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Column Editors: Roselle Adler and Josée Séguin

Recycling assistive technology: Creative solutions for clients and occupational therapists

Roselle Adler and Josée Séguin

Prescription of assistive technology equipment is a common practice for many occupational therapists. In recent years, significant advancements in complex assistive technology (AT), such as in the areas of communication or seating and mobility, have provided clients with greater options to maximize participation in their daily lives. Often a lengthy and comprehensive process, prescribing assistive technology involves a review of a client's existing equipment, as well as trials, training and funding arrangements of the new equipment. Due to the high cost of this type of equipment (approximately $1,000 or more), complex AT is usually prescribed with the intention of client usage for an extended period of time. However, the prolonged use of the AT may be compounded by a number of factors.

Changes in medical status, physical attributes (e.g. weight) and/or functional abilities may render the AT inappropriate to meet the client's needs. Limited community resources may result in a lack of proper training, knowledge or regular follow-up to ensure continued and correct use of the AT. Change of dwelling, school or workplace can render the AT unsuitable for the client's new environment. Finally and perhaps most importantly, the rapid pace of technological advancements allows for new upgraded AT equipment to be continually developed and prescribed, causing existing AT equipment to instantaneously become old and often discarded.

As a result of these factors, often there is a surplus of abandoned or unused AT. This is a particular concern in our society which is increasingly conscious of waste and its effect on the environment. Some provinces across Canada have a government centralized equipment pool or time-limited lease program for specific equipment, where the AT is returned for recycling and/or refurbishing. However, since this type of system is not available to all clients and health care facilities across Canada, the question arises as to how can complex assistive technology be recycled to maximize its usability? The recycling solutions proposed in this article are intended to encourage occupational therapists to evaluate the situation of complex AT in their own region and consider appropriate recycling options for their clients or facilities.

Recycling solutions for clients:

1. Back-up or secondary system

In the event that the primary AT requires repairs, clients can use their old equipment as a back-up system, particularly if the device involves mechanical, electrical or electronic components. Alternatively, clients may use their old equipment as a secondary system concurrently with their primary AT. For example, a secondary AT device can be situated on an upper level or the basement of the client's house, while the primary AT device is used on the main level or in the workplace.

> *"The rapid pace of technological advancements allows for new upgraded AT equipment to be continually developed and prescribed...existing AT equipment instantaneously becomes old and often discarded."*

Secondary systems may also involve reconfiguring the old equipment into new functional devices to facilitate leisure activities, such as recreation or travel. For instance, clients may work with their therapist or vendor to create an adapted toboggan or sailboat with an old seating insert. Clients should be forewarned that reconfiguring AT equipment usually negates any warranty on the original device and use of the new device is at the client's own risk.

2. Donation

(a) Local

Clients can donate equipment to local agencies with established equipment pools. Each local chapter usually has its own regulations with regards to the type of equipment it will accept, based on storage space and client need (e.g. some local chapters will only accept folding wheelchairs due to small storage space). Local agencies in Canada may include, but are not limited, to the following:

- Red Cross Society
- Multiple Sclerosis Society
- Amyotrophic Lateral Sclerosis Society
- Canadian Cancer Society
- Canadian Diabetes Association
- Other not-for-profit community or exchange depots

A donation to vendors or local facilities provides another alternative for clients to contribute locally. Some vendors or therapists maintain an equipment pool of donated used or discontinued equipment and parts for clients who may require repair for old equipment or need a temporary system.

"...how can complex assistive technology be recycled to maximize its usability?"

(b) International

Clients can also donate equipment to international agencies, which sends the equipment to underprivileged countries. Clients should be cautioned that international agencies may not have trained technicians to support the donated specialized equipment/technology and the receiving country may not have the funding or tools for maintenance. It is important to investigate transportation, servicing and liability of the equipment once it is donated, particularly for items which require regular upkeep. The following international agencies can be contacted regarding recycling equipment:

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International agencies based in Canada include:

- Help the Aged Canada
Website:
www.helptheaged.ca
Phone: (613) 232-0727
- David Smith Foundation
Phone: (613) 762-5258
- International HOPE Canada
Website:
www.internationalhope.ca

International agencies based in the United States include:

- Wheels for Humanity
Website:
www.wheelsforhumanity.org
- Roc Wheels
Website: www.rocwheels.org
- Hope Haven
Website: www.hopehaven.org

As a further incentive for client donations, some local or international agencies will provide clients with a tax receipt.

3. Private sale

Clients can choose to sell the equipment if it is not part of a government regulated central equipment pool. Advertising can be posted in places such as the Internet (e.g. E-bay), community center billboards and medical clinic waiting rooms.

Recycling solutions for facilities:

(1) Equipment pool

A facility can maintain an equipment pool, often compiled from client and vendor donations. The equipment pool may involve re-configuring, removing or adding components to the equipment to accommodate clients' needs and may serve as:

- Short-term temporary loans (e.g. for clients who are awaiting funding approval from government or third party agencies for their own device).
- Long-term extended loans (e.g. for clients who may not be eligible for government funding, such as clients with refugee status or people who do not have sufficient personal financial resources).
- Equipment trials or training.
- Emergency repairs (e.g. replace a seized seatbelt or a malfunctioning switch on a communication device).

Equipment pool tips and recommendations:
Clutter is commonly the downside of retaining an AT equipment pool within a facility, resulting in an unsafe environment for workers and unused equipment. To curb this tendency, the facility should consider setting rules regarding the types and amount of AT accepted. Some suggestions include the following:

- For small storage spaces, the facility can take a strip-it-down approach, salvaging removable items from wheelchairs and communication devices. Examples of items include footplates, armrests, mounting hardware, plastic from seat or back interfaces, foams, joystick knobs, battery holders, switch jacks, plugs, mouse parts or hard drives from a computer. Incidentally, some of these items can also be reconfigured for new input devices for adapted toys or computer programs.
- The facility should assign specific personnel for continuous management of the AT. The personnel should be appropriately trained to maintain the AT in good working order, organize the AT in

the available space and perform regular inventory checks to ensure the return of loaned AT or purging AT when it is no longer recyclable.

(2) Non-recyclable equipment

Predictably, not all complex AT can be recycled. Unsafe components which may place a client at risk, such as sharp edges, frayed wires, rusted hardware and disintegrated or compressed foam or gel should be discarded. An AT device should also be disposed of when it is no longer compatible with any current technology to correctly or safely function. Some communities across the country have local depots where these items can be safely discarded.

Overall benefits of recycling:

The recycling solutions discussed in this article emphasize the benefits to the end user; however secondary benefits are also evident. Actively re-using and maximizing the lifespan of an AT device may influence the health care dollars spent on new AT devices. On a very individual level, the concept of giving back to the community can often be satisfied through AT donations. Donations can give clients the opportunity to provide help to others. It can also express gratitude towards an agency or facility from which they received assistance. And finally as the environment remains a high priority, recycling assistive technology could be a very positive outcome in our respective practice as the result may be less equipment destined for the landfill.

Additional reading on the topic:

Polgar, J. M. (2006). Assistive technology as an enabler to occupation: What's old is new again. *Canadian Journal of Occupational Therapy, 73*, 199-204.

Vincent, C. (1999). Practices of recycling assistive technology in Québec. *Canadian Journal of Occupational Therapy, 66*, 229-239.

For comments or questions please e-mail Roselle and/or Josée, the column editors for In Touch With Assistive Technology. They would appreciate your feedback on this article and are interested to hear your ideas for future columns.

Column Editor: Lorian Kennedy

Establishing an occupational therapy private practice partnership

Ruth Duggan, Lisa Saunders-Green, Donna MacLeod and Denise Johnston

In the article published in the November 2006 issue of *Occupational Therapy Now*, "Developing a Business Model for a Private Practice Partnership", we described the process used to establish a business model based on a number of words beginning with the letter "F": freedom to change, fun, financial benefit, flexibility, friends, fine balance, fantastic quality, frank honesty and fair. Once a common ground for a business model is established, one needs to actually build the practice. This article will describe the steps taken by a group of four occupational therapists to establish a private practice company, as well as the benefits and drawbacks experienced. These steps included developing a brand, ensuring we had the appropriate structures and skills, and managing ongoing change within our group.

Branding

Developing a brand that makes us recognizable in the community may appear to be the easiest part of building a private practice. However, we found this to be one of the most difficult tasks to work through as a group. The importance of branding cannot be understated. The name and professional look of the company is your first impression to the business world and community. We extensively brainstormed to come up with a name that not only presented what we wanted to portray as a company, but also would not be confused with other companies as well as be acceptable and memorable to the public and professional world.

Developing a brand involved looking into the local and national business name registry, and field testing our ideas with family, friends and other professionals. Narrowing down our choices and finally deciding on a name took many, many, rounds of brainstorming and feedback. We then hired a graphic designer to create a logo and design how to visually present ourselves to the world. Again plenty of brainstorming and negotiations took place to agree upon a logo and design that we all liked and represented us on our business cards, letterhead and brochures. In the early days, the partners also worked with a website designer to develop a website and found that this was instrumental to further develop the company profile.

Structure

The next step to build the practice included establishing the practical aspects of running a business, such as ensuring we had appropriate clinic insurance and people could easily communicate with us by phone, e-mail or fax. We also had to register our business name. Our group agreed that we wanted to maintain our home offices and provide services solely in the community. We typically see our clients in their home or workplace. While this reduces overhead, it presents logistical challenges to a business that wants to present itself as a unified group.

We needed a common bank account, telephone line, post office box, e-mail and fax. Modern technology allowed us to set up a common virtual telephone number that provides a common number, with a voice menu that allows callers to be connected through to any telephone specified. Callers can choose from a menu and be forwarded to any one of the business partners or associates.

The partners had already agreed on how to distribute the work. Other structural essentials to establish included designing a database to track referrals, defining reporting templates, invoicing procedures, tracking income and expenses, establishing billing rates and deciding what our expectations were with respect to timing of services.

