REHAB MATTERS

The Official Publication of VRA Canada

WINTER 2015/2016

HOW TO
be an "expert" expert

The Balancing Act
& *HOW TO MANAGE IT*

ETHICS & PSYCHOLOGY
in rehabilitation

41831522

ETHICS

Imagine Your Future...

you can change your life!

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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REHAB MATTERS

Official Publication of the Vocational Rehabilitation Association of Canada

WINTER 2015/2016

FEATURES

LETTER FROM THE EDITOR

Welcome back to another issue of *Rehab Matters.* This issue is chock full of fantastic articles handpicked for you and then reviewed by our excellent editorial committee, made up of VRA Canada members. The *Rehab Matters* Editorial Committee is just one of the many committees you can join to make the most of your membership with the association. See our Message from the National President (page 3) for details, and for a full list of the committees and their descirptions check out page 4.

Once again, if you enjoyed this issue of the magazine, I encourage you to submit your own pieces by contacting me at kat.abraham@kmghp.com.

Enjoy the issue and enjoy the beginning of what will undoubtedly be another great year for VRA Canada.

Sincerely,

Katherine Abraham
Editor, *Rehab Matters* Magazine

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Society News

Updates from across the country

Saskatchewan

The VRA Saskatchewan Society held a successful annual general meeting in May; in conjunction with this meeting, Dr. Terry Levitt presented the session "Brain Injury Lessons." This session was well-attended as invitations were extended to other organizations, agencies, etc.

The Saskatchewan Society will be holding a winter meeting with educational opportunities for members on key issues.

On behalf of the Saskatchewan Society Board, we would like to wish everyone happy holidays and the very best in 2016.

Manitoba

On October 22, the VRA Manitoba Society put on a fantastic half-day workshop: "Personality Disorders and the Return to Work." The workshop was well-attended and all evaluations were positive, both for the content and the presenter.

One great outcome is that our presenter, Michael Ellery, PhD, CPsych—who is new to Winnipeg and one of the only psych providers focussing on return-to-work with personality disorders—is taking new referrals, so we were able to connect both members and non-members to a service that they and their clients really need!

Lisa Borchert has been working to engage new board members, including meeting with one vocational rehabilitation professional from the Worker's Compensation Board, who is now considering coming on as a Manitoba Board member. In turn, he approached a co-worker who is now also considering being a board member, too. Lisa is currently speaking with a few more people from private insurance companies and is hoping to have some new board members signed on in January. The majority of these contacts came as a result of the October workshop. Keep up the great work!

The next Manitoba Society meeting is currently being scheduled for January 2016.

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

What does VRA Canada Stand For?

OUR MISSION

VRA Canada and the multi-disciplinary vocational rehabilitation professionals it represents are committed to supporting, assisting, and advocating for individuals experiencing, or at risk of experiencing, disabling conditions along the continuum of achieving or restoring optimum vocational and life goals. These outcomes are achieved through purposeful and intentional development of strategies and interventions that are informed and directed by education, research, experience, and skills, as well as ongoing professional development, unique to the discipline and profession of vocational rehabilitation.

OUR VISION

VRA Canada is the leading national organization committed to professional excellence of and for its multi-disciplinary members, who are recognized by stakeholders as experts in the provision of vocational and pre-vocational rehabilitation services.

VRA Canada is the acknowledged Centre of Excellence providing education, research, and evidence-based best practices.

OUR CORE VALUES

VRA Canada's values are the foundation of who we are and how we practice:

- Trust
- Honesty
- Integrity
- Professionalism
- Excellence
- Transparency
- Accountability
- Advocacy for the Profession, the Professionals, and our Values

Addie Greco-Sanchez, President

REHAB MATTERS
WINTER 2015/2016

A Message from the National President

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

Henry Paulson, former United States Secretary of the Treasury, has been quoted as saying "in just about every area of society, there's nothing more important than ethics". This is true of professional practice in particular, which is why VRA Canada frequently dedicates a *Rehab Matters* to this topic. It is also why most of our conferences and education days have time slots for ethics, and why members need 10 ethics CEUs for every 5 years of practice.

