OCCUPATIONAL THERAPY NOW

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# Table of Contents



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# Everyday Stories . . . profiles of your CAOT colleagues

Danielle Hogan

## Education

I graduated with a bachelor of arts in sociology/certificate in criminology from Memorial University of Newfoundland in 1996. From there, I graduated from the Occupational Therapist Assistant Program at the College of the North Atlantic in 2000. My interest for occupational therapy grew from this experience. My instructor, and later colleague, was my greatest advocate for pursuing a career as an occupational therapist. She instilled in me a sense of self-confidence in my abilities and validated my desire to further my career. With encouragement from my family, I resigned from a full-time position as an assistant and packed my bags to head for Nova Scotia where I graduated from Dalhousie University's School of Occupational Therapy in 2004.

## Career path as an occupational therapist

I have held various positions within the public and private sector since graduation, specifically in mental health, adult rehabilitation, cardiology, emergency, critical care, vocational rehabilitation and physical medicine.

I have been actively involved on provincial, regional and national committees. On a provincial level, I was part of the Newfoundland and Labrador Association of Occupational Therapists Executive from 2005 to 2009, acting as education chair (2005-06) and president (2006–09). From a regional perspective, I held the position of chair of the Occupational Therapy Regional Council from 2008 to 2010 and am currently an Association of Allied Health Professionals Board Member for St. John's Metropolitan region. Nationally, I am a current member of the Certification Exam Committee of CAOT.

## Current role

I work with a case management team in the Mental Health and Addictions Program (Eastern Health). Our team has recently become the first in Canada to adopt and use an evidence-based practice approach called the Strengths Based Model of Case Management out of the University of Kansas. With the adoption of the model, I have also taken on a new role as clinical supervisor and had the opportunity to travel to Kansas for training and mentoring on the model. It has been an awesome opportunity implementing this change within our team and seeing how the model positively impacts our clients' journeys on their road to recovery.

In addition to this role, I continue to work privately on a consultant basis for two vocational rehabilitation clinics.

## Family life

I live in St. John's, where the rain, drizzle and fog may ground flights coming and going but the culture and heritage I eat, breathe and sleep surely does ground me. My family and friends are my world. I have amazing parents who raised my brother, sister and me to be the people we are today. I also have a beautiful sister-in-law, who loves my brother and his sarcastic family and who has given me two gorgeous nephews.

My life is exactly how I imagined it. I treasure the ability to share my experiences with those around me.

## Most important thing I've learned

Two simple words: "it depends." A professor at Dalhousie repeated these words over and over to my class, sometimes igniting anger, sometimes frustration, but most times sending us back to the books to find our own answer to the question. It wasn't until I had my first student, when she asked me a clinical question and I heard myself say "it depends," that I giggled and everything just fell into place. My practice as an occupational therapist has given me the opportunity for a life of continuous learning. I love my occupation, I love challenging my clients and I love being challenged by them - it keeps me current, it ignites a passion in me and it enables me to strive for success both personally and professionally. Perhaps the most important thing I am to learn hasn't happened yet – that's the beauty of occupational therapy, my clients teach me something different everyday. The light at the end of the tunnel is a different colour for everyone – mine is brighter because of the career I chose, the colleagues I work with and the clients I've come to know.

As the 1982 Bruce Moss song, The Islander, says "I'm a Newfoundlander born and bred and I'll be one till I die. I'm proud to be an Islander and here's the reason why. I'm free as the wind and the waves that wash the sand. There's no place I would rather be than here in Newfoundland".

**The author (centre) and family on vacation, 2011.**

# What's new

## The Canadian Association of Occupational Therapists and the Canada Not-for-Profit Corporations Act

**What is the Canada Not-for-Profit Corporations Act (CNCA)?**
CNCA came into force in October 2011 and replaces the Canada Corporations Act. This legislation governs the internal affairs of federal not-for-profit corporations, including the Canadian Association of Occupational Therapists (CAOT).

**What are the requirements of CNCA?**
CNCA is broad-reaching legislation that is intended to align non-profit organizations with updated structures and processes implemented with for-profit corporations. CNCA addresses issues such as member rights and categories, meetings of members, and elections and responsibilities of officers and directors. CAOT members must approve new articles and bylaws before fall 2014 that comply with these requirements. Failure will result in dissolution.

**How will CAOT approach revisions to articles and bylaws?**
Although CNCA imposes change in some CAOT processes, the Association will preserve the intent of our existing articles and bylaws as much as possible. Consultations conducted in 2010 indicated strong member support for the CAOT governance structure and processes as they function well to support the work of the Association. Revisions will be recommended only where necessary to comply with CNCA.

**What are the major changes necessary to CAOT bylaws?**
The most significant impact of CNCA relates to membership categories and elections of officers and directors. Under CNCA, all members are eligible to vote and any member class can veto the decision of another class if the vote affects member benefits. To ensure the wishes of the majority of members is respected in a vote, it is proposed that CAOT will offer only one member class open to individuals meeting requirements for individual membership. Existing CAOT non-voting members will be offered the opportunity to become a CAOT associate or affiliate, with no change in service benefits from the Association.

CNCA requires elections of CAOT officers and directors to occur only at the time of the annual general meeting (AGM) of members. Under CNCA, all members also have the right to vote for all officers and directors, including Provincial/Territorial Board Director positions. It is proposed that provisions will be included in the bylaws to allow members to vote by electronic means should they not be able to attend the AGM in person.

**When will members vote on the revisions to CAOT articles and bylaws?**
The bylaw revisions will be presented to members in two steps:

**Step 1:** Changes to bylaws regarding member categories must be presented to members while the Association is governed under the old Canada Corporations Act to ensure the vote of majority is respected. Membership category changes will therefore be presented to members at the 2013 AGM.
**Step 2:** The application for continuance as a not-for-profit corporation under CNCA will be presented to members for approval at the 2014 AGM, with the revisions to the articles and bylaws necessary to comply with the new legislation.

Questions or comments? Contact Claudia von Zweck, Executive Director at cvonzweck@caot.ca

## CAOT Fellowship Award winner

CAOT is pleased to announce that Julie Lapointe is our first ever CAOT Fellowship Award winner! Congratulations to Julie. She will be joining the CAOT team as a research analyst for a 12-month term.

## Continuing education & learning news

- In 2013, CAOT will launch an opportunity for new graduates, practicing and re-entry occupational therapists as well as internationally educated occupational therapists (IEOTs) to participate in a facilitated online mentorship program. Modeled on the Occupational Therapy Examination and Practice Preparation (OTepp) project Mentorship Module, this facilitated process enables mentees to be matched with mentors according to their personal and professional goals.
- In addition to the Trial Occupational Therapy Exam (TOTE) and the Trial Occupational Therapy Exam Manual (TOTEM), CAOT and the Occupational Therapy Examination and Practice Preparation (OTepp) project are developing an Occupational Therapy Exam Module (OTEM) that will offer facilitated discussions of case studies to assist exam writers with their clinical reasoning process. OTEM will be available in 2013 to any individual writing the CAOT Certification Examination.
- Email education@caot.ca for additional information on these projects. For OTepp news and updates, visit www.otepp.ca. Eligible IEOTs may continue to participate in OTepp modules.

# Letters

## Feedback on occupational therapists as part of Family Health Team (FHT)

I wanted to take this opportunity to give you some honest and extremely positive feedback on the role of occupational therapists in our FHT over the past several months. My experience, and I believe that of my 13 family physician colleagues at McMaster Family Practice, has been so overwhelmingly positive to date, that I can hardly understand how we functioned without having occupational therapists on our team for years previously.

As you know, the McMaster FHT has been fortunate enough to have two occupational therapists working side by side in our clinic with family doctors, social workers, resident physicians, nurse practitioners and many other interprofessional colleagues over the past year. Their input on our most complex, frail and vulnerable patients has been outstanding. Martha and Colleen both bring incredible expertise and even more importantly, an approach to caring for these patients that is innovative, efficient and effective. Their advanced knowledge in functional assessments has seriously improved the safety of many of our patients, and their willingness to engage with patients in all kinds of settings, including their homes, apartments and our clinic, has taken a considerable burden off of other members of the primary care team, thus freeing us up to provide better care for all of our patients.

Perhaps the most pleasant surprise to date has been the positive role that the occupational therapists have had on our resident physicians. They are incredibly keen to teach and with the practical skills they have to offer, they are really helping to fill major gaps in the education of our residents. These learners are often intimidated by complex patients with multiple co-morbidities. With the educational model we have in our clinic, the residents have opportunities each week to co-book appointments with our occupational therapists so they can see first-hand how calmly and expertly they help patients problem solve around meaningful functional dilemmas in their lives.

In summary, an amazing success to date. I'm so very pleased to have the chance to learn from and with these remarkable professionals.

*Dr. Doug Oliver, MSc, MD, CCFP*
Associate Professor, Department of Family Medicine,
McMaster University

**Editor's note:** After receiving this glowing praise, we invited Martha and Colleen to write about their perspective on working with an FHT. See below for their story.

# Occupational therapy in primary health: "Right care, at the right time, in the right place"

Martha Bauer and Colleen O'Neill

Being a member of a Family Health Team (FHT) in primary health care is exciting but not without its challenges. Based on our first year, this relatively new role for occupational therapists in Ontario has truly begun to feel like the "right care at the right time in the right place" (Ontario Ministry of Health and Long Term Care [MOHLTC], 2012).

As background, The Drummond report (2012) highlighted the significant need in Ontario for decreased costs, improved efficiencies and integration of health care systems while providing care across the continuum of the life span and health needs. Drummond recommended that the Ontario government address these fiscal realities in part by using primary care as the main point of contact, thereby reducing the reliance on hospitals for treatment. The purpose of primary health care as reported by the Health Force Ontario document of 2007 is to strive to provide "comprehensive primary health care to respond to the needs of the whole person, and ensure continuity of care, acute and chronic disease management, as well as health promotion and disease prevention." In line with this, using the Canadian Model of Occupational Performance, Klaiman (2004) illustrated that the client-centered focus of occupational therapy in addressing the integration of person, environment and occupation factors with health issues is very compatible with the goals of primary health care as noted above. Thus, the theories and models of

**The authors: Martha (right) and Colleen (left).**

occupational therapy practice are congruent with primary health care and the government's current health policies.

The McMaster FHT is an academic FHT with two clinics and 33 physicians. The FHT includes nurse practitioners and nurses, pharmacists, social workers, dieticians, a lactation consultant and clinical assistants. Family medicine residents are trained within the FHT and are exposed to the interdisciplinary approach to health care. In May 2011, one full-time occupational therapist joined the team and a second was added six months later. Our role was not predetermined. Rather, we were given a mandate to observe the needs of the clinic staff and patients, consider the government directives and develop what we considered most appropriate.

To date, our statistics show 387 referrals over one year. Most clients are seen an average of four to five times. Most referrals are for management of chronic pain (32%) and addressing falls or mobility issues (29%). Other frequent reasons for referral: facilitating return to work (10%), enhancing daily living skills with a mental health diagnosis (10%), and optimizing the maintenance of older adults and persons with disabilities in their homes (12%). Examples of cases include: an adult hoping to stay at work despite chronic pain, a young adult with mental health issues having difficulty searching for employment, an elderly woman striving to maintain participation in basic activities of daily living despite declining mobility, a child struggling with fine motor challenges impacting function at home and school, a young man needing a splint to allow him to safely perform his work duties, and a woman with an acquired brain injury not coping within her group home. We have facilitated improved occupational performance through reactivation programmes, changes to the physical environment, prescribed devices, facilitated goal setting, linking families to community resources, and coordinating with the workers compensation program and long-term disability for improved return to work outcomes. We have run interdisciplinary psychoeducational groups for chronic pain management and co-led anxiety management groups with the mental health staff. We are working on approaches to the management of other chronic conditions. Managing wait lists is becoming important.