Financial planning

Once we knew what the structural requirements were, the partners developed a budget for our common resources, including not only funds for the infrastructure, but also ensuring funds for advertising, insurance, bank charges, and future business development such as proposal development. We clearly defined what we would be personally responsible for, such as our individual home office expenses. This was important because it was understood that we would all work different amounts and earn varying amounts, and thus have variable self-employed income and expenses.

Through consultation with an accountant we defined a way to pool our resources for the common expenses, each of us contributing an equal amount agreed upon based on our budget, and how to account for these expenses to Revenue Canada. Because we did not incorporate our company, we were still considered four self-employed partners and were each responsible for our individual business expenses. With the magic of a basic banking/financial and spreadsheet computer programs, we could easily present our expenses and calculate four equal shares of these expenses, which each of us would then include in our individual tax returns.

We agreed that there may be other incidental expenses, for example to consult with a lawyer or accountant, purchase additional insurance, or resources that would be needed by each one of us. The partners decided that they would discuss new expenses as they arose and defined a test for expenses to consider sharing with the group. That is, would the purchase increase our earning potential, confidence in our practice, customer confidence in our service, and/or enhance/improve our services?

Skills development

As occupational therapists entering the business world, developing new skills from both a professional and business perspective was important. Skills development can vary from formal to very informal. We started by compiling our resources, including books, references, helpful websites and any tools or assessments that were already owned.

From a business perspective, we accessed professionals in the community, often calling in favours from friends, to develop our business skills, such as doing a business review and consulting regarding marketing. We consulted with other business owners in the community to see how they did things and weighed suggestions with how they would work within our model. Questions ranged from what services they offered, to rates of pay and how to manage associates. When new knowledge was needed, we would assign one partner to explore a topic and present to the group for mutual education. For example, what were our responsibilities regarding file maintenance?

About the authors–
Ruth Duggan, Lisa Saunders-Green, Donna MacLeod and Denise Johnston are the four founding partners of Cornerstone Occupational Therapy Consultants, Halifax, Nova Scotia. They can be reached through www.CornerstoneOT.com or 902-446-4660.

In addition to developing business skills, we used mentoring, coaching and support from one another, including editing of all reports, to help hone and/or expand our professional skills. The partners used opportunities to work together on files or teaching each other to develop professional skills. We took opportunities to take courses to meet emerging business opportunities, such as ergonomics and life care planning.

"After four years of partnership, we have an established private sector work environment with proven systems that work for us."

Ongoing development

In keeping with our flexible business model and desire to ensure that the needs of individual partners were met, structure and procedures continue to change to meet our changing needs. In some cases we responded to new professional regulations such as PIPEDA (Personal Information Protection and Electronic Documents Act), but more often it was to meet personal needs such as family, babies, travel, moving out of old jobs and subcontracts, and taking new jobs for the purpose of skill development. The most recent major development and change in our company was to bring on associates; other occupational therapists who work on a contract basis to help with the growing workload demands and to help the partners maintain flexible schedules.

We hold regular reviews of our processes and explore options for change using our individual talents and interests to complete administrative tasks, for example managing the client database and financial resources. However, likely the most important choice was to make use of a funding program for business development for women. Through this fund, we were able to hire a business consultant to work with us to do an extensive review of our business model, structures and processes. This process has further grounded our business model and processes, and has clarified future directions for the group.

Established benefits

After four years of partnership, we have an established private sector work environment with proven systems that work for us. We have a high caliber partnership with a recognizable brand: Cornerstone. We continue to maintain flexibility within our work and maintain diversity and variety of work, with a reliable income, which is important to all of us.

One of the benefits of working within a group of occupational therapists is being able to share our resources to hire a business consultant, the cost of which could have been prohibitive for a single therapist heading out independently. We have maintained a low overhead and managed administrative duties, which has allowed for a very good cost-benefit ratio. In addition to financial benefits, we have social and professional development benefits.

The benefits of bringing on associates is that it allows the primary partners to maintain a reasonable workload, brings in a small amount of additional income to the group, and expands the visibility of the company as we look ahead to providing new services in new markets such as pediatrics, barrier-free design, and health and wellness. The associates benefit from the established brand and professional support provided by the partners.

Often we are working with clients beyond the acute phase of their illness/condition and we are focusing on more than basic life support/self care activities. We work with clients to ensure that they can stay in their homes and participate in the activities that they want. This provides an excellent opportunity to be client centred, truly working with clients to problem solve and find direction in their lives. We are not typically limited by the medical model of the public health care system and have the opportunity to be creative in our work.

Limitations

Private practice is not all rosy or easy. What has been described in this article has developed through hard work and negotiation over the first four years of our partnership. A business partnership has been described as a marriage. The ongoing management of personal needs can be a challenge that all partners must be willing to rise to.

The flexibility of working in the private sector is counter-balanced by a lack of security. Without the backing of a large employer, we need to be extraordinarily aware of professional and legal responsibility. The partners need to justify everything we do so that we can get paid for it – this means researching best practices and defending our recommendations. The partners spend a lot of time report writing and while we do share administrative duties, there is consistently unpaid business and administrative work to be done. The private sector market can be unpredictable and so there are no guarantees of work, a regular pay cheque, or to have work that we enjoy. One often does work that is less enjoyable just to cover expenses.

The self-employed occupational therapist lacks benefits commonly provided by an employer such as group extended health or disability insurance, sick time, maternity leave, paid vacation, paid continuing education and the ability to collect employment insurance (EI). Private insurance and sound accounting advice is highly advisable to compensate for these limitations.

"... the company not only exists because of us, it is us."

Regardless of the limitations, at this point, for us the business is more about our personal needs than the company – the company not only exists because of us, it is us. We may want to change this perspective as time goes on. In the meantime, we manage our business and changing personal needs through retreats, food, fun, camaraderie, laughter and a few tears. Our focus on the adjectives that begin with the letter "F" has helped to keep us all on track, happy and most of all colleagues and friends.

Helpful websites for developing a business partnership

The Interactive Business Planner
http://www.cbsc.org/ibp/home_en.cfm

ACOA Womens Business Initiative
http://www.acoa.ca/e/business/entrepreneurship/wbi/wbi.shtml

CAOT Resources for Private Practice www.caot.ca
http://www.caot.ca//default.asp?pageid=2039

Canadian Revenue Agency
http://www.craarc.gc.ca/tax/business/topics/solepartner/menu-e.html

OT Then: Celebrating our roots in a new column

Column Editor: Sue Baptiste

Sue Baptiste

It is with particular pleasure that I am writing this column today. Recently, the decision has been made to make Occupational Therapy Then (OT Then) a standing column of *Occupational Therapy Now* (OT Now) and I will be the column editor. Also, as chair of the CAOT Archives Committee I have the chance to provide some information about our plans and how they can involve you in the months ahead.

Over the past years, there have been many conversations held about the importance of increasing our knowledge about, and celebrating our roots to better understand and evolve into our professional future. This is without doubt a time of great opportunity, necessitating that we move forward with increased confidence into areas of emerging and innovative practice. Certainly, the roles of occupational therapists as I knew them even within the scope of my own practice history have changed remarkably during the past decades. It is from those colourful and mixed experiences that I have drawn insights to guide my own development. Memories still haunt me of crafting one-armed archery adaptations and adding weights and pulleys to a printing press to aid hip extension, not to mention the importance of a FEPS! (Want to know more? Food for a future column perhaps?)

The role of the CAOT Archives Committee is centred on maintaining an accurate and efficient archival system to ensure that the key and core documents related to occupational therapy in Canada are secured and available as required. This repository resides within the CAOT head office in Ottawa and some specific documents are sent to the federal repository if they meet certain guidelines and indicators. Meeting these expectations requires the commitment of excellent support staff as well as seasonal support to sort and catalogue, and professional input to determine the importance and relevance of the accumulated materials.

However, there is more to establishing and maintaining archives and creating a thread of history than simply the records of day-to-day business, important as they are. The real substance of our profession lies in the stories and experiences shared as we journey from the past, through the present and into the future. This is the true fabric of who we have been and who we will become. It is with this in mind that this column is becoming a regular addition to OT Now.

"...The real substance of our profession lies in the stories and experiences shared as we journey from the past, through the present and into the future."

The Archives Committee is inviting your involvement as members-at-large within local regions. Your role would be to provide stories and connections to occupational therapists and occupational therapy history that would help paint a rich picture of our achievements and experiences. Some seed resources have been given to the committee to begin developing a library of oral histories - conversations held with occupational therapists in their senior years - that will be available through the website as well as in published form from time-to-time. Some oral histories are already in the process of being completed and I would welcome contact from anyone who would like to contribute to this valuable resource.

I would like to formally thank the Occupational Therapy History Group at the University of Toronto for their unfailing efforts to establish OT Then on our radar screens through their regular contributions to OT Now over the past two years and their continued work. I know that they are most willing to be a resource to other groups of occupational therapists to establish further interest groups of this nature across the country.

I welcome the chance to speak with anyone who has an interest in participating in this way. Your involvement can focus on one project or can be as an established contact for your area of the country and all points in between. I look forward with enthusiasm to hearing from you and working together to build these pictures of times past.

About the author –

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The Canadian Association of Occupational Therapists 2006-2007 mid-year report

Claudia von Zweck, CAOT Executive Director

Claudia von Zweck

CAOT is you and me and the thousands of other occupational therapists in Canada working together to promote excellence in occupational therapy. Our membership in CAOT provides the joint expertise, knowledge and resources needed to strive towards our vision of ensuring that all people in Canada will value and have access to occupational therapy. This report outlines the accomplishments that are possible through our collaborative work and highlights the value of continuing membership in CAOT. Activity updates are provided in relation to each of the five strategic priorities of the Association.

