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Medication reminders

Charlene Bennison

Introduction from the column editor

In the course of my work, I often receive requests for information about medication reminders. One such request came from Charlene Bennison, who is a pharmacist and, it became apparent to me, very knowledgeable on this topic. As a result of our initial discussions, I asked Charlene to share her experience and suggestions with OT Now readers. The following discussion is the result of that request. I am sure it will provide a valuable resource for occupational therapists and pharmacists alike. – Elizabeth Stegges

How did you become interested in this topic?

When I was younger, I did a lot of volunteer work with children and adults with developmental disabilities which made me aware of the unique needs of these individuals. As a health care professional, I am concerned that their needs may not be identified or given the appropriate attention, especially the needs of clients who are aging with developmental disabilities.

What are some of the concerns that you have regarding the use of medication reminders by individuals with developmental disabilities?

Occupational therapists are familiar with the learning characteristics of individuals with developmental disabilities. They need more time to process new information. Many clients approach new tasks such as taking their own medications, testing their blood glucose, or learning to use an inhaler correctly, with a high expectancy for failure and a great deal of anxiety. Many of these individuals seem to have what we call “learned

helplessness” and a lack of self-confidence, thus to enable success health teaching information must be provided to them in well-organized incremental steps. These clients also require regular

follow-up phone calls to monitor compliance and comprehension, and reinforce instructions. However, many health care settings, such as a busy community pharmacy or an emergency room, do not have an environment conducive to providing information in this manner or regular follow-up phone calls.

What would you suggest as the ideal characteristics of the pharmacy of choice for these clients?

The most important characteristic is obviously the pharmacist. The ideal pharmacist would have time and desire to spend more time with individuals with developmental disabilities, and contact them regularly. In real life, however, it is sometimes difficult to provide this extra time in a busy, profit driven, productive pharmacy. Pharmacists are trying to receive payment for professional services beyond the produce; for example, education and pharmaceutical care issues. However, most insurance companies are tied to the traditional cost of drugs and minimum dispensing fees. In my experience, I have been allowed more time to help these clients in pharmacies owned by individual pharmacists who have a strong desire to help people. I was fortunate to do some of my research (Bennison 2000, 2005) while working for such an individual. A pharmacy with a quiet, private, counseling room or designated area is also helpful.

What are some of the teaching methods or strategies that you found most useful?

Several teaching methods and strategies have been used to teach self-medication skills. In 1999, I completed a survey of community living workers in Ontario to determine what methods they believed worked best for individuals with developmental disabilities (Bennison 2000). The community live-in workers felt that one-to-one instruction was by far the most helpful method or strategy used. I personally have found this to be true within the pharmacy context as well. Individual teaching provides an opportunity to get to know the

Charlene Bennison, R.Ph., B.Sc.Pharm, CAE, B.Ed., M.Ed. is a pharmacist and elementary school teacher from North Bay, Ontario.

learner's needs, personality, preferences and specific learning problems. It also puts you in touch with home support, i.e., individuals with whom they live, and their support networks. It helps to build trust and allow confidential information to be shared.

As I said before, individuals with developmental disabilities will require more time to process information. So I find that shorter bits of information, about ten minutes long, repeated again on the next visit or by phone, helps to ensure comprehension. Also, teaching sessions should coincide with the times of the day the individual normally would take medications.

Occupational therapists and pharmacists can use problem-solving strategies as another method for teaching individuals with developmental disabilities about taking medications correctly. For example, the health professional needs to encourage the client to rehearse or role-play what to do when a problem arises, such as losing medications, or when the contents don't look the same. Changes to established medication regimens might be problematic for the individual with a developmental disability. Additional training, monitoring, and a temporary return to supervised medication administration may be required. Presenting incorrect examples of medication administration during training may help to increase problem-solving skills and prevent medication errors.

Of course, behavioural instruction techniques can be used to teach self-medication; these have been used extensively with individuals with developmental disabilities. Task analysis, the division of each skill into smaller steps, can be as follows:

1. Hear medication alarm ring
2. Turn off alarm
3. Go to locked medicine cupboard
4. Take out keys
5. Unlock medicine cupboard
6. Take out pill container
7. Open container
8. Take out correct number of pills
9. Put pill container back into medicine cupboard
10. Get a glass of water
11. Take pills with water
12. Put lid back on pill container

13. Lock medication cupboard

14. Reset alarm

The occupational therapist or pharmacist can use task analysis (Harchik, 1994) to chain the steps together at intervals, and then gradually chain all the steps together in the correct order to perform the task.

Are there any types of drugs that are used more often with individuals with developmental disabilities or for which you have more difficulty teaching self-medication?

Yes. Drugs such as anti-depressants, anti-psychotics, anti-anxiety, and anti-convulsants are prescribed more frequently to individuals with developmental disabilities (Feinberg, 1995; Manchester, 1993; Smith & Perry, 1992), predominantly for treating maladaptive behaviours. Their usage is highest with clients in institutional settings (Manchester; Smith & Perry). These medications can affect learning by causing drowsiness and other central nervous system side effects. However, any medication; for example, anti-hypertensives, birth control pills, and antibiotics, can be prescribed for someone with a developmental disability, for acute or chronic conditions. One third of individuals with developmental disabilities who live independently take some type of medication (Harchik, 1994). So it is important that they know how to self-medicate properly and safely.

What teaching tools do you find helpful?

The most helpful tool that we use is the weekly blister package. The pharmacy technician fills one week's worth of medications into a blister pack, the pharmacist checks it for accuracy and proper dosing times, and then we monitor the empty package for compliance. We have found the system helpful with all clients with some cognitive impairment who want to live independently.

Of course there are several other tips for teaching such as colour-coding prescription vials or using daily pill charts, symbols, and pictures. Symbols and pictures are helpful in explaining medication instructions. For example, the face of a clock or digital time can be used on medication containers, charts, or calendars. Pictures of the sun and moon to explain time of day are useful also. Written instructions can be helpful but should be

used only if you have determined the reading ability of your client. Written instructions should be limited to one or two instructions, focusing on one skill at a time. Other tools such as voice mail and cue lights have been used with success. Counter vials and scratch-off labels can be helpful in monitoring compliance by recording when drugs were taken.

Compliance can be measured also by direct means such as drug levels in lab tests, for example glycosylated hemoglobin. Communication amongst health care professionals of these lab results can help individuals achieve independent self-medication.

Do you have a favourite teaching tool?

One type of teaching and compliance monitoring tool in which I am very interested is the electronic or digital compliance tools. Electronic compliance monitoring devices have been used extensively to monitor compliance in drug research trials and to monitor compliance with HIV drug regimens. In my research with community living workers, I found that very few of them had even heard of some of the devices I mentioned (Bennison 2000, 2005). Products such as the Medication Event Monitoring System (MEMS) and MedReminder can be used to track medication administration and compliance. MEMS has several models available that can collect, measure, and analyse prescribed drug regimens. MEMS collects real-time data through a microchip that is embedded in the lid of a vial, and similar products are available for blister packs. Information is transferred from the medication container to a personal computer by means of a communicator in the home or office. Then, compliance information is displayed and can be printed in a report format. Online compliance data management is also an option. These products have tremendous applicability to the teaching and monitoring of self-medication of individuals with developmental disabilities. Data can help the occupational therapist and pharmacist to determine sources of non-compliance (e.g. worries about side effects, distrust of medication, misconceptions about illness). I think electronic devices are the wave of the future and can help people maximize independence.

What factors should one consider when choosing a monitoring or compliance device?

Several factors must be considered. Person factors such as manipulative skills, visual acuity, degree of motivation and competence must be considered. Also, are there any children in the home? The stability of the medication in a device must be considered – is it light or heat sensitive? Does moisture affect the medication? Does the drug come in a tablet or capsule form? Many drugs come in alternative dosage forms such as suppository, injection, liquid and topical. There are many other suggestions for these medications that the pharmacist can offer. One of my concerns as a certified asthma educator is the use of inhalers. Inhalers are one of the most difficult and misused dosage forms of medications. Clients need to be trained and monitored properly. Spacer devices are extremely important for this dosage form and clients need to be trained in their correct use and care.

