CAOT · BC
Canadian Association of Occupational Therapists
British Columbia

CAOT-BC
BRIEFING NOTE
May 2018

Occupational Therapy and Injured Drivers, Passengers and Pedestrians

Introduction

Recent announcements by the Attorney General of British Columbia (BC) and the Insurance Corporation of British Columbia (ICBC) indicate a shift in direction for the Crown Corporation, one that will focus on the recovery of clients that include any driver, passenger or pedestrian injured in a motor vehicle collision. This shift includes significant increases in funding across the spectrum of available medical and rehabilitation benefits for clients and presents an opportunity for ICBC to re-examine service requirements, utilization of health care professionals and desired outcomes. Occupational therapists (OTs) are uniquely positioned to assist ICBC in its goal to transition to a care-based insurance model that will lead to better health outcomes, customer experience and satisfaction, and overall cost effectiveness. CAOT-BC is supportive of the proposed increases in funding and access to medical benefits and presents this paper to raise awareness and knowledge of the breadth and scope of occupational therapy services for clients.

What is Occupational Therapy?

Occupational therapy is a regulated health profession whose role is to enable people to engage in necessary daily activities (also known as occupations) following injury, illness, disability or other barriers. These occupations include all the activities that a person needs and wants to do in their day; for example, self-care tasks, such as bathing, dressing and toileting, home-making, community access, leisure activities, driving and paid or unpaid employment. In BC, OTs are governed by the Health Professions Act of BC[1] and must adhere to regulatory standards to ensure the provision of safe, competent and ethical care in accordance with best practices. OTs must be registered to practice with the College of Occupational Therapists of BC, and their practice is guided by the essential competencies of practice for OTs in Canada (ACOTRO, 2011[2]).

The occupational therapy process involves an objective, assessment of a client's current functional ability, and the requirements of their daily life activities. If an injury prevents an individual from participating in the things they need and want to do, to the extent that they did prior to sustaining an injury, occupational therapy treatment is recommended. Once initiated, OT-led interventions are ideal for helping individuals overcome these challenges to maximize their participation in their daily activities as well as optimize their quality of life.

The Scope of Occupational Therapy Services

OTs are uniquely qualified to assist clients with functional limitations because of their skills, knowledge and competencies across physical, cognitive and emotional domains. OTs are university graduates (Bachelor and/or Master's level trained) and training includes anatomy, neurology, physiology and mental health conditions in addition to occupational therapy theory and practical skills. OTs work with individuals across the lifespan from infancy to older adulthood and in all aspects of the recovery continuum including acute, subacute, rehabilitation, community and chronic phases. In all of these practice areas, OTs address disability in real life settings that matter to clients including home, community, school and work.

OTs are skilled health care professionals providing goal-oriented rehabilitation for clients who have sustained musculoskeletal injuries (soft tissue and orthopaedic), concussions, brain injuries, spinal cord injuries and trauma-induced or aggravated mental health conditions such as PTSD, depression and anxiety. Some interventions serve to minimize the underlying limitation, while others help the individual compensate for the limitation in both the short and long term. OTs provide rehabilitation using a diverse range of interventions, each with the purpose of facilitating improved functioning, enabling clients to apply newly-developed skills.

For injured drivers, passengers and pedestrians, occupational therapy services include but are not limited to:

- Hospital discharge planning/transition
- Home assessments and modifications
- Home medical equipment assessment and prescription
- Seating and mobility assessment and prescription
- Return to work planning and support
- Workplace accommodation assessment and intervention
- Ergonomic assessments
- Rehabilitation case management
- Brain injury rehabilitation
- Life skills training
- Housekeeping capacity assessments
- Cost of future care and life care planning
- Functional capacity evaluation
- Non-pharmacological pain management
- Cognitive behavioural therapy interventions
- Exposure therapy implementation
- Job demands analysis
- Personal care capacity assessments
- Driver rehabilitation including fitness to drive, vehicle modifications, low vision solutions, and driving phobia

When Should Occupational Therapy Services be Accessed?

