OCCUPATIONAL THERAPY NOW

OCCUPATIONAL THERAPY NOW VOLUME 16.6

Table of Contents

ISSN: 1481-5532 Canada Post agreement #40034418

CAOT PRESIDENT
Lori Cyr, OT(C)

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

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

INDEXING
OT Now is indexed by ProQuest and OTDBase.

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

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

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

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

TRANSLATION
De Shakespeare à Molière, Services de traduction

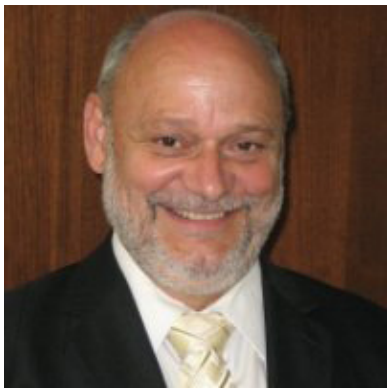
DESIGN & LAYOUT
JAR Creative

COPY EDITOR
Claire Hurd

Everyday Stories

Doing public policy and being an occupational therapist

Reg Urbanowski, OT Reg. (SK), OT(C)



Career path

I began my journey of working in public policy as the executive director of what was then called a 'preventive social services' agency in rural Alberta two years after graduation from the University of Alberta with a diploma in occupational therapy. The agency had varied programming, such as home care and counselling, but also had programs like 'mother's day out' and youth groups. The mother's day out program's primary objectives were to provide a program and place where rural women and pre-school children could gather once a week to socialize and relieve the stresses of being isolated in a sparsely populated rural area of Alberta. The youth groups provided programming for youth in various small villages throughout the area.

I continued that journey and eventually began working at the Department of Occupational Therapy in the Faculty of Rehabilitation Medicine at the University of Alberta. My interest was piqued in public policy again when I worked with students and colleagues to develop outreach programs for people living in the inner city and cultural awareness programs for health-care institutions. It was also through my master's degree thesis work at the University of Alberta, which focused on rural farmers with disabilities and their families, that public policy needs came again to the forefront. The interest in public policy continued with my doctoral work at West Virginia University, which focused on how people's tacit paradigms aligned with stated organizational paradigms in strategic planning. At Dalhousie University I worked with colleagues and students to look at the position of women in the inner city – especially those who had been through the "social service system." For me, the work at Dalhousie culminated when a group of women from a shelter worked with colleagues and students to prepare a presentation to city council that later became a presentation to an international forum on women's rights.

I have always believed in the value of community service for the community, but also as an opportunity for personal growth. My volunteer work with organizations such as the Canadian Mental Health Association and more recently with the United Nations has helped me sharpen my skills in public policy. I have sat on many local, regional and international boards, commissions and other groups. Each one of those experiences has deepened my knowledge and experience in designing, implementing and reviewing public policy.

I also believe that sharing knowledge is important. I have co-taught workshops in policy analysis and taught a graduate course in program evaluation for the Johnson-Shoyama Graduate School of Public Policy. I have also taught a graduate course at the University of Alberta on Global Social Policy and Occupational Therapy.

Over the last seven years I returned to work with the Saskatchewan government as an executive director of a branch, an assistant deputy minister and as a special advisor to the deputy minister of advanced education. Currently, I am the vice-president of strategy and advancement for the Saskatchewan Polytechnic – a position mired in public and organizational policy. This position is about aligning human and financial resources to meet the education and training needs of the province and beyond. I continue to volunteer locally and globally as a United Nations online volunteer. Both roles involve public policy analysis, formulation, implementation and evaluation.

The alignment of public policy and occupational therapy

Do I think like an occupational therapist? Definitely I do. Occupational therapy is "the art and science of enabling engagement in everyday living" (Townsend & Polatajko, 2013, p. 380). Thinking like an occupational therapist means "enabling people to perform the occupations that foster health and well-being and . . . enabling a just and inclusive society so that all people may participate to their potential in the daily occupations of life" (Townsend & Polatajko, 2013, p. 380).

Policy is not magical and it is within the realm of the creative thinking of an occupational therapist. At its simplest "it is goal directed action that outlines the occupational profiles of its actors and agents." (Urbanowski, Shaw, & Chemmuttut, 2013).

To consider a simple example, think of driving. This can be a major issue for occupational therapists working with older adults or people with disabilities. But driving is also an issue for people who create public policy concerning who gets a driver's license or what rules should govern distracted driving.

This thinking process is an occupational therapy process if we think about how engagement is enhanced or constrained by occupation, or how occupation is enhanced or constrained by rules or procedures created by government.

In government, the analyses that I carried out, the policy audits that I oversaw and the policy options that I helped formulate for the elected officials to consider were all about engagement of people in a program or service, or with information that will impact their quality of life. As a vice-president at Saskatchewan Polytechnic, my work affects the working lives of people who work at the institution, as well as students who take courses at the Polytechnic and countless others in the province who benefit from a vibrant, relevant and accessible institution.

How do I demonstrate proficiency in the essential competencies of my profession? Demonstrating proficiencies in areas that are representative of thinking critically are readily apparent in the creation, valuation, evaluation and implementation of public policy. But also apparent is the occupational therapy process. When I look at developing a strategic plan, the occupational therapist in me comes out because I consider how to blend in people's own tacit paradigms into the end result of what we would call a strategic plan.

My clients include policy-makers, faculty, staff, students and employers; my care plan is a strategic plan; the occupational narratives that I collect are the consultations and the discussions with government officials, faculty, staff, employers, students and others in the province and beyond. The interventions are change management strategies, organizational or program policy recommendations, and policy implementation approaches. I monitor success through various forms of policy analysis, policy audits, enterprise risk management and logic forms of program evaluation.

Why do I do it?

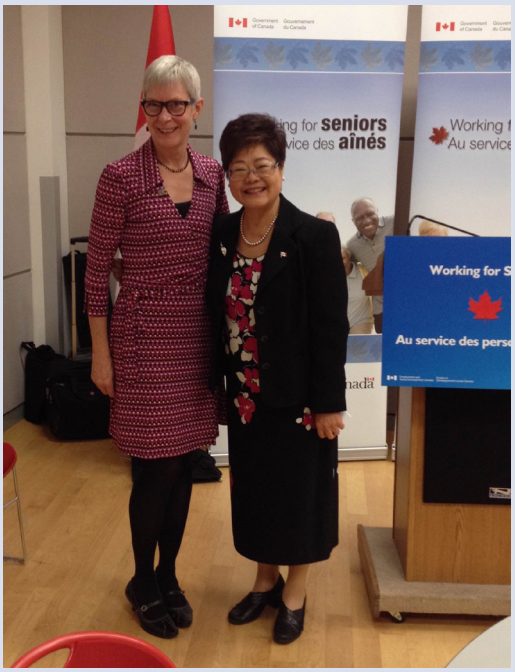
I enjoy the big picture challenge of being able to view an issue from 10,000 metres and then bring that down to an individual person's level and determine what effect a policy might have on their quality of life. Policy work also provides me with what I call "impact leverage," which I define as the span of influence. Knowing that my work could affect a large group of people is at times daunting and yet very rewarding if it improves quality of life.

Reg can be contacted at: reg.urbanowski@saskpolytech.ca

References

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

Urbanowski, R., Shaw, L., & Chemmuttut, L. C. (2013). Occupational science value propositions in the field of public policy. *Journal of Occupational Science, 20*, 314-325. doi:10.1080/14427591.2013.806208



CAOT president, Lori Cyr, with the Honourable Alice Wong, the minister of state for seniors and member of Parliament for Richmond, at an event celebrating National Seniors Day.

Welcome to CAOT's new president - Lori Cyr

On September 30, Paulette Guitard completed her term as CAOT president and passed the torch on to Lori Cyr. Thank you to Paulette for all of her hard work over the last two years! Paulette provided key support and leadership on the national stage representing the profession of occupational therapy.

Lori brings a wealth of experience to her new role of CAOT president. She completed a bachelor of science in occupational therapy at Dalhousie University in 1986. She is currently the practice coordinator/clinical resource therapist for the Mary Pack Arthritis Program in Vancouver and holds a clinical assistant professor appointment with the Department of Occupational Science and Occupational Therapy at the University of British Columbia. Her professional interests include the use of evidence in practice, transfer of clinical knowledge, health literacy, self-management and client education. Lori values volunteerism and has volunteered in the non-profit health sector and with rheumatology organizations for many years. She was a co-convenor of the 2005 CAOT Conference in Vancouver and joined the CAOT Board in 2007.

Lori has already hit the ground running, having attended an event celebrating National Seniors Day hosted by the Canadian Centre for Elder Law on October 3 and presenting her inaugural address as president at CAOT's first Inspirational Talks, held on October 6 in Ottawa. To listen to Lori's address, visit CAOT's Youtube channel at: https://www.youtube.com/channel/UCkV1G8zJxmN8pEnXRwAVKeg

What's new

Special *OT Now* on Occupational Therapy and Universal Design OUT NOW!

The universal design theme issue of *Occupational Therapy Now* is online with free public access. The intention of this special issue of *Occupational Therapy Now* is to provide a broad audience, including occupational therapists, health professionals, clients, policy makers, the general public and other stakeholders, with information on the role of occupational therapy in universal design. Please share this link widely: http://www.caot.ca/default.asp?pageid=466

Do you have ideas about what stakeholders should receive a hard copy of this issue? Send suggestions to: otnow@caot.ca

A few innovative benefit highlights for your coming membership year!

Management Mondays webinars

Building on CAOT's relationship with one of our corporate partners, BDO Canada LLP, Management Mondays is a new free webinar series that will help you navigate through key business issues to manage your private practice.

Our second Management Mondays webinar is titled "Outsourcing your bookkeeping – Why it is so important!" presented by Deanna Lancaster, a chartered professional accountant and senior manager with BDO. She has developed her experience by working on accounting and client service engagements for entrepreneurial businesses, professionals and small businesses.
Join us on January 19, 2015 (12:00 - 1:00 p.m. EST). Register online by January 12, 2015.
For more information and to register for the webinar, go to: http://www.caot.ca/default.asp?pageid=4002

NEW! Retired Membership Network

The Retired Membership Network provides the opportunity to connect and have a voice in matters that concern occupational therapists who have retired or are thinking of retiring. A dedicated webpage has been created for the new membership year to provide specific tools and resources to meet the needs of our retired members: https://www.caot.ca/default.asp?pageid=2340

NEW! Occupational Therapy Student Committee

With the goal of fostering the future of the profession, CAOT's Occupational Therapy Student Committee will network, engage and connect with occupational therapy student representatives to ensure that CAOT can provide them with the resources they need. The group's first meeting was held on September 13, 2014.

NEW! Membership profile

A redesigned member profile has been launched. The new profile allows you to retrieve your insurance certificate number, reset your password and review and update the information CAOT has on your file. To view your profile, go to www.caot.ca, log in as a member and click on "My Profile" in the top right hand corner.

Revised bylaws on CAOT website

To comply with the new Canada Not-for-profit Corporations Act, CAOT has been working to revise its bylaws over the last couple of years. The revised bylaws are now posted on the CAOT website at: http://www.caot.ca//default.asp?pageid=2327

CAOT Fellowship Award winner

CAOT is pleased to announce that the 2014-2015 CAOT Fellowship has been granted to Chelsea S. Gordon. Chelsea is from Saskatoon, Saskatchewan, and holds a bachelor's degree with distinction in psychology from the University of Saskatchewan. In 2014, she completed a master of science in occupational therapy at the University of Alberta, where her research focused on mental health, the role of occupational therapy in assisted suicide and euthanasia in Canada, and occupational therapy in primary health care. Chelsea was also the department representative on the Graduate Students' Association of the University of Alberta during the 2013-2014 academic year. She is interested in professional advocacy and policy, and will be contributing to the to the CAOT team as an intern for a 12-month term beginning September 22, 2014. As the CAOT intern, Chelsea will be provided with opportunities to promote the role of occupational therapists in policy and representation, and will build her leadership capacity in addressing current professional issues.

CJOT impact factor data

The *Canadian Journal of Occupational Therapy (CJOT)* is pleased to share its *2014 Journal Citation Reports®* (Thomson Reuters, 2014) impact factor data. An impact factor is a measure of the average number of times articles from a particular journal have been cited in other articles. For more information, visit: http://www.caot.ca/default.asp?ChangeID=25&pageID=6

Total Cites	Impact Factor	5-Year Impact Factor	Citable Items	Immed. Index	Cited 1/2-Life
608	0.742	-	28	0.143	9.3

Reference

Thomson Reuters. (2014). 2014 Journal Citation Reports®. Retrieved from http://about.jcr.incites.thomsonreuters.com/

The CAOT National Office team

CAOT is proud of the team at the National Office that works to provide members with services, products, events and networking opportunities to assist occupational therapists in achieving excellence in their professional practice. CAOT staff also provide leadership to actively develop and promote occupational therapy in Canada and internationally.

CAOT would like to take this opportunity to introduce the team working for you and the occupational therapy profession.

Janet Craik – Interim Executive Director
jcraik@caot.ca
Janet is responsible to provide leadership in the effective management and daily administration of the association's affairs and represents CAOT nationally and internationally, as well as acts as an ex-officio member of the Board of Directors and other CAOT committees, taskforces and working groups.

Mike Brennan – Chief Operating Officer
mbrennan@caot.ca
Mike works with CAOT executive and staff to implement and execute CAOT's mandate and business operations. Mike also leads the business development of the association, including but not limited to the development of new opportunities, membership categories, programs and services.

Julie Lapointe – Interim Director of Professional Practice
jlapointe@caot.ca
Julie is responsible for advancing excellence in the practice of occupational therapy in Canada and is the primary contact regarding occupational therapy practice for the membership, relevant consumer groups, governments and other organizations.

Giovanna Boniface – CAOT-BC Managing Director
gboniface@caot.ca
Giovanna is responsible for the day-to-day operations of the first provincial chapter of CAOT, providing regional representation and support to occupational therapists in British Columbia.

Elizabeth Steggles – Director of Standards
esteggles@caot.ca
Elizabeth oversees the work of CAOT related to academic accreditation (for both occupational therapy and occupational therapy assistant programs), the National Occupational Therapy Certification Examination, membership credentialing and monitoring, and analyzing policy regarding professional certification and accreditation.

Ryan McGovern – Exam Services and Accreditation Administrator
exam@caot.ca
Ryan administers the processes for the National Occupational Therapy Certification Examination, provides support to the Certification Examination Committee and responds to examination inquiries. He also provides administrative support to CAOT's Academic Credentialing Council.

Havelin Anand – Director of Government Affairs and Policy
hanand@caot.ca
Havelin's role is to increase knowledge and raise awareness about occupational therapy through advocacy initiatives on behalf of CAOT and occupational therapists with governments and public servants. She supports provincial occupational therapy associations in their advocacy efforts and represents CAOT in national coalitions.

Christina Lamontagne – Professional Development Coordinator
education@caot.ca
Christina is responsible for the coordination and evaluation of CAOT workshops, webinars, online modules (OTEM, CROMe and Momentum) and networks that maintain, improve and broaden occupational therapists' skills and knowledge, and advance excellence in the profession.

Chelsea Gordon – CAOT Intern
Chelsea is the recipient of the 2014-2015 CAOT Fellowship Award. She works on projects to address current professional issues and promote the role of occupational therapists in policy and representation.

Suzanne Kay – Human Resources Manager
skay@caot.ca
Suzanne is responsible for the management of the association facilities and resources, including maintenance of information systems as well as the management and administration of human resources.

Nicolas (Nick) McCarthy – Communications Officer
nmccarthy@caot.ca
Nick is responsible for internal and external communication on behalf of the association to advocate and promote occupational therapy as a publicly responsible service providing valuable contributions to the health and well-being of Canadians.

Jeanne Salo – Project Coordinator
jsalo@caot.ca
Jeanne is responsible for managing CAOT contracts and coordinating and participating in a variety of special projects.

Andrea Santos – Executive Assistant
asantos@caot.ca
Andrea provides administrative and coordination support to the executive director and other directors within the national office, as well as the CAOT president, other members of the Board of Directors and CAOT committees.