Of course, cost is a big factor. Many pharmacies charge additional fees for blister packaging and compliance monitoring. This may be a barrier to people who are on a fixed, low income budget, such as clients with developmental disabilities. I think the biggest factor preventing electronic devices from widespread use is cost, which can be as little as twenty five dollars for some basic devices to as much as a few thousand for MEMS. In my experience, occasionally the social worker can obtain approval for payment from insurance companies, but more often it is the pharmacy or drug company that covers the cost of medication reminders. Hopefully an increased awareness of their availability for and applicability to individuals with developmental disabilities will develop when pharmacies begin to offer these services more consistently, leading to more research examining their effectiveness. In my opinion, teaching individuals with developmental disabilities how to self-medicate safely is cost effective for governments and insurance companies. It also would be an area of wonderful and useful research for an occupational therapist or pharmacist.

continued on page 6

Where can I find out more information about electronic compliance devices?

Most of the information I have gathered is from the use of electronic devices in HIV outpatient medication programs. Several drug companies

were at one time providing them for free to HIV clinics and their clients. The Internet provided me with many potential sources for electronic compliance devices. The following is a brief list of some of these companies:

Device and Supplier	Device Description
Medication Event Monitoring System (MEMS) APREX - A Division of AARDEX Ltd. 28490B Whipple Road Union City, CA 94587 Tel: 510-476-1940 www.aardex.ch	Several models are available. MEMS collects, measures, and analyzes client compliance to prescribed drug regimens. It collects real-time data through a microchip embedded in the lid of a vial, transfers it to a personal computer by means of a communicator, and displays and prints reports. Also it has an online compliance data management option.
Med-ic EDM Electronic Compliance Monitor Information Meduary Corporation 2150 Thurston Drive Suite 101 Ottawa, ON K1G 5T9 Tel: 613-745-8400 www.informationmediary.com	This device integrates a microchip into a blister package. It records the time at which the contents of a blister is expelled from the package, keeping a log of the client's use of his or her medication. The data can be downloaded for analysis.
MEDPort/MedGlider Talking Reminder MEDport LLC 23 Acorn St. Providence, RI 02902 Tel: 800-299-5704 www.medportllc.com	This reminder is a standard organizer augmented with a timer that indicates when a pill should be taken through beeping, a voice or a flashing light.
NexDose NexDose PO Box 2850 Key Largo, FL 33037 Tel: 888-848-6639 www.nexdose.com	A small self-contained mini-computer enables clients to take medications properly. Several models can sound an alarm when it is time to take a medication and display the medication name. Software programs are available to help health-care providers program NexDose and evaluate client compliance.
MedReminders ALR Technologies Inc. 101 North Chestnut Street Suite 307 Winston-Salem, NC 27101	This reminder alerts the client and displays the medication or related action to take. Several models are available with a PC programmable option.
Care Partner Telephone with Reminder Lifeline Systems Canada 95 Barber Greene Road Suite 105 Toronto, ON M3C 3E9 Tel: 800-387-8120 www.lifelinecanada.com	This device can be programmed by a healthcare professional, family, or client to provide a reminder to take medications. The model includes features for individuals with visual and hearing impairments, programmed speed dial, and other Lifeline services.

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From public service to private practice: Excerpts from my journey

Dawn Chisholm

In my early years as an occupational therapist, entering into a private practice in occupational therapy was inconceivable to me. I viewed private practice as something held high on a pedestal by our profession in which only very experienced clinicians with business savvy could succeed. I had neither of these characteristics. For me, entering into private practice was not a conscious decision, but one of timing and opportunity.

Following a long adventure to South America, I returned to Canada with no permanent fulltime job prospects in sight. My previous employer hired me as a casual employee, which provided me with an opportunity to discuss private practice options with my supervising therapist, as she also worked privately part-time. The private practice for which she worked had a job opening for an occupational therapist with skills in an area in which I had recent experience. I was extremely interested, and as I had no other imminent job prospects, I interviewed with the company to work as a sub-contractor. I was hired and after only three years of clinical experience, I was thrust apprehensively into a world of which I knew very little.

Immediately I had to purchase equipment and organize a business phone line for my home office. With minimal computer expertise my learning curve was steep. I had numerous fears about my financial situation, as I had limited savings, a large student loan, and constant thoughts that I was entering into a realm that lacked job security. I tried to keep myself grounded by acknowledging that any new job would have its challenges. Private practice would add merely another dimension to the challenge.

Since I was on my own and had no idea how much money I would make as a private practitioner, I decided to accept a permanent part-time position with my former employer. This provided me

with some financial security, which, at that point in my life, was essential for me. Starting out as a sub-contractor instead of as a sole proprietor facilitated my transition. I did not have to deal with the stress of marketing and learning business skills on top of everything else, since most of these things were done for me.

Initially I spent many non-billable hours learning how to organize my files, to follow new assessment and documentation formats, and to schedule my time efficiently. Learning how to bill for my time accurately was, and continues to be, a challenge. How much time, if any, could I bill for problem solving, research and contemplation as I expanded my skills in this area of occupational therapy? Learning to be self-disciplined was also a trial. I began this endeavour at the start of a fabulous summer in Vancouver. Being outside was much more appealing than writing a report. However, I have learned repeatedly that I have to be self-disciplined and efficient with my use of time during assessments and report writing or else a reasonable wage quickly dwindles into a nominal fee. I have learned that when starting out in private practice, or shifting focus within one's private practice, one needs to spend a lot of non-billable time learning the ropes, thus earning an extremely low wage initially and possibly for prolonged periods. Fortunately, I have found that this situation does improve with time and experience! Now, the higher hourly wage offered through private practice enables me to work part-time and decreases my financial anxieties.

Although my initial entrance into private practice was somewhat serendipitous, I quickly found that it was congruent with my philosophy of work and work ethic. I have a firm belief in work-life balance. I also embrace the concept of a four-day work week, enabling me to have more

Constantly 'shifting hats' and maintaining competency in diverse areas of practice on a daily basis can be extremely challenging and hectic.

equilibrium in my life. However, try as I may this does not occur consistently. Deadlines and learning requirements in a new area of practice can dictate if I must work more hours in a week. However, I keep returning to the model of a four-day work week as I believe it reduces my work-related stress. It assists me in maintaining balance in my life and fulfillment with my work, as I can return to work on Mondays feeling rejuvenated and ready for productivity.

I enjoy the ability to create diversity within my workload, however I have learned that too much diversity can be stressful. Constantly 'shifting hats' and maintaining competency in diverse areas of practice on a daily basis can be extremely challenging and hectic. At one point I acted as both a sole proprietor and sub-contractor in various areas of occupational therapy practice, ranging from pediatrics to medico-legal work. I have many diverse interests and love learning new skills, but I am learning to keep myself more focused. I am finally in the process of creating a business plan and vision for future goals. New private practitioners should start this process much earlier than I did, as it provides a framework to guide one's practice more effectively.

My personal challenges, regarding self-disci-

pline (letting the housecleaning wait until after the report is finished), maintaining focus, and not accepting too much work at one time, are always with me. The medico-legal world in particular has been an intimidating area in which to practice. Its frameworks, goals, philosophy and culture contrast greatly with those of occupational therapy. In my first couple years of practice, I knew no one in my peer group who had embraced this path and could have passed on tips and encouragement to help me cope with this intimidating area. However, several years into my practice I was able to enter this field as a sub-contractor with an experienced occupational therapist as my mentor reviewing my reports and fielding questions.