1. Advance leadership in occupational therapy

Leadership requires information, tools and resources that support best practice in occupational therapy. In July 2007, a new CAOT publication will be available to continue the Association's tradition in providing leadership to articulate a collaborative vision and practical strategies for occupational therapy in Canada. In the past year, over 60 CAOT members have contributed to a new publication that builds on the constructs first described in our 1997 landmark document: *Enabling occupation: An occupational therapy perspective*. We welcome you to attend a plenary session at Conference 2007 where this new book will be introduced. Dr. Elizabeth Townsend and Dr. Helene Polatajko, the primary authors of this publication, will host this session.

Conference 2007, with the theme of *Leading the Way to Healthy Occupation*, will feature a number of additional initiatives that advance leadership within our profession. With self- employed occupational therapists now representing over 27% of the CAOT membership, a needs assessment conducted by our Occupational Therapy Practice Committee indicated more resources are required for the rising number of members entering private practice. To address this need, a second publication will be introduced at the conference: *Business in clinical practice: How to get there from here*. The Occupational Therapy Practice Committee has developed new resources for the CAOT website and will also be hosting a pre-conference workshop that explores concepts described in this new publication.

"CAOT is you and me and the thousands of other occupational therapists in Canada working together to promote excellence in occupational therapy."

A new position statement on diversity was completed in collaboration with the Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO), Association of Canadian Occupational Therapy Education Programs (ACOTUP), Canadian Occupational Therapy Foundation (COTF) and the Professional Alliance of Canada. This joint position is an outcome of the leadership forum held in June 2005 on the topic of diversity and occupational therapy.

"Conference 2007 delegates are invited to attend a professional issue forum addressing the assessment of drivers with chronic disabilities ..."

Conference 2007 delegates are invited to attend a professional issue forum addressing the assessment of drivers with chronic disabilities and the translation of evidence-based recommendations in occupational therapy practice. These recommendations were provided to an inquiry completed by the Chief Coroner in Ontario. A national panel, led by Dr. Nicol Korner-Bitensky in conjunction with CAOT members and other Canadian experts in driving, identified these recommendations following the development of a detailed and comprehensive CAOT brief that reviewed evidence, legislation and jurisprudence regarding driver assessments in Canada. We are also using information from this brief to work with the Public Health Agency of Canada to develop a national health promotion strategy for older drivers.

Building on the work of a professional issue forum held in 2006, we are planning a consensus workshop on the topic of feeding, eating and swal-

lowing. The workshop will be organized in 2008 with other health disciplines to develop a preliminary protocol for dysphagia evaluation and treatment. We will also be working with the Canadian Association of Speech Language Pathologists and Audiologists (CASLPA) and the Canadian Physiotherapy Association (CPA) to host a summit in fall 2008 on leadership in primary health. The summit will promote interdisciplinary information sharing and strategy development in areas such as role negotiations, advocacy and media relations.

We recognize the importance of celebrating the work of our profession's leaders. In fall 2006, the first call for nominations was made for a new CAOT award in leadership. The recipients of CAOT awards will be announced at the Awards Ceremony to be held Friday, July 13, 2007 at Conference 2007. For members who are not able to attend, we will be beginning a new tradition by presenting the 2007 Muriel Driver lecture provided by Dr. Mary Egan on the CAOT website. To document the life stories of leaders in occupational therapy in Canada, our Archives Committee is also beginning an oral history project that will be posted on our website. In addition, a new media watch section on the CAOT website highlights our members who have been profiled in the media.

2. Foster evidence-based occupational therapy

We continue to support COTF in fulfilling its mandate of promoting research and scholarship in occupational therapy. In addition to providing our annual $100,000 donation to support the operating costs of the Foundation, we provide in kind services that support COTF fund-raising efforts. This year, for the first time over $4100 was raised by providing members an opportunity to provide a financial donation to COTF at the time of their CAOT membership renewal. We are also working with COTF and other stakeholders to promote funding and publication of research investigating the cost-effectiveness of occupational therapy.

CAOT conducted a review of economic literature relating to occupational therapy wait times, home and primary health. Research evidence supports the cost effectiveness and efficacy of occupational therapy in a number of areas including primary health care, fall prevention and return-to-work programs, as well as post-hip and knee replacement interventions. However, a significant finding of the CAOT report is the need for more research on economic outcomes to demonstrate the value of occupational therapy services to external stakeholders such as funders and policy makers.

Extensive member input was provided in spring 2006 for the development of a new strategic plan for the *Canadian Journal of Occupational Therapy* (CJOT). Work has been undertaken to quickly and effectively implement this strategic plan. A number of new policies were approved in fall 2006 to provide the infrastructure needed to support the mission, vision and priorities of the journal. To decrease the wait time for publication in the journal, funding was also approved for a one time increase in the number of pages for the 2007 volume year. The planned special issue of the journal on the *International Classification of Functioning, Disability and Health* will be published as an additional sixth issue in 2007. To promote dissemination of information published in the journal, agreements have been signed with CINAHL and Ingenta that allow non-members to more easily access online versions of CJOT articles. For a one year trial, CAOT has also arranged to provide members with free on-line access to the *Work Journal*.

"However, a significant finding of the CAOT report is the need for more research on economic outcomes to demonstrate the value of occupational therapy services ..."

3. Advocate for occupational therapy as an essential service

In October 2006, the empowering theme of *Yes I Can* was once again used to celebrate and promote the role of occupational therapy during OT Month. *Yes I Can* recognizes the important role of occupational therapists in breaking down barriers to participation in healthy occupations. Resources were provided to members for their OT Month activities, including case studies, media strategies and promotional materials. For example, a calendar with OT tips for each month of the year was distributed to members. Media releases were circulated to celebrate the winners of citation awards named in provinces across Canada. A special issue of *Occupational Therapy Now* highlighted the work of occupational therapy leaders in a wide variety of roles including research, advocacy, policy and education. Planning has already begun for 2007 OT Month celebrations, with an *Occupational Therapy Now* special issue featuring the work of occupational therapists in promoting participation in valued occupation with older adults.

CAOT advocacy efforts continue to target the role of occupational therapy in primary health care.

Through a CAOT Pan-Canadian awareness strategy, volunteers from across Canada have received training and resources to advocate with local decision-makers for the inclusion of occupational therapy in primary health care services. Development is underway for a population-needs based assessment that will help identify the optimal utilization of occupational therapists within a primary health care setting. The CAOT Stable, Able and Strong Project, a three-year initiative funded by the Public Health Agency of Canada, demonstrates the potential role of occupational therapists in post-fall support services for seniors. This project utilizes peer mentors to assist seniors to engage in occupations important to them after experiencing a fall. A peer mentor guide, fall support resource database and other information developed for the project are currently being trialed in pilot sites located in Calgary, Gatineau and Charlottetown.

In addition to these activities, CAOT is a member of 35 national coalitions that address issues relating to a wide range of topics ranging from chronic disease prevention to active living with older adults. Representation is also provided to government on issues important to occupational therapy. In November 2006, Dr. Mary Law presented a CAOT brief to the Senate Standing Committee on Social Affairs, Science and Technology on the topic of autism spectrum disorder. In late 2006, representatives of CAOT and the Saskatchewan Society of Occupational Therapists (SSOT) met with officials from the University of Saskatchewan as well as with the Saskatchewan Minister of Health and the Minister of Advanced Education and Employment. As an outcome of the discussions, both university and government officials continue to work with CAOT and SSOT to collaboratively address occupational therapy access issues for the benefit of the Saskatchewan population.

4. Develop workforce capacity in occupational therapy

In 2004, CAOT representatives collaborated with other occupational therapy organizations in Canada to develop a health human resources strategy for occupational therapy in Canada. We are now actively working on a number of priorities within this strategy. For example, we have been partnering with Canadian occupational therapy regulatory organizations and the Canadian Institute for Health Information (CIHI) on a Health Canada funded initiative to develop a national occupational therapy human resources database. The purpose of the database is to develop education, demographic and practice information regarding occupational therapists in Canada. After finalizing the content of this database, we signed an agreement with CIHI in fall 2006 to become a data provider for members living in the territories. A comprehensive report on the information collected from CAOT and provincial regulatory organizations in October 2006 will be published by CIHI later this year.

Work continues on the revised version of the *Profile of Occupational Therapy Practice in Canada*. The *Profile* outlines the skills and knowledge required to work in occupational therapy in this country. An initial draft of the revised profile was completed in the last six months and additional work is currently underway to better articulate the competencies required for practice as an occupational therapy support worker. These competencies will form a major building block in a new qualifications recognition process for support workers. The *Profile* will be used in an academic accreditation program for occupational therapy support workers that we will develop in collaboration with the Accreditation Council for Canadian Physiotherapy. The accreditation process will recognize the range of knowledge and skills needed to work in different types of support personnel roles and will involve an analysis of the competencies of individual workers in relation to the requirements of their employment.

CAOT promotes interdisciplinary collaboration in health human resource planning and has been actively working with the Health Action Lobby (HEAL) on this issue. CAOT and other HEAL members participated in workshop hosted by the Federal/Provincial/ Territorial Advisory Committee on Health Delivery and Human Resources (ACHDHR) to provide input for an action plan to support collaborative pan-Canadian health human resources planning. In accordance with this plan, in fall 2006 a project proposal was submitted to Health Canada in collaboration with CPA and CASLPA to develop and pilot test a caseload management framework. This project utilizes the findings of the Health Canada funded CAOT initiative *Toward Best Practices for Caseload Assignment and Management for Occupational Therapy In Canada* completed in 2005.