Lisa Sheehan – Conference & Advertising Manager
conference@caot.ca
Lisa manages the planning and organization of CAOT conferences as well as advertising and web administration for the association. Lisa has worked in most departments during her 18 years at CAOT.

Membership

The Membership Services Department is here to ensure that all members receive value from their membership and that their voices are heard. Together with everyone at CAOT, its job is to create new and innovative products and services that will help members excel in their profession and help build public awareness about occupational therapy in Canada. Membership services is here to help members take advantage of all the benefits CAOT has to offer! For general membership inquiries, contact: membership@caot.ca

Diane Braz Wessman – Membership Services Manager
dbrazwessman@caot.ca

Caleb Ficner – Membership Services Coordinator
cficner@caot.ca

Chantal Houde – Membership Services Representative
choude@caot.ca

Juliana Rodger – Membership Services Administrator
jrodger@caot.ca

Finance

CAOT's finance team is responsible for the administration of resources to enhance and facilitate the professional activities of CAOT, including the planning and administration of the association finances and treasury. For general finance inquiries, contact: finance@caot.ca

Vicky Wang – Director of Finance
vwang@caot.ca

Jiwen Zhang – Business Administrator
jzhang@caot.ca

Mursalin Chowdhury – Business Administrator
mchowdhury@caot.ca

Publications and periodicals

Danielle Stevens – Graphic Design & Production Manager
dtp@caot.ca
Danielle manages production of CAOT publications and communication materials from layout and design to the final printed product.

Stéphane Rochon – Publications Administrator
srochon@caot.ca
Stéphane carries out processes involved in the production of CAOT publications, including processing orders for CAOT publications and subscriptions, data entry for publications billing and tracking copyright requests.

Helene Polatajko – Managing Editor, *Canadian Journal of Occupational Therapy*
cjoteditor@caot.ca
Helene provides leadership for the journal, ensuring that its direction is clear and that its mission is met. In particular she ensures that all aspects of the scholarly integrity of the journal are adhered to from manuscript submission and review through to publication.

Janna MacLachlan – Managing Editor, *Occupational Therapy Now*
otnow@caot.ca
Janna manages all aspects of receiving, reviewing and preparing manuscripts that are published in the *Occupational Therapy Now* practice magazine.

Back to the basics: Sleep and occupation

Mallory Watson, Jennifer Garden, Fern Swedlove and Cary A. Brown

As health-care professionals, we are all concerned with our clients' health and wellness. Sleep is a basic component of a person's well-being and health, not only at the individual level but also within the family unit. Restorative sleep underpins the success of all other interventions offered by occupational therapists (Glomstad, 2003). Glomstad (2003) emphasizes the importance of this perspective, and quotes Karen Summers' keynote presentation at the 2003 American Occupational Therapy Association (AOTA) Conference, stating: "If your clients aren't getting sleep, it is going to be hard for them to participate in therapy" (p. 18).

Sleep as an occupation

The relationships and interactions among the person, occupation and environment are outlined in the Canadian Model of Occupational Performance and Engagement (CMOP-E) (Polatajko et al., 2007). When viewed with a CMOP-E lens, it is clear how sleep aligns with other occupations such as social belonging and nourishment — essential building blocks to enable an individual to participate in their valued occupations. There has been discussion in the occupational therapy literature about whether sleep constitutes an occupation. For the most part, this was put to rest when the 2002 American Occupational Therapy Association Practice Framework categorized sleep as an activity of daily living (ADL), which should be considered a performance area of occupation (AOTA, 2002). In subsequent versions of the practice framework, the importance of sleep was further strengthened by shifting sleep from the category of ADL to that of an occupation in itself (AOTA, 2014). The AOTA (2012) statement on occupation and sleep highlights that "restful and adequate sleep provides the foundation for optimal occupational performance, participation, and engagement in daily life" (p. 2).

Role for occupational therapists with sleep

Researchers and theorists have advanced the discussion of the occupational therapist's role to address sleep deficiency in their practice (Brown, Wielandt, Wilson, Jones, & Crick, 2014; Brown, Swedlove, Berry, & Turlapati, 2012; Fung, Wiseman-Hakes, Stergiou-Kita, Nguyen, & Colantonio, 2013). Fung et al. (2013) skillfully build the foundation for this relationship and state, "Given their skills in relation to the assessment of the personal and environmental issues influencing sleep, occupational therapists are well positioned to enhance their roles in the area of sleep and sleep problems" (p. 385). They highlight that occupational therapists can suggest changes to the environment as well as help people become more aware of their own habits and beliefs, manage their time and stress levels, and modify behaviors that may interfere with sleep (Fung et al., 2013). Further, they assert that "sleep plays an essential role in physical, cognitive and emotional functioning, and in occupational performance and participation; it is now considered within the scope of occupational therapy practice" (Fung et al., 2013, p. 384).

Jennifer Garden is a Canadian pediatric occupational therapist working in private practice, specializing in providing treatment for clients experiencing sleep problems. She came to recognize that sleep interventions were a valuable component of her occupational therapy "toolbox" when she had a first-hand experience with her young daughter who had difficulty sleeping, about which she says the following:

Given our training as occupational therapists, we're taught about normal and abnormal development for humans as well as a host of developmental theories. Funny enough, I don't ever remember learning much about sleep, but I felt that I certainly had some good tools to apply to the problem at hand.

After a couple of weeks of research, reading and some trial and error, we solved my daughter's sleep problems and all was back on track. This allowed me to really "put my thinking cap on." I knew many new parents of infants and young children were going through the same problems. Moreover, I was dismayed there was nothing available in terms of credible resources, or even someone with a general understanding of development and training on how to problem-solve such an evident occupational performance issue. The more research I did on who was providing services, the more disheartened I became for parents and their children, as no one was giving information that was based on a health and wellness model and came from a health-care practitioner.

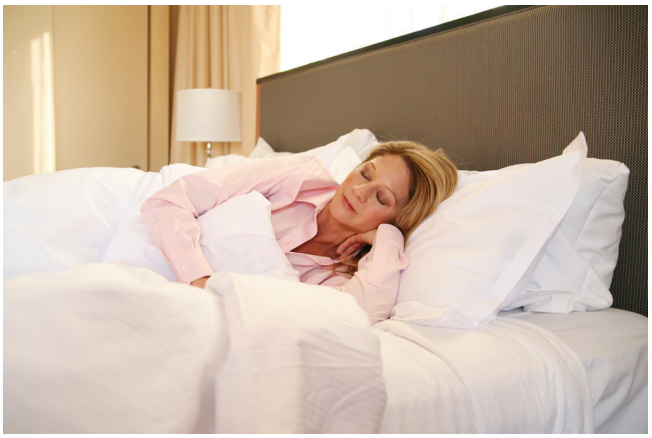
Assisting clients with restorative sleep is an emerging area of practice, and is being incorporated into occupational therapy practices such as Jennifer's pediatric clinics based in Alberta and British Columbia. Mallory Watson came to recognize the importance of sleep as a student occupational therapist when she found applications for knowledge from a range of courses and experience, including a sleep and occupation lecture that associate professor Cary Brown offers to students in their

second year. Mallory tells about the positive outcome she had from applying her sleep knowledge while working with a client on a fieldwork placement who initially presented with memory problems:

Mary had started to forget upcoming events and where she left everyday items. Mary was very forthcoming about her concerns when she was assessed by Mallory, and stated that her memory seemed to be wavering, her mind was foggy and she felt sad. Following unremarkable cognitive screening, Mallory asked about Mary's sleep habits. Mary reported she occasionally took a sleeping pill, at times had difficulty falling asleep and often woke up during the night because of racing thoughts.

Mary and Mallory were able to uncover many habits affecting Mary's sleep, such as working on her computer or watching television until immediately before bed and forcing herself to try to sleep through her racing thoughts. Mallory introduced Mary to basic sleep hygiene principles such as winding down before bed, avoiding blue spectrum light exposure (a consequence of TV viewing or using the computer), having a hot bath before bed and waking up at the same time every morning. Whenever she had racing thoughts, she could turn on a meditation tape and concentrate on a meditation exercise. Mary was very receptive to the recommendations. At her follow-up appointment, Mary reported trying all of the suggested sleep hygiene strategies. With her new sleep routine, she felt like a new woman and was no longer experiencing cognitive or mood problems.

Occupational therapists who work with older adults may find that their clients experience sleep problems that are worthwhile to address. Bensing (2013) highlights that taking a detailed sleep history and incorporating the findings into a client-centred care plan can help reduce fear, anxiety and other factors that are detrimental to sleep in older adults. A large survey by Brown et. al. (2014) revealed that many health-care providers across disciplines working with older adults have limited knowledge about sleep deprivation risk factors, consequences, assessment tools and interventions. The authors caution that occupational therapists should not assume another member of the team will recognize and intervene in a client's sleep problem and stress that it is a shared responsibility, sometimes requiring occupational therapists to use advocacy, knowledge translation and treatment skills (Brown et al., 2014). The AOTA (2002) states that, with older adults, assessments should consider the adequacy of rest and sleep, sleep preparation and sleep participation. The AOTA offers a practical, evidence-based



example of how "therapists working in long-term care settings for older adults [can] develop individual sleep routines, adjust lighting to clearly demarcate day and night, [and] reduce staff noise" (AOTA, 2012, p.1).

Planning for the future

Sleep as an occupation is an emerging area of practice for occupational therapists. There is a growing interest in this area among therapists as they become aware of the value of sleep interventions for their clients. Endorsement by professional bodies (AOTA, 2012), in addition to publications in journals and occupational therapy textbooks such as *Willard and Spackman's Occupational Therapy* (Solet, 2014) as well as stand-alone books like Green and Brown's forthcoming *Occupational Therapy and Sleep* (in press) provide additional validation for integrating restorative sleep into the scope of occupational therapy. With increasing awareness and education regarding sleep, formal or informal sleep screening questions can be incorporated into many occupational therapy areas of practice. For example, sleep deprivation greatly increases the risk of falls for older adults (Stone, Ensrud, & Ancoli-Israel, 2008) but screening questions for sleep are not part of standardized falls risk assessments. The small addition of one or two simple sleep screening questions can be made with minimal effort. Not only do interventions for sleep problems help clients, but they can also have a positive impact on their families and caregivers. This is an exciting time for occupational therapists to showcase their knowledge and evidence for assessing and treating sleep disorders. It will be important to move forward with this evidence and apply our knowledge to best practice.

About the authors

Mallory Watson, MScOT, has focused her research at the University of Alberta on varied aspects of sleep, resiliency of at-risk populations and adult offenders with fetal alcohol spectrum disorder. She can be contacted at: mcwatson@ualberta.ca

Jennifer Garden, MClSc(OT), MSc, is on faculty at Capilano University in North Vancouver, BC. Jennifer has worked in pediatrics for over a decade and is the founder of Sleepdreams Inc., a company that offers services assessing and treating sleep disturbances in children. She can be contacted at: jgarden@sleepdreams.ca

Fern Swedlove, MSc, OT(C), worked as an occupational therapist for 34 years in clinician and editor roles and is now retired. She can be reached at: fswedlove@gmail.com

Cary A. Brown, FHEA, PhD, is an associate professor at the University of Alberta. She has worked as a therapist, researcher and educator in Canada, the United Kingdom and Saudi Arabia. Her current research interests involve sleep and chronic pain. Cary can be reached at: cary.brown@ualberta.ca

References

American Occupational Therapy Association. (2002). Occupational therapy practice framework: Domain and process. *American Journal of Occupational Therapy, 56*, 609-639. doi:10.5014/ajot.56.6.609

American Occupational Therapy Association. (2014). Occupational Therapy Practice Framework: Domain and Process (3rd ed.). *American Journal of Occupational Therapy, 68*(Suppl. 1), S1-S48.

American Occupational Therapy Association. (2012). *Occupational therapy's role in sleep.* Retrieved from http://www.aota.org/en/About-Occupational-Therapy/Professionals/HW/Sleep.aspx

Bensing, K. (2013). *Sleep changes in older adults.* Retrieved from http://occupational-therapy.advanceweb.com/Features/Articles/Sleep-Changes-in-Older-Individuals.aspx

Brown, C. A., Wielandt, P., Wilson, D., Jones, A., & Crick, K. (2014). Healthcare providers' knowledge of disordered sleep, sleep assessment tools and non-pharmacological sleep interventions for persons living with dementia: A national survey. *Sleep Disorders, 2014*, Article ID 286274, 9 pgs. doi:10.1155/2014/286274

Brown, C., Swedlove, F., Berry, R., & Turlapati, L. (2012). Occupational therapists' health literacy interventions for children with disordered sleep and/or pain. *New Zealand Journal of Occupational Therapy, 59*(2), 9-17.

Fung, C., Wiseman-Hakes, C., Stergiou-Kita, M., Nguyen, M., & Colantonio, A. (2013). Time to wake up: Bridging the gap between theory and practice for sleep in occupational therapy. *British Journal of Occupational Therapy, 76*, 384-386.

Glomstad, J. (2003). Is sleep an occupation? *Advance for Occupational Therapy Practitioners, 19*(9), 18. Retrieved from http://occupational-therapy.advanceweb.com/Article/Is-Sleep-an-Occupation-1.aspx

Green, A., & Brown, C. (in press). *Occupational Therapy and Sleep*. London, UK: Jessica Kingsley Publishers.

Polatajko, H., Davis, J., Stewart, D., Cantin, N., Amoroso, B., Purdie, L., & Zimmerman, D. (2007). Specifying the domain of concern: Occupation as core. In E. Townsend & H. Polatajko (Eds.), *Enabling occupation II: Advancing an occupational therapy vision for health, well-being, & justice through occupation* (pp. 13-36). Ottawa, ON: CAOT Publications ACE.

Solet, J. M. (2014). Sleep and rest. In B. A. B. Schell, G. Gillen, & M. E. Scaffa (Eds.), *Willard and Spackman's Occupational Therapy* (12th ed., pp. 714-730). Philadelphia, PA: Lippincott Williams & Wilkins.

Stone, K. L., Ensrud, K. E., & Ancoli-Israel, S. (2008). Sleep, insomnia and falls in elderly patients. *Sleep Medicine, 9*(Suppl. 1), S18-22.

Editor's note: Do you address sleep issues in your practice? Tell us how at: otnow@caot.ca We will share stories of how occupational therapists incorporate restorative sleep into their practice in a future issue of *OT Now*.

Music as a transition for sleep

Meghan J. Harris

Insomnia may be described as dissatisfaction with sleep quality or duration and can include subjective complaints of difficulty falling asleep, waking in the night with difficulty going back to sleep, waking too early, or feelings that sleep has not been restorative (Morin, 2012). Difficulties with sleep are prevalent across many disorders and health conditions affecting individuals across the lifespan. Difficulties with sleep may occur in individuals with neurologic disorders, mental health conditions and physical conditions (Fung, Wiseman-Hakes, Stergiou-Kita, Nguyen, & Colantonio, 2013; Morin, 2012).

The amount of sleep an individual needs varies across the lifespan. Infants and children require more sleep, ranging from 10 to 16 hours per day, while adults are typically reported as needing 7.5 to 10 hours (Solet, 2014). Sleep physiology is broken down into rapid eye movement (REM) sleep, and non-REM sleep (NREM). NREM and REM sleep are thought to be associated with different body functions. NREM sleep is assumed to be related to homeostatic processes contributing to physical rest and improved immune system functioning, while REM sleep is understood as contributing to psychological rest and emotional well-being (Stanley, 2005). Disruptions in the continuity and duration of sleep influence its recuperative effects and may impact physical, cognitive, and emotional functioning, as well as overall occupational performance (Fung et al., 2013).