A unique aspect of our involvement in the FHT is that we actively participate in the education of future physicians through interprofessional education sessions, co-booking assessments with specific clients or having family medicine residents accompany us on half-day electives. The residents spend time observing our interactions with a variety of complex, frail, or vulnerable persons that are seen in the family practice. It has been rewarding to see the dawning of understanding among residents regarding the broad scope of occupational therapy and their awareness of how supportive our profession can be in the management of these complex clients. We feel confident they will take this new interprofessional perspective into their future practice.

Reflecting on our role over the past year, the following are our key impressions. First, the need to be 'a generalist' is essential. Despite many years of practice, we were both challenged to broaden our knowledge and skills to address the wider variety of clients' needs in this setting. Secondly, we have been able to provide care that does indeed align with the goals of primary health care in general and realizes the mandate set out by the Government of Ontario, to address health promotion and prevention of disability, by helping individuals build skills, and/or reduce barriers to improve participation in home, work and/or school. Thus, finally, we are emphatic that OCCUPATIONAL THERAPY is an effective addition to primary health care and provides the "right care, at the right time, in the right place" (MOHLTC, 2012)!

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## Editor's note:

*Occupational Therapy Now* is currently seeking submissions for the September 2013 Special Issue on Occupational Therapy in Primary Health Care. Deadline for submissions: April 1, 2013. To see the Call for Papers go to www.caot.ca > Professional Development > Periodicals and Publications > OT Now. Contact otnow@caot.ca for more details.

## About the authors


**Martha Bauer** has worked for 24 years, primarily in chronic pain programs as well as in private practice working in the auto sector and in employee health. **Colleen O'Neill** has worked in complex care for the past 23 years with varied experiences including seating clinic, palliative care and both in-patient and outpatient rehabilitation.

# Career mobility of occupational therapists in Canada

Claudia von Zweck, PhD, OT (C), CAOT Executive Director

Educational preparation as an occupational therapist in Canada provides a rich base of knowledge, skills and abilities that can be used in a variety of practice environments, with a wide range of population groups. The characteristics of occupation-based enablement are broad and relevant to occupational therapists working in many contexts. As a result, occupational therapists have extensive opportunity to pursue mobility within their career paths in occupational therapy.

This article discusses career mobility of occupational therapists in relation to the 2012 *Profile of Practice of Occupational Therapists in Canada* (Canadian Association of Occupational Therapists [CAOT], 2012). This new version of the *Profile* includes new and updated descriptive information regarding the practice of occupational therapy in Canada.

## The *Profile of Practice of Occupational Therapists in Canada*

The *Profile* (CAOT, 2012) advances a general definition of the work of occupational therapists, which is described in relation to seven roles. Occupational therapists serve a central role as an expert in enabling occupation. Supporting roles include serving as a communicator, collaborator, practice manager, change agent, scholarly practitioner and professional (see Figure 1).

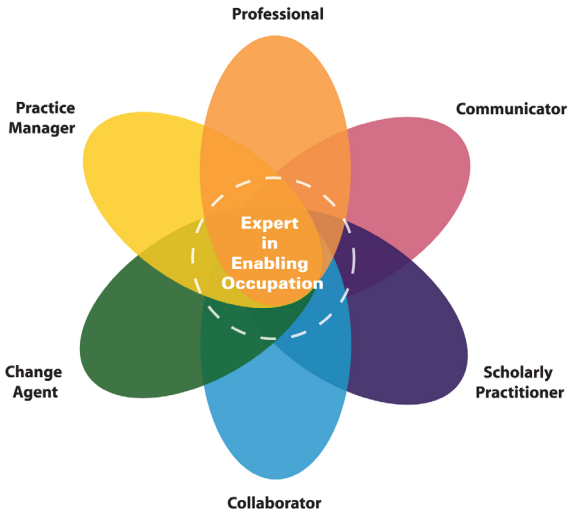


**Figure 1. *Profile of Practice of Occupational Therapists in Canada* (CAOT, 2012).**

## Practice context

Involvement of occupational therapists in each of the seven roles of the *Profile* is not equal, as not all roles may be part of everyday practice. The roles required by an occupational therapist in any situation are influenced by, and depend on the practice context. The practice context refers to the interaction of dimensions that describe both who is providing and receiving services, as well as where the work is undertaken (see Figure 2).


**Figure 2. Occupational Therapy Practice Context (CAOT, 2012).**

1. Client population: Occupational therapists work with clients of all ages as individuals, families, groups, communities or populations. Clients of occupational therapists experience, or are at risk of encountering barriers to occupational engagement, for example restrictions resulting from personal health issues or limitations imposed by physical, social or cultural factors within the environment.

Client needs in occupational therapy are defined in terms of occupation. The enablement of engagement in desired and/or needed occupations of life is the core domain of occupational therapy. Occupations are "groups of activities and tasks of everyday life, named, organized and given value and meaning by individuals and a culture" (CAOT, 2002, p.34).

Data regarding the practice context of occupational therapists are collected by the Canadian Institute for Health Information (CIHI) for all jurisdictions in Canada, except Quebec. These data indicate that in 2010, occupational therapists worked most

frequently with populations experiencing general physical health issues (34.9%) or neurological system problems (8.1%). Eleven percent of occupational therapists worked primarily in mental health (CIHI, 2011). Information collected from the voluntary membership of CAOT indicates occupational therapists work most frequently with adults (69%), with another 23% working only with children (CAOT, 2011).

Little data is collected routinely regarding the occupations addressed by occupational therapists. Information gathered by CAOT indicates some occupational therapists specialize in working with particular occupations such as driving, eating/feeding/swallowing or independent living skills (CAOT, 2011).

2. Occupational therapist: Individual attributes of occupational therapists such as education, experience, gender and culture influence the performance of roles in the occupational therapy practice context. Occupational therapists educated in Canada receive education in university programs accredited by the Canadian Association of Occupational Therapists. Since 2008, all university education programs must lead to a master's level credential to be eligible for accreditation by CAOT. The accreditation process ensures occupational therapy education programs address the knowledge, skills and abilities outlined in the *Profile of Practice of Occupational Therapists in Canada* (CAOT, 2012) and the *Essential Competencies* outlined by the Association of Occupational Therapy Regulatory Organizations (2011). Demographic information collected by CIHI indicates that over 30% of occupational therapists in Canada have a master's or doctorate as their highest level of education (2011). CIHI data also indicate occupational therapy is a female-dominated profession, with males comprising less than 9% of the occupational therapist workforce. The average age of occupational therapists in Canada is 39 years, which is younger than peer health professions such as medicine and nursing where aging of the workforce has raised concerns for replacing workers who will retire in the next decade (CIHI, 2011; CIHI, 2010). The younger age profile of occupational therapists reflects increases in the number of occupational therapists graduating from Canadian university education programs over the past decade but also may suggest a shorter career lifespan.

3. Practice environment: Occupational therapists work in a number of practice environments that may be defined by factors such as the type of employer/funder, site of service provision (e.g., institution, community, clinic), service model (e.g., consultation, intervention) and primary work functions (e.g., clinical service, service administration, education, research and policy development/administration).

In 2010, approximately 31.8% of occupational therapists worked in the community and 11.4% were employed in a professional practice. An additional 45.6% worked in facilities such as hospitals, rehabilitation centres and residential care homes. The large majority of occupational therapists (82.8%) worked for only one employer. Most occupational therapists were permanently employed (74.6%) or self-employed (14.8%), with 10.7% as casual or temporary employees. The self-employment rate tripled among those listing secondary employment positions, reflecting the large number of occupational therapists that supplement regular work with private practice. Almost 83% of occupational therapists worked as direct service providers with clients. An additional 6.9% of occupational therapists were managers, 4% professional leaders/coordinators, 2.8% educators/researchers, with 3.0% holding other positions (CIHI, 2011).

Great variation exists in the work of occupational therapists because of the interaction of elements within the three dimensions that describe practice context. For example. as a client-centred profession, the types of occupations addressed by occupational therapists are shaped by the needs and requirements of the client population, the frame of reference used by the occupational therapist as well as the priorities of the practice environment.

The practice context is also influenced by changes in any of the three dimensions, either internal or external to the profession. As an example, the shift to community-based health services that occurred in the past three decades had a profound effect on occupational therapy. Once primarily a service received in a hospital or other health facility, the site of occupational therapy service has shifted to include a large number of community settings. Currently, reforms to primary health care provide another growth opportunity for occupational therapy service provision in the community. An example of an internal factor influencing the practice context is the desire of occupational therapists to use occupational therapy concepts and values with different client populations and practice environments in their quest for effective occupational enablement, as well as to promote their own career development and interests.

## The occupational therapist career paradigm

The occupational therapist career paradigm can be used to describe career mobility for occupational therapists (see Figure 3). Movement within and through the occupational therapist career paradigm is defined by the continuum of knowledge, skills and abilities described by the *Profile of Practice of Occupational Therapists in Canada* (CAOT, 2012). A spectrum of competencies are described by the *Profile* in a competency continuum, some of which may be expected for occupational therapists at the beginning of their career, while others may be associated with more advanced levels of performance and experience.

Mobility within the occupational therapy profession occurs most frequently among different practice contexts, particularly in the early stages of the career development of occupational therapists. Given the large and evolving range of occupational therapy client populations and practice environments, a wide array of opportunities exist to move into different practice contexts, as defined by the interaction of different client populations, occupational therapists and practice environments.

The occupational therapist career paradigm also describes movement along the competency continuum from entry-level jobs to positions with higher levels of skills, knowledge, responsibility, pay and/or authority within a particular practice context. As entry-level practitioners, occupational therapists begin practice at the competent level. Competent occupational therapists meet or exceed minimal performance expectations for

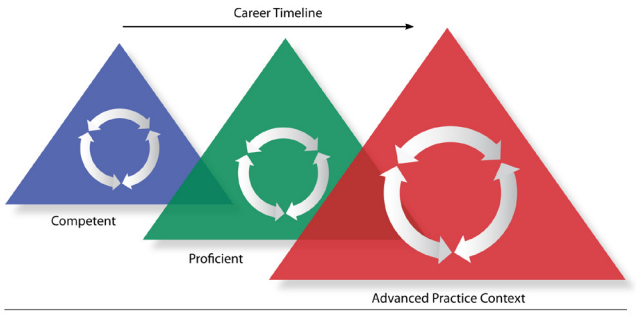


**Figure 3. Occupational Therapy Career Paradigm (CAOT, 2012).**

safe and effective occupational therapy practice. With experience and professional development, occupational therapists may move forward to proficiency in some roles. Proficient practitioners have similar knowledge, skills and abilities but perform with artistry of practice and professional sophistication. Execution of the competencies in the seven roles identified in the *Profile* occurs to a fuller or lesser extent, depending upon the practice context, and knowledge and experience of the occupational therapist. With career progression, occupational therapists may also engage in additional education and gain experience that result in the acquisition of advanced competencies. Advanced competencies include knowledge, skills and abilities needed for activities within the context of occupational therapy practice that are performed beyond the breadth of responsibilities traditionally assumed by occupational therapists. Some career profiles of occupational therapists may be described in relation to the clustering of different advanced competencies that are needed in particular job functions. While occupational therapists work most frequently as clinicians, CIHI data indicate some also assume a wide variety of other functions in research, education, administration and policy (2011). Such functions may require the use of advanced competencies to augment occupational therapy knowledge, skills and abilities. Unfortunately individuals educated in occupational therapy working in advanced practice roles frequently choose not to retain use of the occupational therapist title and are not included in the practice data collected by CIHI. As a result, the data do not reflect a complete picture of the potential occupational therapy practice context.

