REHAB MATTERS

The Official Publication of VRA Canada

FALL 2015

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International *Education Trends*

A LOOK BACK

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Cultural Sensitivity *& International Perspectives*

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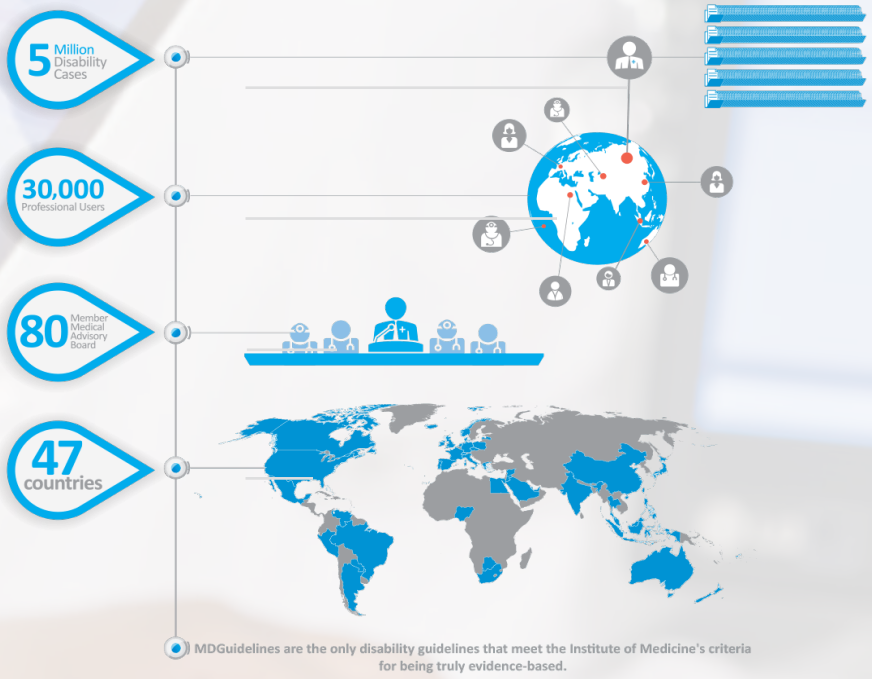

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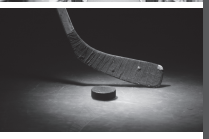
FEATURES



LETTER FROM THE EDITOR

Goodbye summer! It's been a very productive one for VRA Canada and we are pleased to bring you the lastest issue of *Rehab Matters*, filled with memories from this summer's National Conference in Ottawa *(pg. 11)*.

We've also got excellent content from members and stakeholders covering a range of topics within this issue's theme "Cultural Sensitivity & International Perspectives," and more!

If you read this issue and become inspired to submit something of your own to *Rehab Matters*, or if you've been toying with the idea of becoming a contributor for some time now, our Winter issue will focus on Ethics! Send an email expressing your interest in writing to me, at kat.abraham@kmghp.com, and I'll be more than happy to chat with you about submitting your work!

I look forward to hearing from you; until then, please enjoy another issue of *Rehab Matters*!

Sincerely,

Katherine Abraham
Editor, *Rehab Matters* Magazine

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Society News:

Updates from across the country

British Columbia

The BC Society AGM committee has continued to work through the summer on the upcoming Training Day and AGM, set for Friday, October 2, 2015 at the Italian Cultural Centre in Vancouver.

The committee recently confirmed the training day schedule and it will be a fabulous day. Please visit www.vracanadabc.ca for details on the training day, plus registration.

Alberta

Alberta is currently working on details for the 2016 National Conference, Kananaskis style! Stay tuned for details.

Manitoba

The Manitoba Society has completed all plans for our October 22 workshop. This workshop is "Personality Disorder and the Return-to-Work Process." Last year our fall workshop sold out and we had to turn people away. We are really hoping to sell out again this year. Our presenter is a very popular and respected university lecturer and clinical psychologist.

Ontario

Ontario is working to complete the final touches on our fall conference that is to be held on November 6, 2015 in Niagara Falls at the Niagara Hilton. Our keynote speaker will be Jeff Adams, six time Paralympian champion. Jeff will speak to some of his challenges, aspirations, and motivations. Disability management guru Gail Kovacs will offer a two hour workshop on ethics, and Chris Jackson will share his insight in the auto insurance industry. Additional speakers are being recruited for this upcoming education session.

The Ontario fall conference will also offer the recognition of one of our members. We are currently recruiting among our members for submissions for a first time recipient of the Outstanding Contribution Award. Candidate names may be submitted by colleagues, peers, professional contacts, or by individual members who would like to share their outstanding professional achievements. Applicants must demonstrate outstanding abilities, skills, and performance in at least one of the following categories: strategic thinking—analysis and ideas; and/or engagement with clients, organizations, partners, and leadership excellence as identified through action management, people management and/or, financial management. The winning candidate will be honoured with an impressive award at the fall conference AGM.

Ontario continues to look ahead to offer time and attention to our strategic direction. For the second year in a row, we held a one-and-a-half day strategic planning retreat during the month of September. Our aim was to review our direction and ensure that we are meeting our targets, working to ensure that we stay focused to meet the service needs and interests of our members and as a Board, and remain vigilant to offer support and leadership to the incoming Board leaders who will take on their new roles this coming fall. The new leadership of the president and treasurer roles will officially take place at the upcoming fall conference AGM in November 2015.

To see news from your society in this section, please submit your updates to your society's representative!

Addie Greco-Sanchez, President

REHAB MATTERS
FALL 2015

A Message from the National President

Welcome to Your ***Rehab Matters*** Magazine

Summer of 2015 has been a very productive one for VRA Canada. It started with "Inspiring the Ability in All," our national conference in Ottawa. CAVEWAS' preconference led the way with an excellent workshop delivered by Cameron Adams-Webber. Cameron's program "Fantasy, Fiction, or Fact: What Precisely is Your Testimony?" focused on the delivery of expert testimony in the court systems. Thanks to technology, CAVEWAS was able to live stream this program to a broader audience.

For an additional two and a half days, the VRA conference covered topics on disability management, specific impairments, motivation, specific training opportunities, ethics, and a host of other vocationally related topics to enhance our learning and our careers. We laughed and cried as motivational speakers shared their challenges and successes. We danced and sang as we cruised the Ottawa River and shared special moments with our peers. All in all, it was a great success considering conference support was only available to the conference committee for the final four months. Congratulations to the Ontario Society, Managing Matters, MCI Strategies, and KMG Health Partners for working collaboratively to make this happen. The new National Conference Committee is well into planning for 2016 in Alberta. Stay tuned.

Coming out of the conference, VRA Canada established several new national committees to support our soon to be released Strategic Directions. These committees are now fully operational and working on projects and tasks that will enhance current membership services as well as build new ones. We have had a good response to our call for committee members; what a great way to give back to your profession while earning CEUs.

VRA Canada and the College of Vocational Rehabilitation Professionals (CVRP) has adopted an action plan to build clarity and collaboration around education and designations. We have developed sections for information sharing and tools for member input on the respective websites to keep membership and stakeholders apprised and engaged.

Repairs to the official VRA Canada website continue; you may have noticed a quicker response time when browsing. We are preparing to automate membership functions and add more membership services.

The Board of Directors has completed a Strategic Directions exercise with the support of Viki Scott of Scott & Associates Inc. We are currently reviewing a potential plan of action that will provide the association with a strong foundation for the future. VRA Canada, as an organization, is finding its way back to its reason for being as identified in our very first charter of 1970. We are and should be about our members. Our charter reinforces this:

"To promote the interests of the members in relation to the public and the community and particularly, through education and other similar means, to promote and protect the interest and welfare of the members and to endeavour to ensure for them the most favourable conditions of employment."

The language has changed but the intent is still there. We are here for our members. Your membership counts and **Rehab** does **Matter**.

Sincerely,

Addie Greco-Sanchez
President, VRA Canada

VRA Canada | Vocational Rehabilitation Association of Canada

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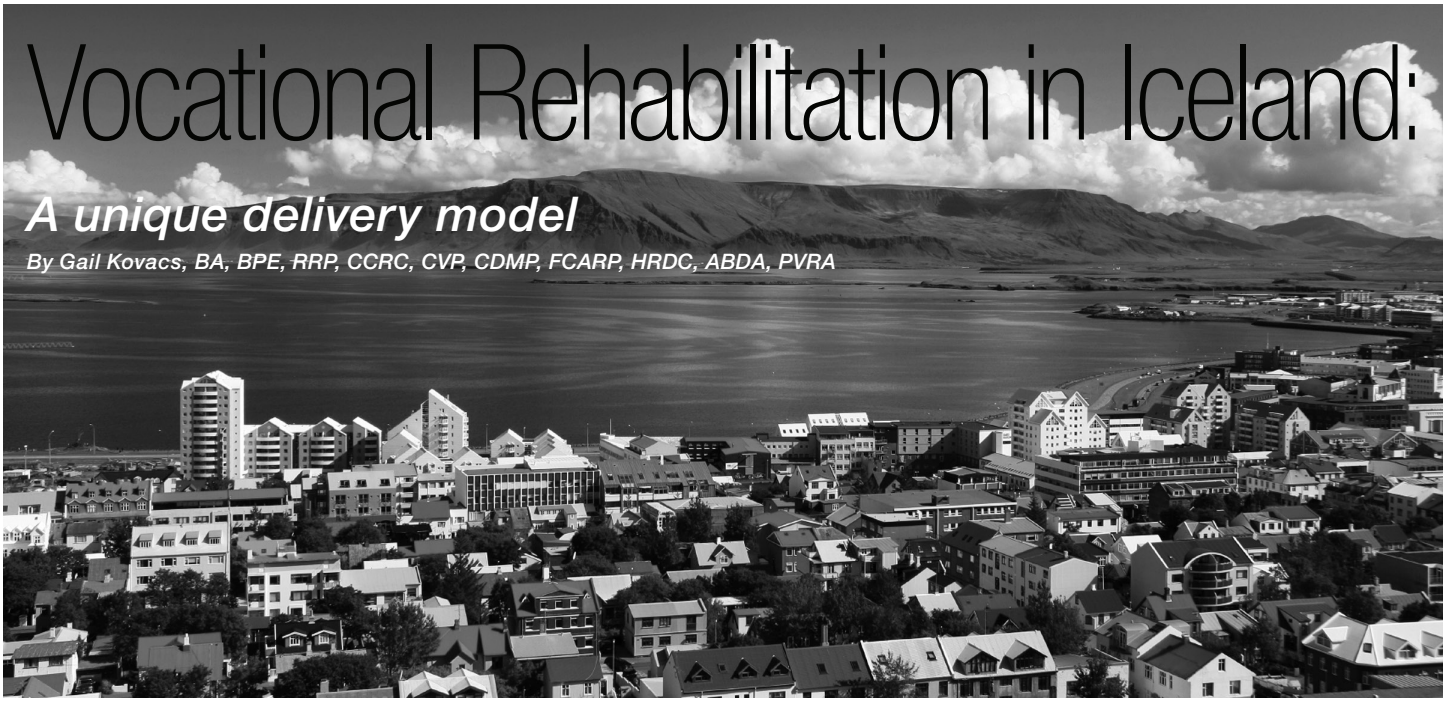
www.vracanada.com/vra-canada-professional-designations

