



Auckland District Health Board – Occupational Therapy

# **Feedback to the Profession - NZAOT Conference 2010**

**Prepared by ADHB Conference Delegates  
Nelson 7 – 10 September , New Zealand**

**October 2010**



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## Introduction

ADHB occupational therapy scholarship recipients express their appreciation for the opportunity to attend this inspiring conference in Nelson. This was the biennial conference of the New Zealand Association of Occupational Therapists, held at the Rutherford Hotel in Nelson over 7<sup>th</sup> – 10<sup>th</sup> September 2011.

*'Shifting sands – Creating our Place'  
'Ngā ia o te wā – Te kimi tūrangawaewae mō  
tātou'*

Through this newsletter, we would like to share some of our reflections and key conference messages with all our wonderful ADHB colleagues. It was a fabulous conference – highly recommend future attendance.

### **Contributors to this feedback include:**

- Anneke Williams
- Bronwyn Nesdale
- Carolyn Simmons Carlsson
- Cheryl Em
- Maria Whitcombe-Shingler
- Tanya Warren
- Wendy Wright

**Overall message of the conference:**  
***“Occupational therapists need to stand up and take responsibility for the future of the profession”***

- Dael Williams reporting in the September NZAOT online news.

In **Section 1.** of the newsletter, we list a range of presentations, the key messages and some of our reflections.

**Section 2.** then provides you with more information.

Note that some presentations only have a short comment and may not have any further detail.

*This is an amalgamation of contributors' thoughts. It does not necessarily reflect the viewpoint of the ADHB, the conference delegates, NZAOT, nor the conference presenters.*

Enjoy reading!

**Anneke, Cheryl & Tanya**



## SECTION 1: KEY MESSAGES

*“ Knowing is not enough; we must apply. Willing is not enough; we must do. Johann von Goethe ”*

### 1.1 Keynote Speakers

#### **Grace O’Sullivan**

***Frances Rutherford Lecture Award Recipient: Time: Occupational Therapy: Setting the Pace***

Have the courage and conviction to challenge the status quo, and BELIEVE (truly believe) in the value of occupation!

Occupational deprivation adversely affects health and well being - The right to engage in occupation is a matter of occupational justice. Life under any circumstances never ceases to have meaning.

#### **Professor Wendy Wood**

***Navigating Shifting Sands: Lessons from wise way finders***

An Inukshuk is a stone person on byways and mountain passes that says “I have been this



way before you and this is a good way”.  
Features of past wise way finders (Inukshuks)  
in occupational therapy:

- Lean into and persevere with disorientating dilemmas.
- Learn from those who illuminate the need for occupation.
- Feed intellectual curiosity, commitment to mentoring, clients best teachers, knowledgeable, scholarly, engaged, visionary, empowering mentors.
- Find your empowering community.
- Build robust communities of practice through compelling occupational visions (Whiteford, Wilding).

### Associate Professor Matthew Molineux

#### *Standing firm on shifting sands*

“Occupation is the means to the end”.

Paradigm independent practice is a problem; occupational therapists don't have a collective viewpoint we can fall back on.

Occupation for health is a powerful idea, and there will be a future drive for occupational therapy as a result.

***Collectively and individually we lack ontological security!***

## 1.2 Culture

### Jane Hopkirk

#### *Whitiwhitia I Te Ora! A call to wellness!*

We need to acknowledge, value and use indigenous knowledge to support wellness; cultural enhancement is critical to enabling best possible outcomes for Maori.

***Importance of whanaungatanga*** - honour Maori ways by finding connections with each other.

It is important to work with families - *Whanau* and *Whanau Ora* - Maori see relationships above occupation.

### Dr Shoba Nayar & Dr Clare Hocking

#### *Navigating cultural space: Learning from the occupational experiences of Indian migrant women*

It is important not to make generalisations about the length of time a migrant has been in NZ, and the 'ways' they may choose to be 'working'. She suggested that occupational therapists think about why our clients engage in the occupations as they do (links into cultural/occupational meaning and safety).

### Mayanne Wiki-Singh and Nellie Neligan

#### *Kaupapa Maori practice*

Emphasis on *Wairua* – *Wai* = water, spiritual  
*Rua* = two. Acknowledged to be the most essential requirement for health. It is believed that without a spiritual awareness an individual can be considered to be lacking in wellbeing and more prone to ill health. *Wairua* may also explore relationships with the environment, between people, or with heritage.

### Cultural Safety Panel Discussion

#### *Firm foundations to fluency*

- Making connections – the concept of cultural fluency – shared stories from representatives from education, WFOT, Maori practitioners - moving towards cultural fluency. Maori perspectives: relationship, spirituality, environment. Need to find ways to support upcoming Maori leaders in occupational therapy.

## 1.3 Students & New Graduates

### Luciana Blaga and Dr Linda Robertson

#### *The acute care environment – A student perspective*

- Clinicians need to go beyond equipment provision, be a positive role model (demonstrating enjoyment of work, workplace and team) and allow time for



debriefing. *'Good placements need preparation'*.

- Nothing can prepare the student (overwhelming environment in different contexts) – takes 2 weeks to adjust to the setting.

### Susanne Keller & Dr Linda Wilson

#### *The Influence of occupational therapy student fieldwork placements on recruitment*

*Three major influences on subsequent recruitment were:*

- The spirit of the teams
- Respect and valuing occupational therapy
- Quality of the supervisor and supervision

### Panel Discussion

#### *Supporting new graduates*

- Learning how to be an occupational therapist is as important as receiving formal supervision, and suggests that learning how to contextualise knowledge (e.g. through role modelling) and reconstruct knowledge (e.g. through well constructed supervision) is essential to bridge the theory – practice divide.

## 1.4 Occupation

### Professor Wendy Wood:

#### *Pre-conference Workshop - Finding the theories that (always!) drive practice*

- 'How am I pulling together the different ideas and values in my practice?'
- Know our worldview – occupation focussed lens – our clinical gaze = our paradigmatic view: focal viewpoint; core constructs; values.

### Dr Kirk Reed

#### *Where has the meaning of occupation gone?*

Meaning shapes people's perspectives of their occupational lives.

Current and most prevalent approach to occupation divides it into general categories of self-care, productivity and leisure – this has little relevance to working with communities and/or collectivist cultures due to different perspectives of occupation.

Bring meaning to the fore through practice, research and theory development.

### Dr Linda Wilson & James Sunderland

#### *A framework for understanding occupations?*

A proposed framework of occupations which categorises and describes the unique characteristics of diverse occupation (assist individuals with the understanding of the motivating or therapeutic benefits of engagement in particular occupations).

This framework may be more useful than self-care, productivity and leisure mainly because they're more in depth, and could lead to a truer representation of the importance of specific occupations to an individual.

### Alison Nelson

#### *Stories of survival through occupational eyes*

"When losses are overwhelming, when we are existing at our most basic level, our quintessential occupational nature can be observed" – occupation is embedded in all our lives, (however they are lived) and the impact of its presence cannot be denied.

### Julie Netto & Professor Errol Cocks

#### *Occupational justice and the stigmatisation of people with mental illness*

Humans are occupational beings who are dependent on occupation for participation. Almost all participants said vocation was "a calling", and something that gives your life meaning when they were asked what it meant to them.



## Dr. Clare Hocking

### *Occupational Justice Workshop*

Occupational justice is founded on beliefs that recognize humans as occupational beings who participate in occupations as autonomous agents. Our viewpoint as occupational therapists should be that occupational participation is interdependent and contextual; a determinant of health and quality of life.