The American Occupational Therapy Association Practice Framework (2014) identifies rest, sleep preparation and sleep participation as occupations within the domain of occupational therapy practice. While sleep is gaining recognition as an important occupation, many occupational therapists fail to routinely assess and recognize sleep difficulties that their clients are experiencing. Occupational therapists focus on supporting performance in occupations by addressing personal, occupational and environmental factors. This makes them well suited to assess, provide education and make recommendations to clients regarding sleep, as well as look into how sleep may be affecting other areas of daily occupation (Fung et al., 2013). At present, a variety of non-pharmaceutical interventions to improve sleep exist (Solet, 2014). These include lifestyle modifications such as a regular sleep routine and decreasing caffeine intake, as well as making modifications to the sleep environment (e.g., decreasing levels of noise and light). An intervention that has a small but emerging evidence base to support its effectiveness for improved sleep is the use of "sedative" music as a transition for sleep. This intervention is simple, cost effective and would be reasonable for an occupational therapist to recommend to clients experiencing sleep difficulties. This paper will present common practices for this intervention as outlined in the literature, review the current evidence base and discuss practice implications.

Evidence base and scholarly review

There appears to be no standardized procedure for the use of music in transitioning to sleep. Generally, classical or other varieties of soft, relaxing music are chosen for a client by a professional, or by the client based on preference. Commercial recordings, such as the *Delta Sleep System*, designed with sleep transition specifically in mind, also exist (Lazic & Ogilvie, 2007). It is recommended that the music be classified as "sedative," meaning the tempo of the track is between 60 to 80 beats per minute, has a smooth melody and a repetitive rhythm (Chen et al., 2014; Knight & Rickard, 2001). Commonly, the chosen music is played before naps and at bedtime for 20 to 45 minutes (deNeit, Tiemens, Lendemeijer, & Hutschemaekers, 2009; deNeit, Tiemens, & Hutschemaekers, 2013). Instructions for the intervention vary; however, treatment protocols reported in recent studies instruct individuals to complete their bedtime routine as usual, get comfortable in bed and to close their eyes and focus on the music without worrying about turning the music off (Chan, 2011; Tan, 2004).

A body of literature exists demonstrating that the use of sedative music for transitioning to sleep has positive effects on sleep quality (i.e., duration, perceived restfulness), however, how this music directly impacts human physiology and the sleep cycle is poorly understood (deNeit et al., 2009; Chang, Lai, Chen, Hsieh, & Lee, 2012). It is suggested that mental arousals related to stress and anxiety prior to sleep onset are

About the author

Meghan Harris is a recent graduate from the University of Alberta and a provisional occupational therapist with Qi Creative Inc. in Edmonton, AB. She can be contacted at: meghan2@ualberta.ca

largely responsible for sleep disturbances. Thus, music acts as a tool for relaxation and distraction (deNeit et al., 2013; Chan, 2011). Research related to human stress and anxiety has revealed that sedative music appears to have a relaxing effect by lowering heart rate, blood pressure, respiratory rate, adrenocorticotrophic hormone levels (Watkins, 1997) and levels of the stress hormone cortisol (Knight & Rickard, 2001; Chan, 2011; Chang et al., 2012). Literature also suggests that music may impact neural pathways in the brain and associated brain centers, affecting emotions, cognition and physiological processes, which influence sleep (Watkins, 1997). While these are suggested mechanisms for how sedative music impacts the body to improve sleep, no definite conclusions have been made.

Six research studies and three meta-analyses looking at sedative music as a transition for sleep were reviewed by this author. The music interventions outlined in the literature involved listening to music during sleep transitions over durations ranging from two to four days (studies using objective measures) (Chang et al., 2012; Chen et al., 2014; Lazic & Ogilvie, 2007), to three weeks (studies using subjective measures) (Chan, 2011; Harmat, Takas, & Bodiz, 2008; Tan, 2004). Interventions have been carried out with a variety of populations, including children, university students, older adults and those with chronic health conditions. Both subjective measures (Chan, 2011; Harmat et al., 2008; Tan, 2004), including self–report questionnaires such as the Pittsburgh Sleep-Quality Index (PSQI) (Buysse, Reynolds, Monk, Berman, & Kupfer, 1989) and objective measures (Chang et al., 2012; Chen et al., 2014; Lazic & Ogilvie, 2007), including polysomnography in a sleep research lab have been used to support the positive effects of sedative music on transitioning to sleep. Research studies using the PSQI revealed that individuals involved in a sedative music intervention group report statistically significant results in improvement of overall sleep-quality (deNeit et al., 2009, 2013; Harmat et al., 2008), as well as various improvements in individual component scores of the PSQI, including shorter sleep latency, longer sleep duration, better sleep efficiency (Tan, 2004), reduced sleep disturbances and less daytime dysfunction (Chang et al., 2012; Harmat et al., 2008). Polysomnography requires research participants to spend consecutive nights in a sleep lab while their brain activity and vital signs are tracked. In studies using polysomnography it has been shown that sedative music can have positive effects on changing the duration of various sleep stages, resulting in changes associated with improved sleep quality in one study (Chen et al., 2014), and increased REM sleep in adults with chronic insomnia in another (Chang et al., 2012). There is one study, however, that refutes these findings. Lazic and Ogilvie (2007) tested the effects of the Delta Sleep System with ten young female students. These researchers found no significant differences in polysomnographic data when, over three consecutive nights, participants were provided with two different interventions (sedative music and periodic tone delivery) and one night of control with no intervention.

Three meta-analyses have been published on this subject (deNeit et al., 2009, 2013; Wang, Sun, & Zang, 2014), and while most of the literature supports the use of sedative music for transitioning to sleep, there are some limitations to note. A major factor to consider is the inability to blind participants and researchers to the control and intervention conditions due to the nature of the intervention being tested (deNeit et al., 2009, 2013). Additionally, most studies used participant self-report questionnaires. These factors may contribute to potential bias within the results and possible placebo effects. Objective studies looking at quantitative polysomnographic data help to reduce subjective bias but problems still exist. First, the experimental sleeping quarters are controlled for room temperature, light and background noise, and the participants are connected to a variety of machines recording heart rate and brain activity. Thus, results may not be generalizable to a sleep experience in one's natural home environment. Secondly, polysomnography is costly and typically involves fewer participants who are often followed for a much shorter time period (usually two to four days) than in studies with subjective measures, which often follow participants for weeks. In the study by Lazic and Ogilvie (2007), which casts doubt on the positive effects of sedative music on sleep, participants were exposed to the music condition for just one night. It is questionable whether one night of exposure to an intervention is sufficient to observe its full effects on sleep patterns.

Practice implications

Using music to aid sleep transition is inexpensive, easy to implement and has potential to be beneficial for a variety of populations, including children, adults, older adults and individuals with psychological disorders, chronic sleep conditions, chronic health conditions and those recovering from major surgery (deNeit et al., 2013). While the research base is relatively small and somewhat inconclusive, a variety of studies exploring music as a transition for sleep have shown improvements in overall sleep quality and other sleep components. While no standard practice guidelines exist for implementing music as an intervention, the common practices described in this article have an emerging evidence base. No specific contraindications have been reported, however, some considerations should be made. It is not fully understood how this intervention affects the human body in terms of facilitating improved sleep and every individual's experience may be different. Research has shown that using enjoyable music *preferred by* and *familiar to* the client may improve the effects on sleep quality and this should be considered when selecting music (Wang et al., 2014). Additionally, studies have often combined sedative music with other relaxation techniques, such as progressive muscle relaxation and visualization, which may have facilitated improvements (deNeit et al., 2009, 2013). If an individual is finding that exclusively using sedative music is not having the desired effects, introducing other forms of relaxation instruction could be beneficial. Finally, it is important to remember that it is suggested that sedative music works as a tool for relaxation and distraction from pre-sleep arousal states caused by stress and anxiety. Therefore, this intervention

is primarily behavioural, with some known physiologic effects, including decreased heart rate, blood pressure, respiratory rate and levels of the stress hormone cortisol (Knight & Rickard, 2001; Chan, 2011; Chang et al., 2012). If a sleep disturbance has organic causes this intervention may not facilitate improved sleep.

Music developed and composed especially to aid sleep may be purchased online through websites such as amazon.ca, or downloaded as applications on smartphones. The music used should be any preferred slow, soft, relaxing and soothing music in the range of 60 to 80 beats per minute. Websites such as www.songbpm.com and www.bpmdatabase.com can be used to identify the beats per minute of preferred songs.

As sleep is now recognized as an important occupation contributing greatly to daily occupational performance, it would be beneficial for occupational therapists to begin building a knowledge base regarding sleep disorders, sleep hygiene and existing interventions such as music to better address difficulties that clients may be experiencing.

Acknowledgements

I would like to thank Dr. Cary Brown at the University of Alberta's Occupational Therapy Department for her guidance and expertise on the topic of sleep in reviewing my work. I would also like to thank her for having confidence in my writing and encouraging me to submit this article.

References

American Occupational Therapy Association. (2014). Occupational therapy practice framework: Domain and process (3rd ed.). *American Journal of Occupational Therapy, 68*(Suppl. 1), S1-S48. doi: 10.5014/ajot.2014.682006

Buysse, D. J., Reynolds, C. F., Monk, T. H., Berman, S. R., & Kupfer, D. J. (1989). The Pittsburgh Sleep Quality Index (PSQI): A new instrument for psychiatric research and practice. *Psychiatry Research, 28*(2), 193-213.

Chan, M. F. (2011). A randomised controlled study of the effects of music on sleep quality in older people. *Journal of Clinical Nursing, 20*, 979-987. doi: 10.1111/j.1365-2702.2010.03368.x

Chen, C.-K., Pei, Y.-C., Chen , N.-H., Huang, L.-T., Chou, S-W.., Wu, K. P., . . . Wu, C.-K. (2014). Sedative music facilitates deep sleep in young adults. *The Journal of Alternative and Complementary Medicine, 20*, 312-317. doi: 10.1089/acm.2012.0050

Chang, E., Lai , H., Chen , P., Hsieh, Y., & Lee, L. (2012). The effects of music on the sleep quality of adults with chronic insomnia using evidence from polysomnographic and self-reported analysis: A randomized control trial. *International Journal of Nursing Studies, 49*, 921-930. doi: 10.1016/j.ijnurstu.2012.02.019

deNeit, G., Tiemens, B., Lendemeijer, B., & Hutschemaekers, G. (2009). Music-assisted relaxation to improve sleep quality: meta-analysis. *Journal of Advanced Nursing, 65*, 1356-1364. doi:10.1111/j.1365-2648.2009.04982.x

deNeit, G., Tiemens, B.,& Hutschemaekers, G. (2013). A meta-analysis on the effect of music-assisted relaxation on sleep quality across the lifespan. *Journal of Sleep Disorders: Treatment & Care, 2*(3).

Fung, C., Wiseman-Hakes, C., Stergiou-Kita, M., Nguyen, M., & Colantonio, A. (2013). Time to wake up: bridging the gap between theory and practice for sleep in occupational therapy. *The British Journal of Occupational Therapy, 76*, 384–386. doi:10.4276/030802213X13757040168432

Harmat, L., Takas, J., & Bodiz, R. (2008). Music improves sleep quality in students. *Journal of Advanced Nursing, 62*, 327-335. doi: 10.1111/j.1365-2648.2008.04602.x

Knight, W. E. J., & Rickard, N. S. (2001). Relaxing music prevents stress-induced increases in subjective anxiety, systolic blood pressure and heart rate in healthy males and females. *Journal of Music Therapy, 4*, 254-272.

Lazic, S., & Ogilvie, R. (2007). Lack of efficacy of music to improve sleep: A polysomnographic and quantitative EEG analysis. *International Journal of Psychophysiology, 63*, 232-239. doi: 10.1016/j.ijpsycho.2006.10.004

Morin, C. (2012). Insomnia: Prevalence, Burden, and Consequences. *Insomnia Rounds, 1*(1). Retrieved from Canadian Sleep Society website: http://css-scs.ca/downloadfolder/150-001_Eng.pdf

Solet, J. M. (2014). Sleep and rest. In B. A. Boyt Schell, G. Gillen, M. E. Scaffa, & E. S. Cohn (Eds.), *Willard & Spackman's Occupational Therapy* (12th ed., pp. 714–730). Philadelphia: Lippincott Williams & Wilkins.

Stanley, N. (2005). The physiology of sleep and the impact of ageing. *European Urology Supplements, 3*(6), 17-23.

Tan, L. (2004). The effects of background music on quality of sleep in elementary school children. *Journal of Music Therapy, 41*, 128-150.

Watkins, G.R. (1997). Music therapy: proposed physiological mechanisms and clinical implication. *Clinical Nurse Specialist, 11*, 43–50.

Wang, C., Sun, Y., & Zang, H. (2014). Music therapy improves sleep quality in acute and chronic sleep disorders: A meta-analysis of 10 randomized studies. *International Journal of Nursing Studies, 51*, 51-62. doi: 10.1016/j.ijnurstu.2013.03.008

Integrating occupational therapy students into correctional halfway houses: An outcome of the 2013 CAOT conference

Marie-Hélène Carrier, Crystal Dieleman, Christine Guptill, Lorie Shimmell, Elizabeth Steggles and Shawn Bayes

In May 2013, the Canadian Association of Occupational Therapists (CAOT) annual conference took place in Victoria, British Columbia. Among the different activities and presentations that took place was a Professional Issue Forum on Occupational Therapy and Criminal Justice. From this forum, new professional connections, ideas, projects and dialogue emerged. One year later, it is interesting to reflect on the opportunities that can develop from such a learning and networking event. During this conference, Elizabeth Steggles, then professional affairs executive at CAOT, had the opportunity to meet Shawn Bayes, executive director of the Elizabeth Fry Society of Greater Vancouver. Quickly, they realized they shared the opinion that there could be an important role for occupational therapists to play in correctional halfway houses.

The Regional Halfway House Association (2014) defines a halfway house as "a community-based residential facility for offenders who have been allowed to serve part of their sentence under supervision in the community" (para. 1). Residents include individuals who are on probation or under parole supervision. According to Correctional Service Canada's 2005 report about individuals incarcerated in federal penitentiaries, 79% of offenders have abused alcohol or drugs, 20% have been hospitalized in a mental health institution and 12% have a current psychiatric diagnosis (Motiuk, Cousineau, & Gileno, 2005).

Occupational therapists enable people to engage in occupations, which includes anything people do in their daily lives (Hammell, 2009; McColl, Law, & Stewart, 1993). The ability of occupational therapists to play an important role in interdisciplinary teams using a rehabilitation approach, particularly psychiatric rehabilitation, is well documented (Krupa, Fossey, Anthony, Brown, & Pitts, 2009; Brown, 2009). Moreover, Eggers, Munoz, Sciulli and Crist (2006) as well as Whiteford (2000) suggest that high rates of criminal recidivism are partly due to the fact that criminal offenders do not have the skills necessary for life in the community. They can become disconnected from their occupational roles and experience occupational imbalance, occupational deprivation and occupational alienation (defined as "the experience of lack of involvement in meaningful occupations emerging from social and cultural exclusion" [Krupa et al., 2009, p. 157]). Thus, enabling engagement in prosocial occupations may reduce rates of criminal recidivism. Involvement of occupational therapists in the rehabilitation of offenders appears logical from both mental health and correctional rehabilitation perspectives.

There is also a substantive body of evidence indicating that risk of recidivism can be effectively lowered when the services and programs provided to an individual are matched to an assessment of their needs and risks (Andrews & Bonta, 2007). Failure to match either the intensity or the type of intervention to the level of risk the individual presents is expected to increase the likelihood of recidivism (Bonta, Wallace-Capretta, & Rooney, 2000). The need to tailor services to the needs of individuals seems to further underscore the potential role of occupational therapy in the criminal justice system. Unfortunately, there is very little evidence examining the impact of occupational therapy services provided to criminal offenders.

The idea of a project to engage occupational therapy in the rehabilitation of criminal offenders residing in halfway houses began to germinate at the conference. Afterward, Steggles and Bayes maintained contact in order to explore possibilities, asking critical questions such as "How is it possible for halfway houses to justify employing occupational therapists without evidence of our effectiveness in community-based correctional environments?" and "How do we generate such evidence when there are so few occupational therapists working in community-based correctional environments?"