Vocational Rehabilitation in Iceland:

A unique delivery model

By Gail Kovacs, BA, BPE, RRP, CCRC, CVP, CDMP, FCARP, HRDC, ABDA, PVRA



In 2009, I spoke at a conference at the University of Salford in Manchester, England. Two vocational rehabilitation consultants, including Ingibjörg Loftsdóttir, the Director of Counselling at the Icelandic Vocational Rehabilitation Fund (VIRK), approached me after my presentation and asked if I would present at their conference in Reykjavik later that year.

I jumped at the opportunity to attend Iceland's conference, with the condition that they would teach me everything I wanted/needed to know about vocational rehabilitation in their country. It was a deal and of great mutual benefit to both parties, as their program was just evolving at that time.

Iceland, a Nordic island nation with an area of 103,000 square kilometres and a population of only 323,000, is defined by its dramatic volcanic landscape of geysers, hot springs, waterfalls, glaciers, and black-sand beaches. The capital, Reykjavik, home to the majority of the population, runs on geothermal power and offers a renowned nightlife scene, as well as Viking history museums. The glaciers in Vatnajökull and Snæfellsnes national parks are popular for ice climbing, hiking, and snowmobiling. Iceland has the best life expectancy, the best free education, and the world's biggest hot tub, the Blue Lagoon. My two hosts happily and proudly exposed me to all of these national treasures.

I was equally fascinated by their vocational rehabilitation system. There are 32,500 companies registered in Iceland, of which 14,500 (45 per cent) are active. 90 per cent of employers have fewer than 10 employees. 188,300 individuals are employed. Nine per cent, or 17,000 people, were off on disability benefits when vocational rehabilitation was initiated in 2008.

The Icelandic labour market is highly unionized with more than 85 per cent of employees belonging to unions. The major labour organization is the Icelandic Federation of Labour (ASÍ), founded in 1916, which is the largest organization of trade unions in Iceland. Most of the unions affiliated to the ASÍ are organized into five national federations. In all, there are 44 unions affiliated to ASÍ federations and seven unions belonging directly to it. Total membership of these 51 unions and branches was 110,028 at the end of 2011, approximately 58 per cent of the Icelandic workforce.

Employers are represented by the Confederation of Icelandic Employers (CIE). The ASÍ and CIE share an office building, indicating how closely they must work together for the benefit of the economy. I bumped into the leads of both these organizations discussing business in the foyer.

When an employee is ill or injured, their benefits are paid in the following manner:

1. Salary from the employer for the first six to 12 months
2. Contributions and payments from the union's sickness fund for the next four to nine months
3. Disability or rehabilitation pension from pension funds and/or from the state thereafter

Vocational rehabilitation is relatively new to Iceland and is delivered through VIRK. The word "virk" means active. VIRK is a not-for-profit organization

> *"Approximately 58 per cent of the Icelandic workforce is part of a union"*

confirmed by law in June 2012. Services are paid for through the Icelandic Rehabilitation Fund which arose in May 2008 from:

- A need for early intervention in vocational rehabilitation
- A need for coordinating payments, assistance, and responsibilities
- A lack of comprehensive government overview in vocational rehabilitation

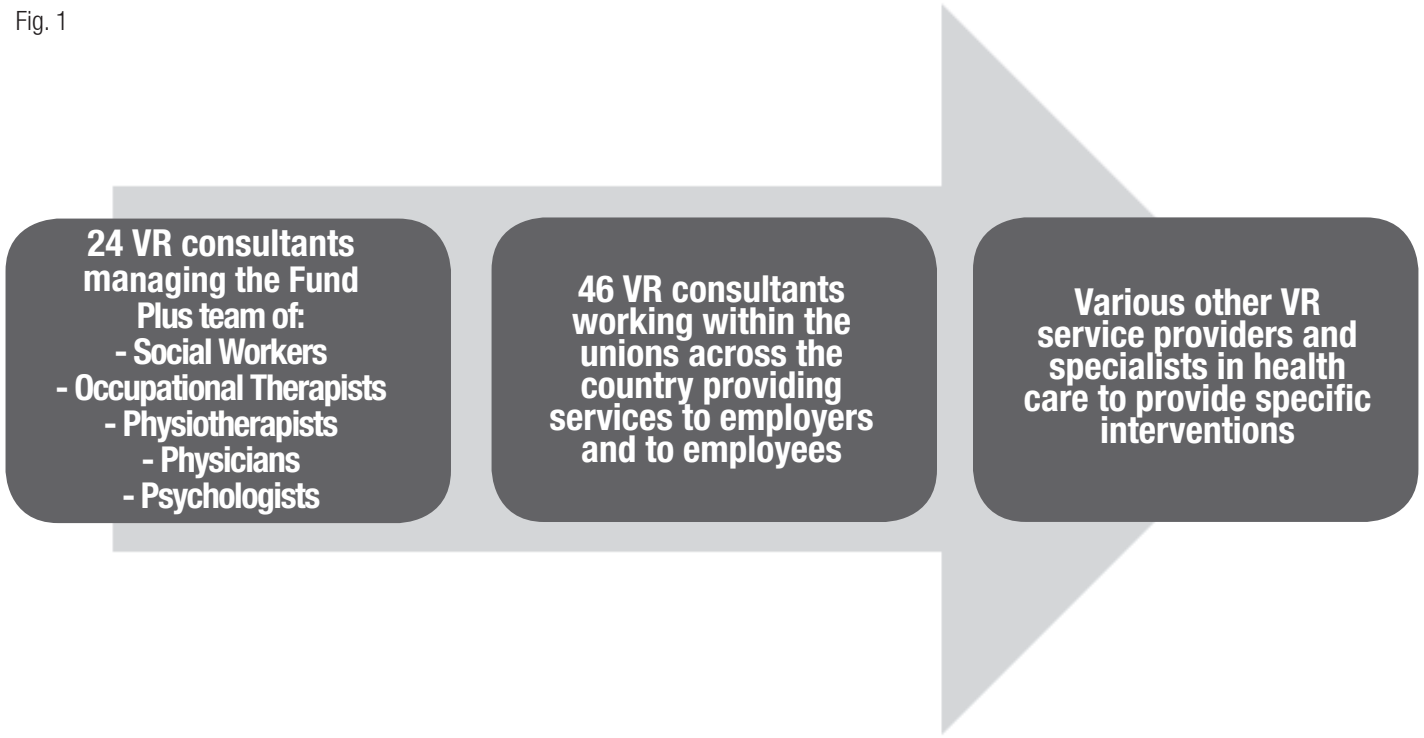
The first vocational rehabilitation employee in VIRK started work in August 2008. The goal of the program is to systematically decrease the probability that employees will lose their jobs due to injury or illness, by increasing their activities and by promoting rehabilitation and other interventions. VIRK's main tasks are:

1. To finance different services and solutions within vocational rehabilitation
2. To provide information and support to employers with the aim of encouraging return-to-work after illness or accident

VIRK is organized as shown in Figure 1 (page 6):

The fact that the vocational rehabilitation

Fig. 1



consultants are attached to unions makes sense when you consider the small size of the employers and the importance of the unions in the country. Very few companies have specialized staff in vocational rehabilitation.

VIRK's main initiatives are:

- To provide consulting services for employees who are ill or have had an accident and are off work for an extended period of time
- To emphasize early intervention in cooperation with the unions and the employers
- To finance and pay for consulting and a variety of interventions that are not generally financed by public funding
- To promote diversity and increased supply of interventions in vocational rehabilitation
- To promote cooperation of those working in vocational rehabilitation
- To change society's attitudes towards sickness
- To support research and development in vocational rehabilitation

Vocational rehabilitation consultants' backgrounds are varied. Initially, VIRK did not require specific educational qualifications. Vocational rehabilitation staff needed experience in the field of consulting, knowledge of the employment market, language skills, communication and interpersonal skills, and a genuine interest in people and their well-being. The trend is toward educational specialization and university degrees. Those of you very familiar with disability management principles and practices will agree that, with such a focus on both the employer and union, the basis for vocational rehabilitation in Iceland has to be disability management or stay in work. Indeed, VIRK is a licence holder for the National Institute of Disability Management and Research (NIDMAR) training modules.

Interventions paid for by VIRK include:

- Consultation and motivation tailored towards individual need
- Evaluation of ability to work based on both health and social circumstances
- Assistance and follow-up with planning of increased activity, health promotion and rehabilitation. This can be, for example, to pay for three months of a special health promotion program at the nearby gym, physical therapy, smoking cessation sessions, etc.
- Assistance and guidance to ensure that the individual receives what he/she is entitled to in the benefits system
- Assistance from a variety of specialists based on evaluation of need. These can be physicians, psychologists, social workers, occupational health professionals, physiotherapists, employment counsellors
- Assistance to obtain continuous education or vocational training aimed at increasing the capacity for work either in former job with accommodations or a new job
- Assistance in obtaining individually designed vocational rehabilitation where the individual, employer, and different professionals work together to find pathways to increased work capacity

For more information on VIRK, watch the YouTube video at http://bit.ly/1N1hdDG.