## Fiona Mains and Dr Linda Wilson

### *Workshop - Changes in community practice*

Look beyond the traditional, look wider at the community/society, think about health promotion and create opportunities. Get involved!

## Steve Park, Dr Anita Bundy & Dr Lindy Clemson

### *The day-to-day experience of occupying time when you have time on your hands*

Consider the experience of spending time as well as the activities clients engage in e.g. sometimes clients may fill time with activities because there is nothing better to do - the experience during that time may not necessarily be quality.

## 1.5 Older Adults

### Karen Goymour

#### *Discharge planning options developed to cope within the pressure cooker of acute wards*

Twenty-five to fifty percent of all hospitalised older people experienced loss of functional independence.

A discharge planning option consisting of a restorative recovery programme, a transitional care programme and an intermediate care programme assist elderly patients to recover and assist with patient flow.

## Jenny Oxley & Barbara Brook

### *Occupational therapy's role in promoting road safety in our ageing population: "Creating our place in shifting sands"*

Road traffic crashes are the leading cause of injury related deaths among 65 -74 year olds and leading cause among 65-85 year olds. Occupational therapists must ask their clients about driving, be aware of fitness to drive guidelines, contact GPs/NZTA (consider Privacy Act) and know when to refer on.

## Professor Wendy Wood

### *Occupation and quality of life among people with dementia in residential settings*

Primates were studied to observe effect of social and physical environment on well-being.

People with dementia have behavioural changes in relation to context – Occupational therapists need to have a role of creating rich and enabling lived environments.

## 1.6 Professional Issues

### Dr Barbara Hooper

#### *Linking ways of doing occupational therapy with ways of knowing: A framework for change*

Occupational therapists must not only learn new skills, but also understand the knowledge that goes with these skills – we must also view our knowledge as tentative to be ready to revise what we think we know.

### Kylie Dodds & Jackie Herkt

#### *Navigating a return to practice*

Research suggests that occupational therapists returning to work often feel less prepared than new graduates, and need appropriate support.



**Aften Lyttle, Merrolee Penman & Dr  
Linda Wilson**

***Online occupational therapy practice: What to consider when creating our place online***

All occupational therapists do not always have the skills necessary for online service development; those offering this type of service need to share their experience with colleagues for it to evolve.

**Penelope Kinney, Linda Wilson, Otago  
Polytechnic**

***Low risk research with high risk participants. A guide to ethical approval for occupational therapy research***

If careful, creative and considerate you can probably research just about anything.

**Merrolee Penman**

***The CCFR... In reality a self-directed learning process. Do we have what it takes?***

Study is looking at the extent to which Aotearoa/NZ occupational therapists believe themselves to be engaged in self-directed learning.

Goal-setting is key to self-directed learning and consequently best practice.

**Launch of Occupational Therapy Strategic Plan 2010-2015 (OTKSS)**

The strategic plan has been developed in consultation with the profession and other aligned key players (OTBNZ, NZAOT, AUT University, Otago Polytechnic). The overall aim of the plan is for the stakeholders and the profession to work co-operatively with key players on a set of six themes to ensure the ongoing development and vibrancy of the profession. The six key strategic themes are:

1. Ensure responsiveness to Māori
- 2+. Maintain and strengthen excellent communication, processes and networks
3. Actively engage in the primary health care/population based health sectors

4. Provide quality education that ensures registration and inspires occupational therapists to reach their full potential
5. Conduct excellent research to advance knowledge and practice
6. Create effective leadership

The intention is to build on current achievements while providing a clear direction for the profession as it moves forward. OTKSS looks forward to working with stakeholders and key players to create a stronger and more secure future for occupational therapy in Aotearoa/New Zealand. Downloadable form [www.otboard.org.nz](http://www.otboard.org.nz)

## 1.7 Mental Health

**Emma Tokolahi, Susannah Limbrick ,  
Wendy Wright, Kate Whelan & Kunal  
Adlakha ★**

***New waves, familiar sensations: Sensory modulation across the lifespan***

Occupational Therapists are well placed to lead the way for assessment, treatment, planning and implementation of sensory modulation.

The Sensory Profile can be used as part of a person's overall assessment to help reveal any possible sensory issues that are impacting on a client's daily occupations.

Sensory interventions can be implemented with all developmental age groups.

**Dr. Daniel Sutton**

***Examining the use of sensory interventions in acute mental health services: A pilot study***

Can sensory interventions reduce the use of seclusion and restraint in mental health services?

Daniel provided an overview of a pilot study implemented across different Mental Health Services in Auckland.

Sensory interventions can be effective in modulation arousal and distress and may contribute to a decrease in using seclusion.



Occupational therapists play an important role in development and facilitation of sensory interventions.

### **Sarah Redfearn & Micaela Kena**

#### *The use of creativity as a vehicle for change in young people: An evolving model of practice*

Occupational therapists can make a difference in enhancing occupation by being creative with the use of psychodynamic theory, the cycle of change framework and the power of activity can help to remediate occupational dysfunction.

### **Emma Tokolahi & Cheryl Em-Chhour ★**

#### *Leaping Hurdles: Evaluation of the effectiveness of an occupation-based group for children addressing anxiety, low mood and occupational disruption*

The developmental stage of 10-14 year olds is largely full of transitions and change. With any form of disruption to their day-to-day occupation, as a result of low mood or anxiety, their ability to engage in their occupations to their full potential is hindered. The Leaping Hurdles group, developed by occupational therapists in Auckland CAMHS have identified through research that it is an acceptable and effective group for reducing symptoms and behaviours related to anxiety, depression, disruptive behaviour and strengthening a young person's self concept.

## **1.8 Children & Young People**

### **Jill Ford**

#### *Enabling Successful Schooling: A case study to explore successful local schooling for a student with very high needs*

Focus on building inclusive school communities

Successful local schooling creates multiple opportunities to build social relationships,- the

child can 'be there and be an active participant' and to 'be a learner'.

### **Dr. Polly Yeung**

#### *Citizenship: The value of social participation. A comparison between young people with and without cerebral palsy (CP)*

Participation of social activities for young people with Cerebral Palsy can create a space for a healthy sense of being in their community and increased citizenship participation.

### **Rita Robinson**

#### *Workshop: Teachers literacy expectations shaping the occupational experiences of new entrant students*

Rita presented three stages of handwriting from her masters research: occupation, cyclic process and the handwriting tool.

There is more to handwriting than learning the alphabet – it is about becoming literate! As occupational therapists our interventions need to be mindful of teachers' evolving expectations around handwriting.

## **1.9 Physical Dysfunction**

### **Sharon Downie**

#### *Redesigning occupational therapy service delivery for elective neck and back surgery patients*

Improved productivity may be gained through pre-surgical occupational therapy involvement for these patients.

### **Annie Kenning**

#### *Accessible housing in New Zealand: A public health concern*

Australia has a strategy that encourages people to use universal design in their homes. New Zealand could use strategies around housing and positive ageing.



### **Raewyn Aprea**

#### *Voice Recognition Software: Is it the way of the future for us and our clients or just smoke and mirrors?*

Raewyn is from Talklink. Dragon voice recognition software discussed. Useful links:

[www.dtsl.co.nz](http://www.dtsl.co.nz);

[www.voiceperfectsystems.co.nz](http://www.voiceperfectsystems.co.nz);

[www.talklink.org.nz](http://www.talklink.org.nz).

### **Dr Clare Hocking**

#### *Expanding the basis of practice: learning from people with impairment*

Important to honour naturally arising strategies - clients' own practical approaches to managing difficulties as opposed to diagnosis specific practice.

## **1.10 Rehabilitation**

### **Dr Mary Butler**

#### *Lives that speak: A collaborative research project*

"As wounded, people may be cared for, but as story tellers they care for others" (Frank, 1995, p.90).

