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# Mouse alternatives: Software and hardware options

Nadia Browning

*Computers are commonly used for education, productivity and/or leisure activities including surfing the web, playing games, and using e-mail. Use of a mouse has become an integral part of accessing computers. If using a standard mouse is difficult due to limited movement, decreased strength or fatigue, then adapted access methods may enhance performance of computer-based activities.*

There are several considerations when choosing an access method. First, it is important to identify what the individual needs or wants to do with the computer. Second, a task analysis of the chosen activity is required to identify what is needed to perform the desired activity. For example, to play Solitaire on the computer, the user needs to be able to control mouse movements, click and drag. Keep in mind all of the mouse functions: single click, double click, click and hold, drag and release. The third consideration is to understand the individual's specific abilities. For example, a person who has active but decreased range of motion in their hands may find a trackball easier to use than a regular mouse. Information such as hardware and software requirements and the compatibility between the device and the computer system are also important considerations.

This article presents current software and hardware alternatives to the standard mouse. Options are categorized according to the individual's ability. As technology is constantly developing, Internet sites are included to provide detailed and updated information on the product or program mentioned. Incidentally, many software programs are available for free in demonstration or trial versions.

## **Performance concern:**

### **Individuals who can access a keyboard but who have difficulty using a regular mouse**

(e.g., individuals with arthritis, mild ataxia or tremors)

#### **Options**

##### **1. Numeric keypad available on a regular or alternative keyboard**

Mouse Keys is an accessibility option included in the Windows operating system. When activated, Mouse Keys uses the keys on the numeric keypad to accomplish mouse functions. Easy Access provides this option within the Macintosh operating system. Expanded keyboards, such as the Intellikeys, include a mouse overlay and an optional matching keyguard. A small keyboard, such as the Magic Wand, also allows the numeric keypad to be used as a mouse. View more information at:

- [www.geocities.com/politalk/win95/mousekey.htm](http://www.geocities.com/politalk/win95/mousekey.htm)
- [support.microsoft.com/default.aspx?scid=kb;en-us;139517](http://support.microsoft.com/default.aspx?scid=kb;en-us;139517)
- [www.microsoft.com/windowsxp/using/accessibility/default.aspx](http://www.microsoft.com/windowsxp/using/accessibility/default.aspx)

For Easy Access within Macintosh operating system, view:

- [www.disability.uiuc.edu/infotechaccess/training/macintosh/geteasyaccess.html](http://www.disability.uiuc.edu/infotechaccess/training/macintosh/geteasyaccess.html)

##### **2. Hand-controlled alternative pointing devices**

###### **a) Alternative mouse that replaces the standard computer mouse**

Some mice have extra buttons or functions that may be customized through software. Others simply connect to the computer without software, such as the GlidePoint ([www.glidepoint.com/](http://www.glidepoint.com/)), and Touchpad ([www.abilityhub.com/mouse/touchpad.htm](http://www.abilityhub.com/mouse/touchpad.htm)). AutoClick is a software feature that allows users to select locations on the screen without having to physically click the mouse. View more information and download free demo versions of AutoClick software at:

- [www.madentec.com/action/try.html](http://www.madentec.com/action/try.html)
- [www.polital.com/pnc/](http://www.polital.com/pnc/)
- [orin.com/access/dragger/index.htm](http://orin.com/access/dragger/index.htm)
- [www.sensorysoftware.com/softwareinfo.html](http://www.sensorysoftware.com/softwareinfo.html)

**b) Touch screens**

This is a good option for children with a short attention span who may benefit from a more direct response to pointing. Touch screens are hardware that can be added to a monitor. Some are also built into special monitors and respond to mouse functions with the touch of a fingertip ([www.ability-hub.com/mouse/touchscreen.htm](http://www.ability-hub.com/mouse/touchscreen.htm)).

**c) Trackballs or joysticks**

Trackballs uses a stationary ball that rotates around its own axis to move the cursor such as the Kensington Expert Trackball ([www.kensington.com/html/1121.html](http://www.kensington.com/html/1121.html)). These devices vary in size of the ball and functions offered. The Joystick uses a stick to control the cursor movements and the buttons responds to mouse clicks. Handles come in various shapes for easier grips, e.g. "T", "O" or "P". View resources and links to products at:

- [www.aroga.com/com\\_access/mouse\\_alternatives.asp](http://www.aroga.com/com_access/mouse_alternatives.asp)
- [www.infogrip.com/](http://www.infogrip.com/)
- [www.rjcooper.com/sam-joystick/index.html](http://www.rjcooper.com/sam-joystick/index.html)
- [www.techconnections.org/resources/guides/Mouse.cfm](http://www.techconnections.org/resources/guides/Mouse.cfm)

**Performance concern:****Individuals who can use their hands to control a pointing device but have difficulty with physical access to a regular, expanded or mini keyboard**

(e.g., individuals with muscular dystrophy)

**Option****On-screen keyboard accessed using a regular or alternative mouse, or a pointing device**

On-screen keyboard programs provide an image of a keyboard on the computer screen allowing keyboard access to the user who cannot physically access external keyboards. The on-screen keyboard is used with programs such as Clicker4 ([www.cricksoft.com/us/products/clicker/default.asp](http://www.cricksoft.com/us/products/clicker/default.asp)) and Wivik3 ([www.aroga.com/com\\_access/onscreen\\_keyboards.asp](http://www.aroga.com/com_access/onscreen_keyboards.asp)) to control the computer and to write. Keys are generally selected by mouse (or an alternative pointing device) or scanning access with switches (discussed later in this article). Many of the on-screen keyboards offer a grid with mouse functions. View additional products and information at:

- Screen Doors 2000 and Discover Screen  
[www.madentec.com/action/try.html](http://www.madentec.com/action/try.html)  
 Click-N-Type  
[www.lakefolks.org/cnt/](http://www.lakefolks.org/cnt/)

**Performance concern:****Individuals who can use part of their body to control an alternate pointing device, but have no hand function**

(e.g., individuals with spinal cord injuries, artificial upper extremity limbs, or mild cerebral palsy)

**Option****Mouse emulation**

Some individuals may not have enough strength, range of motion or endurance for a hand-controlled alternate mouse, but may be able to use head, eyes and/or feet movements instead. Mouse emulation technology is used with on-screen keyboards to allow the user to perform mouse functions. Examples include:

**a) Head control**

Head Tracking uses head movements to emulate mouse control. Try Tracker 2000 ([www.madentec.com/](http://www.madentec.com/)) or Origin Instrument's HeadMouse ([www.orin.com/index.htm](http://www.orin.com/index.htm)).

**b) Speech recognition**

Speech recognition software uses dictation to input text and control the computer and software applications. This input method requires training and users need to have consistent speech and cognitive abilities to remember the commands and be able to cope with noise interference in the environment. View some software options at:

Naturally Speaking

[www.dragonsys.com/naturallyspeaking/](http://www.dragonsys.com/naturallyspeaking/)

FreeSpeech

[www.speech.philips.com/freespeech2000/](http://www.speech.philips.com/freespeech2000/)

ViaVoice

[www.software.ibm.com/speech/](http://www.software.ibm.com/speech/)

**c) Mouth-activated mouse**

A mouth-controlled mouse is often used for individuals with paralysis, or progressive illnesses such as muscular dystrophy or multiple sclerosis. The USB Integra Mouse uses lip pressure for mouse movement and air pressure for button clicks ([www.tashinc.com/catalog/ca\\_usb\\_integra\\_mouse.html](http://www.tashinc.com/catalog/ca_usb_integra_mouse.html)). There are several mouth-operated joystick mice with sip and puff type clicking, such as: Jouse 2 ([www.jouse.com/](http://www.jouse.com/)), Electricjoy ([www.genesisone.net/electricjoy.htm](http://www.genesisone.net/electricjoy.htm)), Integra-Mouse ([www.lifetool.at/show\\_content.php?sid=70](http://www.lifetool.at/show_content.php?sid=70)) and QuadJoy ([www.quadjoy.com/](http://www.quadjoy.com/))



## A sense of place

*Kathy Hatchard*



Striving for a culturally sensitive practice is an inherent value shared by occupational therapists around the world. Yet while its importance is unquestioned, measurement of its attainment is unclear. Dillard and colleagues<sup>1</sup> define culturally competent practice as “an awareness of, sensitivity to and knowledge of the meaning of culture”. The development of this competency, key in the education of occupational therapists, has received international attention in the profession in recent years<sup>2,3,4</sup>. The influences of rapid societal changes, mobilization and cross-cultural interplay present complex and potentially daunting challenges to understanding resultant occupational performance. Guiding meaningful doing requires careful attention to an individual’s roots and values and his/her sense of place in the world. The less emphasized importance of also integrating one’s own views about culture has been stressed as key to progressing from cultural sensitivity to the integration of culturally effective intervention<sup>5</sup>. I recently learned that being open to the learning required on all these levels is not only about growth but also about validation. Let me recount my experience...

My gaze travels vertically, taking in the four tall support beams etched with ornate native carvings. They stretch upward from the sunken floor to support the skylight above, the nightscape of evening stars beyond. I am an invited guest at a literary reading at the En’owkin Centre, an indigenous school of creative arts, culture, ecology and governance. On

entering the centre for the first time this evening, despite living only two kilometres to the north, I am struck by the difference in the sense of place due to its aura of tradition and community. As an occupational therapist, I have visited the aboriginal schools and many homes, but not this place of creativity and gatherings. I have a sense, here, of being the observer of the heart of an inward journey, without having shared the pathway. I feel a tone of respectful welcome. I feel the symbolic distance travelled from my former Ontario home to the Okanagan and onward yet to this heartland of indigenous culture. I quell my sense of feeling out of place by surveying a display of writings by aboriginal authors. I am further impressed to learn that the school also houses the country’s first aboriginal publishing centre. I inquire as to the origin of this unique name, “En’owkin”. I am given a white sheet of paper with simple print.

The gathering is small, mostly native. I find a seat and casually peruse the white paper, very aware of my visitor status. I learn that En’owkin is a metaphor. It is created by the three syllables of the word “n?awq̓n”: ‘n’ means ‘inside or into’, ‘aw’ means ‘seep or drip’, and ‘qn’ means ‘from the head or apex’<sup>6</sup>. Collectively, the image is of something dripping into the head or seeping, single drop by single drop, into the head and, in this way, understanding an issue through a piece-by-piece process. The paper then describes this application to the way in which the Okanagan people used this term when there was a problem to solve in the community. All of the people would be asked to contribute their perspective, no matter how small or seemingly insignificant or contrary that might have been. All were called on not only to express their thinking, but also to take responsibility in seeing the views of others and in creating a solution that considered the needs of all of the community. Finding one’s sense of place in piecing together complex puzzles: it sounded very familiar. I peer out a window into the darkness overlooking the winding road

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## I have been touched by the traditions observed including the practice of initially introducing oneself based on one's family and place of origin.

that forks left to the destination ski resort and right to the heart of the First Nation's reserve.

*It is late fall, yet the sun is high overhead. The government vehicle winds its way upward through the rolling hillside as the town blurs in the distance below. The intermediate care mental health residence seems many kilometres back. We draw attention from approaching drivers. My passenger, a native woman in her early twenties, seems buoyed by the understated nods and waves. She has begun to speak in detail about our destination, the adult education school, a small white clapboard building on the reserve's periphery. I have not seen this animation before. We pass grazing livestock and the neighbourhood of modern homes amidst the natural grasses and Ponderosa pine. The dampening effects of the illness and an uncertain prognosis have made the timing for resuming education difficult to discern. My suggestion of an educational assessment at a mainstream learning centre had been abruptly rejected. Still, there had been encouraging progress since the early days of admission.*

*At first, all attempts at rapport building had been politely rebuffed, the days whiled away in sleepy refuge. Surveying her stark room, the limited personal effects strewn on the floor, the message was clear that the time here was temporary, a medical necessity and a fleeting opportunity for connection. As the weeks passed, a brief window of interaction emerged: the late afternoon game of pool. A camaraderie had emerged: Yet, the signs of elicited emotion would repeatedly dim at the end of the game as a distant wistfulness took their place.*

*This outing is to provide much needed insight for both of us. As we are led into the school's office, it soon becomes evident that a workable way of engaging here is not only feasible but expected. The coordinator speaks in forthright terms and outlines basic starting points. The woman brightens at the mention of a class about Okanagan language and culture and the means to provide a gradual re-entry. I sense her breathing deepen, despite the frankness of the expectations. I consciously step back from the dialogue. This is not the gesture of an outsider acknowledging a cultural bond. Rather, these are actions based on knowledge of occupation, on the observed match between need and resources and the sense of place evolving before me, not unlike the pool ball finding the pocket.\**

I am drawn from my reflection as the evening's special guest is introduced. Joy Harjo, a renowned Aboriginal writer and musician with roots in the Muskogee tribe in Oklahoma and now a university professor of native culture begins what will be over an hour of readings, casual narrative and interspersed expression of her themes by solo saxophone. I am intrigued by the richness of the verse, the depiction of adversity overcome, and of the returning to this grounded place to reflect and share. I am mesmerized by the way her fingers turn the pages of the large volume of writing (mostly published, some not), which seem to hold no difference in their personal significance. The fingers wander and the pages turn. The search is without intensity, for there is a natural connectness amidst the myriad of tales. The voice never falters in telling the background anecdotes. Her work is drawn from her relationship to the earth. The content is rich with native culture, but I am mostly intrigued by this oneness with occupation, this subtle reflection on reaching potential and place.