If you ever get the opportunity to travel on business, do so; you will not regret it. There is so much to learn and experience.

To view references for this article, visit our website www.vracanada.com/media.php

Gail Kovacs, BA, BPE, RRP, CCRC, CVP, CDMP, FCARP, HRDC, ABDA, PVRA, CBDMA, has been working in vocational rehabilitation and disability management for 41 years. She is currently the International Director of Vocational Services for KMG Health Partners, an international vocational rehabilitation training and management company. She is also the current Board Designated Representative for VRA Canada. She can be reached at gail.kovacs@kmghp.com or 647-924-2044.

CAVEWAS Corner

Alternative Career Path: An IMG's persective

Nuturing the hope of bridging programs for IMGs

By Islam Miftari, MD, MS, RRP

CAVEWAS Corner

Dear fellow colleagues and readers, here is our most recent contribution to CAVEWAS Corner.

As many of you know, CAVEWAS (Canadian Assessment, Vocational Evaluation and Work Adjustment Society) is a member society of VRA Canada, serving in large part to represent and support the professional and developmental needs of vocational evaluators as well as professional rehab personnel specializing in work adjustment of injured workers and the like. In this section, you will find current and candid articles authored by CAVEWAS members, non-members (and future members alike) that will share, discuss, and communicate with you developments and changes affecting our membership. Amongst them issues of best practice, professional development and designation, as well as industry trends.

We hope you continue to find the content in this section stimulating, motivating, and informative and we encourage your ongoing participation and contributions.

Enjoy!

CAVEWAS National Board Of Directors

If you are a CAVEWAS member and have any ideas, opinions, or thoughts relevant to this section and you would like to share, discuss, and communicate them in the next issue, please contact: Melissa Bissonnette at mbissonnette@insightadvantage.ca. We also encourage you to join our group on LinkedIn.

IMGs (International Medical Graduates) Continually Welcomed to Canada

Citizenship and Immigration Canada is still following an open policy of immigration allowing thousands of skilled professionals, among them International Medical Graduates (IMGs) and their families, to legally move to Canada. The assumption is that the IMG is a skilled professional who would bring their education, knowledge, and working experience to Canada, and the federal and provincial governments would welcome their settlement through various programs. As Canada has been one of the leading countries in absorbing thousands of skilled professionals each year, it seems that this program is still working, at least at the federal level. As an IMG who moved to Canada, I have taken advantage of this opportunity and want to share some insights from my personal experience that may produce interest when discussing the integration of IMGs into the Canadian medical system in particular, and into the Canadian workforce in general.

IMGs Integration into the Canadian Health System

Looking at current yearly quotas of IMGs entering residential programs in family medicine and/or other programs, and subsequently the number of IMGs being licensed to practice in Ontario, we notice that these quotas are still too low with fewer than five per cent. One could say this is surprising for a country in which physicians are still in a high demand. What are the rest of the 95 per cent of IMGs doing? Where do they go? Are they integrated into the Canadian workforce? Are they satisfied with their status? Are there other programs for their integration into the Canadian health system? Are there other bridging programs? These numbers represent very good reasons to raise many questions, too many questions for which there are unfortunately limited answers. In this context, it is evident that consideration of alternative career pathways is something to be taken very seriously for the IMGs themselves, as well as the respective institutions and various programs designed to absorb them into the Canadian workforce.

What IMGs Bring to the Table

What do IMGs represent? What do they and their families bring to the table for Canadian institutions, companies, and businesses?

One could say, IMGs bring with them broader perspectives for their professional advancement. IMGs also bring a diversity in education, knowledge, and professional experience. They could have several years of experience obtained in other health systems, which may have significant differences when compared to the Canadian health system. Many IMGs have years of experience in vocational rehabilitation, disability management, and return-to-work, in addition to exceptional transferable skills, such as case management, assessments, experience dealing with mental health and addiction, injury prevention, health education and promotion, as well as having superior professional ethics, motivation, analytical and problem solving skills, communication and organizational skills, multiculturalism, multilingualism, and many other qualities. In many European countries, MDs specialize into general practice and occupational health areas. Regardless, in the UK for instance, they are required to undertake training in job retention and VR and to maintain their skills through five days of CEUs per year.

This wide spectrum of professional qualities is an asset to the Canadian economy and should be treated as great potential, but, is this the case? Paradoxically not yet. In this contextual situation, looking at alternative career pathways may be one of the answers to at least partially help IMGs integrate into the Canadian workforce.

Alternative Career Pathways for IMGs

In 2013, VRA Canada and KMG Health Partners, encouraged by Health Force Ontario, launched an accelerated training program providing education and assistance on vocational rehabilitation and disability management to foreign trained health practitioners who have decided to pursue an alternative career. This program was aimed to prepare them for certification exams and to become Certified Disability Management Professionals (CDMP), Registered Rehabilitation Professionals (RRP), and/or Certified Vocational Professionals (CVP). Although the program is still being evaluated, initial outcomes are promising. A good percentage of these individuals are now working in VR and/or disability management. Several others are involved in practicum to ensure they are gaining direct work experience. Four individuals have returned to their home countries carrying the knowledge of, and appreciation for, vocational rehabilitation. With this understanding and passion, they are trying to implement and/or improve services "back home."

This program was designed to complement IMGs' previous vocational rehabilitation and disability management experience and skills. This experience may have been developed in circumstances that are different in regards to countries, regions, and cultures, and their knowledge may not have been obtained in the scope of an integrated program such as this one, but this accelerated program upgrades on components that in some way bridge IMGs' experiences with the Canadian practice. KMG was able to find a precise learning fit for every participant by assessing their skills and knowledge to determine learning modules from which they would benefit most, customizing the program according to their skill gaps.

Looking Ahead (or What's the Perspective?)

It would be wrong to assume that if there were more such bridging programs available for IMGs, most of them would redirect their professional perspectives toward them. In other words, this is not an assumption that most IMGs would pursue an alternative career path if one was offered to them. Certainly, this would attract a good number of IMGs, which is the aim of these bridging programs. It is essential for information about these programs to reach IMGs, to help them to make an informed decision.

Evidently, IMGs in Canada have opportunities and professional perspectives. Pursuing a better future for them and their families is a real and achievable goal. Nurturing the hopes they had when they decided to move to Canada would open new professional perspectives. In the context of vocational rehabilitation and disability management, the expertise of IMGs will significantly help the Canadian economy, and lessen the burden of the current price of absenteeism. The opportunity is here, let's use it.

Islam Miftari, MD, MS, RRP, is an experienced family physician who moved to Canada from Kosovo, in 2010. He did his Hubert H. Humphrey fellowship at Johns Hopkins University in Maryland, USA, in the program of public health policies with a focus on substance abuse. He completed his MS degree in addiction studies in 2012. After the completion of two accelerated programs for CDMP and CVP (2014), his current professional interests are addiction issues and mental health, in the context of vocational rehabilitation and disability management.

The Scottish National Health System:

The integration of disability management services

By Karen Michelazzi, BHSC PT, MCPA

The Scottish National Health System (NHS) was formed in 1948 to act as the primary funding source and management vehicle for all health related services across Scotland.

Similar to our publicly funded health care system in Canada, the primary aims of the newly formed NHS stated:

- that it meet the needs of everyone
- that it be free at the point of delivery
- that it be based on clinical need, not ability to pay

The most recent statistics indicate that the Scottish NHS now employs 160,000 staff, with a budget of £11.9 billion (approximately $24 billion Canadian) in 2012/2013.

One of the primary challenges recently faced by the NHS was that the Scottish mortality rate continues to be one of the highest in Europe. The subsequent white paper, "Choosing Health: Making healthier choices easier," (1) illustrated strong links between health, work, and well-being. As a result, the NHS formed the Scottish Centre for Healthy Working Lives (SCHWL) in order to develop and implement strategies for improving health and well-being in the workplace. The Scottish government established three pilot vocational rehabilitation services in Dundee, Tayside, and Lothian to conduct an independent review of sickness absence and created a national planning group for a proposed Independent Assessment and Advisory Service.

The primary aims of the SCHWL included:

- Acting as a national catalyst and facilitator for health at work within Scotland
- Guiding employers on how their practices could be changed to improve health and reduce absence
- Embedding these changes within employers by engaging with the SCHWL to make a significant difference to the health and well-being of their employees
- Achieving employer benefits in key performance indicators within their organization, e.g. reduction in sickness absence and costs

The three initial pilot sites used a multi-disciplinary team model, which required the selection of team members and the definition of professional boundaries. Professionals needed to address their deficit in knowledge about workplace vocational rehabilitation and return-to-work processes. It was identified that all team members needed to achieve a common understanding of workplace absence and disability management through further education. SCHWL conducted a review of available education in the UK and found that it was often condition-specific to defined health problems, such as neurological conditions like brain injury, and that it was often not focused on the workplace or return-to-work. The goal was to educate their health providers on how they could bridge the gap between primary health services and return-to-work when patients/employees were still engaged in the health care system. It should be noted that the Scottish system does not have a designated path or system for injured or ill workers like Workers' Compensation. As all individuals are streamed through a common benefits path, it was viewed that the process of creating a bridge was critically important.

After reviewing a number of education options, KMG Health Partners was selected to deliver the NIDMAR program to selected health professionals working within the NHS. Most health professionals were occupational therapists working within the NHS rehabilitation departments, but there were also nurses and physiotherapists who completed the program. KMG initially administered a self-assessment questionnaire to guide the selection of modules to specifically meet the knowledge and skills gaps of the health professionals taking the program. KMG further customized the program to meet local legislation and standards, and used local case studies to ensure relevancy and practical application. The instructors were highly experienced professionals who offered expertise and recent case studies to reflect current practice.