Occupational therapy services should be initiated when a client is unable to return to the activities they value. Access to occupational therapy is based on a client's ability to do the things they need and want to do, regardless of the type or severity of the injury. Early and timely access to occupational therapy is important to ensure the best outcome for any client. There are a number of "red flags" to look for when determining if an injured driver, passenger or pedestrian needs to see an OT:

1. The individual has not returned to work, school, volunteering, or other necessary and meaningful life roles;
2. The individual reports difficulty or inability to care for themselves, their family or their home;
3. Other health care professionals report that the individual has not returned to their pre-injury activities or life roles;
4. The individual is progressing slowly, or not making progress in treatment with other health professionals (for example, physiotherapy, registered massage therapy or chiropractic care);
5. The individual is reliant on prolonged use of home support and/or home making services.

A client with any of these red flags should be referred to an OT as soon as possible to ensure they get the care they need to regain function and return to their daily activities. To locate an OT in BC, visit www.findanOT.ca

The Occupational Therapy Process

Initial Assessment

The occupational therapy initial assessment looks very similar across practice setting and diagnosis. With consent, the OT uses a variety of means including interview, standardized and non-standardized assessment to determine what the client is having difficulty doing, and what components are contributing to this. These components may be physical, cognitive, emotional or environmental. During the initial assessment, the OT also selects the appropriate theoretical approach(s) and identifies the client's strengths and resources.

Intervention

Taking the information gathered during the initial assessment process, the OT then works collaboratively with the client to set targeted outcomes (or goals) for therapy and determine an intervention or action plan to meet these outcomes. Since this plan is developed based on the individual's specific needs and goals, occupational therapy interventions may look very different from case to case, even for clients with the same diagnosis. Interventions may include modifying the environment, supporting the client to build skills or increase capacity, or adapting the task to make it more approachable for the individual. The plan is then put into place, either directly by the OT, or indirectly through a supervised rehabilitation assistant (RA), and progress is monitored. Modifications to the plan are made as needed.

Evaluation

At this stage, the OT and client evaluate whether or not the targeted outcomes have been reached. If targets have not been met, or additional difficulties have arisen for the client, the OT may re-assess and reset the plan. If targeted outcomes have been met, the therapy process concludes.

Common Misconceptions about Occupational Therapy

1. **OTs are only involved in return to work: False**
   OTs support clients to return to all activities of daily life (occupations). This includes self-care tasks, such as bathing, dressing and toileting, community access, leisure activities, driving, as well as productivity, such as home-making and paid or unpaid employment.
2. **OTs are only involved in catastrophic injuries: False**
   OTs help injured drivers, passengers and pedestrians return to the things they need or want to do, regardless of the type or severity of the injury. Anytime an individual is unable to participate in their activities of daily life, they should be referred to an OT. OTs have the skills and training to address physical injury and disability as well as cognitive and emotional conditions preventing clients from engaging in their valued occupations.
3. **OTs are only involved in case management: False**
   OTs are regulated health professionals who help clients return to their necessary and valued daily activities. Occupational therapy work requires a certain degree of clinical case management, such as the development and communication of a customized multi-disciplinary care plan; however, the central component of the OT role is to provide direct client care with the goal of supporting the return to pre-injury/disability activities [3].

Efficient and Effective Care

As experts in function, OTs utilize functional markers to guide continuation, modification or conclusion of services. With treatment guided by function as opposed to symptoms, the focus is on enabling the individual to overcome barriers and return to activities of everyday living.

OTs frequently work with rehabilitation assistants (RAs) in order to provide efficient services. In accordance with COTBC standards of clinical oversight and management, OTs assign and delegate components of care, where appropriate. Use of RAs in OT practice not only lowers the cost of service delivery but also extends occupational therapy intervention.

Benefits for the Auto Insurer

Occupational therapy enables injured drivers, passengers and pedestrians to return to necessary and valued pre-injury activities, while minimizing reliance on family, caregivers and other external supports. Outcomes and benefits of occupational therapy intervention include:

- Whole-person and integrated approach to care
- Improved engagement of the client in the care process
- Improved quality of life
- Prevention or improved self-management of chronic conditions
- Reduced pain and suffering
- Reduced costs of future care

Recommendations

Occupational therapy is well-positioned to support ICBC as it transitions to a greater focus on the care and recovery of injured drivers, passengers and pedestrians and CAOT-BC encourages the development of a model that focuses on quality of life and return to participation in meaningful activities following a car crash. Collaboration with CAOT-BC in the development of policies and protocols that guide appropriate and timely referral to occupational therapy service will ensure ICBC meets its mandate to help injured drivers, passengers and pedestrians return to their pre-injury level of daily function. This briefing note serves as a primer for such collaboration and partnership and outlines information which will be useful in developing such plans.

