury (ABI). At the time of his injury, he was not working and identified his most significant role as being a "family man," orchestrating and hosting family gatherings. After receiving typical interventions for his acute brain injury, Norm was admitted to the in-patient ABI service of a large academic rehabilitation hospital. Within days of admission, Norm, in collaboration with a family member and an ABI team member—on this occasion not an occupational therapist—created the following typical goals: to improve the function of his right arm, to walk again and to be independent with showering and dressing.

In the usual way, the interprofessional team made plans to identify barriers and address them, with the ultimate aims of discharging Norm with improved "functional ability" and making advances toward achieving his goals within a targeted time frame. Significant barriers identified were Norm's hemiparesis, inability to ambulate, poor organization and sequencing skills, distractibility and ineffective communication (due to aphasia); as well, he showed signs of deteriorating mood and increasing frustration.

A focus on occupational performance

Norm's occupational therapist looked beyond Norm's impairments and the self-care goals identified on admission in order to broaden and deepen her understanding of Norm's meaningful occupations. Norm and his family revealed his passion for making elaborate family meals and hosting dinners during which they could spend hours together enjoying food, conversation and camaraderie. Therefore, Norm and his occupational therapist decided to work on meal preparation tasks due to the inherent meaning they held for Norm.
To increase Norm's competence in meal preparation, the occupational therapist introduced adaptive approaches and tools (e.g., one-handed cutting boards and communication tools). Concurrently, the occupational therapist educated Norm and his family about how using these occupations as therapy provided a means to work on physical (e.g., weight bearing through his affected arm) and cognitive skills (e.g., planning and sequencing) with the hope that the resulting skill refinement would generalize into improvements in Norm's occupational performance across situations.

Although Norm's therapy was focused on enhancing his occupational performance, it did not improve. In addition, his low mood continued, despite the use of meaningful tasks to work on his skills. These outcomes may have been due to the use of these tasks as a *means* to his goal of performance skill development (i.e., therapeutic use of activity), rather than them being related to his *end* occupational goal of hosting a family dinner. Over the course of his in-patient rehabilitation stay, Norm, his family and the interprofessional team observed minimal improvements in his physical, cognitive and communication skills and no improvement in his occupational performance. Norm discontinued working toward his self-care goals, as he found them frustrating and inconsequential. His mood continued to deteriorate.

Considering engagement and the fit chart

To make sense of Norm's story, consider the CMOP-E and, in particular, the application of the occupational constructs of performance and engagement, including their places in the Fit Chart (Polatajko, 2007; see Figure 1). The Fit Chart helps practitioners to organize and understand a client's occupational performance and engagement and helped us to understand Norm's experience of his occupational challenges. We see that Norm's occupational *performance* was challenged due to the lack of "fit" between his capacity (his abilities, skills and knowledge) and the demands of the occupation and the environment. We can also understand the lack of "fit" in his occupational *engagement* due to his level of motivation, interests, sense of meaning and self-efficacy (the mediators of his occupational performance). The lack of fit between what Norm wanted to do and the demands of the