Over a period of five years, KMG educated more than 50 professionals across Scotland who were able to introduce this knowledge and skill into the health care system, as well as create strong links between health treatment and the employer/workplace in order to facilitate return-to-work.

The documented benefits achieved by SCHWL include:

- Establishment of a national standard for return-to-work practice
- Creation of a common understanding of vocational rehabilitation/disability management and requirements of return-to-work across members of the multi-disciplinary teams. Professional boundaries blurred to the advantage of the client, i.e. patient-centred plan from patient entry to return-to-work.
- Increased confidence of health team to support and facilitate successful RTW
- Increased communication with employers to achieve common goals
- With more than 50 Certified Disability Management Professionals (CDMP) now working throughout the NHS, it has achieved a critical mass of professionals with similar levels of expertise and visibility

In addition to meeting the SCHWL objectives, the benefits to service users was also significant. Of the 4,379 clients/employees who received health services, 83 per cent of clients reported that Working Health Services (WHS) had helped them to remain at/in work, six per cent reported that it hadn't helped them, and for the remaining 11 per cent the result was unknown.

Employers also reported they were able to see changes in key performance indicators, such as reduced sickness absence within their organization. Many employers also indicated this service helped to guide their internal practices in relation to health at the workplace so that they could improve the health and wellbeing of their employees.

A key example of the demonstrated benefits was achieved within the NHS staff itself, which traditionally has a higher rate of absence in the UK. As one of the largest employers in Scotland, the Scottish NHS set a target of reducing absence rates from 5.6 per cent to four per cent in 2006. In 2008, the NHS launched "Easy Access to Support You" (EASY), an early intervention service for NHS staff in NHS Lanarkshire. In 2010, the introduction of NIDMAR educated-CDMP was added into this service. The subsequent findings were reported in an NHS Interventions Report, supported by the University of Glasgow and Professor Ewan Macdonald, and additional contributors (2). The key findings of the project included:

- The EASY service was effective in reducing sickness absence in terms of hours lost in NHS Lanarkshire
- The richness of the database gives detailed information on absences by cause, duration, job role
- Sickness absence incidence shows a year on year downward trend
- Absent staff contacted on "Day 1" more likely to return to work than those contacted on subsequent days
- Cost effective: value of hours saved in sickness absence comfortably exceeded cost of delivering service
- Savings to the NHS calculated to be £781,535 per year (approx. $1,591,205 CAD)
- Return on investment is £2.27 for every £1 on disability management services within the NHS, which included the cost of replacement staff

The outcome of the SCHWL initiative was the adoption of this approach as a permanent strategy imbedded within the Scottish NHS. As a result, Scotland now has a critical mass of skilled disability management practitioners embedded within the NHS (largest single group in the UK); individuals/employees can self-refer to the services; benefits are experienced by both employers outside the NHS, as well as the NHS employees; and the NHS has demonstrated reduced absence rates and costs.

These services have contributed to successful bids by the NHS to deliver disability management services to other employers, and have proceeded to make the Scottish NHS the only public sector organization in the UK to achieve such results.

To view references for this article, visit our website www.vracanada.com/media.php

Karen Michelazzi, BHSC PT, MCPA is a registered physiotherapist who has been working in the rehabilitation and disability field for more than 25 years. Karen is the owner and CEO of KMG Health Partners, an international rehabilitation and disability management company established in 1996 to deliver education and consulting services to organizations and professionals in the field. She can be contacted at Karen.michelazzi@kmghp.com.

INSPIRING THE ABILITY IN ALL

The **2015 National Conference** took place in our nation's capital, Ottawa, Ontario, this year. VRA Canada members from across the country, including all seven societies and CAVEWAS, attended and helped to make the event a great success. We had presenters covering a variety of topics related to the vocational rehabilitation field.

Thank you to the Ontario Society and the rest of the conference planning committee for all your hard work in making this year's National Conference the success that is was.

Of course, the conference would not be possible without the support of our sponsors. Sincere thanks goes out to every sponsor for their continued support of VRA Canada and its members *(pg. 14)*.

JUNE 16-19, 2015: Please enjoy a photo look back at this year's conference events and attendees *(pg. 12-13)*.

If you missed out on any of the excitement, we are looking forward to doing it all again in Alberta next year, for the

2016 National Conference and AGM.

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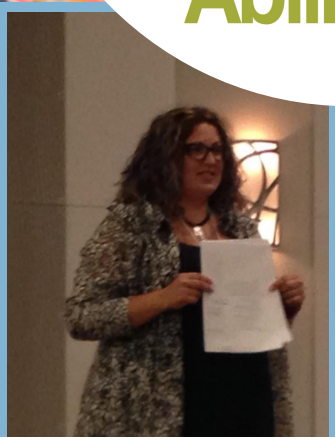

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Education Trends in Vocational Rehab & Disability Management:

An International Perspective

By Karen Michelazzi, BHSC PT, MCPA

During the past 10 years, KMG Health Partners has had the opportunity to deliver education and training in the vocational rehabilitation and disability management fields to public and private sector organizations in a range of countries including Canada, the United Kingdom, Sweden, Slovakia, Belgium, the Netherlands, the Czech Republic, the United States, Norway, and Iceland. This experience has provided us with a unique opportunity to observe local trends and develop educational programs that are aligned with local practice, knowledge, and skills in these various countries.

Overview of Current International Practice and Practitioners

The international approach to disability management and vocational rehabilitation varies widely across the countries we have engaged with, and in most cases, the education of the practitioners in the field is in parallel to the developmental stage of each country's social programs for employment and return-to-work.

The educational standards and requirements for practitioners runs from no formal academic education, to master's and doctorate levels. The level of education is usually in alignment with the type of role they are in and the employment programs they are delivering; in other words, practitioners function at administrative/technical levels, up to professional roles with fully independent decision-making authority.

In countries where no credential or educational requirement is in place, practitioners can enter and work in the field with high school level education. The United Kingdom is a notable example of a developed country with long standing employment programs, but with minimal to no education requirements or credentials required for delivery. Where fully developed social programs, educational requirements, and certification/credential requirements are in place, a bachelor's or master's level education is usually the standard; the United States has high numbers of individuals with master's level education practicing in this field.

> *"A number of trends are influencing the edcuational pathways of practitioners"*

The educational pathways available to practitioners include:

- "In house" and/or on the job training
- Short-term vocational programs delivered by technical schools, professional associations, and private organizations. Some programs lead to certification.
- A university degree in vocational rehabilitation, case management, and/or related fields like social work and health care
- Master's programs

Key Trends Influencing Education

There are a number of trends that are influencing the educational pathways available to practitioners, including:

- Increasing recognition by governments and corporations of the economic benefits of robust RTW programs and educated practitioners
- Desire by practitioners to professionalize
- Commitment to establish national standards of practice
- Establishment of professional associations for practitioners
- Desire for practitioners to self-regulate

Trend: National and International Standards of Practice

Some countries such as Australia, the US, and Canada have long-standing standards of practice in place. Countries with more recent adoption of standards, such as the UK, have looked to already developed standards as a benchmark and often ultimately adopt similar standards. In the UK, KMG was directly involved with the recent development of Standards of Practice for the UK Vocational Rehabilitation Association, and also developed the British Standards Institute PAS 150, which provides standards for case management

delivery in health, occupational health, vocational rehabilitation, and social care across the UK.

Trend: Establishment of Professional Associations

Countries such as Australia, Canada, and the US have well-developed professional associations to support practitioners and recognize this as a specialized field with a unique body of knowledge and skills. There are ongoing requirements for continuous professional development, re-certification, and collective representation. In some countries, practitioners function as a sub-specialty of existing professional streams, like occupational health.

Trend: Innovation in Education Delivery

With advances in technology, there is now improved access to education via online delivery, making it more accessible to a greater number of existing and potential practitioners. The establishment of educational pathways that provide clear options for educational and professional progression have been created in most developed countries. The implementation of national standards of practice as a benchmark helps to ensure educational program content meets local legislation and practice, while benchmarking against broader international standards. As it is an evolving field, one of the challenges is ensuring that educational content remains current and reflects the legislative and policy frameworks for each country.

Examples of Educational Pathways and Practices

Slovakia is currently on the path to transitioning from sheltered employment programs to competitive employment—a similar situation and approach as in many Eastern European countries. Through engagement in several EU funded projects over the past eight years, KMG has had the opportunity to deliver bespoke education and training to individuals developing policy and social programs in Slovakia. The current practitioners in this field typically have a university degree in a related field, like social work or health care, but no vocational-specific education stream. There is currently no professional association or credential process in place.

In the UK, the majority of practitioners in this field have historically worked directly or indirectly in programs delivered by the Department for Work and Pensions (DWP).

Approximately 87 per cent of individuals practicing in this field have no formal training beyond high school, one of the lowest rates of post-secondary education in the developed countries. While the UK has now developed standards of practice and has established a national Vocational Rehabilitation Association, there is still no formal certification process in place for practitioners in the vocational rehabilitation and disability management field.

"Countries seeking to initiate or further develop education options for practitioners have a wide range of choices"

A study released by the DWP in October 2010 indicated strong interest by practitioners to professionalize (1). In response to these factors, KMG developed the Return-to-Work Practitioner (RTWP) program to provide foundational knowledge and skills in vocational rehabilitation and return-to-work for front line workers. KMG has also been working with the University of Salford to create pathways for those who wish to gain further education in this field, with the goal of providing RTWPs advanced standing toward a university degree. This staged approach helps to meet the immediate need for standardized education of front line workers, while offering an opportunity and clear path for further education and professionalization.