### **Linda Ritchie & Valerie Wright-St Clair**

#### *In an aging world: understanding the community integration experiences and needs of older adults following traumatic brain injury*

Community integration ought to be a primary occupational goal and perceived needs and satisfaction are important.

### **Sandy Rutherford, Kathryn McPherson, Nicola Kayes & Felicity Bright**

#### *Identity oriented goal training after TBI: A new approach to client-centred goal-setting*

Sandy used the idea of clients choosing a hero/ the identity of someone they admire

and mapping out their identity considering facts, goals, feelings, actions/strategies, appearance, place, setting.... and using this to assist with goal setting.

### **Dr Ted Brown**

#### *Can you perceive what I see? The reliability and validity of three adult visual perceptual tests*

It was nice to have some gritty quantitative research to balance the predominantly qualitative research presented (and the Australian nougat he shared with us all was really nice).

### **Susan McNulty**

#### *Occupational therapy for chronic headaches*

The migraine brain likes a 'boring brain' i.e. routine and structure

### **Belinda Simpson**

#### *Pets providing therapy*

In *Animal-Assisted-Therapy*, the dog is used as an integral part of the goal directed intervention. The increased attention to task and emotional security provided by the animal's presence encourages the client to communicate, develop better organisational skills and retain learned behaviours.

### **Jane Cowan-Harris**

#### *How modern technology and design has affected our workplaces and the impact on occupational therapy practice*

A practical presentation explaining the effects of poor posture when seated for long periods at the computer; looking at the environment, position of desk, PC, type of chair etc as well as lighting. A timely reminder as many of us spend increasing time at PCs, both at work and at home. Jane gave many practical suggestions e.g. stand up every time you talk on the telephone, look away from pc regularly. Further info –

[www.sitrightworkwell.co.nz](http://www.sitrightworkwell.co.nz)



## SECTION 2: EXPANDED INFORMATION

*If you would like more information about the key messages and presentations read on ... only the authors' names are listed below and correspond with the above content.*

### 2.1 Keynote Speakers

#### Grace O'Sullivan

Grace is completing action research to hear the voices of people of people with Alzheimers. Time. Social connections are important...(Reynolds, Hean, Lim, 2005).

Occupational therapy: "A vision that exceeds capacity" (Townsend, 2009). The importance of occupation in people's lives is increasingly acknowledged at all levels. Occupational therapists can be a proactive agent of change: Trust our knowledge base, challenge the status quo, champion occupational justice. WE are at a pivotal time.

When we stand in different places in the world, we naturally develop different perspectives on the world and interpretations of the world (Gadamer, 1996).

Your past always goes before you to shape the new understandings of the present (Symthe, 1996).

Whatever I have encountered in the past now sticks to me as memories as (near) forgotten experiences that somehow leave traces on my being (Van Manen, 1980).

Life under any circumstances never ceases to have meaning (Frankl, 1964).

Imagination is more important than knowledge (Einstein, 1929).

***Have the courage and conviction to challenge the status quo, and BELIEVE (truly believe) in the value of occupation!***

Grace described her work in dementia units and the success in being able to have residents discontinue their use of anti-psychotic medication. This was achieved through tailored programmes of daily occupations, meaningful to each resident (involved educating and training caregivers).

Grace shared with us what this has meant for the families of people with dementia, as their loved family member has had positive changes of behaviour, and improved ability to engage with them. This in itself is an amazing achievement, but Grace has gone on to lobby senior people within our health system about the needs of those with dementia, and is doing a doctorate to ensure she is listened to.

Personally, I found Grace really inspiring - she has such a firm belief in what she is doing and in the value of her profession, with a resultant 'quiet confidence' which is really encouraging for those of us who may feel we are not assertive enough to stand firm on those shifting sands.

#### Professor Wendy Wood

An Inukshuk is a stone person on byways and mountain passes that says "I have been this way before you and this is a good way".

Features of past wise way finders in occupational therapy:

- Lean into and persevere with disorientating dilemmas (e.g. such as those which defy usual responses and solutions); they offer gateways.
- Learn from those who illuminate the necessity of occupation; e.g. some clients can be influential teachers enabling us to see what matters most in occupational therapy. Symbolic others can be mentors or role models – including those who teach us how NOT to practice. Commitment to mentoring, clients best teachers, knowledgeable, scholarly, engaged, visionary, empowering mentors.



- Feed your intellectual curiosity about the field; there is no end to possible new areas; experiential ways of navigating professional journeys.
- Find your empowering community; e.g via professional identity, areas of expertise, interests. **Locate yourself into your empowering community but first (need to) find self as an Occupational Therapist.** “Selfing” can help us see more clearly how / who we have been, who we are and who we are becoming. The importance of finding a place where the identities most important to us can find expression.
- Build robust communities of practice through compelling occupational visions (Whiteford, Wilding).

Mentoring leaves a lasting impact. Mentors I have known and loved: Nedra Gillette, Beatrix Wade, Wilma West, Gail Fiddler, Gary Keilhofner, Mary Reilly.

- A firm persuasion in our work AJOT, Susan Coppola – “opened a window onto the Historical review of complexities of people’s real life techniques...”.
- Strategies to Advance Gerontology Excellence( 2008)
- Deeper into the Heart of the Matter Betty Hasselkus
- Beatrix Abreu - Professional Identity and Workplace Integration
- Collaborative rather than expert.
- Yerxa - Founder of occupational science - Learning to love the questions- “to be truly helpful as an occupational therapist I would need to deal with all the bumbling, confusing mess of real life”
- Reilly - “why do humans and other creatures play?”
- Ayres - “how is the CNS affected by the environment and need to learn”.
- Mary Law - CMOP Occupational Therapy: A Journey
- Occupation and Occupation in Practice (Whiteford, Wright St Clair).
- Driven by curiosity.
- Why? How?

- Occupational participation is the experience of how we seek meaning in life...it can delight, it can defeat.
- Suzanne Peloquin
- Occupations- Strands of Coherence in Life “The more I learnt about occupational therapy, it seemed like the very best of engaged teaching.”

### **3 Questions to ponder:**

1. What is your compelling and special robust community?
2. What strategies are you using to become a more audacious wayfinder?
3. How are you now, and how might you better build robust communities in wayfinding to reach new destinations?

### **Associate Professor Mathew Molineux**

**Make sure Occupational Therapy is still one of the “great ideas” Mary Reilly.**

Historical review of occupational therapy shows a broad to narrow medical focus – the reductionist view recognised in history.

### **Core assumptions:**

- Human’s occupational nature
- Occupational problems and challenges
- Occupation based practice.

**What is the contemporary paradigm? We must be able to recognise, articulate and put into practice our paradigm.**

- Pre paradigm – paradigm – crisis- new paradigm ----
- Shared commitment /belief / perspective.
- Mechanistic paradigm – reductionist – Occupational Therapy needs to be occupation based.

### **What is our unique expertise?????????**

**Equipment, assistive devices, home modifications, splinting, techniques?:** Is this the be all/end all of occupational therapy? (NO!) Only if they are just one part of an occupational therapy programme? Use of occupation to achieve an occupational outcome?



**ICF - participation, activity, health.** Refer NZ physio definition: includes function, environmental factors, quality of life.

**Idea of occupation and health has come to the fore; we need to work on our occupation focus.** Refer “Occupational Perspective and Health” Wilcock.

**Historical problems:**

- Prescription by Doctor
- feminine gender bias- social and political landscape, access to higher education
- Professionalism- increase in degree of, establishment of education programmes, way we see ourselves, way we present ourselves.