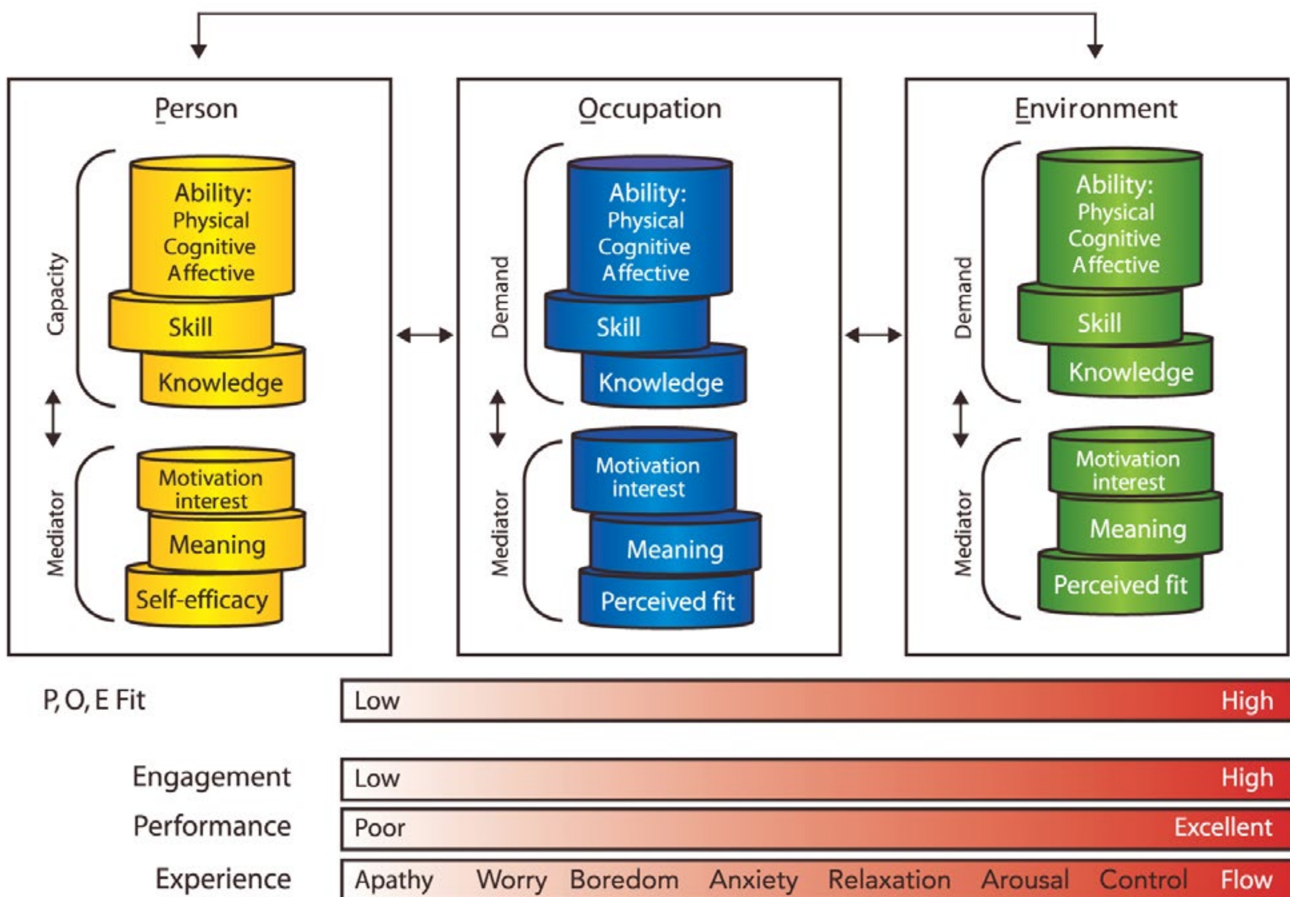

Figure 1. **The Fit Chart (Polatajko, 2007). Reproduced with permission from CAOT Publications ACE.**

occupation and environment resulted in his poor performance, low engagement and what appeared to be the experience of apathy in the rehabilitation environment.

The Fit Chart includes the concept of experience states and flow (from Csikszentmihalyi's work, 2003) and illustrates that the complexity of the occupation's challenge in relation to the person's capacity to meet that challenge occurs across a continuum of experience. This continuum, depicted in a linear way in the Fit Chart, comes from Csikszenthihalyi's graph-like depiction of everyday experiences that maps flow and control (positive states) and apathy and worry (negative states) along this continuum. The concept of flow complements our understanding of Norm's occupational performance and engagement issues.

Norm's physical, cognitive and affective abilities were diminished after his brain injury. Accordingly, the meal preparation tasks that were chosen for therapy sessions were simplified to better match his abilities. However, Norm still required assistance to prepare simple meals. The environment where these skills were practised was in the rehabilitation facility, and although the space was accessible and contained tools designed for individuals with hemiparesis, it lacked other important contextual factors for Norm, namely the social and cultural variables found in his natural home setting. With all of these changes, it is reasonable to believe that Norm's motivation, interest, sense of meaning and self-efficacy were also affected. Norm's response of continued low mood suggests that focusing on the performance of meal preparation may not have been meaningful, and certainly the approach was not effective.