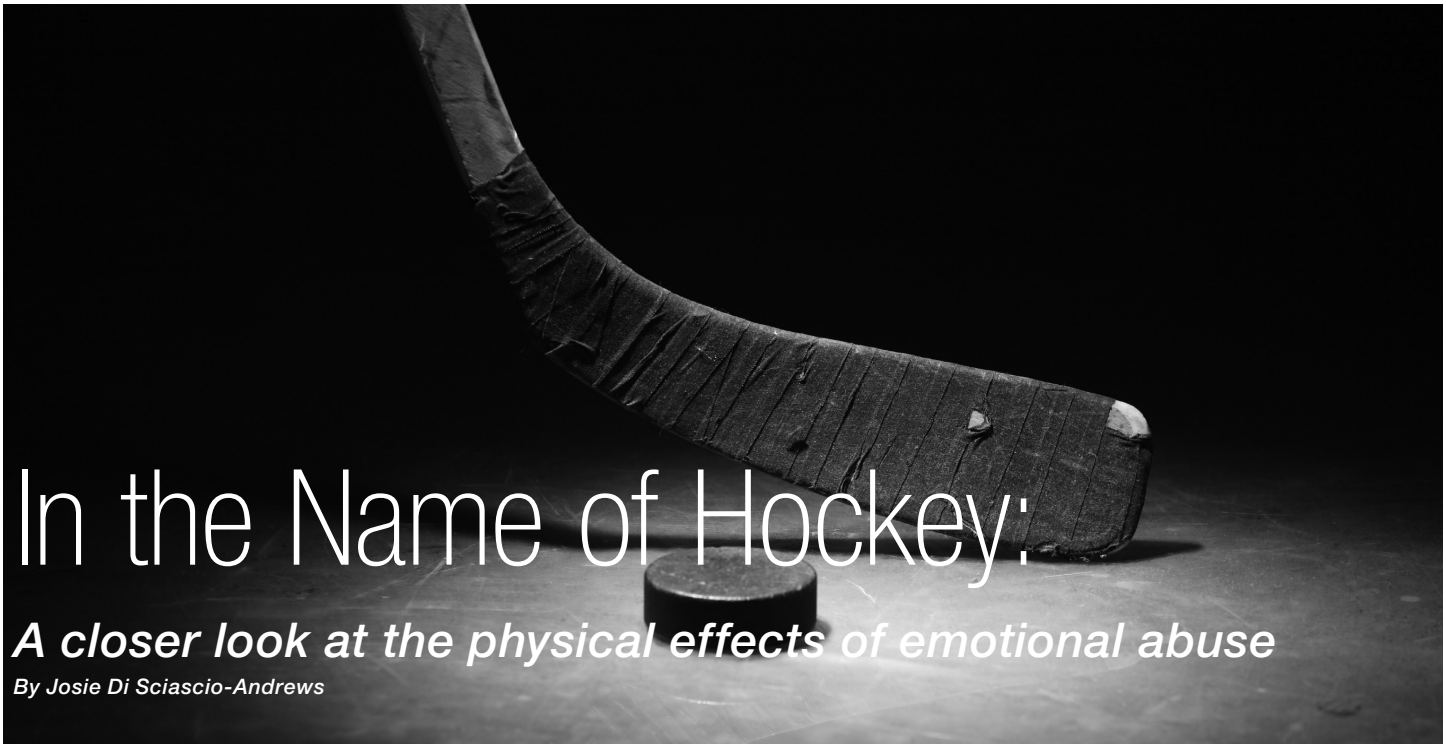
Canada continues to require well-educated, skilled professionals in the vocational rehabilitation and disability management fields. In a combined approach with VRA Canada and Health Force Ontario, KMG delivered a Canadian pilot program to provide education to foreign-trained health professionals. The majority of individuals were regulated health professionals licensed in other countries, but who have experienced significant barriers to re-licensing in Canada. Many expressed a strong desire to apply their skills and knowledge in a parallel profession. The KMG pilot program—launched in Canada in September 2014—delivered an education program to foreign-trained health professionals who met specific selection criteria (e.g. language capability) and demonstrated interest in becoming a professional in the vocational rehabilitation and disability management fields. The program offered a combination of education, skills development, and in some cases an internship was arranged for individuals to gain work experience in the field.

The educational requirements for practitioners in this field runs from no formal education to Masters level, and is in alignment with the development of each countries social programs, desire to standardize and professionalize, and the recognition that delivery of these services requires distinct skills and knowledge.

Countries seeking to initiate or further develop education options for practitioners have a wide range of choices, which ideally meet both the current and future requirements for the delivery of effective and cost-efficient social employment programs.

To view references for this article, visit our website www.vracanada.com/media.php

Karen Michelazzi, BHSC PT, MCPA is a registered physiotherapist who has been working in the rehabilitation and disability field for more than 25 years. Karen is the owner and CEO of KMG Health Partners, an international rehabilitation and disability management company established in 1996 to deliver education and consulting services to organizations and professionals in the field. She can be contacted at karen.michelazzi@kmghp.com.



In the Name of Hockey:

A closer look at the physical effects of emotional abuse

By Josie Di Sciascio-Andrews

Trauma, whether physical or emotional, can be at the root of many mental health issues. A concussion from a blow to the head in a hockey game, or by heading a ball in soccer, are both well-documented causes of brain damage that could bring with them pyramidal, lifelong consequences. The emotional trauma associated with such injuries is less well-known or discussed. Like some physical injuries, emotional trauma can often be attributed to the manifestation of a mental illness. According to ongoing scientific discoveries, mental illness is an organic disorder, a physical manifestation of trauma in the organ of the brain. Any trauma to the brain can result in very similar effects. Whether the precipitating cause of trauma is physical or emotional does little to alleviate the resulting damage incurred by a young person. The negative ramifications that could manifest as a consequence of trauma, will affect the individual for the rest of his life, as well as the lives of his family.

In my book *In the Name of Hockey*, I take a closer look at emotional abuse in youth sports and try to demystify the effects of emotional abuse in children's lives. I wrote the book as a way to alleviate the damage of what happened in my own children's lives, and to define it for myself and for other parents faced with this issue.

The damage of emotional abuse is, at first, not as obvious as that of concussions, physical, or even sexual abuse. There are no bruises, no scars, and therefore people often overlook or minimize the effects. According to Psychology Today however, the damage of emotional abuse can be more harmful and long-lasting than physical abuse because the abuse tends to be more frequent (1). Children are deeply affected by negative comments from parents, coaches, and other adults they look up to and respect. Children who are criticized, yelled at, and put down consistently feel humiliated, shamed, and degraded. Over time these children begin to believe what the adults in their lives say about them. If the abuse is chronic, a pattern of negativity begins to destroy a child's spirit and motivation.

> *"Damage caused by emotional abuse can be longer-lasting than that of physical abuse"*

It has been medically documented that emotional abuse causes learning difficulties and emotional problems by altering brain chemicals. During fearful events, the brain receives an increase in adrenaline and cortisol which has a dramatic effect on how memories are processed and stored; too much cortisol will result in impaired memory and learning (2). In fact, one of the main indicators of emotional abuse in children is poor school performance and/or behavioural problems. Sometimes this includes aggression, bullying, and delinquent behaviours such as drug use, and in many cases self-mutilating and suicidal behaviours. In many studies, emotional abuse had a significant association with lifetime substance misuse, comorbidity, and mental illness. In one study in the British Journal of Psychiatry (3) it was found that "severe childhood trauma appears to have occurred in about half of patients with bipolar disorder and may lead to more complex psychopathological manifestations." An article in Psychiatric Times states that "in adults with schizophrenia, dissociative symptoms have been found to be associated with a history of emotional abuse, as well as physical abuse. Emotional abuse and neglect were found to be associated with substance use in patients with schizophrenia. Emotional abuse, along with other childhood traumas, represent a risk factor for suicide attempts in patients with schizophrenia" (4).

When we look at causes of mental illness, we find a lack of definite knowledge of causation. It is an accepted theory that most people with mental disorders have a genetic predisposition for it (5), and childhood trauma can be the switch that causes a mental disorder to manifest. According to Carolyn Spring, in association with PODS Online, dissociative identity disorders do not have a biological cause, but rather "result from chronic and overwhelming trauma and abuse in childhood, starting at a very young age, generally at the hands of a caregiver" (6). Such is the aetiology of depression, substance abuse, bipolar disorder, schizophrenia, as well as all

other types of dissociative disorders. Emotional abuse leaves a unique type of scarring on brain tissue that is observable via CAT scans, much in the same way as blunt physical head trauma. Dr Jens Pruessner, associate professor of psychiatry at McGill University in Montreal, notes that "changes [in the brain] are seen in regions associated with understanding and controlling emotions, and recognizing and responding to the feelings of others" (7). Pruessner conducted studies that found "a thinning in areas [of the brain] that have to do with self-awareness and emotional regulation, areas in the pre-frontal cortex and medial temporal lobe, which typically show activation when people are asked to think about themselves or reflect on their emotions" (7). Studies like Dr Pruessner's provide evidence of the structural changes of the brain that lead to mental dysfunction in abuse victims. It is as if they are abused forever: once at the instant of first abuse, and then forever by the brain damage caused by maltreatment.

With knowledge of the many problems caused as a result of emotional abuse, it is not surprising to learn that many incarcerated people were emotionally traumatized as children. Many live down to the abusive expectations, resulting in negative life outcomes following them as self-fulfilling prophecies. The changes in the brain seen in abuse victims were not small. Pruessner says, "If a region [of the brain] typically was 5 mm thick on average, in abuse survivors it was just 3 mm to 4 mm" (7). This differential is indicative of a significant loss of brain tissue: a similar result to those found in scans of patients with schizophrenia.

A decrease in size and connectivity in regions of a child's brain that has been overwhelmed by maltreatment can be viewed as a miracle of sorts: an adaptive, self-protective response. The tragedy of its deleteriousness is evident in the fact that it interferes with the full expression of the child's potential. Not only does the brain protect itself against emotional abuse, but as a result it numbs itself to healthy sensation and experience. Metaphorically speaking, emotional abuse cuts off the neuronal branches of a tree that was otherwise meant to bloom to its fullest potential but is instead, through the violence of words, forever amputated, minimized, and blunted.