During a short break, I continue my reading. I learn that the En'owkin process seeks to move the community forward in its problem solving based on its collective responsibility to "the land, the people, the family and the individual"<sup>7,8</sup>. The order of the words seems significant. For a group challenged to maintain these principles amidst a myriad of influences, the En'owkin centre must seem a harbour of sorts.

As the evening closes, I tell my host that I have been touched by the traditions observed including the practice of initially introducing oneself based on one's family and place of origin. She explains her full introduction would actually be much more detailed if done formally and speaks the Okanagan words, describing place and ancestry in a way that reminds me of the sounds a bird makes when contentedly surveying the world from a favourite perch.

The evening has stirred the pangs of loss that come with travelling far from roots and familiarity. It has simultaneously brought comfort through the universal bonds of family, history and connectedness. I reflect on my observations and realize how easily one can lose this sense of place. I am conscious of the similar challenges facing occupational therapists. While guiding our clients, we must respond sensitively to the many interacting factors that affect occupational performance. Culture, in all its complexity, is but a part<sup>9</sup>. No amount of cultural education will ensure optimal practice. It is in partnering with our clients, consistently colouring each unique picture of 'occupation,' that we will continue to define our sense of place. To do so effectively, we must emulate the

\*modifications for confidentiality

noble Aboriginal approach to seeing the full picture, gaining perspective respectfully, like raindrops on one's forehead.

### About the author

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## The challenge of acting ethically in our legal environment

Muriel Westmorland, Jasmine Ghosn and Ron Dick

As occupational therapists we are all familiar with the word *ethics*. Ethical codes guide our practice and remind us that we have a moral duty to our clients and colleagues when it comes to practising our profession. The word *ethics* is derived from the word *ethos* (character) and *moral* from the latin word *mores* or customs. While law often embodies ethical principles, ethics and law are far from co-extensive. Lying or betraying a confidence of a friend would be condemned by many as unethical, but these actions are not prohibited in law. Perhaps more importantly ethics is concerned with *behaviours that affect others*<sup>1</sup>. The term *moral* and its derivative *morality*, along with *ethics* and *ethical* are somewhat ambiguous in meaning. Many people use these terms interchangeably and likely mean *correct* or *right* according to current social norms. Simply put, morality begins with the self, in that each of us has internalized values, beliefs and ideals about how to act in the world. Many of these beliefs and values are learned from the communities in which we live, work and interact (families, educational systems, community, cultural and societal systems).

As occupational therapists we may “wake up” to these issues when faced with difficult client decisions that require us to stop and consider, “What do we do in this situation?” We have our ethical principles to guide us and we also have laws. The relationship between ethics and the law is complex, and not all ethical behavior can be enforced or guided by law. The assumption, “If it’s legal, it must be ethical” does not acknowledge potential complexities of relationships, situations and circumstances. Laws are created when a group of people decide to create rules that are for the common good with consequences for those who do not obey. Laws often limit or restrict behaviours, telling us what things we cannot do, and in the process set minimally acceptable standards. The laws of the land usually reflect the morality of the community or country; for example, *do not steal*, or *do not hurt others*. Koniak<sup>2</sup>, however, states that “ethics is about obligations above and beyond the requirements of law” (p.11). When we reflect ethically we are considering how to act or behave, we are weighing our obligations (legal and profes-

sional) as well as our personal values and the potential effect our actions may have on others.

Problems arise if the law or our professional colleges require us to behave in ways that are apparently outside of our own personal morality, given a certain set of circumstances.

### Some examples

1. You are aware that in order to share patients’ personal health information, you must do so with implied or informed consent, unless there is a legal exception in the circumstances. What is the actual practice of health professionals in your work setting? Would you encourage the breach of privacy laws if it is in the best interest of your patient?
2. An adult client tells you she doesn’t like visiting her family home because she doesn’t like hearing her parents fighting and yelling. She mentions that her father sometimes smacks her siblings (ages 12 and 14) at the dinner table. You are aware that if there are reasonable grounds to believe that child abuse is occurring there is a legal duty to report it to the appropriate authorities. But if you’ve never observed the alleged abuse, and the children and family in question are not even your clients, and your client asks you not to do anything about it, will these factors influence what you do? What if the reported abuse is more blatant, but the client’s family lives in another country?
3. A client tells you about how he is working *under the table* to earn extra money and also stealing groceries from the supermarket because social assistance isn’t paying enough. On the one hand you don’t want to encourage this behaviour, but by doing nothing are you giving the message that the behaviour is condoned? How do you handle the situation without being judgmental? Would you be obligated to report more serious or violent crimes?
4. You have recommended a power wheelchair for a client to use indoors, but you are certain that this client will

## The assumption, “If it’s legal, it must be ethical” does not acknowledge potential complexities of relationships, situations and circumstances.

likely use it outdoors. The client is cognitively able to understand his limitations and has told you he intends to use the chair outside. You are about to prepare a discharge summary outlining the safety considerations, and the coordinator for the home tells you that if there are any safety concerns with the wheelchair, the client will be denied placement. The client begs you not to say anything about his intention to use the chair outside. What would you do?

5. You have been retained by an insurance company to prepare a report about the claimant that would strengthen the case of the insurer. You are aware that the person you examined has limitations for which the insurer should provide compensation. What would you do?
6. You are aware that your client, an elderly woman living in the community, is becoming very frail and weak, and you are concerned about her safety. She is showing signs of dementia, and admits she is having trouble with her memory. You know that a neighbour has been helping the woman with her finances, but you don’t think the neighbour is handling the money in the woman’s best interests. Part of you wants to report the matter to the Public Guardian and Trustee, but if you do, it’s possible the woman will be admitted to hospital and taken out of her home, and this will make her very unhappy. What would you do?
7. One of your colleagues is having an addiction problem and you believe that if she doesn’t get help soon, it could affect her work. Your colleague tells you she is getting help and you have confidence she will overcome the addiction. She asks that you not tell anyone at work, and not report her to the College. What would you do?

### What should you do?

- Be aware of what the law says; stakes are high.
- Be aware of what your professional regulatory body, or college requires; again stakes are high.
- Consider your own morality and ask yourself, “When might I choose to act in defiance of the first two?”
- Be aware of your own internal values, beliefs and ideals, and how these might influence how you act.
- You might ask, “What is it that the parties involved want, and what are the best interests of the client?”
- Apply traditional ethical principles to help clarify things; encourage autonomy of the individual, and while doing no harm ensure justice for all involved.

- Be aware of your own internal values, beliefs and ideals, and how these might influence how you act.
- Consider whether you are being honest, compassionate and loyal to the person who is counting on you.
- Remember your ethical code of practice and weigh up the *ought*, as it is called in the ethics literature – “What ought I to do under these circumstances given that the client’s best interests need to be respected?”
- Remember you have an obligation to do the right thing.
- Talk to others: peers, colleagues, supervisors, ethics resource teams, associations and colleges.
- If you realize you don’t have good supports... create them! Form a peer support group, acquire a mentor, and negotiate more supervision resources from your employer.
- Determine whether a law or rule needs to be changed, and communicate your views to your provincial and national professional associations, since part of their role is to lobby governments on behalf of the profession.

### About the authors

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# From knowledge transfer to knowledge translation: Applying research to practice

Leslie Stratton Johnson

There is a new buzz word that is frequently mentioned related to integrating research and practice: KT. While this term is getting lots of air-time, it is not clear that everyone is talking about the same thing. KT has been used to describe two closely related ideas: *knowledge transfer* and *knowledge translation*.

As the need for accountability increases, occupational therapists are challenged to deliver evidence-based practice. This involves clinicians using research evidence, along with clinical knowledge and reasoning, to inform practice<sup>1</sup>. For research uptake to occur, the researcher provides knowledge to the user who implements the knowledge. The knowledge provision step is integral; the terms knowledge transfer and knowledge translation both acknowledge the complexities and challenges of this transmission between the researcher and the user.

## What is knowledge transfer?

Between the 1950s and the 1990s, the literature related to the flow of research findings from researcher to user generally discussed knowledge transfer<sup>2</sup>. This term describes the one-way flow of knowledge from researchers to potential users including policy makers, clinicians and clients; it is also considered the responsibility of researchers<sup>3</sup>. The methods of knowledge transfer can be active or passive, depending on the transfer goals<sup>4</sup>. It has been well established that the more participatory and targeted the transfer activity, the more likely it is to result in application<sup>5,6</sup>.

Lomas<sup>7</sup> categorized three types of transfer activities which researchers may use. These range from passive to active and include:

*Diffusion* is designed to promote awareness. Knowledge is made available via journals, newsletters, web sites, and mass media but is not directed toward a specific target. The goal is simply to “get the information out there”.

*Dissemination* involves using intentional activities to share research findings strategically with particular stakeholders, such as by mailing results to intended audiences and

holding workshops and conferences to share findings. The goal is both to create awareness and change attitudes.

*Implementation* involves the most active transfer activities with the goal of creating a behaviour change. These strategies include efforts to overcome barriers to implementing the research information, through activities such as face-to-face contacts with experts and establishing audit and reminder systems to encourage users to change their behaviour or practice in light of research findings.

Knowledge transfer methods and actions are dependent upon who is initiating the research activities<sup>8</sup>. Lavis et al.<sup>9</sup> identified the following three models of knowledge transfer based on the degree to which the transfer is researcher-directed.

*Research-push*: This describes research which is initiated by, conducted by and transferred by the researcher. This satisfies the researcher’s curiosity; it is then the responsibility of the researcher to get the information to others who share this interest.

*User-pull*: This occurs when the decision maker or group commissions research with a predetermined use in mind.

*Exchange*: This is the most complex model in which researchers and decision-makers work together to build research questions relevant to their mutual needs and skills.

## Effectiveness of knowledge transfer

There are concerns regarding limited knowledge uptake. This is often attributed to the reality that researchers, policy makers, and clinicians inhabit “different worlds”<sup>10,11</sup>. This concept is known as the “two-communities” theory<sup>12</sup>. In other words, simply receiving knowledge does not necessarily lead to using it, especially if the parties do not share the same focus, language, culture or research agenda<sup>13,14</sup>.

Reading printed educational materials and attending didactic educational meetings have generally not proven to be effective in changing behaviour or professional practice<sup>15</sup>. More specifically, Craik and Rappolt<sup>16</sup> noted that the process of knowledge transfer from evidence to practice within the rehabilitation professions is not well understood. Based on

their qualitative study, suggestions to improve application of research evidence in occupational therapy practice included using structured reflection and case application<sup>17</sup>. Law and Baum<sup>18</sup> have noted that clinicians can encounter barriers to knowledge uptake at both the system and individual level. At the system level, significant barriers may include a lack of administrative support and no time to read and integrate research information into practice<sup>19,20</sup>. At an individual level, clinicians may have limited skills in interpretation and application of research findings<sup>21,22</sup>. These barriers can create a gap between researchers and clinicians. Even when clinicians have the time to read and the skills to analyze research, whether they can change their practice depend on economic, administrative and cultural barriers within the organization or community<sup>23</sup>.

### Bringing researchers and clinicians together

Attention has turned to bridging the cultural gap and moving toward more effective knowledge transfer. Suggestions to researchers have been put forward to promote knowledge uptake. Maclean et al.<sup>24</sup>, building on the work of Lavis et al.<sup>25</sup>, outlined the following components and strategies which should be considered by researchers to promote the uptake of their findings:

#### 1. The message

Rather than data, suggestions regarding application of research are most helpful. For clinicians, this may include evidence-based guidelines.