## Professional identity as an occupational therapist

Occupational therapists throughout their careers may seek out positions that use their knowledge, skills and abilities in unique and innovative ways. For example, individuals educated as occupational therapists in Canada have pursued careers as health-care executives, leaders of social and community agencies, high-ranking government officials as well as top researchers and educators. Professional identity as an occupational therapist is not restricted to individuals working in practice contexts labeled with a job title in occupational therapy. Alternatively, the work of occupational therapists is defined by congruency with the core values and beliefs that inform the occupational therapy profession.

Retention of the occupational therapist title throughout the career span, regardless of practice setting or job title, is considered a professional privilege and responsibility to promote recognition and accountability of the work of occupational therapists. Occupational therapists are therefore actively encouraged to proclaim and celebrate their professional identity, regardless of practice context.

## Conclusion

The career paradigm outlines opportunities for personal and professional development of occupational therapists in Canada. Education as an occupational therapist in Canada, as outlined in the career paradigm, can lead to a variety of interesting and rewarding career paths that share the core domain and values of the occupational therapy profession. Such career development is integral for recruitment and retention within the occupational therapy workforce but also to move forward the mandate of the profession to promote occupational engagement among the people of Canada. Occupational therapists are encouraged to retain their professional identity as they pursue the many career paths available to them.

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**For more information, please contact Claudia von Zweck at cvonzweck@caot.ca**

COLUMN EDITOR: ALISON SISSON

# Articulating rural and remote practice

Alison Sisson

A number of years ago I moved from Toronto, a large metropolitan city, to Whitehorse, a town of 26,000 people in Yukon. Keen in my new position as an occupational therapist in long-term care, I remember working with a resident early on to prescribe a wheelchair. Mentally, I ran through the steps: work with the client to set goals around mobility, complete a thorough assessment, identify the best options, work with a vendor to obtain wheelchairs for trial, make adjustments to the wheelchair, and complete the paperwork. If the wheelchair prescription was especially complex, I would refer the client to the seating clinic at the local rehabilitation hospital.

As I started the prescription in Whitehorse, I quickly realized that I would have to change my process. My client required a tilt-in-space wheelchair, but due to the high cost of shipping in the North, the local vendors were not able to secure tilt-in-space wheelchairs for trial. I borrowed a tilt-in-space wheelchair from another client, made a few modifications, and with the blessing of the wheelchair's owner, gave it to my client for the day. My client was pleased with the wheelchair.

Ordering was my next challenge. The wheelchair I had borrowed was no longer manufactured. Due to the lack of additional tilt-in-space wheelchairs in the territory to trial, and a very liberal funding program for equipment, we decided to order a chair with maximum adjustability, then trial various backs and cushions. I applied to the territorial program for funding and we ordered the wheelchair from the 'spec' sheets. When the wheelchair arrived we adjusted it for the client.

On an early visit to a client in a remote community that receives home care rehabilitation services only a few times a year, I realized that the type of wheelchair I provided and my process would have to change again. During that visit, a client and I discussed briefly what kind of wheelchair would work for him and I took measurements. On returning to Whitehorse, I reviewed the wheelchairs in stock, picked one that I thought would work and modified it the best I could for use on the rugged landscape. I shipped it off to my client through a local company. A few days later, I called, and while his wife worked the wrenches and screwdrivers, I fielded concerns from the client and made suggestions regarding wheelchair modifications. I provided safety education over the phone.

In looking back at those initial experiences of prescribing wheelchairs in the North, I am struck by how profoundly the environment, whether urban, rural or remote, affects occupational therapy practice. I recently read an article on medical practice in Australia by Smith and Hayes (2004) describing how rural and remote medical practice differs from urban practice in terms of the context, content and process of care. In the same vein, this article explores definitions of urban, rural and remote, and then through another clinical illustration, further describes how occupational therapy practice also varies in terms of context, content and process of care based on the practice setting.

## What is urban, rural or remote?

While many of us have a general notion of 'urban' from living in or visiting a major Canadian city, and likewise a sense of 'rural' from living in a small town or taking a drive through the countryside, standard definitions of these concepts remain illusive. Six different technical explanations on how to use points (postal codes), distances (commuting activity) and areas (census divisions, etc.) have been elucidated by Statistics Canada to determine degrees of rurality, with the percentage of Canada's population living in rural areas varying from 22% to 38% (DuPlessie, Beshiri, Bollman, & Clemenson, 2001). Unfortunately these definitions produce boundaries around areas that have little to do with health, and are more convenient for administrative or statistical purposes, while producing anomalies "that do not correspond with our intuitive sense of what is rural [or] remote..." (Pitblado, 2005, p. 164). For example, using a postal code to define rurality may make sense when discussing postal services and mail systems, but create inconsistencies when discussing health care services. The CAOT Rural and Remote Practice Network uses the definition of rural being any community with less than 10,000

## About the author

**Alison Sisson, MSc, BScOT,** has worked as an occupational therapist and policy analyst in a number of different settings in Yukon over the last ten years. She currently works for the Yukon Workers' Compensation Health & Safety Board. When she's not working, she can often be found out exploring the rural landscape on her skis or bike. Alison can be contacted at: Alison_sisson@yahoo.ca

people and the definition of remote being any community not within a two-hour commuting distance from a community with a population of 10,000 or more. According to these definitions, Whitehorse would be both urban and remote; however my sense after ten years of living here is that the environment functions much more like a rural community without many of the services and resources you would expect from an 'urban' centre. Descriptions of Canadian communities which exemplify our intuitive ideas of urban, rural and remote follow and will serve in this paper as a basis for a discussion of occupational therapy practice in each of these contexts.

## The contexts

Vancouver is an example of an urban Canadian environment. Metro Vancouver is considered the third largest metropolitan area in Canada, and has a population of approximately 2.1 million (City of Vancouver, n.d.). Vancouver has a full spectrum of health services, including a major rehabilitation hospital. The University of British Columbia in Vancouver has a school of rehabilitation. Typically in an urban environment an occupational therapist can specialize by providing service to one type of client, for example, to clients requiring outpatient stroke care, or home care clients requiring mental wellness services.

Whitehorse, in Yukon, could be considered an example of a rural Canadian environment. The town is connected to major cities in Western Canada by roads, although the distance from Whitehorse to Vancouver is over 2300 km. The main hospital is a 49-bed acute care facility, which supports most of the territory. Until recently, all occupational therapy services in Yukon were centralized in Whitehorse. In a rural environment such as this one, occupational therapists provide service predominantly to one sector, such as acute care, home care, education, or paediatrics, but likely work with the full spectrum of diagnostic groups within that sector. Typically clients are sent south to Vancouver for more specialized services, such as paediatric seating assessment or in-patient stroke rehabilitation.

Old Crow, a village of approximately 600 people in northwestern Yukon, is an example of a remote community. There are flights into Old Crow, but no permanent roads. The village is serviced by a health centre staffed with nurses. The Vuntut-Gwitchen First Nation also provides some personal care and homemaking services. In this remote environment, occupational therapists from the home care, education and paediatrics sectors visit the community from Whitehorse a few times per year. Occasionally follow-up is provided by video or phone conferencing. In terms of occupational therapy services, clients are typically sent down to the Whitehorse hospital for driving assessments, specialized splinting or orthotics services, or when their needs can not be addressed in the community. Outpatient medical specialty services and acute care are also provided in Whitehorse.

Next, a case scenario will be applied to each of these three contexts, demonstrating differences in the role of the occupational therapist in each.

## Case scenario: A client with dysphagia

A 56-year-old woman who sustained an anoxic brain injury 35 years ago presents with recurrent pneumonias. She is starting to lose weight. She lives at home with family and community support. The occupational therapist is concerned that her swallowing ability is changing and wonders how best to manage the situation (case scenario is fictitious).

**Metropolitan/urban context:** In Vancouver, the occupational therapist providing services through home care would likely advocate with the client's family doctor for a referral to an interdisciplinary dysphagia assessment team. After making the referral, the therapist might liaise with the team and assist the family to implement the recommendations.

**Rural context:** In Whitehorse, there is a CT scanner but no videofluroscopy clinic. Based on a bedside swallowing assessment, the occupational therapist must decide whether the dysphagia can be dealt with conservatively and locally (with interventions that may include dietician referral, speech-language pathology referral [if available], trial of various food textures, etc.) or if they need to advocate for the client to be sent down to Vancouver for videofluoroscopy. If the client is referred south, the therapist may assist with arranging the following: flights, an escort and accommodation while in Vancouver, resources to assist the client onto the plane, and assistive devices to ensure the client's needs are met while in the South. Once the recommendations are received from the assessment team, the occupational therapist assists with their implementation. There may be an additional delay if specific equipment or products need to be ordered through the local vendor. In this context, not only is the therapist required to have the skills to assess the need for a dysphagia team assessment, but to use advanced problem solving skills to evaluate the severity of the need, and to weigh that need against the potential risks of travel. The occupational therapist also needs advanced communication, team-building and organizational skills.

**Remote context:** In Old Crow, the nurse at the health centre


**Author skiing in Old Crow, Yukon.**

and the visiting occupational therapist work closely together with the family and the First Nation community health liaison worker. The therapist, along with the team and family, must decide whether it is crucial for the client: a) to be sent to Vancouver for videofluoroscopy (which involves at least two flights south, a multi-day stay, then two flights back north), b) see a dietician and speech-language pathologist urgently in Whitehorse (which involves one flight south and back), or c) wait for the next visit from the dietician from Whitehorse (who is scheduled to visit again in three months) and during the occupational therapy visit, educate the family on various textures to trial based on a bedside assessment. In this context, the therapist will consider all the risk management issues identified for the rural environment, which are heightened by the increased flight distance and limited medical services in the remote community. The occupational therapist will likely also consider the family's comfort in negotiating a larger centre. The therapist may provide videoconferencing follow-up from Whitehorse, which requires skill in using the technology with minimal technological supports.

## Conclusion

I often think back to my first weeks in Yukon and those initial wheelchair prescriptions. I now recognize that many areas of my practice are different because of my rural practice environment. I assess clients for dysphagia differently, without access within the territory to the 'gold-standard' of videofluoroscopy. However, I've learned when to advocate with the physician for someone to be flown south for a full dysphagia assessment, and when to assess and treat someone to the best of my ability locally. I recognize that if I want to apply compression to a client's swollen lower extremities, I will have to learn to perform an ankle-brachial index to rule out arterial disease, as there is no technician in the territory to perform the test. I am starting to look at how I can provide services differently for my aboriginal clients, as I get to know their unique histories and cultures, and their communities. I now understand that rural practice is in fact extremely complex and involved, and in that sense, it is an advanced practice and a specialty in itself. And while I'm a specialist in rural practice, I recognize that I may always struggle to maintain certain skills, such as my ability to conduct and interpret a variety of cognitive assessments or to assess and prescribe complex wheelchairs because of the wide range of populations I work with.

Compared with urban practice settings, rural and remote practice requires occupational therapists to provide a wider range of services to a diverse clientele, to rely more on relationships with a broad range of professionals and paraprofessionals to enable the simplest of client interventions, and to manage client issues related to the extensive inconvenience of longer timelines, environmental barriers, physical distances, and additional costs. Rural and remote practice is multifaceted and innovative... and, for those who catch the bug, rewarding.

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**The Rural Practice column is seeking submissions**

Does this article resonate with you and your practice? Then we'd love to hear from you! The Rural Practice column is looking for submissions that articulate unique rural or remote perspectives of occupational therapy practice, including lessons learned, practice models being applied, and clinical anecdotes.