Tracey Fortune’s research showed that occupational therapists were filling the gaps in service in their teams, this is a sink into the quicksand/ shows a need for identity.

We need paradigm-dependent practice versus paradigm-independent practice, assert a professional identity, trust in how we see the world. Ontological security (a term from sociologist, Giddens)

**Reflective practice: How ontologically secure are you?**

Suggestions:

- Look at our particular skills (tacit reasoning)
- Concentrate on limited areas- boundaries on practice.
- Skilful pruning and controlled development, reason well.
- Commit to occupational therapy research, occupationally focussed.
- Reframe into occupational terms.
- Embrace and encourage wider recognition of the value of occupation.
- Share expertise.

**As an occupational therapist:**

- Can you assess a person as an occupational being?

- Can you explain your role as an occupational therapist?
- Could you design a service for anybody, for example people detained on Christmas Island?

**Collectively and individually we lack ontological security!**

**OCCUPATION FOR HEALTH!!!**

**Carolyn’s comments from Dr Molineux keynote:**

We need to respond effectively – as occupational therapists. The history of occupational therapy helps us to understand where we have come from, why, and where we are now. Are we practising within our current and shared paradigm? Do we have a shared commitment / belief as a profession – a shared worldview?

Paradigm-dependent practice should reflect our core beliefs – our shared framework – touchstone – our ways of seeing the client. Do we trust this? Do we share it with others? How ontologically secure are we?

What is our *unique* expertise? Is it equipment & modifications – No! Is it physical modalities? No! Is it about improving and maintaining occupational performance and occupational engagement – Yes!

We need to build a firm solid foundation – articulate our professional philosophy! Occupation permeates all that we do – walk the talk! Our practice should focus on occupation. Use the language of occupation. Research our domain of concern. Reframe practice into our domain of concern. Firmly ground ourselves in occupations – humans as occupational beings – occupation for health. Recognise this and articulate it.



## 2.2 Culture

### Jane Hopkirk

Jane presented her masters research which compared Maori and occupational therapy perspectives on health so that people can understand what effective provision by occupational therapists is for Maori service users, and develop cultural capability of Maori practitioners. Her results show there is some alignment in some health perspectives and not in others. We need to acknowledge and, value and use indigenous knowledge to support wellness. Cultural enhancement is critical to enabling best possible outcomes for Maori.

Jane used questionnaires, hui, and key informant interviews with Maori to gather her data. Interviews were with Pakeha and Maori – occupational therapists and Maori health workers, most Pakeha were in universities; Maori in health services. This is an important study and we need to read more about it.

*This bit I got off Twitter -(Merrolee Penman & Dr Molineux's comments:*

Importance of *whanaungatanga* - honour Maori ways by finding connections with each other. We all carry an internal veil and this shapes what we see and interpret. Occupational therapy health perspectives - occupation, client centred, environment, occupational perspective. Maori perspectives: relationship, spirituality, environment. Western occupational therapy perspective gets in way of being responsive to Maori ways, as do organisational barriers. Maori health workers - what is occupation - day to day self, meaning value, identity, participation, growth, learning. Key perspectives of health: Maori empowered to be Maori, strong identity. Jane's framework - 'culture is central to practice'. Really need to work with families - *Whanau* and *Whanau Ora*. Maori see relationships above occupation. Maori believe everything has a life force, so

modification to environment may require negotiation.

### Dr Shoba Nayar & Dr Clare Hocking

Doctoral study. 25 Indian migrant women living in NZ were interviewed, regarding how they perform occupations in a new environment. The outcome of the study is a substantive grounded theory, describing how these women engage in a dynamic process of navigating cultural spaces, interweaving aspects of NZ and Indian cultures.

Shoba spoke about the women:

- Working with Indian ways
- Working with NZ ways
- Working with the best of both worlds

#### **Implications for practice:**

- There needs to be observation and discussion of the ways Indian women explore these spaces
- There needs to be consideration of client cultural safety

Shoba emphasised the importance of not making generalisations about the length of time a migrant has been in NZ, and the 'ways' they may choose to be 'working'. She suggested that occupational therapists think about why our clients engage in the occupations as they do (links into cultural/occupational meaning and safety)

Full abstract available in September 2010 issue of NZJOT.

### Mayanne Wiki-Singh & Nellie Neligan: **Kaupapa Maori practice**

The *wahine* spoke about *wairua*, the importance of being aware of this, and of connecting my *wairua* with my client's *wairua*, the first time we meet. Suggested this is achieved by thinking very positive thoughts at the first meeting. They spoke of the meaning of *wairua*, as of a river flowing, and when you successfully achieve that connection, the two rivers will flow together, and be stronger. They also spoke about the need that each person has for a place where they belong, and the importance of this in relation to identity.



They explained that in Maori culture, they look from the inside outwards, looking at the heart/*ngakau* and mind/*hinengaro* first. They expanded on this, explaining and discussing, gave example of someone they had seen who had all the clinical manifestations of an acute episode of mental illness needing admission, but until they had made the connections re: *wairua* with this person, it would not be right to go ahead and arrange the admission to the hospital far from this person's home. They ended their session with a *waiata* in a beautiful and haunting harmony.

*This was a short presentation, using simple terminology, was not academic, did not say things I had not heard before, and yet in the manner of their presentation and the symbolism used, I was deeply affected by this presentation, and really felt the wairua of these women mingling with my own. Even as I write this, I am aware of experiencing the emotions I had at that time. Hard to bring this across – you needed to be there!*

## 2.3 Students & New Graduates

### Luciana Blaga and Dr Linda Robertson

Survey results (72 returned questionnaires):

- Students generally valued/liked the area and viewed it as an excellent learning environment
- Strong agreement for the need of occupational therapy in acute physical care (APC)
- Student more pragmatic /procedural in their approach
- Involvement of cognition in performing functional task not clearly articulated
- Nothing can prepare the student (overwhelming) – takes 2 weeks to adjust to the setting
- Need for informal and formal supervision as well as timely feedback/debriefing
- Data gathering was regarded more holistic than interventions

- Only profession to put things into perspective

**Factors impacting on satisfaction:** depends on supervisor, therapist confidence to do role, therapists positivity, closeness of the occupational therapy team (meeting over lunch), referral process, MDT/IDT was considered influential, personal preference – did like fast pace

**Learning:** excellent learning environment (general /base knowledge), gain knowledge on medical conditions, how a team works, seeing occupational therapy process in full, learning about hospital, spend 1:1 time with patients

**Clinicians:** In supervision – go beyond equipment provision, be a positive role model (demonstrating enjoyment of work, workplace and team) and allow time for debriefing. *'Good placements needs preparation'*

**Appropriateness of setting for new graduates:** Good learning environment – structured, repetitive, wide variety of conditions, clear expectations, good supports however busy/fast pace

### Susanne Keller & Dr Linda Wilson

Findings from a descriptive qualitative study (questionnaires sent to students and semi-structured interviews):

**Three major influences on subsequent recruitment were:**

- The spirit of the teams
- Respect and valuing occupational therapy
- Quality of the supervisor and supervision

**Five minor influential findings were:**

- Location, social and emotional aspects
- Grounding for career development
- Type of practice
- Benefit to employers
- Model of supervision

### Panel Discussion: Supporting New Graduates

Findings from a New Zealand study (Robertson & Griffiths, 2009) confirmed



biggest issues for new graduates were searching for role clarity, inadequate supervision, an insufficient grasp of skills and uncertainty in team responsibility, underpinned by lack of confidence. Conversely, they felt confident about their ability to research and find information in response to gaps in their knowledge. This study demonstrates that learning how to be an occupational therapist is as important as receiving formal supervision, and suggests that learning how to contextualise knowledge (e.g. through role modelling) and reconstruct knowledge (e.g. through well constructed supervision) is essential to bridge the theory – practice divide.