#### 2. The target audience

The message's target audiences must be clearly identified and the specifics of the knowledge transfer strategy should reflect their needs. The same message regarding best practice will not work for clients, therapists and policymakers alike. Instead, design specific messages for each audience's needs.

#### 3. The messenger

The credibility of the messenger can be as important as the message itself. Rappolt and Tassone<sup>26</sup> indicated that occupational therapists rely heavily on peers as educational resources.

#### 4. The knowledge transfer process and infrastructure

While printed materials such as journal articles are used most often, the most effective means of knowledge transfer is personal interaction. These interactions may include writing via

email, listservs, blogs, discussion rooms, interest group meetings and round table discussions.

#### 5. Evaluation

Knowledge transfer performance measures should be appropriate to the target audience and the objectives. For clinicians, the objective may be to change practice to match the evidence and improve client outcomes; for policymakers, the objective may be informed debate.

At the end of the day, no matter how well-packaged the information is, knowledge transfer will always be limited in that the delivery is top-down and researcher-centric<sup>27</sup>. If the information does not address the questions that interest the user, it is not useful.

### Knowledge translation

The term *knowledge translation* has emerged more recently to describe a broader concept which includes all the steps between the creation of knowledge and its application. Rather than beginning at the point at which a message is to be delivered (as knowledge transfer often does), knowledge translation describes an active, multi-directional flow of information which begins at project inception. Partnerships, which are integral in knowledge translation, are encouraged among researchers (within and across disciplines), policy makers and managers, health care providers, and health care users<sup>28</sup>. Interactions and exchanges occur before, during, and after the project with the goal of developing research questions, setting a research agenda, and then determining actions<sup>29</sup>. Knowledge translation, while set in the practice of health care, draws on many disciplines to help close the gap between evidence and practice. This may include informatics, social and educational psychology, organizational theory, and patient and public education<sup>30</sup>.

The Canadian Institutes of Health Research (CIHR) has put forward the following definition of knowledge translation:

*Knowledge translation is the exchange, synthesis and ethically-sound application of knowledge – within a complex system of interactions among researchers and users – to accelerate the capture of the benefits of research for Canadians through improved health, more effective services and products and a strengthened health care system<sup>31</sup>.*

The focus of the CIHR knowledge translation model is the knowledge cycle symbolizing the process of formulating research questions, conducting research, strategically publishing and disseminating research, and then generating new, context-specific knowledge by applying research findings in

different settings. This new knowledge in turn feeds future research questions – and the cycle continues<sup>32</sup>.

Knowledge translation draws on some key models and methods of knowledge transfer, but it describes a broader and more integrated approach. When describing an exchange, it is useful to determine whether you are discussing a one-way transfer of information (knowledge transfer) or a multi-directional transfer of information (knowledge translation).

There is increasingly more interest in enhancing opportunities for knowledge translation, representing a major shift in Canadian funding agencies' health priorities. Formerly, research was often funded with only minimal attention to the process of disseminating information; current funding emphasizes developing dynamic mechanisms that engage players whose decision-making will be informed by the research<sup>33</sup>. Research agencies and educational facilities are also taking the lead by offering and sponsoring seminars and courses on the theories, guidelines, and tools of knowledge translation.

Although knowledge translation is the term used within the health disciplines, others use a different vocabulary to meet their own needs. For example, organizational literature refers to *knowledge management* when describing the way knowledge develops as it flows through different contexts<sup>34,35</sup>. *Knowledge mobilization* is the term that social sciences and humanities use to describe this process<sup>36</sup>. Words are powerful and these terms reflect the nuances of activity and thinking within the specific disciplines.

### Implications for occupational therapy

Clinicians, researchers, academic and fieldwork educators, clinical practice leaders and policy makers all need to be aware of the concepts of knowledge transfer and translation. Occupational therapists have integral skills and practice insights to help set research agendas. Using knowledge transfer principles is integral to our educational endeavours – with our clients, students, colleagues and the public. Being grounded both in knowledge transfer concepts and the knowledge translation process will lead to more satisfying and effective exchanges and ultimately enhance therapists' translation of evidence into practice. Attention to this process will also promote lively discussion among occupational therapists and their stakeholders.

It's not easy, though. Putting new knowledge into practice is a complex process. It depends on both the occupational therapists' knowledge and ability as well as supportive organizational factors to put it into practice. Embracing the

two-way knowledge translation process requires extensive consultation and partnerships. While these strategies are in keeping with client-centred practice, they may require occupational therapists to move out of familiar contexts.

Lots of people are talking about KT — knowledge transfer and knowledge translation — and for good reasons: these need to become integral concepts in occupational therapy practice and important strategies in our goal of providing client-centred, evidence-based practice. Let's keep talking.

### About the author

Leslie Stratton Johnson, BHSc(OT) resides in Winnipeg, Manitoba where she wears several hats as a registered occupational therapist: community clinician, part-time faculty member in the Occupational Therapy Department, School of Medical Rehabilitation, and graduate student. She is interested in the process of linking research and day-to-day occupational therapy practice and can be reached at johnsonl@cc.umanitoba.ca

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### Suggestions for further reading

- Institute for Work and Health: Knowledge Translation and Exchange available at:  
<http://www.iwh.on.ca/kte/kte.php>
- Cochrane Musculoskeletal Group: Knowledge Translation available at:  
<http://www.cochranemsk.org/professional/knowledge/default.asp?s=1>

Celebrating diversity in occupation  
CAOT Conference 2005



Mary Clark Green

Most Vancouverites participate in a conspiracy that propagates the rumour that it's always raining on the West Coast. Unfortunately, with full sun and temperatures reaching as high as 28 degrees Celsius the secret is out. Out-of-town delegates who attended the 2005 CAOT Conference hosted with the British Columbia Society of Occupational Therapists (BCSOT) are challenging their assumptions and exploring possibilities.

If they are researchers it might be something like:  
*How does weather influence engagement in occupations? Or, if you took 650 delegates and randomly assigned 50% to attend conference and 50% to read on the beach, which would demonstrate a greater understanding of occupational balance?*

If they are practitioners it might be something like:  
*Where are the occupational performance challenges in the Vancouver area? People look really healthy; they seem to make time for leisure and they must have sufficient productivity to afford the housing. The communities appear inclusive and diverse. How can I make a living here?*

If they are students, it could be one of three:  
*Darn, why didn't I consider UBC? How do I get a fieldwork placement out here? I am definitely coming back here to work.*

Despite appearances there are many occupational challenges to overcome so that we may continue to celebrate diversity in occupation and build inclusive communities, not just in Vancouver

and B.C. but across the country. These two themes were illustrated both colourfully and sensitively in the opening ceremonies held Thursday morning. The ceremonies began with our National anthem sung beautifully by Jerrica Santos, a grade 11 student from Fraser Heights who was also a finalist in Canadian Idol Season Two. Delegates were then greeted with a Chinese lion dance performed by the Shung Ying Kung Fu Club. This was followed by a welcome song by Tso'kam, a traditional Lillooet singing group from Mount Currie who are part of the Coast Salish people. It was truly a culturally diverse welcome.

Following the vivid performances, keynote speaker Sam Sullivan took us through his personal journey of regaining independence after he became paralysed due to a skiing accident when he was 19. He recognized the work of occupational therapists and cautioned us to value the social net that is essential for inclusiveness and to be careful not to lose it. Sam had first hand experience with this, having had to work his way out of the welfare trap. "When I ended up on welfare, I was pleased that I would be getting \$400 a month and I thought I would be able to move forward on this stable foundation." Sam soon found out that he might be penalized if he earned extra income while on welfare. He also learned that the benefits of a wheelchair and attendant care were also in danger. Sam felt the system kept him from moving ahead because it provided no incentive to do so.

Quality of life is important to Sam, and seven years after his accident he began the first of several initiatives that would help Canadians with disabilities to



Eugene Tse from Edmonton, Alberta  
and Sametta Cole from Oshawa, Ontario



Poster presentations allow for presentation of complex data and more presenter-delegate discussion.

better enjoy life. After starting the Disability Sailing Association, he moved on to create The Vancouver Adaptive Music Society. His own band was called “Spinal Chord”. Not having reached fame and fortune as a rock musician, Sam admitted that he suppressed these urges and decided to go into politics in 1993.

He and fellow Vancouver City councilor Tim Louis are both disabled, but Sam was careful to say, “We are on council because it’s accessible. It’s not accessible because of us.” Sam explained that people who believed in inclusiveness had built a city where it was possible to be disabled and an active politician. Sam himself has continued to create organizations that build enabling environments such as TETRA, the B.C. Mobility Opportunities Society and Access Challenge.

Sam concluded that our next challenge is to put the disability model into other areas where people are marginalized, such as those with drug addictions. He contends that it is not a morality issue but a short-term medical issue and long-term disability issue. “I am not sick,” announced Sam. “I am disabled.” Sam described it as a long-term issue that we manage versus a short-time issue that we fix, if possible. It’s important that we all grasp this and ensure that others do as well. “Please keep doing what you are doing,” were Sam’s parting words to the occupational therapists present.

We were honoured again with international guests who, having enjoyed Prince Edward Island’s conference, returned to see the West Coast. Our occupational therapy friends included Jenny Butler, chair of the Council of the College of Occupational Therapists at the British Association of Occupational Therapists (BAOT) and Beryl Steeden, also of BAOT; Carolyn Baum, president of the American Occupational Therapy Association (AOTA) and Maureen Peterson also of AOTA. The World Federation of Occupational Therapists (WFOT) was represented by Canadian occupational therapist Sharon Brintnell, who is their honorary treasurer. Presenting at conference were distinguished international leaders Gail Whiteford of Australia and Charles Christiansen of the United States. We were also pleased to see other delegates from the U.S., Australia and Sweden.

Following the opening ceremonies, delegates enjoyed

coffee with many prestigious authors of CAOT publications. Practitioners, educators and students could meet with Mary Law and Anne Carswell, two of the six authors signing the 4th edition of the COPM. Mary also joined Lori Letts to sign the *Programme Evaluation Workbook*. Carolyn Baum was there for the Paediatric Activity Card Sort (PACS); Mary Egan was close by for *Discovering Occupation* and the *Spirituality Workbook*. Anne Kinsella was on hand for *Reflective Practice*, and Liz Townsend joined Mary Egan and was also available for *Enabling Occupation* and the accompanying workbook.

Once the Trade Show opened, the conference was in full swing. The exhibitor booths spilled into the hallways, and together with the poster presentations forced delegates to make difficult choices regarding what sessions to attend. Decision making was complicated further by two excellent professional issue forums on clinical practice guidelines and building an ethical framework. There was truly something for everyone from networking with private practitioners to tips on writing in the *Canadian Journal of Occupational Therapy (CJOT)*.

Conference is seldom a 9-5 phenomenon; various meetings were set up for early morning and the evening, before during and after the formal three days of conference. In the interest of balance, however, all delegates were encouraged to forget business for at least two evenings. Thursday evening the Vancouver Aquarium Marine Science Centre took delegates on an underwater adventure with the beluga whales.

Below: Elisabeth Dutil and Louise Demers at the CAOT Publications book signing.  
Right: Gail Whiteford, from Australia and Mary Law from Hamilton, Ontario.



Over 200 delegates attended the gala dinner at the Vancouver Aquarium Marine Science Centre

Dinner followed with a silent auction that raised over \$3500 for the Canadian Occupational Therapy Foundation (COTF) and the BC Society of Occupational Therapists' Research Fund. On Friday, UBC students hosted delegates at a downtown Irish pub and then poured them downstairs to experience one of the city's hottest dance clubs.

The highlight of each and every conference is the Muriel Driver Memorial Lecture. This year, Dr. Johanne Desrosiers disappointed no one. She provided a lecture that will not only mark a significant era in our profession but one that will give rise to many discussions over the coming years, as we engage in discussions with our health care colleagues to define participation and demonstrate its relationship to occupation. Watch for her full lecture in the October 2005 issue of *CJOT*.

The list of recipients of awards provided by CAOT and COTF during the annual awards ceremony continues to grow. Over 150 certificates of appreciation were awarded, along with impressive provincial/territorial citation awards, an award of merit, and the prestigious awards of CAOT Fellowship, the Helen P. Levesconte award and the Muriel Driver Memorial Lectureship. See pages 18-22 for details.