# Exposing the emperor: Meditations on credulity and occupational therapy

Karen Whalley Hammell

*The following is an abridged version of a paper presented as a plenary talk at the 2011 CAOT Conference in Saskatoon and at the OT4OT Virtual Exchange for World Occupational Therapy Day in October 2011.*

It was a huge honour to be invited to present a Plenary Lecture at the 2011 CAOT Conference. I am humbled by this privilege and sincerely grateful to those who proposed and supported me. My paper addresses credulity, evidence, occupational therapy's theories, and the research that informs both our theories and practices. I'll begin with credulity: the disposition to believe on insufficient evidence; and if there is one message that I hope you will remember from this paper, it is this: *We need to believe less, and think more.*

## The Emperor's New Clothes

I'd like, first, to recall one of Hans Christian Andersen's (1837) stories. Once upon a time, an emperor hired two weavers who promised to make him the finest suit of clothes. They said the suit would be made from a wonderful fabric that was invisible to anyone who was lacking in intelligence. When they presented the emperor with his suit, he was unable to see it, but he did not express his qualms for fear of appearing to be uneducated or unsophisticated. All his ministers did the same and the emperor marched in a procession in front of his subjects. Word had spread about this magical suit, and everyone pretended to admire it so they would not be ridiculed. However, a small child – who had not been told how she should think - called out that "the emperor has no clothes". The emperor, and his followers, needed to believe less, and to think more.

The story about the emperor's new clothes emphasizes the importance of challenging the claims of others – of asking whether what we are told matches what we actually experience. It also highlights the importance of fostering an intellectual climate in which questions can be asked and assumptions can be challenged without fear of ridicule or dismissal. Of course, I am not implying that our profession's forerunners, our theorists and leaders should be equated with the two weavers in the story, whose intention was to make false and deceptive claims and to profit from the foolishness of others. But I do want to suggest that our profession can ill-afford to assume the role of the emperor's ministers and minions, who failed to think critically. It is important to acknowledge that, on occasion, the theoretical emperor has no clothes. We need the courage to question, to challenge and contest every assumption that is not supported by evidence, and we need to foster the intellectual climate that encourages this sort of skepticism. Of course, the issue of what constitutes 'evidence' is a thorny one, and I'll get back to this a little later.

## Intellectuals and intellectual critiques

I want to assert that I think every person deserves respect. But I also want to suggest that one of the problems within our profession is our collective tendency to encourage conformity, revere our leaders and promote a culture of respect that teeters on deference. I support calls for professionals to challenge the beliefs and assumptions in their field, continually raise questions, confront dogma, unmask conventional and accepted ideas, take nothing for granted and be unwilling to accept unquestioningly what the powerful have to say (Said, 1996). However, in my experience, this isn't always an easy thing!

## Occupational therapy, gatekeepers and intellectual critiques

As a frequent contributor to several occupational therapy journals, I am often both perturbed and amused by the comments my work provokes from some reviewers. For example, I have challenged the belief that occupational therapists practise consistently in a client-centred manner. Although I'm well aware that our professional rhetoric portrays occupational therapy as a client-centred profession, and I know that many occupational therapists engage in exemplary client-centred practices, my experience also suggests that sometimes occupational therapists practise in a manner that serves the interests of their employer, their career, their business or financial status rather than the interests of clients.

In response to this rather self-evident assertion, some of my reviewers have asked me to provide evidence-based support for my claim that occupational therapists do not all, at all times, practise in a client-centred manner. As an advocate of believing less, and thinking more, I admit that this *is* a reasonable request.

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However, it also leads me to ponder: When the occupational therapy profession produces statements to the effect that occupational therapy is, at all times, a client-centred profession – as it does rather frequently – where is the evidence or support for this claim? And why are these writers not obligated to provide support for the assertion that occupational therapy *is* a client-centred profession? The fact that this belief is repeated rather often does not make it true.

More than 15 years ago, Mocellin (1995, p.502) noted: "When core assumptions, which are considered essential to the underpinning of occupational therapy, are perceived by some to be under threat, considerable efforts are made to enforce conformity". My experiences suggest this is still true today. I have been told several times – and as recently as 2011 - that it is disrespectful to other scholars to critique their concepts, theories and models of occupation. It is difficult to imagine similar reactions to the possibility of intellectual debate occurring within any other profession or academic discipline. One cannot imagine a similar argument being made by a scientist. Thus, some commentators ponder whether occupational therapy is, indeed, a scientific discipline, or whether it is a cult (Kelly & McFarlane, 2007). I suggest that we need a passionate commitment to creating and fostering an intellectual environment in which questions can be asked, challenges raised and different perspectives acknowledged and addressed.

*"We need to acknowledge that what we intuitively believe to be true might be false – that believing something does not make it true."*

## Sciosophy

I recently came across the concept of sciosophy. Sciosophy is a system of what claims to be knowledge but is without scientific basis; astrology is an example. I suggest that in the past, rehabilitation might also have been considered a form of sciosophy, and I know I need to provide you with some evidence for this assertion.

I have been fascinated, throughout both my career and my personal life, by spinal cord injuries and the process of rebuilding a life in an altered physical form. Not many years ago, the rehabilitation professions asserted:

- that depression was an inevitable consequence of spinal cord injury,
- that those people with the most profound levels of impairment following the highest levels of spinal cord injury would suffer the most profound levels of depression,
- and that the experiences of quality of life would be highest among those with the lowest levels of injury and thus the most residual physical function.

These assumptions might seem fairly self-evident, but they were also wrong. A very significant quantity of research, in different countries, among men and women, old and young, and among different ethnic groups has shown convincingly that although levels of depression *are* high among people with spinal cord injury, most people who sustain these injuries do not become depressed. Research has also shown that depression is not predicted by the level of spinal cord lesion, or even by the completeness of cord lesion; and it has shown that the experience of high quality of life – or of low quality of life – does not correlate with the level of spinal cord injury (Hammell, 2004a).

So, why is this relevant or important? It illustrates how wrong we can be when we base our theories on common sense rather than evidence. After all, common sense tells us that people who are completely paralysed below the neck will be more depressed and will report a lower quality of life than those with low, incomplete paraplegia who can use their hands and arms; and common sense would be wrong. And this is why we need to be committed to challenging our assumptions. We need to acknowledge that what we intuitively believe to be true might be false – that believing something does not make it true.

## Assumptions and occupational therapy

'Assumptions' are ideas that we assume to be right, or common sense, and that we take for granted. Common sense is the product of a specific culture and of a specific point in history, and has been described as "the taken-for-granted terrain on which more coherent ideologies and philosophies must contend for mastery" (Hall, 1986, p. 431).

Occupational therapists have promoted certain assumptions that derive from common sense but that are unable to withstand critical scrutiny. These include the ableist and right-wing ideology that humans are all able to affect their health positively using their hands and willpower, and the assertion that all humans participate in occupations as autonomous agents. These also include the belief that occupational engagement always contributes positively to life's meaning, and the assumption that occupations invariably contribute positively to health. I have deconstructed these assumptions in previous published work (Hammell, 2009a), but wish to note here that these assumptions are the products of a specific cultural history and the values promoted in our own society. This is unsurprising, of course, because occupational therapy's dominant theories and models have been formulated by people who share many cultural assumptions because of their social position as privileged, able-bodied, white, English-speaking, middle-class, urban-dwelling residents of the minority, or 'First World'. Clearly, of course, these specific cultural perspectives are unlikely to be shared by the majority of the global population, and evidence shows that they are not.

For example, dominant occupational therapy theories extol the importance of independence, and of focusing on individual goals because these are the values promoted within Western, capitalist societies. But these are not universal values. In fact, to many of the world's people, desires for independence and individualism are viewed as signs of immaturity. And cross-cultural explorations of the concept of leisure – which is central to Canadian occupational therapy theory – demonstrate that this is an ableist, urban, class-bound and uniquely Western construct for which many linguistic groups do not even have a word (Hammell, 2009a).

## The 'categories' of occupation

It was several years after I had assumed my role as a full-time caregiver before it began to dawn on me that my own daily occupations did not fit within occupational therapists' categorisations of self-care, productivity and leisure and I began to have doubts about this framework. Moreover, my doctoral research into the experience of life following high spinal cord injury identified further problems with this system of categorising occupations. And then my mother suffered a very severe stroke with significant loss of vision and was cared for, at home, by my father, and it occurred to me that neither of *their* daily occupations really fit the three categories either. In fact, the most important dimensions of daily life that are so frequently identified by people with severe impairments and those who love them – the ability to contribute to others *even at the expense of one's own physical health, and to do things with others* – were not readily addressed by the three categories that occupational therapists had chosen to name (Hammell, 2009b). It also occurred to me that the choice to prioritize these particular three categories – self-care, productivity and leisure – had not been derived from clients' experiences or from research but from common sense. And I've already claimed that common sense is an inadequate basis for theory.

## Occupational therapy and evidence

This brings me to contemplate the nature of evidence, and particularly the nature of the evidence that might usefully inform our theories. It is unfortunate that 'evidence' within occupational therapy has tended to be defined and legitimized in terms derived from a very specific understanding of evidence-based medicine. It is surely both erroneous and unhelpful for our profession to define the parameters of valuable knowledge according to the dictates of medicine, a profession with interventions so different from our own. The concept of evidence-based practice was first developed by clinical epidemiologists and subsequently emulated by other disciplines that aspired to be viewed as scientific. Regrettably, many of these disciplines have failed to attend to the criticisms of, and challenges to, evidence-based medicine that have been taking place within the medical literature for at least the past 15 years – indeed, from the inception of evidence-based medicine itself (Cohen, Stavri, & Hersh, 2004).

Critics within medicine have drawn from the history and philosophy of science to argue that evidence-based practice – as it is usually conceived – fails to recognize the impossibility of neutrality in interpreting data, or the impossibility of making objective observations (Cohen et al., 2004; Harari, 2001). They contend that much of the existing evidence base is flawed and potentially irrelevant because it has been developed from research undertaken without consideration of the issues and outcomes that matter to disabled people[1] . Social work theorists have noted that although evidence-based medicine is imminently suitable for drug trials and perhaps also for establishing cause-and-effect relationships between various treatments to body parts, it is difficult to identify how transferable the principles of evidence-based practice might be to human lives (Pease, 2009). Importantly, philosophers of science contend that there can be no such thing as a hierarchy of evidence (Glasby & Beresford, 2010).

Moreover, critical theorists challenge the Eurocentrism – or belief in the superiority of Western knowledge – that accords a higher status to specific forms of scientific inquiry than to other forms of knowledge, such as experiential knowledge (Cohen et al., 2004; Pease, 2010). Even within the medical literature it is recognised that scientific, therapeutic and ethical clinical practice will only result from intellectual flexibility and from obtaining information derived by different methods and from different viewpoints (Harari, 2001).

Many researchers acknowledge that no one research method is inherently better than another. They also contend – and this is the point I really want to highlight – that the "experience of service users and carers can be just as valid a way of understanding the world as formal research" (Glasby & Beresford, 2010, p. 268). This brings me back to the issue of trying to ground the theories that inform our research and clinical practices in evidence derived from clients' perspectives, and also to my problem with the categorisation of all occupations as self-care, productive or leisure.

## Occupational therapy theory: Whose categories of occupation?

My own early attempt to identify meaningful categories of occupation from existing research literature built on Wilcock's (1998) formula, of doing, being and becoming, and added a further dimension – that of belonging (Hammell, 2004b). However, it is worth noting that many years before occupational therapists espoused the importance of doing, being and becoming, Maslow (1987) had already identified these same three domains as of concern for psychology. Nor was this formulation unique to the professions of psychology and occupational therapy. For example, Parse (1992) had articulated a nursing theory of human becoming that identified health as a process through which people become who they want to be. Moreover, Maslow (1987) had also identified the importance of belonging on his hierarchy of needs, demonstrating that the addition of this fourth dimension had been neither original nor insightful on my part. As I pondered those domains of concern to psychologists and to nurses that had been grafted into our profession's theories, I began to wonder what all this had to do with occupation, and

[1]Critical disability theorists employ the term 'disabled people' to denote people who are disabled (disadvantaged) by social and political responses to their impairments. Their perspective renders the euphemism 'people with disabilities' completely meaningless.

more importantly, whether any of this would make sense to our clients. I suspected that it might not.

