



Canadian Association of Occupational Therapists
Association canadienne des ergothérapeutes

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U of T occupational therapy student Heather Moyse participated in the 2006 Winter Olympics as the brakeman for the Canadian women's bobsled team - Canada 1. They missed a bronze medal by less than 1/10th of a second! Her story begins on page 5.



Photo: David Buston

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Letter to the editor

Dear Ms. Clark

I was surprised to read the title *The Canadian Holocaust- retrieving our souls*. I sympathize with the plight of the First Nations people. However, to use the word "Holocaust" is inappropriate. Six million Jews in addition to hundreds of gypsies and physically/mentally challenged people were exterminated, sent to the gas chambers.

*Occupational therapist
Debbie Bauer, CAOT member*

Editor's Note

Many thanks for your letter of concern. We did consider many definitions of the word holocaust in our decision to print the title as written by the author. We found, that although the term 'holocaust' is most frequently used in reference to World War II, this is not the only holocaust that has occurred in the history of mankind. These definitions were carefully reviewed in terms of the word's appropriateness in refer-

ence to the treatment of the First Nations people in Canada and also in how it might be perceived by those who feel that the term holocaust should be reserved for the atrocities of World War II. This information was shared with the author who felt that the term was appropriate and is used by others in describing the residential schools and First Nations treatment in Canada.

*Sincerely
Mary Clark
Managing Editor, OT Now*

Dear Ms. Clark

The fundamental objection of the Jewish community to the use of this term to describe any genocide other than the one which decimated the Jewish people can be summarized as follows:

1. Those who were murdered by the Nazis were progressively stripped of their rights, their humanity and their lives. Even in death they were denied the dignity
continued on p. 4

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Editorial

Mary Clark

Thirteen years ago, when former *CJOT* Editor Geraldine Moore and I presented a paper at the CAOT Conference in Edmonton, Sue Forwell, the speakers' introducer, stated that I had been editor of the National newsletter for over 13 years. It threw my entire presentation. Thirteen years – could it have been that long? Well, it was, and now after moving the newsletter to *Occupational Therapy Now*, I've pushed it to 23 years and I am in equal disbelief. To grossly understate the situation, it's probably time for a change.

I've always maintained that I have had one of the best jobs the profession has offered in Canada. As editor of *Occupational Therapy Now*, I have had the pleasure of working with both established and new writers who volunteer their time to write about what matters to them and about what matters to the profession. The support that I have received from my column editors, the CAOT National Staff and the CAOT Editorial Board, including the now defunct *OT Now* Advisory Committee, has been outstanding. A special thanks goes to our translator and colleague Luce Ouellet who quietly translates no less than 10,000 words each issue, ensuring that language is not a barrier to accessing articles in *OT Now*. I am leaving at a very positive time and am happy to pass the red pen on to my colleague Fern Swedlove, who is transferring her editorial prowess from *CJOT* to *OT Now*. I thank you all very much.

Other editors have not been as fortunate. Setting the editorial direction and policies for association publications is not easy. Developing frameworks to ensure editorial independence and balancing the public's right to know with the desire to protect a profession's reputation, have been brought to the forefront with the February firing of the senior editors of the *Canadian Medical Association Journal (CMAJ)*. Apparently the Canadian Medical Association (CMA) had been unhappy over published editorials and news

reports that challenged the positions of the association and shed light on questionable practices of members of other health professions. The result was to replace the editors with what the publisher described as "a fresh approach".

CMAJ is a peer reviewed medical journal that provides health information to Canadian doctors and the public, and which, according to the early electronic release on March 16 of an editorial in the *New England Journal of Medicine*, is ranked as the 5th leading medical journal in the world. In addition to peer reviewed research articles, it publishes commentaries and news reports. All three types of articles are quite capable of containing information that is contrary to the positions of the CMA, so policies concerning editorial independence require careful consideration. The *CMAJ* editorial board felt that news reporting in the journal is as important as peer reviewed research papers. They placed the two side-by-side. In some ways, you could say they popularized their journal. In my opinion, they successfully married scholarly academic writing with acute journalism. Bravo.

In doing so they broadened the appeal of the journal, and maintained that it is an important publication not just for Canadian doctors but also the Canadian public. The full journal is available online and thus accessible to anyone with access to the Internet. It is one of the few, if not the only, health professional journals to do so in Canada, and therefore has moved beyond enlightening just its own to enlightening the public in general.

Unfortunately the *CMAJ*'s editorial board failed to convince the association to move beyond serving just its own. The CMA appears to have difficulty with open debate regarding their positions and with responsible journalism that holds professionals accountable for unethical practices. This shortcoming has drawn international attention and brought to the forefront the issue of the 'public's right to know'. Interestingly, the outrage over the firings has come from both within and

outside the medical profession. *CMAJ* was indeed successful in developing a loyal audience outside of its own.

At CAOT, we have two separate publications. *OT Now* is the association's voice; it publishes CAOT reports, commentaries, practice information and the occasional consumer tip. We can't afford reporters and writers, so investigative journalism is out. *OT Now* frees *CJOT* to concentrate on scholarly publishing, and whether this scope should be broadened may be one of the points discussed at the upcoming editorial board's strategic planning session for *CJOT*. CAOT actively explores and monitors access to its information including *OT Now* and *CJOT*. Increasing access to our publications, as has *CMAJ*, is one way to increase the public's recognition of occupational therapy and its role in promoting health and people's quality of life. It may be time to challenge

occupational therapists in Canada to support all of CAOT's efforts, including encouraging the association to continue to explore new ways in which it can further increase accessibility to its publications.

I can see the smile developing on those who have heard my speech before. You have to forgive my passion; in my 23 years I have watched the profession evolve from discussing the therapeutic use of activity to researching the effectiveness of interventions that enable occupation. I see the impact of occupational therapy, and believe the public has a right to know of its effectiveness and its challenges. I leave my job undone. There is so much to tell, and we must find more ways in which to do this, well beyond our internal audience. After all – how can we be client-centred and insular at the same time?

I anxiously await the next chapter.

Letter to the editor, continued from p. 2

of a grave. Survivors who wish to commemorate the death of loved ones have no grave to visit, no headstone to touch. In many cases they lack even a date of death to allow them to utter the Kaddish prayer. For these individuals, the term "Holocaust" represents the only graveyard they will ever know. Misuse of that term is therefore seen as improper.

2. There have been many incidents of genocide in human history but many of these have been given a special identifier by those who grieve. Our friends in the Roma community refer to their experiences under the Nazis as the Pourranous ("The Devouring"). Members of the Ukrainian community refer to the deliberate starvation of their people under Stalin as the Holodomar. To bring the matter closer to home, how would members of the First Nations community in the United

States feel if other groups appropriated such terms as Trail of Tears or such tragic landmarks as Wounded Knee for their own uses? How would members of Canada's First Nations communities respond to usage of the term Residential School to describe any experience but their own?

The issue, you see, is not solely whether the term Holocaust "fits" other acts of genocide (and there are many who would argue that the Holocaust was unique - or at least unprecedented - in history), but also has to do with sensitivity to the individuals who suffered and died under Nazi terror and to the larger Jewish community that has been collectively traumatized by this tragedy.

Len Rudner
National Director of Community Relations
Canadian Jewish Congress

Pushing the boundaries: occupational challenges and the drive to reach potential

Heather Moyse

Over the past five months I have undergone an incredible occupational experience. As the brakeman for the Canadian women's bobsleigh team – Canada 1 – along with my pilot Helen Upperton, we ranked second in the world and placed fourth at the Olympics. In this article I share my reflections as an Olympian and a future occupational therapist, with a view of the power of one's sense of doing and path to occupational mastery.

This time last year, I was in my first year of the master's program in occupational therapy at the University of Toronto, and playing rugby for the national senior women's rugby team. At the same time this year, I was in Italy competing in the Olympics. Although I have been involved in many different sports over the years, bobsleigh wasn't even a part of my vocabulary a year ago; however, since I was introduced to it in August it has become a significant part of my occupational repertoire. One might ask why someone would leave everything they know and do so well, and pick up a relatively random sport that they've never even seen before. Well, the answer is that

the challenge was too tempting to resist.

In the summer before the 2002 Winter Olympics, a recruiter approached me from Bobsleigh Canada. It was an Olympic year and the first year that women's bobsleigh was an Olympic event. He pitched to me that as a sprinter and rugby player, I was ideal and potentially would do really well with an 'almost' guar-

antee to become an Olympian. For many people, the chance to become an 'Olympian' would win over anything else, but for me that pitch was not enough. Throughout my athletic career I always competed for the love of the sport and strived to reach occupational mastery in every sport I tried. Rugby was my main sport, however as it is not an Olympic event my goal was the World Cup, which only happens every four years. Simply becoming an Olympian wasn't appealing enough for me, because it didn't seem to be much of a challenge at the time. I didn't want it if it was going to be 'handed' to me. As well I had other occupational dreams. I wanted to work in a developing country and had plans to move to Trinidad and Tobago that fall. I was going to be developing sporting programs for people with disabilities and I ended up spending the next two and half years doing just that.