In order for any field of practice to be acknowledged as a profession it must have the following:

- A definition
- A scope of practice
- Standards of Practice
- A list of competencies
- A set of values
- A code of ethics
- A disciplinary process
- Education
- Continuous professional development
- Credentials
- A professional association
- A college of practice

Thanks to you the members, over the course of 45 years, all of these components have been gradually developed and solidified within VRA Canada. Vocational rehabilitation has earned its right to be called a profession and you are widely acknowledged as professionals. Your display of professional and ethical approaches has been even more evident this year as the association has embraced change, introduced new providers, undertaken new initiatives, and asked for your tolerance and patience as we move into the next five years of our strategic direction. Change is never easy but together we have and will continue to make it work. The positive results of this year's changes and ethical considerations for best practice will be evident as we move into 2016.

Embracing change in a highly ethical manner are your Board of Directors and National Committees. On Page 4, you will find a list of your National Board members and their responsibilities, as well as a listing of all VRA Canada committees, their mandates, and their memberships. These committees were either reinstated or newly formed as part of the Strategic Directions document recently adopted by the Board, and soon to be available on our revamped website. Please review these committee details closely and show appreciation when appropriate. These individuals work tirelessly and diligently on your behalf and for the betterment of the field.

"Vocational rehabilitation has earned its right to be called a profession"

As we finish 2015, activities still scurrying, I hope you are as excited about the potential for our field in 2016 as I am. Meanwhile, I wish you and yours a safe and happy holiday season. Relax and enjoy.

Sincerely,

Addie Greco-Sanchez
President, VRA Canada

VRA Canada | Vocational Rehabilitation Association of Canada

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Addie Greco-Sanchez
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President-Elect
Chair of Government Relations

Audrey Robertson
Director, British Columbia Society
Chair of Finance & Risk Management

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Chair of Education

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Wanda Yorke
Director & *Chair of Membership*

Jac Quinlan
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VRA Canada Committees

2015-2016

1. Board Designated Representative:
Gail Kovacs

2. Executive Committee: To act for the Board on urgent matters arising between regular Board meetings in cases where it is not possible to convene a meeting of the Board, and to do other things as delegated by the Board to the Committee.

3. Ethics Committee: To ensure VRA Canada's Code of Ethics is current, promoted, and adhered to by reviewing any ethical complaints and administering ethical decision-making processes and outcomes. *Due to the nature of this committee, members are kept anonymous.*

4. Audit, Finance, & Risk Committee: The Audit, Finance, & Risk Committee assists VRA Canada in fulfilling its oversight responsibilities in the areas of financial reporting, internal control systems, risk management, the annual audit processes, and compliance with laws and government regulations.

Chair: Audrey Robertson

Members: Addie Greco-Sanchez
Leeann Tremblay
Paul Holtby

5. Nominations Committee: To oversee the nomination and selection process for the National Board for select director positions.

Chair: Shelley Langstaff

Members: Addie Greco-Sanchez
Gail Kovacs
Laura Smillie
Samantha Schellenberg

6. Education Committee: To oversee the development of excellent professional educational and training programs for the membership of VRA Canada and other professionals.

Chair: Jennifer Chladny

Members: Charity Warwick
Colleen Avery
Gail Kovacs
Laird Hurley
Lily Murariu
Muhammad Raza
Phyllis Spencer

7. Membership Committee: To review membership details and make suggestions for growing the membership year upon year.

Chair: Wanda Yorke

Members: Inna Avshalom
Sherry Bettridge
Tara White

8. Student Advisory Committee: To provide guidance and advice to VRA Canada on early student involvement with the association and on membership services that would benefit students.

Chair: Ravi Persaud

Members: Ema Rado

9. Conference Committee: To provide guidance, advice, and support to the Society Conference Committees for the delivery of the annual conference.

Chair: Lisa Borchert

Chair for the Society: Shelley Langstaff

National Members: Audrey Robertson
Gail Kovacs
Jeff Cohen

10. Government Relations Committee: The Government Relations Committee is committed to reviewing, developing, and supporting issues that promote a positive, pro-active economic environment with social progress and enhanced quality of life. VRA Canada believes that laws and regulations should best serve the public without acting as a detriment to its business development and growth.

The purpose of the committee is to influence our elected officials to establish regulations and policies that will improve the various environments to where our members provide service. The issues are raised by our membership and evaluated by the Government Relations Committee with a recommendation to the VRA Canada Board of Directors and the provincial societies. *Due to the nature of this committee, members are kept anonymous.*

11. Community Relations Committee: To identify community services and programs that may serve people with disabilities, hire vocational rehabilitation professionals, and/or be interested in a collaborative relationship with VRA Canada.