At this point, I began to read as many reports of qualitative research as I could about the experience of rebuilding a life following a serious injury or life-altering illness. I wondered whether it was possible to identify meaningful categories from the perspectives of people whose circumstances had compelled them to examine their priorities and occupations. How did they describe those occupations that were personally meaningful, or that made their lives worthwhile? This was not a formal meta-synthesis, but an informal inquiry that aimed to satisfy my own curiosity.

From my own research into the experience of living with a high-level spinal cord injury, and from the evidence presented in the form of clients' words in multiple studies of people living with such challenges as cancer, amyotrophic lateral sclerosis (ALS), stroke, multiple sclerosis and severe, persistent mental illness, I identified four categories of occupation – or dimensions of occupational meaning – that I outlined in a 2009 paper (Hammell, 2009b). I contend that the four categories that I identified - restorative *occupations*; *occupations* fostering belonging and contributing; doing *occupations*; and *occupations* reflecting life continuity and hope – are all clearly centred on occupation and are therefore, perhaps, relevant to our theory and practice. This represented my very amateur attempt to explore how a theory of occupation might look, if it was informed by the perspectives of service users and from evidence derived from their experiences. And I am told that occupational therapists in different parts of the world are discovering what I discovered for myself: that it is a great deal easier to categorise one's own daily occupations into these four categories, than to try to slot them into the privileged triad of self-care, productivity and leisure.

## Research: A client-centred practice?

Client-centred practice is promoted as being an approach to practice that is concerned with realigning power and with ensuring that occupational therapy is informed by, and relevant to, clients' lives, values and priorities. Research is one of occupational therapy's practices and yet there has been little effort within our profession to determine how client-centred philosophy should influence occupational therapy research such that *research* is informed by and relevant to, clients' lives, values and priorities (Hammell, Miller, Forwell, Forman, & Jacobsen, 2012).

In Australia, national guidelines have been established to ensure that all research concerning the health of indigenous Australians includes consultation and collaboration with indigenous groups and is designed to produce outcomes of direct benefit to indigenous people (Nelson & Allison, 2007). I am sure occupational therapists would support any such effort to demonstrate respect for the equality and dignity of all people. But what about our own research? Do *our* study participants deserve any less respect? Surely we need to consider whether our own research consistently includes consultation and collaboration, and is designed to produce outcomes of direct benefit to the people we choose to study?

Recent research has affirmed that disabled people want to be engaged actively in shaping research agendas and to be involved as partners in designing, implementing, disseminating and evaluating research that is of relevance to their priorities and needs (Priestley, Waddington, & Bessozi, 2010). For a client-centred profession, this is truly encouraging. However, a recent literature review of all the articles that were published in six leading occupational therapy journals during the 11-year period from 1999 to 2009 found that out of 4290 articles, only 18 described collaborative research undertaken by occupational therapists with clients or consumer groups. Although this total of 4290 obviously included many papers that did not concern research, it is apparent that occupational therapists during these 11 years had minimal involvement in research reflecting the profession's espoused commitment to client-centred practice (Hammell et al., 2012). If our theories and our practices are to be informed, both by relevant evidence, and by clients' perspectives - congruent with our espoused client-centred principles – then our research practices are going to have to change.

Although considerable debate within our profession has focused on institutional barriers to client-centred *clinical* practice, little attention has centred on either the institutional or professional barriers to client-centred *research* practice. However, it seems to me that if our profession's clinicians - to a very significant degree - have found ways to engage even challenging groups of clients in collaborative partnerships, there would seem no reason why researchers might not be able to do the same.

## Occupation, well-being and quality of life

I referred earlier to the large volume of research findings indicating that mental health and perceptions of quality of life are not dependent upon physical abilities. However, what researchers have found, is that to have a positive quality of life, people need to have the ability and the opportunity to engage in activities and events that increase their enjoyment, success, and meaning in life. Moreover, a substantial body of research evidence finds that perceptions of positive quality of life and of well-being are associated with meaningful relationships, and with participation in social, voluntary, leisure, employment and community activities.

In fact, these findings suggest that our profession has an exciting future! Many researchers, from many disciplines, are reporting the importance of occupation to the well-being of individuals, and community-based researchers are identifying the importance of working with communities to enable people's engagement in shared occupations that are found to contribute to the well-being of entire communities.

There is a place for all of us – students, researchers, clinicians, educators, managers and academics – to advocate for, and engage in, client-centred research practices: research that exemplifies our client-centred principles, enhances our understanding of the relationships between occupation and human well-being, and that draws from a diversity of perspectives to generate the evidences to underpin our theories and models. And it is up to all of us to counter credulity by fostering an intellectual climate in which we are free to challenge our profession's beliefs and assumptions, raise questions, confront dogma, unmask accepted and conventional ideas, and contest what the powerful have to say (Said, 1996).

As a profession, we might commit to believe less, and think more.

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# When are you a leader? You might be surprised.

Wendy Pentland

Occupational therapy students and new practitioners need to hit the ground running as leaders. In this era of health-care system complexities, challenges and periodic chaos, there is a need for practitioners with fresh perspectives, innovative ideas, the ability to remain unattached to "this is the way we have always done it", the openness and energy required to make changes, and the self-awareness, confidence and courage to sit at the table and speak up.

When I teach final year occupational therapy students about leadership, we begin by having a conversation about the ways in which they see themselves as leaders. The majority respond by saying things like, "I don't have enough clinical experience yet," "I'm too young," "I am not usually a leader," "I prefer to let those who like to lead be the leader," "I am not comfortable being a leader," "I need to develop my leadership skills," and "I don't know enough yet." As we talk further, it becomes clear that the students block seeing themselves as leaders by applying their working definitions and models of leadership. Their definitions of a leader tend to lie more in the realm of someone who has a special set of skills, who motivates others and guides or tells them what to do, and who has experience and wisdom and a clear, 'correct' vision.

As the course continues, we spend time looking more closely at what leadership might be. I offer students numerous definitions, from the more traditional 'command and control – leader knows best' models to the more recent conceptualizations of transformative leadership, where leading is seen more as the capacity to bring out the best in individuals and groups. Two notions that really seem to resonate with the students are, "Leadership is authentic self-expression that adds value" (Cashman, 2008) and "You can lead from any chair" (Zander & Zander, 2000). Both of these perspectives shift the notion of leadership from that of one person knowing the way and getting others to follow, to one where each of us has an important and unique contribution to make. As individuals we have our own unique set of personal values. As occupational therapists we bring our distinct and unique set of the profession's values to our work with all of our clients and colleagues. We lead then, through identifying what those values and uniquenesses are, owning them and having the courage to live and act congruently with them (despite fears of reprisal, disapproval, being wrong, or inviting conflict). We lead by offering ourselves to those around us. In this notion of leadership, we are all leaders in some way all of the time.

Professionally (and often personally) we distinguish between the person and the environment. All too often we fail to acknowledge the extent to which WE as humans are a significant part of the environment, and the extent to which we are its creators. Similarly, we can also recreate and change the environment, including the nature of its expectations, its systems and its relationships. As course discussions evolve, many of the students begin to expand their definitions of leadership to recognize that as occupational therapists, we lead by living, acting and taking a stand for what we value and believe to be important, whether that is in our own personal lives, with clients, or in our workplace and professional practices. We do this by advocating and communicating with others on behalf of clients, by volunteering with our professional associations, and in how we balance all of what we value and believe matters in our lives.

It is not always easy to lead from our authentic self, as the currents, pressures and expectations we perceive from the systems we live in constantly encourage our conformity. A step we can take to help us lead in integrity with our true self is to get very clear about what is important to us and what we value. Then, we can continue to remind ourselves that holding firm to our values and authenticity requires courage, a willingness to risk, self-trust, and the belief that what we have to offer adds value.

A poem by Marianne Williamson (1996) speaks very powerfully about the leadership power in simply offering our true selves:

*Our deepest fear is not that we are inadequate.*
*Our deepest fear is that we are powerful beyond all measure.*
*It is our light, not our darkness that most frightens us.*
*We ask ourselves, Who am I to be brilliant, gorgeous, talented, fabulous?*

## About the author

**Wendy Pentland, PhD, OT Reg.(Ont.), PCC,** is an associate professor of occupational therapy at Queen's University where she teaches courses in systems level communication, and coaching and counseling in occupational therapy. Wendy is an ICF certified professional coach with a personal and executive coaching practice. She invites you to visit her website at www.wendypentland.com.

*Actually, who are you not to be? ...*
*Your playing small doesn't serve the world.*
*There's nothing enlightened about shrinking so that other people won't feel insecure around you. ...*
*And as we let our own light shine, we unconsciously give other people permission to do the same.*
*As we are liberated from our own fear, our presence automatically liberates others.*

As occupational therapists and as teachers, mentors and clinical supervisors of a new generation of occupational therapists, it is essential to be aware of the values that we are modeling and to have the courage to let our own light shine. As we support students in learning the professional competencies and clinical skills needed for practice, we must at the same time ensure that we aren't just rewarding conformity but are also challenging, encouraging and celebrating their ability to speak up, and their contributions from their own values and uniquenesses.

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PRIVATE PRACTICE INSIGHTS

COLUMN EDITORS: CHRISTEL SEEBERGER AND JON RIVERO

# Setting your fees in private practice: How much are you worth?

Jane Simmons

Occupational therapists in private practice set their own fees and rates for their services. Fee setting is a challenging task that must be negotiated by a large proportion of our occupational therapy colleagues. Statistics taken from the Newfoundland and Labrador Occupational Therapy Board for 2012 show that 20.6% of therapists in the province earn some or all of their income from private practice (K. Doyle, Registrar, personal communication, August 10, 2012.) In this article I will share knowledge and lessons I've learned about fee setting over my 18 years of working in private practice.

I feel there is a growing demand for occupational therapists in services which can easily be provided in a private practice setting, and therefore an increasingly diverse array of clients and services for which to set fees. I have worked in private practice since 1994 and note that there are an increasing number of individuals, organizations and groups who are willing to pay for occupational therapy services including: insurance companies (workers compensation boards, short/long term disability providers, insurance related to motor vehicle accidents); lawyers (related to personal injury, medical malpractice, cost of future care, expert witness testimony) and employers (injury prevention training, fitness to work evaluations, pre-employment/post-injury disability management, assessment and rehabilitation services, ergonomic assessments, and mental health and wellness programming). I have found that other services such as splinting and orthotics, and paediatric or school assessment and intervention services may be covered for those fortunate enough to have occupational therapy included in their employee health benefits.

As an example of employee health benefit coverage for occupational therapy services, the plan for Government of Newfoundland and Labrador employees (which added occupational therapy to their list of health benefits in 2010) covers occupational therapy for an annual eligible expense of up to $500.00 per calendar year per person insured under the plan (including employees and their covered family members). Beneficiaries will be reimbursed for 80% of this eligible expense (i.e., $400.00) (Government of Newfoundland and Labrador, 2012).

In addition, I have found that many clients will pay out of pocket for occupational therapy services. This is often for orthotics and splints, ergonomic services, home assessments and accessibility or universal design advice, professional business or life coaching, and children's services. Clients are often willing to pay to get ahead of wait-lists in understaffed hospitals or school services.

Given the variety of clients therapists may be seeing in private practice and the institutional parameters and expectations of companies paying for services, setting fees can be a daunting task. From my years of experience in private practice since 1994, with many good years, but some not so good, I would provide the following words of advice.