COTF held its third annual Lunch with a Scholar featuring Dr. Elizabeth Townsend, director of the occupational therapy program at Dalhousie University. This event raised funds for COTF and also raised consciousness regarding occupational justice and our roles in it. Dr. Townsend proposed an audit strategy for enabling occupational justice con-

Below: Delegates discuss an ethical framework during one of the professional issue forums. Right: Art Jonker, an established artist, provided the illustration for the back of the conference host committee t-shirts.



sisting of 1) critical occupational analysis, 2) human resources analysis, 3) power analysis and 4) accountability analysis. This strategy merits a detailed look by individual occupational therapists and the organizations which represent them.

At the closing ceremonies, CAOT President Diane Méthot congratulated past members of the CAOT Board of Directors who made the brave decision to move the Association office to Ottawa. Having been in Ottawa for ten years, the Association is now able to position itself more closely with the federal government, consumer and other health professional groups on health and social issues affecting the occupational well-being of the people of Canada. Diane's full address will be available on the CAOT web site at [www.caot.ca](http://www.caot.ca)

The B.C. Host Committee co-chaired by Lori Cyr and Brendan Tompkins had the support of a small but dynamic committee who fanned out to bring in many local therapists as volunteers. Congratulations to all of the B.C. therapists who helped make the conference a success. Conference coordinator Gina Meacoe and other members of the CAOT National Office staff along with the Conference Steering Committee also worked tirelessly to support the vision of *Celebrating diversity in occupation*.

Plans for next year's conference have already begun. Thanks to this year's host committee, the Montreal team is equipped with a suitcase of aids and "home-made medicines" to help them to cope with the occupational challenges over the year. The Scientific Conference Planning Committee has

revised the abstract writing guidelines and review process. More information is available on page 31.



**Visit [www.caot.ca](http://www.caot.ca) and click on the Montreal Conference logo for more information. See you next year! À bientôt.**



## ANNOUNCING THE 2004/5 CAOT AWARD RECIPIENTS

*CAOT awards celebrate the contributions of volunteers to our Association. Volunteers fulfil many important roles. They are members of the Board of Directors, they chair and sit as members of committees and represent the Association on national coalitions and task forces. As well, our volunteers contribute to the development of CAOT products and services such as our journal, practice magazine and web site.*

### Fellowship Awards

*This award has been established to recognize and honour the outstanding contributions and exceptional service of occupational therapists. Fellows of CAOT are eligible to use the credential FCAOT.*

#### Johanne Desrosiers

Muriel Driver Memorial Lecturers are recognized leaders in the Canadian occupational therapy community and receive a Fellowship as part of their Award. This year's lecturer and new fellow is Johanne Desrosiers.

#### Sue Forwell

Sue is a visionary, enthusiastic, focused, dedicated person who puts 100% of her energy into everything she does and inspires others with her vision and energy. She is a highly respected leader, educator, researcher and volunteer both within the profession of occupational therapy and in the field of multiple sclerosis.

#### Dr. Helen P. LeVesconte Award for Volunteerism Paulette Guitard

*This award is given to an individual or life member of CAOT who has made a significant contribution to the profession of occupational therapy through volunteering with the Association. It celebrates the achievements of Dr. LeVesconte who had a great influence on the development of occupational therapy in Canada and was very involved with CAOT.*



Paulette Guitard has a significant history of volunteering for CAOT for more than a decade. She has consistently reviewed CAOT documents and articles for the *Canadian Journal of Occupational Therapy*. She was involved with the Membership Committee from 1994 to 2002. Her bilingualism has provided an expertise to CAOT not easily found either regionally or nationally. Most recently, Paulette was the Chair of the Academic Credentialing Council, a role she took on after seven years as a committee member. In her role as a member of the Council, Paulette contributed and continues to contribute to the maintenance and revision of high standards of practice in educat-

ing future occupational therapists. As part of the committee, her work impacts significantly on the profession, as graduates from occupational therapy educational programs are well prepared to provide quality occupational therapy services. Paulette conducted multiple university program accreditation visits; six nationally accredited programs have been evaluated by Paulette.

Paulette spoke a few words after receiving the award. She acknowledged the influence of her high school teacher on choosing occupational therapy and expressed regret that the profession is still not known enough. Paulette looks forward to her new position on the CAOT board to help promote occupational therapy.

### CAOT Student Awards

*Each year CAOT provides a student award to a graduating student in each Canadian university occupational therapy education program who demonstrates consistent and exemplary knowledge of occupational therapy. Last year's winners were:*

Sylvia Arruda, Queen's University  
Marie Beaumont, Université d'Ottawa  
Marie-Hélène Biron, McGill University  
Julie Charbonneau, Université de Montréal  
Heidi Haldemann, Dalhousie University  
Debra Johnston, University of Western Ontario  
Alison Leduc, McMaster University  
Jana Phung, University of Alberta  
Valérie Poulin, Université Laval  
Heidi Reznick, University of Toronto  
Tracie Jo Sparks, University of British Columbia  
Katrina Wernikowski, University of Manitoba



Johanne Desrosiers, 2005 Muriel Driver Memorial Lecturer and new CAOT fellow with Réjean Hébert who is the Quebec recipient of the the CAOT/Provincial Citation Award (see page 20).

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## Muriel Driver Memorial Lectureship Award

### Jan (Miller) Polgar, PhD, OT(C)



*Since Dr. Polgar's undergraduate days she has demonstrated similar qualities to those shown in Muriel Driver's significant contributions to the profession and she has used these unselfishly to advance occupational therapy both nationally and internationally.*

Dr. Polgar's research has firmly established the profession in new areas of practice. Her creative yet pragmatic approach has reached into the board rooms of Canada's leading financial and industrial institutions, helping to connect the concepts of health and occupation and raising the profile of occupational therapy at important decision-making tables. Dr. Polgar's dedication also reaches close to home where she is a committed educator and mentor. She values the important work of professional associations and regulatory organizations and has volunteered on many boards and committees throughout her career. The following is a detailed account of her many accomplishments in all these areas of professional service.

Dr. Polgar received her BScOT from the University of Toronto in 1978, her MAOT from the University of Southern California in 1983 and her PhD from the University of Toronto in 1992. She received several honors during her academic preparation including a Ministry of Health Fellowship, an Ontario Graduate Scholarship and the University of Toronto Physical and Occupational Therapy Alumnae Scholarship.

Dr. Polgar's early clinical work focused on rehabilitation and pediatrics at both the G.F. Strong Rehabilitation Centre in Vancouver and the Children's Rehabilitation Centre of Essex County in Windsor, Ontario. She has been on faculty at the University of Western Ontario since 1982 and an Associate Professor at the same university since 2000. She was also the acting director of the department at Western as well as a tutor and instructor at both Mohawk College and the University of Toronto.

Dr. Polgar's professional contributions lie in the areas of seating and mobility, safe transportation and professional issues. She is currently a member of the Board of the Canadian Seating and Mobility Conference and she carried the research portfolio on the Canadian Adaptive Seating and Mobility Association Board. Dr. Polgar has supervised numerous graduate research projects on topics such as the effect of sitting positions on infant's upper extremity function and the reliability and clinical utility of selected outcome measures with adult clients participating in seating clinics.

Her own research focuses on this area and she has been both the principal investigator and the co-investigator on grants related to a toileting system for children and high school students with severe positioning problems, a client-specific outcome measure of wheelchair and seating intervention and the effects of two methods of pelvic stabilization on occupational performance of children and adolescents with cerebral palsy. Dr. Polgar's work in this area has been published in *Physical and Occupational Therapy in Pediatrics*, and presented at numerous local, national and international conferences.

Her most recent area of academic involvement relates to the investigation of safe transportation for seniors through The Automobile of the 21st Century (AUTO21). Dr. Polgar is without a doubt a champion for improving the health and safety of vulnerable persons through her continued leadership role as a distinguished researcher with AUTO21. AUTO21 is a national research initiative supported by the Government of Canada through the Networks of Centres of Excellence Directorate and more than 120 industry, government and institutional partners. The Network currently supports over 230 top researchers working at more than 35 academic institutions, government research facilities and private sector research labs across Canada and around the world.

Within this network Dr. Polgar was elected and served as a member of the Board of Directors of AUTO21. Her role in this network is to demonstrate the importance of considering the person and their occupational needs in the development of vehicles and safety devices. Dr. Polgar's research projects in this network focus on how to keep vehicle occupants safe. While today's cars are safer than ever, many of the safety features have been designed to protect the body type of the average adult male. The efficiency of these safety features may decrease for passengers that are smaller in stature, younger or older.

The first component focuses on increasing protection for young children and the older adult in vehicles. For young children and babies, safety seats are an effective way to increase vehicle safety when installed and used correctly. Unfortunately, 80% of child safety seats are installed incorrectly, thus decreasing their effectiveness in reducing the



threat of injury during an accident. This project evaluated the efficiency of intervention programs that teach parents how to correctly restrain children in vehicles.

The second component of the project gathers ideas and opinions from seniors about their concerns for their own safety when traveling in a vehicle as well as for those of other vehicle occupants. Issues include use of vehicle safety features, ability to get in and out of the vehicle, and concerns with other vehicle design features. In all of these areas Dr. Polgar has made a significant contribution to developing graduate students' interest in health and safety research, and she has presented extensively, disseminating information on how best to design and make person-centred improvements to enhance vehicle safety for the users. The grant monies Dr. Polgar has received for these various initiatives exceeds \$600,000.

Dr. Polgar's scholarly excellence has been recognized through the acceptance of her publications in numerous other journals including *Qualitative Health Research*, the *Canadian Journal of Occupational Therapy*, and *Exceptionality Education Canada*. She has been invited to submit chapters in books such as both the ninth and tenth editions of Willard and Spackman's *Occupational Therapy* and the *Introduction to Occupation* edited by Christiansen and Townsend. She is a co-author with Dr. A. Cook on the 3rd edition of *Cook and Hussey's Assistive Technology*. Her work has also been acknowledged by her peers through acceptance of conference presentations across Canada, at several locations in the United States and in Australia.

Dr. Polgar's commitment to her professional associations is very impressive and is shown through her ongoing involvement at both the provincial and national level. She has been chair elect, chair and past chair of CAOT's Certification Examination Committee and continues to organize local sessions for item generation. At the national level she has also served as the vice-president of the Association of Canadian Occupational Therapy University Programs. She has undertaken many areas of responsibility for the College of Occupational Therapists of Ontario including academic representative on the council, chair of the Quality Assurance Committee, and member of the registration committee, academic review sub committee and the practice review sub-committee. The knowledge Dr. Polgar brings to these committees is irreplaceable, and her willingness to maintain a high level of involvement serves as evidence of the value she places on the advancement of her profession.

Dr. Polgar is a committed educator who gives freely of her time and expertise to ensure that her students reach their maximum potential. She receives excellent teaching evaluations and does not hesitate to go the extra mile to ensure the quality of the educational experience received by students at all levels in the Faculty of Health Sciences at the University of Western Ontario. The students, faculty and staff in the School all joined enthusiastically to nominate Dr. Polgar in recognition of her many significant contributions to the profession.

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### **Awards of Merit**

*These are given to acknowledge significant contributions to the profession of occupational therapy.*

#### **James Zamprelli**

Jim is a Senior Researcher of the Policy and Research Division with the Canada Mortgage and Housing Corporation.

#### **CAOT/Provincial Association Citation Awards**

These awards acknowledge the contributions and accomplishments to the health and well being of Canadians of an agency, program and/or individual within each province or territory who is not an occupational therapist. The awards are usually presented to recipients during National Occupational Therapy Month. Réjean Hébert attended this year's conference and was presented with the award by the Quebec

association's president Françoise Rollin. Details regarding these awards are published on the CAOT web site.

#### **Ordre des ergothérapeutes du Québec**

**Réjean Hébert**

#### **Ontario Society of Occupational Therapists**

**Heart and Stroke Foundation of Ontario**

#### **Prince Edward Island Occupational Therapy Society**

**Nora Jenkins**

#### **Newfoundland and Labrador Association of Occupational Therapists**

**Independent Living Resource Centre**

**Family and Child Care Connections**

#### **COTF Grants and Scholarships 2004**

##### **Master's Scholarships**

Mari Basiletti & Susan Nelson

continued ...