About the authors

Marie-Hélène Carrier, BSc, was a student in occupational therapy at the University of Ottawa on fieldwork placement at CAOT at the time this article was written. **Crystal Dieleman, PhD, OT Reg.(NS),** is an assistant professor, School of Occupational Therapy, Dalhousie University. **Christine Guptill, BMus, BSc, MS(OT), PhD, OT Reg. (Ont.),** was the CAOT research fellow at the time this article was written. **Lorie Shimmell, MSc, BHScOT, OT Reg. (Ont.),** is the director of clinical education, occupational therapy, and assistant professor in the School of Rehabilitation Science at McMaster University. **Elizabeth Steggles, OT Reg. (Ont.),** is the director of standards with CAOT and an assistant clinical professor, School of Rehabilitation Science, McMaster University. **Shawn Bayes, M.M. McGill,** is the executive director of the Elizabeth Fry Society of Greater Vancouver and the President of the Canadian Association of Residential Options for Women in conflict with the law (CAROW). **For more information, contact Elizabeth Steggles at:esteggles@caot.ca**

To address these challenges, they had the idea to integrate occupational therapy students on fieldwork placements into halfway houses. In this way, the role for occupational therapists, as well as benefits for the residents and staff in these environments, could be examined.

The integration of occupational therapy students into halfway houses can have several benefits. Firstly, in a climate of fiscal restraint, introducing students to halfway houses is an effective strategy for ensuring that residents have the benefit of occupational therapy services without those services placing a financial burden on the halfway house. Secondly, role-emerging placements are an important means for innovation of roles and expansion of the profession's contribution to occupational participation and well-being. Thirdly, according to the authors, a student may benefit from opportunities to explore the potential innovative roles of an occupational therapist in this partnership, which would not exist in a setting where a specific mandate for the occupational therapy role already exists. Fourthly, evidence of the benefits of occupational therapy to residents and staff in halfway houses can be established through student project work, environmental scanning and pilot-testing of various interventions. Lastly, student involvement may also illuminate the possible valuable contributions of occupational therapists as more permanent team members in terms of the day-to-day functioning of the halfway house, and would promote a greater understanding of the role of occupational therapy among halfway house staff and residents.

Elizabeth Steggles and Lorie Shimmell, director of clinical education in occupational therapy at McMaster University, visited a halfway house in Guelph, Ontario, to better understand this environment. The meeting focused on helping them to understand the services provided at this halfway house, as well as discussion of potential roles and contributions of occupational therapists in this specific setting. Potential roles identified for occupational therapy involvement include assessment, intervention and goal-setting in the areas of community integration, substance abuse management, exploration of leisure and prosocial occupations, acquisition of skills (e.g., those required for activities of daily living, parenting, working, socializing, emotional regulation, independent living, etc.) and reacquisition of occupational roles. Early discussions focused on collaboratively investigating how the work in this halfway house and occupational therapy would intersect. Emphasis was placed on an environmental assessment that could be completed on-site by the students, alongside the organization's stakeholders (executive, staff and clients) during the pilot process. The goals of this assessment would be to determine the type of occupational therapy involvement that would be beneficial and aligned with the mission and values of this setting in terms of direct service and work with staff and executives at a systems level, as well as to develop appropriate projects, including individual and group programming. To support a mutually beneficial partnership, occupational therapy students would deliver evidence to support all aspects of this work, contributing to both their personal learning and the goals of the project.

Dr. Crystal Dieleman, an assistant professor at Dalhousie University and facilitator of the Professional Issue Forum at the 2013 CAOT Conference, was approached by CAOT to direct the research component of this project. Halfway houses are all quite different; therefore, the roles of occupational therapists will vary from one site to another. For this reason, in consultation with Dr. Christine Guptill, research fellow at CAOT, Dr. Dieleman proposed starting with a pilot project, collecting data from two sites. It was decided that an interpretative phenomenological approach would be most appropriate to help understand the experiences of halfway house residents and staff, as well as those of the occupational therapy students. Funding is currently being sought to fund this pilot project. Data from this project would provide the foundation for a more comprehensive nationwide study, allowing researchers to explore and understand the role of occupational therapy in the halfway house sector across Canada.

When meeting with the project team, aside from the palpable excitement, one observes an omnipresent social conscience, part of the members' roles as citizens and as professionals. It is becoming increasingly common for occupational therapists to engage in service provision with people outside of traditional health institutions and medical settings. The profession's scope of practice transcends the boundary between health and social domains. Even if an environment does not have the funds to support a professional, pilot projects can explore service potential and benefit the community through social rehabilitation and the reduction of recidivism. It is therefore a social responsibility to mitigate the barriers to healthy occupation that exist in the correctional sector. The authors' social awareness informs the planning of this project in the hope of creating a sustainable and enduring legacy through student projects. These projects should allow for continuity between fieldwork placements and enable the halfway house staff and subsequent student occupational therapists to continue previous work and improve services. Regardless of where student occupational therapists practice upon graduation, the experience of working in a halfway house environment will promote greater self-awareness of biases or judgments they may hold, enabling them to challenge these preconceptions in future endeavours.

This summary provides a glimpse into the process and deliberations that originated from a CAOT Professional Issue Forum that aimed to advance thinking about a unique, underserved practice area. This project is innovative in its use of a new model involving research, student occupational therapists in fieldwork placements and a forward-thinking collaboration that brings together stakeholders with common goals from correctional, professional and university communities.

References

Andrews, D. A., & Bonta, J. (2007). *Risk-need-responsivity model for offender assessment and rehabilitation 2007-06*. Retrieved from http://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/rsk-nd-rspnsvty/index-eng.aspx

Bonta, J., Wallace-Capretta, S., & Rooney, J. (2000). A quasi-experimental evaluation of an intensive rehabilitation supervision program. *Criminal Justice & Behavior, 27,* 312-329.

Brown, C. (2009). Functional assessment and intervention in occupational therapy. *Psychiatric Rehabilitation Journal, 32*, 162-170. doi: 10.2975/32.3.2009.162-170

Eggers, M., Munoz, J. P., Sciulli, J., & Crist, P. A. (2006). The community reintegration project: Occupational therapy at work in a county jail. *Occupational Therapy in Health Care, 20*, 17-37. doi:10.1080/J003v20n01_02; 10.1080/J003v20n01_02

Hammell, K. W. (2009). Self-care, productivity, and leisure, or dimensions of occupational experience? Rethinking occupational "categories." *Canadian Journal of Occupational Therapy, 76*, 107-114.

Krupa, T., Fossey, E., Anthony, W. A., Brown, C., & Pitts, D. B. (2009). Doing daily life: How occupational therapy can inform psychiatric rehabilitation practice. *Psychiatric Rehabilitation Journal, 32*, 155-161. doi:10.2975/32.3.2009.155.161

McColl, M. A., Law, M., & Stewart, D. (1993). *The theoretical basis of occupational therapy: An annotated bibliography of applied theory in the professional literature.* Thorofare, NJ: Slack.

Motiuk, L., Cousineau, C., & Gileno, J. (2005). *The safe return of offenders to the community: Statistical overview April 2005*. Retrieved from http://www.csc-scc.gc.ca/research/sr2005-eng.shtml

Regional Halfway House Association. (2014). *Frequently asked questions*. Retrieved from http://halfwayhouses.ca/en/region/rhha/page/frequently_asked_questions_3/

Whiteford, G. (2000). Occupational deprivation: Global challenge in the new millennium. *British Journal of Occupational Therapy, 63*, 200-204.

COLUMN EDITOR: PATRICIA DICKSON

Executive function and occupational therapy: Lessons drawn from the literature and lived experience with 22q11.2 deletion syndrome

Jude Driscoll

Nearly all of my twenty-seven years of practice as an occupational therapist have been in the community, but I only first saw the phrase "executive function" (EF) ten years ago on a neuropsychology report. The process of learning what those words actually meant in terms of occupation inspired me to write this article. The knowledge I gained affected my personal life, influencing how I manage the effects of a family member's executive dysfunction that is caused by a rare genetic condition, 22q11.2 deletion syndrome (22q). In addition, I now believe that individuals with executive dysfunction can benefit significantly from occupational therapy.

My family member has lived in supported living situations in the community for twelve years. I believe this individual's occupational performance potential could have been enhanced had there been earlier occupational therapy intervention, though our family's lived experience has included only infrequent adverse events. Due to tailored supports, reasonable expectations and healthy routines, most of our experiences have been optimal.

Poulin, Korner-Bitensky and Dawson (2013) indicate that less than one per cent of occupational therapists assess EF in stroke rehabilitation settings. In my experience, a lack of assessment of EF is also present among community therapists. Some therapists I have spoken with indicate that they do not know much about EF but that their caseload pressures do not allow for an in-depth review of related literature, assessments and interventions. I took up the challenge to learn more about EF. As my family member was not diagnosed with 22q until 25 years of age, I was looking for information to help reduce adverse events and build a sustainable plan. Given that executive dysfunction may mean enduring poor judgment skills and ongoing support needs, there are cost implications, both financial and human.

My purpose in writing this article is to share the resources and lessons that I have found most helpful as an occupational therapist and a parent of someone with executive dysfunction, and to help therapists avoid common pitfalls. I will share my perspective on some of the needs of individuals with executive dysfunction and possible areas in which occupational therapist involvement would be beneficial, based on the literature and my personal experience as a parent.

Executive function and dysfunction

Executive functions "refer to high-level cognitive functions that are responsible for the initiation, planning, sequencing, and monitoring of complex goal-directed behaviour" (Poulin, Korner-Bitensky, McDermott, Dawson, & Ogourtsova, 2011, para. 1). EF includes concepts such as inhibition, working memory, divided attention and flexibility (Poulin, Korner-Bitensky, & Dawson, 2013). Ward (2010) organizes EF into three layers, including self-regulation, higher-order reasoning skills (to analyze, to conclude, to problem solve and to evaluate), and organization and integration of information for awareness (to get the big picture and enable thinking). EF plays a significant role in an individual's ability to delay gratification, manage pressure and stress, and build and maintain positive social and work relationships to attain good quality of life (Wheeler, 2012).

A number of conditions are linked with executive dysfunction, including Tourette syndrome (Lavoie, Thibault, Stip, & O'Connor, 2007), fetal alcohol spectrum disorder (FASD; Wells, Chasnoff, Schmidt, Telford, & Schwartz, 2012), autism spectrum disorder, attention deficit hyperactivity disorder (Cramm, Krupa, Missiuna, Lysaght, & Parker, 2013), traumatic brian injury (Ward, 2010), Parkinson's disease, schizophrenia and stroke (Poulin et al., 2013). There are also some lesser-known conditions associated with executive function difficulties, including the one my family member was diagnosed with: 22q, a genetic disorder caused by the deletion of a small piece of chromosome 22. It is also known as velocardiofacial syndrome and DiGeorge syndrome (U.S. National Library of Medicine, 2014). 22q presents with both congenital and later-onset manifestations, which may include congenital heart disease, intellectual disability and mental illness (Butcher et al., 2012). Statistics from the Hospital for Sick Children (2014) estimate that 22q affects 1 in 4,000 Canadians, making it "one of the most common genetic causes of learning disabilities" (para. 1).

Performance-based assessments in the community

A topic in the literature that resonated deeply with my experience was the importance of assessing people in the community with performance-based EF assessments that are relevant to the individual's actual occupational needs. In an online lecture, Wolf (2013) refers to occupational therapists as experts in community involvement and encourages that assessments be done in individuals' own community environments, where difficulties related to EF naturally surface in daily life. I concur with Wheeler (2012) when he suggests that assessing a person in a group as well as in unstructured settings will reveal both strengths and needs

that likely will not appear when testing one-on-one in a structured, isolated office setting. From experience with my family member, who has average to low-average language skills, I know that an uninformed assessor in such an office setting may develop overly high expectations of performance.

Insight may be impaired in individuals with executive dysfunction, and could present as over-estimating their own abilities, setting unrealistic goals and having decreased awareness of the feelings and needs of others (Wheeler, 2012). To account for these issues, I suggest that assessment of occupational performance issues ideally should include interviews with those who are familiar with the person, such as family, teachers and support staff.

Many EF assessments exist; I have found the Stroke Engine website helpful for overviewing the pros and cons of many of these assessments (see resource list at end of this article). Chan, Shum, Toulopoulou and Chen (2008) suggest that EF assessments should be considered based on how well they approximate the real world for individual clients. For example, if your client never writes cheques, an assessment of this skill is inappropriate. On the other hand, assessing use of an ATM may be more relevant.

Wolf (2013) suggests that therapists be aware of how much useful information the results of standardized assessments offer for treatment planning (e.g., the Multiple Errands Test gives limited information for this purpose). He suggests a mixed method, combining clinical reasoning with performance-based testing.

Enhance performance

Many interventions for addressing executive dysfunction can be found in the literature. I would like to highlight some that I personally have found effective from my own experience:

- Teach individuals to practice attending and to improve occupational performance through a relaxed state of alertness. One technique, called STOP (space, time, organization and people), helps individuals to "read the room" and look for the cues they need to interpret situations (Ward, 2010).
- Wells and colleagues (2012) explored the efficacy of calendar planning with youth with FASD aged 16 to 21 and conclude it is useful for self-evaluation and for strategy development.
- Memory aids to help sequence tasks and prepare for daily activities may help decrease anxiety and the number of "meltdowns." Online tools and smartphones can assist with planning and organization (e.g., Google Calendar, Evernote and Personal Brain). Tailored supports can become lifelines for users.
- Social worker Diane Malbin advocates for adjusting the environment and adjusting expectations, based on a neurobehavioral approach (Malbin, 2002). I concur with this approach; expecting organization from a person with executive dysfunction can cause relationships to erode.

Based on my 32 years of lived experience, I also recommend the following strategies to help individuals with executive dysfunction:

- Model appropriate social interactions.
- Teach safe use of internet to support socialization while promoting personal safety.
- Communicate using a calm tone of voice and demeanour, maintain a non-judgmental positive attitude and work to maintain engagement in social interactions. Acknowledge the individual's feelings, and in case of distress, try to distract with humor.
- Provide ample processing time and periods of quiet.

Occupational therapy involvement at key life stages or transitions can also be crucial. In my opinion, preparing for the transition from school to work or supported work, and from home to living in the community, are very important times to engage in EF assessments and interventions. Occupational therapy can make a significant contribution to enabling smooth transitions due to the instrumental activities of daily living that are involved. As parents age and as a youth becomes an adult, it can be a challenge to avoid adverse events (e.g., those relating to money, food or exploitation). As vulnerable persons, lacking judgment and problem-solving skills, people with executive dysfunction can easily get involved in difficult situations. The balance between independence and protection is delicate; reducing risk while fostering choice and independence is essential.

Knowledge transfer

There is abundant literature about EF intervention for people with acquired executive dysfunction, for example, resulting from stroke or traumatic brain injury. I found less literature addressing treatment for those born with executive dysfunction, due to conditions such as 22q, FASD and Tourette syndrome.

Butcher et al. (2012) detail widespread deficits in cognitive and social performance among individuals with 22q, resulting in functional performance limitations, including on the ability to work. Their review found that challenges related to executive dysfunction often overshadow the individual's strengths, and can result in isolation from the mainstream due to difficulties with multitasking and social awareness. Karas, Costain, Chow and Bassett (2014) found that when an individual with 22q does not initiate tasks or interactions, employers or care providers may think the person is apathetic or lazy. Instead, he or she may actually be having difficulty with awareness, initiation and problem solving. Occupational therapists can assist clients, families, support staff and employers to develop an understanding of underlying EF factors associated with behaviour and performance.

Fortunately, my family member has strong social skills and likes to help others. However, when demands are greater than a person with executive dysfunction can handle, irritability and frustration can become agitation. This may lead some people

About the author

Jude (Kirsch) Driscoll, Diploma in Occupational Therapy, has been committed to innovation throughout her practice, starting with her work with neonates and in the Learning Clinic at the Children's Hospital of Eastern Ontario. In Prince Edward Island, as both a manager and practitioner, she demonstrated the value of occupational therapy in the community and in workers' compensation settings. She has recently begun a part-time private practice. Jude welcomes correspondence at: jdriscollot@gmail.com

to attribute negative personality traits and labels to individuals if they do not understand that such behaviours can be related to brain physiology. Occupational therapists can help clients to develop insight into these brain-based needs and help others around them to understand the importance of cues, adaptations and accommodations (Butcher et al., 2012). Therapists can also work with clients to facilitate active coping skills (Wheeler, 2012). Emphasis should be put on the clients' needs, not their behaviour. This will help in the identification of compensatory strategies and accommodations.