And so I continue to learn and increase my confidence and skills in private practice work. I have learned that so many of my core occupational therapy skills are transferable to very different areas of practice, and the creative possibilities are endless. Currently my private practice is in more traditional occupational therapy practice areas, but I do think my business will evolve into more non-traditional, less common areas of practice. I enjoy providing a value-added service, often filling in gaps where public services are not able to provide sufficient options for many of my clients. Enabling clients to achieve their maximum level of occupational performance in and satisfaction with all areas of their lives within the contexts of big business, law and insurance, is very rewarding. Sub-contracting remains a large part of my practice, but as I learn more about marketing and develop my business savvy sub-contracting will evolve into a lesser role. I love the flexibility and autonomy that private practice provides. Being my own boss affords me the opportunity to balance hard work with time off; I can go away for a week or two without having to compete with coworkers for the most desirable vacation times. Within my daily schedule I can work long hours when I am motivated, and if I am having an "off day" I go for cappuccino or to a yoga class and then return and try again later. And maybe one day I will even make a slightly larger annual income than I would if I worked for the government.

Private Practice Insights

This new column focuses on ways to enhance the success of private practice and ensure access to quality occupational therapy services.

Authors are invited to submit articles regarding:

- Profiles of successful occupational therapy practitioners describing how and why they entered private practice, their motivations and what sustains them.
- Specific market(s) and how occupational therapy services are delivered.
- Challenging business situation(s) and how they were resolved. Examples could include mergers, tax audits, partnerships, providing student placements, etc.
- Successful management practices such as record keeping, budgeting, requests for proposals, hours of operations, fee schedules, marketing communications, etc.
- Examples of collaborative projects that enhance business success for occupational therapy practices.

For further information contact the managing editor or Column Editor Lorian Kennedy; e-mail: lorian@telusplanet.net

The community network: A resource for occupational therapists

Alexandra Lecours & Claire Dumont

The community organization network has an established, recognized role in the health care sector in Canada. Along with the public and private health organization networks, the community network provides significant assistance to the population through its services and activities (Government of Canada, 2000; Government of Québec, 2001). Its philosophy and general structure, which focuses on the members taking responsibility for themselves, makes the community network a resource that is both distinct from and complementary to the public network. At the beginning of the 2000s, the federal government established a government policy, the Voluntary Sector Initiative (Government of Canada, 2000), which recognized the contribution of the community network to the well-being of the Canadian population and provided it with financial assistance. However, most of the support for and legislation governing community organizations comes from the provincial governments. For example, the Québec government also has a policy for this area of activities (Belley, 2002; Government of Québec, 2001), and the community network is regulated by the Secrétariat à l'action communautaire autonome (Ministère de l'emploi et de la solidarité sociale)(Government of Québec, 2002). In Nova Scotia, the Department of Community Services is responsible for these functions (Government of Nova Scotia, 2005).

Moreover, in addition to services to the population, the community organizations provide worthwhile opportunities for volunteering, an important occupation (CAOT, 2002). This article is intended to increase occupational therapists' knowledge of the community organization network with respect to the following three points: 1) its place along the continuum of rehabilitation services; 2) volunteering as occupation, and 3) the procedure for and summary of the results of

a project entitled *Exploration des ressources communautaires pour l'intervention en réadaptation* [Exploration of community resources for rehabilitation intervention].

The role of the community network in the continuum of rehabilitation services

Generally, three major phases in rehabilitation are discussed in the literature: the acute phase in a hospital setting, the intensive rehabilitation phase in a rehabilitation centre, and the reintegration phase which involves integration and support for integration into the community. Occupational therapists usually are involved in various ways in all three phases, and often the community organizations are identified as partners in the reintegration phase (Government of Québec, 2001). However, several studies have shown that there are difficulties within and discontinuities among the phases (Dumont, Gervais, Fougeyrollas & Bertrand, 2004; Gadoury, 1999; Government of Québec, 2001). The findings suggest that individuals working in the public and private health networks have little knowledge of the community organizations, how they operate, and the opportunities they can offer. The community organizations have funding issues, high turnover of staff, and lack of stability (Government of Québec, 2001). In addition, as a study by Hébert, Maheux and Potvin (2002) found, only one in three occupational therapists working in the centres locaux de services communautaires (CLSCs) in the province of Quebec systematically offers full treatment to the clients, takes the time to explore new interests, and creates contact with the community resources. Hébert and colleagues also suggested that university training may be a source of some of the current difficulties in the reintegration phase. They found that occupational therapists practising in CLSCs qualified their preparation for community practice as insufficient,

which may pose an obstacle to the continuity of services between the public and community organizations.

Volunteering as occupation

In recent years, researchers in occupational therapy questioned the significance of volunteering as an occupation for people with mental health issues. This research suggests that volunteering can be a meaningful occupation for these individuals, enabling them to participate in the social life of their communities (Clark, 2003; Oxley, 1995; Rebeiro & Allen, 1998). It also found that individuals with mental health issues perceive this occupation to have a positive effect on their mental health condition (Clark, 2003; Oxley, 1995). Even though it is recognized that volunteering is benefi-

cial for the community as well as for people with mental health issues, many factors hinder this kind of involvement for numerous individuals. A study was carried out in the United Kingdom on this question, exploring the factors facilitating and constraining involvement in paid or voluntary work among participants who had experienced a stroke (Lock, Jordan, Bryan, & Maxim, 2005). Its results suggest that following re-engagement in productive occupations certain individuals have feelings of social oppression resulting from the limitations of institutional infrastructures, practices and structures as well as from the judgment of colleagues. Thus many obstacles remain, preventing the positive occupational participation of individuals with disabilities.

Procedure and summary of results for a project entitled Exploration des ressources communautaires pour l'intervention en réadaptation [Exploration of community resources for rehabilitation work]¹

Context of the project

The main purpose of this project was to provide a portrait of the community organizations and their resources for individuals receiving occupational therapy services. The first step was to determine if the required information could be gleaned from pre-existing sources. Many Canadian directories of community organizations are available². These various documents usually include the mission of the organizations, the services and activities they offer, the geographical regions they serve, fees charged, open hours and contact information. However, only a few of the directories have specific information that is needed by occupational therapists to enable their clients' occupations, such as accessibility by public transportation and universal accessibility with respect to parking, doors, restrooms, etc. This insufficiency led to the next step of this project, which was to create a directory of community organizations for Quebec City and Chaudière-Appalaches regions (administrative regions 03 and 12 of the province of Quebec). This new directory included all the items listed above as well as the funding formulas and the staff training.

Classification and description of the community organizations

The community organizations were classified according to two aspects: the services offered to the public, and the types of volunteer activities available. In this sense, the only participation requested from the community organizations was to answer questions on both the services offered to the public and the possibilities for volunteer work. The sample was selected using a non-probability method, judgment sampling (Lefrançois, 1992). Of the 530 organizations listed in the Quebec City and Chaudière-Appalaches regions, 187 met the selection criteria, which meant that the community organization had to be: 1) within the meaning of the law; 2) established and stable in the community such as steady funding sources, web site or any other form of publicity; 3) easy to reach by telephone, and convenient hours of operation; 4) a francophone organization; 5) established in the administrative regions 03 or 12 of the province of Quebec; and 6) using the services of volunteers. Of those organizations, 135 participated in the study which involved a telephone interview.

¹ This study (Lecours & Dumont, 2004) was carried out at Université Laval, in Quebec City, during the summer of 2004. The complete results are available on the Internet.

² The provincial ministers responsible for legislation concerning community organizations can be approached to consult the directories of these organizations for a particular region. In addition, the federal organization Volunteer

Canada (2005) offers, through its web site, links to the directories of various organizations within each province. It also has a comprehensive list of international, Canadian and provincial organizations, including over 200 volunteer centres in Canada. In addition to these governmental resources, The United Way-Centraide (2005) lists its affiliated community organizations on its web site for each region of the country.