Chair: Gail Kovacs

Members: Gerry Tullio
Inna Avshalom
Jaspreet Soor
Kim Davies
Muhammad Raza
Rafiq Ahmed
Tara White

12. Research & Development Committee: To interact with research institutes and universities delivering programs in the field to ensure our members are aware of best practices, to ensure research we need is on the horizon, and to build collaboration.

Chair: Gail Kovacs

Members: Dr. Deena Martin
Imran Khokar
Jaspreet Soor
Rafiq Ahmed
Tara White

13. Information Management Committee: To ensure the availability, integrity, and currency of the association's website.

Chair: Paul Holtby

Members: Gail Kovacs

14. Editorial Committee: Through a process of peer review and comment exchange, the committee ensures that *Rehab Matters* maintains a high quality, interesting, and relevant standard of information for its readers.

Chair: Katherine Abraham

Members: Alex Jackson
Colleen Steinman
Dulce Felix
Gail Kovacs
Lynda Nolis Salvagio
Maria Cabas
Marty Berger
Robert Allen
Sonia Clarke
Tamara Bilec
Theresa Richard
Viki Scott
Wendy Nailer

Ethics in Vocational Rehab & Law

And how to navigate them

By E. C. Carla Zabek, Barrister & Solicitor

The practice of vocational rehabilitation (VR), as with most areas of human care, has evolved in ways that highlight the importance of ethical issues. Science and research continue to discover new diagnosis and treatment options and clients are increasingly becoming better informed. At the same time, litigation continues to expand in frequency and complexity, and health care professionals of all types must consider in their decision-making the cost and policy implications of their advice and recommendations.

Ethics deals with fundamental questions of right and wrong and the conduct that may follow:

> *"Ethical issues arise when not all values can be respected. The values in conflict must then be prioritized and the essence of 'doing ethics' is to justify breaching the values that are not respected."*
> - Margaret Somerville (1)

In the field of VR, ethics deals with the moral quandaries that arise in the context of providing services to clients. Often, these arise more from the context of the client's condition than from the condition itself. Morality and of course religion provide guidance or answers and attempt to prescribe human behaviour. But the law does as well. As a VR practitioner, you will in the first instance be subject to specific legal regulation focused primarily on standards and competence. But as the provider of a variety of professional services you will also be subject to the standards and restrictions set out in legislation, and as a result of court decisions. These have developed mainly in response to issues in the medical context but whether explicitly or otherwise, they provide a useful framework for ethical (and legal) decision-making in the field of VR.

Guiding Principles Reflected in the Law

Traditional approaches to medical ethics rely on four well-established principles. These are used as starting points for an ethical approach to any activity that involves diagnosis or treatment of a condition afflicting an individual. For the purposes of this article, what is important is that while the regulation of health care professionals varies in detail across Canada, the law strives to further and protect the values embodied in these four principles. Adherence to them is the best way for any health care practitioner to ensure compliance with the law (as well as defending a lawsuit when things go wrong).

These principles are:

"Ethical issues arise when not all values can be respected"

1. Autonomy: the paramountcy of the autonomy of the client

2. Beneficence: the best interests of the client as the guiding criterion in decision-making combined with...

3. Non-maleficence: minimizing harm and striving for equity in the allocation of resources

4. Respect for Human Rights: letting or enabling the client to come to their own decisions (provided there is no issue as to competence or ability to do so) is at the centre of the health care provider and client relationship. This must be so regardless of whether the client's decision is considered by the health care provider to be right or wrong.

The second principle puts the best interests of the client at the centre of any care decision. What is best for an individual in a particular case should emerge from the interaction

between the health care practitioner's best judgment and the client's informed wishes. The most difficult issues arise when these conflict, when they diverge over the course of rehabilitation, or when the bottom line of the analysis really is that there is little or nothing to be done.

"Consent is required before one can provide any form of care"

While at some level it would seem to be either implicit in the role of a health care provider or self-evident, "doing no harm" as a guiding ethical principle has a key role to play in most decisions. This is because few diagnoses and courses of treatment are 100 per cent beneficial or risk-free. To the extent this is the case, it is always necessary to consider the possibility of harm and take steps to avoid or mitigate it whenever possible.