Conclusion

I advocate for a well-supported life in the community for those living with executive dysfunction, whether they are present from birth or acquired later in life. Occupational therapy has much to offer in helping such clients achieve their goals. I believe occupational therapy can provide crucial insights and strategies to both clients and their support teams by bridging the cognitive, affective and physical spheres while addressing occupational goals and adapting the environment.

Given the prevalence of executive dysfunction among many client populations, I encourage occupational therapists to learn more about this relevant topic. More informed clinical reasoning relating to EF (and 22q) will maximize the occupational potential of clients. In addition to the reference list, the following resources may be helpful.

Executive function resources:

1. Stroke Engine: http://strokengine.ca/intervention/index.php?page=topic&id=90 This website has lots of great resources relating to executive function intervention.
2. occupationaltherapy.com webinars: http://www.occupationaltherapy.com/ot-ceus/live/ Search for "executive function" to find videos and webinars.
3. The American Occupational Therapy Association. (2013). Cognition, cognitive rehabilitation, and occupational performance. *American Journal of Occupational Therapy, 67*, S9-S31. doi:10.5014/ajot.2013.67S9
4. Cramm, H. A., Krupa, T. M., Missiuna, C. A., Lysaght, R. M., & Parker, K. C. H. (2013). Executive functioning: A scoping review of the occupational therapy literature. *Canadian Journal of Occupational Therapy, 80*(3), 131-140. doi:10.1177/0008417413496060
5. Cramm, H., Krupa, T., Missiuna, C., Lysaght, R. M., & Parker, K. C. H. (2013). Broadening the occupational therapy toolkit: An executive functioning lens for occupational therapy with children and youth. *American Journal of Occupational Therapy, 67*(6), e139-e147. doi:10.5014/ajot.2013.008607
6. Diane Malbin has produced many resources relevant to FASD, many of which address executive dysfunction. http://www.fascets.org/

22q resources:

1. Velo-Cardio-Facial Syndrome Educational Foundation: www.vcfsef.org
2. University of California Davis MIND Institute: www.ucdmc.ucdavis.edu/mindinstitute Enter "22q" into the search function on the website to find many helpful articles.
3. The Dalglish Family Hearts and Minds Clinic for 22q11.2 Deletion Syndrome at University Health Network in Toronto. http://www.uhn.ca/PMCC/PatientsFamilies/Clinics_Tests/Dalglish_Family_Heart_Mind_Clinic

References

Butcher, N. J., Chow, E. W. C., Costain, G., Karas, D., Ho, A., & Bassett, A. S. (2012). Functional outcomes of adults with 22q11.2 deletion syndrome. *Genetics in Medicine, 14*, 836-843. doi:10.1038/gim.2012.66

Chan R., Shum, D., Toulopoulou, T., & Chen, E.Y., (2008). Assessment of executive functions: Review of instruments and identification of critical issues. *Archives of Clinical Neuropsychology, 23*, 201-216. Retrieved from www.sciencedirect.com/science/journal/08876177/23/2

Cramm, H., Krupa, T., Missiuna, C., Lysaght, R. M., & Parker, K. C. H. (2013). Broadening the occupational therapy toolkit: An executive functioning lens for occupational therapy with children and youth. *American Journal of Occupational Therapy, 67*(6), e139-e147. doi:10.5014/ajot.2013.008607.

The Hospital for Sick Children. (2014). *22q11 deletion syndrome*. Retrieved from http://www.sickkids.ca/PaediatricLaboratoryMedicine/Laboratories-Services/Molecular-Genetics-Laboratory/Test-Services-Available/22q11-Deletion-Syndrome.html

Karas, D. J., Costain, G., Chow, E. W. C., & Bassett, A. S. (2014). Perceived burden and neuropsychiatric morbidities in adults with 22q11.2 deletion syndrome. *Journal of Intellectual Disability Research, 58*(2), 198-210. doi:10.1111/j.1365-2788.2012.01639.x

Lavoie, M. E., Thibault, G., Stip, E., & O'Connor, K. P. (2007). Memory and executive functions in adults with Gilles de la Tourette syndrome and chronic tic disorder. *Cognitive Neuropsychiatry, 12*(2), 165-181. doi:10.1080/13546800600826371

Malbin, D. (2002). *Trying Differently Rather Than Harder* (2nd ed.). Portland, OR: Author.

Poulin, V., Korner-Bitensky, N., & Dawson, D. R. (2013). Stroke-specific executive function assessment: A literature review of performance-based tools. *Australian Occupational Therapy Journal, 60*(1), 3-19. doi:10.1111/1440-1630.12024

Poulin, V., Korner-Bitensky, N., McDermott, A., Dawson, D., & Ogourtsova, T. (2011). *Executive Function Intervention*. Retrieved from http://strokengine.ca/intervention/index.php?page=topic&id=90

U.S. National Library of Medicine. (2014). *22q11.2 deletion syndrome*. Retrieved from http://ghr.nlm.nih.gov/condition/22q112-deletion-syndrome

Ward, S. (2010). *Executive function skills: Practical interventions for adults with traumatic brain injury; Part 1.* [Video course]. Available from http://www.occupationaltherapy.com/ot-ceus/course/executive-function-skills-practical-interventions-1036

Wells, A. M., Chasnoff, I. J., Schmidt, C. A., Telford, E., & Schwartz, L. D. (2012). Neurocognitive habilitation therapy for children with fetal alcohol spectrum disorders: An adaptation of the Alert Program®. *American Journal of Occupational Therapy, 66*(1), 24-34. doi: 10.5014/ajot.2012.002691

Wheeler, S. (2012). *Providing occupational therapy for individuals with traumatic brain injury* [Recorded webinar]. Retrieved from http://www.occupationaltherapy.com/ot-ceus/course/executive-cognitive-functions-following-traumatic-1397

Wolf, T. (2013). *Executive function assessment* [Online course]. Retrieved from www.occupationaltherapy.com/ot-ceus/course/executive-function-assessment-1456

COLUMN EDITORS: CHRISTEL SEEBERGER AND JON RIVERO

Enhancing fieldwork opportunities within private practice settings

Donna Barker, Rachel Stack, Carolyn Miller, Heather MacEwen and Susan Rappolt

Canadian occupational therapy programs must include a minimum of 1000 hours of supervised fieldwork hours (Canadian Association of Occupational Therapists, 2011), which have historically occurred within publicly-funded hospitals. Approximately 25% of occupational therapists now work in private practices (Canadian Institute for Health Information, 2012). Students planning on working in or developing private practices need experiential training in relevant service delivery models, regulatory and documentation standards, risk management and business practices, as well as in assessments, therapeutic approaches and interventions. However, to date, private practice fieldwork placement opportunities have been limited in number.

Previous studies have identified substantial barriers to providing fieldwork placements in private practices, including fluctuations in caseloads and atypical hours, liabilities for patient and student safety, ethical issues concerning disclosure and consent, and financial losses due to unbillable time for teaching. In the same studies, some private practitioners argue that entry-level students are not sufficiently trained for complex and often litigious private practices (Doubt, Paterson, & O'Riordan, 2004; Sloggett, Kim, & Cameron, 2003; Thomas et al., 2007). Strategies to overcome these barriers have been proposed, including the introduction of different models of supervision, flexing placement periods within the academic curriculum and sharing students between preceptors and organizations (Doubt, Paterson, & O'Riordan, 2004; Sloggett, Kim, & Cameron, 2003; Thomas et al., 2007). This article will report on a recent study that examined Ontario private practitioners' experiences of barriers to providing fieldwork placements and their receptiveness to strategies to enhance their capacity to provide placements. Survey results were interpreted to create ten tips for successful fieldwork education in private practices.

Survey of Ontario private practitioners

Methods: Based on the relevant literature and expert opinion, an online survey was developed to clarify the challenges of providing occupational therapy private practice fieldwork placements, and to examine private practitioners' receptivity to strategies to increase their capacity to provide placements. In addition to gathering demographic data, the survey asked respondents to identify which barriers reflected their own experiences and collected their responses to possible solutions, including qualitative comments. "Private practice" was defined as services funded by third-party payers such as the Workplace Safety and Insurance Board, auto insurance, private insurance or by individual clients.

The survey was piloted with 17 private practitioners and revised prior to its dissemination to occupational therapists registered with the College of Occupational Therapists of Ontario as private practitioners. No identifiable risks or benefits were associated with participating in the study. The University of Toronto Research Ethics Board approved all phases of the study. Quantitative survey data were analyzed descriptively through the survey tool, as well as by the chi-square test, and Spearman's rho and Kendall's tau correlational analyses using SPSS statistical analysis software. Respondents' qualitative comments were analyzed by content and thematic analyses.

Results: The survey was completed by 247 occupational therapists. Survey respondents' sources of funding included automobile insurers, workers' compensation, other private or government funding and individual fee-for-service payments. Sixty percent of respondents reported that they were self-employed, 31% were employees of privately owned for-profit companies and 9% reported concurrent self-employment and employment with a private enterprise. Forty-three percent had been in private practice for more than 10 years and 75% identified direct care services as their primary role. Two-thirds carried out their practices in client's homes or workplaces and another 14% provided services in their solo practice home offices. In the past five years, only 20% had provided a fieldwork placement. The respondents' experiences of challenges to providing fieldwork placements are summarized in Table 1, and their responses to possible strategies to increase their capacity to provide placements are summarized in Table 2.

Respondents submitted a total of 952 wide-ranging qualitative

Table 1
Challenges to Entry-Level Clinical Education in Private Practices

	Challenges to entry-level clinical education in private practices	Percentage of responses
1.	Fluctuations in caseloads	87.6
2.	Lack of physical space/resources to accommodate students	65.8
3.	Concerns that students are not sufficiently prepared	76.6
4.	Costs/loss of revenue associated with student supervision	75.2
5.	Students present a liability issue	72.9
6.	Unsure about criteria for clinical teaching and supervision	60.5
7.	Concerns about client satisfaction with student involvement	74.4
8.	Concerns about quality of care when students involved	72.3
9.	Concerns about students involved in legal cases	71.8

Note. **The challenges listed above reflect quantitative responses to survey questions asking whether the listed challenge was present in respondents' practice.**

Table 2
Solutions to Increase Entry-Level Clinical Education in Private Practices

	Solutions* to increase entry-level clinical education in private practices	Percentage of responses
1.	Offer joint placements (student supervised by two preceptors)	69.6
2.	Augment academic curriculum with private practice content	51.1**
3.	Increase honoraria	54.5
4.	Provide a preceptor handbook on supervising students in private practice	49.8
5.	Involve private practitioners in screening students for their setting	50.2
6.	Assign more than one student to a preceptor	6.5

*** The solutions above reflect the most frequently selected solutions to listed challenges. Some solutions were most frequently selected for more than one challenge. Where one solution was selected for more than one challenge, the higher percentage of responses is presented.**
****This includes academic content on accountabilities, liabilities, legal and regulatory considerations, quality of care and client satisfaction, assessments, documentation standards and interventions specific to private practices.**

comments linked to the quantitative questions. Many respondents elaborated on specific costs associated with supervising students, as well as the lack of their employing organization's support for student supervision. Concerns included logistical issues such as potential breaches of personal privacy in home offices, scheduling treatments given the typically irregular hours of private practices and responsibility for student transportation.

Tips for university clinical education coordinators

Deliberation and interpretation of the quantitative and qualitative data and associated literature resulted in "10 tips." Tips 1-5 suggest how private practice placements can be structured and implemented successfully. Tips 6-10 focus on supporting preceptors and sustaining collaborative fieldwork partnerships in the private sector.

Tip 1: Learn the characteristics and capacities of the private practice setting

University fieldwork coordinators should recognize the different types and foci of private practice settings and become familiar with their values, cultural norms and resources for supporting student learning prior to soliciting placements. For example, private practice organizations may have more space and caseload flexibility to support fieldwork placements than a solo private practitioner. Involvement in direct, indirect and non-direct client care will vary across populations and practice foci, affecting the learning opportunities available. Private practitioners who work with relatively litigious populations may be reluctant to provide placements due to potential liabilities and legal restrictions on services that can be delegated to students.

Careful planning and correspondence between the university coordinator and the private practitioner are needed to design a student learning experience that meets university standards, is appropriate to the private practice setting and is acceptable to the potential preceptor. Reviewing university objectives at each level of fieldwork will assist private practitioners in understanding their roles as preceptors. Introductory placements offer students exposure through observation, which, according to our respondents, can be readily accommodated in many private settings. Specific skill development is feasible in both solo and corporate private practices through careful delineation of student and preceptor roles and expectations. Senior students who must demonstrate practice-ready competencies may require additional preparation and prescreening for placements at private practices at which insurance claims create adversarial relations among stakeholders and litigation is frequent.

Tip 2: Provide opportunities for shared placements

Among our respondents, caseload fluctuations were identified as the most frequent barrier to offering placements. Providing opportunities for private practitioners to share students, either within or across different organizations, was seen as a possible solution that would increase opportunity for direct client experience. Shared placements need some common features, for example, client diagnoses, but do not require identical student roles. For example, a placement split between an inpatient trauma unit and a private company providing trauma rehabilitation would provide invaluable learning across the care continuum.

Tip 3: Provide training for preceptors

Private practitioners have fewer connections with university programs than those in hospitals with formal university partnerships, resulting in less familiarity with curriculum, regulations and teaching methods. University fieldwork coordinators should provide easily accessible information about the curriculum, teaching theories and methods, policies and procedures, clinical evaluation tools, regulatory college standards and regulations, and professional association fieldwork guidelines through user-friendly formats such as webinars, online modules, manuals and workshops. Potential preceptors should have confidence that faculty are also available for personal consultation and assistance throughout fieldwork placements.

Tip 4: Prepare students academically for private practice placements

Core academic curriculum specific to private practice will increase students' capacities to engage and contribute during fieldwork

About the authors

Donna Barker, MSc, BSc(OT), OT Reg.(Ont.), is the director of clinical education in the Department of Occupational Science and Occupational Therapy at the University of Toronto. She can be reached at: donna.barker@utoronto.ca

Rachel Stack, BSc, MClSc(OT), OT Reg.(Ont.), at the time of writing was a fieldwork coordinator in the Department of Occupational Science and Occupational Therapy at the University of Toronto. Rachel is currently working as the quality improvement lead at the South West Local Health Integration Network (LHIN). She can be reached at: rachel.stack@lhins.on.ca

Carolyn Miller, BA, RN, is the manager of recruitment, retention and regulatory compliance with the CBI Health Group and has been working with a variety of allied health profession students in various private practice settings for over 18 years. She can be reached at: cmiller@cbi.ca

Heather MacEwen, MClSc, OT Reg./L, is the lead occupational therapist at Associated Learning and Language Specialists in Redwood City, California. She can be reached at: heather@heathermacewen.com

Susan Rappolt, PhD, OT Reg.(Ont.), is the chair of the Department of Occupational Science and Occupational Therapy at the University of Toronto, and an associate professor in both that department and the Graduate Department of Rehabilitation Sciences. She can be reached at: s.rappolt@utoronto.ca

placements, increasing the likelihood of positive teaching and learning placement experiences, which may, in turn, increase the preceptors' willingness to take more students. Teaching students relevant legislation, documentation procedures, business practices, service delivery models, assessments and interventions commonly used by private practitioners in the classroom reduces the burden on private preceptors to convey this foundational knowledge. Creating a library of setting-specific student learning resources would also reduce the burden on preceptors.