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A shift in focus to occupational engagement

In a later session, Norm and the occupational therapist reviewed the meaning of meal preparation for Norm and established that cooking was an opportunity for Norm to gather his family and be a host, which he defined as his primary role. Based on this perspective, Norm and his occupational therapist decided to host a party, as this better reflected the actual meaning of the goal than did simple meal preparation. The team and Norm's family became involved in execution of this party and Norm was involved in every step of orchestrating the event, with the support of his entire team. The revised focus on occupational engagement became more predominant and occupational performance became a less significant part of the objectives and approach.

Norm's experience of the occupation was enhanced by being the host of the party. In this context, he realized an occupational goal, one of occupational engagement, though he was not performing the task of cooking. Norm's previous experiences cooking may have resulted in worry due to a poor fit between his personal capacity and the demands of the occupation and environment. During the party, he experienced more control, realizing that he was once again hosting his family. Due to his high engagement in the occupation, Norm would have had a greater potential to experience flow, or the feeling of being completely immersed in an activity, with full involvement, enjoyment and energized focus (Csikszentmihalyi, 2003). Norm's improved fit with his occupations and enhanced experience also began to extend beyond the specific activity of hosting, and the rehabilitation team noted improved mood and engagement across all therapies and daily routines. Equally importantly, Norm and his family increased their understanding of what was important for them to do together, and they experienced how someone can be engaged in what he is doing regardless of what task components he performs, thereby learning how to engage Norm in occupations. With this new understanding, Norm and his family made plans to add a kitchen and gathering space on the level of their home accessible to him. This planning was facilitated by his occupational therapist. Also, the interprofessional team's views started to shift regarding what can be meaningful occupational engagement outcomes for patients, particularly for those who may be unable to make gains in the physical, cognitive and communication domains.

Norm's story highlights the importance of effective enablement, specifically regarding occupational engagement. It is a complex task to involve clients in meaningful goal setting, tackle their challenges and collaborate on solutions that enable both occupational performance *and* engagement. Occupational therapists are encouraged to use the CMOP-E and the Fit Chart as cornerstones of their practice to achieve these important occupational outcomes.

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Occupational Therapy Now cover image contest

We received many excellent images from readers in response to the inaugural *OT Now* cover image contest. Thank you to Isabella Cheng and Bonnie Klassen for their time and creative input as contest judges. The winning images will appear on covers throughout 2016 and early 2017. Several other images were awarded honourable mention and will be profiled over the next several issues. Below are two images from Emma Smith, along with her explanations of why these images are meaningful.

"This photo represents the possibility of overcoming when there seems to be no options. Climbing often requires one to look for hidden opportunities to overcome challenges, or to approach a task in an alternate way. I think occupational therapists often help their clients to find these opportunities in their day-to-day lives."

"This photo represents the possibility of movement and action. Although the boats are still, they have great potential. I like to think of all the activity they will see in their lives, and the hours of meaningfulness they will hold for the ones who use them."

SENSE OF DOING

TOPIC EDITOR: SHANON PHELAN

From street life to lodging: Reflections on Tim's occupational journey

Tracey Faulkner

The words of Dr. Brené Brown (2011), researcher, professor, author and businesswoman, resonate well as I begin my reflection: "You're imperfect and you're wired to struggle but you are worthy of love and belonging." This quotation reminds me that we are all imperfect humans doing our best on this journey of life, struggling at times and soaring at others. Most importantly, it allows me to reflect on the humanity that we, as occupational therapists, bring to the work we do, partnering with clients on their occupational journeys. In this narrative, I will share my experience working with one man as he accomplished his journey from chronic homelessness into housing and enriched occupational experiences. This change was made possible by his courage and willingness to trust others.

I first met Tim (a pseudonym) at the local shelter in the fall of 2014. I was the newest member of a clinical team created to support local Housing First teams who work diligently to house individuals with a history of chronic homelessness, many with significant substance use and/or mental health challenges. After a few brief encounters with Tim, I started to get a better understanding of who he was and what his occupational strengths and challenges were. He agreed to meet with me weekly as we moved into winter.

Occupational profile

To present Tim's occupational profile, I have drawn upon the Person-Environment-Occupation (PEO) Model (Law, Cooper, Strong, Rigby, & Letts, 1996):

Person

Tim is of average height with a slim build and is in his seventies. He typically wears heavy boots and a multi-pocketed safety vest over a winter jacket. Pockets in each layer of his clothing are loaded down with a variety of items: pens, pieces of scrap metal and almost any little trinket you can imagine! Tim shared that he had been residing in the area without a home for over twenty years. I later learned that Tim had lost his wife as a result of a fire and that he maintained contact with several of his children and grandchildren.