**New Graduates:**

- Emotionally charged year from feeling terrified ----- confident
- Multiple language – learning how to communicate with varying people (teams, clients & occupational therapists)
- Communicating what you have never done
- Contextualising knowledge / Learning how to be an occupational therapist is as important as receiving formal supervision
- Reconstructing knowledge / Moving from knowing about to knowing how (not knowing enough for immediate answers, confirmation of intervention)
- Important to have formal and informal supervision and role models
- Supervision needs to be reflective and goals set for growth and development

Need time to think and reflect – often don't know what to look for – need access to senior occupational therapist, support

**Do fieldwork placements assist in adequately preparing the students?**

Dependent upon quality of fieldwork experience, model of supervision used, quality of supervision provided, degree of autonomy allowed – important that students had autonomy at end of placement. ?? core skills = prioritising ability / discernment. Ownership of decision making

**Fieldwork supervisors** - Need to be good role models (be positive on all matters), provide a positive environment, and provide good quality supervision

**New Graduate supervision**

1:1, peer supervision or group supervision

## 2.4 Occupation

### Professor Wendy Wood: Pre-conference workshop

*(Strong linkages here with Wendy's keynote and Matthew Molineux keynote; also Barb Hooper's paper).*

Often difficult to locate theory in practice. How do you direct attention to the salient theory? Or student's say "I cannot see / saw no theory in that practice". We use tacit theory/knowledge all the time in practice. We need to articulate it! So theory is embedded in all of our clinical processes, places and tools. E.g. equipment – adaptive compensatory approach – biomechanical approach, environmental approach. Theory is an abstraction = concepts = ideas. We tend to create fuzzy linkages in our theorising – how we construct treatment then can be fuzzy! Look at 'how am I pulling together the different ideas and values in my practice?'

We assemble theory in practice: assemblers of theory in action. We apply the key elements of our conceptual practice models. We assemble of theoretical ideas and concepts in action. We pull from our models – it's dynamic, fluid, changeable. But, we need to ensure there is 'goodness of fit' however. Do we? Create those casual linkages in our assembling of theory? Or do we fall back on our own personal theories?

**First we need to be an occupation-centred practitioner – assemble theory from that platform!**



**Know our worldview – occupation focussed lens – our clinical gaze = our paradigmatic view:** focal viewpoint; core constructs; values.

This is the stuff for supervision and reflection – examine “thin slices” of our clinical actions and interventions for their theoretical soundness.

### Dr Kirk Reed

Bringing meaning to the fore through practice, research and theory development

Meaning is complex and tends to remain hidden: Three main themes:-

- The call (what demands, excites, what we care about)
- Being with (special bond, working together gives occupation meaning, doesn't matter that each experience different)
- Possibilities (what is opened up or closed down)

There is scant attention to the meaning of occupation in the literature. Commonly used categorisations of occupation should be opened up to include meaning e.g. occupation has been categorised as Self Care, Productivity and Leisure but new emerging categorisations can acknowledge meaning.

### Dr Linda Wilson & James Sunderland

A proposed framework of occupations which categories and describes the unique characteristics of diverse occupation (assist individuals with the understanding of the motivating or therapeutic benefits of engagement in particular occupations).

**Nine categories of occupation** (inherent nature of the occupation) described:

- Connect and Acknowledge - connecting across time and space with oneself, other(s), sharing those connections i.e. celebrations, recording, research, religious
- Compete and Challenge – providing oneself better than other e.g. games, puzzle sport

- Cultivate and Appreciate – involvement with the natural world, finding cultivating harnessing e.g. agriculture, cooking, cuisine, gardening, hiking, tramping, horticulture
- Foster and Promote – involvement with the human world as an individual e.g. bathing & grooming, childcare & development, education & training
- Influence & Control – changing/shaping what happens in a society e.g. government, law, governance & management, political activity, special interest group
- Make and Transform- bringing into existence e.g. art, craft, construction, engineering
- Perform & Participate – Representative of human experience designed to be shared with others, changes or different during sharing e.g. dancer, music, poetry, storytelling – books/plays/films
- Sustain & Replace ensures the survival of the individual e.g. drinking, eating, eliminating, reproduction
- Trade & Transport – relocation or repositioning of both tangible and intangible e.g. removals, travel, retail and commerce

### Alison Nelson

Alison studied the effects of incarceration in labour camps on the occupations of living survivors of the Holocaust.

**Themes emerging were:**

- Occupational loss
- Survival occupations
- Occupational transitions and re-creations

Most who attended found this a really powerful and moving presentation which illustrated how important occupations are to human existence, hope and recovery.



### Dr Clare Hocking: Workshop

Clare presented the WFOT position paper on human rights in relation to human occupation and participation.

Refer to:

[http://www.wfot.org/office\\_files/WFOT%20HR%20PP%20with%20Canadian%20Enablement%20Model.pdf](http://www.wfot.org/office_files/WFOT%20HR%20PP%20with%20Canadian%20Enablement%20Model.pdf)

WFOT was apolitical until 2007. Some member countries are not signatories to the UN declaration of Human Rights.

***Occupational justice is founded on beliefs that recognize humans as occupational beings who participate in occupations as autonomous agents. Our viewpoint as occupational therapists should be that occupational participation is interdependent and contextual; a determinant of health and quality of life ...*** (Townsend and Wilcock)

Occupational Justice relates to the power to participate and be included in occupations. We need to consider that the wellbeing of a community is undermined if individual rights to occupation are compromised.

Clare presented guiding principles including the right to:

- participation in a range of occupations (contextual nature)
- support
- choice
- valuing of unique contribution
- recognition of the effects of abuse, control and global conditions

Workshop participants then separated into groups to look at the impact on health, development, wellbeing, citizenship. Also they looked at the barriers to occupation and the occupational therapy skills, knowledge and role.

#### ***Challenges for occupational therapists:***

- Accepting responsibility
- Raising awareness
- Working collaboratively
- Teaching and developing accessibility
- Addressing cultural sensitivity and competence issues

### Fiona Mains & Dr Linda Wilson: Workshop

Started with brief history of trends in occupational therapy, with most recent trend being to work with whole society - ecological perspective, social model of disability, work with whole family to sustain, shift to health promotion focus.

#### ***New (old?) ways of working:***

- With groups and communities
- Reduced individual referrals
- Consultant not therapist
- With agencies
- With ST interventions
- Skills and resources building
- Developing, educating and empowering, as well as treatment

#### ***Occupational therapists:***

- Predominantly female
- In 1987, 38% of occupational therapists were under 30 yrs old
- In 2000, 61% are over 35, and 27% are over 45
- Thus, occupational therapists are staying in practice for longer, and need to cope with changing models of practice

Health funding is changing from institutional focus to community focus. Shift from reactive to proactive – early intervention, health promotion, community development. Professional intervention to self-management.

***Occupational therapy services need to focus on primary care, population-focused, community development/strengthening.***

**Challenges:** some may see it as not traditional occupational therapy; working with health rather than disability

#### **The community practice course at Otago:**

Learning outcomes:

- Describe connections between health and disability theory and community orientated practice
- Describe a range of community orientated opportunities (or create these opportunities)
- Develop a sound proposal



Scaffolding learning is used in fieldwork practice, where students are given a project with an identified need. But in the community practice course, they give us (the uni) a project with an identified need.