Tip 5: Assign appropriate students to private practice placements

Some evidence suggests that students' personal characteristics (independence, self-direction, assertiveness, flexibility and creativity) are particularly desirable in private practices settings (Sloggett, Kim, & Cameron, 2003). Students need detailed descriptions of settings' expectations to determine their relevance to their own interests, personal resources and learning needs. Some private practices require students to have a car and be available during evenings and weekends. Half of our respondents wanted to pre-screen potential students before placement. Providing an opportunity for the private practitioner and student to examine their expectations prior to placement can be reassuring for both parties. Inviting private practitioners to deliver "lunch and learn" seminars to students about their services and practice settings may also assist students' self-selection and contribute to the overall "fit" between the student and placement.

Tip 6: Engage private practitioners in academic teaching

Recruiting private practitioners to share their clinical expertise through lectures and lab instruction strengthens their links to the university, allows for networking among faculty, students and clinicians, and exposes students to the expertise and nuances of private practice. Engaging private practitioners in committees to guide curriculum content, as well as in student and faculty research projects, helps to build positive working relationships and increases the likelihood of successful private practice fieldwork placements.

Tip 7: Provide university space for students on placement

Space for students is often scarce in solo private practices and small companies. Finding space for preceptors to teach specific skills and provide feedback and evaluation, and for students to plan treatment and write reports, is particularly challenging when practices are in clients' homes or workplaces, or practitioners' home offices. Providing office or lab space for teaching and learning may ameliorate both the students' and preceptors' stress levels.

Tip 8: Provide excellent customer service

To build and maintain positive relationships with privately funded occupational therapists and organizations, university coordinators should provide timely and effective support. In private practices, time translates directly into personal income and company profits; therefore, delayed assistance in resolving student performance issues or slow responses to inquiries may decrease preceptors' offers of future placements. Prompt responses show appreciation for the preceptors' time and effort, given their competing priorities.

Tip 9: Provide relevant incentives and rewards

Incentives and rewards may justify private practitioners' involvement in fieldwork within a for-profit organization. Some universities are able to provide honoraria as tokens of recognition and appreciation. Preceptors may be eligible for status or adjunct university appointments that include free online library access, reduced continuing education rates and recognition in newsletters or on websites, and can add distinction to resumes. Certificates and letters of appreciation to preceptors and employers may add value and lend prestige when used for recruitment and marketing. Astute practice organizations will capitalize on their links to university departments to enhance their learning environments and build a culture of continuing professional development.

Tip 10: Advertise the benefits of supervising students

University departments can actively promote the benefits of fieldwork education for private practice organizations and practitioners on their main web page and prominently in other media channels. Articles in alumni or professional magazines that highlight the critical need for and valuable academic contributions of private practitioners who are preceptors will not only provide public acknowledgement of the department's esteem and gratitude for preceptors, but can also offer case examples of how and why preceptorship can be a winning investment.

Conclusion

The shortage of fieldwork opportunities in private practice settings is a serious challenge in occupational therapy. Students need exposure, the development of specific knowledge and skills, and the attainment of competencies that are unique to private practices if they are to launch successful careers in an increasingly privatized environment. Occupational therapy education programs are encouraged to invest in collaborative planning with private practitioners to overcome barriers, establish reasonable expectations for successful placements and provide incentives and rewards to build and sustain capacity for private practice fieldwork education.

References

Canadian Association of Occupational Therapists. (2011). *CAOT academic accreditation standards and self-study guide (2011)*. Retrieved from https://www.caot.ca/acc/Standards%20and%20SSGuide%20Rev%20EN%202010-11.pdf

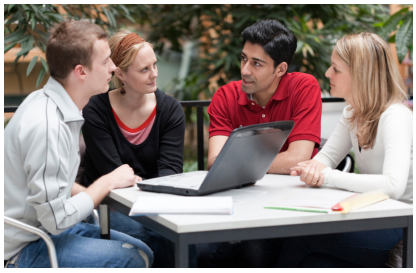
Canadian Institute for Health Information. (2012). *Occupational Therapists in Canada, 2011– National and Jurisdictional Highlights.* Ottawa, ON: Author.

Doubt, L., Paterson, M., & O'Riordan, A. (2004). Clinical education in private practice: An interdisciplinary project. *Journal of Allied Health, 33*, 47-50.

Sloggett, K., Kim, N., & Cameron, D. (2003). Private practice: Benefits, barriers and strategies of providing fieldwork placements. *Canadian Journal of Occupational Therapy, 70*, 42-50.

Thomas, Y., Dickson, D., Broadbridge, J., Hopper, L., Hawkins, R., Edwards, A., & McBryde, C. (2007). Benefits and challenges of supervising occupational therapy fieldwork students: Supervisors' perspectives. *Australian Occupational Therapy Journal, 54*, 2-12.

STUDENT PERSPECTIVES



COLUMN EDITORS: LAURA HARTMAN AND CHRISTINA LAMONTAGNE

International learning: Lessons that extend beyond the physical classroom

Lydia Bonanno, Katie Campbell, Jeff Haveman, Joanna Smorhay and Danaka White

In July of 2011, a group of students from the School of Occupational Therapy at Western University attended the International Public Health course offered by what is now Oslo Akershus University College of Applied Sciences, located in Oslo, Norway (http://www.hioa.no/eng/Studies/HF/Evu/iph). This first venture proved to be such a valuable experience for the participants that the university has continued to support sending students every year since.

In 2011, the three-week course integrated 48 students from 27 different countries (including Ghana, Egypt, the Netherlands, Austria, Uganda and others) representing various health-care disciplines. The students lived alongside each other in residences near the university and attended classes together on subjects including HIV/AIDS, child soldiers and models of health care. They completed group assignments involving creating solutions to current world health issues and also participated in field trips and cultural experiences in and around Oslo.

As the group of students representing Western University, we discussed our individual and collective learning objectives prior to departure. These included furthering our knowledge of current issues in international public health, particularly the relationship between health and wealth in today's world. Through the use of a reflective online blog and group discussions during the course, we realized that the knowledge we acquired reached beyond the physical walls of the lecture halls and the topic of international public health.

We came to understand that the most valuable part of our experience was the cross-cultural interaction with other international students, both inside and outside of the classroom environment. Practicing cultural competence is imperative for developing therapeutic rapport and helping clients achieve their outcomes (Paul, 1995). Prior to attending the course, many of us thought of ourselves as being culturally competent as a result of living in Canada, a diverse multicultural nation. While in Norway, however, we quickly learned how cultural differences can create barriers between health-care professionals and their clients and colleagues. Such potential problems are strongly influenced not only by personal experiences, beliefs and professional backgrounds, but also by public and government policies, which differ greatly around the world.

Cultural competence (Paul, 1995) and reflection (Kinsella, 2001) are important parts of occupational therapy practice. This article explores how reflecting on our experiences helped us develop a deeper understanding of the various elements of culture that influence our diversities. This has and will continue to enable us to create more meaningful therapeutic relationships with our clients and effective relationships with our colleagues.

Communication

In our interactions with the international student body of the International Public Health course, we found that variations in students' proficiency of the English language, word choice and non-verbal communication practices sometimes prevented shared understanding. One of the more obvious challenges included our use of slang or idioms that others found difficult to understand. The phrase "that was a piece of cake" resulted in a puzzled look from a Danish student. After hearing an explanation of the idiom, he later attempted to use it in a context that was not quite appropriate. Incidents like this have encouraged us to consider more carefully how others may (mis)interpret questions and comments in clinical settings. We learned that an individual's level of fluency in a language can create the impression that he or she will be familiar with particular expressions or associations, though this is dependent on cultural context.

Cultural perceptions of education and health care

The cultural differences within such a diverse group of students were most apparent in the variety of beliefs and behaviours surrounding education and health. We reflected on how occupations related to education and health were perceived and practiced by people from different cultures. During in-class activities, we observed differences in how students from other countries approached the program (e.g., coming late to class, speaking tangentially instead of focusing on the topic or task at hand, or spending many hours reading over material) and initially made judgments about their level of interest and motivation, which we later recognized were based on inaccurate assumptions. We were also able to see how others interpreted our approach to group projects and began to recognize our Western focus on efficiency.

Our group work allowed everyone to share perspectives on how health care and education around the world are conceptualized. As Canadian students, we view education as a rite of passage and an essential component of our development. However, our

international classmates shared that, in many countries, education is believed to be a privilege to which not everyone has access. In some countries, access to health care was solely determined by economic status, while in others the quality of health care one could receive was dictated by ethnicity, gender or religion. Learning about the realities of education and health-care practice in other nations was an eye-opening experience that has guided us to reflect on our perceptions regarding the accessibility of education and health care in Canada. We may take access to these things for granted, and it is important to understand that our clients and co-workers may have different perspectives and experiences.

Occupational perspectives and Innovation Camp

Differences in attitudes surrounding education and health care also revealed the potential practice challenges of understanding what others perceive as meaningful occupations. Occupational therapists strive to ensure that occupational therapy goals have purpose and meaning for their clients. Understanding the meaningfulness of goals for individuals can be difficult, even when working with people of similar cultures, and it becomes even more challenging when cultural barriers exist (Lum et al., 2004).

The challenge of navigating diverse cultural practices, beliefs and customs was most apparent to our group during the "Innovation Camp" portion of the program. Innovation Camp required groups of four to five people from different countries to develop a product or service to assist individuals living with HIV/AIDS. It was difficult to put our own biases and judgements aside when some group members expressed opinions and beliefs regarding persons with HIV/AIDS that we did not agree with. For most Canadian students, it was difficult to understand the experiences of individuals who came from areas that have a high prevalence of HIV/AIDS and where discrimination against people living with these conditions is tolerated and overt. As groups tried to develop "perfect" solutions, it became clear how our cultural backgrounds, influenced by our ethnicities, nationalities, experiences and chosen professions, impacted our values and beliefs and thus could easily influence our practice. Once we engaged in dialogue with classmates, we were able to share our opinions openly and broaden our perspectives. This helped to deepen the quality and relevance of groups' proposed solutions to reducing the impact of HIV/AIDS in a variety of cultural contexts. Recalling this experience reminds us that it is important to develop a deep understanding of our clients within their specific cultural context, in order to optimize the quality of care and to ensure treatment is truly client-centred (Canadian Association of Occupational Therapists, 2002).

Advocating for occupational therapy on a global level

In addition to the cultural differences that we observed during group projects, it was also apparent that there were many interprofessional cultural differences. Our group contributions included an occupational focus, but many other group members did not have experience working with occupational therapists, and at first it was difficult for them to understand and appreciate our perspective. We continued to advocate for the importance of an occupational perspective, and at the same time showed our colleagues that we valued their opinions. Some of our groups began to embrace our perspective, while others continued to insist on basing their work on the medical model, despite our best advocacy efforts. Although this was very frustrating at the time, the experience of advocating for our profession was good practice for us as students about to begin our careers. Throughout our careers, we will need to navigate the politics of the health-care system and work with individuals from a variety of professional backgrounds, each with their own culture. Colleagues, clients and the general public may or may not understand the perspective we have as occupational therapists, but it is important to continue advocating despite the challenges we may face. We will embrace opportunities to engage in dialogue with others to increase their knowledge and understanding of occupational therapy in an effort to advance and enhance the profession and to open doors to collaboration.

Impact of international learning on practice

We believe that this intercultural learning opportunity afforded us the chance to not only learn about current issues in international public health but to also broaden our understanding and awareness of culture and its impact on practice. We have become more flexible in our thinking and less ethnocentric, and are thus better able to identify stereotypical patterns of thinking. These kinds of changes in thinking after an international experience have also been observed and supported in various research studies (e.g., Barker, Kinsella, & Bossers, 2010; McAllister et al., 2006). Having graduated, we continue to use this increased awareness and flexibility to ensure that our clients' unique and individual needs are being met, despite pressures from organizational expectations. We are better prepared to recognize when our clients' cultural needs are being overlooked and when a plan congruent with their values and beliefs is needed.

Among the essential competencies for an occupational therapist practicing in Ontario is the ability to communicate with both clients and colleagues in a way that is conducive to overcoming possible barriers (College of Occupational Therapists of Ontario, 2011). Our international experience has enriched our ability to work within diverse interdisciplinary and multicultural teams. Not only do we understand the roles of other professions, but we see how education and culture can also influence perspectives on practice. Knowledge gained from our experience will help us recognize and overcome barriers within our professional relationships and

Celebrating Canada Day abroad at a party hosted by the Canadian students. From left: Joanna Smorhay, Jamie Hurst and Katie Campbell.

collaborate more effectively.

Our learning in both Norway and Canada was not limited to the classroom setting, nor did it stop upon the completion of our degrees. We will always remember setting out to learn about international public health in a lecture hall in Oslo and, in addition, gaining insight into the cultures, values and beliefs of others. This kind of learning was possible because we seized the opportunity to take time to understand and get to know other aspiring health-care professionals. We challenge you to seek clarity with clients by asking questions that broaden your understanding of their backgrounds, to help situate yourself within their cultural perspectives and create mutual understandings of occupational importance (Craik, Davis, & Polatajko, 2013).

Acknowledgements

The authors wish to acknowledge support received through Western University's International Curriculum Fund and the Faculty of Health Sciences International Study Abroad Support Fund, as well as professors Trish Tucker and Ann Bossers for their role in developing this course initiative.

References

Barker, A., Kinsella, E. A., & Bossers, A. (2010). Learning in international practice placement education: A grounded theory study. *British Journal of Occupational Therapy, 73*(1), 29-37.

Law, M., Polatajko, H., Baptiste, S., & Townsend, E. (2002). Core concepts of occupational therapy. In Canadian Association of Occupational Therapists, *Enabling occupation: An occupational therapy perspective* (Rev. ed., pp. 29-56). Ottawa, ON: CAOT Publications ACE.

College of Occupational Therapists of Ontario. (2011). *Essential competencies of practice for occupational therapists in Canada* (3rd ed.). Retrieved from http://www.coto.org/pdf/essent_comp_04.pdf

Craik, J., Davis, J., & Polatajko, H. J. (2013). Introducing the Canadian Practice Process Framework (CPPF): Amplifying the context. In E. A. Townsend & H. J. Polatajko (Eds.), *Enabling occupation II: Advancing an occupational therapy vision for health, well-being & justice through occupation* (2nd ed., pp. 229-246). Ottawa, ON: CAOT Publications ACE.

Kinsella, E. (2001). Reflections on reflective practice. *Canadian Journal of Occupational Therapy, 68*(3), 195-198.

Lum, J. M., Williams, A. P., Rappolt, S., Landry, M. D., Deber, R., & Verrier, M. (2004). Meeting the challenge of diversity: Results from the 2003 survey of occupational therapists in Ontario. *Occupational Therapy Now, 6*(4). Retrieved from http://www.caot.ca/default.asp?pageid=1162

McAllister, L., Whiteford, G., Hill, B., Thomas, N., & Fitzgerald, M. (2006). Reflection in intercultural learning: Examining the international experience through a critical incident approach. *Reflective Practice, 7*(3), 367-381.

Paul, S. (1995). Culture and its influence on occupational therapy evaluation. *Canadian Journal of Occupational Therapy, 62*(3), 154-161.