## When setting fees you have to think about a number of things:

- Does your regulatory body have any regulations that must be followed regarding setting of fees and billing practices? When you agree to take on a case, you need to ensure that you are able to meet the needs of the client without violating your code of ethics or requirements of your regulatory body.
- How much money do you wish to make yourself and pay your staff if you choose to hire any?
- How many hours per day do you have available to invest in your work?
- How much profit do you wish to make?
- Do you have any competitors? If so, how much are they charging?
- How are your services the same or different from your competitors and is this worth more to your clients?
- What are your costs for running your business?
    - Weekly/biweekly payroll
    - Monthly benefits plan
    - RRSP contributions/pension plan
    - Workers compensation insurance cost (you should have this even if self-employed)
    - CPP, EI, annual leave and income tax expenses for employees
    - Administration expenses – e.g. office manager and others that are not revenue-generating
    - Cleaning expenses
    - Office expenses including things such as furniture, office supplies, paper, and photocopy/printing costs
    - Bank charges (overdraft & chequing, bad debt)
    - Rent/mortgage/business tax
    - Professional fees (accountant, legal, etc.)
    - Assessment tools
    - Treatment tools
    - Training and education expenses
    - Mileage, travel time, preparation time/set-up
    - Research and development

Once all these things are considered, develop a business plan in consultation with business advisors, bank managers, lawyers, accountants and other experts relevant to your business plan. Talk with other clinicians who provide similar services where possible, including other provincial and national resources. Explore what they are charging for their services, and if possible, determine how your services will be different from what they provide, how they are similar and what value-added service you can provide. Do not sell your services for less than they are worth. Make it worth your while and ensure you represent your profession well. Know the limits of what you are able to provide with your background and experience and refer to others when the scope of practice is beyond yours!

## Some other ideas to keep in mind:

- Develop a network of private practice occupational therapists in your area who provide similar services. Meet to discuss the process of setting fees for services and other private practice issues.
- You could send out a survey similar to that used by CAOT-BC and get feedback from other occupational therapists in your region about what they are charging for certain services (see reference below).
- Feel confident to charge more if you have extra training, specialities, unique services or high overhead.
- Consider mileage, travel time, preparation or set-up time and research and development into your quotes.
- If you have a small business and performing tasks such as writing proposals and quotes, and marketing are the sole responsibility of the owner, ensure your lost time for such administration is built into your fees.
- Hire consultants on a fee-for-service basis. Pay them for work that has been completed only when they are ready to invoice for specific services that they have provided on behalf of your company. This will ensure that your cash flow is optimized, thereby reducing overdraft charges from your bank. If your consultants are paid a salary, ensure that the salary agreed upon is contingent upon meeting certain revenue targets. Depending on your overhead expenses (benefits, annual leave, etc.), business advisors with whom I have spoken have advised me that salaried employees should generate at least 2.2 times their salary in order to cover all employment expenses. I strongly recommend that an employee's revenue generation compared to their pay is reviewed on a regular basis and that adjustments are made as necessary. Your business can be negatively affected if someone is being overpaid for the work they are doing and/or is not completing adequate billable work and submitting invoices on a regular basis.
- As occupational therapy groups or associations, we cannot set uniform fees for our professional services as it violates criminal laws enforced by the Competition Bureau of Canada related to price fixing. Surveys can be completed and we can advocate as a unified group to ensure fees pay us adequately for our time, while permitting us to do what we love! Of note, the only way a set fee can be developed is if it is negotiated between a client and a provider (or group of providers). We have a contract like this in Newfoundland and Labrador between 'Licensed Occupational Rehabilitation Providers' (of which occupational therapy is included) and the Workplace Health, Safety and Compensation Commission.
- Write contracts with regular clients in order to ensure reasonable payment schedules.
- In cases where clients are involved with third-party litigation and cannot pay you until their case is settled, you may wish to refer them and their legal counsel to agencies that fund rehabilitation services for clients who are waiting for settlements. Such agencies are beneficial as they permit the injured client to get the required treatment to optimize their recovery without settling their case prematurely in order to fund your services on their own. While the client will pay the interest accumulated on these loans to the agency that supported their rehabilitation, it is one less thing for you to carry as a long-term receivable.

I have been in business since 1994 and feel that I have learned many things the hard way! I do feel that I have finally figured out the best way to run my practice, cover my costs and be profitable. I love what I do and could not think of any better way to be in control of my life than private practice! Setting fees can be one of the harder things to get your head around, but once there, it will be clear! If anyone wishes to contact me to learn more about this process or how I have made my private practice work, please email me at jsimmons@iohs.nf.net.

Jane Simmons is also the Chair of CAOT's Occupational Therapy Practices Committee. If you would like more information about this committee, please contact Jane directly.

## Jane's recommended 'go-to' resources:

- Arturi, G. (2003). Setting your fee for occupational therapy services. *Occupational Therapy Now, 5*(3), 6-9.
- OT Networker (CAOT members' online database for connecting occupational therapists) https://www.caot.ca/ebusiness/source/members/otsearch.cfm
- OT Finder (CAOT's public database) http://www.caot.ca/ebusiness/source/otfinder/index.cfm

## Occupational therapy fee information:

- Ontario auto insurance fee information for health professionals: http://www.fsco.gov.on.ca/en/auto/autobulletins/2012/documents/a-03-12-1.pdf
- Government of Canada job market report for occupational therapists: http://www.workingincanada.gc.ca/report-eng.do?

## About the author

**Jane Simmons, president/occupational therapist with Integrated Occupational Health Services (www.iohs.ca) in St. John's, N.L.,** has been in private practice since 1994. Her company specializes in work related assessment and treatment services, in addition to home based interventions. Clients include industry, insurance companies and the legal community. Jane currently employs two full-time and 14 part-time contractual staff who provide services across the province.

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- Bridle, M., & Hawkes, B. (1990). A Survey of Canadian Occupational Therapy Private Practice. *Canadian Journal of Occupational Therapy, 57*, 160-166.
- Every two years, a survey is conducted in British Columbia to poll private practice occupational therapists on their fees. This report is published and made publically available, and is used by funders. This is posted on the CAOT-BC website: http://www.caot.ca/default.asp?pageid=4125

The Private Practice Insights column co-editors also recommend a newly published FREE resource for occupational therapists in private practice: http://clinicserver.com/free-resources/ebooks/beasmartclinician/. This resource was put together by occupational therapist, Kelly Lawson.

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# Letters

## Praise for *Restoring the Spirit: the Beginnings of Occupational Therapy in Canada, 1890-1930*, written by Judith Friedland

Dear Judy,

Congratulations on your enormous achievement!


Your long-standing commitment to occupational therapy underlying countless hours of detailed research has produced at last, a history of Canadian occupational therapy for students, practitioners, and interested others. By reflecting on the personal journey that brought you to the role of historian, it affords readers like me an objective view of our own journey...with attendant anxieties, frustrations, questions, ambiguities, fears, satisfactions, etc. Your writing triggered them all!

My first job was in a DVA [Department of Veterans' Affairs] Hospital in London, Ontario where we were told that the older ladies wearing green uniforms like ours were the graduates of the WW1 class and they worked with the WW1 veterans. In hindsight, I think we might have learned a lot from them (especially after reading your book) but the lines of demarcation were very clear, and looking back, I doubt that we would have had the maturity to appreciate their stories. In the last job I had before I retired, one of my responsibilities was to interpret occupational therapy to groups of high-profile business people for the purpose of a hospital fundraising campaign. As I was allotted only a few minutes, I found the Model of Human Occupation the key to a short and snappy pitch (or so I thought!) and I remember thinking... just as I'm about to retire I have finally figured out how to explain occupational therapy!

In between those two jobs there were all kinds of experiences which your book captured ... and "restoring the spirit" says it beautifully. Two passages in particular left me feeling appreciative and ...yes, liberated! One was the impartial, objective view of Goldwin Howland [CAOT's first president] and company and the second was the factual description of how it was determined that the course in occupational therapy would be combined with physiotherapy. To this day, I wonder how Helen LeVesconte and Isobel [Robinson] and Thelma [Cardwell] maintained their sanity. I know they had lots of support but it surely was an uphill battle...and for 20 years!

Thank you so much Judy, for this great contribution to the annals of occupational therapy. May it serve not only as our history, but as the inspiration to new generations of occupational therapists to enrich the lives of people and the communities in which they live.

And may you know great satisfaction from your accomplishment,
Warmest regards,
*Pat Fisher*

PRACTICE SCENARIOS

COLUMN EDITOR: MARY STERGIOU KITA

# The PEO and Ready, Set, Go: Preparing clients to return to work following a burn injury

Daisy Won and Mary Stergiou-Kita

## Case study

Mr. Smith is a 27-year-old welder who sustained a burn to 8% of his total body surface area during work at a welding company. While welding overhead, sparks got underneath his leather work gloves and ignited his clothes. With the help of a co-worker, Mr. Smith was able to extinguish the fire and remove his coveralls. However, he sustained burns to his right medial bicep, axilla, chest and trunk, and as a result, received a skin graft on the burn areas (donor site: right thigh). Mr. Smith began receiving interdisciplinary outpatient burn rehabilitation services one month following the graft. Good functional progress is evident in his upper extremity (i.e. mobility and strength) and physical endurance, and the burn and donor sites have healed well. However, he continues to experience potential work limitations related to reduced tolerance for bilateral overhead reaching, lifting (currently 70 lbs. maximum), and thermoregulation and hypersensitivity issues in the burn regions. You have been asked to assess Mr. Smith's ability to return to work and develop a return to work plan.

## Introduction

Returning to work following a burn injury is a complex process due to various medical (e.g., wound care, physical deformities, psychological and cognitive impairments), social (e.g., worker's and co-workers' expectations, attitudes and beliefs about disability) and environmental factors (e.g., temperatures, equipment/tools, fast-paced and demanding workplace cultures). With their knowledge and skill sets, occupational therapists are well positioned to facilitate effective and safe return to work by integrating knowledge about the person/worker, the occupation and job demands, and the workplace environment, and by liaising with the employer, worker, funding/referral source, and health-care team. The Person-Environment-Occupation Model (PEO) allows interdisciplinary teams to visualize the interactions between person, environment and occupation factors that affect occupational performance (Law et al, 1996). In this paper we use our clinical experience, the PEO Model as a guiding framework and the concepts of 'Ready, Set, Go' to illustrate key factors and processes relevant to return to work practice for clients who have sustained burn injuries.

## Getting READY: Understanding personal factors: Body system impairments and functional issues resulting from burns

A burn injury can be caused by a variety of heat sources including hot water, a fire, or an electrocution. Various body systems and functions can consequently be affected. For example, cardiovascular issues such as arrhythmias may arise and the respiratory system may be affected through inhalation injuries from chemical fires, resulting in breathing difficulties. Impairments of the skin and musculoskeletal systems can lead to hypertrophic scarring, joint contractures, decreased range of motion and strength, pain and hypersensitivity. Nervous system impairments can affect attention, memory and higher cognitive functions, and may result from electrical injuries or falls subsequent to an explosion (Pliskin et al., 2005; Singerman, Gomez, & Fish, 2008). Psychological sequelae such as anxiety, depression, and post-traumatic stress disorder are also commonly reported in relation to physical disfigurement and concerns of re-injury, particularly if workers are returning to a worksite where the initial burn occurred (Noble, Gomez, & Fish, 2006; Esselman et al., 2007). The occupational therapist must consider all of the above areas in order to determine both the worker's personal strengths and functional limitations resulting from the injury. Mr. Smith's specific personal strengths and limitations are illustrated in Figure 1.