### Doctoral Scholarships

Jane Davis & Sonia Gulati

### Thelma Cardwell Scholarship

Alison Douglas

### Goldwin W. Howland Award

Melanie Levasseur

### 2004 Research Grant • Carolina Bottari

### 2004 Marita Dyrbye Mental Health Award • Cathy White

### 2004 Publication Grant • Janine Theben and Susan Doble

### Roulston/COTF Innovation Award

University of Ottawa

McGill University

University of Alberta

University of Manitoba

University of Toronto

University of Western Ontario

### Certificates of Appreciation

*These are given to CAOT Chairs, committee members and Board Directors who have completed their terms.*

Jocelyn Campbell

New Brunswick Board Director

Sandy Delaney

Newfoundland and Labrador Board Director; Risk Management Committee member; CAOT Logo Advisory Committee member

Wendy Lintott

Certification Examination Committee member

Mary Manojlovich

Past President, Newfoundland and Labrador Board Director; participant in the Enhancing Interdisciplinary Collaboration in Primary Health Care Group Consultation

Huguette Picard

WFOT Alternate; Chair, Nominations Committee, Member of Federal Election Action Team.

Susan Novo

Chair, Archives Committee

Kimberley Smolenaars

Nova Scotia Board Director

Marnya Sokul

Certification Examination Committee member

Louise Demers

Editorial Board member

Laurie Snider

Editorial Board member; Academic Credentialing Council Indicator Project Working Group member

Kristine Roth

Membership Committee member

Heather Beaton, Rebecca Bonnell, Sabrina Chagani, Sylvia Coates, Shallen Hollingshead, Jean-Phillippe Matton, Karen More, Farah Namazi, Janice Perrault, Stefanie Reznick, Rochelle Stokes and Susan Varughese  
Student Committee members

Claire-Jehanne Dubouloz

Canadian Journal of Occupational Therapy Review Board member; Academic Credentialing Council Indicator Project Working Group

Emily Etcheverry

Canadian Journal of Occupational Therapy Review Board member; Chair, Conference 2003 and 2004 Scientific Program Committee; Academic Credentialing Council Indicator Project Working Group member

Francine Ferland

Membre du comité de rédaction de la revue canadien d'ergothérapie

Marilyn Conibear

CAOT Logo Advisory Committee member

Susan Varughese

CAOT Logo Advisory Committee member

James Watzke

CAOT Logo Advisory Committee member

Andrea Coombs

Conference 2003 and 2004 Scientific Program Committees member

Lisa Mendez

Conference 2003 and 2004 Scientific Program Committees member

Jane McSwiggan

Conference 2003 Scientific Program Committee member

Carol Zimmerman

Conference 2003 Scientific Program Committee member

Heather Cutcliffe

Conference 2004 Host Committee Co-Convenor

Mari Basiletti

Conference 2004 Scientific Program Committee member

Charyle Crawley

Conference 2004 Scientific Program Committee member; Student Representative

Tina Pranger

— facilitator; panelists: Debra Coleman, Carol Tooton, Phil Upshall, Marie Basiletti  
2004 Occupation and Mental Health Professional Issue Forum

Lili Liu

— facilitator; panellists: Sharon Baxter, Sharon Carstairs, David Morrison  
2004 Occupation and End-of-Life Care Professional Issue Forum

Elizabeth Taylor — Chair; Members: Catherine Backman, Paulette Guitard, Vivien Hollis, Terry Krupa, Micheline Marazzani, Mary Ann



McColl, Helene Polatajko, Micheline Saint-Jean, Elizabeth Townsend  
Academic Credentialing Council Indicator Project Working Group

Mary-Andrée Forhan, Darla King  
2004 Federal Election Action Team members and participants in the  
Enhancing Interdisciplinary Collaboration in Primary Health Care  
Group Consultation

Joyce Braun, Anne Marie Brosseau, Victoria Cloud, Sandy Daughen,  
Mary Beth Fleming, Lise Frenette, Christina Goudy, Sheila Heinicke,  
Beverly Lamb, Suzanne Lendvov, Jane McCarney, Jacqueline McGarry,  
Tracy Milner, Lorraine Mischuk, Connie Mitchell, Sandra Moll,  
Susanne Murphy, Linda Petty, Luigina Potter, Tipa Prangrat, Barbara  
Rackow, Susan Rappolt, Cindi Resnick, Fiona Robertson, Brenda  
Ryder, Barry Trentham, Hilda-Marie Van Zyl, June Walker Wilson,  
Diane Zeligman  
2004 Federal Election Action Team members

Ron Berard, Linda Bradley, Patricia Byrne, Jody Edamura, Kara  
Gorman, Mary Harris, Linda Hirsekorn, Carolyn Kelly, Sally  
MacCallum, Laurie Misshula, Erin Mitchell, Marie Morrow, Louise  
Nichol, Susan Reil, Jill Robbins, Jennifer Shin, Stephanie Wihlidal, Barb  
Worth, Bonnie Zimmerman  
Participants in the Enhancing Interdisciplinary Collaboration in Primary  
Health Care Group Consultation.

Kathy Corbett  
Participant in the Enhancing Interdisciplinary Collaboration in Primary  
Health Care Group Consultation and the consultation workshop for  
the CAOT ethics framework.

Marion Hutton  
Participant in the Enhancing Interdisciplinary Collaboration in Primary  
Health Care Group Consultation and Certification Examination  
Committee – Item Generation Workshops.

Jean-Pascal Beaudoin, Ron Dick, Lara Haddad, Josée Lévesque, Mary  
O'Callaghan, Margo Paterson, Susan Swanson  
Participants in a consultation workshop for the CAOT ethics frame-  
work

Deb Cartwright, Natalie MacLeod Schroeder, Angela Mandich, Leann  
Merla, Susan Mulholland, Toni Potvin, Vikas Sethi, Lynn Shaw  
Certification Examination Committee Item Generation Workshop par-  
ticipants

Aman Bains, Jason Hawley, Alexandra Lecours, Gabrielle Pharand-  
Rancourt, Carrie Stavness  
CAOT Student Representatives

Brenda Fraser  
CAOT Representative to the Coalition for Enhancing Preventive  
Practices of Health Professionals

Debra Cameron  
CAOT Representative to the National Children's Health Indicator  
Working Group Conference

Niki Kiepek  
CAOT Representative to the National Children's Alliance on Aboriginal  
Youth Conference



## May 2005 Board Meeting Highlights

The CAOT Board met on May 29 and 30, in conjunction with the CAOT conference in Vancouver, British Columbia. Meeting outcomes are listed below.

- Approval of a new 3-5 year strategic plan as follows:

*Mission* - Advance excellence in occupational therapy.

*Vision* - All people in Canada will value and have access to occupational therapy.

*Values* -

- Integrity
- Accountability
- Respect
- Equity

*Strategic priorities* -

- Advance leadership in occupational therapy.
- Foster evidence-based occupational therapy.
- Advocate for occupational therapy as an essential service.
- Develop workforce capacity in occupational therapy.
- Advance CAOT as the national occupational therapy professional association in Canada.

The new strategic plan will be implemented beginning October 2005.

- Approval of the 2005-2007 Canadian Occupational Therapy Foundation (COTF) partnership agreement and the 2005-2006 COTF donation agreement, under which CAOT provides a \$100,000 donation to the Foundation.

- CAOT awards policies are currently under revision and will be completed for the Fall 2005 call for nominations. A communications plan to promote the awards program as well as a web site awards section will be developed, and production of a descriptive booklet will be considered.

Approval of the following 2005 CAOT Citation Awards to be given during OT Month 2005:

- William (Bill) Poluha,**  
Manitoba Society of Occupational Therapists.
- Cathy Shoesmith,**  
Manitoba Society of Occupational Therapists.
- Dwight Allaby,**  
New Brunswick Association of Occupational Therapists.

- Approval of the revised CAOT Continuing Professional Education Position Statement. This will be translated and posted on the CAOT web site this summer.

- Committee Chair Appointments:

- **Heather White,** Chair-Elect of the Certification Examination Committee beginning October 1, 2005.
- **Jane Cox,** Complaints Committee Chair beginning October 1, 2005.

- A Willis Canada presentation on CAOT directors' and officers' liability insurance.

- Award of a five-year accreditation from 2004-2009 to the Queen's University occupational therapy program, with the option to extend this for another two years until 2011 upon receipt of a report to the Academic Credentialing Council during the second year of operation of the master's entry program.

- Receipt of the Health Canada funded CAOT Report *Toward Best Practices for Caseload Assignment and Management for Occupational Therapy in Canada*, which will be translated and posted on the CAOT web site.

- Approval of a new Board communications policy.

- Endorsement of the World Federation of Occupational Therapists' definition of occupational therapy, which will be posted on the CAOT and OTworks.ca web sites.

- Approval of the Position Statement on Health Human Resources: In Occupational Therapy, which will be published on the CAOT web site and in the October 2005 issue of the *Canadian Journal of Occupational Therapy*.

- Receipt of the update report on occupational therapy support personnel with the following directives:

- The CAOT Membership Committee will review eligibility of provincial support personnel associations for affiliate CAOT membership and students of occupational therapy support personnel education programs for student membership in CAOT.
- The Academic Credentialing Council will review the issue of accrediting occupational therapy support personnel education programs.
- CAOT will review and revise the 2002 version of the *Profile of Occupational Therapy Practice in Canada* to ensure it reflects the continuum of skills and knowledge currently needed by the occupational therapy workforce to meet the health needs of Canadians.

The next Board meeting will be held November 25-26, 2005 in Calgary.



## On your behalf

### NATIONAL COALITIONS AND ALLIANCES

#### Active Living Coalition for Older Adults (ALCOA) — [www.alcoa.ca/e/index.htm](http://www.alcoa.ca/e/index.htm)

CAOT is a roundtable member of ALCOA. Darene Toal-Sullivan, who represents CAOT on ALCOA, will follow up on future possibilities for CAOT to continue its involvement in the areas of falls prevention for older adults and seniors' mental health. The diabetes project was extended into 2005. Approximately 20,000 copies of the Be Active Eat Well guides were distributed and ALCOA will continue to disseminate the guides and other resources produced by the project. Louise Beaton is the CAOT representative on the project. CAOT is also a member of the new Older Old Adult's Health Committee (OOAH) which was created in July 2004. The objectives of the OOAH is to improve the health and well being of adults 80+ years of age through the development of training material and resources to promote the benefits of healthy living.

#### Chronic Disease Prevention Alliance of Canada (CDPAC) — [www.cdprac.ca](http://www.cdprac.ca)

CDPAC is a networked community of organizations and individuals who share a common vision for an integrated system of chronic disease prevention in Canada. The focus of the alliance is on the three leading chronic diseases in Canada: cancer, cardiovascular disease and diabetes. In the March 2005 federal government budget, \$300M was made available through the Public Health Agency of Canada for healthy living and the prevention of chronic disease. There will be consultations in each province and territory to develop public health goals for Canada, hosted by Federal Minister of State for Public Health Carolyn Bennett and Manitoba Minister of Healthy Living Theresa Oswald. The first roundtables were held in Winnipeg, Toronto, Regina, Edmonton and Prince George in March and April 2005. Summaries of these meetings will be posted on a public health goals web site at <http://www.healthycanadians.ca>. Additional information and opportunities for consultation will also be available on the web site.

#### Canadian Coalition on Seniors Mental Health (CCSMH) — [www.ccsmh.ca](http://www.ccsmh.ca)

CCSMH's mission is to promote the mental health of older persons/seniors by connecting people, ideas and resources. CAOT was a member of the education sub-committee which developed an inventory of educational

materials for front-line workers. This inventory is available on the CCSMH web site. Darene Toal-Sullivan is the CAOT representative on the Coalition.

#### Canadian Working Group on HIV and Rehabilitation (CWGHR)

<http://www.hivandrehab.ca>

The CWGHR is a national non-profit organization which promotes innovation and excellence in rehabilitation in the context of HIV through research and education.

In February 2005, funding through Health Canada's Capacity Building Fund was approved for the project Interprofessional Learning in Rehabilitation in the Context of HIV: Stakeholder Capacity Building through Development of New Knowledge, Curriculum Resources, and Partnerships. Dr. Debra Cameron from the University of Toronto will represent CAOT on the advisory committee for this project. The objectives of this project are to: increase awareness of CWGHR and rehabilitation stakeholders of existing curriculum resources, educational initiatives, programs and tools in rehabilitation in the context of HIV and multi-disciplinary education; and identify and build upon effective multi-disciplinary strategies for exchanging knowledge, skills and tools.