Work was completed in November 2006 on the *Workforce Integration Project*, a 19-month initiative funded by the Government of Canada Foreign Credential Recognition Program that investigated issues and solutions for helping international graduates to work as occupational therapists in Canada. The final report reflected input provided by over 150 participants and outlined seven recommendations for future action. In follow-up to the recommendations, CAOT has initiated a number of changes to the national

certification examination, including a plain language translation of exam items that will be implemented for the July 2007 examination sitting. A new section of the CAOT website was created for international graduates as project findings indicated our online resources are the most frequent starting point for individuals wanting to work as occupational therapists in Canada. CAOT also received funding from the Foreign Credential Recognition Program for a follow up project to be completed in partnership with ACOTRO and ACOTUP. The intent of the project is to identify the potential pathway(s) followed by international graduates from the point of initial consideration of immigration to successful registration and integration into practice. The project will serve to identify assessments, remediation and supports needed as international graduates move through the pathway.

5. Advance CAOT as the national occupational therapy professional association in Canada

The Association's future and the success of our work are dependent upon our members support and involvement. We therefore strive to advance excellence in the products and services offered to members. We continuously monitor services using member feedback and other external reviewers to implement meaningful improvements. For example, in fall 2006 we introduced a re-designed website and enhanced Information Gateway online resources to assist members with obtaining evidence for their practice. A Governance Review Task Force has been established to ensure CAOT objects, bylaws and rules and regulations remain current, comply with relevant legislation and outline structures and processes that facilitate effective Association governance. We continue to make improvements to our academic accreditation process through the work of three sub-committees addressing the orientation and training of reviewers, guidelines for review teams and implementation of accreditation indicators.

The CAOT Code of Ethics was revised in 2006, along with the development of a new ethical framework. Free online education sessions on the use of the ethical framework will be offered for members on the CAOT website in spring 2007. *Occupational Therapy Now* was redesigned in 2007 and a colour online version is now available to improve readability. Our financial audit indicated a substantial excess surplus from one time income sources such as grant activity and conference income. This surplus allowed our Board of Directors to approve investment in a number of new projects, such as increased publishing capacity of the *Canadian Journal of Occupational Therapy* in 2007. The surplus will also be used to cover a portion of operating expenses in the coming year to avoid the need for a membership fee increase. Due to our financial success, this will be the fifth consecutive year the CAOT Board of Directors recommend that member fees not increase.

"This high approval rating reflects the dedicated efforts ... to ensure our Association has a strong national voice on issues that influence our profession."

Our annual membership survey completed in fall 2006 indicated a high level of satisfaction with all CAOT products and services. Large gains were made in approval of our work representing occupational therapy to governments and other external stakeholders. This high approval rating reflects the dedicated efforts of CAOT volunteers and staff who work with our partners to ensure our Association has a strong national voice on issues that influence our profession. Join CAOT in celebrating these achievements at our upcoming annual general meeting. The meeting will be held Saturday, July 14, 2007 at the Delta St. John's Hotel in Newfoundland.

Reflections on applying to graduate school

Jennifer Klein, Zofia Kumas-Tan, Alison Douglas and Noémi Cantin

Reflecting upon how little we knew at the outset of our careers as graduate students, we felt it was important for fellow occupational therapists to understand the process for applying to post-entry level graduate school and the ways that your application can help position you for a favourable graduate school experience.

To pursue a graduate degree or not to pursue a graduate degree? To answer this query there are many issues to consider. The more obvious ones include: Why do I want to go into graduate school? What are my options for graduate education? What does the application process involve?

Why go to graduate school?

While the answer to this question is personal and situation specific, pursuing a graduate degree can lead to personal growth and give you access to a number of exciting opportunities. If you are seeking a new career within the profession, a graduate degree can open doors to not only faculty positions in occupational therapy programs, but also to leadership and research positions within various organizations.

Figure 1 summarizes the potential benefits of a graduate degree.

If you are passionate about a particular area of practice, completing a graduate degree may assist you in creating a multidisciplinary network of researchers and clinicians who share your interests. Through your coursework and research you will have the opportunity to participate in the production of evidence that may support, challenge or change current practices.

What are your options for graduate education?

By 2008, the majority of the 12 Canadian universities with occupational therapy programs will also offer post entry-level graduate programs in occupational therapy or rehabilitation science. While completing a graduate degree within a rehabilitation program may be the logical choice for some occupational therapists, it is not the only option available. Other alternatives for graduate education include the following: business and administration, education, epidemiology, health promotion, human movement science, psy-

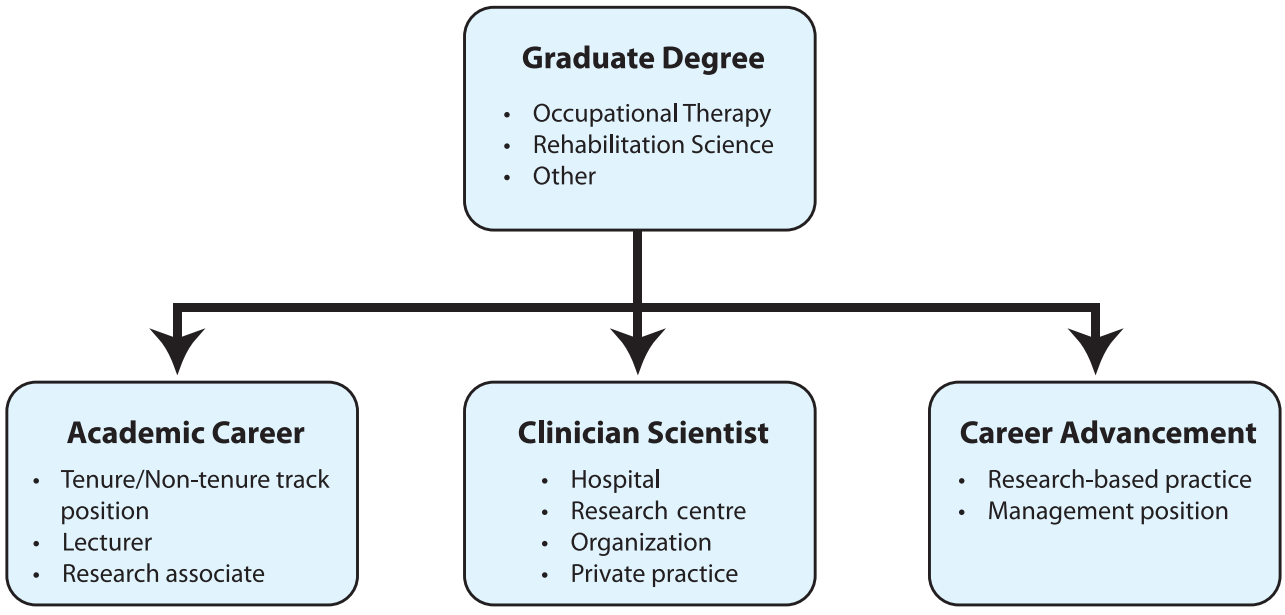

Figure 1: Benefits of graduate education

chology, public health, medical sciences or social sciences. For those considering a Master's degree, there is also the option of taking a professional leadership degree or a research degree. The former allows students to develop expertise in critical thinking and in particular practice areas without the requirement of completing a thesis; the latter allows students to hone their research skills and to generate new knowledge within the profession. Finally, there is the choice of enrolling in an on-site program or a distance (online) program. On-site programs tend to offer more supportive environments to complete a degree; online programs have the advantage of being flexible, allowing students to juggle the competing demands of family, work and school life (McCruden, 2002).

What are the nuts and bolts of applying for graduate education?

When you are starting to get your application ready, there are several tips which you may find helpful. These suggestions will be most relevant to occupational therapists considering research degrees. However, most of the tips are also applicable to people considering professional leadership degrees; instead of developing a research question, these individuals will need to identify an area of professional interest in which they wish to develop their knowledge and skill. The following are tips for you to consider when applying to graduate school.

1 Research the program

Check websites for all programs in which you are considering. Ensure you have done online research before directly contacting programs. You can look at the credentials of individuals in programs which interest you to get ideas of the wide variety of possible options.

2 Start well in advance

Deadlines of programs and scholarships are often earlier than anticipated and you may need to apply for scholarships in the fall prior to your year of entry. When you are requesting references from former faculty members and employers, these individuals need time to read your curriculum vitae (CV) and write a pertinent letter that demonstrates your strengths for the program. Plan on taking three times longer than anticipated to update your curriculum vitae and write your letter of intent.

3 Choose your advisor wisely

The relationship that you will have with your advisor is arguably the most important factor in the outcome of your graduate experience (Bair & Haworth, 2004), more so than the choices made regarding which university, program or classes. Seek recommendations. Consider asking occupational therapists (i.e. clinicians, faculty members and members of professional organizations) for their opinion about potential advisors. The authors discovered that they could gain important information even across provinces regarding potential supervisors. Set up a meeting, preferably in person whenever possible. Bring to this meeting or send ahead of time your CV, a rough outline of research interests and written questions. Trust your intuition upon meeting with them. Students in professional leadership degrees do not have thesis advisors. However, they may be assigned a graduate advisor to assist them with decisions and issues that arise during their graduate experience.

"... The relationship that you will have with your advisor is arguably the most important factor in the outcome of your graduate experience."

4 Meet with students enrolled in the program of interest

Questions to ask can include: What have their experiences been in the program? What is the environment like (e.g. university, city and student life)? What did they do that helped to make their graduate experience positive? What would they do differently? Who would they recommend and not recommend for advisors? How long did or will it take for them to finish their program? What courses are offered and any comments on courses taken?

5 Write a strong letter of intent

A letter of intent is a one-page statement of your research interest, skills and argument for the need to research a particular area. Remember that you are not obligated to complete the project which you initially outlined. It is a proposal, not a contract. Once you have entered the program and your knowledge broadens in your research area, your research question may change. A key reason for the requirement of a letter of intent is for reviewers to see that you have the skills necessary to complete a graduate degree. Your letter of intent should demonstrate your ability to think critically, write coherently and succinctly, develop an argument and demonstrate knowledge in

the proposed area. It is important to take some time to consider this letter.