Environment

Tim shared that he spent most of his daytime hours in the city and occasionally in nearby towns, and most of his evenings and nights at the local shelter with upwards of 100 other individuals. Tim described that he would sleep with his boots and clothing on "for fear of having my property stolen" (personal communication, December 2014). In the mornings, he would grab a coffee and a donated pastry and be off for the day, sometimes going to the local soup kitchen for a midday meal.

Occupation

A typical day for Tim would include touring the area on one of the many bicycles he had stashed around the city. Cycling was his primary method of transportation after having had his driver's license revoked as a result of his hoarding behaviour—in this case, filling the vehicle with so many items that the windows were obscured, impairing his safe operation of the vehicle. Tim proudly shared that he often bartered with a number of local business owners for items to repair his bikes and bike trailers or to use for other numerous projects. He also collected discarded beverage containers and would occasionally pick up "odd jobs" to supplement his pension income. Tim identified with several area churches and managed his own finances. The highlight of his week was attending the Housing First Art Program, offered twice weekly downtown at the local community arts centre.

Figure 1. **Introducing Tim.**

Facilitating occupation using a capability approach

Working using the capability approach defined by Sen (1985, 2005) and discussed in Townsend (2012) and Hammell (2015), wherein the emphasis is on client strength and the promotion of occupational justice, Tim and I continued to build professional trust, breaking down barriers often encountered by clients with mental health challenges, and focused our attention on Tim's primary occupational goal of finding a place to call home. His vision included an apartment where he would "feel safe and [could] do the things [he] like[s] to do" (personal communication, January 2015).

Over several months, we viewed a number of apartments and submitted several social housing applications, but these were denied due to concerns about Tim's eccentricity, mental health issues (including hoarding behavior) and ability to manage his daily occupations. With his consent, we submitted an application to the local seniors' housing organization. Tim, freshly showered and looking sharp in new-to-him clothing, agreed to meet with the applications director, and although we were advised that the seniors' apartments were full, we were invited to tour the local downtown lodge and meet with the manager.

On the day of the tour, we were greeted warmly by the lodge manager, who respectfully used Tim's full name and took the time to direct all conversation toward him. As we toured the lodge, we were introduced to several of the regular staff. I watched Tim carefully during the tour; I saw him listening attentively and scanning the environment. As he greeted a few past acquaintances, I saw glimmers of hope cross his face. After the tour, we were welcomed to return for lunch the following week, after which the lodge manager offered him a one month trial. Initially, Tim was not keen on the idea of lodge living. However, Tim and I reviewed his finances and budget, as well as discussed the pros and cons, and he decided to accept. We worked to ensure that the first month's rent and tenant insurance were paid, and that some furniture and other pertinent items were secured through the generosity of the Salvation Army and the Furniture Bank. We celebrated moving day with balloons and goodies. I recall the joy I felt that day at seeing Tim being ushered welcomingly into his new home by the lodge's staff and residents.

Occupational transitions: Doing, being, becoming and belonging

After living for so many years on the street, Tim's admission to the lodge was a significant adjustment not only for him, but also for the staff and the other residents. It took time for him to grow accustomed to the meal schedule, to being served and to the communal living experience, as well as to adjust to his new safe space and not feel the need to be constantly on guard. Early on, we noticed that he was often very tired and agitated in the morning and he shared that he was up most of the night "watching TV documentaries and learning as a much as [he could]" (personal communication, June 2015). To assist in his housing and occupational transitions, our team supported Tim with visits three to four times a week for the first four months, working to help him establish a sense of belonging and security. Research by Andonian and MacRae (2011) identified social participation as being attained as a result of a sense of belonging, healthy and active living, and acceptance of differences and change. The lodge manager, her staff and the other residents made incredible efforts to welcome and accept Tim, to change their expectations, to help him adjust to some of the daily routines, and to include him in lodge activities and outings. As the weeks and months progressed, we continued to observe a shift from doing and being to becoming and belonging (Wilcock, 1998; Hammell, 2014; Rebeiro, Day, Semeniuk, O'Brien, & Wilson, 2000).