Table 1: Categories of community organizations, numbers of organizations included in the sample and main services offered

Category of organization (mission)	n	Main services offered
Food aid and collective kitchens	7	Food bank, collective kitchens
Family assistance	12	Support, sponsorship, telephone help line, training, information, self-help groups, individual meetings
Assistance for the elderly	7	Recreation, training, information, food bank, friendship visits
Assistance for women	8	Lodging, relief, self-help groups, support, sponsorship, training, information, telephone listening, individual meetings
Assistance for men	4	Training, information, telephone help line, self-help groups, coffee house, conferences, individual meetings
Assistance for young people	12	Support, sponsorship, recreation, homework assistance, training, information
Alcohol, drug addiction and gambling	11	Telephone listening, self-help groups, conferences, individual meetings, training, information, work place internships
Literacy	3	Training, information, self-help groups, individual meetings
Mutual aid	29	Transportation support, friendship visits, food and clothing banks, self-help groups
Teams of volunteers in institutions and/or in the health network	7	Friendship visits, support and sponsorship, miscellaneous assistance to users
Recreation	2	Recreation
Social participation	22	Workplace internships, individual meetings, recreation, training, information, self-help groups, adapted workstations
Promotion and collective	10	Recreation, adapted workstations, conferences, defence of rights, training, information
Services externes de main-d'œuvre (SEMO) [external labour services]	1	Training, information, individual meetings, work place internships.

Classification according to the services offered to the public: The following variables were documented to demonstrate the services offered to the public: 1) the name of the organization and its contact information; 2) the open hours; 3) the geographical area served; 4) the type of organization (national, provincial, regional, municipal); 5) the area of intervention; 6) the target clientele; 7) the mission of the organization; 8) the resource

person to contact; 9) the funding formulas; 10) universal access to physical facilities; 11) the services available; and 12) staff training.

Table 1 shows the categories for the organizations classified. For each category, information on the main services offered is provided. The complete classification and the information on all twelve variables is available on the study's web site (Lecours & Dumont, 2004).

Table 2: Types of volunteer activities in the community organizations and numbers of organizations included in the sample

Type of volunteer activities	n
Transportation support	16
Assistance with homework	3
Help at a food bank/ meals-on-wheels	23
Housekeeping	11
Facilitation	16
Telephone listening	15
Secretarial tasks	18
Sales/funding activities	7
Telephone calls/friendship visits	14
Board of directors/ working committees	135

Classification according to the types of volunteer activities available: With respect to volunteer work, the data collected from the telephone interviews were used to document the following four elements: 1) the opportunities to do volunteer work in the organization; 2) the types of volunteer activities; 3) volunteers' responsibilities; and 4) the possibilities for remuneration. Analysis of the responses on these variables showed that the personnel of the community organizations are mostly volunteers, that there is no particular requirement for working in them, that the schedules are flexible and that there are many opportunities to take on challenges and set new goals for oneself. Volunteers are expected to be punctual, respect commitments, have a positive attitude, demonstrate mutual aid, and respect others. It is essential to specify that we are referring here to volunteer activities in community organizations such as youth centres or collective kitchens. This study did not include sites for professional reintegration such as adapted work centres, which focus on productivity and competitiveness. The main opportunities for volunteer work offered by the community organizations are related to the activities listed in Table 2.

Possible interventions for the occupational therapist
The occupation of volunteering is viewed as an important productive occupation within the

Canadian Model of Occupational Performance (CAOT, 2002). It is a significant focus for occupational therapists, who often are involved in enabling their clients to return to various productive occupations such as volunteering. Returning to volunteer activities may be an occupational performance goal of a father who is recovering from depression or a nurse with hemiplegia who can no longer be a part of the fulltime labour force. Their activities at various organizations could include staffing a telephone help line in a support organization for young people or getting involved as part of a team of volunteers in a hospital centre. The results of this project suggest that community organizations are open to accepting volunteers and offering a chance for re-engagement into an area that holds occupational meaning and purpose for individuals with disabilities. Nevertheless, the literature indicates that obstacles, such as transportation problems and architectural barriers, still remain and limit realistic occupational participation in these organizations.

Conclusion

The community organization network has an extremely important role in the rehabilitation continuum in Canada. Professionals in public and private health institutions must develop further their knowledge of community organizations as well as collaborate with them to enable individuals with disabilities to take full advantage of the supports and volunteer work available to them in these organizations. There is, however, still a long way to go in order to harmonize a partnership between the public, private and community organizations, in particular in terms of the definition of roles, which could be the subject of further studies (Belley, 2002; Clément, Tourigny, & Doyon, 1999). Educational programs in occupational therapy need to ensure that they are preparing their students for entry into community practice as well as the more traditional settings. Occupational therapists must work towards enabling the occupational participation of their clients, engaging them in more social occupations such as volunteering, as well as providing them the links to community supports that they require. Further documentation of the factors that facilitate or limit the occupation of volunteering for individuals with disabilities in community organizations is warranted.

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ad

Ask a lawyer



Jasmine Ghosn,
BSc(OT), LLB

Dear Jasmine,

I am an occupational therapist working in a return to work program in the community. Recently I was hired by an employer who was responding to a request made by one of his employees for accommodation for disability in the workplace. A conflict exists between the employer and the employee as to what reasonable accommodations can be provided in this situation. I have been asked to assess the employee's abilities on the job and to make recommendations. How far is an employer required to go when accommodating an employee with a disability? Are there any legal issues to consider when making recommendations for return to work?

Sincerely,

Solution Oriented

Dear Solution Oriented,

The options for accommodation of persons with a disability in the workplace are evolving significantly with technological advances and alternative work arrangements being implemented more readily. In addition, more and more cases are being heard before human rights tribunals and the courts, and the law in this area is well established now in statutes and case law.

The consequences to employers who fail to respect their duty to accommodate employees with a disability can be significant, as was made clear in the recent unprecedented decision of the Ontario Superior Court of Justice, which ordered an employer, Honda Canada Inc., to pay \$500,000

in punitive damages to a former employee who had chronic fatigue syndrome. The Court held that this high damage award was warranted, after it concluded that the employer wrongfully dismissed the employee to avoid its duty to accommodate the employee (Keays v. Honda Canada, Inc., 2005). The Court frowned upon the employer's "confrontational attitude" in the accommodation process, and

found that the employee's refusal to participate in a medical examination proposed by the employer was "motivated by a legitimate concern that his rights were being violated" (Keays v. Honda Canada, Inc., 2005). The case sends a very strong message to employers that they must act in good faith when an employee requests accommodation.

The duty to accommodate generally requires that the most appropriate accommodation be determined and then undertaken, short of undue hardship. The accommodation process is a shared responsibility and requires the cooperation of everyone involved to identify possible solutions. Employers and their agents, such as occupational therapists, should approach accommodation in a manner that most respects the dignity of the employee, to the point of undue hardship.

Dignity includes consideration of the *process* for accommodation, and the individual's participation in it. The process should be an individualized approach that takes into account the respect of privacy, autonomy, and integration of the person's unique needs. While all parties concerned with the accommodation process are required to show a willingness to explore solutions, in every case it is important to consult with the individual involved. This approach has been endorsed by the Supreme Court of Canada when it recently considered the term "disability" and made it clear that disability has a broad meaning and includes a subjective

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Column Editor:
Muriel Westmorland

... one must take into account the evolving biomedical, social and technological developments, including a socio-political dimension that emphasizes human dignity, respect and the right to equality.

component – one based on the individual's perception of the disability. When determining the essence of a disability, one must take into account the evolving biomedical, social and technological developments, including a socio-political dimension that emphasizes human dignity, respect and the right to equality. In addition, society's response to a real or perceived disability is to be considered in the "discrimination" analysis (Quebec v. Boisbriand (City), 2000; Quebec v. Montreal (City), 2000; Granovsky v. Canada, 2000).

In explaining what "accommodation" means, the Ontario Human Rights Commission (OHRC) suggests the following:

Accommodation is a process and is a matter of degree, rather than an all-or-nothing proposition, and can be seen as a continuum. At one end...would be full accommodation that most respects the person's dignity. Next is phased-in accommodation over time, followed by the most appropriate accommodation only being implemented once sufficient reserve funds have been set aside. Alternative accommodation (that which would be less than "ideal") might be next... [This] might also be accomplished at a later date if immediate implementation would result in undue hardship. Or alternative accommodation might be implemented as an interim solution while the most appropriate accommodation is being phased in or implemented at a later date. (OHRC, 2000)

The Supreme Court of Canada has established a framework for examining whether the duty to accommodate has been met. Once the employee makes his or her disability needs known to the employer, the employer has an obligation to accommodate the employee, unless the employer can prove on a balance of probabilities that the standards, requirements or rules in the workplace:

(1) were adopted for a purpose or goal that is rationally connected to the function being performed;

(2) were adopted in good faith, in the belief that it is necessary for the fulfillment of the purpose or goal; and

(3) are reasonably necessary to accomplish its purpose or goal, in the sense that it is impossible to accommodate the claimant without undue hardship (British Columbia (Public Service Employee Relations Commission) v. BCGSEU, 1999).