1. BC Government: Professional Regulation
2. COTBC: Essential Competencies of Practice for Occupational Therapists in Canada
3. See CAOT-BC Issue Paper: Occupational Therapy and Case Management

APPENDIX 1: Supporting Evidence

OT and Musculoskeletal Injury:

Dorsey, J., & Bradshaw, M. (2016;2017;). Effectiveness of occupational therapy interventions for lower-extremity musculoskeletal disorders: A systematic review. *American Journal of Occupational Therapy, 71*(1), 7101180030. 10.5014/ajot.2017.023028

Hardison, M. E., & Roll, S. C. (2016). Mindfulness interventions in physical rehabilitation: A scoping review. *The American Journal of Occupational Therapy : Official Publication of the American Occupational Therapy Association, 70*(3), 7003290030p1. 10.5014/ajot.2016.018069

Marik, T. L., & Roll, S. C. (2016;2017;). Effectiveness of occupational therapy interventions for musculoskeletal shoulder conditions: A systematic review. *American Journal of Occupational Therapy, 71*(1), 7101180020. 10.5014/ajot.2017.023127

Roll, S. C. (2016;2017;). Current evidence and opportunities for expanding the role of occupational therapy for adults with musculoskeletal conditions. *American Journal of Occupational Therapy, 71*(1), 7101170010. 10.5014/ajot.2017.711002

OT and Brain Injury:

Berger, S., Kaldenberg, J., Selmane, R., & Carlo, S. (2016). Effectiveness of interventions to address visual and visual-perceptual impairments to improve occupational performance in adults with traumatic brain injury: A systematic review. *The American Journal of Occupational Therapy : Official Publication of the American Occupational Therapy Association, 70*(3), 7003180010p1. 10.5014/ajot.2016.020875

Radomski, M. V., Anheluk, M., Bartzen, M. P., & Zola, J. (2016). Effectiveness of interventions to address cognitive impairments and improve occupational performance after traumatic brain injury: A systematic review. *The American Journal of Occupational Therapy : Official Publication of the American Occupational Therapy Association, 70*(3), 7003180050p1. 10.5014/ajot.2016.020776

OT and Spinal Cord Injury:

Polgar, J. M. (2006). Assistive technology as an enabler to occupation: What's old is new again. *Canadian Journal of Occupational Therapy, 73*(4), 199-205. 10.1177/000841740607300403

Pritchard, S. (2013). Enhancing primary care for persons with spinal cord injuries: The role of occupational therapy on an interdisciplinary team. *Occupational Therapy Now, 15*(5), 5.

Wong, A., Papadimitriou, C., Whiteneck, G., Deutsch, A., Heinemann, A., Goldsmith, A., . . . Lenze, E. (2016). Engagement trajectories and outcomes in SCI rehabilitation for patients receiving inpatient occupational therapy. *Archives of Physical Medicine and Rehabilitation, 97*(10), e11-e11. 10.1016/j.apmr.2016.08.030

OT and Mental Health:

Burson, K., Fette, C., Orentlicher, M., Precin, P. J., Roush, S. N., & Kannenberg, K. (2017). Mental Health Promotion, Prevention, and Intervention in Occupational Therapy Practice. *American Journal Of Occupational Therapy*, 711-19.

Champagne, T. (2011). The influence of posttraumatic stress disorder, depression, and sensory processing patterns on occupational engagement: A case study. *Work (Reading, Mass.), 38*(1), 67.