Course content:

- Community health enterprises
- Models of social health PHOs
- Health promotion
- Community support groups
- Inclusive community structures and systems
- Community rehabilitation and WHO concepts of strengthening communities
- Health and ability as social equity and opportunity
- Social and occupational justice
- Facilitating social action
- Social and political lobbying

Terms:

- Brief outline of possible project
- Occupational relationship and perspective
- Need
- Identify target population
- Expected outcomes and evaluation tools
- Intervention strategy
- Profession specific skills
- Personal interest or expertise

**Assignment:**

- Prepare of proposal to a govt agency
- A new initiative
- Evaluation of current project
- Development of research project
- Must be in line with general principle of contributing to community participation

**Three student projects were then presented:**

**1.** Dana Campbell's "Time for Refinement" which was a programme to assist new retirees. She gave background, and details re her 8 session plan for this group-

- What they did before and are doing now (meaningful)
- Goal setting
- Looking after self/keeping young
- Giving back to community
- Socialising/networking
- Grief

- Balance/getting organised
- Summary and celebration/fun

Occupational perspective, MOHO, utilised the Well Elderly study, integrity between what you value and want to do and what you actually do.

**2.** Ingrid Wilson's "pushing the limits" a programme for younger people living with chronic illness. Aligned with Arthritis NZ strategic plan. She presented this herself, stating that her intended needs outcomes were:

- Improved self-confidence
- Opportunity to network
- Proactive management of disease and its effects
- Reduce future implications/effects of the illness

She went on to outline her project, suggesting an evening group, to meet fortnightly for 10 weeks, 1<sup>st</sup> hour for education (energy conservation, joint protection, food and alternative meds, exercise etc) and 2<sup>nd</sup> hour for support. She proposed an elective session in managing pregnancy.

**3.** The North East Valley buddy Programme – this was a project proposing linking young people (teenagers) with older people, would need a careful matching process and close monitoring. This project's aim was to address occupational deprivation in both groups, provide occupational balance, utilise occupation as both a means and an end.

After the presentation, we broke into groups, each group choosing an issue and discussing ways of addressing this. Our group chose the problem in NZ of community mobility for our clients when they are no longer able to drive, and suggested that occupational therapists needed to be active in investigating options, lobbying etc, both locally and nationally. Some small towns had solutions e.g. a supermarket sponsoring a bus which picks people up outside their homes, the bus leaves and returns at a set time each day. Occupational therapists need to be aware of



what is available in their communities, otherwise work on creating solutions. A list was passed around at the end, with people writing down their names if willing to be part of a group looking at this issue.

### Steve Park, Dr Anita Bundy & Dr Lindy Clemson:

Sequential exploratory design to identify the content for a self-report questionnaire.

12 participants aged 40-65, living with AIDS and a co-occurring chronic health condition. 4 interviews each over 7 months.

#### 4 major areas of spending time:

- With others – good friends and family
- In activities – making extra money, spiritual, medical appointments
- In places – holidays, around other people not comfortable with
- Experiences in spending time- may be good, or may fill time as there is nothing better to do

**Implications for practice:** look at how clients spend time as well as at their activities, understand desired time frames, and include goals that focus on experience of spending time.

## 2.5 Older Adults

### Karen Goymour

Strategies developed to allow the elderly the opportunity to recover from 'acute event' that brought them into hospital without going to DHB Assessment and Treatment Rehabilitation Ward and assist with patient flow.

#### **Three programmes developed:**

Restorative Recovery Programme – 4 week slow rehabilitation programme

- Age >65 years, physical disability, known to NASC, not able to tolerate intensive rehab
- Assessment by acute ward, goal orientated functional approach
- Overall Goal: to return home

- Baseline Assessment – initial interview, cognitive assessment, Barthel score

The Transitional Care Programme – 1 week programme

- Allows natural recovery to occur/benefit from structured restorative programme
- Criteria: not known to NASC, recovery period no more than 7 days in residential care environment
- Assessment on acute ward
- Issues: f/u was telephoned based, not an in-depth assessment

Intermediate Care Programme – goal directed rehab programme

- Criteria: <65 years but like in age and interest, restorative focus, no significant acute changes, potential for improvement and able to participate, would not benefit from AT+R
- Assessment on acute ward with comprehensive functional assessment
- Weekly monitoring

### Jenny Oxley & Barbara Brook

Road traffic crashes are the leading cause of injury related deaths among 65 -74 year olds and leading cause among 65-85 year old

- People over 75 have x4 the risk of dying per kilometre travelled
- Driving is a key role in everyday life – contributes to older persons self esteem, independence, involvement in social activities
- Driving is an intrinsically complex task – requires ability to respond flexibly and safely to unexpected events. Involves high level of executive function (this is the first thing to go with dementia)
- Cognitive components of driving – reaction times, eye hand coordination, divided attention, complex attention, planning, concentration, decision making, impulsivity and insight
- How is driving affected?
  - reduced physical function and or frailty, poor vision (difficulty operating controls, unable to



- check blind spots, poor positioning on road, poor judgement of distances/speeds
- slowed information processing (slow responses to potential hazards, slow changing gears, late braking)
- reduced selective attention (distracted, reduced ability to multi task, poor decision making, late braking)
- impulsivity (rushes manoeuvres, dangerous in complex situations, disregard of own & others safety)
- poor insight (blames faults onto other drivers, unable to regulate and modify behaviour, takes risks)

**Occupational Therapists responsibilities:**

Ask about driving, contact medical doctors/GP or NZTA (under privacy Act) with concerns, be aware of medical aspects of fitness to drive guidelines, know when to refer to specialist occupational therapist

**Professor Wendy Wood**

LEQL (“Lived Environment and Quality of Life”) model is a dementia-specific model of the lived environment and life quality.

The Lived environment – an enriched physical environment and an enabling social environment.

**Quality of Life Domains:**

- Occupational engagement
- Retained capacities
- Positive affect

**Environment or facility can be occupationally Enabling or Disabling**

- In a study of primates psychological well-being was able to be gauged by observing occupational use of time. The effects of the social and physical environment on well-being were explored by studying two groups of chimpanzees in different zoos – one group had a rich social group, but a poor physical environment, the other had

a large natural environment, but a problematic social group.

- A comparison between residents in two Alzheimer’s Special care Units (one being a homelike facility, the other a traditional nursing facility) was carried out to determine the effect of environment on the behaviour of those with dementia.

**Findings:**

- The behaviour of people with dementia changes markedly in response to their surroundings – it’s impossible to take a static snapshot.
- (With dementia clients) we need to look at snapshots across contexts:
  - Down times
  - Meal times
  - Television times
  - Activity times
- Domains of time use:
  - Gaze
  - Functional mobility
  - Communicative Behaviour
- Inadequate environments (e. g. barren physical environments) have the potential to decrease occupational engagement through causing withdrawal/agitation and behavioural distress – there is benefit to having more “homelike” facilities for patients with dementia.

**Occupational therapists need to:**

- Move into the role of trainers, mentors and consultants to caregivers.
- Draw on clients’ retained capacities
- Maximise opportunities for spontaneous environmental interactions across the day
- We need to always hold onto the concept of hope, and understand the importance of environments that provide interest and pleasure in order to maximise quality of life for those with dementia.

**2.6 Professional Issues**



### Dr Barbara Hooper

Occupational therapists must not only acquire new skills throughout their practice, but also obtain the concealed understanding behind the knowledge that accompanies these skills (rather than learning by rote). In turn, we must regard all knowledge as tentative in order to be open to potentially revise what we think we know. This presentation suggested a theoretical framework to link ways of knowing/doing.