Editor's note

Readers may also be interested in reviewing CAOT's *Joint Position Statement on Diversity,* released this year: http://www.caot.ca/default.asp?pageid=4294

CAOT's position statement on *Occupational Therapy and Cultural Safety* can be found at: http://www.caot.ca/default.asp?pageid=4035

About the authors

Lydia Bonanno, Katie Campbell, Jeff Haveman, Joanna Smorhay and **Danaka White** are graduates of the Master of Science in Occupational Therapy program at Western University, class of 2012. They can be reached by contacting Katie Campbell at: kcampbellsmith@gmail.com

ENHANCING PRACTICE: RURAL PRACTICE

COLUMN EDITOR: ALISON SISSON

"All those things you never thought": Perspectives from occupational therapists practicing in rural British Columbia

Robin Roots, Les Smith, Helen Brown, Lesley Bainbridge and Linda Li

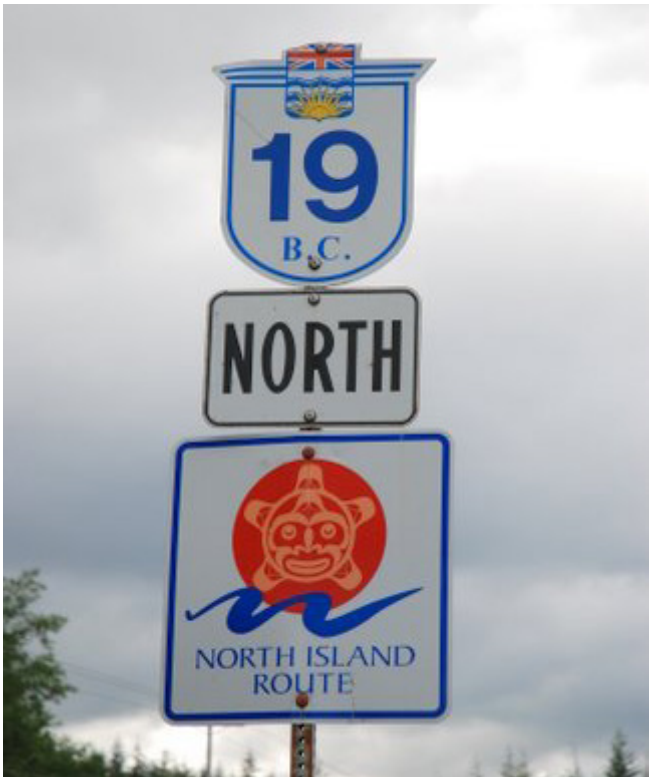
Working in rural and remote settings in Canada presents both rewards and challenges for occupational therapists (Wielandt & Taylor, 2010). In British Columbia (BC), roughly two-thirds of the land area is considered to be rural and is home to 14% of the provincial population (Statistics Canada, 2011). Yet the most recent data from the Canadian Institute for Health Information (CIHI) indicate that less than 4% of occupational therapists in BC work in rural communities (CIHI, 2011). This translates into approximately one occupational therapist per 10,000 people living in rural areas, or one fifth of the provincial and national workforce average of 4.9 occupational therapists per 10,000 people living in urban areas (CIHI, 2011). This shortage is compounded by a relatively high number of vacancies and attrition rate (Smith, 2008), requiring employers to better understand the factors that attract occupational therapists to rural practice and retain them (Roots & Li, 2013). Rural health care practice is typically characterized by diverse and large caseloads of complex cases with limited referral options and resources, and poor access to continuing professional development opportunities (Bourke et al., 2004; Sheppard, 2005). Yet, little is known about the practice of occupational therapists working in rural BC and what supports would assist in recruitment and retention.

Much of the research on occupational therapy practice in rural areas has been done in Australia (Boshoff & Hartshorne, 2008; Devine, 2006; Mills & Millsteed, 2002); however in 2010, Wielandt and Taylor surveyed occupational therapists working in rural Alberta and Saskatchewan to identify the rewards and challenges of their practice. In addition to finding that participants cited rewards more often than challenges, they noted that a significant number of occupational therapists working in rural areas did not consider their practice to be "rural" because they were able to access resources and professional development online (Wielandt & Taylor, 2010).

Given the challenge of recruitment and retention of occupational therapists and physiotherapists in rural regions, we conducted a study to better understand the practice of these professionals working in northern and rural BC, and the supports needed to meet the challenges of rural practice. Using a qualitative research design, we conducted interviews with a sample of six occupational therapists and 13 physiotherapists living and working in rural communities in northern BC (Roots, Brown, Bainbridge, & Li, 2014). As there is no standard definition of rural in Canada, we defined a rural community as having a population of less than 15,000 people. In this article, we share some of the perceptions of occupational therapist study participants on rural practice in northern rural BC. Our findings offer some insight into rural practice and how employers, educators and professional organizations can support occupational therapists in rural practice across Canada.

Rural practice is shaped by a bigger definition of health

Geography has been considered a determinant of health in Canada (Romanow, 2002). Compared to residents in urban areas, rural residents have higher rates of chronic diseases, including arthritis, of being overweight and obese, and of traumatic injuries (CIHI, 2006). While the causes of this disparity are complex, participants in our research described how "rural" was more than just the environment that clients lived in;



it had a pronounced influence on the person and occupation as well. They described their practice as being shaped by the rural context as if it was a backdrop to the whole person-occupation-environment model (PEO; Law et al., 1996), as illustrated in this quote from an occupational therapist participant:

> *I think it [rural practice] is about learning about a place, learning about the history and each person's story. That's a huge thing about rural. It opens your practice up to a bigger definition of health and about social determinants and about wellness. I think it is about community structures like, 'is there a pool we can go to?' It is also about what, how, can people access things to be well and healthy? [P]*

The community in rural practice

Participants described their role as frequently becoming involved in community development and participating in community activities that promote health and wellness. This allowed participants to contribute their occupational therapy skills and knowledge and build relationships in ways that went beyond the individual client and had a larger impact on the health of a community.

> *You are a part of community and its about supporting a community towards health and social determinants and supporting people to garden and do all those things... that's going a lot of ways towards managing their chronic disease. [P]*

Consistent with the person-occupation-environment model (Law et al., 1996), this community involvement contributed to occupational therapists knowing clients in different contexts, which frequently assisted them in their practice, but also presented the challenge of never escaping the role of being an occupational therapist when working in a rural community.

Reaching out to the occupational therapy community to support practice

Networking has been noted in the literature as an important activity and skill for occupational therapists in rural practice as a means to mitigate the isolation often associated with working in rural areas (Devine, 2006; Lee & MacKenzie, 2003). While technology facilitates connections and increases access to resources for rural occupational therapists (Wielandt & Taylor, 2010), many of the occupational therapists we interviewed placed significant value on face-to-face networking and hands-on learning to reduce their isolation.

> *I was just recently on education in [big city] and just being able to connect there with OTs. I just kind of forgot, it's like, 'oh yeah, there's all these other OTs out there!' And it was so great just to talk. [C]*

As such, professional networks and associations have an important role in bridging the geographical distance and supporting rural practitioners. The occupational therapists in our research indicated that their professional association could do more to support members working in rural areas.

> *To tell you honestly, our provincial society, they are more focused on helping OTs working in urban areas than OTs working in rural areas. [B]*

The recent development of the Canadian Association of Occupational Therapists Rural and Remote Practice Network (http://www.caot.ca/default.asp?pageid=4135) is an initiative that offers a forum for occupational therapists in rural practice to share ideas and network with others working in rural communities. For the network to be responsive to the needs of rural therapists, an active membership is necessary, making needs known.

Practice implications

The findings from this research offer a glimpse into some of the features of the practice of occupational therapists in rural BC. The therapists that participated in this study described how their practice was influenced by the rural context, aligning with the PEO model. They reaffirmed the need for occupational therapists entering rural practice to not only have a broad range of knowledge and depth of skill but also to be prepared for the breadth and variety of roles that an occupational therapist holds in a rural community (Boshoff & Hartshorne, 2008; Millsteed, 2001). Being resourceful in seeking out research applicable to the rural context and the support of colleagues was the most frequently cited attribute of occupational therapy practice in a rural community. In preparation for rural practice, training programs should consider offering students the opportunity to learn about population health and ways that they can assist and advocate for better social determinants of health for their clients. To assist with recruitment and retention, employers and professional associations would do well to offer support for professional networks and accessible continuing professional development both online and in person, recognizing the importance of face-to-face contact when many practitioners are isolated (Boshoff & Hartshorne, 2008).

Acknowledgements

This research was conducted as part of the requirements for a Masters of Science in Rehabilitation Sciences: Roots, R. K. (2011). *Understanding rural rehabilitation practice: perspectives of Occupational Therapists and Physical Therapists in British Columbia* (Master of Science (Rehabilitation Sciences), University of British Columbia, Vancouver, BC. Retrieved from

About the authors

Robin Roots, MSc, PT, is an instructor in the Department of Physical Therapy at the University of British Columbia (UBC), and is located at the University of Northern British Columbia in Prince George, BC. She can be contacted at: robin.roots@ubc.ca **Les Smith, MSc, OT,** is the director of programming at the Child Development Centre of Prince George & District. **Helen Brown, PhD, RN,** is an assistant professor in the School of Nursing at UBC. **Lesley Bainbridge, PhD, PT,** is the director, interprofessional education, in the Faculty of Medicine and associate principal of the College of Health Disciplines at UBC. **Linda Li, PhD, PT,** is an associate professor in the Department of Physical Therapy at UBC, and researcher at the Milan Ilich Arthritis Research Centre, Vancouver.

http://circle.ubc.ca/bitstream/handle/2429/33022/ubc_2011_spring_roots_robin.pdf?sequence=1

Broader results of the study discussed in this article were first published in the journal, *Rural and Remote Health* (http://www.rrh.org.au): Roots, R. K., Brown, H., Bainbridge, L., & Li, L. C. (2014). Rural rehabilitation practice: perspectives from occupational therapists and physiotherapists in BC. *Rural and Remote Health*, 14: 2506. Retrieved from: http://www.rrh.org.au/articles/subviewnew.asp?ArticleID=2506

Robin wishes to thank Drs. Li, Bainbridge and Brown for their guidance on her thesis committee; the Canadian Arthritis Network, Arthritis Health Professions Association and the Physiotherapy Foundation of Canada for financial support to conduct this research; Les Smith for his guidance interpreting the implications for occupational therapy; and, last but not least, the occupational therapists and physiotherapists who participated in this research study.

References

Boshoff, K., & Hartshorne, S. (2008). Profile of occupational therapy practice in rural and remote South Australia. *Australian Journal of Rural Health, 16*, 255-261. doi: 10.1111/j.1440-1584.2008.00988.x

Bourke, L., Sheridan, C., Russell, U., Jones, G., DeWitt, D., & Liaw, S. T. (2004). Developing a conceptual understanding of rural health practice. *Australian Journal of Rural Health, 12*, 181-186.

Canadian Institute for Health Information. (2006). How healthy are rural Canadians? An assessment of their health status and health determinants. *Canada's Rural Communities: Understanding Rural Health and Its Determinants.* Retrieved from https://secure.cihi.ca/estore/productSeries.htm?locale=en&pc=PCC336

Canadian Institute for Health Information. (2011). *Occupational Therapists in Canada, 2010: National and Jurisdictional Highlights and Profiles*. Retrieved from http://www.cihi.ca/CIHI-ext-portal/pdf/internet/OT2010_HIGHLIGHTS_PROFILES_EN

Devine, S. (2006). Perceptions of occupational therapists practising in rural Australia: a graduate perspective. *Australian Occupational Therapy Journal, 53*, 205-210. doi: 10.1111/j.1440-1630.2006.00561.x

Law, M., Cooper, B., Strong, S., Stewart, D., Rigby, P., & Letts, L. (1996). The Person-Environment-Occupation Model: A transactive approach to occupational performance. *Canadian Journal of Occupational Therapy, 63*, 9-23.

Lee, S., & MacKenzie, L. (2003). Starting out in rural New South Wales: the experiences of new graduate occupational therapists. *Australian Journal of Rural Health, 11*, 36-43.

Mills, A., & Millsteed, J. (2002). Retention: an unresolved workforce issue affecting rural occupational therapy services. *Australian Occupational Therapy Journal, 49*, 170-181.

Millsteed, J. (2001). Factors affecting the retention of occupational therapists in rural services. *Occupational Therapy in Health Care, 14*(3/4), 55-72.

Romanow, R. J. (2002). *Building on Values: The Future of Health Care in Canada.* Retrieved from http://publications.gc.ca/site/eng/237271/publication.html

Roots, R. K., & Li, L. C. (2013). Recruitment and retention of occupational theapists and physiotherapists in rural regions: a metasynthesis. *BMC Health Services Research,* 13:59. Retrieved from http://www.biomedcentral.com/content/pdf/1472-6963-13-59.pdf

Roots, R. K., Brown, H., Bainbridge, L., & Li, L. C. (2014). Rural rehabilitation practice: perspectives from occupational therapists and physiotherapists in BC. *Rural and Remote Health, 14*: 2506. Retrieved from: http://www.rrh.org.au/articles/subviewnew.asp?ArticleID=2506

Sheppard, L. (2005). What the people want - Delivery of health services in rural and remote Australia. *Internet Journal of Allied Health Sciences & Practice, 3*(4). Retrieved from: http://ijahsp.nova.edu/articles/vol3num4/sheppard.htm.

Smith, L. (2008). *Northern Health Rehabilitation Strategy 2008-2012*. Prince George, BC: Northern Health Authority.

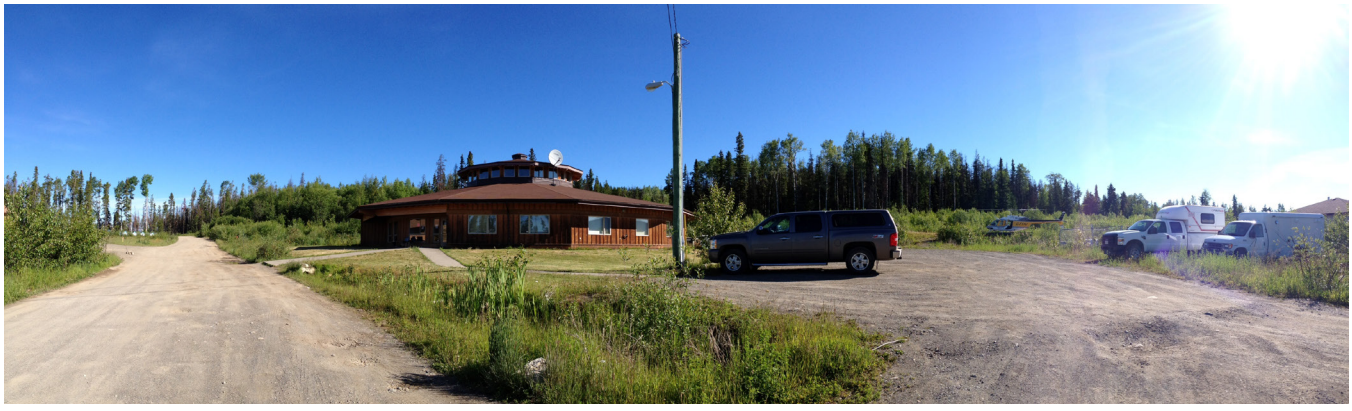
Statistics Canada. (2011). *Population, urban and rural, by province and territory.* Retrieved Sept 21, 2013, from http://www40.statcan.gc.ca/l01/cst01/demo62a-eng.htm

Wielandt, P. M., & Taylor, E. (2010). Understanding rural practice: Implications for occupational therapy education in Canada. *Rural and Remote Health, 10:* 1488. Retrieved from http://www.rrh.org.au/publishedarticles/article_print_1488.pdf

Editor's notes:

CAOT-BC offers Special Interest Groups and Practice Networks to CAOT members in BC. Members who are able to join a teleconference line are invited to join the networks, which include driver rehab, dysphagia, leadership, mental health, paediatrics, private practice and seating/assistive technology. Get more information on the CAOT-BC website: http://www.caot.ca/default.asp?pageid=4129

As Ms. Roots and colleagues point out in their article, rural and remote occupational therapy practice and the community in which practice is situated are closely intertwined and influence each other. Do you have a unique story about how a community has influenced your practice? How do you participate in your community as a rural or remote occupational therapist? The Rural Practice column would love to hear from you!



Takla Lake Health Centre, Takla, BC. Photo by Emile Whittemore.

Musicians' health: A developing role for occupational therapists

Christine Guptill

In 1991, I entered university as a music student. I love music; it completes my life, formed a large part of my identity at that time, and was how I was known to many of my friends. I knew that pursuing music at university would mean a lot of practicing and a lot of performing. Until this point, I had never had any trouble with playing my instrument (the oboe), though unbeknownst to me, some of my colleagues likely already had. In a 2009 study of students entering first-year university, Brandfonbrenner found that 79% had a history of playing-related pain, while 37% reported a history of performance anxiety (Brandfonbrenner, 2009).