The few people who knew about that Olympic chance respected and understood my decision, however, they still wondered how I would have done in bobsleigh. Although I never once regretted my decision, I often wondered too. Opportunities such as these rarely come along twice, so when I was approached again this past year, in the summer before the 2006 Winter Olympics, I couldn't say no a second time. It still wasn't an easy decision and I endured much internal debate. I had enjoyed immensely my first year as a professional master's student, had made some great friends and was excited about becoming an occupational therapist. In addition, I would have to give up a rugby tour to France with the National team; I found myself in a complicated situation and had to rethink my occupational goals. Could I leave the two main occupations that had given me a name and helped define my identity, and enter a world where I was anonymous, in a sport that I knew nothing about? But... the challenge was too appealing. Could I learn a new sport? Could I master it in less than five months? It was a challenge that, as an athlete, I found hard, and ultimately impossible, to resist. I suddenly found myself in a new environment, with new people, doing a brand new occupation, trying to learn all of the ropes in

Photo David Buxton



U of T occupational therapy student Heather Moyse (left) with pilot Helen Upperton

As a future occupational therapist, reflecting on my experiences over the past year, I've realized that people do different occupations for the same reason, or the same occupations for different reasons.

a very short period of time – like a baby on wobbly legs, learning how to walk for the very first time.

Although I was showing a lot of potential in the beginning, people doubted my ability to transfer my testing skills to pushing at the top of a track. That made me even more determined. I didn't put all my previous occupations on the backburner – put my master's degree on hold, move away from friends and family, and jeopardize my chance to make the Rugby World Cup team – just to play around! I was going to make the experience worthwhile, and prove that I deserved to be there. I'm a fast learner. So why couldn't I do it? Why couldn't I be the fastest brakeman in the world? I really didn't know much about bobsleighting. Therefore, it was the challenge that I initially fell in love with, not the sport!

The whole season was a whirlwind, and at times a roller-coaster ride with emotions and intensity. Lifting weights was an occupation which I had never done and never wanted to do. However, I decided that if I really wanted to see what I could accomplish in five months, I would commit to doing the full program. At first, it was hard to do things in training that were so foreign to me while my team mates were breezing through the workouts. But I was determined to see this challenge through, and succeeded in posting the fastest times in the world, setting four new push-start records during the World Cup season. I came to love the sport as well as the challenge, and I no longer felt lost in my new occupation.

Being at the Olympics was an exclamation point at the end of a fairly surreal season. This whole year happened so fast that I'm just now beginning to realize what I've actually accomplished. Throughout the year I was just doing my job, pushing as fast as I could, and somehow I made it. I think I was down-playing the Olympics for so long to avoid being caught up in all of the distractions – the people and the cameras. I was there for the Olympic 'competition', not the Olympic 'Games', and I just had to stay focused and do my job – push the sled as fast as I possibly could. Whether we were ranked tenth or second it wasn't going to change what needed to be done.

At the Olympics, Helen and I set another push-start record, breaking the old record by 0.06 seconds, and we finished fourth, 0.05 seconds away from a medal. Fourth place is a tough place to be, but my race is the first 50 metres. After that point I have no control over the downtime, so as long as I can be the fastest in my role, I've done my job.

Since arriving home many people have asked about my experience at the Olympics, being in an environment of occupational mastery. It's strange. For spectators, an Olympic medal or a world record means that you're the best – a prime indicator of occupational mastery. However, I believe that I'm the same as many world-class athletes who, although sometimes pleased with their performances, know that there is always room for improvement. I can always get better and do more. Although I now hold push-start records at five tracks, those are now records to be broken – either by someone else or again by me. I know that I have accomplished a great deal over the past five months, but maybe that's what makes an elite athlete elite – the drive and determination never to be 'just satisfied' with a performance. Maybe that's what has helped me to 'master' the other occupations in my life, and why I had turned down the 'almost' guarantee of being an Olympian the first time. For me, if it's not challenging, then it's not as appealing! So, I set the bar for each challenge, but once that's reached, I raise the bar higher. For me, the ultimate challenge is... how high can I raise the bar?

As a future occupational therapist, reflecting on my experiences over the past year, I've realized that people do different occupations for the same reason, or the same occupations for different reasons. People are driven by various forces, having come from diverse past experiences and, therefore, the sense of meaning and purpose of our clients can vary. By understanding this, it will help us, as occupational therapists, to enable our clients' potential. People need to feel as if they can – a real sense of doing! Someone once said, "By facing our challenges, we discover our potential." Many people thought that I was crazy to start bobsledding but after five months I competed in the Olympics, so now I know I can!

An occupational therapist's intellectual property: FAQs

Tapas K. Pain

Occupational therapists are creative by design, and as enablers of occupational engagement they often develop innovative assistive technology (and other intellectual property) within a clinical setting. However, commercializing that intellectual property, with seamless reintegration into a clinical setting, remains an often-insurmountable obstacle for most occupational therapists primarily because of the lack of publicly accessible “how-to” information and support.

Some occupational therapists, like Patty Rigby of Bloorview Kids Rehab (formerly Bloorview Macmillan Children’s Centre), are fortunate enough to have internal support in this area with access to engineers, like Steve Ryan, who are more experienced in such commercial ventures¹, and committees focused on researching and answering inevitable questions that arise. Recently, Rigby and Ryan (2005) described their experience in the commercialization of their Embrace™ Pelvic Positioner. In an interview with this author, Rigby explained

that as part of that project, they were required to explore commercial prospects for their pelvic positioner. In doing so, Rigby was able to delegate certain aspects of the project, including arranging for adequate protection of their innovation, disclosure to third parties, locating commercial prospects, assignment of their rights (under the terms of Bloorview’s intellectual property policy), and subsequent licensing concerns (for Bloorview).

Most occupational therapists do not have access to the

same internal resources for handling intellectual property as Rigby, placing them at an informational disadvantage. This article aims to answer some frequently asked questions (FAQs) that arise, specifically geared toward intellectual property issues for occupational therapists.

How can assistive technology created in a clinic be protected from commercial theft?

Patents protect functional aspects of inventions (either products or methods) for 20 years from the date of the filing of an application (assuming the patent is actually granted) (Canadian Intellectual Property Office (CIPO), 2004). In Canada, methods of medical treatment generally are not patentable but diagnostic methods are. To be patentable, an invention must be: i) novel; ii) useful (i.e., solve a known problem); and iii) non-obvious² in light of that which is already publicly known. Patents are national in scope, and country-specific. Industry Canada provides facilities for filing national patent applications and applications under the Patent Cooperation Treaty (facilitating filing in multiple foreign jurisdictions including the United States, Asia, Europe, Australia and others).

If the technology is not patentable, are there other forms of protection?

In certain instances where products are not patentable, they may be eligible for protection by industrial design (CIPO, 2003) (also known as ‘design patent’). Registered industrial designs are good for ten years from the date of registration but are limited to protecting shape, configuration, and ornamentation, whereas patents protect

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¹Mr. Ryan's experience includes being named in five other patents and design registrations.

²A proper discussion of the concept of obviousness is beyond the scope of this paper.

Assistive technology can get to market by individual development, licence, or sale to third parties.

functionality. Alternatively, depending on the technology and the manner in which it is used and disclosed, it may be suitable for protection by trade-secret.

How can disclosure of the technology be made safely?

Disclosure to commercial prospectors can be: 1) unconditional; 2) subsequent to a non-disclosure (or secrecy) agreement; or 3) subsequent to filing a patent application. The first method of disclosure is not recommended, and the second and third are reasonably effective at deterring both short and long-term commercial misappropriation (infringement). In the third, if a patent is issued, the deterrence level increases, and is generally the most effective of these three methods. Patents offer nationwide relief against infringers whereas non-disclosure agreements must be enforced on a province-by-province basis (and are generally more problematic).

What's in a name?

Consumers (including therapists) tend to identify products and services by brand (i.e., trade-marks). For example, the word “Embrace” in Embrace Pelvic Positioner and the acronym EPP arguably act as trade-marks, allowing therapists to distinguish this brand from another, and identify the commercial source of this product as (depending on the agreement involved) BodyTech NW of Seattle, WA, Patty Rigby and Steve Ryan of Toronto, Ontario, Bloorview Kids Rehab, or the University of Toronto.³ The value of a trade-mark, when properly grown and nurtured, often can overshadow the value of a patent (consider for example the trade-mark IBM™ and then try to list from memory ten patents owned by IBM™). Trade-mark registrations are federal in scope, relatively inexpensive, and can be renewed perpetually (CIPO, 2005).