**Ways of Knowing:** Refers to a belief system, a lens through which we regard the world.

- Are made up of beliefs about the certainty of, and authority of knowledge.
- Shape how we engage professional knowledge in practice.

**Framework – Four categories:**

1. Absolute knowledge: is certain, fixed, belongs only with the experts.
2. Transitional knowledge: Uncertain in some areas, applied to life by an instructor, explored by peers.
3. Independent knowledge: Largely uncertain, held by peers *and* authorities.
4. Contextual knowledge: Knowledge is uncertain but judged as more or less substantiated.

**Summary:** Current ways of doing are frustrated if based on former ways of knowing. Occupational therapy practice requires *contextual* knowing in order for us to see that what happens in our practice is crafted by social processes and can be re-crafted by us – this is the only way we can practice successfully.

### Kylie Dodds & Jackie Herkt

Qualitative research - grounded theory.  
**Criteria:** break 3 years or longer, been through transition back to profession after a 5 year break (21 entered interest and 16 met criteria).

- Returning to practice was daunting – worse than a new graduate, registration difficult, needed support to return and mentoring.

- Strategies that assisted return to work: keep updated, find support, practicing therapists – be supportive
- Professional connectedness impacted by grounding (time spent in profession) and identity as an occupational therapist – sense of belonging to profession

### Aften Lyttle, Merrolee Penman & Dr Linda Wilson

All occupational therapists do not always have the skills necessary for online service development; those offering this type of service need to share their experience with colleagues for it to evolve.

### Merrolee Penman: *The CCFR*

Merrolee presented her current doctoral study which is using mixed methods to look at the extent to which Aotearoa/NZ occupational therapists believe themselves to be engaged in self-directed learning.

Data is being gathered via a self-directed learning self-rated questionnaire and then, with permission from therapists, analysis of the CCFRs followed by semi-structured interviewing.

This will be a very useful study when completed in helping us to understand what it takes to be self-directed learners – are we there yet? And to use the CCFR better.

## 2.7 Mental Health

### Ema Tokolahi, Susannah Limbrick, Wendy Wright, Kate Whelan & Kunal Adlakhia – ADHB ★

There is emerging evidence to support sensory modulation and the use of sensory tools in mental health practice.

- Occupational Therapists are well placed to lead the way for assessment, treatment,



planning and implementation of sensory modulation.

- Dr. Winnie Dunn has developed the Sensory Profile with an aim to help understand a person's sensory processing patterns.
- Case studies presented demonstrated the benefits of using the sensory profile and sensory interventions across the lifespan – child and adolescent, adult and older person's mental health.
- Case studies illustrated respectively the use of sensory modalities to address function, symptom management and quality of life from an age appropriate perspective.

### Dr. Daniel Sutton

Alternative methods to reduce the use of seclusion and restraint in mental health services are being explored within the wider Auckland region. Sensory based interventions that help regulate emotional responses have attracted worldwide attention however there is little literature and studies examining the efficacy of sensory interventions with adults experiencing acute mental health difficulties. A pilot study (Te Pou) was implemented across four different mental health sites with dedicated sensory rooms. Two other sites were selected as controls.

- Over a six month period, data was collected through qualitative and quantitative using pre-post intervention ratings.
- Early findings suggest that sensory interventions can be effective in modulation arousal and distress and may contribute to a decrease in using seclusion.

Occupational Therapists have an important role in the development of sensory interventions.

### Sarah Redfearn & Micaela Kena

Occupational therapists working with young people with drug and alcohol misuse; eating disorders; self harm and risky sexualised behaviour have produced a 'change model' unique to occupational practice. Three elements of this model include the use of psychodynamic theory, the cycle of change framework and the power of activity to remediate occupational dysfunction. This approach has been successful and has been seen to be beneficial in comparison to talking therapies.

### Ema Tokolahi & Cheryl Em-Chhour –

#### ADHB ★

New initiative developed in the ADHB Child and Adolescent Mental Health Services (CAMHS) by occupational therapist. The leaping hurdles group is an occupation-based anxiety and mood management group for children aged 10-14 years. A parallel parenting group that include psycho-education is run alongside the children's group.

The aim of the group is to reduce symptoms of anxiety, depression and to increase the level of participation in childhood everyday occupations. The Leaping Hurdles group was evaluated using psychometrics for children and parents, together with clinician rated scores and client feedback.

- **Key findings:** Acceptable and effective group for reducing symptoms and behaviours related to anxiety, depression, disruptive behaviour and strengthening a young person's self concept.

## 2.8 Children & Young People

### Jill Ford

Jill presented the findings of her thesis which focuses on occupational justice in education. She used single site case study methodology –



one child's local school site – one student with a disability – to gather her data. The study explored what it takes to enable successful school for a child with disability.

Jill revealed successful local schooling needs to offer opportunities for meaningful engagement in the tasks of everyday schooling. The student should be acknowledged as being 'a kid who is like the other kids' who belongs and who contributes to his class and school. Successful local schooling creates multiple opportunities to build social relationships, - the child can 'be there and be an active participant' and to 'be a learner'. In addition Jill found that inclusive school culture (which also includes focussing on building community and inclusive attitudes) occurs when the setting enables school staff, students, parents and service providers to work together to build a community of support for a student with very high needs. In this setting problems were solved together and multiple opportunities for success were created. 'Max is here, he is just like everyone else' and 'we can do it'. Jill's study contributes a Model for Successful Local Schooling based on an ecological approach.

### **Dr. Polly Yeung**

Citizenship and social participation is a key component of as a way of providing the opportunity to participate in activity and to interact with others. It contributes to wider goals of social inclusion and solidarity. Polly conducted a research to compare the levels of activity participation self-efficacy and life satisfaction between Australian young people with and without Cerebral Palsy.

Australian young adults with CP reported less citizenship participation, especially in social participation, than their healthy peers; yet, their levels of self-efficacy and life satisfaction did not differ. Take home message: Polly emphasised the importance of social leisure as a source of socialization. With the help of customised services such as goal setting and coaching/guidance and family support,

positive citizenship participation can be achieved.

### **Rita Robinson**

Rita presented three stages of handwriting from her master's research: occupation, cyclic process and the handwriting tool.

There is more to handwriting than learning the alphabet – it is about becoming literate! As occupational therapists, our interventions need to be mindful of teachers' evolving expectations around handwriting.

We should consider the role of literacy in handwriting.

Rita says we do not need to be experts in literacy or even handwriting; however we do need to draw on our knowledge of occupation to be able to ask the right questions – consider human, physical environments and the task itself. Also, the developmental skills the child brings to the task.

Rita's Stages of Handwriting Tool can help us discuss handwriting issues with teachers; frame goals and interventions strategies.

## **2.9 Physical Dysfunction**

### **Sharon Downie**

Monash Medical Centre, email: [Sharon.downie@southernhealth.org.au](mailto:Sharon.downie@southernhealth.org.au)

The project demonstrated that improved productivity may be gained through pre-surgical occupational therapy involvement for elective/ neck back surgery patients. Psychosocial, home access issues, early education regarding activity, expectations and community supports.

### **Annie Kenning**

Annie is in Private Practice, Australia. Annie suggests the need for creating and increasing public awareness of what accessibility means, the features of an accessible home, and why it is essential so people can age in place.



In the North Island of New Zealand, 77% over 65 and 88% overall were seeing community occupational therapist for access issues. This is a huge economic cost. \$426, 000, 000 per year is spent on aged care. By 2051 25% will be over 65. *Research is required!*

Australia has “Australia towards 20/20” that encourages people to use universal design in homes. New Zealand could use strategies around housing and positive ageing.