Resources are limited and one cannot help every person who needs it. Every decision to treat results in an allocation of scarce resources. How is this to be guided? The traditional approach says that clients in similar situations should have the same care. In allocating resources, one should assess the impact of the decision on others, not just the immediate others, such as other clients and caregivers or family members, but beyond that: to the system, the institution, society, etc.

Related Principles and their Regulation

More recently we have seen the advent of a set of second order principles which spring from the first four. These concern the concepts of confidentiality and privacy, and of consent and capacity. They involve less subjectivity than the first four principles and better lend themselves to specific legal regulation. Most provinces in Canada have in place statutory regimes for the protection of health care related records and individual privacy, and for the determination of capacity issues in the context of providing client consent to medical treatment. To greater or lesser degree, these various legislative schemes offer useful and effective mechanisms for dealing with these types of issues.

As with other professional relationships where trust is key, client confidentiality implies respecting the client's privacy. This is also an element in preventing discrimination on the basis of someone's condition. Accordingly, most treatment and diagnosis records will be subject to confidentiality (with the exception of situations where a greater harm would flow from maintaining the confidentiality than from breaching it—for example, in cases of matters of public health or of specific conditions such as HIV where there is often a legal requirement to report it).

Court decisions at various levels have clarified that for client autonomy to have full meaning there must also be a related duty on the health care provider to disclose to the client any information that can reasonably be considered relevant to the client's decision. The requirement for consent (which also follows from the principle of autonomy) is of course well-established in law and practice: consent is required before one can provide any form of care. Clear and comprehensive but understandable consent forms will address this requirement but also provide significant protection to a health care provider in the event of litigation.

The application of these principles is seldom easy and they often conflict. That is where a strong ethical framework is required to handle the situations that VR professionals may face during their careers. The law in the form of statutes and court decisions will assist in the decision-making but only to a point. While the vocational rehabilitation practitioner would do well to conduct their work with regard to the legal requirements as much as possible, sound judgment and regard to the basic four principles will always be required.

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

Carla Zabek has been practicing management-side labour and employment law since her call to the bar in 1991. For many years, she was a partner with the Toronto firm of Hicks Morley Hamilton Stewart, Storie LLP, Canada's pre-eminent law firm in the areas of labour and employment law on behalf of management.

CAVEWAS Corner

Ethics in Assessment

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

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. This includes 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.

Oprah Winfrey says "real integrity is doing the right thing [and] knowing that nobody's going to know whether you did it or not." Real integrity is a basic principle for vocational assessors who work in confidential and isolated spaces, and often with clients who have very little knowledge or understanding of assessment processes and protocols. Fortunately, most vocational assessors do practice professionally and ethically.

In vocational rehabilitation, the areas of professional practice that receive the most ethical complaints include privacy/confidentiality, informed consent/choices, client rights, record keeping, conflict of interest, and formal testing. This is one reason why Codes of Ethics have entire sections dedicated to vocational assessment (see Fig. 1).

Fig 1.

Code of Ethics	***Standard/Value Statement***	***Values***
VRA Canada	5. Evaluation, Assessment, & Interpretation "Vocational Rehabilitation Professionals shall provide quality vocational evaluation and assessment services through the use of valid and reliable assessment tools and techniques. Vocational evaluation and assessment services should be provided in a manner consistent with the best practice principles of the profession. They recognize the historical, social prejudices in the misdiagnosis and pathologizing of certain individuals and groups."	5.1 Validity and Reliability 5.2 Informed Consent 5.3 Release of Information to Competent Professionals 5.4 Research and Training 5.5 Competence to Use and Interpret Assessment Instruments 5.6 Assessment Techniques and/or Instrument Selection 5.7 Conditions of Assessment Administration 5.8 Multicultural Issues/Diversity in Assessment 5.9 Scoring and Interpretation of Assessments 5.10 Security 5.11 Obsolete Tests and Outdated Results 5.12 Assessment Construction 5.13 Forensic Evaluation

Fig 1. continued...