Do I sell or licence the technology, and where does the money go?

Assistive technology can get to market by individual development, licence, or sale to third parties. Individual development requires tenacity, know-how, a detailed business plan, and usually significant investment capital. Under a licence, a licensee pays royalties to a licensor for ongoing usage and exploitation of a patented technology (or trade-secret). The royalties can be directed in several ways, including stimulating further research and development, funding and expanding clinical practices, or rewarding investors, thereby creating a desirable future investment environment. A sale typically transfers all rights (including patents), is a one-time event, and leaves the seller without recourse subsequent to the sale.

How is the technology brought back to clinical practice after sale or licence?

This question is often the most significant for health-care practitioners. Commercialization and exploitation of therapeutic technologies does not necessarily mean the technology becomes unavailable to the originating therapist, originating clinic, or the public. Even when technologies are sold, it is possible to obtain and implement non-exclusive perpetual royalty-free licences in exchange, permitting continual clinical and public access. Such reversionary interests should be negotiated and detailed early in any commercial dealing to avoid significant and expensive conflict. The cost of including this feature in a larger commercial deal can be negligible.

Where do we go from here?

Protection of intellectual property is only the first step to successful commercialization, and thereafter the therapist's choice of direction is governed largely by entrepreneurial will and/or an employer's intellectual property policy, if applicable.

³ Supra note 1.

⁴ Incorporation is not necessary, and is normally done to limit personal liability, offer a structured investment environment, raise capital, and reduce tax liability. Entities can be incorporated federally or provincially, and often the choice of jurisdiction is driv-

en by tax considerations. Even where incorporation is selected, therapists and clinics are not obligated to incorporate as a not-for-profit corporation. Corporate structures tend to have higher profitability, overhead, visibility, monetary liability and accountability (to shareholders, banks and government).

Some of the questions and answers above assume that the therapist in question has no desire to leave a clinical setting. Where a therapist does choose to leave, other questions inevitably arise, such as: "Must I incorporate a company?"⁴; "What should be included in a supplier and distributor agreement?"; "Do I have to register for a goods and services tax (GST) number?"; "What are my product liability issues?"; and "Should I carry insurance?". Answers to these and other inevitable questions are beyond the scope of this paper, and should always be sought from experienced legal and business counsel.

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Declarative title: Do people with schizophrenia improve equally in learning to cook in a clinic and at home?

Structured Abstract

Summary of Duncombe, L. W. (2004) Comparing learning of cooking in home and clinic for people with schizophrenia. *American Journal of Occupational Therapy*, 58(3), 272-278. (Prepared by CAPs Advisory Group Member)

Research Objective: The purpose of this study was to compare learning of cooking skills in two contexts (home compared to clinic) for individuals with long-term schizophrenia.

Design: Quasi-experimental design with pre and post measures.

Setting: The cooking lessons were held either in a clinic setting or in the home environment. The clinic setting was a classroom with a kitchen on a quiet floor of a university building. Minimal distractions existed and the environment remained calm and organised. Since most participants lived in group homes, the kitchens of those environments were described as cluttered with equipment and supplies. On many occasions staff and other residents interrupted the cooking sessions, which may have affected the attitude or the focus of the participants.

Participants: The forty-four participants were people who received the diagnosis of nonparanoid schizophrenia (n=19) or schizoaffective disorder (n=25) at least five years prior to the beginning of the study. All participants showed negative symptoms of schizophrenia. The age range of the participants was 27-62 years, with a mean age of 45.5 years (SD=8.5). Most participants were men (n=26). Most (n=38) lived in one of 12 group homes; the remaining six lived in supported apartments. All participants could access a kitchen. Twenty-five had cooked or, at the time of the study, were preparing some of their own meals, while 19 had minimal exposure or experience in cooking. Participants were matched on cognitive level; one of each pair was randomly assigned to either a clinic or home cooking group, with the other assigned to the remaining group.

Outcome Measures: Cognitive level of participants to their matched pair was measured with the Allen Cognitive Level Screen (ACLS-90) administered by the principal investigator. Cooking skill was assessed using the Kitchen Task Assessment-Modified (KTA-M) both before and after the intervention. The KTA-M was developed in a previous study by the author. It combined the cooked pudding task of the Kitchen Task Assessment (KTA; Baum & Edwards, 1993) with a scoring system to evaluate cooking performance adapted from the Rabideau Kitchen Evaluation Revised (Neistadt, 1991). Each one of the 40 steps of the task was scored on a six point ordinal scale of 0-5. A total score was obtained with 200 representing maximal independence. Face validity, and interrater and test-retest reliability of the KTA-M were demonstrated in an earlier pilot study by the author.

Intervention: Each participant was seen individually four times, on a weekly basis, in the designated site by a research associate blind to the study purpose. During the first session, the KTA-M was administered. Afterwards, the cooking lesson began, emphasizing the aspects of cooking required to perform the cooked pudding task. Each participant received a handout listing ten steps necessary for cooking simple food (such as washing hands before cooking). Each guideline was discussed with references to the cooked pudding task. During the second session, participants made a sandwich, emphasizing seven of the ten guidelines. The third session was dedicated to learn how to cook ramen soup and integrating all the cooking guidelines. Finally, at the fourth session, the KTA-M was administered a second time to measure change.

Main Findings: One significant difference was found at baseline between participants in the two groups: the home group mean score on the KTA-M was significantly higher than of the clinic group ($t=-2.07$, $df=42$, $p<0.026$). Participants in both groups scored significantly higher on the KTA-M after cooking lessons ($t=5.57$, $df=21$, $p<0.0001$ for the clinic group; $t=7.81$, $df=21$, $p<0.0002$ for

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Beginning June 15, 2006
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the home group). The author asserts that this difference reflects the learning of the cooking skill. A greater variability was observed in the clinic group, as the participants with the two lowest KTA-M scores were assigned to this group. Participants with initial lower KTA-M had significantly more change in KTA-M than individuals with initially high KTA-M scores ($t = -3.39$, $df = 37$, $p < 0.001$). There were no statistically significant differences in scores on KTA-M between the two groups based on where the learning took place ($b = -1.8$, $df = 42$, $p < 0.23$).

Conclusions: Participants assigned to the home environment performed better initially than the clinic group. This finding is interesting in light of the clinical observation that interruptions and distractions in the home environment should have made the learning process more challenging. This

raised the question of the role of the context: does that difference reflect the supporting role of a familiar environment or can it be explained by other unaccountable differences between the two groups? Were the lowest scores observed in the clinic group due to the unfamiliarity of the clinic setting or are they artifacts of randomization? Learning new skills in the home was not better than learning in the clinic for people with schizophrenia in this study. Further research on the effect of context on learning for people with cognitive dysfunction and schizophrenia is recommended.

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Commentary on Duncombe (2004)

This study focuses on a very relevant aspect of occupational therapy interventions for people with schizophrenia: how and where skills must be taught to ensure better functional outcomes. The author demonstrated a good integration of how cognitive processes may affect learning in individuals with schizophrenia, as was apparent in the literature review, the sampling strategy and the intervention protocol. Duncombe was also quite transparent and thorough in the description of the research protocol and the limitations of the study. Despite the quality of this paper, one may be perplexed by a few aspects of the study, notably the choice of outcome measures, the differences between the two groups and how this research informs clinical practice.

Measurement Issues

Duncombe wanted to measure the learning of cooking skills. The acquisition or learning of skills is demonstrated and measured more easily than

the application or performance of skills in the relevant environment (Anthony, Cohen, Farkas & Gagne, 2002). While learning relates to the capacity of the person to acquire a skill, performance conveys how the individual uses this skill in the real life context (Goldstein, 1981). Generalization of the learning in a real-life context remains a challenge for most psychoeducation and skill training programs (Anthony et al., 2002; Deleu & Lalonde, 1999), hence the need for teaching skills in the environment where they will be used (Corrigan, 2003; Test & Stein, 2000). Even if the author wanted to examine the impact of the context on the learning of cooking skills, the ultimate test lies in the ability of the person to apply those skills on a day-to-day basis. No efforts were made to gather complementary data describing how the learning was reflected in participants' occupational performance.

continued on page 12

One could argue that the KTA-M measures strictly a cooking task and not the ability to cook.