Fox J, Erlandsson L and Shiel A (2017). A systematic review of the effectiveness of occupational therapy interventions for improving functioning and mental health for individuals with anxiety and stress-related disorders. Front. Psychiatry. Conference Abstract: ISAD LONDON 2017: Perspectives on Mood and Anxiety Disorders: Looking to the future. doi: 10.3389/conf.fpsyt.2017.48.00016

Ikiugu, M., Nissen, R., Bellar, C., Maassen, A., & Van Peursem, K. (2017). Clinical effectiveness of occupational therapy in mental health: A meta-analysis. *American Journal of Occupational Therapy, 71*(5), 1. doi:10.5014/ajot.2017.024588

Kohn, M., Hitch, D., & Stagnitti, K. (2012). Better access to mental health program: Influence of mental health occupational therapy. *Australian Occupational Therapy Journal, 59*(6), 437-444. doi:10.1111/1440-1630.12005

Lambert, R. A., Harvey, I., & Poland, F. (2006). A pragmatic, unblinded randomised controlled trial comparing an occupational therapy-led lifestyle approach and routine GP care for panic disorder treatment in primary care. *Journal of Affective Disorders, 99*(1), 63-71. doi:10.1016/j.jad.2006.08.026

Psychological Implications of Minor Injury Motor Vehicle Crashes:

Andersson, A., Bunketorp, O., & Allebeck, P. (1997). High rates of psychosocial complications after road traffic injuries. *Injury, 28*(8), 539-543. doi:10.1016/S0020-1383(97)00083-1

Frommberger, U. H., Stieglitz, R., Nyberg, E., Schlickewei, W., Kuner, E., & Berger, M. (1998). Prediction of posttraumatic stress disorder by immediate reactions to trauma: A prospective study in road traffic accident victims. *European Archives of Psychiatry and Clinical Neurosciences, 248*(6), 316-321. doi:10.1007/s004060050057

Mayou, R., & Bryant, B. (2001). Outcome in consecutive emergency department attenders following a road traffic accident. *The British Journal of Psychiatry, 179*(6), 528-534. doi:10.1192/bjp.179.6.528

Mayou, R., Bryant, B., & Ehlers, A. (2001). Prediction of psychological outcomes one year after a motor vehicle accident. *American Journal of Psychiatry, 158*(8), 1231-1238. doi:10.1176/appi.ajp.158.8.1231

Ottosson, C., Nyrén, O., Johansson, S., & Ponzer, S. (2005). Outcome after minor traffic accidents: A follow-up study of orthopedic patients in an inner-city area emergency room. *The Journal of Trauma: Injury, Infection, and Critical Care, 58*(3), 553-560. doi:10.1097/01.TA.0000152634.66513.AF

Stålnacke, B. (2009). Relationship between symptoms and psychological factors five years after whiplash injury. *Journal of Rehabilitation Medicine, 41*(5), 353-359. doi:10.2340/16501977-0349

Stålnacke, B. (2010). Post-traumatic stress, depression, and community integration a long time after whiplash injury. *Mental Illness, 2*(1), 4-e4. doi:10.4081/mi.2010.e4

Wang, C., Tsay, S., & Elaine Bond, A. (2005). Post-traumatic stress disorder, depression, anxiety and quality of life in patients with traffic-related injuries. *Journal of Advanced Nursing, 52*(1), 22-30. doi:10.1111/j.1365-2648.2005.03560.x

Psychological Implications of Major Injury Motor Vehicle Crashes:

Kendall, E., & Buys, N. (1999). The psychosocial consequences of motor vehicle accidents.*Journal of Personal and Interpersonal Loss, 4*(1), 47-66. doi:10.1080/10811449908409716

Kendrick, D., Kelllezi, B., Coupland, C., Maula, A., Beckett, K., Morriss, R., . . . Christie, N. (2017). Psychological morbidity and health-related quality of life after injury: Multicentre cohort study. *Quality of Life Research, 26*(5), 1233-1250. doi:10.1007/s11136-016-1439-7

Mayou, R. A. (2002). Psychiatric consequences of motor vehicle accidents. *Psychiatric Clinics of North America, 25*(1), 27-41. doi:10.1016/S0193-953X(03)00051-0

Ursano, R. J., Fullerton, C. S., Epstein, R. S., Crowley, B., Kao, T., Vance, K., . . . Baum, A. (1999). Acute and chronic posttraumatic stress disorder in motor vehicle accident victims.*American Journal of Psychiatry, 156*(4), 589-595. doi:10.1176/ajp.156.4.589