You will need to choose an area of research. To do this you should consider what area needs further research development and more importantly, what makes you passionate? A significant determinant to keeping you motivated to degree completion is your passion to explore your research question. You can ask another graduate student to read your letter of intent. He/she can provide valuable feedback on the clarity and train of thought. If you are using a letter of intent for a scholarship application, be careful about the use of technical language. The letter of intent needs to be understood by panel members with disparate backgrounds.

6 Choose a research project suited to your needs and preferences

There are two options when selecting a research topic with your advisor. For the first option you can decide to work on a project that your advisor has already designed. The benefits to this option are that there can be a faster starting time from writing the proposal to gathering data, as well as potentially more security and guidance. Funding is usually already approved. The second option is to develop your own research project. This option provides more freedom to manage and determine what happens within your research, however, you may also have less guidance and it can bring uncertainty.

7 Do not worry about being a mature student

If you have been away from the academic setting for a long time, it is important not to be intimidated by the technological advances since your schooling years. Mature students often do better academically than their younger peers (Hoskins, Newstead & Dennis, 1997). A study of mature students' experiences in health care programs noted a theme that support networks were important to their success (Shanahan, 2000). Make sure to find out how to access these resources in the first few weeks of beginning your program. One of the authors made sure to sign up for workshops (that were often free of charge!) and requested technical assistance from fellow students and information technology support personnel. Acknowledge and celebrate the number of years you have of clinical experience. These clinical years enabled you to become an expert in certain areas, helped develop your research priorities and interests, as well as demonstrated your commitment to the research outcome.

"Our experiences have not only enhanced our professional experiences, but they have also enriched our personal lives."

For the authors, the perceived barriers in pursuing graduate studies were not as great as first appeared. It is our hope that these lessons are useful and encourage other occupational therapists to pursue graduate studies. Our experiences have not only enhanced our professional experiences, but they have also enriched our personal lives.

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Beyond the test manual of the Cognitive Competency Test (CCT)

Briana Zur

Column Editor: Sandra Hobson

Like many other clinicians working in the field of dementia in the community, I became increasingly frustrated with the assessment tools being used to measure a person's cognition and ability to live safely. The available assessment tools, which include the Cognitive Competency Test (CCT), had many limitations. In my role as an occupational therapist on a geriatric assessment outreach team my team members, including geriatricians and geriatric psychiatrists, frequently requested the results of the CCT to aid in diagnosis and to predict functional implications in everyday life. In the climate of increased accountability within the health care system and the need for evidence-based practice, I began to question the rigor of the data underpinning the CCT.

As I began to investigate the reliability and validity of the CCT, I recognized my own lack of skill and knowledge and so as an empty-nester, I decided to embark on what had been a fantasy of mine: to return to the academic world to study and obtain a Master's degree. My goal in pursuing graduate education is to enhance my ability to make decisions regarding my practice and to be able to read and understand research publications. As my quest began, I started to read everything I could get my hands on regarding the CCT.

Description of the CCT

In 1986, Wang and Ennis addressed the need for an objective and standardized evaluation of cognitive competency and developed the CCT as an assessment tool with the intention that it would reflect the multidimensional concept of mental competency. Wang and Ennis recognized that no one test would be able to measure cognitive competency and therefore viewed the CCT as a component of an overall comprehensive battery of a mental competency evaluation (Wang & Ennis, 1986). Up until 1986, competency was only measured in a medical-legal sense or in the context of psychiatric illness and the information was gained mostly by interview. Wang and Ennis wanted to address the issue of cognitive competency as "an ability to know and to make use of knowledge" (Wang, Ennis & Copland, 1992, p. 1).

The CCT is designed as a test that "incorporates the concept of multidimensionality of cognitive skill and adopts a practical approach by simulating daily living skills" (Wang & Ennis, 1986, p. 120). The test assesses a wide range of cognitive skills, incorporating twelve subtests that can provide information about a subject's cognitive strengths and weaknesses. These subtests can be combined to yield an Average Total Score (ATS), which is "believed to be an objective, direct, and quantifiable documentation of an individual's level of cognitive competency" (Wang et al., 1992, p. 40). The cognitive skills measured by the CCT include orientation to personal information, social intelligence, memory, reading, financial management, safety, judgment and spatial orientation. The authors of the CCT indicated that the test can also be helpful to identify areas of specific concerns that can be used to guide possible interventions.

Use of the CCT by occupational therapists

Occupational therapists are routinely asked to assess a person's ability to manage in the community and to predict a person's ability to live safely and independently in their home environment. Unpublished survey results indicate that the CCT and the MMSE (Mini Mental Status Examination) are the most commonly used assessment tools among occupational therapists in Ontario (Aronson, Barr, Kyle & O'Keeffe, 2002; Assessment tools, 2004). The CCT is the second most utilized assessment tool by occupational therapists in Canada as reported in a survey of cognitive assessments used for older adults (Douglas, Liu, Warren & Hopper, 2005). From a clinical point of view, the tool helps to provide information about how individuals will perform their daily living tasks from a cognitive perspective.

Anecdotal information suggests that some occupational therapists are not using the CCT in its entirety and some are using it to assess the cognitive component of other tasks such as driving. This non-standardized use of the CCT and its use in the assessment of skills that it was not intended to measure further affects the

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interpretation of the results. There is no evidence at this time to indicate whether occupational therapists are using this test as part of a larger protocol, which may include an observational assessment of functional tasks.

"... the CCT is an assessment tool commonly used by occupational therapists to determine a person's ability to live independently by assessing cognitive competency and determining safety and risk."

Research supporting the reliability and validity of the CCT

The information about the CCT first appeared as a description of a pilot study (Wang & Ennis, 1986). The purpose of this study was to administer the test in a standardized way to an independent group (n=10) and a dependent group (n=8). Results of the pilot study indicated that the CCT had the ability to differentiate between the two groups (dependent and independent).

In 1992, there was an expanded study done with a larger sample (n=26) of three groups: 10 people with cerebral vascular accidents (CVA), 16 people diagnosed with dementia and a normative sample size of 50 normal older adults (Wang et al., 1992). The results of this study indicated that the normal aging sample performed significantly better than the clinical groups on almost all subtests and Average Total Score (ATS). The CVA and dementia groups did not differ significantly on these variables, except for the memory subtest where the CVA group performed significantly better than the dementia group (Wang et al., 1992). There was an attempt to identify cut-off points that separated the subjects into groups of normal, grey area (not conforming to a category) and impaired.

Discussion

There appears to be limitations to the CCT and the research examining it to date. Wang and Ennis (1986) state that due to the small sample sizes the CCT should be labelled as a research test when reporting results. Neither the pilot nor the expanded study involved correlating the CCT to other tests of cognition or function, which would be an important step in its validation. The authors predicted that a poor performance in the CCT would be indicative of the presence of some impairment in cognitive skill that may significantly affect one's ability to live independently. However, there was no prospective study following subjects into the community to verify these findings.

The authors state that further research is required to verify and finalize their work (Wang & Ennis, 1986). There is a reference to further research pending to expand the normative base and the clinical utility of the CCT, but an extensive search of the literature did not reveal any subsequent publications by the original authors. None of the results have been published in a peer reviewed journal, but rather are reported in book chapters and in the CCT test manual.

Despite the very little published evidence to support its use since its initial publication over 20 years ago, the CCT is an assessment tool commonly used by occupational therapists to determine a person's ability to live independently by assessing cognitive competency and determining safety and risk. As clinicians we assume that cognitive impairment and a decreased ability to make decisions increase the potential risk of harm and decrease safety for people who are living in an independent living situation. In my readings, I have found that there are several studies that report a high correlation between cognitive impairment and functional impairment (Barberger-Gateau et al., 1992; Juva & Makela, 1997; Laks et al., 2005). Perhaps it is the incorporation of functional based tasks within the context of assessing cognition that is the strength of the CCT. This could account for the reason that occupational therapists are so comfortable using this assessment tool despite the lack of published evidence regarding its applicability. The CCT may be a unique assessment tool

The Cognitive Competency Test is described as sampling a wide range of cognitive skills and items that are reality based, representing situations that range from concrete living skills to abstract problem solving.
The 12 subtests include:

- Personal Information
- Card Arrangement
- Picture Interpretation
- Memory: Immediate
  - Delay
- Practical Reading Skills
- Management of Finances
- Verbal Reasoning
- Route Learning and Directional Orientation:
  - List
  - Locate
  - Orientation
  - Pathfinding

that indirectly determines the ability to live safely and independently by assessing the cognitive processes required in daily living skills.

"The CCT requires further research to provide reliability, construct and criterion validity to determine if it can be considered as best practice."

Conclusions and future directions

Risks that are associated with community based living can be difficult to quantify (Kane & Levin, 1998). Because the implications of a finding of incapacity are so significant for an individual, it is imperative that occupational therapists are aware of the limitations of the tools that are used during assessments of cognition; when possible, occupational therapists should chose evidence-based tools in their assessment of cognitive competency. The lack of a uniform or consistent operational definition of cognitive competence and its measurement have contributed to a lack of standardization in assessment protocols for cognitive competency (Kuther, 1999; Malloy, Darzins & Strang, 1999).

The CCT was developed over 20 years ago and since then there have been many changes in the delivery of health care. There is now an increased emphasis on accountability and health care spending restraints have spurred interest for the use of evidence in the practice of occupational therapy. Best practice encourages the use of evidence along with clinical knowledge and reasoning (Ilott, 2004). As occupational therapists, we should pursue researching measurement tools that have more rigor (Law & Baum, 1998).

The CCT requires further research to provide reliability, construct and criterion validity to determine if it can be considered as best practice. At this time, it is reasonable to conclude that the CCT has a minimum standard of face validity, but that has yet to be examined. This determination would be a positive step towards providing scientific validity to its use and acceptance as best practice or to its removal from the occupational therapist assessment tool kit.