To match participants in the two groups, the cognitive abilities of participants were measured by the ACLS-90. Although there is little evidence of its validity, the ACLS-90 is used widely in the U.S. as a gold standard for screening cognitive functioning. Duncombe thoroughly describes how the outcome measure was chosen. The Kitchen Task Assessment (KTA) (Baum & Edwards, 1993) and the Rabideau Kitchen Evaluation-Revised (RKE-R) were considered. For the purpose of this commentary, it is worthwhile to review what those tools measure. The KTA measures the cognitive support a person needs to complete a cooking task (Baum & Edwards, 1993; Gitlin, 2005). It never was intended to be a measure of cooking skills, as observations focus on only one activity, and scoring is related to the executive functioning demonstrated through that activity. While the RKE-R focuses on the assessment of cognitive and perceptual abilities of an individual, it also measures light meal preparation skills; but primarily, the RKE-R is used to “determine the functional sequencing ability” of the clientele for whom it was intended originally (Neistadt, 1994, p. 433). It could be argued that the KTA-M cannot assess effectively occupational performance more than the original assessment tools from which it is derived. Is it a true reflection of the functional outcome for which occupational therapists strive? One could argue that the KTA-M measures strictly a cooking task and not the ability to cook. The summation of the KTA-M items by the author is controversial as there is an increased awareness that mathematical operations, like creating a total score, are strongly discouraged within an ordinal scale (Ancelle, 2002; Stein & Cutler, 2001), because it cannot be assumed that the differences between scores are equal within or across different items of the scale.

Issues in comparing groups

Baseline measures of cooking skills demonstrated that the control group scores were significantly lower than those of the experimental group. Since the groups were not equivalent at baseline, it makes the comparison between groups more challenging. This could have been compounded by the

researcher's focus not on the final score of the KTA-M but on the change from the baseline to final scores for the two groups. As the author noted, there was a ceiling effect; this means that the participants who performed well at baseline could not improve their scores as much after the intervention. One may wonder to what extent their final score is a true reflection of their learning or compounded by the limitations of the assessment tool. In this context, given that the possibilities for improvement were different between the two groups and that they may not have been well captured by the outcome measure, it remains difficult to conclude anything on the effect of the learning environment. Perhaps the experimental and control group should have been paired not only on the cognitive level of the participants but also on their cooking skills. Culture was not discussed or considered as a variable, although it may have impacted on cooking performance.

Intervention Issues

Duncombe never discussed the possible impact of the similarities between what was taught during the training program and the task of the KTA-M. This may also explain part of the change observed between the baseline and final scores. To reduce researcher bias, research associates who participated in the administration and in the training of participants were blind to the purpose of the study. The author, however, fails to control another source of bias: since the research associates were aware of the baseline scores, this may have affected the training they provided, or more importantly, the research associates' final assessment. The question remains: is the change related to the learning of cooking skills or how the individuals learned to perform better on the next administration of the KTA-M? This issue is of relevance to research, but also to practice when therapists are evaluating outcomes by using a pre and post intervention tool. How can we best ensure that we are not “teaching to the test”?

Applications to Research and Practice

Despite those concerns, this article remains rele-

One may wonder to what extent their final score is a true reflection of their learning or compounded by the limitations of the assessment tool.

vant to research and practice. It demonstrates the challenges involved in the design of research protocols focusing on occupational performance. Choosing outcome measures and reducing bias are challenging tasks as researchers strive to develop a protocol that reflects what practitioners would do in real life without, at the same time, compromising the robustness of their findings. There is a substantial consensus that in-vivo learning is preferable to minimize issues related to generalization and transferability of skills, and this article does not produce sufficient evidence to challenge this belief. The discussion section of the paper alludes to considerations in each setting that should be kept in mind. The study raises some thought provoking, although ambivalent, results and points out the need for continued research. Therapists in practice are encouraged to continue focusing on interventions to improve functional living skills and performance in occupations, including cooking. The challenge is not only to find the setting that best meets the learning needs of the client, but also to identify measures of the functional performance of cooking, rather than simply the learning of the task without application to everyday occupational performance.

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Interested in reading more CAPs?

Column editor Lori Letts and the CAPs Advisory Group have now completed three CAPs. These are available online to CAOT members and also by PDF through CAOT Publications. Email publications@caot.ca with the name of the CAP and issue date.

Brief occupational therapy increased self-management behaviour in adults with early rheumatoid arthritis but had no effect on functional or health status at two year follow-up. November, 2005

Systematic review of the literature concluded that there is an evidence base for occupational therapy interventions with people aged 60+ living independently in the community. January, 2006

Clinical reporting by occupational therapists and speech pathologists falls short of therapists' intentions and parental expectations. March, 2006

If you are interested in writing a structured abstract or commentary, please email Lori Letts at: lettsl@mcmaster.ca

IN MEMORIAM

Jocelyn H. Alexander
1924-2005



Jocelyn H. Alexander died in August 2005 after a long and interesting life. During WW II she served in the Women's Royal Canadian Naval Service (WRCNS), following which she enrolled in the first expanded occupational therapy course at the University of Toronto, graduating in 1949. During her 40 years of practice Jocelyn worked in Hamilton, Ottawa, Montreal

and Kingston. While working at Kingston Psychiatric Hospital she was instrumental in implementing Anne Mosey's Recapitulation of Ontogenesis theory as the framework organizing occupational therapy practice hospital wide. She returned to Ottawa in 1973 as head therapist at Ottawa General Hospital (OGH). When the new OGH was planned, she designed its occupational therapy department but elected to stay at the old hospital when it converted to geriatric care (now the Elisabeth Bruyere Health Centre). Joce retired in 1989 and spent many happy years in Wakefield, Quebec.

Jocelyn practised client-centred therapy long before the term was coined. She considered diagnosis less important than forging an alliance with her clients that encouraged them to be self-reliant and improve their quality of life. Not only was she a sought-after fieldwork supervisor, she was a brilliant mentor to generations of young therapists, always encouraging them to think for themselves. She was incredibly generous with her time and expertise and was a wonderful role model. Joce was pragmatic, straightforward, wise, well-informed, non-judgmental and compassionate towards all, valuing their uniqueness. The lives of all who knew her were enriched, and her family, friends and colleagues sorely miss her.

To honour her memory a new Young Adult Section of the Biblio Wakefield Library is being developed. Contact: Glennis Cohen, Biblio Wakefield Library, 20 Valley Drive, Wakefield, Quebec, J0X 3G0.

Tal Jarus appointed as Head of UBC Division of Occupational Therapy



The Division of Occupational Therapy is delighted to announce that Dr. Tal Jarus is the new Head, Division of Occupational Therapy and began her five-year term on February 16, 2006. Dr. Jarus has exten-

sive academic experience in research, teaching, graduate supervision and administration. Previously she was Associate Professor and Chair, as well as Head of the Graduate Program, in the Department of Occupational Therapy at Tel Aviv University in Israel. Dr. Jarus earned a BOT at Hebrew University in Jerusalem, and completed her MA and PhD within the Department of Occupational Therapy at New York University.

Dr. Jarus' primary area of research and graduate supervision is motor learning with an emphasis on skill acquisition, retention and generalization. Her other research interests include work and work-related injuries, and the use of technology in occupational therapy. Dr. Jarus' work appears in many peer-reviewed journals that include: *American Journal of Occupational Therapy*, *Canadian Journal of Occupational Therapy*, *Developmental Medicine and Child Neurology*, *Israeli Journal of Occupational Therapy*, *Occupational Therapy Journal of Research*, *Physical and Occupational Therapy in Pediatrics*, *Physiotherapy Canada*, and *Work: A Journal of Prevention, Assessment & Rehabilitation*.

Seeking new column editor

After a few dedicated years, Elizabeth Steggles has stepped down from her position as column editor for *In Touch with Assistive Technology*.

If you are interested in this volunteer position, please email Fern Swedlove: otnow@caot.ca



2005-2006 mid-year report

CAOT Executive Director Claudia von Zweck

In October of 2006, we marked the tenth anniversary of locating the CAOT National Office in Ottawa by introducing a new strategic plan. This plan builds on the partnerships we have created in Ottawa to represent our profession on national issues and advance our mission of promoting excellence in occupational therapy in Canada. Many CAOT activities in the first half of the 2005-2006 membership year have reached out to involve our members and other partners in collaborative projects that are directed toward achieving our strategic priorities. The following is a progress report on our activities.