While sitting in a car, my son and I were looking at some trees that had been truncated and had re-grown branches from their sheared torsos. The branches had lost their natural flow of a typical tree. These trees grew up and out strangely and my son aptly described "those trees are like a person who was cut off from what they really want to do in life and who they really want to be." This was years before his diagnosis. These words were a prophetic expression from a mind that was assessing its own journey between points in time.

These days, my family is healing and re-building. The worst has happened, back in what was supposed to be the blissful world of childhood. My wonderful little boy was young when he was initiated into the world of rep hockey—the highest level of competitive hockey, with a rigorous try out format. His life was budding with infinite potential. In his teens, he came out of that world, wrung out, deflated, and changed. His branches razed by the violence of the words and actions of the people who were supposed to be teaching and nurturing him.

> *"Emotional abuse causes learning difficulties and emotional problems by altering brain chemicals"*

After years of plummeting self-esteem, depression, post-traumatic stress disorder, flashbacks, substance abuse, and concurrent mood swings, my son was finally diagnosed with psychosis. His mind—altered by emotional abuse—was finally calmed by a relatively mild newcomer on the landscape of anti-psychotic medications. The drug has given my son his life back, by regulating his brain's neurotransmitters. He is well now, but we still have a long way to go.

Like a concussion (or any other brain injury), extended periods of psychosis cause damage to brain tissue. It will take a long time, if ever, for my son to fully get back to the person he used to be. But we are hoping, praying, and re-building. He is re-growing branches from where his abuser's words cut off his self-esteem, his volition, and his resolve to try new things. He is re-growing his joy for life.

We may never know for sure if emotional abuse was the cause of my son's brain disorder. What we do know is, mental illness is caused when a child's genetic predisposition is triggered by trauma (5). Without the trauma of being emotionally abused in hockey, would my son have been fine? We don't have those answers, we only have our experience. I lived through it with him. I was on the receiving end of the abuser's wrath when I stood up for my son and when I started supervising him at games and practices to spare him maltreatment. I was there, educating myself, looking up information, gathering evidence. The abuser would shrug off anything I presented because, as he would explain, "everyone talks that way in the hockey world" and that I was "too sensitive." I saw doctors, therapists, and family counsellors. I gave my child the best life I could by spending time with him, protecting him, and honouring his feelings. In the end, I learned that it didn't matter.

Abuse happens even when one doesn't mean for it to happen. It happens between the perpetrator and the child, and it is indelible in that child's mind.

I wrote *In the Name of Hockey* more than a decade ago, when my son had not yet been diagnosed with a mental illness. The book was a direct result of the growing stack of research I had piling up on my dining room table; research that I gathered to clarify to myself what was happening and to help my son. People say that we do the best we know how to do at the time; this is really true for me. I educated myself to protect my son. Armed with the knowledge of mental health issues in children and the effects of emotion abuse, I was and am able to give my son the care he needs and deserves. The goal of the book is to raise awareness about children's mental health issues, along with the physical effects of emotional abuse, and to create an ongoing dialogue to help prevent further suffering of children and parents.

Emotional abuse hurts children. It hurts families. It is never worth it, not even in the name of hockey.

To view references for this article, visit our website www.vracanada.com/media.php

Josie Di Sciascio-Andrews's non-fiction publication In the Name of Hockey *was published by FriesenPress and is available in libraries and bookstores and online worldwide. She lives, teaches, and writes in Oakville, Ontario. Josie has also written four collections of poetry, including one coming out in October 2015. Josie has been shortlisted for several poetry prizes including, Descant's Winston Collins Best Canadian Poem Prize and The Malahat Review's Open Seasons Award.*

A Japanese Perspective on Vocational Rehabilitation:

A look at Japan's National Rehabilitation Centre in Saitama

By Francois Paradis, MA, CVE

This article originally appeared in the Summer 2014 edition of *Rehab Matters*. To view accompanying graphs, visit http://bit.ly/1LOFOWs.

I have been actively involved in the field of vocational rehabilitation in Toronto for more than 13 years and have a keen interest in improving my skills and knowledge of vocational assessment. Being self-employed has made the process challenging, as there are fewer opportunities to learn from others when working in isolation. This is why I enjoy discussing the challenges of our profession with colleagues whenever I have opportunities. I am always interested in learning new approaches, tools, and methods that could make my work more effective. With that goal in mind, I was fortunate to have the opportunity and privilege of visiting a vocational rehabilitation centre in Japan to witness firsthand their approach to vocational rehabilitation. The purpose of this article is to relate what I have witnessed and to contrast it with my own experience of vocational assessment.

My experience in Canada

Since I began my career as a vocational evaluator, I have worked in both the non-profit and for-profit sectors. I have been primarily involved with the Ontario Workers' Compensation system, the Ontario Disability Support Program and the health/auto insurance sector and have witnessed a variety of vocational rehabilitation approaches. There are a few points in common that I have noticed:

- The above systems offer a decentralized approach to vocational rehabilitation. While intake, adjudication, and case management services are typically provided in house, various contractors are relied upon to provide vocational rehabilitation services to people with disabilities. Such services may include medical assessments, vocational assessments, employment counseling, job search training, job coaching, etc. This type of system allows providers of vocational rehabilitation services to access the varied expertise of contractors and their objectivity.

- In the vocational assessment process, evaluators are expected to follow an objective and rigorous methodology to evaluate the employability of people with disabilities. Objective medical evidence must be taken into account, along with the results of standardized tests, which are compared to data provided by occupational classifications in terms of aptitudes, physical demands, and interests.

- Vocational evaluators provide employment recommendations but are typically not involved in the implementation of the vocational rehabilitation services they recommend. Services such as academic skills upgrading, vocational skills training, job search training or job coaching are usually implemented by other providers and rehabilitation professionals at a later stage.

- These vocational rehabilitation programs are meant to be client driven and tailored to the needs, potential, and vocational interests of each individual.

Vocational Rehabilitation in Japan

According to the Japanese Ministry of Health, Labour, and Welfare (MHLW), there are about 7.88 million people with disabilities in Japan, among an approximate population of 127 million. These are divided into the categories of physical, intellectual, and mental/psychiatric disabilities.

The Japanese government's primary measure to promote competitive employment for people with disabilities is the so-called Quota-Levy and Grant system. Based on this system, private companies with 200 employees or more (100 employees or more as of April 2015) are required to have a minimum of two per cent of employees with disabilities. Public companies have a quota of 2.3 per cent. This is a "stick and carrot" system, whereas employers failing to meet their quota are required to pay a fine of ¥50,000 (approximately $535) per month per employee below quota. Part of the monies levied is utilized to provide financial support to employers meeting their quota requirements. These grants may be used by employers to partially cover their costs incurred to hire or continue to employ persons with disabilities. The employment rate of persons with disabilities in private companies has slowly but steadily increased, from 1.47 per cent in 2002 to 1.69 per cent in 2012. Although the two per cent target has not yet been reached, the trend suggests that the Quota-Levy and Grant system is an effective measure.

Japan has also put in place a complex structure of services designed to facilitate training and employment for people with disabilities. *(To see a partial organizational chart, visit our website.)*

People with disabilities seeking employment can access vocational rehabilitation services through public employment security offices (Hello Work), local vocational centres (one in each of Japan's 47 prefectures), or at one of the two national vocational rehabilitation centres.

This article will focus on the National Vocational Rehabilitation Centre located in Saitama, Japan, where I was offered a tour of the facilities and services as well as meetings with the staff.

The National Rehabilitation Centre in Saitama, Japan

On November 8, 2012, I visited the National Rehabilitation Centre for Persons with Disabilities (NRCD), which is located in the district of Tokorozawa, Saitama prefecture.

I was accompanied by two facilitators and interpreters. This rehabilitation centre is very large (225,180 Sq m, or about the size of 35 American football fields) and is comprised of several departments, including;

- A clinic providing physical rehabilitation services

- A research institute
- A college providing training programs to future rehabilitation professionals
- A vocational rehabilitation centre (NVRCD) offering vocational evaluations, employment counselling and skill training programs for people with disabilities
- Sports facilities and dormitories for participants with disabilities

We were first greeted at the centre by Ms. Yoko Nishimura, chief of international cooperation of NRCD, who first offered us a tour of the physical rehabilitation facilities. One area is dedicated to the physical rehabilitation of people with physical disabilities and those who have sustained post traumatic injuries, including traumatic brain injuries. Rehabilitation services are provided by occupational therapists, physiotherapists, and by other professionals with relevant qualifications.

The tour followed with a visit of the pre-vocational training department, which offers programs for applicants that need to develop their work readiness skills. One such facility is the simulated laundry group training program, which primarily targets people with intellectual and mental disabilities. Under the guidance of vocational instructors, participants learn how to launder, press, and fold cloth. We also visited an area where participants are trained to work in the retail sector to stock shelves, perform inventory control, and provide customer service. Another area provided housekeeping training in a simulated hotel room environment. All simulated work environments were very realistic but unfortunately, I was not allowed to take pictures, for privacy reasons.

All participants acquire and/or accentuate their skills under the supervision and guidance of instructors. I had an opportunity to meet with several of these instructors and inquired as to their approach. They noted that the purpose of these pre-vocational programs is to nurture proper work attitudes, to provide participants with basic work skills, communications skills and to evaluate their performance and progress. At this stage, a proper work attitude and motivation are more important than work performance. To achieve these goals, instructors provide a close mentor-trainee relationship to foster trust.

Following our visit of the pre-vocational training department, we had lunch at the cafeteria, which employs people with disabilities. I noted that I was served in a timely fashion and provided with good customer service.