During the transition, Tim and I also worked on his self-care and mannerisms and some instrumental activities of daily living (laundry, budgeting, organizing). He agreed to an assessment with home care services and accepted twice weekly shower assistance. Over time, we have noticed a decrease in his agitation, and for the most part, he is now cheerful and chatty. All but a few of the residents have openly embraced his presence and the staff, with the lodge manager's support, have gained his trust and are assisting with his efforts to maintain cleanliness and limit his tendency for collecting items. My favourite memory of Tim's journey thus far is seeing him enjoy a delicious meal and all the festivities at the lodge's Christmas party. He appeared very animated and relaxed, singing along with the music and complimenting others on the food, the music and the décor. There were even a few teary eyes in the room, including mine and the lodge manager's.

Building sense of self through doing

I also witnessed the transformation of Tim's occupational identity through participation in old and new occupations (Christiansen, 1999; Kielhofner, 2002). Tim and I initially typically met in a local coffee shop or fast food restaurant. I would occasionally connect with him at the art centre because I knew his attendance there was meaningful and regular. As demonstrated by Thomas, Gray, McGinty and Ebringer (2011), art programs provide an opportunity for meaningful occupational engagement and participation, as well as routine and a positive, secure environment. Similar to Thomas and colleagues' (2011) findings, Tim's sense of identity and confidence continued to grow with the help of this form of social inclusion and was enhanced when his artwork was recently acknowledged in a public art display at the art centre.

We also saw Tim's confidence and sense of self grow when we facilitated a job interview with the director of the downtown Clean Sweep program and he was offered weekly part-time work. He continues to enjoy his work with the program director, in which he cleans and repairs small engines. He is considering developing a prototype bicycle equipment cart to ease the physical work of other employees.

About the author

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Among the more exciting components of community engagement, from Tim's perspective and supported by various researchers (Rebeiro, 2001; Blank, Harries, & Reynolds, 2015), are the enhanced opportunities it provides for participation in meaningful and desired occupations, as well as the powerful increase in a person's sense of identity it can create. Since moving into the lodge, Tim has increasingly enjoyed a variety of leisure occupation opportunities, including pet therapy, museum visits and a fishing trip to the mountains. Tim's own words resonate loudly: "The real joy is that I feel I can be myself and that I can enjoy the good people and good thoughts" (personal communication, December 2015).

***Figure 2.* Tim and a display of his art.**

Conclusion

This narrative has provided you with the story of one client's successful transition to housing and enhanced social inclusion through occupation, from this writer's perspective. I have found meaning in not only getting to know this creative, resilient and intelligent man, but also in having the opportunity to advocate for his rights to housing, occupational justice, engagement and identity.

My hope is that the story of Tim's journey will be a strong reminder that occupational engagement and performance are not just about individualism and independence, but also about building trust, earning respect, facilitating meaningful participation and establishing a sense of community connectedness (Hancock, Honey, & Bundy, 2015; Norman, Pauly, Marks, & Palazzo, 2015). It also speaks to Hammell's (2015) reflections on the capability approach: "The essence of this perspective defines *capabilities*, not as physical or cognitive abilities but as the freedom or *opportunity* to choose what one wishes to do and to be, and to act on these wishes" (p. 81).

Acknowledgments

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OT THEN

TOPIC EDITOR: HADASSAH RAIS

The melding of work and the mending of spirit: Applied arts at Mount Allison University and occupational therapy at the University of Toronto

Judith Friedland

The following article was originally published in an exhibition catalogue for the Owens Art Gallery at Mount Allison University (2015). It is reprinted here with permission from the gallery. The original article can be found in:

Owens Art Gallery. (2015). *All Things Useful and Artistic: Applied Arts at Mount Allison University 1906-1960*. Sackville, NB: Mount Allison University.

When injured soldiers of World War I began to return to Canada for treatment and convalescence, women who were skilled in crafts offered their help. The soldiers often faced a lengthy convalescence and these women, known as ward aides, provided 'occupations' at the bedside, on the wards, and in workshops. Specific crafts were selected on the basis of what the injured soldier showed an interest in and could tolerate, and whether the craft could be adapted to meet the soldier's limitations; for example, crafts could be used to improve physical function through building muscle strength and increasing joint range, and also to improve cognitive functioning by requiring increasing degrees of concentration, attention to detail, and problem-solving. With a long-term goal of re-establishing the injured soldier into his home and family and into a work setting, actions were graded both within an activity and across activities to gradually build skills and stamina. As an example, weaving on a small loom that was specially constructed for use in bed could be graded from a simple to complex pattern and from minimal to maximal exertion. That occupation could be followed by basket-weaving on the ward, and then woodworking in a special workshop. However, the crucial first step was for the ward aide to engage the soldier. It was her job to help restore his spirit which had been sorely challenged if not destroyed by war. For that she needed compassion, an ability to teach, and ingenuity.