Strategic Priority #1

Advance leadership in occupational therapy

CAOT members have a long history of working together to provide a vision for the conceptual grounding, processes and outcomes of occupational therapy in Canada. In the 1980s this vision was articulated in a series of publications produced through a partnership between CAOT and Health Canada. They were combined and published in 1991 by CAOT as the *Occupational Therapy Guidelines for Client-Centred Practice*, which was followed in 1997 with the introduction of *Enabling Occupation: An Occupational Therapy Perspective*. All these publications have been integral in guiding Canadian occupational therapy practice and are used in many countries around the world. Over the past six months, CAOT has been engaged in a process to develop a new publication which will be complementary to these current CAOT documents, and will provide a vision for the future of occupational therapy practice and education in Canada. This document will reflect the changes that have occurred in the context of occupational therapy practice in the past decade due to shifts in Canadian health and social policy, increased emphasis on evidence and accountabili-

ty, and the development of a new occupational language and models of health. The initiative is led by primary authors Dr. Elizabeth Townsend and Dr. Helene Polatajko, in conjunction with a national advisory panel. CAOT members will have an opportunity to provide input into the development of this new publication through surveys and focus groups. As well, a member consultation session will be hosted at Conference 2006 in Montreal on Thursday June 1, 2006.

CAOT continues to work on several additional new publications to lead occupational therapy in Canada. These publications include an annotated bibliography of research on the Canadian Occupational Performance Measure as well as the McGill Ingestive Skills Assessment. Also, the publications *Functional Capacity Evaluation* and *Business in Practice: How to Get There* are planned for publication in 2006. In addition, the CAOT Membership Committee has developed a new ethical decision-making framework and workbook that will be posted on our web site for CAOT members later this year. A revised version of our *Code of Ethics* will be available to accompany this framework. These documents were developed using input provided by members and other stakeholders during a professional issue forum held in Vancouver in June 2005.

CAOT recognizes Canadian leaders in occupational therapy through our awards program. A new web site section was created in the fall of 2005 that celebrates the achievements of our past award winners. All members are invited to join us in recognizing our newest award winners at our Awards Ceremony on June 2, 2006 in Montreal.

As part of our national occupational therapy awareness campaign, CAOT will be developing a special consumer issue of *OT Now* that profiles leaders in occupational therapy in different areas including practice, research, education, adminis-



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tration and policy-making. The issue will highlight the achievements of our members and promote the diverse career opportunities available to occupational therapists in Canada. In addition, CAOT will be meeting with representatives from the Association of Canadian Occupational Therapy University Programs (ACOTUP), the Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO), the Canadian Occupational Therapy Foundation (COTF) and the Professional Alliance of Canada (PAC) in June 2006 on the topic of leadership to foster inter-organizational efforts to promote and recognize leaders in occupational therapy.

Strategic Priority #2

Foster evidence-based occupational therapy

CAOT is involved in several initiatives to support the development of research and promote evidence-based decision-making in occupational therapy. For example, CAOT continues to provide financial and in-kind support to COTF to foster occupational therapy research. In the past year, our work with COTF has resulted in the development of several new critical reviews, which will be disseminated in CAOT publications.

A new column on Critically Appraised Papers (CAPs) was launched in *OT Now* in the fall of 2005 to help members to identify and use evidence in their practice. The column is accompanied by a time-limited online discussion of the findings on the CAOT web site. Our new OT Education Finder on the CAOT web site includes our new CAPs, plus other professional development opportunities available to occupational therapists in Canada. This past fall CAOT offered several continuing education workshops, including hands-on sessions to help members search for research evidence using resources on the CAOT Information Gateway. More of these workshops will be held in 2006.

Watch for our launch of a new evidence-based practice web portal later this spring that will add to our existing online resources. As well, many sessions at our 2006 Conference will assist occupational therapists with integrating research

evidence into practice. With our theme of “Evidence and occupation: Building for the future”, the conference offers a wide variety of presentations that highlight the research contributions of Canadian occupational therapists. CAOT will be hosting a professional issues forum at the conference on “research without borders”. Eminent researchers will be invited to this session to identify strategies to support collaborative research in occupational therapy. A CAOT position statement on clinical practice guidelines in occupational therapy will be published later this year based on input provided at a 2005 professional issues forum.

Strategic Priority #3

Advocate for occupational therapy as an essential service

CAOT is actively involved with over 35 partner organizations to represent occupational therapy as an essential service for the health and well-being of Canadians. A wide array of topics is addressed in these collaborative efforts, ranging from end-of-life care to housing to patient safety and public health strategies. A major thrust of our activities has been focused on gaining recognition for the value of occupational therapy in primary health care services. Currently, we are completing work on two large multi-year projects that have resulted in the development of a framework for interdisciplinary collaboration in primary health care and a collaborative mental health charter. Consultations for the development of these documents were held with members in forums across Canada. Revised position statements were published on the topics of primary health care, home and community care and continuing professional education.

CAOT launched the “Yes I Can” theme for OT Month in October 2005. A special issue of *OT Now* was developed for OT Month that highlights how occupational therapists promote an inclusive society and break down barriers to occupational participation. Other OT Month activities included the submission of articles to consumer and workplace journals about occupational therapy and the development of resource information and promo-



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tional items for use by members to advocate for occupational therapy. The CAOT Pan-Canadian Awareness Campaign was introduced during OT Month with a reception in Ottawa attended by representatives of government and partner organizations. This grassroots strategy involves occupational therapists from across Canada using resources prepared by CAOT to inform government, policy-makers, funders and referral agencies about what occupational therapists can bring to primary health care.

The initial phase of the new three year Stable, Able and Strong Project is nearing completion. This project hopes to demonstrate how occupational therapists can make a difference in community development. Peer support resources for seniors who have experienced a fall will be developed and tested in pilot sites in Calgary, Prince Edward Island and Ottawa.

Strategic Priority #4

Develop workforce capacity in occupational therapy
CAOT recognizes the importance of health human resource planning to ensure access to occupational therapy services in Canada. In 2004, CAOT and other stakeholders articulated a health human resources strategy for occupational therapy. CAOT is working on several components of this strategy.

An essential element of the human resources strategy is the development of a consistent source of data regarding the occupational therapy profession. CAOT is one of several data providers involved in the development of a database of information for occupational therapists in Canada. This project, funded by Health Canada and coordinated by the Canadian Institute for Health Information, will result in the availability of needed data for occupational therapy by 2007.

CAOT also continues to work on the issue of caseload guidelines for occupational therapy. Currently, funding is being sought for a project to follow up on recommendations from the 2005 CAOT report on caseload guidelines. The CAOT Board of Directors also approved funding for a project proposal for a qualifications recognition framework for occupational therapy support work-

ers. This framework would help occupational therapists to understand the competency level of support workers when assigning components of their work. In a related project, CAOT is undertaking a review of the *Profile of Occupational Therapy Practice in Canada*, a document that outlines skills and knowledge needed to practice occupational therapy in Canada. The *Profile* serves as the basis of the certification examination blueprint as well as standards for academic accreditation of university occupational therapy programs. The revised *Profile* will address the range of skills and knowledge needed for occupational therapy practice in Canada, from support worker to an advanced occupational therapist practitioner.

The CAOT Workforce Integration Project, funded by the Government of Canada Foreign Credential Recognition Program, is investigating barriers and enablers for international graduates wishing to work in Canada as occupational therapists. Findings of the study will be shared with members and other stakeholders in consultations across Canada later this spring to develop recommendations for future action. The Certification Examination Committee already has initiated several changes to the certification exam to ensure international graduates are not disadvantaged unfairly. Funding was approved in the fall of 2005 for a full plain-language translation of examination items following a successful trial earlier in the year. The number of distractors for each multiple choice item was reduced recently from five to four and the length of the exam will be shortened, beginning with the July 2006 sitting. These changes were made to ensure the exam tests knowledge rather than endurance. Our analysis has indicated that these changes will not impact the performance of the exam in evaluating knowledge areas.

Strategic Priority #5

Advance CAOT as the national occupational therapy professional association in Canada

CAOT strives to provide valued services and products for members. A number of our CAOT committees have undertaken initiatives to gather input to



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improve our services over the past year. For example, in 2005 CAOT introduced several changes to the *Canadian Journal of Occupational Therapy (CJOT)*, including the development of a new early electronic edition. To make further plans for *CJOT*, members of the CAOT Editorial Board held focus groups and sought feedback using an online survey. The member input was used in a strategic planning exercise that reviewed the overall vision for the journal.

Recommendations from this review will be provided to the CAOT Board of Directors later this spring. In addition to this activity, the CAOT Awards Committee reviewed and revised all our award policies to ensure consistency and fairness. The Conference Scientific Review Committee initiated a new Abstract Review Board for the peer review of presentations submitted for our 2006 Conference. The CAOT Academic Accreditation Council developed three working groups to ensure excellence in our accreditation process. Currently, the working groups are reviewing the training and orientation provided to accreditation reviewers, developing guidelines for on-site and off-site review teams and monitoring the implementation of the new academic accreditation indicators. The new academic accreditation indicators were imple-

mented in the accreditation of Dalhousie University in November of 2005.