The onus is on the employer to prove undue hardship. Where this occurs it must be addressed on a case-by-case basis, taking into account the applicable human rights legislation in that specific province. Ontario has a very restrictive definition and has only three considerations for determining undue hardship: (1) cost; (2) outside sources of funding, if any; and (3) health and safety requirements, if any. Other jurisdictions include other factors, such as employee morale, or conflict with a collective agreement with a labour union. The evidence adduced by the employer to prove undue hardship must be objective, real, direct and, in the case of cost, quantifiable (OHRC, 2000).

Generally, conclusions about inability to perform essential duties should not be reached without actually testing the ability of the person on an objective basis (OHRC, 2000). For example, an employee returning from disability leave should be given an opportunity to prove his or her ability to perform the pre-disability job before assigning alternative work.

The OHRC (2000) summarizes the duties and responsibilities in the accommodation process as follows:

The person with a disability is required to:

- advise the accommodation provider of the disability (although the employer does not generally have the right to know what the disability is);
- make his or her needs known, preferably in writing;
- answer questions or provide information regarding relevant restrictions or limitations, including information from health professionals where appropriate;
- participate in discussions about accommodation solutions;

The accommodation process is a shared responsibility and requires the cooperation of everyone involved to identify possible solutions.

- co-operate with experts;
- meet agreed-upon performance and job standards once accommodation is provided;
- collaborate on an ongoing basis to manage the accommodation process; and
- discuss the disability only with those who need to know, and only as it pertains to the need for accommodation.

The employer is required to:

- accept the employee's request for accommodation in good faith, unless there are legitimate reasons for acting otherwise;
- obtain expert opinion or advice when needed (e.g., from a qualified health professional);
- take an active role in investigating solutions;
- keep a record of the accommodation request and actions taken;
- maintain confidentiality;
- limit requests for information to those reasonably necessary for the purpose of accommodation;
- grant accommodation in a timely manner, to the point of undue hardship; and
- bear the cost of any required medical information or documentation; for example, doctors' notes. (pp. 23-24)

Health and Safety Risks

In some cases, occupational health and safety requirements that have been established by law or industry standards may be waived to accommodate a person with a disability in the workplace. Generally, health and safety standards designed to protect workers, clients or the public often will satisfy the undue hardship test. However, if it is proven that the rule or standard was designed to circumvent human rights legislation it will not meet the test (OHRC, 2000).

In the appropriate circumstances, a person with a disability may choose to assume the risks of participating in work that has been modified to accommodate the disability. However, where the risk is so significant that it outweighs the benefits of equality, it may be considered to create undue hardship. When accommodation places an individ-

ual at risk for harm, the person responsible for accommodation is obliged to explain the potential risk to the individual (OHRC, 2000).

Conclusion

Understanding the rights and obligations in the accommodation process can help occupational therapists to improve the service they provide to their clients, whether employers, individuals or both, in a return to work program. Disability accommodation programs should be monitored and evaluated on an ongoing basis to ensure that they are feasible and meet the needs of all involved. By working with employers and persons with disabilities, occupational therapists may be an asset in helping the parties involved in an accommodation request find solutions that can avoid harsh sanctions by the courts and human rights tribunals. In an era where requests for accommodation in the workplace may be on the rise, occupational therapists involved in return to work programs should familiarize themselves with the applicable provincial human rights laws and guidelines.

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The information provided above is not intended to be legal advice. Readers are encouraged to contact their provincial/territorial regulatory organizations for the specific legal requirements for documentation and other matters pertaining to client records. A list of occupational therapy regulatory organizations can be found on the CAOT web site in the contacts section.

Developing the "sense of doing": Lessons from my left foot

Helene Polatajko & Jane Davis

In our inaugural *Sense of Doing* article we shared with you our hopes that this column would help deepen your understanding of human occupation and foster your development as an occupation-based practitioner. We have tried to do this by sharing with you the occupational stories of real people. In some cases these stories were told about people, as witnessed by their therapists; in other cases these stories were told by the people themselves. In all cases the stories were intended to invoke in you a greater appreciation of the idiosyncratic nature of the human occupational experience; to cause you to examine your own occupational lives; and to encourage you to use your own occupational experiences to gain more insight into the occupational significance of the experiences of the clients you serve each and every day!

While I hope this column is serving to support the accomplishment of this lofty goal in all of us, last summer I had a humbling reminder of the wisdom found in the adage "*experience is the best teacher*". I learned that no matter how elegant the story, no matter how eloquent the teller, there is nothing like the lived experience to hone one's sense of doing, courtesy of my left foot.

The experience...

Scene I - A picturesque harbour in Croatia on a beautiful Sunday morning in May: Four people prepare to disembark a pleasure craft moored alongside the promenade, in search of the perfect cup of cappuccino. Three head to the back of the boat, one goes to the side. Just before initiating the approximate four-foot jump she wonders, "Is this too high for me? -Nah!"

Scene II (24 hours later) - An emergency room in Slovenia: "I can't stand on it, but I am sure it's only soft tissue damage," she explains to the attending physician. "All I need is an anti-inflammatory."

"Well let's just get an X-ray to be sure, you never know," says the doctor.

Scene III (that evening) - A hotel room bathroom in Italy: She attempts to rise from the toilet seat, loses her balance, falls backwards and, despite a desperate attempt not to, smashes the fresh cast on her left foot into the floor. She sits up, inspects the damage in disgust and thinks, "I can't believe this. I can't even get off the toilet by myself! I'm supposed to be an OT. I'm supposed to know how to use crutches, how to adapt occupations, how to manage without weight-bearing. One little joint shouldn't disable me!"

Scene IV (two weeks later) - In a garden in Canada: "No, you don't need to do this ... you can't do this. I'll do it," he admonishes. "I can, and I will. Just help me get down on the ground", she insists. Reluctantly, he lowers her to the ground with a loaded gardener's tool belt around her waist, places a gallon can under her left knee and positions the first of 40 flats of impatiens close by. Triumphantly, she begins her annual occupational ritual of planting her garden.

Scene V (3 months later) - Arriving at the airport in St. Louis: She argues with the gate agent, "What do you mean there is no wheelchair for me; it was ordered when the tickets were booked!?! Yes, I can walk with my crutches but not that far

... I was suddenly no longer an occupationally competent individual. That such a major shift in my own *sense of doing* could result from the injury of one single joint, floored me!

and not carrying my luggage and no, I can't wait for an hour for a wheelchair to be brought here. I am supposed to be at a meeting in an hour." With no help in sight and the closest taxi stand nearly a mile away, she negotiates with her colleague to carry her luggage and begins to walk with her crutches. Spying a luggage cart, the two exchange glances, her colleague begins to load the luggage and she climbs aboard.

My sense of doing ...

The 'she' in the above story, as you may have surmised, is me, Helene. Last May, I fractured my calcaneus, the fracture radiating into the subtalar joint. While not requiring surgery, I was required to refrain from any weight-bearing for ten weeks – a performance demand which drew on every trace of recall I had from occupational therapy school about adapting my occupations and my environment, as well as a whole lot of creativity. But that was the easy part! It only took one failed trial of putting on my shorts to remember: *dress the affected side first; undress it last*. My biggest challenges came from things that I had never heard about in my orthopaedics classes, or read about in my Internet searches on treatment for a calcaneus fracture; they were challenges that can not be accommodated by crutches, wheelchairs, paint cans or dressing strategies. My biggest challenges were being fatigued by the metacognitive overload that results from constantly having to think through previously automatic tasks; being beaten by doors that are too heavy to pull open while balancing on one foot; and, most humbling, losing my sense of myself as a competent individual because I needed help to do everything! The key word here is '*do*'. The performance demands emanating from not being able to weight-bear caused me to reconceptualize my occupational sense of self; I was suddenly no longer an occupationally competent individual. That such a major shift in my sense of doing could result from the injury of one single joint, floored me!