I have gleaned two lessons from the examination of this tool. One should be careful not to assume simply because an assessment tool purports to be standardized, that it should be used as best practice. Also, this assessment tool should be used with caution and its limitations should be acknowledged.

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Occupational therapists as life skills educators: Experiences at the Gage Transition to Independent Living program

Laurie Mitchell and Elaine Gunaratne

The Gage Transition to Independent Living, often referred to as the Gage, is a community program of West Park Healthcare Centre in Toronto. Individuals 18 years and over with physical disabilities who have been living at home with parents or at an institution come to reside at the Gage to learn to live independently within a 24-hour attendant service setting. Clients reside in 10 accessible one bedroom apartments in a co-op building in uptown Toronto. Clients typically stay in the program for approximately one year until they have achieved the majority of their goals before moving into permanent housing.

The Gage program provides clients with the opportunity to work with attendant care staff, life skills educators and a health educator to learn more about their care needs and develop the skills required for independent living while supported in this transitional setting. Often parents have performed personal care and household management tasks for youth with lifelong disabilities so these individuals may not be completely aware of all of their needs. Individuals with acquired disabilities have to learn new ways to perform their daily tasks and learn about how to manage available supports. In permanent housing with attendant services, clients must know about and direct every aspect of their care.

After an initial period of transition to the Gage setting, the life skills educator completes an assessment with each client. Based on the assessment findings, the life skills educator assists the client to express individualized goals. Typical goals may include learning how to bank/budget, shop, plan and prepare meals, access the community, deal with stress, be assertive and self-advocate. These goals form the basis of the clients' customized program at the Gage. As occupational therapists, the life skills educators are able to use a client-centred approach, apply knowledge to assess areas of occupational performance and attend to the environmental impact on performance. Life skills education is done largely on a one-to-one basis, the classroom being the client's apartment and various places in the community such as the bank, grocery store and busy streets. When appropriate, group workshops are facilitated which provide opportunities for the clients to learn from each other.

Client satisfaction interviews are completed just prior to someone leaving the transitional program and one month after they move to permanent housing. This article reviews clients' opinions regarding the transitional living program and their new communities from interview data collected between January 2002 and May 2006. Also in the following section, the authors reflect on factors that appear to affect client transition to independent living and identify future directions to consider for those working in the area of transition programs.

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Client feedback about the Gage program

Clients were positive about their experience in the program. Some of their comments included the following: "My life skills educator helped me with problem solving, encouraging me to know when to step back and when to go forward. I believe this was the right program for me," said one participant. Another person stated: "I got used to directing my own care. I learned about community resources and experienced using my life skills for shopping, banking, etc. I learned to do some problem solving for daily issues."

After reviewing the interview data, the authors concluded that there are certain aspects of the transitional living program that seem to make a difference and include the following factors:

Program customization - Each client's program is customized around what they want and need. This allows for the best chance for success as the client is able to develop their own goals and make plans to fulfill these goals throughout their stay in the program.

Daily practice - Daily practice with various staff during one-to-one sessions facilitates skill development

in areas like problem solving, decision making, organization, time management, stress management and assertiveness. Attendant care staff and educators spend time at different stages of the program to ensure that clients really understand every aspect of their care.

Team communication - Meetings are held at regular intervals with the client, life skills educator, health educator and attendants to allow for progress review and to plan ahead, keeping everyone informed about an individual's stage in the program.

Continuing education - Staff and clients participate in continuing education and keep in touch with changes in various areas (e.g. housing, funding, government and available community agency supports).

Relevant connections - Maintaining and developing partnerships and connections within the community is essential. Past and present partnerships and connections with children's services, education, vocational, recreational services and disability related organizations allow a fluid and natural progression for clients' transition. These connections allow regular sharing of relevant information with others working in the area of transition.

Active listening – Remaining attentive by actively listening to clients and other consumers with disabilities keeps the program relevant.

Clients' experiences in their new communities

It seems from their comments that clients often find that there are new challenges during this next transition. One participant said about her new area: "It's a busier area of the city. There are some nice areas in my new neighborhood, but if you turn the wrong way, there are some not-so-nice areas. A lot of buildings in my new area are not accessible. It's harder to find an accessible coffee shop." When referring to the booking schedule with attendant services, another person said: "I don't feel consideration for my life style, my school etc. Not enough flexibility in the schedule."

In discussing life in permanent housing after the Gage, certain factors seem to affect clients' adjustment in their new communities and include the following:

Orientation - If clients are oriented to the new apartment and the new community, this helps to build their confidence in transferring the skills they learned at the Gage.

Supports - Moving from the transitional living program means losing a certain amount of support from familiar attendants, life skills and health educators. Additional support from family, friends, new staff and other agencies seems to be a positive factor in clients' adjustment, especially during the initial period after the move.

Flexibility - In housing units with attendant services, clients have designated times for their personal care and household management bookings. Clients often speak about the need to have some flexibility within the schedule. This flexibility enables them to participate in occupational performance activities beyond their care bookings (e.g. work, school, hobbies and sports).

Acceptance of change - Clients experience many changes as they move from the transitional living program to permanent housing. Some of the changes may include the size/layout of the new apartment, rules in the building, new staff and changing existing relationships (e.g. if parents are visiting the new location less often). Clients appear to adjust to their new environment if they are prepared for and have a positive outlook on these changes.

Future directions

Based on client feedback and years of experience working in the field of transitional living, the authors propose several recommendations for improving the transition process to independent living:

Community supports - Each client is different and has different needs for living in the community. Options for flexible supports are needed in the community. Following their move to permanent housing, ideally clients need to be linked to a system that provides the level of support that suits their individual needs for at least a three-month period.

Lifelong supports - It is apparent that some clients will always need some support for areas such as organization and money management. However, few lifelong supports are presently available for those with physical disabilities as there are for individuals with intellectual disabilities. Organizations working with adults with physical disabilities need to partner

with each other to propose and implement such life-long supports.

Communication with housing projects - Transitional programs need to continue to develop communication with the staff/managers at housing projects where the clients are moving to. By transitional programs keeping up with changes, clients can be thoroughly prepared and experience a more successful adjustment once they move.

Future research - The Gage is in a unique position to participate in research about clients' transition to permanent housing. Seeking funding/support for research to allow for data collection at the six month and one year mark would gather further information of how clients adjust to their new communities. This information could contribute to the development of best practices of disciplines working with youth transitioning to adult services.

The feedback from clients has been very valuable, not only to evaluate the current program but also to identify areas where the Gage staff and clients could advocate for expansion of services in the community.

Acknowledgement

The authors would like to thank all the clients and colleagues who contributed their time and knowledge to support this article.

Highlights from the March 2007 CAOT Board of Directors meeting

Erica Lyle, CAOT Communications Coordinator

A Canadian Association of Occupational Therapists (CAOT) Board of Directors meeting was held by teleconference on March 28, 2007. Following approval of the minutes from the November board meeting and the President's Report, the following matters were discussed:

Finances and budget

The audited financial statements for the fiscal year ended September 30, 2006 were approved and the CAOT Board of Directors commended the fiscal responsibility and management of the organization. The following items will be presented to CAOT members at the Annual General Meeting (AGM) on Saturday, July 14, 2007:

- Audited financial statements.
- Recommendation that the accounting firm of BDO Dunwoody be appointed as auditors for the fiscal year 2007-2008.
- Due to the sound financial position of CAOT, a motion that 2007-2008 membership fees will remain the same as the current year.

Awards and nominations

- The Awards Committee Report was presented and received by board members. CAOT honours fellow occupational therapists who have made outstanding contributions to advancing the profession. This year's award winners will be announced on Friday, July 13, 2007 during the Awards Ceremony at the annual conference in St. John's, Newfoundland and Labrador.
- A report of the Nominations Committee was received by the CAOT Board of Directors and included a full slate of nominees for outstanding board positions. An announcement of the board appointments will be made at the upcoming annual general meeting in St. John's and posted on the CAOT website.

Special projects

The positive financial position of CAOT allowed for the approval of the following special projects:

- Funding for an academic credentialing council policy meeting.
- Support for an indicator working group face-to-face meeting.
- Resources for the development of an on-line mentoring resource.

Other business

- The CAOT Board of Directors endorsed a new policy on consumer presentations for annual CAOT conferences.
- A joint position statement on diversity was endorsed by the CAOT Board of Directors. The position statement was developed by the following organizations: Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO), Association of Canadian Occupational Therapy University Programs (ACOTUP), Canadian Association of Occupational Therapists (CAOT), Canadian Occupational Therapy Foundation (COTF) and Professional Alliance of Canada (PAC). The statement will be posted on the CAOT website at: http://www.caot.ca/default.asp?pageid=2120

From Korea to Canada: The journey for occupational therapist Jinyoung Park

Fern Swedlove, OT Now Editor

Jinyoung Park

In 1998, shortly after obtaining a Bachelors degree in occupational therapy from Yonsei University in Wonju, South Korea, Jinyoung Park began to make plans to eventually live and work in Canada. But Jinyoung was not prepared to move to Canada unless it meant that she would arrive fully prepared to work as a registered occupational therapist; she did not want to leave her profession behind in South Korea.

As with many people who decide to leave their homeland and move to Canada to begin a new life, Jinyoung was not that different from the thousands of immigrants who come to Canada each year. She desired professional growth, respect and a better quality of life. What is unique about Jinyoung's journey is her perseverance and will to overcome the necessary obstacles to work in Canada as an occupational therapist.

Jinyong had known many people who had immigrated to Canada and were not able to work in their chosen professions. But her vision of this new life did not include working as a cashier or waitress as she had always wanted to work in health care and loved her job as an occupational therapist. "I like to help people and my work makes me feel valuable and productive," says Jinyoung, "I find the whole area of occupational therapy exciting and interesting and I wanted to do this work for as long as possible."