In the early years of the war, ward occupations were not an organized effort, but as time went on, and casualties mounted, this intervention was seen as essential by the Military Hospitals Commission of Canada and the position was formalized. By 1918, special training courses for ward aides were offered at the University of Toronto (U of T). Three Mount Allison graduates of the Art Department attended: Greta Ogden, Wenonah Brenan, and Margaret Harris. In the spring of 1919, a course was also offered at McGill University in Montreal; it attracted seven Mount Allison graduates: Vesta Taylor, Sybil Calkin, Marjorie Ayer, Ada Ford, Bessie Bole, Jean Smith, and Marian Terry.[1] The courses were designed to give the women a better understanding of what the soldier had suffered, physically and emotionally, and some knowledge of hospital procedures. There were also classes in crafts – many of which were likely not needed by Applied Arts graduates from Mount Allison and elsewhere.[2] Letters of reference from the Military Hospitals Commission considered graduates of the ward aides course "qualified to teach patients a variety of crafts; for example, basketry, wood work, metal work, weaving, bookbinding, and bead work."[3] The courses were in great demand despite the fact that acceptance meant that the applicant had to agree to be posted anywhere in Canada and work for the Department of Soldier's Civil Re-establishment for at least one year upon graduation.

Even before the war an affinity between Mount Allison University and what was to become occupational therapy had been apparent in the person of Thomas Bessell Kidner. Kidner had been brought to Canada from England in 1900 by the Macdonald Manual Training Fund to organize the teaching of manual training in Nova Scotia.[4] From 1904 to 1911, Kidner was the Director of Manual Training and Household Science for New Brunswick. Like other reform educators of his day, Kidner was committed to the development of manual skills

Class in Woodwork—First Year, Occupational Therapy

Courtesy of University of Toronto Archives and Records Management.

as a means of improving education. In an address to the students of the Household Science class at Mount Allison in 1905, he congratulated the program for exemplifying "the spirit of modern education, the spirit of investigating and *doing*, as opposed to the older spirit of passive receptivity"[5] (author's italics). Kidner continued with this type of work in Calgary from 1911 through 1915 when he was appointed Vocational Secretary for the Military Hospitals Commission of Canada. In his new position he was to help re-establish Canada's disabled soldiers by returning them to their former jobs or, where necessary, by retraining them for new ones. It was Kidner's program that was carried out by the ward aides and soon became known as occupational therapy.[6] In 1917 Kidner became a founder of the (American) National Society for the Promotion of Occupational Therapy and in the 1920s he served three successive terms as its President. Thus his presence in the Atlantic Provinces pre-war, and particularly his lengthy stay in New Brunswick, may well have influenced women from the area to take up the work when war came.

When the war was over, occupational therapists sought to expand their work to civilian populations and to establish a permanent educational program. The diploma program at U of T began in 1926 and until 1950 it was the only program in Canada. Once again, preparation in an applied arts department was considered a distinct advantage and the link between Mount Allison and occupational therapy (first established by Ogden, Brenan, and Harris) was continued. Indeed by 1931 there was talk of a collaborative program whereby students could attend the applied arts program at Mount Allison and then transfer to the occupational therapy program at U of T for their second academic year and two months of hospital experience. The minutes of a meeting of the Department of University Extension, which housed the course in occupational therapy, dated 29 October 1931 noted that "It should be understood that this arrangement would continue until such time as the University of Mount Allison could give the whole course . . ."[7] By 1933, courses had been set out and the plan for affiliation appears to have been agreed upon. In 1939, Mount Allison President Trueman wrote W.J. Dunlop, the Director of the Department of University Extension, to confirm that the arrangements still stood, noting that Mount Allison has "greatly developed our handicraft work and I feel that there is the possibility of more students becoming interested." Dunlop's response makes it clear, however, that the arrangement had not been acted upon: on 11 December 1939, he wrote "so far, not a single student has taken advantage of the arrangement we made six years ago."[8]