CAOT surpassed our goals for revenue generation in 2004-2005 because of higher than anticipated attendance at Conference 2005 and efficiencies implemented at National Office. As a result, CAOT is able to use surplus revenues to help us to meet our operating expenses in 2006-2007, eliminating the need for a membership fee increase. In addition, CAOT has been able to invest in a number of special projects such as our plain language project, the development of our proposal for a qualifications recognition process for support workers and hosting special issues forums on important topics for the future of our profession.

Summary

The first six months of this membership year have passed quickly, with many activities underway to address our new priorities. Please join us at our annual general meeting in Montreal on June 1, 2006 for your opportunity to obtain more information regarding our work as your national professional association. Your comments and input are welcome as we begin to plan activities for our next membership year.



**Plan to attend the CAOT Annual General Meeting (AGM)
and other conference events to learn more about
how CAOT represents you. AGM is June 1 @ 10:00 am**

Why government relations matter

Donna Klaiman, Director of Standards and Professional Affairs

CAOT is perceived by the federal government as the leading national representative of the profession's interests, traditions, skills and knowledge. The federal government looks to us as the body mandated by its members to articulate how occupational therapy contributes to the health and quality of life of Canadians.

Similar to other professional groups, occupational therapists must demonstrate that their services are cost-effective by drawing on evidence to support their practice.

To be effective, our interactions with government must address challenges as well as opportunities in the political arena. Many interests compete for government resources. Governments in turn are increasingly conscious of the need to account for spending by obtaining high value for the dollars they invest in health services and programs. Similar to other professional groups, occupational therapists must demonstrate that their services are cost-effective by drawing on evidence to support their practice. Since decisions affecting our profession are made by the federal and provincial governments, both must be targeted in making the best possible case for our services. Consequently, our efforts feature close collaboration with provincial professional associations and researchers.

CAOT's government relations activities primarily involve ongoing interaction with the federal government on such matters as: health and social policy; the financing of health services; support for professional education and research; and use of human resources, including occupational therapists, in the delivery of health services. CAOT employees engaged in government relations are registered as lobbyists under the federal Lobbyists Registration Act (Government of Canada, 2005). Federal registration involves making the process of lobbying transparent. It identifies who you are, whom you intend to lobby and what you intend to lobby. CAOT also complies with the Code of Professional Conduct and adheres to standards of

best practice set by the Government Relations Institute of Canada (GRIC, 1995).

What does CAOT do?

In interacting with government, CAOT:

- Anticipates and responds to evolving priorities in health and social policy.
- Often collaborates with other professional organizations in offering an expanded perspective on health policy issues.
- Draws government's attention to priorities for the profession such as equal access to our services, support for human resources planning and research funding.
- Monitors government initiatives in areas of immediate interest and concern to the profession.

What are the current priorities?

Primary Health Care

CAOT believes that Canadians have a right to quality services provided by interdisciplinary teams of health professionals including occupational therapists. We point out that our own services effectively prevent injury and promote health among individuals, groups and communities by encouraging participation in occupations or daily activities. Given the current major restructuring of primary health care, CAOT highlights the importance of funding arrangements that finance occupational therapy services within primary health care teams. To this end, we have pursued the following strategy in dealing with government:

- We advocate for approaches that will provide public financing for a broader range of health professionals, including occupational therapists, working collaboratively to supply high quality primary health care at an affordable cost.
- We work with coalitions backing these approaches.
- We advocate for profession-specific and interdisciplinary research whose outcomes provide evidence to support the value of interdisciplinary collaboration in the provision of primary health care. (CAOT, 2005a)

Health human resources

CAOT recognizes the importance of health human resource planning to ensure access to occupational therapy services in Canada. CAOT believes that a sustainable and effectively integrated workforce is essential to the health of Canadians through timely access to the right professionals within their community. Consequently effective planning for the right human resources should be based on criteria reflecting existing and projected needs. To ensure that there are sufficient numbers of suitably trained occupational therapists to meet these needs, CAOT:

- Communicates to decision-makers and funders the added value of occupational therapy to the health and quality of life of Canadians.
- Sensitizes decision-makers to disparities in the financing of health professionals engaged in community practice and the constrained access to occupational therapy services.
- Promotes and participates in research to enhance best practices in planning for the human resources needed for high quality health care.
- Maintains partnerships with government, stakeholders and other professional organizations that share a similar vision of an integrated workforce engaged in health care. (CAOT, 2005b).

Home and community care

CAOT's position is that all people of Canada have a right to quality home care and community services, including end-of-life care, provided by an interdisciplinary team of health professionals that includes occupational therapists. Home and community care services should be coordinated within an expanded range of health services. They should be accessible, affordable, timely, and provided by the most appropriate health professional. In its relations with government, CAOT:

- Advocates for funding models for home and continuing care that include occupational therapy services.
- Works with coalitions advocating for similar initiatives related to home and continuing care strategies.

- Promotes profession-specific and interdisciplinary research attesting to its cost effectiveness. (CAOT, 2005c, 2005d)

Recent activities

The Pan-Canadian Awareness Campaign is a strategy that involves occupational therapists from across Canada using resources developed by CAOT. All levels of government, policy-makers, funders and referral agencies will be informed about the potential benefits, as well as affordable costs, of occupational therapy in providing high quality and effective primary health care services.

Enhancing Multidisciplinary Collaboration in Primary Health Care (EICP, 2004) and the Canadian Collaborative Mental Health Initiative (CCMHI) are two major initiatives funded through Health Canada. Representing the interests of its members, CAOT has collaborated with other health professionals to develop principles and a framework for interdisciplinary collaboration in primary health care and a collaborative mental health charter.

The CAOT Workforce Integration Project, funded by the Government of Canada Foreign Credential Recognition Program, is investigating barriers and enablers for international graduates looking to work in Canada as occupational therapists.

The Occupational Therapy Data Set Project, a key component of the human resources strategy, is funded by Health Canada and coordinated by the Canadian Institute for Health Information. The goal of this project is to develop a consistent source of data regarding the occupational therapy profession. CAOT is one of several data providers involved in the development of a database of information for occupational therapists in Canada.

Upcoming events

CAOT will participate in a high level "think tank" which will address a key public policy concern on how to measure cost effectiveness in primary health care. The objective of this meeting is to develop a framework to guide future research on relating costs and outcomes in primary health care. The meeting is being convened by the

Department of Health Policy, Management and Evaluation at the University of Toronto, the Canadian Alliance of Community Health Centres and the Ontario Health Centres.

CAOT will contribute to the discussions at "The Taming of the Queue 3", a national meeting on wait time measurement, monitoring, and management. The objective of this meeting is to examine key issues that have the potential to transform how access to health services is managed. This meeting is being arranged by a Steering Committee of federal and provincial health associations and governments.

CAOT has been invited to attend the Public Policy Forum "Integrating Immigrants: Building Partnerships that Work". This forum will engage federal, provincial and municipal government representatives, non-profit organizations, educational institutions, regulatory organizations, immigrant groups, employers and business groups to share and define effective partnerships for national decision-making relating to the integration of immigrants.

Full reports on these initiatives will be made available by fall 2006.

For more information on CAOT's government relations' activities visit www.caot.ca or contact Donna Klaiman, Director of Standards and Professional Affairs (1-800-434-2268 ext. 229 or dklaiman@caot.ca)

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The acculturation of internationally educated health professionals in Canada

Claudia von Zweck and Pamela Burnett

Internationally educated health professionals coming to work in Canada bring innovation, and offer diversity and culture to the Canadian workforce. In addition, they play an important and growing role in meeting demands for health care services in Canada. However, successful integration into the workforce is not assured for many professionals who come to work in Canada. As part of the CAOT Workforce Integration Project, Canadian policy and strategies regarding the integration of internationally educated health professionals were reviewed. Findings of this review are outlined below.

Immigration, cultural diversity and workforce growth

Throughout history immigration has enriched Canada's social and cultural life, and stimulated the growth of the economy. Canada now has one of the highest rates of immigration among the thirty member countries of the Organization for Economic Co-operation and Development (Ruddick, 2000). The aging Canadian population and falling fertility rates have lead to a large dependence upon immigration for the growth of the workforce. Between 1991 and 2001, approximately 1.8 million immigrants came to Canada, an increase from 1.2 million in the 1980s (McIssac, 2003). Over 70 percent of labour force growth in Canada was attributable to immigration in the 1990s, a rise from 13 percent a decade earlier (Ruddick, 2000).