In my first two years of university, I was sick with bronchitis both at Christmas and at the end of term. I chalked this up to a natural tendency to develop lung infections and the proximity with other people living in residence. I later learned that the anxiety I experienced around exams and performances was more than what some of my colleagues experienced, and that my body's stress response can involve a viral infection. Little did I know that many music students experience performance anxiety, as well as generalized anxiety and depression (Hildebrandt, Nübling, & Candia, 2012; Spahn, Strukely, & Lehmann, 2004).

As I began to prepare for my first recital, which was to be graded and worth 100% of a full-year credit, I began to experience numbness and tingling in my right hand. I attended a workshop at the school where I learned about some of the physical health concerns facing music students. Although I felt out of place, I attended the campus sports medicine clinic. After a few weeks of wearing an off-the-shelf splint that seemed only to make things worse, I was referred to an occupational therapist who watched me play and made some suggestions about my posture, positioning and practice routine. Working with this occupational therapist helped me to reduce my physical symptoms and convinced me that occupational therapy was the career for me.

Finding answers to the problem of musicians' and performers' injuries excites and eludes me. In this article, I will share with you the challenges in enabling occupation for musicians and outline the potential role of our profession.

The musicians' environment

Many musicians in Canada are self-employed (Hill Strategies Research, 2009). This means they may have no pension plan, no extended health or workers' compensation benefits, and no disability insurance, unless they have purchased these pricey products (and many have not). At the last mandatory census, musicians reported average income well below the poverty line (this does not include musicians who have 'day jobs,' such as being a music teacher). In addition, female artists earn much less than men, and earnings for visible minorities in the arts are particularly low (Hill Strategies Research, 2009). Musicians tend to be highly educated; an American study found that across all genres, musicians had an average of 3.5 years of post-secondary education, and the rate was highest in classical musicians with 4.2 years (Chesky & Devroop, 2003). Moreover, getting a university degree does not ensure a higher income in the fine arts in Canada (Tal & Enenajor, 2013).

In addition to these discrepancies in social determinants of health, musicians experience a very high prevalence of both physical and mental health concerns related to their playing. Work that is considered risky in the occupational health and safety world, such as assembly line workers and grocery store checkout clerks, have physical injury prevalence rates of between 41 and 56% (Zaza, 1998). Recent studies of professional orchestral musicians in Australia, however, indicate injury rates of 84% (Kenny & Ackermann, 2013). In terms of physical injuries, women musicians seem to have more injuries than men (Zaza & Farewell, 1997), and violinists, violists and pianists have more injuries than other instrumentalists (Dawson, 2002). Singers also have difficulties; viruses that might give an average person the sniffles can prevent singers from performing altogether. Gastroesophageal reflux is a common, silent culprit in singers, while misuse or overuse of the voice can cause issues such as vocal fold nodules (F. Reimer, Reg. CASLPO, personal communication, March 2014). Hearing loss is also very prevalent among musicians, since many instruments and performance situations have peak volumes well above the recommended maximum daily sound exposure of 85 decibels for eight hours (National Institute for Occupational Safety and Health, 1998; Dr. Marshall Chasin, personal communication, March 2014).

How can musicians have double the prevalence of health problems when compared to some other relatively risky occupations? There seem to be many possible factors, including repetitive motion and awkward postures; instruments that were designed in the middle ages for the 50th percentile male; highly precise work demands, where 80% accuracy would never sell tickets; questionable or unsafe working conditions,

including unacceptable sound level exposures, abusive conductors, and open orchestra pits with no nets to catch falling debris, or falling actors; an oral educational tradition that includes no information about anatomy, physiology, biomechanics, psychology, sociology or (until recently) business practices; a culture of silence about health concerns, and which encourages unhealthy behaviours such as binge drinking and frequent travel; and a society that compensates professional hockey players significantly more than performing artists. Not to mention the fact that health-care practitioners learn little to nothing during their training about the culture and needs of performing artists, and have a tendency to advise "just stop playing and do something else" (Brandfonbrener, 2003).

Enabling occupation for musicians

So with all of these challenges, what role does occupational therapy play in the lives of musicians? The Taxonomic Code of Occupational Performance tells us that everything from finger flexion through to performing in a symphony orchestra are within the domain of concern of occupational therapists (Polatajko et al., 2013, p.19, Figure 1.1). *Enabling Occupation II* cites the World Health Organization's definition of health as "a resource for everyday life, not the objective of living." (WHO, 1986, p.1, as cited in Polatajko et al., 2013, p. 24). This is significant because the prevalence of health problems among musicians is so high. If nearly all musicians will encounter health challenges – not unlike athletes and dancers, who are always at risk of injury – then the number of musicians in perfect health at any given time would be quite small. It is important, therefore, for occupational therapists to consider healthy living and health promotion in their work with musicians.

Polatajko et al. (2013) describe how the absence of occupation "leads to a general deterioration of the human spirit" (p.15; adapted from Howland, 1933, p. 4). As noted above, health practitioners unfamiliar with the meaning of music to many musicians and its role as central to their identity are baffled by the tenacity of their commitment to this occupation. If you aren't making much money, you find it stressful to perform, and it hurts when you play, why do it? Occupational therapy leaders in our history have given voice to how important it is for clients to "live, not merely exist (Cardwell, 1966), [to be] engaged in activities that are meaningful to them (Shimeld, 1971) [and] in their own environments (McKay, 1974)" (Polatajko et al., 2013, p.16). These excerpts illustrate our core belief, that occupation is essential to health, well-being and happiness, and provides musicians with a reason to carry on.

My own work has demonstrated a wide range of meanings that musicians ascribe to their engagement in musical occupations (Guptill, 2011). For some musicians, music is central to their identity, as necessary as breathing, and they would do anything to continue to be engaged in music, no matter what the level, in whatever capacity they could. For others, if they had to compromise their performance and settle for a community orchestra level instead of the Toronto Symphony, they would not be interested anymore. For these musicians, the motivation to engage in musical occupations might be more related to accuracy, achievement and accolades, rather than simple love of music. As occupational therapists, we know that neither meaning is wrong; it is simply a demonstration of the variety and importance of context in the determination of occupational meaning (Yerxa, 1998, as cited in Polatajko et al., 2013, p. 21).

The Canadian Model of Occupational Performance and Engagement (Polatajko, Townsend, & Craik, 2007) tells us about the importance of the environment in which an occupation takes place, and encourages us to consider specific factors (e.g., the physical environment, including stage lighting and chairs; the social environment, considering whether relations are collegial or toxic and competitive; the institutional environment, including unionization and access to health and workers' compensation benefits; and the cultural environment, considering whether the musicians' work is valued in the society in which they live). Music also occupies an intriguingly dynamic position among the domains of self-care, productivity and leisure. While professional musicians might classify music as productivity, it often has overlap with leisure. In addition, many people use music as a means of self-expression and stress management that can be classified as self-care.

Finally, it is important to emphasize that while engaging in a musical occupation may contribute to health and well-being, it can also have a negative impact on health. Many conditions are exacerbated by engagement in music, such as tendonitis, performance anxiety or addiction to a performance high. We need to consider how we enable occupation in these individuals; our role may be influenced by our theoretical foundations in client-centred practice and occupational justice (Guptill, 2012).

Our role in enabling musicians' engagement in musical occupations could be highly diverse (see Table 1). For inspiration, I turn to the Canadian Model of Client-centred Enablement (Townsend, Polatakjo, Craik, & Davis, 2007). In particular, I gravitate towards the words advocate, collaborate, educate and engage. To me, these are important roles in addressing musicians' health that are largely ignored in the emerging discipline of performing arts health care. It should not surprise you, then, that I provide workshops to National

About the author

Christine Guptill, BMus, BSc, MS(OT), PhD, OT Reg. (Ont.), 2013-14 CAOT Research Fellow, holds bachelor's degrees in both music performance and biology, a master of science in occupational therapy from Western Michigan University, and a PhD in Rehabilitation Sciences. She completed a post-doctoral fellowship at McMaster University in the School of Rehabilitation Science. She is a founding member of the musicians' health advisory team at National Youth Orchestra Canada, where she acts as the primary care occupational therapist. Currently, she is employed part-time at VHA Home HealthCare where she delivers occupational therapy services in the community in London, ON. She can be reached by email at: christine_guptill@alumni.uwo.ca

Youth Orchestra Canada and university music and music education students. You can see why I spend my spare time serving in multiple roles with the Performing Arts Medicine Association. You will understand why I am blogging about my first five kilometre race and the meditation series I am undertaking with my daughter: to inspire musicians and those who teach and care about them, and to take action in support of their own well-being.

I encourage occupational therapists to take this "road less travelled," as they have much to offer musicians. I find it extremely rewarding to enable musicians to bring joy and meaning to my life. They inspire me in my occupational therapy work, and in my musical occupations too.

Table 1
Role of occupational therapy in enabling occupation for musicians

Analysis of the occupation, including physical, mental and emotional demands
Ergonomic modification – e.g., posture, seating, adaptive equipment
Work rehabilitation – e.g., return-to-work planning, coordination and support
Upper extremity rehabilitation
Mental health care and rehabilitation, including psychotherapy
Chronic pain intervention
Primary care - being the first point of contact in the health system, and referring to other practitioners when needed
Complementary and alternative approaches – e.g., acupuncture, myofascial release
Education on injury prevention and health promotion
Support to access appropriate benefits/social services
Advocacy for better, more affordable care and working conditions for musicians
Public policy development to support musicians' health
Research, e.g., analyzing census data on musicians, interviewing musicians about their health experiences
Capacity building in occupational therapy by mentoring and training students in this field of practice through fieldwork placements and academic curricula

Suggested resources

Performing Arts Medicine Association (PAMA): www.artsmed.org PAMA's next Canadian regional meeting will be in Toronto; March 8-9, 2015. PAMA's annual symposium will be in Snowmass/Aspen, CO, July 8-12, 2015.

Musicians' Clinics of Canada, located in Hamilton and Toronto: http://www.musiciansclinics.com/home.asp

Medical Problems of Performing Artists journal, indexed in Medline: http://www.sciandmed.com/mppa/

Sataloff, R. T., Brandfonbrener, A. G., & Lederman, R. J. (Eds.). (2010). *Performing Arts Medicine* (3rd ed.). Narberth, PA: Science & Medicine Inc.

Heman-Ackah, Y. D., Sataloff, R. T., & Hawkshaw, M. J. (2013). *The Voice: A Medical Guild for Achieving and Maintaining a Healthy Voice.* Narberth, PA: Science & Medicine Inc.

My blog: http://performingwell.tumblr.com/

References

Brandfonbrenner, A. (2009). History of playing-related pain in 330 university freshman music students. *Medical Problems of Performing Artists, 24*, 30-36.

Brandfonbrener, A. (2003). Musculoskeletal problems of instrumental musicians. *Hand Clinics, 19*, 231-239.

Chesky, K. & Devroop, K. (2003). The effects of college music instruction, gender, and musician type on income from performing music. *Medical Problems of Performing Artists, 18*, 72-77.

Dawson, W. (2002). Upper-extremity problems caused by playing specific instruments. *Medical Problems of Performing Artists, 17*, 135-140.

Guptill, C. (2012). Injured professional musicians and the complex relationship between occupation and health. *Journal of Occupational Science, 19*, 258-270.

Guptill, C. (2011). The lived experience of professional musicians with playing-related injuries. *Medical Problems of Performing Artists, 26*, 84-95.

Hildebrandt, H., Nübling, M., & Candia, V. (2012). Increment of fatigue, depression, and stage fright during the first year of high-level education in music students. *Medical Problems of Performing Artists, 27,* 43-48.

Hill Strategies Research Inc. (2009). *A statistical profile of artists in Canada based on the 2006 census.* Retrieved Sept.15, 2014, from http://www.hillstrategies.com/content/statistical-profile-artists-canada

Kenny, D., & Ackermann, B. (2013). Performance-related musculoskeletal pain, depression and music performance anxiety in professional orchestral musicians: A population study. *Psychology of Music*. Advance online publication. doi: 10.1177/0305735613493953

National Institute for Occupational Safety and Health. (1998). *Criteria for a recommended standard: Occupational noise exposure, revised criteria 1998.* Retrieved from http://www.cdc.gov/niosh/docs/98-126/pdfs/98-126.pdf

Polatajko, H. J., Davis, J., Stewart, D., Cantin, N., Amoroso, B., Purdie, L., & Zimmerman, D. (2013). Specifying the domain of concern: Occupation as core. In E. A. Townsend & H. J. Polatajko, *Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-being, & Justice through Occupation* (pp. 13-36). Ottawa, ON: CAOT Publications ACE.

Polatajko, H. J., Townsend, E. A., & Craik, J. (2007). Canadian Model of Occcupational Perfornace and Engagement (CMOP-E). In E. A. Townsend & H. J. Polatajko, *Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-being, & Justice through Occupation* (p. 23). Ottawa, ON: CAOT Publications ACE.

Spahn, C., Strukely, S., & Lehmann, A. (2004). Health conditions, attitudes toward study, and attitudes toward health at the beginning of university study: Music students in comparison with other student populations. *Medical Problems of Performing Artists, 19*, 26-33.

Tal, B., & Enenajor, E. (2013, August 26). Degrees of success: The payoff to higher education in Canada. *In Focus*. Retrieved from http://research.cibcwm.com/economic_public/download/if_2013-0826.pdf

Townsend, E. A., Polatajko, H. J., Craik, J., & Davis, J. (2007). Canadian Model of Client-Centred Enablement. In E. A. Townsend & H. J. Polatajko, *Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-being, & Justice through Occupation* (p. 110). Ottawa, ON: CAOT Publications ACE.

Zaza, C. (1998). Playing-related musculoskeletal disorders in musicians: A systematic review of incidence and prevalence. *Canadian Medical Association Journal, 158*, 1019-1025.

Zaza, C. & Farewell, V. T. (1997). Musicians' playing-related musculoskeletal disorders: An examination of risk factors. *American Journal of Industrial Medicine, 32*, 292-300.

Update from the Canadian Occupational Therapy Foundation

New awards for 2015 COTF McMaster Legacy Fund

This first award from the McMaster Legacy Fund honours two occupational therapy faculty members from McMaster University who retired in 2008: Penny Salvatori and Mary Edwards. Penny and Mary have always been passionate about clinical education – Penny as the chair of the Mohawk and McMaster occupational therapy programs from 1985 to 1998, and Mary as the professional practice coordinator for more than five years. This award is intended for occupational therapy clinicians, to provide some seed or pilot funding to enable them to gain knowledge, build evidence and enhance their roles as clinical educators, tutors, and/or preceptors of occupational therapy students. Collaborations between practitioners and academic researchers are also encouraged.

The scope of this award can include projects such as:

- Literature reviews about clinical education
- Inquiry into innovative models of fieldwork education
- Evaluation of interprofessional learning and placement experiences
- Integration of evidence-based inquiry into practice
- Qualitative exploration into lived experiences of clinical educators in many roles

This first award amount is $1,500 for one year. Details about applying are available on the COTF website: www.cotfcanada.org

OEQ / COTF Clinical Research Grant ($5,000)

COTF is partnering with the Ordre des ergotherapeutes du Québec (OEQ) on this award in the 2015 Research Grant Competition. A clinician and researcher from the OEQ membership will partner with a clinician and researcher from the CAOT membership. COTF and OEQ will each contribute $2,500 to the award. Applicants can apply in English or French.
English link: https://app.smarterselect.com/programs/16013-Canadian-Occupational-Therapy-Foundation

The importance of research: a student's perspective

Research in occupational therapy is important because it allows me to better understand the direction of occupational therapy in my country. From a nearer perspective, while completing research as part of my studies in occupational therapy, I found research conducted in Canada allowed me to really understand the role of the occupational therapist because it is easier for me to situate myself within the Canadian health-care system. I am proud when I find Canadian research because very often the subject gets me reflecting on the practice context insofar as what is described. In addition, I believe that practices that are innovative or proven effective by Canadian research help clinicians to better serve the public and justify their role with managers and clients.

Sara-Gabrièle M. Savard
Université Laval

Canadian Occupational Therapy Foundation

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

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

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

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

Make a donation now! www.cotfcanada.org

COTF is the only organization that provides funding solely to occupational therapists who are CAOT members!