After about six years of working in Seoul at two rehabilitation centres, Jinyoung did not think that she could continue to work in Korea as an occupational therapist past the age of 40. In Korea, not only do occupational therapists have no autonomy and are under the direct supervision of a physician, but the hours are long, salary is low and the expectation is that each occupational therapist will treat over 20 people a day.

Her long journey to come to Canada began in early 2000. First Jinyoung decided to master her English as she knew that this was critical to having a future in Canada. At that time her English was only at a beginner level. After work every day, Jinyoung studied English for up to 7 hours for 3 years. Also, at the same time she began to save money to pay for all of the expenses to become certified to work as a Canadian occupational therapist.

After Jinyoung mastered English, she studied for the necessary exams. Jinyoung sailed through her first two exams needed for Canadian certification: the CAOT National Certification Exam and the TOEFL English language examination. But it was the TSE (Test of Spoken English examination) that would prove to be her uphill battle. After nine attempts and a year of constant instruction, Jinyoung passed the test. How did she continue to persevere? "I would go home and cry each time I failed and then get up and go back to study the next day," she said. Jinyoung did not see quitting as an option, although she describes the 6-year journey to complete the exams and to prepare for everything prior to leaving Seoul as feeling like being in a dark tunnel with no guarantee of success.

But success did come to Jinyong in September 2005, when she arrived in Vancouver with all of her certification requirements fulfilled in order to work in British Columbia. A few months later, she began as a casual occupational therapist with Providence Health Care and was hired in a permanent position in July 2006. Jinyoung works at two sites: Mount St. Joseph Hospital and Youville Residence. She is thrilled with her work in long term care and also provides occasional interpretive services for Korean clients. Jinyoung has found her colleagues have been extremely supportive and helpful and that "as long as you are capable of learning things quickly, you are fine in a new situation," she said.

Jinyoung now helps provide advice to other Korean occupational therapists who are interested in moving to Canada. As far as Jinyoung knows she is the second occupational therapist from Korea now working in Canada and credits her colleague in Toronto for paving the way for her to successfully immigrate. Although she misses her home, family and friends in Korea, Jinyoung loves her new country and life in Canada as an occupational therapist.

Column Editors: Lili Liu and Masako Miyazaki

Promoting global health through a telehealth initiative

Masako Miyazaki

It is a challenge to provide basic health care across Canada due to the large land mass and low population density. Approximately half of the Canadian population of 30,000,000 people live in cities close to the US border. The rest of the people living in Canada are scattered across the country. Just for comparison, the province of Alberta is three times larger than Japan and there are only 3,000,000 people in Alberta and 120,000,000 in Japan. Within Canada, we have different time zones, landscapes, weather and people from different heritages.

After learning about the shortage of clinical placements in remote and under-serviced communities, I decided to get involved in developing a telehealth centre to try to make a difference. The term telehealth describes the delivery of health services, educational programs, research and technological development using interactive video, audio, computer technology and associated health equipment. Telehealth is a global term which includes telemedicine, telenursing, telerehabilitation and telepharmacy. Telemedicine has been in existence since the development of x-ray imaging technology. However, the technology has lagged behind the imagination of telemedicine's forefathers. Now health care delivery to a remote site is limited only by our imaginations.

About the author –
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Four University of Alberta staff members assisted with the development of a telehealth centre: Dr. L. Liu, assistant professor in the Department of Occupational Therapy, Ms. M. Kilfoil, assistant professor in the Department of Physical Therapy, Mr. E. Rodgers, programmer analyst and myself. In 1995, we travelled several times to the Two Hills Health Care Centre (250 km from Edmonton) to conduct a needs assessment, plan the facility and negotiate with technology providers. This initiative was established in partnership with the Lakeland Regional Health Authority and we would not have been able to start our telehealth project with out their support. The preparatory stage tested everyone's commitment and dedication. Throughout this period, we developed a strong sense of mutual respect, trust and commitment which has been the foundation for our success.

The University of Alberta approved the establishment of the Coordinating Council of Health Sciences (CCHS) Telehealth Centre (a virtual centre) after we received a generous donation of telehealth technology from the Hughes Aircraft Canada in 1996. Following a careful evaluation of numerous technologies, LinkCare (Website: http://www.linkcare-bcn.org/) was selected based on its capacity and potential for future expansion - namely satellite linkage. Most of the remote regions did not have the ISDN network and a dial-up method would not accommodate a large volume of data transmissions.

The Coordinating Council of Health Sciences is comprised of the Faculties of Rehabilitation Medicine, Nursing, Pharmacy and Pharmaceutical Sciences, Physical Education and Recreation, Medicine and Oral Health Sciences. The CCHS Telehealth Centre was created in February 1996 to meet the mandate of the University of Alberta and the needs of the community. I was appointed as the Director of the CCHS Telehealth Centre and during that time the CCHS Telehealth Steering Committee was also established. The steering committee is comprised of two representatives from each faculty.

The administrative site is located in the Faculty of Rehabilitation Medicine in Corbett Hall. In order to establish the centre, members of each faculty created their own strategic plan and worked vigorously to establish their constituent sites. The Faculty of Nursing was the second site to be established. This was followed by the Faculty of Medicine which received a donation of telehealth equipment from TELUS. The last site was established at the dental pharmacy building and their equipment was donated by SONY Canada.

Despite the expansiveness of this country as we move forward with the implementation of telehealth across Canada, distance will not be a hindrance. Telehealth will reach across geographic distances and we will be in a position to benefit from each others'

strengths for the betterment of service, education, research and development. The technology has the potential to expand our practice and enhance our clients' lives in their communities.

Learn more about telehealth. Visit the Health Canada website and follow the links to telehealth. A variety of articles and reports published from 1999 to 2005 on this subject are available to download. The website link for telehealth is http://www.hc-sc.gc.ca/ hcs-sss/ ehealth-esante/tele/index_e.html. Read the CAOT position statement on telehealth and teleoccupational therapy at http://www.caot.ca /default.asp?ChangeID=190&pageID=187

Countdown to Conference 2007 - Leading the way to healthy occupation

Erica Lyle, CAOT Communications Coordinator

There are many reasons to attend the annual Canadian Association of Occupational Therapists (CAOT) Conference including engaging and motivational speakers, educational workshops, and a trade show featuring innovative products and services. But the conference, held this year in St. John's, is more than that – it is an opportunity for you to provide input on critical issues. Plan to attend a professional issue forum where you can participate in lively discussions on significant topics. And be sure to purchase a ticket for this year's social event, it is sure to be an "out of this world" experience.

CAOT Professional Issue Forums

1. Driving and occupational therapy

This forum will enable occupational therapists to explore how to incorporate research on driving into practice. Learn more about the findings of the national CAOT project led by Dr. Nicol Korner-Bitensky, including a review of current driving guidelines, as well as research evidence regarding health conditions and their impact on driving. Participants will have the opportunity to:

- Learn about current legislation regarding mandatory reporting of medical conditions;
- Provide input into screening and assessment recommendations; and
- Take away practical tools to translate evidence into practice.

2. Access to occupational therapy services

Occupational therapists are concerned about the impact on the growing demands for people who have limited or no access to occupational therapy. You will have the opportunity to find out more about this critical situation and assist in developing an action plan. Participants will contribute to solutions by:

- Identifying issues that hinder access to occupational therapy services;
- Determining collaborative strategies to improve access to occupational therapy services; and
- Contributing to the revision of a CAOT position statement and action plan on access to occupational therapy services.

Social event: A night at the GEO Centre

If you are curious about the expanse of the solar system, changes to our climate or the geological makeup of the earth, plan to visit the Johnson GEO Centre. A 10-minute drive from the Delta St. John's Hotel, you will have an opportunity to explore an exhibit on the Titanic, learn about the amazing story of our planet or enjoy the many remarkable geological displays. You will be treated to a meal with local flavour in a three-storey high reception hall under replicas of our solar system. Following dinner, enjoy the sounds of traditional Newfoundland music and a live auction hosted by the Canadian Occupational Therapy Foundation. Tickets for this amazing evening must be pre-purchased at a cost of $50 plus HST. A double-decker bus is scheduled to leave the hotel lobby at 18:00. For full conference details and registration visit www.caot.ca. To donate an item for the COTF auction, please contact Sangita Kamblé at skamble@cotfcanada.org.

Column Editor: Sandra Hobson

Occupational therapy educational, treatment and resource materials: Who are the owners and what are their rights?

Tapas K. Pain

Occupational therapists frequently develop written, recorded and procedural methods and materials for client education, treatment programs and other clinical purposes. Sometimes these materials (also referred to as intellectual property) are developed in teams, as spin-off projects or extensions of clinical research. Possibly the materials may be a result of a hobby or moon lighting project from home. Because these materials are usually both clinically and commercially valuable, an occupational therapist leaving for another position or for the private sector will often want to take and use those developed materials for their own purpose. But who owns those materials and what rights does the creator have?

Employee contracts and intellectual property policy

For an occupational therapy employee, the starting point to answer this question is their employment contract and secondarily any employer intellectual property policy. Employment contracts often definitively state that any employee-produced intellectual property in the course of employment is automatically employer property. Defining the course of employment is a challenge because if one digs deep enough, there is often some connection between the employee and the employer that gave rise to the property in issue. But how much of a connection is enough? Consider whether the occupational therapist worked on the materials during employer (clinic) time, as well as used clinic support staff, clients, computers, funds, the clinic name (for enhanced credibility), and/or networks of people (contacts) through relationships formed at the clinic. There is more gray matter here than the human brain and so it is easy to get conflicting views of what course of employment means.

About the author –
Tapas K. Pain, M.Sc. (Phm.), LL.B., CAOT member, is a lecturer at the University of Ontario Institute of Technology and partner at Pain and Ceballos. Tapas is a patent and trade-mark lawyer, licensed in Canada and the United States. Tapas is pleased to answer questions based on this article at 905-851-8542 or 1-866-282-2570 extension 221, or by e-mail at tpain@painceballos.com

In context, it is understandable why many employers are vigilant in enforcing their intellectual property policy and why they almost always demand employee full disclosure. Many employees would be surprised however to learn that employers usually apply these policies in an employee–beneficial manner, to encourage future intellectual property development, as well as employee performance and loyalty (e.g. less employee turnover equals more cost savings).