Almost one half of all new immigrants who came to Canada between 1980 and 1996 entered the workforce. The average level of education of immigrants coming to Canada in the 1990s was higher than in previous cohorts and the Canadian born population (Albion, Finnie & Meng, 2005). Professionals are now the largest group of immigrants coming to Canada, with increasing numbers intending to work in occupations that have defined requirements for entry to their professions (Citizenship and Immigration (CIC), 2003a). The proportion of skilled workers planning to work within regulated occupations increased from 16

percent in 1990 to 42 percent in 2000 (CIC, 2003b). The rise in professionals coming to Canada reflects both labour market demands as well as federal immigration legislation that favours highly skilled individuals (CIC, 2003b).

Recruitment of internationally educated health professionals

Canada is not self-sufficient in producing health professionals and has long relied upon graduates of foreign education programs as a partial solution to meeting health human resource shortages. With the addition of immigrants from new source countries, this practice has become more difficult. Prior to the 1990s, the United Kingdom was the dominant source country for individuals coming to Canada (CIC, 2001). The nature of education for most health professions in the Commonwealth countries is generally well known and accepted in Canada, but immigrants from newer source countries may require in-depth assessment and additional training (Health Canada, 2004). Recent immigrants have come from all over the world, with Asian countries as the largest source of individuals wishing to work in regulated occupations (CIC, 2003b).

Many reasons influence the decision of internationally educated professionals to leave their home country including: poor remuneration; limited career opportunities; unsatisfactory working conditions; discriminatory practices; and an oppressive political climate (i.e., human rights abuses, threats to personal security, and civil war). They choose to come to Canada because of higher salaries and benefits, better work environments, an improved quality of life for themselves and their family, and/or the desire to join family members (Diallo, 2004; Grondin, 2004).

Canada, in addition to other developed nations, has been criticized for recruiting health professionals from countries that cannot afford to lose their health human resources. This criticism has lead to a call for initiatives such as a memorandum of agreement with developing countries regarding a reciprocal educational exchange of personnel (Canadian Nurses Association & Canadian Medical Association, 2005).

The apparent disconnect between Canadian policy that promotes workforce integration and the reality faced by immigrants when arriving in Canada comes at a great cost.

Canadian acculturation goals and outcomes

Acculturation refers to phenomena that occur when different cultural groups come together, such as when international graduates emigrate from their homelands to settle and work in Canada.

Acculturation results in the need for individuals to develop new relationships and behaviours to adapt to their changing environments (Berry & Sam, 1997). Canada promotes workforce integration as the acculturation goal for individuals who come to work in this country (CIC, 2005b). This type of integrative approach would allow professionals to work in Canada within their field of expertise while respecting their individual need and desire to retain their social and cultural identity from their society of origin.

Canada's approach to the integration of immigrants into Canadian society has been described historically as a "mosaic" that promotes and celebrates multiculturalism (Porter, 1965; Statistics Canada, 2001). Integration is considered to be a two way process, involving both a commitment from newcomers to adapt to life in Canada as well as adaptation of Canadians to new people and cultures (CIC, 2003a). Integrationist societies such as Canada are expected to accept and value diversity, and cater to different cultures. Such societies are considered to be more welcoming to immigrants through the availability of a range of social and cultural groups and networks that may assist an individual with the acculturation process (Berry, 1997).

Despite Canada's acculturation strategy, workforce integration has been unattainable for many professionals coming to this country. Many recent immigrants to Canada have not been able to access jobs that match their formal qualifications, particularly those immigrants who belong to visible minorities. Less than half of the professionally trained new Canadians who arrived in 2002 were able to work in their field of expertise in Canada (Delaney, 2005). The education received by immigrants outside of Canada frequently does not obtain the same market value in Canada

(Metropolis Project Team, 2003). As a result many professionals coming to Canada have become marginalized in their attempts to work in their area of expertise.

The apparent disconnect between Canadian policy that promotes workforce integration and the reality faced by immigrants when arriving in Canada comes at a great cost. The Conference Board of Canada estimated that the economic impact of not recognizing the credentials of new Canadians is approximately \$2.3 billion in lost productivity (Delaney, 2005). Difficulties with acculturation in Canada also have been linked to negative outcomes such as lower motivation and community participation, reduced health status and increased social deviance and conflict (Berry, 1997).

Immigrants may face many changes in values, practices and beliefs when they come to Canada. Adaptation to these changes may compound already existing stress-related disorders and other mental health issues which may have been caused by negative experiences in their homeland. Learning to manage in an unfamiliar environment takes time and can create confusion and self-doubt regarding expected social and professional occupational roles, particularly for individuals unable to work within their area of expertise (Bochner, 1994). Such newcomers may be forced to take jobs of lower social status and prestige, and face the financial consequences of their underemployment.

Low levels of income are common for immigrants in their initial years in Canada

Approximately 40 percent of recent immigrants have incomes less than half of the median income of Canadian-born residents (CIC, 2001). While trends indicate that participation in the workforce and income increase with time, immigrants arriving in Canada since the 1990s have achieved a lower level of labour market success than persons coming to the country in previous decades (McIssac, 2003; Ruddick, 2000).

The need to facilitate the integration of internationally educated health professionals is required to prevent a needless loss of human capital and ensure a diverse and sustainable Canadian health care workforce.

Influencing change to promote workforce integration

The Government of Canada and the provinces and territories agreed at a First Ministers Conference in 2004 to accelerate the workforce integration of internationally educated health professionals to address shortages and reduce waiting times for health care. The 2005 federal budget in Canada allocated funding to support a range of initiatives that will create the required foundation for the efficient assessment and integration of internationally educated health professionals. It is recognized that health professionals will be better able to remain and advance in their profession the sooner they are able to gain work experience in their area of expertise (CIC, 2005a; Health Canada, 2005).

Promoting change to facilitate the workforce integration of internationally educated health professionals requires the coordinated involvement of many groups and stakeholders because of the complexity of issues that can affect acculturation. Governments at the federal, provincial and territorial levels as well as cities and communities, service providers, employers, labour, professional and regulatory bodies, post-secondary educational institutions, the business community and other stakeholders are all considered to have a role (CIC, 2005b).

Summary and conclusions

The growth, prosperity and cultural diversity of Canada have been shaped by immigration. Workforce opportunity and the need for labour market growth has resulted in increasing numbers of internationally educated professionals coming to Canada intending to work in regulated occupations. However, recent immigrants have experienced lower rates of labour market success than persons coming to Canada in previous decades. This results in both economic and human costs. The facilitation of the integration of internationally educated health professionals is required to prevent a needless loss of human capital and ensure a diverse and sustainable Canadian health care workforce.

CAOT initiated the Workforce Integration Project in May 2005 with funding from the Government of Canada's Foreign Credential Recognition Program to examine the facilitators and barriers experienced by international graduates wanting to work in Canada as occupational therapists. The findings of the Project will be used to develop recommendations for future action to address identified issues. An advisory committee has provided input into this project. Representatives of the Association of Canadian Occupational Therapy University Programs (ACOT-UP), Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO), Professional Alliance of Canada (PAC), Canadian Occupational Therapist Assistant/Physiotherapist Assistant Educators' Council (COPEC), Canadian Health Professionals Secretariat of the National Union as well internationally educated occupational therapists are members of this committee.

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Qualification recognition framework underway for support personnel

Donna Klaiman, CAOT Director of Standards and Professional Affairs

At the November 2005 meeting, the CAOT Board Directors decided to lead the development of a human resource strategy to address support personnel in occupational therapy. Occupational therapists require a well-educated support personnel workforce to work with them effectively to deliver quality occupational therapy services in Canada.

The idea to create a support personnel strategy was initiated by the findings of a project to determine the feasibility of academic accreditation for support personnel educational programs. Key stakeholders told us they supported an academic accreditation process for college-based support worker programs, as it would serve to maintain the standards of education and recognize the qualifications of the graduates. At the same time employed support workers who may be college graduates or trained on the job would require opportunities for competency and qualification recognition, and continuing education to meet changing work demands. Therefore it is important

to address the competency recognition requirements and "upskilling" for both groups.

This decision adds another dimension to the current CAOT human resource strategy.

The Board has commissioned a proposal to obtain external government funding to support the development of a competency recognition framework for support personnel. The framework will identify the components and mechanisms that will facilitate qualification recognition and continuing education for all support personnel, college trained and trained on the job. This type of initiative will require a co-ordinated approach with many stakeholders. CAOT plans to work in collaboration with occupational therapy support educators, unions, employers, and provincial and federal governments to develop this framework. Planning is currently underway.

For more information:

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1-800-434-2268
dklaiman@caot.ca



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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.