The National Vocational Rehabilitation Centre for Persons with Disabilities (NVRCD)

Our afternoon visit was dedicated to the vocational rehabilitation centre and included a Q&A session with the head of the NVRCD. This facility is a division of the larger NRCD but is quite extensive in itself. The NVRCD can accept about 200 trainees and offers programs that are typically one year in length. The following vocational training programs are primarily aimed at people with physical disabilities:

- Mechatronics programs (mechanical engineering design, electronic engineering design as well as assembly and inspection)
- Business administration and information technology (e.g. Business accounting, office administration, desktop publishing, software developing, web design)
- Design programs (interior design, architectural CAD)
- Massage therapy, shiatsu, acupuncture, and moxibustion training programs are also offered to people with visual disabilities to prepare them for employment as physical therapists

NVRCD also has a job development section that offers programs designed for people with mental and developmental disabilities. This section provides the following courses:

- Assembly work course: participants receive training on assembly, inspection, and various light tasks in a manufacturing setting
- Office work course: this include training on basic operation of computers and the acquisition of skills and relevant clerical work, such as data entry, document management, mail sorting, and delivery
- Product distribution and retail course: trainees acquire knowledge and skills related to product distribution, including retrieving products from storage areas, inspecting products, processing of payment slips and distribution. Trainees also acquire skills relevant to the retail sector, including product display, packaging, packing, and inventory control.

Each program provides vocational instruction and hands-on training in realistic simulated work environments. The ratio is about five trainees per instructor and therefore, each participant receives a lot of individual attention. Instructors also help their trainees to find and maintain employment by acting as job developers and by negotiating accommodations or job modifications with employers. Training programs are adjusted to the specific needs of employers and to the characteristics of each trainee, which helps promote a smoother transition into the workforce. The vocational instructors I spoke to indicated that employers are motivated to hire people with disabilities, not only because of employment quotas but also to improve their public image as socially responsible companies. I was informed that the work placement rate is generally over 80 per cent, with a majority of graduates finding competitive employment.

Employment retention is facilitated by vocational instructors, who are familiar with their students and who meet regularly with employers to discuss potential issues and to negotiate appropriate accommodations at work. Job coaching services are also provided to employees with disabilities to ease their workplace integration and to monitor their progress and performance.

Admission and Vocational Assessment

People with disabilities typically apply at the NVRCD through their local Hello Work office and must provide a disability certificate completed by a medical doctor. Graduates of pre-vocational programs offered by the NRCD may also apply.

As part of their admission process, applicants undergo an extensive vocational assessment over a period of one week. The purpose of the vocational assessment is two-fold: to determine which applicants are suitable for NVRCD's vocational rehabilitation services and to match each applicant with the appropriate vocational training program. Applicants with intellectual or mental disabilities tend to be referred for more physically demanding employment such as laundry work, warehousing, assembly, or cleaning. Applicants with physical disabilities tend to be referred for sedentary work in the IT, business administration, and design sectors. People with visual impairments may be referred for physical therapy programs.

As indicated below, the vocational assessment process differs according to the type of disability:

Applicants with Physical Disabilities

Day 1: Intake interview and initial evaluation of aptitudes (Japanese version of GATB); test of Japanese literacy

Day 2: Test of mathematic skills; counselling session to review initial test results and to identify in which program candidate hopes to enroll (only for candidates who passed the initial evaluation)

Day 3, 4, 5: Situational assessments tailored to the training program in which the candidate wishes to enroll; interview by training instructors (day 4)

Day 6: Follow-up session with vocational assessor for final determination of acceptance and for program selection

Applicants with Intellectual or Mental Disabilities

Day 1: Intake interview and initial evaluation of aptitudes (Japanese version of GATB); test of Japanese literacy; test of mathematic skills

Day 2: Counselling session to review initial test results and to identify in which program the candidate hopes to enroll (only for candidates who passed the initial evaluation). Situational assessment to assess potential productivity issues such as work tolerance and concentration.

Day 3: Individual consultation

Day 4, 5, 6: Situational assessments tailored to the training program in which the candidates wish to enroll; interview by training instructors (day 5)

Day 7: Work trial in simulated work environment. The candidate's ability to work in a group is also evaluated.

Day 8: Follow-up session with vocational assessor for final determination of acceptance and for program selection

As outlined above, the vocational assessment does include some psychometric testing, but emphasizes the use of situational assessments to evaluate a person's employability and for program matching purpose. Counselling and interview sessions with vocational evaluators and vocational instructors are also important to help the applicant explore the various training options offered at the facility. Applicants that are not deemed ready for employment may be referred to pre-vocational training programs offered at the NRCD or to other pre-vocational services agencies.

I had the opportunity to interview one of the vocational evaluators there and was told that vocational evaluators/counsellors rely more heavily on their experience and judgment to assign applicants to the appropriate training program rather than basing their decision on the results of standardized tests. This is in part due to the fact that many applicants do not perform well on psychometric tests, such as the GATB, due to their disabilities, and as such, situational assessments and counselling are considered more reliable methods of assessing employment potential. Additionally, Japan's occupational classification system is mainly designed for statistical and general counselling purposes and as such, it does not provide information on aptitude requirements or physical demands, as the Canadian NOC does. Therefore, standardized test results cannot be directly compared to the Japanese occupational classification.

Impressions

In my opinion, NRCD's system has the following strengths:

- A comprehensive and centralized system of service delivery is offered. Each step of the program is quite well integrated, which promotes effective feedback among rehabilitation professionals at various stages of the vocational rehabilitation process, from admission to employment.
- Vocational instructors are the key strength of this system as they follow students from initial training to employment and nurture a positive relations with potential employers
- There is a strong partnership between the rehabilitation centre and employers. The Quota-Levy and Grant system acts as an incentive for employers. However, corporate social responsibility also appears to be an incentive and this may be a factor typical of the Japanese culture.
- There is a strong emphasis on post-employment services through provision of counselling services for employers, job accommodation, and job coaching services for employees with disabilities

Some limitations of NRCD's system may include:

- A lack of flexibility; applicants must choose among a limited number of training programs
- The rehabilitation centre gets to choose who is accepted. Rejected applicants are referred out.
- NRCD offers an "all-inclusive" service model that is costly. Situational assessments tend to be resource intensive and time-consuming. This centralised approach requires a high degree of coordination, planning, and monitoring and may create a limitation on the number of applicants the centre can accept (about 200 per year).

I provided in this article a brief overview of Japanese government policies and the vocational rehabilitation services provided by the NRCD. In my opinion, there are a few lessons that can be learned from the Japanese approach to vocational rehabilitation.

- In Canada, several providers of vocational rehabilitation services favor a decentralized approach. They would benefit from implementing stronger communication channels between various rehabilitation professionals, which would help increase the effectiveness of services provided.
- In spite of their added cost, situational assessments and work trials would be an effective supplemental tool to vocational assessments in identifying suitable employment options for people with disabilities.
- A stronger partnership between providers of vocational assessment, vocational training and employers would help ensure that vocational services are better adjusted to the needs of people with disabilities and employers. This in turn would help increase job placement and retention rates.
- At the government level, the Japanese Quota-Levy and Grant system has demonstrated its effectiveness over the past decade. The province of Ontario has measures intended to promote employment of people with disabilities. For example, it enacted in 2005 the Accessibility for Ontarians with Disabilities Act, which includes a set of requirements for employers to make their hiring process more accessible to people with disabilities. At the federal level, the government of Canada provides the Opportunities Fund to help people with disabilities prepare for, obtain, and maintain employment or self-employment. Eligible employers may apply for funding on the behalf of people with disabilities to receive funding.

My visit of the NRCD was a great opportunity to witness firsthand how vocational rehabilitation is approached in Japan. We can learn and benefit from best practices of vocational rehabilitation around the world. Combining our objective methodology to vocational assessment with the practical elements of assessment and strong employer ties favored in Japan, would help improve the effectiveness of vocational rehabilitation services in Canada.

To view charts & references for this article, visit our website www.vracanada.com/media.php

Francois Paradis, MA, CVE, is a certified vocational evaluator with over 10 years of experience in the field of vocational assessment. He completed a Master's of Art in Guidance Counselling at Laval University in Quebec in 1995 and became a Certified Vocational Evaluator (CVE) in 2006. Francois has been on CAVEWAS' board of directors since June 2012. He has been working actively as a vocational evaluator in the Greater Toronto Area since 2001. His experience includes providing vocational evaluation services for WSIB, HRSDC, Veteran's Affairs, Ontario Works, legal firms and Auto/Health Insurers.

Wellness Centre

DECONSTRUCTING OVERWHELM

Do you ever ask yourself: "Where did the day go? Where did the week go? Where did the years go?" Do you look at the stuff you have to do and wonder, "How the heck will I get all this done? How will I survive this week/month/year? Where did all the fun go?"

Do you sometimes feel bogged down and overwhelmed by it all?

It makes you wonder: what did we do before email, voicemail, twitter, and the rest of the internet? We live in times of unprecedented busyness. The demands and pace of work and life are at an all-time high, and they don't appear to be slowing down any time soon. Work is frenetic; change is constant; and so is life. We all juggle a lot: careers, families, volunteer/personal pursuits, and more!

Of course, most people do choose much of what's on their plates. We all want to work hard, produce, and contribute. We want our life to include family, friends, meaningful pursuits, interests, volunteering, and learning. We used to have seasons that were busier than others. Today, it appears that every day is the season of rush. We want it all, but at what cost? Underneath the surface of high performance, you must notice a few signs of wear and tear on your personal and professional well-being. The damage might seem subtle but what's really happening to us?

Overwhelm erodes our well-being and our ability to flourish personally, professionally, and organizationally. Running too long on overload can derail even the most successful people. The feelings of overwhelm are not imagined, nor are the consequences.

Thought-provoking considerations:

1. As the loads of work (and life) become heavier, and with tougher deadlines, how can we organize our obligations and ourselves in a way that is brain-friendly and allows us to handle our loads more effectively and with less stress?

2. The brain can't distinguish between an angry lion and a tough workload, so how can we use our mind to appropriately bring that perceived threat back into its respectful cage and put the brakes on the stress response?

3. If mood is central to coping, how do we get better control over our emotions to reap the rewards of the positivity advantage?

4. If quality sleep is essential to our well-being and our ability to cope and thrive, how do we get an ample dose of quality sleep, if we are challenged in that area?