Code of Ethics	Standard/Value Statement	Values
College of Vocational Rehabilitation Professionals (CVRP)	5. Evaluation, Assessment, & Interpretation "Certified Vocational Professionals [CVP] will provide quality vocational evaluations through the appropriate selection and use of valid and reliable assessment techniques and tools. They recognize the historical, social prejudices in the misdiagnosis and pathologizing of certain individuals and groups."	5.1 Informed Consent 5.2 Validity and Reliability 5.3 Competence to Use and Interpret Assessment Instruments 5.4 Assessment Techniques and/or Instrument Selection 5.5 Conditions of Assessment Administration 5.6 Multicultural Issues/Diversity in Assessment 5.7 Scoring and Interpretation of Assessments 5.8 Release of Information to Competent Professionals 5.9 Research and Training 5.10 Security 5.11 Obsolete Tests and Outdated Results 5.12 Assessment Construction 5.13 Forensic Evaluation 5.14 Informed Consent in Vocational Evaluation
Commission on Rehabilitation Counsellor Certification	Section G: Evaluation, Assessment, & Interpretation	G.1 Informed Consent G.2 Release of Information to Competent Professionals G.3 Proper Diagnosis of Mental Disorders G.4 Competence to Use and Interpret Tests G.5 Test Selection G.6 Conditions of Test Administration G.7 Test Scoring and Interpretation G.8 Assessment Considerations

The fact that all of these standards exist is evidence these organizations are serious about and committed to promoting high technical and ethical standards for professional level skills and behaviours in the assessment area. In recent years, there has been an increase in discussions about how to make sure proper ethical conduct is not only advocated but also applied as best practice. Even after a code of ethics is adopted, each organization struggles with issues of both enforcement and education.

Educational activities are particularly important. Case studies are highly effective at demonstrating how ethical issues may be analyzed and how judgments may be used to evaluate behaviour. Open forums for discussions of ethical issues, disseminating realistic problems that involve judgments about appropriateness of behaviour, and group learning activities that pose ethical dilemmas are also beneficial to the learner's development.

Conducting Internet research in ethics and assessment is also an interesting experience. In doing so, I came across a website by James Bach's, the owner of Rapid Software Testing (1). So how does this relate?

James has summarized how he stays safe in his business through his code of business conduct. The similarities between technical testing in software and formal testing in vocational rehabilitation are impressive. James' code of conduct includes the following:

- Know what a test is
- Maintain reasonable impartiality
- Report everything that I believe, in good faith, to be a threat to the product (client) or to the user thereof (direct stakeholders), according to my understanding of the best interests of my client and the public good
- Apply test methods that are appropriate to the level of risk in the product (client) and the context of the project (assessment)
- Alert my clients to anything that may impair my ability to test
- Make my clients aware, with alacrity, of any mistake I have made which may require expensive or disruptive correction
- Do not accede to requests by my client (or others) to work in a wasteful, dangerous, or deceptive way
- If I do not understand or accept my mission, it shall be my urgent priority to discover it or renegotiate it
- Do not deceive my clients about my work, nor help others to perpetrate deception
- Do not accept tasks for which I am not reasonably prepared or possess sufficient competence to perform, unless I am under the direction and supervision of someone who can guide me
- Study my craft. Be alert to better solutions and better ways of working.

"Even after a code of ethics is adopted, each organization struggles with issues of both enforcement and education"

Thank you, James, for this insight and reinforcement of best practice. While our association and governing bodies might provide us with the rules and regulations within which we must work and respect, it is up to us to embrace and adopt these guidelines. Like James Bach, we may also choose to establish our own governing principles to better ourselves and our practices.

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.

MEMBERSHIP UPDATES

New Members
Agnieszka Szymanowicz
Andrea Mous
Auspitz Shauna
Barrette-Cairns Julie
Barry Reiter
Basi Manjit
Bator Gustaw
Caroline Xue-Wei Lin
Christine Giroux
Daniel Dalla Rosa
Derek Larsen
Doronne Alexander
Gail Wood-Clark
Heather Cleveland
Heidi Cauvin
Ho Ariel
Iva Keighley
Jamie Lofthang
Jamie Harris
Janice Melvin
Jennifer Gardner
Jennifer McGuire
Johnston Melody
Justin Kline
Kimberly McCormack
Li Sue Man
Lim Jacqueline
Linda Pleskach
Macchia Floriana
Marcus Alexandre
Martynuk Alison
Mary Rose Hackbart
Melissa Correia
Michele Meehan
Nicole Dutchak
Paul Conyette
Rachael Maxcy
Rachelle Ferguson
Russell Crystal
Shanti Shivpaul-Autar
Shauna Streich
Shavonne Powell
Stephanie Wright
Sue Man Li
Swenson Patricia
Tara Topping
Trevor Hassall
Valerie Culham
Vande Vezina
Victoria Holmes
Zeina Hamouche