## About the authors

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**Mary Stergiou-Kita, PhD, MSc, BSc (OT), OT Reg. (Ont.),** is a research scientist at St. John's Rehabilitation Hospital, Sunnybrook Research Institute, and an assistant professor in the Department of Occupational Science and Occupational Therapy at the University of Toronto. She can be reached at: mary.kita@utoronto.ca.

## SETting up: Preparing the worker, and understanding job demands and the workplace environment

Following the initial step of identifying the relevant personal factors, therapists must gain an understanding of the job demands and workplace environment, and begin to prepare the worker for returning to work. Mental preparation to face co-workers is necessary due to potential physical disfigurement and related issues of confidence and self-esteem. Social interactions between the worker and employer may also not have occurred during rehabilitation, and mental preparation can be as simple as planting the seed that a visit to the workplace is going to take place in the near future. Reviewing the purpose of the job site analysis with the injured worker and probing to see if there are any concerns related to work re-entry, even if there are no apparent psychological issues, is prudent and may prevent fear and anxiety issues from developing.

A job site analysis allows the therapist and the worker to gain an understanding of the physical, cognitive, social and psychological demands of a job as well as workplace environment issues that may act as facilitators or barriers to return to work (Lysaght, 1997). For example, 'red flags' and triggers related to the site and cause of the accident can be addressed with the worker to minimize negative work re-entry experiences and re-injuries. Information regarding job demands can assist in developing targeted therapy goals and can be used to monitor when a worker is nearing the required work abilities. By comparing a worker's current functional abilities and required job demands, work accommodations can also be proposed. Work accommodations commonly employed for workers who have sustained burn injuries include permitting rest breaks to moisturize and stretch the burn scar; allowing workers to complete tasks from a seated position to relieve pain and compensate for decreased endurance; allowing the use of automatic machinery (e.g., crane, pump truck), assistive devices such as extended handles to compensate for decreased range of motion and reach, and modified or lighter tools and equipment; modifying work temperatures to compensate for thermoregulation issues; and the provision of alternate job duties or an alternate job position.

The key occupational demands and environmental issues relevant to Mr. Smith's case are highlighted in Figure 1.

Excess perspiration occurs in healthy skin after a burn injury due to the replacement of burned sweat glands with scar tissue. This altered thermoregulation creates heat intolerance issues, particularly when the surface area of the burn is large and in certain work environments such as kitchens (e.g., chefs) and outdoor work (e.g., construction workers). During a job site analysis, the potential for temperature control should be determined. At Mr. Smith's work, he may be uncomfortable as a result of constant heat sources from welding, the physical nature of the work and being surrounded by metal materials that act as heat conductors. Knowing if excess perspiration will

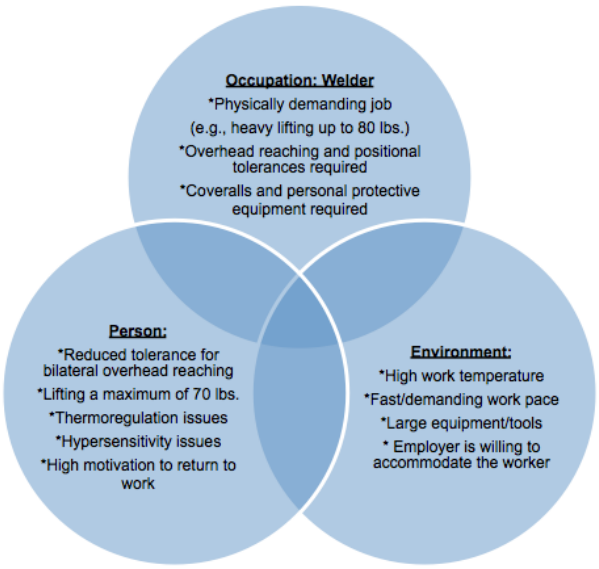


**Figure 1. Mr. Smith's PEO factors influencing occupational performance.**

create social issues is also relevant in creating a more positive return to work experience (Tjulin, Maceachen, Stiwne, & Ekberg, 2011; Fadyl & McPherson, 2008).

Burn scar contractures, physical disfigurement and pain are common following burns. Contractures and pain can significantly decrease range of motion when they cover a joint. To flatten burn scars, customized burn pressure garments are essential and worn by workers for 23 hours per day for up to two years post-injury. Psychological intervention focused on teaching pain management strategies can also be employed (Li, Gomez, & Fish, 2010). Due to the location of his burn, Mr. Smith will need to wear burn pressure garments over his full torso. It will be necessary to ensure that petroleum products, caustic chemicals and tar, which can damage the material of the pressure garments, are avoided at work. Through a job site analysis it is discovered that Mr. Smith uses petroleum products, however, his pressure garments will be protected from damage as they are worn under his uniform. Of greater concern may be the aggravation of his thermoregulation issues due to the extra body heat produced from wearing the garments under his clothing and coveralls.

Numbness and hypersensitivity to touch and temperature are also key characteristics of burn injuries that can limit performance during physical tasks such as constant standing, lifting or carrying. During a job site analysis, it is beneficial to review work processes and procedures to identify tasks in which hypersensitivity may be an issue. A rotation of job tasks to break up constant static standing is a good solution to reduce numbness and maintain work performance. Specific to Mr. Smith's hypersensitivity issues, aggravation of the burn scar can be caused by friction against the burn pressure garment (e.g., with right arm extension). If rubbing causes significant distraction during work, which can compromise safe lifting, modified or alternate job tasks can be proposed.

## Getting ready to GO back to work: Developing a return to work plan

When the worker demonstrates the required strength, mobility, endurance, and psychological readiness to engage in work tasks, and medical clearance is provided for a work trial, a gradual return to work plan can be developed. Consultations with the burn surgeon and ongoing communication with the health-care team and employer are essential to determining readiness and relevant job modifications and accommodations. A graduated return to work plan, and subsequent updated plans, are developed that detail job tasks, work restrictions and accommodations, work schedule and pertinent therapy notes such as upcoming surgeries. Encouraging the worker by providing ongoing support and feedback, highlighting progress and strengths, and problem-solving when issues occur can facilitate a successful return to work process.

## Conclusion

Using a case study, our clinical experience, the PEO Model and the concepts of 'Ready, Set, Go,' this paper illustrates the key factors and processes to consider in order to facilitate return to work following burn injuries. Key issues experienced by workers following a burn can include scarring, joint contractures, pain, sensory and thermoregulation issues, cognitive impairments and psychosocial challenges such as anxiety, depression and post-traumatic stress disorders. When assisting individuals to return to work, occupational therapists must consider these issues in relation to the worker, his/her functional status, work demands, the workplace environment, and the workplace's ability to provide relevant accommodations.

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# Trauma-informed practice: An emerging role of occupational therapy

Dana Snedden

COLUMN EDITOR: REGINA CASEY

**Editor's note:** *OT Now* welcomes this article on a specific practice that attends directly to complex trauma issues, an often overlooked area of practice. Further, we hope that it stimulates conversation and dialogue on the need to incorporate trauma-informed approaches within recovery-oriented service delivery as recommended by our new mental health strategy document titled *Changing directions, changing lives: The mental health strategy for Canada* (Mental Health Commission of Canada, 2012).

This article presents an approach to the emerging occupational therapy role in a community-based interdisciplinary traumatic stress program. Specifically, an occupational therapy model, the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Townsend & Polatjako, 2007), is linked to a particular trauma model of practice, Herman's (1997) Triphasic model. These will be discussed in order to: 1) understand the occupational performance challenges of people who manage the impact of trauma in their daily lives and 2) to identify how occupational therapists can work with people who live with trauma in order to facilitate recovery.

## Service background

The Traumatic Stress Program of Eastern Health, Newfoundland and Labrador, focuses on service delivery to individuals who experience a specific kind of trauma called complex or Type II trauma (see definition below). The service is provided at the tertiary level and is staffed by a team of trauma therapists (professional backgrounds include social work and psychiatric nursing) as well as an occupational therapist. It emerged in 2006 as a result of an identified gap in services for individuals who presented in emergency services and required access to appropriate and extensive trauma counseling.

Trauma is defined as a bodily or mental injury usually caused by an external agent (Rosenbloom & Williams, 2010). "Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life" (Herman, 1997, p. 33). From this perspective, once someone has experienced trauma it becomes more difficult to engage in everyday activities.

## Complex (Type II) trauma

Complex (Type II) psychological trauma refers to repetitive or prolonged exposure to traumatic stressors that involve harm or abandonment and often occur at developmentally vulnerable periods in a person's life (Courtois & Ford, 2009). It affects as many as one in seven to one in ten children. Often perpetrated by someone known to the victim, it usually involves a fundamental betrayal of trust in primary relationships. This is why Type II trauma is associated with a much higher risk for the development of post-traumatic stress disorder (PTSD) than Type 1 (single incident) trauma (33-75% risk versus 10-20% risk) (Courtois & Ford, 2009).

Clients who attend the Traumatic Stress Program have complex PTSD and often face a number of occupational challenges. A key criterion for the diagnosis of PTSD is impairment in the functioning of life skills such as the ability to socialize, work, attend school, or manage family responsibilities (Baranowsky, Gentry, & Schultz, 2011). Features of PTSD may include a combination of the following: difficulty regulating affective impulses and traumatic re-enactments, alterations in attention and consciousness, alterations in self-perception, difficulty in interpersonal relationships, impairment of life skills, and difficulty establishing a system of meaning that offers hope for the future (Rosenbloom & Williams, 2010).

Herman's (1997) Tri-Phasic model conceives the recovery from complex trauma to proceed in three stages: safety and stabilization, remembrance and mourning (trauma memory processing), and reconnection. During stage one, the primary goal of recovery is to enable the person to make a gradual shift from a state of 'unpredictable danger' to a state of 'reliable safety', meaning that individuals begin to trust stimuli from the environment and their own reactions. During stage two, the survivor, in a non-linear fashion, processes traumatic memories and how these events have shaped their life. The third stage of recovery involves the reshaping of one's identity through participation in meaningful occupation and healthy relationships (Baranowsky et al., 2011; Courtois & Ford, 2009; Herman, 1997). It is during Herman's third stage of recovery that the occupational therapy core skill of enablement (Townsend & Polatjako, 2007) is particularly helpful. During

**Table1. Trauma and the Canadian Model of Occupational Performance and Engagement**

| Construct | Impacts of trauma (Rosenbloom & Williams, 2010). |
|---|---|
| *Person*<br>• Cognitive<br>• Affective<br>• Physical<br>• Spirituality | Impaired concentration, dissociation, intrusive images, and nightmares.<br>Fear, anger, guilt, grief, numbing, loss of trust, and loss of self-esteem.<br>Sleep disturbance, disordered eating, altered libido, and hyper-arousal.<br>Loss of hope and greater meaning in the world. |
| *Occupation*<br>• Self-Care<br>• Leisure<br>• Productivity | } Disruption, loss and/or alienation from activities of daily living, leisure, school, work, social participation and valued life roles. |
| *Environment*<br>• Cultural<br>• Social<br>• Institutional<br>• Physical | Attitudes (victim blame/stigma).<br>Lack of individual and community supports, low socioeconomic status.<br>Policies/laws within hospitals, governments or employers may be deterrents to seeking help or justice.<br>Inability to access services (physical location of services, such as from a remote location, or stigma attached to mental health facilities). |

this third stage of recovery, the opportunity to engage in meaningful occupation is recognized as essential in actualizing posttraumatic growth, and subsequently, recovery.