As occupational therapists we are uniquely concerned with our clients' doing; we talk about how this doing is the result of the interaction of

cognitive, affective, and physical components, yet we tend to focus on one in isolation from the others. We assess our clients' ability to do, but often we do not take the time to understand their 'sense' of doing. All the information and treatment I received centered on the physical aspects of my injury, yet my 'real' performance problems were related to my cognitive fatigue and my affective well-being, and how they influenced my sense of doing. Early on in my recovery, my orthoped, who has a great sense of humour, told me that not only would I have a full recovery from my injury (although it would take about a year) but from now on I would have a new skill, predicting the weather. Little did he know that through this experience I would come to fully understand the true significance of the cognitive, physical and affective interaction that is central to all "doing".

The witnessed sense of doing...

As an observer, witnessing Helene's experience unfold, I, Jane, began to appreciate to a greater extent the importance of *enabling* occupation, rather than "doing for others". Although an important social gesture, which demonstrates care and compassion for others, doing for others does not make sense for occupational therapists. Doing the gardening for Helene, an important annual occupational ritual for her, would have further diminished her sense of competence. Instead I was relegated to enabling her gardening, which included making sure the wheeled cart she was using to move the flats of flowers along after herself as she 'bummed' through her task was secured on the hillside. This small adaptation enabled her to maintain some sense of personal autonomy and occupational competence, and to engage in personally meaningful occupations.

To enable our clients to perform, we need to attend to their significant occupations; we need to understand the idiosyncratic nature of their occupations, their meaning and their sense of doing. Gage (2003) did when she attended to Jeff, the artist's, desperate need to paint again, and enabled him to make the decision to allow someone to help him with his daily self-care routine so that he

To enable our clients to perform, we need to attend to their significant occupations; we need to understand the idiosyncratic nature of their occupations, their meaning and their sense of doing.

could have the strength and energy to paint. “The “magic” of participation in meaningful occupations compared to the lack of fulfilment sometimes created by the struggle to be independent” was an important lesson Jeff taught us. Stier (2004) learned to curb her assumptions about occupational participation, and listen to the occupational stories of her clients after Mrs. Fraser, a 90-year-old, suggested she couldn’t come to therapy because she worked full-time. Amoroso, Dharamshi and Lee (2004) learned from John, the model car builder, that we can know our clients’ sense of doing, even when they can’t verbally express it, by observing their engagement patterns and interests.

Our lessons from ‘Helene’s left foot’ are that the lived experience is the greatest of all teachers,

and that as occupational therapists we can bear witness to these experiences and hope to learn from them so that we can enable the clients we are privileged to serve more successfully. Thus, we encourage you to remember to draw and reflect upon your experiences so that you can better understand the experiences of your clients; to find parallels in your lives to help you develop insight into the lives of your clients; to hone your own sense of doing.

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ads

Declarative title: Clinical reporting by occupational therapists and speech pathologists falls short of therapists' intentions and parental expectations

Structured Abstract

Summary of Donaldson, N., McDermott, A., Hollands, K., Copley, J. & Davidson, B. (2004). Clinical reporting by occupational therapists and speech pathologists: Therapists' intentions and parental satisfaction. *Advances in Speech-Language Pathology*, 6(1), 23-38. (Prepared by Joan Versnel, CAPs Advisory Group Member)

Finding the Original Article

If you find a CAP of interest, consider reading the original source. We prefer not to limit our selection of evidence based on how easy the journals are to access. The following are a few strategies that you can use to access journal articles that may not be readily available through traditional means.

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Research Objective: The purpose of this study was to explore therapists' and parents' perspectives on clinical report writing and to examine the usefulness and benefit of occupational therapy and speech pathology reports for parents.

Design: Qualitative.

Setting: The participants were recruited through two university clinics, one for occupational therapy and one for speech pathology, offering assessment and intervention for children, ages four to eleven. These children had a wide range of diagnoses, including delayed or disordered speech and language development, developmental coordination disorder, autistic spectrum disorder, attention deficit disorder and dyspraxia.

Participants: Three occupational therapists, eight speech pathologists and fifteen parents consented to participate in the study. The therapists were recruited through telephone and personal contact. The parents were selected purposely to exclude those whose children had received previous therapeutic services. The parents had a range of education and economic backgrounds.

Methods: Three methods were used: questionnaires with therapists; semi-structured in-depth interviews with parents; and document review of therapy reports. Speech pathologists completed questionnaires containing queries on reasons for writing reports, perceived usefulness of reports to parents, and factors to consider when writing reports for parents. After reviewing these, the questionnaires were modified to include questions on work history, time involved in report writing, length of reports, use of profession specific jargon, and views on assessment processes; the revised questionnaires were distributed to the occupation-

al therapists. The semi-structured, in-depth parental interviews were preceded by the review of a topic guide by the parents to encourage personal reflection and prepare the participants for the interview process. These interviews, conducted at parents' home or work, were audiotaped and transcribed verbatim. The interviewer was not involved in providing care to any of the families. Member checking was completed five months following the initial interview. Document review, which was conducted independently by two researchers, involved examining the assessment reports sent to the fifteen families who consented to participate in the study.

Analysis: The occupational therapists' and speech pathologists' questionnaires and parent interview data were analyzed for emergent themes. The reports were assessed for readability and style to provide context for understanding these themes.

Main Findings: Four major themes were identified: therapists' intentions and parents' expectations of the report; relationship between assessment session and report; readability of the report; and use of the report. The parents perceived differences between the occupational therapists' and the speech pathologists' reports. While both professions' reports were found to contain information about their child's abilities, the speech pathologists' reports provided fewer recommendations or practical strategies. Most parents reported that it was important and helpful to have both written and verbal reports about their child's assessment. Parents stated that they did get some verbal

reports at the time of the assessment and this verbal information was very helpful when they had to interpret the written report. However, most parents also stated that they would have liked an opportunity to have more verbal explanations at the time they received the assessment reports. With respect to readability, parents identified three key issues: use of profession specific jargon, report

layout, and report length. Many parents reported that it was difficult to understand the profession specific jargon. Parents perceived the use of jargon as a reflection that reports were not written for them, but rather for other health professionals. The readability index of both professions' reports was at a university-educated level, suggesting that parents with less than that amount of education may have had difficulty in understanding the writing. Several parents identified that a brief summary at the beginning of the report of the child's strengths and identified needs would help to allay anxiety while reading the rest of the report. While therapists were aware that the reading of reports was difficult, and tried to be as succinct as possible, parents stated that they would rather have a longer report that explained things more fully than a short report that was not detailed. Many families reported that they used the reports for a variety of purposes including educating other family members and school personnel, confirming their concerns, and as a tool that they could re-read when needed. Parents offered several suggestions to improve the reports including: linking the child's difficulties on assessment tasks with everyday activities to give a context to the challenges; using a rating system to convey scores on subtests and measures which were often difficult to interpret and confusing to understand; and receiving verbal feedback from the therapists to supplement the information parents received in the written reports.

Conclusions: The authors suggested that therapists should combine verbal and written forms of communication. Redesigning the reports to be more useful to parents, particularly with respect to intervention suggestions, was recommended. Scores on measures and tests need to be interpreted for parents in functional ways to enhance parental understanding. The authors recommend avoiding report proformas, and individualizing each report. Specific suggestions identified by the authors included: 1) creating a bank of lay explanations for profession-specific jargon; 2) relating assessment findings to functional tasks; 3) providing specific recommendations and plans for intervention; and 4) noting the future implications of the child's difficulties.