Todd Tran, CAOT representative to CWGHR, continues to also represent CAOT on the Canadian Rainbow Health Coalition. The objective of the Rainbow Coalition is to address the various health and wellness issues that people experience in their sexual and emotional relationships with people of the same gender, or as a result of a gender identity that does not conform to that assigned to them at birth. <http://www.rainbowhealth.ca/english/index.html>

#### Quality End-of-Life Care Coalition (QELCC)

The QELCC believes that all Canadians have the right to quality end-of-life care that allows them to die with dignity, free of pain, surrounded by their loved ones, in a setting of their choice. The Coalition believes that to achieve quality end-of-life care for all Canadians there must be a well-funded, sustainable national strategy for palliative and end-of-life care. It is the mission of the Quality End-of-Life Care Coalition to work together in partnership to achieve this goal. Cynthia Stilwell, from Nova Scotia, has recently been appointed as CAOT's first representative to the QELCC.

#### The Coalition for Public Health in the 21st Century (PHC21)

The PHC21 is a partnership of national non-government, professional, health and research organizations committed to making Canadians the healthiest people in the world by advocating for an effective nationally led public health system. The purpose of PHC21 is to improve and sustain the health of Canadians by advocating for policies that strengthen the public health system. Gayle Restall, from Manitoba, has been recently appointed as CAOT's first representative to the PHC21.

#### Canadian Alliance on Mental Illness and Mental Health (CAMIMH)

[www.miaaw-ssmm.ca](http://www.miaaw-ssmm.ca)

CAMIMH promotes the establishment and implementation of a Canadian action plan on mental illness and for mental health that reflects a shared national vision for meeting the needs of persons with mental illnesses and enhancing the potential for the positive mental health of Canadians. CAOT joined CAMIMH in April, 2004 as a core member. Diane Méthot is the CAOT representative on CAMIMH.

For the first time, CAMIMH coordinated Mental Illness Awareness Week in Canada, which was held October 4-10, 2004. CAMIMH has also recommended the development of a substantial project to better measure mental health literacy in Canada and an accompanying social marketing campaign.

Also in October, 2004 CAMIMH's Management Committee met with Minister Dosanjh and senior Health Canada officials to discuss a number of mental health and mental illness issues. CAMIMH submitted suggestions for the Minister's consideration and he subsequently announced the following: an inter-departmental network of senior government officials whose responsibilities include mental illness or mental health issues and the Honourable Michael Wilson as the Minister's Special Advisor on mental health issues in the federal work force. The Minister also called on CAMIMH to develop support among the provincial Ministers of Health for a meeting of Health Ministers in early 2006 with the sole agenda item of mental illness, mental health and addiction issues in Canada. This could lead to a subsequent meeting of First Ministers that would endorse a national mental illness, mental health and addiction accord.

A Call for Action developed by CAMIMH includes a plea for more data collection and



surveillance of mental illness in Canada. In March 2005, CAMIMH, in partnership with the Public Health Agency of Canada, hosted a workshop that will result in the development and funding of demonstration projects to inform a national surveillance initiative for mental illnesses in Canada.

**Mental Health Support Network of Canada (MHSNC) — [www.mdm.ca/cmhsn](http://www.mdm.ca/cmhsn)**

The MHSNC, a network of 12 health organizations, was launched October 10, 2001 in response to the events of September 11, 2001 to provide trusted advice, education and support to the public and the professional community during times of disasters, terrorism and emergencies.

A meeting of the MHSNC was held December 15, 2004 prior to the tsunami disaster. At that time the focus of the meeting was on the development of a document *Talking About Disaster: Guide for Standard Messages* by the US National Disaster Education Coalition. The document provides key messages that are common for many organizations in times of disasters/emergencies. The Canadian Red Cross was given permission to revise the U.S. publication for Canadian use (the content of the guide has not been changed). Members were in agreement that there is a leadership opportunity for MHSNC to develop a health emergencies component to the Guide that would incorporate psycho-social aspects. MHSNC members agreed to delegate action items to a small working group comprised of the Canadian Red Cross, Canadian Medical Association, Canadian Psychological Association and the Emergency Social Services Division of Centre for Emergency Preparedness and Response.

After the tsunami disaster, a core group of MHSNC members met to revise the four brochures in the Coping with Stress series developed post 9/11. The brochures now address reactions to stressful events in a more generic fashion without reference to a specific event. The Public Health Agency of Canada is reformatting the brochures for an electronic and print version. It is expected that they will be ready mid-April 2005. CAOT requested copies for Board members as well as pdfs in English and French to post on our web site. These resources will also be shared with WFOT.

**Getting a Grip on Arthritis**  
**[www.arthritis.ca/gettingagrip](http://www.arthritis.ca/gettingagrip)**

The Arthritis Society and several partners received over \$3.8 million through the Primary Health Care Transition Fund for the implementation of the Getting a Grip on Arthritis project. The goal of this project is to

increase the ability of primary health care providers and people with arthritis to work together in managing arthritis. The project supports primary health care providers in their delivery of arthritis care by emphasizing prevention, early arthritis detection, comprehensive care, appropriate and timely referral to specialty care and education in the self management of arthritis. The deliverables include 30 accredited workshops on arthritis best practices for primary health care providers across Canada over the next two years. This is supported through the provision of a newly developed Arthritis Best Practices Toolkit to be used by providers and patients.

Mary Manojlovich represented CAOT at the Newfoundland and Labrador Stakeholder session December 9, 2004 for the Getting a Grip on Arthritis project. The objectives of this session were to assist in the identification of workshop sites, faculty and the timing of the workshops; and to identify arthritis specialists in the communities participating in the workshops as well as arthritis community resources.

Occupational therapists from across the country have been involved in the development and delivery of the workshops, specifically the occupational therapy, joint protection and assistive devices component. By the end of June 2005, thirty workshops will have been held across Canada in rural and urban settings. Sydney Lineker, Director of the Getting a Grip on Arthritis project, wrote an article for *Occupational Therapy Now* which appeared in the May, 2005 issue.

For more information, contact the Getting a Grip on Arthritis Regional Coordinators: Wendy McCrea, Alberta and British Columbia, [wmccrea@arthritis.ca](mailto:wmccrea@arthritis.ca); Iris Bussey, Atlantic Provinces, [ibussey@arthritis.ca](mailto:ibussey@arthritis.ca); Sheila Renton, Ontario, [srenton@arthritis.ca](mailto:srenton@arthritis.ca); Sylvia Jones, the Prairies, [sjones@arthritis.ca](mailto:sjones@arthritis.ca); Jocelyne Gadbois, Quebec, [jgadbois@arthritis.ca](mailto:jgadbois@arthritis.ca).

**Human Resources Development Canada: Office for Disability Issues (ODI)**

The ODI will develop an information package for health care professionals that will provide them with detailed information about federal programs and services that require a medical (health professional) assessment. The five federal programs that require a medical certificate include: Canada Pension Plan Disability Pension, Disability Tax Credit, Canada Study Grants for Students with a Permanent Disability, Residential Rehabilitation Program for Persons with Disabilities and the Veterans Affairs Disability Pension Program.

The Standing Committee on Human Rights

and the Status of Persons with Disabilities June, 2003 report entitled: *Listening to Canadians: A First View of the Future of the Canada Pension Plan Disability Program* made the following recommendations pertinent to health professionals:

*" that a comprehensive information package be developed to provide a description of each federal disability program which requires medical/health assessments, its eligibility criteria, the full range of benefits available, copies of sample forms, and any other relevant material." — recommendation 3.2*

*" that Human Resources Development Canada (Department of Social Development), provide the comprehensive information package to all health care professionals and put in place an outreach program to provide them with the information and education." — recommendation 3.6*

Sharon Brintnell represented CAOT in January 2005 at an ODI consultation regarding the package.

**National Children's Alliance**

The Alliance seeks to develop Canadian policy that sustains families, builds healthy children, families and communities, and remains accountable to Canada and the world. Debra Cameron and Debra Stewart, both members from Ontario, are the CAOT representatives to this coalition.

Since 2004 NCA has been working on a national youth agenda. The discussion paper, *Why Canada Needs a National Youth Policy Agenda*, can be found at [www.nationalchildrensalliance.com/nca/pubs/2004/youthpolicy.htm](http://www.nationalchildrensalliance.com/nca/pubs/2004/youthpolicy.htm). The paper clearly identifies the issues and reasons for the NCA to catalyze systemic transformational change and provide momentum towards concrete civic and policy engagement. A National Youth Forum was held in Kingston in March with representation from youth throughout Canada. The report is expected to set out the issues that youth perceive to be the most important in setting policy. This report was to be released in June 2005.

**HEALTH AND SOCIAL POLICY**  
**2005 Federal Budget Analysis**

The 2005 budget is not a health budget. Nevertheless, the Finance Minister pledged an additional \$805 million in direct federal health investments spread evenly over the next five fiscal years. The Conference Board of Canada identified some of the investments indicated in the 2005 Budget. These are summarized below:



- \$200 million over 5 years to support initiatives in the areas of health human resources, wait times initiatives and performance reporting.
  - \$75 million over 5 years to accelerate and expand the assessment and integration of internationally educated health care professionals.
  - \$15 million over four years for wait times initiatives (in addition to the \$5.5 billion in wait times reduction funding from the September 2004 agreement) that will build on and complement jurisdiction-specific initiatives (e.g. research on wait times, and the development of benchmarks and indicators).
  - \$110 million over 5 years to be used by the Canadian Institute for Health Information (CIHI) to improve the data collection and reporting of health performance information.
  - \$300 million over 5 years to the Public Health Agency of Canada for an integrated strategy on healthy living and chronic disease.
  - The Aboriginal Diabetes Initiative will receive increased funding, growing from \$25 million in the first year, to \$55 million at maturity (as part of the \$700 million Aboriginal health package).
  - Funding in this Budget complements the May 2004 announcement of doubling the funding for the Canadian Strategy on HIV/AIDS over the next 5 years from \$42.2 million to \$84.4 million annually.
  - Building on a February 4, 2005 announcement of purchasing 9.6 million doses of antivirals at a cost of \$24 million to create a national stockpile, the budget provides an additional investment of \$34 million over 5 years to assist in the development and testing of a prototype vaccine for an influenza pandemic.
- Social investments include:
- \$5 billion over five years for the development of a new early learning and child care initiative - a key commitment in last year's speech from the throne.
  - Enhancing tax assistance for persons with disabilities and caregivers through expanded eligibility for the disability tax credit and other measures.
- In summary, there is no additional financial support for primary health care renewal or for an integrated health human resource strategy. However, as part of the political agenda, the budget will address wait times, add more internationally educated health care professionals and equipment to the system and focus on better public health and wellness.

**CAOT Analysis**

- CAOT is well positioned within the current public policy context to advance its strategic objectives. While the Association is working towards an integrated health human resources (HHR) strategy with the Health Action Lobby (HEAL), CAOT is also able to address occupational therapy HHR issues very adequately with the public funding it has secured to date. The government's wait time strategy opens the door to new research that could look at the impact of an effective HHR workforce on wait times. The conference, Taming of the Queue, which took place on March 31, 2005 addressed the current development in wait times research provincially and internationally. It is clear that researchers and decision-makers recognize the importance of HHR based on population health needs as an essential factor in finding solutions for wait times for health services.
- There are numerous pressures on the government to invest in a pan-Canadian HHR strategy. These are coming from the Public Health Coalition for the 21st Century, HEAL, the Quality of End-of-Life Coalition and the Health Council of Canada.
- The Public Health Coalition for the 21st century (PHC21) will be working to consult with the Public Health Agency of Canada on its Integrated Strategy on Healthy Living and Chronic Disease. According to PHC21, the government still needs to invest in a pan-Canadian health human resource strategy and a coordinated plan to rebuild the public health system. Gayle Restall is the CAOT representative to the Coalition.
- Further funding to implement Primary Health Care Reform is an area of strategic concern for CAOT (see below).