Dr Clare Hocking

This presentation calls for the development of a new strand of knowledge learning about clients’ own practical approaches to managing difficulties as opposed to diagnosis specific practice. Knowledge of these strategies will provide innovative new solutions. Reveal things therapists don’t naturally consider. Important to honour naturally arising strategies.

Assistive technology, energy conservation, work simplification, universal design, environmental modifications all came from industrial strategies in the 1940s and 1950s. Scientific knowledge, universal application, decontextualized, expert language as opposed to everyday language.

Evidence from research – we need to know what people are doing. Some people work out their own ways, clients swap information. Refer article by Murphy, Hocking and Reed.

Also articles by Bytheway, 2001; Nygard, 2008; Nygard, Ohman, 2002; Sidenvall, Nydah, Fellstrom, 2001; Yuen, Gibson, Yau; Mitcham, 2007.

## 2.10 Rehabilitation

### Dr Mary Butler

Dr Mary Butler has worked/ researched collaboratively with brain injured artist and film maker William Fairbank. Refer: [www.williamfairbank.com](http://www.williamfairbank.com)

William created the sculptural “The Forest Stations” a series of sculptures that are on

permanent display in Lincoln Cathedral, England. These Stations of the Cross are a visual phenomenology of disability and compassion: having a disability is “our ontology”.

“As wounded, people may be cared for, but as storytellers they care for others” (Frank, 1995, p.90). Recommended book “The Diving Bell and the Butterfly.” The sculptures use 139 pieces of wood, from all over the world. The sculpture of Jesus being helped by his mother was incredible, it was of their hands holding, and one could relate it to the vulnerability of those who have had a TBI, and how the sculpture represented root family support and energy going both ways.

### Linda Ritchie & Valerie Wright-St Clair

Feasibility study to identify reliable community integration (CI) measures, examine older adults reported CI experiences and needs following TBI, compile a database of local TBI-focused services, and develop a qualitative interview guide. Falls most common cause of TBI in elderly.

The CI Questionnaire (Salter et al., 2008) is most widely used measurement tool.

Non-drivers have poorer CI. Social integration was important and was the domain with poorest outcomes, and had the closest association with satisfaction of life.

Practice implications: Community integration ought to be a primary occupational goal and perceived needs and satisfaction are important. Always check in with clients, don’t assume, ask re needs (before as well as after the TBI), keep checking in.

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### Sandy Rutherford, Kathryn McPherson,

### Nicola Kayes & Felicity Bright

Sandy used the idea of clients choosing a hero/ the identity of someone they admire and mapping out their identity considering facts, goals, feelings, actions/strategies,



appearance, place, setting - and using this to assist with goal setting.

### Dr Ted Brown

Visual perception has a key role in determining ability to perform e.g. ADL's. Three recently developed standardised adult visual perceptual tests were compared with respect to reliability and validity, with a sample of 172 healthy adult participants, and 49 who had a stroke. The tests were the Motor-Free Visual Perceptual Test-3 (MVPT3), the Developmental Test of Visual Perception-Adolescent and Adult (DTVP-A), and the Test of Visual Perceptual Skills 3<sup>rd</sup> edition (TVPS3). Internal consistency, test-retest reliability, convergent validity and discriminative validity of the tests was examined using Cronbach alpha co-efficients, Intra-class correlation coefficients and T-test statistics. Results: the 3 tests exhibited varying degrees of validity and reliability. All 3 scales were able to differentiate between healthy participants and participants with stroke. All 3 scales also exhibited moderate to good levels of internal consistency and test-retest reliability. The DTVP-A appeared to be the best assessment to use with adult clients.

For anyone wanting to read full article: Brown, T., Bourne, R., Sutton, E., Wigg, S., Glass, S., Burgess, D., Elliot, S., & Lalor, A. (2010). The reliability of three visual perception tests used to assess adults. *Perceptual and Motor Skills*, 111(1), 45-59.

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### Susan McNulty

Headaches, at the University of Southern California Hospital, are labelled as chronic if you experience them more than 15 days a month. Presentation focussed on migraine headaches, which are a neurological disorder: The person has a reduced threshold for stimuli plus a trigger – leads to neurones firing – leads to dilation of arteries and inflammation – leads to migraine.

**Triggers:** more than a 100 have been identified, vary, individual. They include stress letdown, hormones, body posture, poor sleep and exercise, weather, scents, pollution, diet (choc, wine, cheese).

The migraine brain likes a 'boring brain' i.e. routine and structure.

Occupational Science:

Lifestyle balance – regular circadian rhythms

Habits

Self efficacy and perceived control

**Current treatment:** involves MDT, mostly led by neurologists and nurses. Involves medication, psycho-educational approach, look at client resources, pain diary.

### What can occupational therapy do?

- Progressive purpose:
- Increase knowledge of habits and triggers
- Help with adaptation of behaviours
- Improve quality of life
- Reduce headaches

The presenter runs groups, over 8 weeks, sessions covering:

- Lifestyle balance
- Regular habits and routines (individual for each person)
- Dietary triggers
- Stress management
- Ergonomics (include indiv home visits e.g. posture at computer)
- Sensory processing – given a questionnaire from which an Adult Sensory Profile is obtained
- Pain communication - Drs, family, friends
- Managing a headache e.g. breathing, stretching, yoga

Outcome measures are taken – COPM, MIDAS

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### Belinda Simpson

**Animal-Assisted-Therapy** has been used at Abano Rehabilitation since 2007. The dog is used as an integral part of goal-directed therapy, with the occupational therapist conducting the session and using the dog as a modality to facilitate development of skills



## NZAOT Conference 2010 – Feedback to ADHB Occupational Therapists

needed by the client to achieve independent functioning. The dog aids motivation, provides physical benefits e.g. increased ROM and improved fine motor skills, also increased attention and emotional security. All this helps client communicate, develop organisational skills and retain learned behaviours.

Belinda, is an occupational therapist and has epilepsy. She demonstrated the skill of her dog *Tana* at the session, as well as showing video clips of Tana's therapy sessions with clients. (Tana warns her when she is about to have a seizure, and she is thus able to drive)

Youth Justice young offenders help to train therapy dogs.

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*We hope you have enjoyed sharing Conference 2010 with us through this newsletter, as much as we all enjoyed attending the conference. They just get better and better ☺*



## Watch out for the NZAOT 2011 Clinical Workshops

Northland is excited to be hosting the **2011 NZAOT Clinical Workshops, Baskets of Knowledge**

**When:** 3<sup>rd</sup> – 5<sup>th</sup> November 2011

**Where:** Copthorne Hotel & Resort Bay of Islands, Paihia - located on the water front right next to the Treaty Grounds with a plethora of restaurants and accommodation in Paihia just a 5 minute drive away.

**Start Planning!** Not only to attend but also to present and show case the fantastic work that ADHB occupational therapists are involved in.

## Celebrate!

# Occupational Therapy Week

25 - 29 October 2010

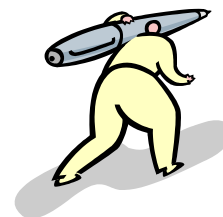
OCCUPATIONAL THERAPISTS: Enabling maximum potential

**Occupational therapists: integral to the team -** Maximise this opportunity to improve the understanding of the purpose and value of occupational therapy, amongst your work colleagues.

**Occupational therapy: the difference between life and living -** Help the public to understand what occupational therapists do, and when/how they might use one.

**Occupational therapists: united around the world -** World Occupational Therapy Day (27 October) marks the unity and solidarity of the occupational therapy community from 66 countries around the world. Commemorate the important contribution of occupational therapists to the health and wellbeing of millions of people around the planet.

END!



Any 'typos' are to be excused!