Contact details of authors of appraised paper: Nerina Scarinci (nee Donaldson), Division of Speech Pathology, The University of Queensland, Brisbane, Australia: email: n.scarinci@shrs.uq.edu.au

Column editor: Lori Letts

Commentary on Donaldson et al., 2004

Joyce Magill-Evans

This study of report writing, which is a basic, time-consuming part of occupational therapy practice, addresses an important topic and a gap in the literature. Therapists, committed to family-centred service, wrestle with the challenge of writing for parents as well as teachers, funding agencies, and other professionals including physicians. An informal survey of 30 Alberta paediatric occupational therapists indicated that a single report addressed multiple audiences, which almost always included parents. Some therapists wrote primarily for teachers as the school was their client. Target audiences for initial assessments and discharge reports varied. Outside of textbooks (Case Smith, 2005; Dunn, 2000) and practice guidelines, little peer-review literature exists that addresses perceptions of occupational therapy reports, particularly from the viewpoints of consumers such as parents.

This Australian study sought to explore both therapists' and parents' perspectives on report writing using multiple methods. The occupational therapists' perspective was based on only three therapists (of six contacted) who responded to a questionnaire that was not well described. Thus, the therapist perspective was drawn largely from the responses of eight speech pathologists (of ten contacted) to a questionnaire that was a different version with fewer questions than the one completed by the occupational therapists. For the parents who were interviewed, the sample was more adequate and inclusive of occupational therapy, with ten families (of fourteen contacted) whose children had received an occupational therapy assessment and five families (of fifteen contacted) whose children had received speech pathology

assessments. Thus, this study is best viewed as a description of what parents of four-to-eleven-year-old children want and need related to assessment reports from a university clinic setting. The children had diagnoses such as autism,

developmental coordination disorder, and attention deficit disorder. Parents of children with other diagnoses (e.g., cerebral palsy, developmental delays) also seen commonly by occupational therapists or seen in other settings (e.g., clinic or inpatient) may have slightly different needs of and experiences with therapists' reports.

The study results for parent interviews are based on relatively sound qualitative research that can be applied to practice. The findings encourage occupational therapists to individualize reports and avoid report proformas or templates. Specific suggestions include providing test scores with a functional interpretation, and recommendations that include practical strategies applicable to home and school. Parents appreciate an explanation of how their child's assessment results apply to everyday living, an indication of how the child's difficulties might affect future performance, and receiving information verbally as well as in a written format. When reports had jargon, parents assumed that the reports were not intended for them.

University and clinically based educators need to help students learn to write with the target audience firmly in mind, using jargon sparingly or clearly defining terms, carefully presenting and interpreting scores, and considering readability and grammar. Therapists need to reflect regularly on the effectiveness of their written reports and seek feedback from the report recipients. Future research could address occupational therapists' perspectives on report writing, parents' perspectives on reports for children in early intervention programs or adolescent services or with other diagnoses, and the perspectives of consumer groups such as teachers, schools, funders, and other professionals. An on-line discussion focusing on how therapists currently evaluate their reports, and addressing the problem of writing for multiple audiences, would be interesting and timely.

References

- Case-Smith, J. (Ed.) (2005). *Occupational therapy for children* (5th ed.). St. Louis, MO: Mosby.
- Dunn, W. (2000). *Best practice occupational therapy in community service with children and families*. Thorofare, NJ: Slack.

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Evidence-based practice skill building: On the road with CAOT's Information Gateway

Kathy Van Benthem, CAOT Professional Education Coordinator



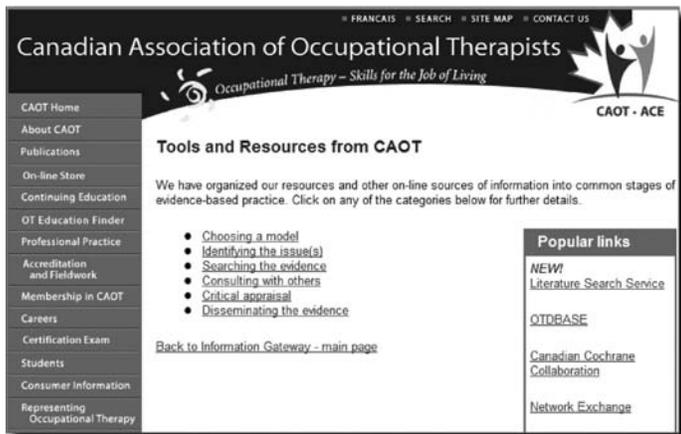
Workshop Instructor Kathy Van Benthem with participants at Ottawa session in November 2005

From April to November 2005, CAOT provided nine Evidence-based Practice (EBP) workshops in Manitoba, Alberta, British Columbia, Saskatchewan and Ontario, with more planned for the spring and summer of 2006 in the Atlantic Provinces and Quebec. Each workshop is free of charge and open to all CAOT members. The rationale for the workshop reflects the findings of a research study led by Joyce Magill-Evans and Kerry Pain at the University of Alberta in 2001. They found that occupational therapists are eager to adopt the principles of evidence-based practice and are looking to professional associations, such as CAOT, to become the “hub of information” for EBP resources (Magill-Evans & Pain, 2001, p. 17). The core principles of evidence-based occupational therapy are reflected in its definition as the “client-centred enablement of occupation based on client information and a critical review of relevant research, expert consensus and past experience” (CAOT, 1999, p. 269). Thus, the workshop’s objectives are to inform participants of the EBP tools and resources accessed via the CAOT Information Gateway, and provide a guided opportunity for formulating clinical questions and locating and appraising relevant evidence.

This workshop and the Information Gateway demonstrate CAOT’s commitment to research uti-

lization skill building and the promotion of EBP. The development of the structure and content of the workshop follows the current evidence base for continuing education of health care professionals; this suggests that interactive workshops have a greater potential than didactic sessions to make significant changes in practice (Thomson O’Brien, et al., 2005). The EBP workshop contains a strong practical component, during which participants may perform a search using various databases, including OTDBASE (a Canadian occupational therapy database). Participants viewed this ‘hands on’ component as very valuable, and in many cases were able to take home new sources of evidence for their practice. Further opportunities for learning included the sharing of strategies which support other critical elements related to individual and organizational change in practice. Topics included peer collaboration for EBP projects, such as journal clubs, as well as clinical guideline development and organizational support such as developing policies relating to availability of time and EBP resources.

Based on the feedback from over 100 participant evaluations, the Information Gateway appears to address common EBP issues, such as gaps in knowledge and skills, and time constraints. It links to valuable databases, and pro-



vides a user-friendly tutorial and glossary. The design of the Information Gateway enables easy and quick access to current skill and knowledge building resources for the busy clinician, researcher or educator. The screen snap shown above illustrates how some of the tools and resources are organized in the Information Gateway.

Evidence-based practice evolves constantly; accordingly, the tools and resources on the Information Gateway will be updated routinely, and will undergo changes over the coming months to accommodate the new Evidence-based Web Portal. The web portal will be accessible to anyone via a link from the CAOT and World Federation of Occupational Therapists web sites' homepages. The Information Gateway, available only through CAOT membership, will consist of a specialized

collection of tools and resources including the continued free access to OTDBASE, and links to the *Canadian Journal of Occupational Therapy* and *OT Now* full-text articles, as well as other literature and tools currently under development.

CAOT looks forward to continued collaboration with its members as we strive to enhance occupational therapy practice with quality evidence. Be sure to watch for an EBP workshop coming to a city near you, as CAOT continues on the road with the Information Gateway!

References

- Canadian Association of Occupational Therapists (CAOT), the Association of Canadian Occupational Therapy University Programs (ACOTUP), the Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO), and the Presidents' Advisory Committee (PAC). (1999). Joint position statement on evidence-based occupational therapy. *Canadian Journal of Occupational Therapy*, 66(5), 267-269. Retrieved January 13, 2006, from <http://www.caot.ca/default.asp?pageid=156>
- Magill-Evans, J., & Pain, K. (2001) How can professional associations support evidence-based practice? A members' perspective. *Occupational Therapy Now*, 3(5), 17.
- Thomson O'Brien, M. A., Freemantle, N., Oxman, A., Wolf, F., Davis, D., & Herrin, J. (2005). Continuing education meetings and workshops: Effects on professional practice and health care outcomes. *The Cochrane Database of Systematic Reviews 2005, Issue 4.*

Profile update in progress



The *Profile of Occupational Therapy Practice in Canada* (2001) is currently under review by a project committee with representatives from across Canada and various occupational therapy organizations. The committee held their first meeting in Ottawa in October 2005. The purpose of the *Profile* is to

Back row from left to right:

Claudia von Zweck, Vivien Hollis, Christine Luscombe-Mills, Donna Collins, Susan James, Giovanna Boniface

Front row from left to right:

Nancy McKay, Elizabeth Townsend, Donna Klaiman, Ann Bossers, Jean-Pascal Beaudoin, Micheline Saint-Jean, Debra Stewart

describe the performance expectations related to the roles and functions of occupational therapists in Canada. It is used to help in the development of academic standards and in the preparation of a blueprint for a national certification examination. It also functions as a self-assessment tool for lifelong learning.