Eileen Chadwick's book *Ease: Manage Overwhelm in Times of 'Crazy Busy'* (1) offers practical ideas and tools to better organize ourselves in a way that works with our brains. Chadwick suggests ways to pre-empt a mind-full, bogged-down state of mind and shift to a more mindful (conscious and intentional) way of navigating work and life.

Mind Full? Organize with the Brain in Mind

Here are a few tips on how to achieve an organized mind:

1. Get it out of your head; write it down

2. Get a grip on your schedule

3. Prioritize and triage

4. Manage distractions

5. Reign in the multitasking

6. Learn to say no

7. Manage that paradox of choice at the buffet of life

Develop Conscious and Empowering Mindsets

1. Tame the inner critics; time to control that inner guilt!

2. Climb your mountains one step at a time

3. Ask, "What can I do now?"

4. Use powerful questions to assist with determining priorities, capabilities, etc.

5. Pause, Park, Reflect: Harness the power of journalling to learn about yourself

6. Clear the cache: Take a break, take a walk, complete a puzzle, spend time with a pet

Mood Matters: Hone the Positivity Changes

1. Check your positivity ratio (Visit www.positivityratio.com to take an online positivity-ratio quiz)

2. Create a happiness portfolio

3. Boost the positivity habit in your daily life

4. Get a good night's sleep

Keep these tips in mind as you navigate our busy world to make it a bit more manageable.

To view references for this article, visit our website www.vracanada.com/media.php

Wellness Centre is a quarterly column prepared by Viki Scott, RC(c), BSc, RRP, CHRM, MBA, ADR(c.

LMS PROLINK Protector

The LMS PROLINK Protector is your direct source for insurance related tips and information

What is "informed consent" with regards to the treatment of a client?

- It is a basic accepted principle that "every human being of adult years and of sound mind has the right to determine what shall be done with his or her own body"
- This principle is applicable not only to surgical operations but also to all forms of medical treatment, rehabilitative treatment, and to diagnostic procedures that involve intentional interference with the person
- It is intended to protect the individual's right to "security of the person," as stated in the Charter of Rights and Freedoms

How is "informed consent" essential from a risk management perspective?

- Allegations that consent to treatment was lacking or inadequate, continue to be a frequent claim against physicians. This issue also represents a significant risk factor for any treating professional.
- Enhances communication and the special relationship of trust between you and your client
- If consent is not given by the patient:
    - Health care professional may be found liable in battery
        - "Battery" is:
            - Treatment provided without the client's consent
            - Treatment given that goes beyond client's consent

What factors must be present to ensure "informed consent" is received?

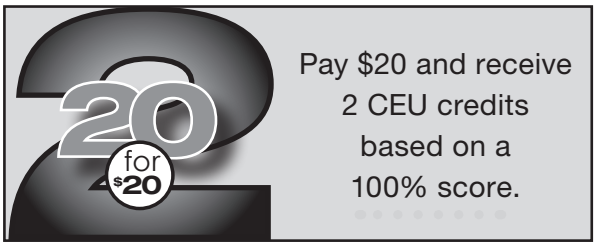
- Client must have the mental capacity to authorize treatment
    - Refers to the intellectual ability to reach a reasoned choice about treatment
    - Everyone is presumed mentally capable, unless there is some reason to question this. It is the responsibility of the person obtaining the consent to assess the individual's capacity
    - The test of capacity is the same for everyone and is based on the treatment professional's opinion of whether the person has the ability to understand the nature and effect of the treatment being proposed
    - Should the treatment professional obtaining consent determine that the client is incapable of giving consent, a substitute decision-maker must be identified and give proper informed consent for the treatment before it can begin
    - It is important to note that a judgment of capacity/incapacity is not a permanent determination. Capacity is considered situational and it can be influenced by fatigue, pain, medications, etc.
- Client must receive proper disclosure of information from the treatment professional
    - Information provided must be what a "reasonable person in the client's position" would want to know to make a decision
    - This includes the anticipated benefits and the "material" risks of the treatment
    - Such risks include those probable, even if not serious, as well as those that are unlikely, but serious
- Consent must be specific to the proposed treatment
    - Consent need not be obtained for every single step of a treatment plan, however the main elements should be identified and discussed
- Client must have an opportunity to ask questions and receive understandable answers
    - Clients are entitled to receive information in the language that they can understand
    - The professional is obligated to explain the information in lay terms and, should the client speak another language, translation ought to be made available
- The consent must be voluntary
    - Client consent must be freely given and not obtained through undue influence or coercion
    - Subtle influences, like the inherent power imbalance between the client and professional, may lead clients to do what they perceive as the professional's wish, despite the client's own personal preference
- Consent must not be obtained by misrepresentation of information
    - The treatment professional may not slant the information presented to lead the client to any one decision, even if the professional thinks it is in the client's best interests
    - This does not prevent the professional from expressing an opinion as to the best course of treatment. Accurate and impartial information on all treatment alternatives and options must be provided

Does client consent have to be written?

- Consent may be implicit (i.e. patient holding out injured hand for examination) or explicit (i.e. professional's verbal request to examine patient's injured hand)
- Explicit consent may be either verbal or written
- Both forms of consent are legally acceptable, however, should questions arise later as to the nature and extent of the client's consent, expressed verbal consent or implicit consent can be problematic
    - Written consent is generally more typical for high risk treatment
    - The mere fact that a client has signed a consent form is not necessarily adequate proof that the consent process was valid
        - Most legal challenges involve a challenge of the validity of the consent, based on whether the client received adequate information to make the decision

For more information on LMS Prolink and VRA Canada's insurance program, visit **www.lms.ca/vracanada**.

To have your insurance questions answered by the pros, submit them to kat.abraham@kmghp.com



The answers to the following questions are derived from the content within this publication. Each question has a CEU value of 0.1. If all questions are answered correctly, you will receive two CEU credits, for a total of eight per year. In order to participate in this unique offer, you may go online to www.vracanada.com and fill out the required information and questionnaire online. Alternatively, you may fill out the form and complete the quiz below and mail them, along with a cheque in the amount of $20 (plus applicable provincial taxes) addressed to VRA Canada. CEU quizzes from previous issues may be completed at any time; there is no expiry date. To complete previous CEU quizzes please log in to www.vracanada.com. **Good Luck!**

1. Of the employed population of Iceland, how many people were on disability benefits in 2008?
   A: 5%
   B: 9%
   C: 16%
   D: 27%

2. The Scottish National Health Service was formed in 1948 for what reason?
   A: To gain independence from health service providers in England
   B: To assist military medical units as part of war relief
   C: To provide alternatives to private medical companies
   D: To act as a primary funding source for all health related services across Scotland

3. What does Psychology Today say can be more harmful (long-term) to children than physical abuse?
   A: Malnutrition
   B: Emotional abuse
   C: Lack of education
   D: All of the above

4. What does IMG stand for?
   A: International Medical Guidelines
   B: Information Management Group
   C: International Medical Graduate
   D: It's a file extension for image files

5. How many people with disabilities are there in Japan?
   A: 2.44 million
   B: 5.11 million
   C: 7.88 million
   D: 10.9 million

6. IMGs have yet to receive opportunities and be appreciated for their professional perspectives in Canada.
   A: True
   B: False

7. In countries where no VR credential or education requirement is in place, people can practice with a high school level education.
   A: True
   B: False

8. What was the unemployment rate of persons with disabilities in Japan in 2012?
   A: 2.4%
   B: 1.69%
   C: 1.11%
   D: 0.76%

9. What was created as a result of a lack of comprehensive government overview in vocational rehabilitation, among other things?
   A: Icelandic Vocational Rehabilitation Fund
   B: Confederation of Icelandic Employers
   C: Icelandic Federation of Labour
   D: Vocational Health Services Association of Iceland

10. How many people does the Scottish NHS employ?
    A: 85,000
    B: 100,500
    C: 155,000
    D: 160,000

11. What countries have long-standing standards of practice (in vocational rehabilitation)?
    A: Australia, Czech Republic, Netherlands
    B: UK, USA, Canada
    C: Australia, USA, Canada
    D: Sweden, Belgium, Norway

12. At Japan's NRCD, physiotherapists may not provide rehabilitation services.
    A: True
    B: False

13. What country is the leader in absorbing skilled professionals?
    A: UK
    B: Canada
    C: Australia
    D: Japan

14. Researchers have found physical results of emotional abuse in the brain, in the form of thinning or loss of brain tissue.
    A: True
    B: False

15. VIRK has not always required specific educational qualifications.
    A: True
    B: False

16. 83 per cent of people who received health services in Scotland reported that Working Health Services (WHS) helped them remain in/at work.
    A: True
    B: False

17. To whom does Japan's NVRCD's job development section provide programming?
    A: People with mental and developmental disabilities
    B: High school and college level interns
    C: Certified rehabilitation professionals
    D: None of the above

18. Dissociative identity disorders have been found to stem from biological causes.
    A: True
    B: False

19. Slovakia does not have a vocational-specific education stream for VR.
    A: True
    B: False

20. IMGs in Canada have opportunities and professional perspectives.
    A: True
    B: False

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To the Automotive Training Centre;

My name is Chad Williams. I was an injured worker when Worksafe and I decided that the Dispatching and Transportation Operations program at the Automotive Training Centre would be a good fit for my situation.

At first I was hesitant, as I had no experience in this industry. Being out of school for 20 years, I wasn't sure of what to expect from adult learning. The professional staff at ATC was very helpful to me, and understood where I was coming from and what my goals were, and helped me to achieve them.

Both of the instructors, Jerry Virtanen and Lawrence Candiago have a wealth of knowledge and understanding of the transportation and trucking industries, and are able to pass that along to their students. With the education that I now possess, I am now working full time as Head Dispatcher for a major trucking company in the lower mainland. This would not have been possible for me without my training here at ATC, and without the level of teaching and value of the materials taught here.

I would like to thank the staff at the Automotive Training Centre for helping me rejoin the workforce, and to succeed in the Dispatching field.

Sincerely,
Chad Williams, Graduate

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