**Pan-Canadian Awareness Strategy for Occupational Therapy in Primary Health Care**

The Pan-Canadian Awareness Strategy is an outgrowth of three other initiatives: CAOT's Federal Election Action Campaign (2004), the Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) initiative and the Canadian Collaborative Mental Health Initiative (CCMHI). The two latter initiatives, funded through Health Canada's Primary Health Transition Fund, aim to have a significant impact on reforming the primary health care system in Canada by exploring conditions necessary for health providers to work together effectively to provide best possible outcomes for clients. Yet, as the 2005 budget analysis reveals, there has been no mention of any funds earmarked for interdisciplinary col-

laborative primary health care services. Moreover, unless the health services provided are medically necessary as defined in the Canada Health Act, the provinces and territories have the decision-making power to determine how the health transfer dollars are spent.

Recognizing that the prospect for public funding of occupational therapy services in primary health care is very remote, CAOT will be proactive in influencing the development of municipal, provincial/territorial and national policy on issues such as: the importance of occupation for the health and well-being of the population and recognition of occupational therapy as an essential service in key areas such as home, community and end-of-life care within the context of interdisciplinary collaborative primary health care teams.

This two-year initiative will establish a dynamic network of CAOT members and stakeholders interested in political advocacy. They will be trained and well informed in order to respond to issues on behalf of CAOT. The Pan-Canadian Awareness Strategy will be launched in October 2005 in conjunction with OT Month.

The objectives of the strategy are to:

- Increase CAOT's capacity for political advocacy.
- Promote awareness and increase access to occupational therapy services through the political process at all levels of government.
- Establish relationships with targeted politicians at all levels of government to influence the development of municipal, provincial/territorial and national policy on the importance of occupation for the health and well-being of the population and recognition of occupational therapy as an essential service in primary health care.

Participants will promote the following messages:

- The Canadian Association of Occupational Therapists (CAOT) recognizes:
- That all people of Canada should have access to the right health professional at the right time in their community throughout their lifetime.
- That an interdisciplinary collaborative primary (ICP) care health care team is an effective way to respond to the health needs of the Canadian population.
- That occupational therapy is an essential service and resource to promote health and support well-being and should be funded as a key primary health care provider.

Questions regarding this strategy should be addressed to Donna Klaiman at: [dklaiman@caot.ca](mailto:dklaiman@caot.ca)



## News from the Foundation

### Upcoming competitions

#### August 31

OSOT Research Education Award

#### September 30

Goldwin Howland

Thelma Cardwell

Doctoral Scholarships

Master's Scholarships

Janice Hines Memorial Award

For details and application forms, see the Grants section at [www.cotfcanada.org](http://www.cotfcanada.org).

### Upcoming fundraising events

#### August 8

Invacare Golf Tournament in the Greater Toronto Area

#### October

Art Ability in Toronto (we encourage artists to donate items). For more information, please contact Sangita Kamblé by e-mail at: [skamble@cotfcanada.org](mailto:skamble@cotfcanada.org)

### Congratulations!

The purpose of the Roulston/COTF Innovation Award is to recognize innovation in one of the following areas:

- best design project
- most innovative idea developed during course work
- most innovative research project
- best fieldwork placement in private practice
- most innovative program development

The following six universities received \$100 to be awarded to a student of their choice, based on the award criteria:

University of Alberta

McGill University

University of Manitoba

University of Ottawa

University of Toronto

University of Western Ontario



### Remember to update your contact information

COTF would greatly appreciate it if you would inform Sandra Wittenberg of any changes to your contact information. Sandra can be reached by e-mail at: [swittenberg@cotfcanada.org](mailto:swittenberg@cotfcanada.org) or 1 (800) 434-2268, ext. 226.

## Your support counts!

COTF sincerely thanks the following individuals, companies and organizations for their generous financial support during the period of March 1 to April 30, 2005. COTF will acknowledge donations received after May 1, 2005 in a future issue.

Marte Bachynski

Sue Baptiste

Gillian Barr

Denyse Blanco

Giovanna Boniface

Jane Bowman

CAOT

Deb Cameron

Donna Campbell

Patricia Card

Anne Carswell

Mary Clark Green

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1 anonymous donor

# National Occupational Therapy Month: Yes, I Can!

Lauren Klump, CAOT Communications Coordinator

*This year marks the second time that we're holding our national awareness campaign over the full month of October, giving you a greater window of opportunity to promote our profession. We encourage you to do whatever you can to spread the word about occupational therapy during National OT Month. Any activity, no matter how small, can make a difference!*

This year's National Occupational Therapy Month theme is "Yes I Can!" and will communicate an empowering message that all people can and should participate in their desired activities, regardless of age or ability. This theme was chosen for its universal appeal and its relevance to a wide spectrum of practice settings and client ages. We hope you'll find it easy to incorporate the "Yes I Can!" theme into your OT Month activities!

CAOT will be developing a "Yes I Can!" logo that will complement the existing "Skills for the Job of Living" artwork. We are also developing a series of vignettes that will showcase how occupational therapists work with people in different settings (in the home, at work, in the community, etc.) to enable people to do what they want to do and improve their quality of life. These vignettes, along with supporting

information, will be placed on the CAOT web site. We encourage you to download and use them in your OT Month promotional efforts, which could include distributing the information via local newspapers, community centres, or outreach events. Watch the CAOT web site for more tips, sample news releases, public service announcements, graphics and a promotional item order form. The OT Works web site ([www.otworks.ca](http://www.otworks.ca)) also contains consumer information you may find helpful.

The special edition of *OT Now*, released in early September, will complement the "Yes I Can!" theme by showcasing occupational therapy's role in independence and autonomy for all people, and in supporting and advocating for an inclusive society. A colourful poster will be mailed with this issue, in the form of a wall calendar, with images of clients who have experienced success through occupational therapy.

A National OT Month Committee has been formed and is meeting each month to share plans that are underway in the provinces, the territories, at the Canadian Occupational Therapy Foundation and at CAOT. Each organization is developing strategies to promote the OT Month theme and how to best convey the "Yes I Can!" message. For information regarding your province or territory's specific initiatives, please contact the individual committee member for your area.

## Further information

The National OT Month Committee will continue to keep you informed as more plans solidify across the country. Watch for updates on the CAOT web site and in your provincial/territorial communications. In the meantime, take a look at these 10 steps to a successful month and start planning now.

## Steps to a successful National OT Month

### 1. Know where you are headed.

The goal of Occupational Therapy Month is to promote awareness of occupational therapy in the community and because this year's theme is so broad, you really can't go wrong! Your target audience could include parents, schools, or senior citizens as well as third-party payers who may include insurers, workers' compensation boards, employers, etc. Is there a particular threat or opportunity in your area that could be addressed through an OT Month strategy? Contact your provincial/territorial association for assistance or consider using information from [www.otworks.ca](http://www.otworks.ca), which has occupational therapy tips and information for people of all ages.

## 2005 OT MONTH COMMITTEE MEMBERS

Lauren Klump	CAOT	lklump@caot.ca
Sangita Kamblé	COTF	skamble@cotfcanada.org
Suzanne Bruton-Toombs	BCSOT	suzybt@shaw.ca
Carrie-Lee Watters	SAOT	www.saot.ca
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Lilli Ju	NBAOT	lhju@health.nb.ca
Gina Hanley	NSSOT	nssot@ns.sympatico.ca
Melissa Croskery	AYOT	Melissa.Croskery@gov.yk.ca

## 2. Organize your OT Month committee.

The combined efforts of your committee members can make planning successful and interesting. Ask people to volunteer. It may be challenging to recruit people because everyone has such busy schedules, so you may need to approach them with a message of “more hands make less work for all.” Don’t forget to invite students, too. At your first meeting, schedule future meetings so that everyone can plan around these dates and times and make a commitment to attending. Then... brainstorm and plan away!

## 3. Who do you hope will learn something about occupational therapy?

Choose an area or a group of people in your community that has a need for OT services or that you think knows little about the profession or has a limited viewpoint of it. OT Month is your chance to augment or change their perspective.

## 4. What do you want people to learn about occupational therapy?

This will depend on who you’re targeting. Here are a few examples:

*In the workplace ...*

- How occupational therapists help people to return to work via functional capacity evaluations, work-site analysis, employee education, ergonomic analyses, etc.
- How occupational therapists can help employers to reduce stress on the job.

*In schools ...*

- How occupational therapists can help students perform better in specific tasks like handwriting or improving their motor coordination.
- How occupational therapists can work with teachers to accommodate students with disabilities.

*In the home ...*

- How occupational therapists can offer strategies to assist with specific activities, e.g. if someone has difficulty bathing, the occupational therapist can recommend equipment such as a bath bench or a powered bath lift.
- How occupational therapists can provide advice on universal design, so people can build or modify their homes to suit their current and future needs.

## 5. Plan the how.

You’ve determined what you want to say, and to whom. Now consider how you can best accomplish this. Through activities or events? A media contact program? A direct mail campaign?

## 6. Plan the when and where.

What is the best time of day/evening for your chosen activities/events? What are the best days of National OT Month for these? Where should you hold your events? At your workplace? Outside the workplace?

## 7. Your OT Month committee is key.

Once you’ve decided what you want to say, who you want to hear it, how you’re going to do it, when and where... you are ready to put your plan into action. Make a list of what has to be done and when, and assign specific responsibilities to each OT Month committee member. Have regular committee meetings to make sure you are on schedule.

## 8. Who else can assist you?

Is there a public relations or communications officer in your workplace? If yes, ask your own experts how they might help make OT Month successful both in your workplace and outside.

*Can you afford it?* Sometimes the ideas are brilliant but require more money than you have to make them happen. Perhaps you can get companies or organizations to sponsor your ideas. Develop a list of ways to publicly acknowledge your sponsors. For example, you could thank them on your pamphlets or display signs at your events.

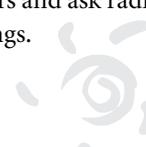
## 9. During National OT Month

Use your poster and the September *OT Now*. Display them in your facility or outside to reach a new group of people. Use the OT fact sheets available on the CAOT web site. Include them in news releases to the media for background information, submit them to your facility’s newsletter or give these out during presentations. You may wish to place the fact sheet information on your own letterhead. Make sure you include your own contact information: name, address, phone and fax numbers.

Take photos of activities, people, displays, etc. You can use them in your facility’s newsletter, or the local media might be interested in receiving one or two with a news release about your event. Be sure to get signed permission from any staff or clients appearing in the photographs.

## 10. After National OT Month

- Have a wrap-up meeting with your OT Month committee as soon after the month as possible. You’ve worked hard and congratulations are in order!
- Remember to thank everyone who helped make the month such a success. A thank-you note is always appreciated and increases the chance these people will help again next year.
- Do make notes about what worked, what didn’t, what should stay the same or what could be changed for next year. These notes will be very helpful for next year’s committee. If you write things down while they’re still fresh in your mind, planning National OT Month next year will be much easier!
- Of course, keep a file of any media coverage: Save clippings from newspapers and ask radio and TV stations for copies of the recordings.





# CAOT Learning Services

## Continuing Professional Education

### CO-HOSTED WITH CAOT

June 1-3

**CAOT 2006 Conference. Evidence and occupation: Building the future.** Call of papers deadline: August 1. Montreal, Quebec. Tel: (800) 434-2268, ext. 228; e-mail: conference@caot.ca.

### ENDORSED BY CAOT

September 16-21

**2005 International Occupational Therapy Conference.** Conception and Development of the Occupational Therapy Profession in Mainland China. Qingdao, China. www.hkiot.org/ot2005/whole\_e.htm

September 17-18

**The Multicontext Approach to Cognitive Rehabilitation: Awareness, Memory and Executive Dysfunction.** Vancouver, B.C. Speaker: Joan Togli, PhD, OTR. Provider: Dianna Mah-Jones, Occupational Therapy Consultant

1243 W 64th Ave, Vancouver BC, V6P 2M7. Tel: (604) 263-8730; Fax: (604) 263-8730

September 21-23

**Canadian Seating and Mobility Conference.** Toronto, ON. Contact: Tel: (519) 662-3542; Fax (519) 662-4730; www.csmc.ca

September-April

**1. Modern Management, 2. Continuous Quality Improvement for Health Services and 3. Risk Management and Safety in Health Services.** (All distance learning). Contact: Cheryl Teeter, Canadian Healthcare Association, 17 York St., Ottawa, ON K1N 9J6. Tel: (613) 241-8005, ext. 228; www.cha.ca.

November 3-4

**From Research into Practice.** Toronto. Provider: A collaboration by the Canadian Language & Literacy Research Network, Integra, Learning Disabilities Association of Ontario and Toronto District, OISE/ University of Toronto, The Hospital for Sick Children. Contact Person: Mary-Gayle Goebel, Tel: (416) 226-9756; Fax: (416) 221-9926; e-mail: mggoebel@interlog.com.