Why Trueman was so interested in occupational therapy is not clear although it is possible that his cousin, Elizabeth McLeod, who was Head of the Mount Allison Fine Art Department from 1916 to 1935, encouraged him. She had met with Florence Wright, a graduate of both the ward aides course and the diploma course at U of T (and also a graduate of the Ontario College of Art) when Wright visited Mount Allison in the summer of 1931 and it is likely that the topic was discussed. Trueman's continuing interest in occupational therapy was apparent when he agreed to become a member of the Honorary Advisory Board of the Canadian Association of Occupational Therapy in 1932.[9] Meanwhile, the idea that Mount Allison and U of T did actually take advantage of their relationship persisted and in 1940, Marion (Terry) Gibbon, a graduate of Mount Allison and a student in the ward aides course given in Montreal wrote "...There is room for expansion [of occupational therapy] in this province [New Brunswick], as there are a number of hospitals that might and should be serviced, as well as *an excellent opportunity for part training at Mount Allison University which has an affiliated course with Toronto University.*"[10] (author's italics)

Courtesy of CAOT Publications ACE.

Looking at the occupational therapy curriculum at U of T in 1926 it's easy to see the affinity with the Applied Arts Department at Mount Allison. In addition to the medical courses (anatomy, physiology, psychology, psychiatry, etc.), the program provided courses in art and design and practical classes in a host of crafts, including leather-work, pottery, woodwork, metal work, rug-making, bookbinding, bead work, weaving, jewellery-making, and basketry, to name the more popular.[11] However, as time went on, the emphasis on crafts began to decrease and by the late 1970s crafts had all but disappeared. Indeed the teaching of crafts was an issue for any academic program – whether at U of T or at Mount Allison – as there was a sense that 'making things' should not be part of a university curriculum. This criterion was not imposed by the institution in the case of U of T; rather, it came from within as occupational therapy strived to raise its academic standing.

About the author

Judith Friedland is professor emerita in Occupational Science and Occupational Therapy at the University of Toronto, and a former chair of the department. Her recent research has focussed primarily on the early history of occupational therapy and has included the book, *Restoring the Spirit: The beginnings of occupational therapy in Canada, 1890-1930,* which was published by McGill-Queen's University Press in 2011.

As Virgil Hammock has said in comparing the status of fine art with applied art programs at Mount Allison "it was better to be a thinker than a doer."[12] No one talked then of the thinking that could accompany the doing: what is creativity, what is meaningful occupation, what is the value of having pride in making something with your hands, how does being engaged divert the individual from stressful – or even pathological – thoughts, etc.[13]

The philosophy of William Morris and the Arts and Crafts movement seemed to permeate the thinking behind the use of crafts in the treatment of injured soldiers. It was understood that art was, as Morris had professed, for all, and that included patients.[14] Furthermore, many of the articles that were produced were intended to be useful.[15] Usefulness was important as there was often the potential for patients to supplement their family's income (when articles could be sold in a craft shop), or to save the family money (when articles could be used at home). However, good design and proper execution were critical if items made in occupational therapy were to be sold. Thus one reason why the occupational therapy program at U of T wanted to attract Mount Allison graduates (and those from other art schools) was to ensure that graduate occupational therapists could not only teach crafts but could ensure the production of saleable items. For the art graduate herself, with few options in the early 20th century for women who wanted to work outside the home, being able to apply her art-making background in a paying job must have been attractive. Occupational therapy offered a challenge, a sense of adventure, and an opportunity to help.

By war's end, it was realized that Canada's economy could not afford to have its injured soldiers remain dependent. The importance of work had been stressed by Kidner from his manual training days through to his role as Vocational Secretary and it marked his influence on occupational therapy. This melding of work and mending of spirit in the goal of the occupational therapist could be seen in the crest worn on her hat (along with her renowned green uniform).[16] The crest was triangular in shape and showed a clenched fist holding a hammer and resting on a bar, with a rising sun in the background. The symbols related to the nobility of work and how it could light up mind, body, and spirit. The Latin words *Per Mentum et Manus ad Sanitatem* were soon added[17] ("Through mind and hand to health") making for a good description of the process and the outcome for which early occupational therapists strove. Mount Allison graduates from the applied arts program who became occupational therapists found their art background to be a great advantage. They used it to make an important contribution to the well-being of injured soldiers in WWI and to lobby for the importance of occupational therapy for civilians.[18] They were artists who were highly skilled in crafts and they had the ability to engage the soldiers and hold their interest as they taught them new skills. Through the use of his mind and his hand, the soldier then began his journey to health.