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

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January-April 2007
Advanced Research Theory and Methods for Occupational Therapists (OCCU 5030). Instructor: TBA.

Program Evaluation for Occupational Therapists (OCCU 5043)

Instructor: Dr. Reg Urbanowski

May-June 2007

Identity and Transitions (OCCU 5040)

Instructor: TBA.

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.

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Dates: on-line May 8-14.

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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.

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June 1, 11:00 – 11:30 a.m.
Annual General Meeting

June 1, 3:30 – 5:00 p.m.
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June 3, 12 noon – 1:30p.m.
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*Please contact Sangita Kamblé at skamble@cotfcanada.org for a Donor Declaration Form. Donor Declaration Forms should be returned no later than May 24, 2006. Thank you.

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New for 2006

COTF's 2005 Annual Report is now posted on the web site.

Please visit
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more news on page 28

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COTF sincerely thanks the following individuals, companies and organizations for their generous financial support during the period of January 1 to February 28, 2006. COTF will acknowledge donations received after February 28, 2006 in a future issue.

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COTF would greatly appreciate it if you would inform Sandra Wittenberg of any changes to your COTF contact information. Please email Sandra at: swittenberg@cotfcanada.org or call 1-800-434-2268, ext. 226.



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Did you know that the Canadian Occupational Therapy Foundation is the only Foundation in Canada that supports research and scholarship grants for occupational therapists? COTF's mandate is to fund and promote research and scholarship in occupational therapy in Canada.

Did you know that COTF has a variety of research and scholarship grants to which occupational therapists can apply?

- Research grants include COTF's research grants, critical literature reviews and the Isobel Robinson Historical Research grant.
- Scholarships include master's, doctoral, Thelma Cardwell and Goldwin Howland.
- For three years, COTF is also partnering with CIHR to offer a doctoral research award in the amount of \$22,000.
- Other current awards include the Marita Dyrbye Mental Health Award, the Janice Hines Memorial Award, the Roulston / COTF Innovation Award.

COTF also works with the provinces to assist them in the building of their provincial education and research funds. This partnership enables provinces to reach their goal more quickly in being able to award provincial grants.

An integral part of offering the various research and scholarship grants involves fundraising. COTF is involved in fundraising activities, such as the Silent Auction and Lunch with a Scholar at the CAOT Conference and a variety of direct mail campaigns. COTF encourages monthly donations from its donors and greatly appreciates all contributions made. COTF is your foundation. Its success is dependent on you!

For more information about COTF, please visit our web site at www.cotfcanada.org or contact Sangita Kamblé, Executive Director at skamble@cotfcanada.org.

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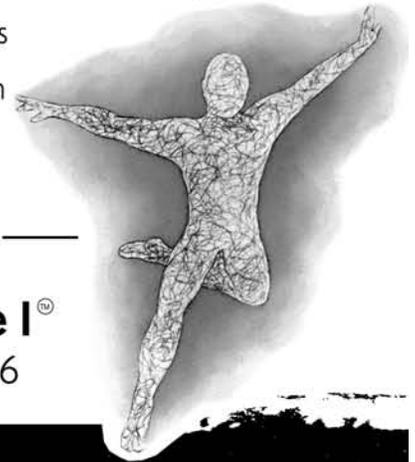
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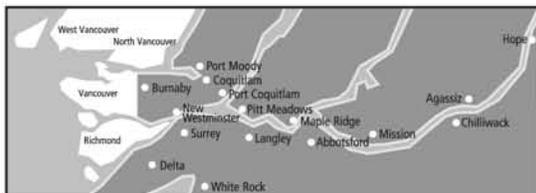


imagine

THE POSSIBILITIES!

Fraser Health, British Columbia's largest and fastest growing health region, is dedicated to creating a work environment that inspires individual and collective contributions, recognizes excellence and innovation in practice, and supports life-long learning.

Dare to follow your dream! Come join our 21,000 employees and 2,200 physicians and embark on a journey that will transform your dreams into reality.



■ Occupational Therapists

We currently have full-time, part-time and on-call opportunities for Occupational Therapists in our Acute Care Hospitals and community-based programs. A Bachelor's degree in Occupational Therapy, current registration with the BC College of Occupational Therapists and eligibility for membership with the Canadian Association of Occupational Therapists is required. Current experience may be required for certain opportunities.

Please visit our Career Opportunities website at www.fraserhealth.ca for a detailed listing of these opportunities and to apply online. You may also contact Recruitment Services toll free at 1-866-837-7099 for more information. Relocation reimbursement may be available for some opportunities.

Have a work environment where excellence, innovation and learning are valued, and work with leaders in the health care field. Why settle for less?

Imagine the possibilities...then live them.



www.fraserhealth.ca



The American Occupational Therapy Foundation (AOTF), located in the heart of Bethesda, Maryland, invites applicants for the position of Executive Director and to serve as Chief Executive Officer. Chartered in 1965 as a 501(c)(3) not for profit organization, AOTF advances research and education in occupational therapy. The Executive Director is responsible for analyzing environmental trends, recommending and interpreting policy, and implementing innovative programs to further the Foundation's vision, mission, and strategic directions.

The ideal candidate must:

- possess a graduate degree in a field aligned with the focus and requirements of AOTF;
- have a minimum of 5 years senior administrative/management experience in a health-related field;
- demonstrate a proven track record of effective leadership;
- be an excellent communicator and possess the interpersonal skills necessary to ensure success in a dynamic professional organization;
- possess senior-level fund-raising experience and knowledge of higher education, research, and federal agencies concerned with health-related issues and priorities;
- demonstrate the ability to conceptualize, communicate, and act in creative ways; and
- represent the organization's diverse interests and priorities with finesse.

The Executive Director will:

- exercise innovative leadership to advance the work of the AOTF;
- direct and supervise staff and consultants to plan, organize, direct, and control programs that address the goals established by the Board of Directors;
- cultivate and secure financial support through corporate fund-raising, annual and planned giving, and acquisition of external grants;
- recruit and coordinate the efforts of volunteers who contribute to the work of AOTF;
- communicate the Board's vision for the profession throughout the professional community and to the general public; and
- serve as the voice of AOTF in representing the Foundation's interests and issues.

AOTF offers competitive compensation, a comprehensive benefits package and is an equal opportunity employer. For more information on AOTF see: www.aotf.org. Review of applications will begin immediately and continue until position is filled. Applicants should submit a letter of interest, résumé, and references to: The American Occupational Therapy Foundation, Executive Search Committee, PO Box 51104, Durham, NC, 27717.

Occupational therapy then: Stories from our past

If these walls could talk, what would they tell us?

Heather McDonald

The OT Then teaser in the March/April 2006 issue shed light on the street festivals, which raised funds for the Toronto Curative workshop. Curatives centres were lay-sponsored and volunteer-organized agencies that promoted occupation to restore health and well-being. They grew out of the rehabilitation of injured soldiers and evolved to serve people with a variety of diagnoses, both in the centre and in the community.

Curative workshops existed in Brantford, Hamilton, Toronto, Windsor and Montreal, from the early 1920s until the 1950s. Featured in this photo is the Toronto Curative workshop at 331 Bloor Street West. This centre was well connected with community organizations such as the Girl Guides of Canada and the Imperial Order of the Daughters of the Empire (IODE) service organiza-



tion, and local hospitals. It also hosted classes for occupational therapy students from the University of Toronto.

To find out more about the role of the curative workshop in the community, occupational therapy and occupational justice in this time, visit OT Then on the CAOT web site.

Value #

CLIENT FOCUS & INTEGRATION



We strive for a seamless system, readily navigated by our clients.

our values speak volumes about who we are

Join us on beautiful Vancouver Island

As an organization we have created and embraced a set of values that guides all our activities and makes Vancouver Island Health Authority (VIHA) the special place it is to work.

Enhancing our offer of a unique and progressive working environment is the enviable lifestyle afforded by Vancouver Island – spectacular seascapes, breathtaking mountains, Canada's mildest year-round climate and facilities in larger urban centres, small cities and coastal towns.

We currently have a variety of positions for Occupational Therapists interested in working in a collaborative, inter-disciplinary environment in which your expertise is highly valued.

Based in a variety of settings in communities across Vancouver Island, our work environments offer tremendous diversity. Current opportunities include acute care, home and community care, early intervention and rehabilitation services.

Staffed with individuals characterized by pride in their work and a passionate commitment to caring for the whole person – body, mind and spirit – VIHA is quickly becoming healthcare's foremost employer of choice. If our values resonate with you, let's discuss what you're looking for.



Contact:
Vancouver Island Health Authority
Employment Services
Fax: 250.370.8570
Email: jobs@viha.ca

www.viha.ca

Check weekly for current opportunities.