### ONGOING

#### Myofascial Release Seminars

Myofascial Release I, Myofascial Release II, Fascial-Pelvis Myofascial Release, Cervical-Thoracic Myofascial Release, Myofascial Unwinding, Myofascial Mobilization, Paediatric Myofascial Release. Various Canadian and U.S. dates. Instructor: John F. Barnes, PT. Contact: Sandra C. Levensgood, Myofascial Release Seminars, 222 West Lancaster Avenue, Paoli, PA 19301. Tel: (800) FASCIAL (327-2425); Fax: (610) 644-1662; e-mail: paoli@myofascialrelease.com; www.myofascialrelease.com.

### WEB-BASED

#### DISTANCE EDUCATION

**Acquire an Expertise in Driving: Evaluation, Adaptation & Retraining.** Bilingual Program. Dates: September-December; January-April; May-August;. Provider: School of Physical and Occupational Therapy at McGill University. Contact: Isabelle Gélinas, PhD, 3654, Promenade Sir-William-Osler, Montreal, QC H3G 1Y5. Tel: (514) 398-4514; Fax (514) 398-6205; e-mail: isabelle.gelinas@mcgill.ca; www.autoeduc.ca.

### DALHOUSIE SERIES

September-December

**Advanced Studies in Enabling Occupation (OCCU5010).** Instructor: Robin Stadnyk

**Identity and Transitions (OCCU5040)**

Instructor: Dr. Raewyn Bassett

January-April 2006

**Advanced Research Theory and Methods for Occupational Therapists (OCCU 5030).** Instructor: Dr. Brenda Beagan

**Community Development for Occupational Therapists (OCCU 5042).**

Instructor: Dr. Loretta de Rozario

**Program Evaluation for Occupational Therapists (OCCU 5043)**

Instructor: Debra Boudreau

Contact: Pauline Fitzgerald, School of Occupational Therapy, Dalhousie University, Forrest Bldg., Room 215, Halifax, NS B3H 3J5. Tel: (902) 494-6351; e-mail: p.fitzgerald@dal.ca.

### NIDMAR COURSES 2005-2006

#### Effective Disability Management

**Programs (Module A).** Dates: on-line Sept. 12-18 & Oct. 3-9.

**Legislation and Disability Management (Module I).** Dates: on-line Nov. 21-Dec. 4; May 8-14.

**Workers' Compensation and Return to Work (Workshop Module J).**

Dates: on-line Nov. 28-Dec. 4.

**Insurance and other benefits (Module L).** Dates: on-line Sept.2-18.

**Disability Management in Unionized Organizations (Module N).** Dates: on-line Oct. 3-9; Feb. 27-March 5.

**Disability Management from a Human**

**Resources Perspective (Module P).** Dates: on-line Nov. 7-13; Feb. 27-March 5.

**Marketing and Education in Disability Management and Return to Work (Module U).** Dates: on-line Oct. 31-Nov. 6.

**Information Management (Module V).** Dates: on-line Nov. 14-20; Feb. 20-26.

**Job Analysis (Module E).** Dates: Oct. 24-30.

Provider: National Institute of Disability Management and Research (NIDMAR). Contact: Heather Persons, NIDMAR, 830 Shamrock Street, Suite 202, Victoria, BC V8X 2V1. Tel: (604) 736-2578; Fax: (604) 733-2519; e-mail: Heather.Persons@nidmar.ca; www.nidmar.ca.

### Graduate Certificate Program in

**Rehabilitation Sciences (University of**

**British Columbia and McMaster**

**University).** Five required courses offered

Jan.-April & Sept.-Dec. each year and

include: Evaluating Sources of Evidence,

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Effective Rehabilitation Programs, and

Facilitating Learning in Rehabilitation

Contexts. Some courses eligible for online

masters programs.

Information: www.rehab.ubc.ca or

www.fhs.mcmaster.ca/rehab/

### Graduate Program in Post-Secondary

**Studies (Health Professional Education).**

Memorial University of Newfoundland.

Centre for Collaborative Health

Professional Education and Faculty of

Education. Tel: (709) 737-3402; Fax: (709)

737-4379; e-mail: edugrad@mun.ca;

www.mun.ca/sgs/

# Consider submitting an abstract to the 2006 CAOT Conference

*Jacquie Ripat, Chair Scientific Program Committee*

Evidence and occupation: Building the future



The CAOT national conference is an annual event greatly anticipated by occupational therapists in Canada. The conference provides a venue for members to hear and share the latest in research, practice and professional issues. Through this article, I will provide some insight into the abstract selection process and some practical suggestions for your next submission.

## Process of submission and selection

The process of submitting to the annual conference is outlined on the web site. Students of entry-level programs have an extended deadline to accommodate their academic schedule. This category has been expanded to include those presenting work done in the previous year as an entry-level student. The process of selection is also outlined on the web site. A new Abstract Review Board has been struck this year to reduce variability between reviews.

## Writing an abstract

Abstracts are judged according to the published criteria. The criteria may change from year-to-year, so be sure that you read them carefully each year you submit. Reviewers will judge your abstract against the criteria, subtracting marks for non-conformance.

The requirement to include headings with abstracts is new. Headings ensure consistency and ease the work of reviewers. Abstracts should be written in an informative style, including all of the necessary information about the presentation topic.

Note, and make use of, the word limit to fully describe the presentation content. Shorter abstracts may not provide enough information to judge the quality of presentation, while lengthy abstracts will be returned for truncation. Uninformative sentences or generic statements that do not specifically relate to your work waste valuable word space and should be deleted.

Abstract writing is an iterative process: Write it. Leave it. Read it. Revise it. Start well in advance of the deadline and request feedback from a colleague. Double-check your

spelling and grammar prior to submission. You want to ensure that reviewers perceive you as an expert in your area; errors may send reviewers a negative message.

## Choice of format

Carefully weigh the choice of poster, paper or extended session. Although it is often personal preference, some work is more suitable for one format than another. Poster presentations can present a large amount of data and promote informal discussions with delegates. Recently, there has been less competition for poster slots because fewer individuals select this format. Extended session abstracts must include facilitation of a group discussion or learning experience. There are often a high number of submissions and a low number of slots available, creating competition for the extended sessions.

A submission category must be chosen. Some abstracts do not easily lend themselves to categorization. The categories cover both the scope of practice and client ages. If your abstract could fall under more than one category, consider the competition and choose strategically. The Scientific Program Committee sets acceptance rate targets for each category based on the premise that more submissions indicate more interest and work being done in the area. With 400 submissions and 200 presentation slots, we would establish an approximate category acceptance rate of 50%. If 30 people submit to one category, we set an approximate target of accepting 50% or 15. Thus the chance of getting accepted is the same.

Presenting at a national conference is a professional highlight for many occupational therapists. The opportunity to discuss your professional passion and to network with others who share your enthusiasm is exhilarating. I look forward to seeing you at the next conference!

**Deadline for submitting abstracts  
August 1, 2005**

**See [www.caot.ca](http://www.caot.ca) for more information**



## Join us in Montreal for the 2006 CAOT Conference

CAOT is pleased to announce that its 2006 Conference, Evidence and Occupation: Building the future, will be held in Montreal, Quebec. We hope you'll join us in this unique, vibrant metropolis to share evidence for occupational therapy.

### What to do and see in Montreal

Montreal, the metropolis, has everything a big city can offer. It is also a one-of-a-kind multicultural city that blends its French accent with those of over 80 other ethnic communities, and charms visitors with its Euro-Canadian ambiance. Montreal is also innovative and invigorating, offering a whirlwind of modern and traditional cultural creations. Montreal's downtown bustles with life at the foot of its mountain, while history is rooted in the old quarters near the river. With its year-round party atmosphere, Montreal beats to the rhythm of its festivals: jazz, comedy, cinema, fireworks and more! The city beckons you to discover its fashionable boutiques and famed cuisine, over 30 km of indoor pedestrian walkways, and its lively casino. Stroll through its colourful streets and typical neighbourhoods representative of a mosaic of nations, take a ride along one of its many bicycle paths, party in its inviting bars... Montreal? Oui, s'il vous plaît!

### Explore the old city

Riding in a horse-drawn carriage around the eighteenth- and nineteenth-century residences of Old Montreal, you will discover the imposing neo-gothic Notre-Dame Basilica, as well as museums that recount the past, such as the Pointe-à-Callière museum and the Centre d'histoire de Montréal. At the Old Port, you will find the Montreal Science Centre, a vast complex dedicated to science that also includes an IMAX theatre. The Old Port is also the starting point for trips along the turbulent Lachine Rapids.

### Pulsate to the rhythm of the city

Downtown abounds with department stores, boutiques and cinemas, not to mention major museums, such as the Montreal Museum of Fine Arts, the Musée d'art contemporain, the McCord Museum of Canadian History and the Canadian Centre for Architecture.

### Objective: Recreation!

Île Notre-Dame and Île Sainte-Hélène are synonymous with vacationing fun. At Parc Jean-Drapeau, you'll have a ball at Québec's largest amusement park, La Ronde, and at the beach. At the Biosphère, in the former U.S. pavilion from Expo 67, you'll discover the secrets of water, while at Steward Museum, located inside an authentic fort, you'll learn about the history of the New World. In the east end of the city, in the Hochelaga-Maisonneuve neighbourhood, you will find irresistible attractions, such as the Olympic Park, host to the 1976 Olympic Games, which boasts the tallest inclined tower in the world. On the same site, you can also visit the Biodôme, a magical place that is home to four ecosystems. Nearby, the Montréal Botanical Garden, one of the world's largest gardens, introduces you to a host of horticultural universes, including a Chinese garden and a Japanese garden, and at the Insectarium you can observe insects from around the world!

### Culinary pleasures

From award-winning restaurants to ethnic food stores to locally grown products, Montreal is a city oozing with a thousand flavours. Discover everyone and everything behind the cuisine that's melted the hearts of food lovers far and wide.

### Double-decker city

When in Montreal, look down and you'll see double. That's because it is really two cities in one. Above ground is the largest concentration of stores in the country, underneath lies miles of commercial space; every nook and cranny filled with more shops and boutiques.

### Life is a festival

All year and every year, Montreal hosts over 40 festivals ranging from the traditional to the wildly avant-garde. Jazz, laughter, food and snow are just four of the many reasons Montrealers take to the streets, theatres and clubs, and party for weeks on end.

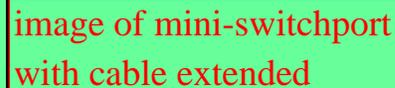
— Bonjour Québec, le site touristique du Québec  
et Tourisme Montréal

*Montréal is truly an experience: old world charm, French joie de vivre and a modern style all its own.  
Come feel Montreal — a dynamic, modern and warm city!*

# Mini-SwitchPort

*A very inexpensive, mini switch interface, with 28" retractable cable*

image of mini-switchport

image of mini-switchport with cable extended

(shown here with our 1" [Compact Switch](#))

(click pics for larger image)

Mini-SwitchPort provides a place to plug switches into a computer. There are 2 switch inputs in Mini-SwitchPort. When you plug a switch(es) into a the Mini-SwitchPort jack(s), the switch(es) 'become' standard mouse-clicks (Win: left, right; Mac: click, click), and with installation of the accompanying Switchhopper (yes, that's right) software, you can configure each button to 'be' any mouse-button event or keystroke you'd like!

*And the cable is retractable!*

Mini-SwitchPort does not interfere with the operation of other pointing devices, such as a mouse. It works in addition to your mouse. Your mouse retains all of its normal functions (with SwitchHopper software asleep).

Mini-SwitchPort is 2.5" long x 1" wide x .75" tall.

Mini-SwitchPort will take any switch (1/8" or 3.5mm mini, standard size for all switches)

Mini-SwitchPort uses the SwitchHopper software for Windows and Mac OS

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## Computer Access

### Switch Click

**\$114. U.S.**

#25000 USB

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Simply plug it in to the computer and press Switch Click to simulate a left mouse click.

The Switch Click plugs into the USB port on the CPU, the USB mouse plugs into the second USB port or a USB Hub.

May be used in conjunction with a PS2 or Serial external mouse.

The Switch Click comes with an external switch jack to accommodate any of Tash's single switches.

#### Switch Click Specifications

Diameter	4.5 in	11.5 cm
Height	2.5 in	6.3 cm
Weight	9 oz	200 g