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[1] M. Gibbon. "History of occupational therapy in the Maritimes". *Canadian Journal of Occupational Therapy, 7*, no. 2 (1940): 73-74. A number of other women from the Maritime Provinces and Newfoundland are known to have become occupational therapists; for example, Mary Black, Eileen Keeffe, Alice Murdoch, Lillian Sweeney, Jean Blanchard, and Edith Hunton. No doubt there are more.

[2] Many women who became occupational therapists attended art programs; for example, at the Pratt Institute in New York, The Boston School of Art, and The Ontario College of Art in Toronto.

[3] Library and Archives Canada, Department of Veterans' Affairs fonds.

[4] J. Friedland and N. Davids-Brumer. "From Education to Occupation: the story of Thomas Bessell Kidner." *Canadian Journal of Occupational Therapy, 74*, no. 1 (2007): 27-37.

[5] *Allisonia*, Vol. III, No.1, Sackville New Brunswick, November 1905, 228.

[6] The original plan for re-establishing injured soldiers was instigated by a Toronto woman, Ina Matthews, who had been providing occupations at the bedside for convalescing soldiers in Sydney, Nova Scotia at the home of her sister Mrs. J.K.L. (Ethel) Ross. Matthews worked with others to bring the matter to the attention of Ottawa in Sessional Paper 35a. See *Restoring the Spirit: The beginnings of occupational therapy in Canada, 1890-1930.* Montreal: McGill-Queen's University Press, 2011.

[7] University of Toronto Archives and Records Management (UTARMS), Department of University Extension. See also W.J. Dunlop. "A brief history of occupational therapy." *Canadian Journal of Occupational Therapy, 1*, No. 1 (1933): 6-10.

[8] Mount Allison University Archives, 7837/1A/307

[9] Mount Allison University Archives, 7837/1A/307

[10] M. Gibbon. "History of occupational therapy in the Maritimes". *Canadian Journal of Occupational Therapy, 7*, no. 2 (1940), p.74: 73-74.

[11] UTARMS, Calendars for Academic Programs. These calendars do not show any record of china painting.

[12] V. Hammock "Art at Mount Allison." In *Liberal education and the small university in Canada,* by Christine Storm, 105-113. Montreal, Mc-Gill-Queen's University Press, 1996.

[13] Occupational Therapy programs now study these questions in earnest as they pursue knowledge in occupational science. The history of the profession's focus on engaging in meaningful activity is explored in Friedland, *Restoring the Spirit.*

[14] William Morris, "I do not want art for a few, any more than education for a few, or freedom for a few." The Lesser Arts, In *Hopes and Fears for Art*.

[15] Morris "Have nothing in your homes that you do not know to be useful, or believe to be beautiful" The Beauty of Life, In *Hopes and Fears for Art.*

[16] The work done by these women attracted the attention of newspapers and magazines. See for example, G. Pringle, "God Bless the Girls in Green" in *MacLean's* Magazine, February 15, 1922.

[17] The crest was designed by N. Burnette and S. Fryer and was used in various iterations until 1988.

[18] Margaret Harris graduated from the Arts and Crafts program at Mount Allison in 1912, attended the second ward aides course offered in Toronto in 1918, and remained there to teach for several months. She also produced teaching materials for weaving and rug-making. Upon her return to New Brunswick, she was appointed provincial ward aide supervisor. However, by 1924, both she and Ada Ford had left for the US to take on teaching positions at the School of Occupational Therapy in St Louis, Missouri. Wenonah Brenan, became the principal of the ward aides course at McGill just two months after graduating from the ward aides course at U of T. She then went to Camp Hill Hospital in Nova Scotia and oversaw the work in that province, moved to the US, and eventually ended up teaching household science at Cornell University. Both women fought for the extension of occupational therapy to civilian populations. Greta Ogden came home to New Brunswick to work at Old Government House Military Hospital in Fredericton before returning to Mount Allison to teach and to continue with her fine work in china painting and embroidery.