## The CMOP-E and the impact of trauma

Occupational therapists who are interested in developing their role within trauma services may choose to use the CMOP-E (Townsend & Polatjako, 2007) for three main reasons. Firstly, the model may help to generate an understanding of the unique impacts of trauma on everyday life. Impacts of trauma specified within the core constructs of CMOP-E are described in Table 1, above. Secondly, CMOP-E can be used to guide the recovery process with individuals who experience complex trauma. As such, it provides a framework with core constructs to identify the challenges in occupational performance and engagement during each phase of treatment and recovery. In addition, using CMOP-E can be a valuable asset to an interdisciplinary team approach to trauma. For example, CMOP-E helps survivors and team members generate an understanding that occupation occurs in the context of the person's daily life, and of the interaction of person, occupation and environment (Townsend and Polatjako, 2007).

## The emerging role of occupational therapy within a Traumatic Stress Program

Pre-screening: When participants first begin the program, they enter a pretreatment phase where screening and intake occur and an individualized treatment plan is developed. The occupational therapist first meets with the client during this phase to assist with assessment and goal setting by completing the Canadian Occupational Performance Measure (COPM) (Law et al., 1994). The COPM enables the client to understand how trauma affects all areas of their lives, allowing them to develop and prioritize their goals for the program and their larger recovery journey (Harper, Stalker, & Templeton, 2006).

**Phase I:** Safety. Participants, (either through an individual or group stream), partake in education about trauma and traumatic response/re-enactment. Safety planning and the introduction of coping skills also occur. Within this phase, the occupational therapist co-facilitates a Safety and Wellness Recovery Action Plan (WRAP) group. Created by Copeland (2002), WRAP is an extensive wellness plan that identifies triggers, warning signs and strategies to cope. While many WRAP groups are peer run, this modified Safety and WRAP group requires additional knowledge and expertise in teaching the trauma-specific safety skills of self-soothing, grounding, containment, and expression strategies, as well as the ability to practice self-rescue (Baranowsky et al., 2011). It is anticipated that this group will be eventually co-facilitated by a trained peer.

**Phase II:** The trauma story. Survivors work with trauma therapists individually or in groups to prepare for telling their trauma story and to process, remember and mourn the loss associated with the impacts of trauma on their lives. Topics include establishing healthy boundaries, self-esteem, shame, guilt and forgiveness. The occupational therapist may co-facilitate this work in a group setting, however, at present, does not do this trauma-processing work individually with clients.

**Phase III:** Reconnection and aftercare. The primary goals in this phase are to identify disconnection with oneself and one's community and to redefine a future in terms of posttraumatic growth and resilience (Baranowsky et al., 2011). The occupational therapist works with clients individually and in groups during this phase and the treating trauma therapist will provide additional one-to-one and/or group support. In addition, a peer may co-facilitate an alumni group (see description in Table 3). Intervention enables the survivor to focus on engagement in meaningful occupation by ensuring that the safety needs of the individual are met. (Bryant, Craik,

& McKay, 2004). The majority of goals chosen by participants are focused on reconnecting with social and leisure occupations as well as work or school.

Groups emphasize the value of engaging in healthy occupation and may lead to the client changing occupational performance skills and patterns to promote wellness, role competence, satisfaction and improved quality of life (Cara, 2005). In addition, participation in meaningful occupation provides a distraction from stressful thoughts and events while also promoting feelings of competence and control with the learning of new skills (Scaffa, Gerardi, Herxberg, & McColl, 2006). Table 2, below, describes current reconnection and aftercare trauma groups and Table 3 describes groups that are under development.

**Table 2. Reconnection and aftercare trauma groups**

| Life in Balance | Healthy Relationships and Reconnection |
|---|---|
| Focus: Creating wellness and balance in self-care, leisure and productivity occupations. | Focus: Building healthy relationships and community access/awareness. |
| Method: Uses digital photography as a storytelling method to move beyond trauma, represent oneself, build skills and create change. | Method: Uses a combination of education and self-reflective activities to reconnect with oneself and one's community. |

**Table 3. Reconnection and aftercare trauma groups in development.**

| Vocational Support | Alumni | Express Yourself |
|---|---|---|
| Focus: Exploring return to school and/ or work. | Focus: Survivor/peer support. | Focus: Learning new skills and alternate ways to express and process thoughts and emotions. |
| Method: Education, support and exploration of community resources to support return to school and work opportunities. | Method: Drop-in style, loosely structured with some education and activity components (no time limit on participation in this group). | Method: Uses a combination of visual arts, music and movement activities for self-expression. |

## Conclusion

Developing the role of an occupational therapist on any interdisciplinary team can be a daunting challenge. This article provides an illustrative example of a successful addition of occupational therapy services within an interdisciplinary traumatic stress program. A back-to-basics approach of using research evidence and the alignment of an occupational therapy model with a trauma recovery model remains critical to the success of developing the emerging role. The fact that these models are congruent results in being better able to both generate a rich and situated understanding of occupational performance strengths and challenges and to identify recovery-promoting solutions with people who manage this level of trauma.

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ENHANCING PRACTICE: ADULTS

# Outdoor falls in Canadian winter: Realities from Quebec

Marjorie Désormeaux-Moreau

COLUMN EDITOR: PATRICIA DICKSON

Mrs. Lachute, 54, lives on the second floor of a duplex and must use an exterior spiral staircase to exit her house. Last winter, as she was going out to do her shopping, Mrs. Lachute slipped on an icy step and slid to the bottom of the stairs. She was lucky to end up with nothing more than a broken ankle.

While many people take advantage of the winter weather to strap on their skis, snowshoes or ice skates, others like Mrs. Lachute, will face the many challenges that winter conditions pose for the prevention of falls.

## What are the impacts of falls?

In Canada, falls are a major cause of injuries, including hip and upper limb fractures (Morency et al., 2010), dislocations and brain trauma, not to mention the stress and pain that may also result (Gagnon & Lafrance, 2011).

## What is the relationship between wintertime and falls?

Many studies have shown that the rate of falls varies significantly according to the season and associated weather conditions (Bélanger-Bonneau, Rannou, Thouez, & Damestoy, 2002; Bischoff-Ferrari, Orav, Barrett, & Baron, 2007; Douglas, Bunyan, Chiu, Twaddle, & Maffulli, 2000; Morency, Voyer, Beaylne, & Goudreau, 2010). In Montreal, for example, the number of hospitalizations resulting from falls increases by about 25% in winter (Morency, 2008). There are many factors associated with winter that can contribute to falls. Studies conducted in the northern United States and Quebec have shown that a rise in the number of falls in winter is clearly associated with a drop in temperature to -5 °C and below, as well as with snowstorms, frost, and freezing rain (Bischoff-Ferrari et al., 2007; Morency et al., 2010). This is explained by the fact that surfaces covered with snow and ice increase the slipperiness of sidewalks and stairs, as well as driveways and parking lots (Morency et al., 2010).

Not everyone is affected in the same way by these weather conditions. While no significant difference has been observed on the basis of gender (Morency et al., 2010), two studies carried out in Montreal have shown that most people who have fallen outdoors in winter are under 65 years of age (Levy et al., 1998; Morency et al., 2010). This is easy to understand since people under 65 are likely involved in more active occupations and are more exposed to unfavourable weather conditions than older people, so their rate of falls is more closely correlated to those conditions (Bischoff-Ferrari et al., 2007). In fact, as proposed in the Health Belief Model, developed by public health researchers (Rosenstock, 2000), people under the age of 65 don't generally consider themselves at risk of falling, which can alter their perception of the dangers posed by winter conditions. However, even from the age of 30, normal aging of the body involves physical and sensory changes that have a major impact on balance (World Health Organization, 2007) and thus on the risk of falling.

## All this considered, what are the possible solutions?

It would hardly be realistic merely to advise people to stay inside in order to avoid falling. People aged 50 to 65 often have jobs, either paid or volunteer; they may still have young children at home; they may be acting as caregivers; and so on. In short, the type of occupations they are engaged in and the demands of those occupations require that they leave their homes and move about outside. Moreover, leaving the house increases a person's opportunities for occupation, particularly in physical activities. Since physical activity is one of the factors that protects people against falls (Fauchard & Le Cren, 2009), it is important to encourage individuals to maintain their physical and social activities.

Advice for clients to help reduce their risk of falling in winter:

1. Remind clients to dress warmly when they go out; someone who is cold tends to hurry and hurrying increases the risk of falling (Bell, Gardner, & Landsittel, 2000). Similarly, we should encourage clients to give themselves extra time when they go out in order to avoid weather delays and thus the feeling of running behind schedule.

## About the author

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2. Inform clients that it is important to wear proper footwear and that it can be helpful to use detachable grip soles that fit over regular footwear. Remind them that these soles are not for indoor use and should be removed once they reach their destination.
3. Recommend clients check that external stairs and railings are sturdy and in good repair. Recommend the installation of non-slip surfaces on steps and lighting to illuminate stairs. Encourage them to keep their external stairs free of objects and to clear them promptly after a snowfall.
4. Suggest that clients keep a pail of sand or abrasive material near the door of the house to ensure that they do not have to walk on a frozen surface.
5. Work within the community to set up information kiosks or distribute pamphlets on the risks of falling in winter. Health education is a good way of making people aware of their vulnerability and the risks they face in order to promote changes in habits and behaviour (Rosenstock 2000).
6. Raise awareness at the level of municipal government about the issue of falls in winter. More frequent snow clearing and sanding operations in certain areas, particularly densely populated neighbourhoods and commercial arteries, could substantially reduce the number of falls.
7. Develop partnerships or agreements with the municipality to promote the creation of a citizens' monitoring service, through which people can report slippery, broken or badly maintained sidewalks or other situations that might cause a fall or accident.

In conclusion, although cold, blizzards, and freezing rain are part of the reality of winter in Quebec and most of the rest of Canada, it is possible for us, as occupational therapists, to help reduce the incidence of falls caused by winter conditions. By offering personalized risk-reduction strategies, we can help our clients avoid falls and the resulting injuries, which will ultimately help them to continue engaging in their various occupations.

So this winter, let's help our clients keep their feet on the ground.

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# Update from the Canadian Occupational Therapy Foundation

## COTF's Research and Scholarship Review Committee:

The 2010-2012 COTF Research and Scholarship Review Committee ends its mandate with the adjudication of the 2012 COTF Scholarship competition. Thank you to this committee for the great work that they have done for COTF. The members are:

Deb Cameron, Chair
Brenda Beagan
Kim Larouche
Leanne Leclair
Susanne Murphy
Gayle Restall
Annette Rivard
Annie Rochette

## The 2013-2015 committee members are as follows:

Deb Cameron, Chair
Brenda Beagan
Johanne Higgins
Kim Larouche
Leanne Leclair
Joyce Magill-Evans
William Miller
Susanne Murphy

The members of the committee are not all replaced at the same time. A system has been implemented to ensure continuity. Best of luck to the new committee and thank you to the members for volunteering for this imperative task.

## Why occupational therapists donate to COTF:

Terry Krupa, PhD, OT Reg. (Ont.), FCAOT:
"Receiving the support of COTF scholarship and research funding was a tremendous benefit early in my career as a researcher. First, it developed my self-confidence when setting up a program of research, which seemed overwhelming. Second, the credibility it gave to scholarship and research related to occupation and occupational therapy enabled me to keep my focus on these areas of study. Finally, this support helped to increase my 'competitive edge' when I went on to apply for funding from national granting agencies. I now count on COTF funding to do the same for my research students."

Gail Teachman, PhD (Candidate), OT Reg. (Ont.):
"In the first year of my PhD, I applied for a Doctoral Scholarship from our Canadian Occupational Therapy Foundation. It was important to me to align my work with occupational therapy research and to challenge myself to consider how my work might inform occupational therapy practice. I was thrilled to hear that my application was successful and then, to proudly take my place alongside other scholarship recipients when the COTF awards were announced at the CAOT conference in 2011. I felt a great sense of community and support from my peers across Canada on that day."

The impact of funding COTF is real. It makes a difference. Please become a donor!

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