News from the Foundation

Upcoming Competitions

March 1

Ontario Society of Occupational Therapists (OSOT) Presentation Award	\$1,000
OSOT Multi-Disciplinary Presentation Award	\$1,000

March 31

Marita Dyrbye Mental Health Award	\$500
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April 1

Society of Alberta Occupational Therapists (SAOT) SAOT Research Award	\$500
SAOT Research Education Award	\$500
SAOT Research Presentation Award	\$500

For details and application forms, see the Grants section at www.cotfcanada.org.

New for 2006

COTF's 2005 Annual Report will be posted on our web site in the spring.

Please visit www.cotfcanada.org.



2006 CAOT Conference

COTF will have a few events at the 2006 CAOT Conference. You are encouraged to attend!

- AGM: June 1, 11 a.m. – 11:30 a.m.
- Grants Session: “Being Successful in Research”
June 1, 3:30 p.m. – 5:00 p.m.
- Live Auction: June 1 at the Cabane à sucre
- Silent Auction: June 1 and 2 at the COTF Booth
- Lunch with a Scholar: Helene Polatajko, PhD,
OT Reg. (Ont.), OT(C), FCAOT,
“Framing Our Practice in Occupation –
Framing Our Occupation in Research”
June 1, noon - 1:30 p.m.

Silent and live auction

COTF welcomes donated items for the silent and live auctions to be held in Montreal during the CAOT Conference. We appreciate donations such as art work, jewelry, gift items, crafts, cards and photography.

Donor declaration forms must be completed and sent to COTF. If a donated item was purchased by the donor, COTF requires the original receipt. If the donor purchased the item and does not have the receipt the donor has to provide some form of comparable pricing such as printed information or a web site address.

Art work valued under \$1,000 must be accompanied with printed information or a web site address and artwork over \$1,000 must be professionally appraised.

Income tax receipts will be issued for the value of the items upon the completion of a donor declaration form.

Please contact Sangita Kamblé at skamble@cotfcanada.org for a Donor Declaration Form. These forms should be returned no later than May 24, 2006. Thank you.

more news on page 26

Your Support Counts!

COTF sincerely thanks the following individuals, companies and organizations for their generous financial support during the period of November 1 to December 31, 2005. COTF will acknowledge donations received after December 31, 2005 in a future issue.

Ability Health Care Supplies Inc.
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CAOT Endorsed Courses

CO-HOSTED WITH CAOT

June 1-3
CAOT 2006 Conference. Evidence and occupation: Building the future. Montreal, Quebec. Tel: (800) 434-2268, ext. 228; e-mail: conference@caot.ca.

ENDORSED BY CAOT

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.

April 5-9
Certificat A-One (Arnadottir Occupational Therapy – ADL Neurobehavioural Evaluation). Centre Hospitalier de l'Université de Montréal (CHUM). Contact: Elaine Vachon, Tel: (514) 890-8000, ext. 14124; Fax: (514) 412-7221; e-mail: chum_aone@yahoo.ca

May 8
Getting Kids in Sync: A Sensory Processing Approach to Challenges Associated with Autism, ADHD, Learning and Behavioural Disorders. Sheraton Four Points, Montreal, QC. Contact: Caroline Hui, OT, Tel: (450) 242-2816; Fax: (450) 242-2331; e-mail: choose2learn@yahoo.ca

June 9-10
Evaluation and Treatment of Visual Perceptual Dysfunction in Adult Brain Injury: Part I. Wascana Rehabilitation Centre, Regina, SK. Provider: Regina Qu'Appelle Health Region. Instructor: Mary Warren MS, OTR. Contact: Peggy Bacon, Tel: (306) 766-5613; Fax: (306) 766-5595; e-mail: peggy.bacon@rqhealth.ca

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. Levengood, 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.

DALHOUSIE SERIES

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 2006

Effective Disability Management Programs (Module A). Dates: on-line Jan. 9-15; March 27-April 2.
Legislation and Disability Management (Module I).

Dates: on-line May 8-14.

Workers' Compensation and Return to Work (Workshop Module J). Dates: on-line TBA.

Insurance and other benefits (Module L). Dates: on-line Jan. 16-22; Sept. 1-16.

Disability Management in Unionized Organizations (Module N). Dates: on-line Feb. 13-19.

Disability Management from a Human Resources Perspective (Module P). Dates: on-line Feb. 27-March 5.

Marketing and Education in Disability Management and Return to Work (Module U). Dates: on-line Feb. 5-11; May 8-14.

Information Management (Module V). Dates: on-line Feb. 20-26.

Job Analysis (Module E). Dates: on-line March 6-12.

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.

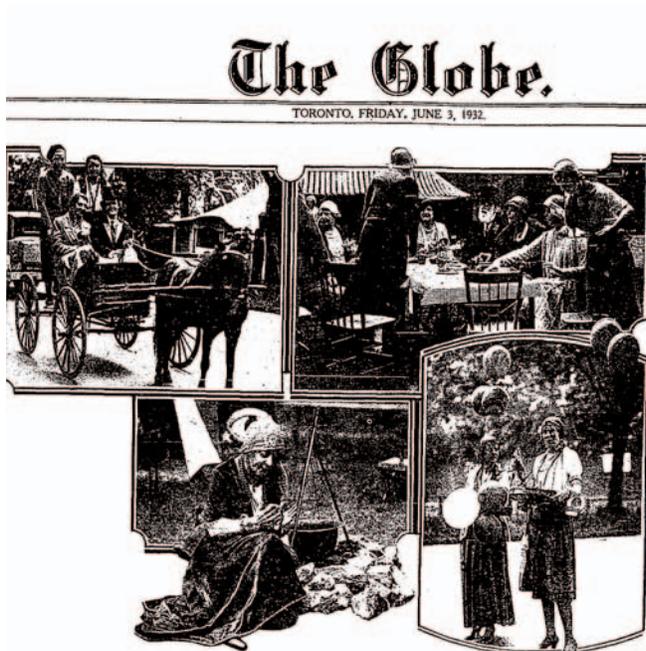
Graduate Certificate Program in Rehabilitation Sciences (University of British Columbia and McMaster University). Five required courses offered Jan.-April & Sept.-Dec. each year include: Evaluating Sources of Evidence, Reasoning and Clinical Decision Making, Measurement in Practice, Developing Effective Rehabilitation Programs, and Facilitating Learning in Rehabilitation Contexts. Courses eligible for online masters programs at both universities. 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.

For more information about CAOT endorsement, e-mail education@caot.ca or Tel. (800) 434-2268, ext. 231

Watch for our next teaser in the May issue
 –OT History Interest Group at U of T and CAOT Archives Committee

Occupational therapy then: Stories from our past



Why are these women all dressed up?

Each summer throughout the 1930s supporters of the Occupational Therapy Society organized a weekend fundraising extravaganza. This was no small gathering! Everyone who was anyone could be seen at these annual outdoor public festivals. One could see or be seen by Lieutenant Governors, health officials, philanthropists, university presidents and a variety of Lords and Ladies. Toronto newspapers covered the story annually, often with front-page coverage. – Barry Trentham

What annual occupational therapy event caused such a stir? Check for the answer on the CAOT website at www.caot.ca.



Newspaper clips courtesy of the Globe and Mail. Links to PDFs of full articles available on the CAOT website.