"The general rule is that employees producing intellectual property in the course of their employment do so for the benefit of their employers."

The general rule is that employees producing intellectual property in the course of their employment (considering the factors outlined above and other factors) do so for the benefit of their employers. Sometimes this is a very good thing, as it is often the employer who assumes all financial and legal liability for that intellectual property. Where an employer opts for at least partial ownership (and a correspondingly proportional financial and legal liability), the employee will sometimes need a license from the employer to subsequently use those materials for their own purpose. Conversely, if the employer disclaims ownership and if the employee occupational therapist leaves, the employer may be unable to use or exploit the materials for their own purpose without a contract or license from the former employee. Contracting and licensing rights for developed materials is very common and almost always beneficial for all the people concerned.

For the occupational therapist who is a consultant or contractor, a contract (preferably in writing, but oral contracts can be binding) typically governs ownership of the material in question and its terms are usually negotiable.

When working in a team environment, it is especially important to clearly identify intellectual property ownership at an early stage. In the absence of an employment or other private contract, there is no easy general rule regarding ownership in a team environment.

Copyright and moral right

Ownership is further complicated when attempting to distill exactly what rights exist and what rights the alleged owner(s) seek(s). For ideas that are written, recorded, published in a fixed medium or displayed (as in written manuals, play performances, recordings, specific software code, etc.), an owner typically seeks copyright protection. Copyright is an exclusive right to publish or reproduce an expressed idea and gives rise to a corresponding right to prohibit others from doing so without authorization. It lasts for the lifetime of the author/creator plus 50 years.

Authors/creators also generate moral rights, which are the right to the integrity of the work and in reasonable circumstances, a right to be associated with the work or remain anonymous. Moral rights are not normally assignable (transferable) and this can present a quandary when the owner of the copyright is different from the creator. Moral rights are often an issue when dealing with images, manuscript portions and sound recordings because they can all be readily applied to different contexts, some of which a creator may find objectionable.

Patents, industrial designs and contracts

Where a method or procedure of performing a task (e.g. rehabilitation), a device or both are created, rights may arise under patents, industrial designs and/or a trade-secret contract. Patents protect inventive functional solutions; subject to conditions, they prohibit any unauthorized commercial use of the patented article or method for up to 20 years from the date of filing in Canada. Industrial design registration protects the shape, ornamentation and/or configuration of an article and can last 10 years from the date of registration. Trade-secret contracts protect competitively advantageous confidential information and can be perpetual, but must be rigidly policed. Competitively advantageous information refers to trade secrets that provide a business with some type of commercial (hence competitive) advantage that is not available to their competitors.

When the relevant rights have been identified, it is usually easier to deal with ownership. One of many principles of best practice in this area is to address ownership in the early stages of creation, avoiding unnecessary and protracted conflict.

Update from the COTF

CANADIAN OCCUPATIONAL THERAPY FOUNDATION

To fund scholarship and research

Congratulations to the 2006 scholarship recipients

Doctoral Scholarship - **Jennifer Landry and Jill Lava** ($3,000 each)

Master's Scholarship - **Margaret Grant and Susan Jurczak** ($1,500 each)

Master's Invacare Scholarship - **Skye Barbic** ($2,000)

Goldwin Howland Scholarship - **Alison Douglas** ($2,000)

Thelma Cardwell Scholarship- **Noémi Cantin** ($2,000)

SickKids / COTF Master's Scholarship - **Marie Racine Brossard and Heather Boyd** ($5,000 each)

Upcoming Competitions

June 4
BCSOT Shaughnessy Research Grant

August 31
OSOT Research Education Award

September 1
NSSOT Education Award

September 30
COTF Master's Scholarship (2 x $1,500)

COTF Doctoral Scholarship (2 x $3,000)

Invacare Master's Scholarship (1 x $2,000)

COTF / SickKids Master's Scholarship (2 x $5,000)

Thelma Cardwell Scholarship (1 x $2,000)

Goldwin Howland Scholarship (1 x $2,000)

Janice Hines Memorial Award (1 x $1,000)

Francis and Associates Continuing Education Award (1 x $1,000)

October 15 – Last time offered
COTF / CIHR Doctoral Award (1 x $22,000)

Your support counts!

COTF sincerely thanks the following individuals, companies and organizations for their generous financial support during the period from December 1, 2006 to January 31, 2007. COTF will acknowledge donations received after January 31, 2007 in a future issue.

Edgar Balsom
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2007 CAOT Conference in St.John's, Newfoundland:

Plan to attend these three COTF events at the conference!

1. **COTF Session – Using Research in Practice: July 12 from 3:30 p.m. to 5 p.m.**

2. **Live Auction: July 12 at the social event**

3. **Silent Auction: July 12 and 13 at the COTF Booth**

   Auction Guidelines

   - COTF welcomes donated items for the silent and live auctions. COTF appreciates donations such as art work, jewelry, gift items, crafts, cards and photography.
   - If a donated item is purchased for the auction (s), an original receipt is required.
   - If an item is being donated and a receipt is not available, the donor has to provide some form of comparable pricing such as printed information or a web site address.
   - An appraisal must be included for art work.
   - Any item under $1,000 must be accompanied with printed information or a website address. If the item is over $1,000 it must be professionally appraised.
   - Income tax receipts will be issued for the value of the items upon the completion of a donor declaration form. Please contact Sangita Kamblé at skamble@cotfcanada.org for a form. Please return the fully completed form by June 25, 2007.

4. **COTF Annual General Meeting: July 14 11 a.m. to 11:30 a.m.**

5. **Lunch with a Scholar - Terry Krupa, PhD, M.Ed., B.Sc. (OT): July 14 from 11:30 a.m. to 1:00 p.m.**

Occupational therapists frequently work with people who experience positive occupational and social recovery, following lengthy and profound disruption of their occupational performance and experiences. Led by Dr. Terry Krupa, this presentation will discuss research methods focused on revealing such complex processes of change. It will include a discussion of how the influence of occupational therapy services can be captured in research related to complex change processes. Dr. Krupa is a professor in the School of Rehabilitation Therapy at Queen's University. She teaches in the area of occupation and mental health as well as qualitative methods in health care research. Dr. Krupa's research focuses on the community lives of people with serious mental illness.

CAOT endorsed courses

CO-HOSTED WITH CAOT

July 11 - 14

CAOT 2007 Conference: Leading the way to healthy occupation

St. John's, Newfoundland
Tel: (800) 434-2268 ext. 228
E-mail: conference@caot.ca

CAOT LEARNING SERVICES WORKSHOPS

Enabling Occupational Performance Through Home Modification and Universal Design

Dates: May 31 & June 1, 2007
Speaker: Kathy Pringle

Webinar for Self-employed Health-care Professionals

Dates: Session A - September 20, 27 and October 11, 2007
Session B - November 15, 22 and December 6, 2007
Speakers: Bradley Roulston & Hilary Drummond

Contact: Education Administrator
Tel: (800) 434-2268, ext. 231
E-mail: education@caot.ca
www.caot.ca

ENDORSED BY CAOT

7th National Workshop for Driver Rehabilitation Specialists

Date: May 4 & 5, 2007
Location: Ottawa, Ontario
Keynote Speaker: Nicol Korner-Bitensky
Provider: The Ottawa Hospital and Transport Canada

Contact: Helen Zipes
hzipes@ottawahospital.on.ca
613-737-8899 ext 75415

"Many ideas grow better when transplanted into another mind than in the one where they sprang up."

Oliver Wendell Holmes, Jr. (1841 – 1935) was an American jurist

Insight Following Brain Injury

Date: May 14 & 15, 2007
Location: Kamloops, BC
Instructors: Kit Malia and Anne Brannagan

Contact: Hazel Plumbley
The Rehab Group tel: (250) 314-0377
toll free: 1-888-421-5551
E-mail:hplumbley@therehabgroup.ca
www.therehabgroup.ca

CANADIAN HEALTHCARE ASSOCIATION

Risk Management and Safety in Health Services

Course starts every September.

Continuous Quality Improvement for Health Services

Course starts every September.

Modern Management

Correspondence course
September 2007 - April 2008

Contact: Cheryl Teeter, Director,
CHA Learning, 17 York Street, Ottawa, ON, K1N 9J6
Tel: (613) 241-8005, ext. 228
Fax: (613) 241-5055
E-mail: cteeter@cha.ca

WEB-BASED DISTANCE EDUCATION

Dalhousie University Series:

Advanced Qualitative Data Analysis (OCCU 6502)

June – August, 2007
Instructor: Dr. Raewyn Bassett

Advanced Studies on Enabling Occupation (OCCU 5010)

September - December 2007
Instructor: Dr. Robin Stadnyk

Evidence-Based Practice (OCCU 5041)

September - December 2007
Instructor: Dr. Joan Versnel

Community Development for Occupational Therapists (OCCU 5042)

September - December 2007
Instructor: Dr. Loretta do Rozario

Advanced Research Theory and Methods for Occupational Therapists (OCCU 5030)

January - April 2008
Instructor: Dr. Grace Warner

Program Evaluation for Occupational Therapists (OCCU 5043)

January - April 2008
Instructor: Jocelyn Brown

Identity and Transitions (OCCU 5040)

Spring/Summer 2008
Instructor: Jocelyn Brown

Contact: Pauline Fitzgerald
School of Occupational Therapy, Dalhousie University, 5869 University Avenue, Forrest Bldg, Room 215, Halifax, NS, B3H 3J5.
Tel: (902) 494-6351
E-mail: p.fitzgerald@dal.ca

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