New RRP
Alan Alinsub
Amy Syed
Andrew Crosby
Andrew Sinclair
Ariel Ho
Cameron Adams-Webber
Caroline Lin
Christine Ruedl
Crystal Russell
Derek Schriver
Gurpreet Buttar
Jaspreet Soor
Jennifer Estabrooks
Jennifer Lam
Jennifer McGuire
John DeDonato
Judith Wiens
Julie Crate
Juliet McEwen
Kara Francis
Katherine Meg MacNeill
Kathleen MacDonald
Kerri-Lynn Lapier
Kristina Belskaya
Leigh Craney
Lovetta Monteiro
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Salam Hassan
Sharon Moseley-Williams
Sharron Phillips
Shavonne Powell
Tami Moffatt
Tina Piche
Trish Joris
Wendy Bluhm
Yasar H. A. Abu-Awad
Yvonne Chau

New RVP
Codie Jordan
Rachael Maxcy
Renuka Goodapati
Vicki Hannon

New RCSS
Christine Giroux
Lisa Pereversoff
Stephanie Wright

TO APPLY for a professional designation, please visit our website:

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

Note from the CAVEWAS President

A brief message from Jennifer Chladny

This year has been a very busy one for CAVEWAS and has included some very exciting developments; none of which would have been possible without the continued dedication of our Board of Directors. I want to express my sincere gratitude to this talented, tireless, and dedicated group who worked along me all year.

They include:

- Marcus Bachmann, Past-President
- Teri Pereira, Secretary
- Renee Daudlin-Iacobelli, Treasurer
- Francois Paradis
- Paul Holtby
- Melissa Bissonnette
- Jodi Webster
- Jeff Cohen
- Scott Munro
- Eleonore Zanette

The following are a few highlights from 2015 pertainig to CAVEWAS and its members:

CCVE

The Canadian Certified Vocational Evaluator (CCVE) credentialing process is well under way. CAVEWAS and the College of Vocational Rehabilitation Professionals (CVRP) have been working closely together to support the implementation of the application process, exam preparation workshop, and study guide. We have commenced the first grandfathering phase of the CCVE and will have the next phase rolled out before the end of December 2015. We expect to see the CCVE pre-exam workshop, study guide, and exam in place by early spring 2016. For those with other credentials, the workshop will be pre-approved for CEUs by both VRA Canada and CVRP through one Attendance Verification Form. It will also be highlighted on the CAVEWAS, VRA Canada, and CVRP websites.

"He or she who serves almost always benefits more than he or she who is served"

The Conference

CAVEWAS held a very successful training session and Annual General Meeting in Ottawa this year. Cameron Adams-Webber shared with us his extensive knowledge and skill in the area of forensics in a workshop titled "Fantasy, Fiction or Fact: What Precisely Is Your Testimony?" René Maillet joined us as well to provide an update on the National Occupational Classification.

Close to 50 people attended in all, some in person and others via live video stream. Feedback has been excellent thus far, encouraging us to hold similar sessions in the future, with live-streaming as much as possible to meet your professional requirement needs. Plans for next year's conference and AGM in Kananaskis, Alberta, are under way.

Education

Your Education Committee is working towards adding more training seminars and workshops for 2016, including the CCVE pre-exam workshop as well as training in psychometrics and standardized testing measures and in Transferable Skills Analysis (TSA). We will make use of enhanced technology as we accommodate our national membership and our current Certified Vocational Evaluator (CVE) and Registered Vocational Professional (RVP) designation holders.

In collaboration with VRA Canada's Education Committee, we are also investigating external conferences, seminars, and courses that reflect assessment and work adjustment

domains. We will be negotiating reduced rates for you to attend these events and will ensure wherever possible that activities are pre-approved, so uploading Continuing Education Units to your profile will be simpler and more effective.

CAVEWAS will be launching an improved website in early 2016. This new site will allow us to offer online workshops, seminars, and courses.

Other Initiatives

- Continuing to develop articles for CAVEWAS Corner in *Rehab Matters*
- Working with VRA Canada to market and promote the services we offer
- Working closely with various newly formed VRA Canada committees like Government Relations, Community Relations, Research & Development, and Information Management (website) to ensure the voice of CAVEWAS members is heard
- Supporting a new VRA Canada/CVRP action plan to more clearly define roles and functions, and to move designations to CVRP over time

We Need You

Like others before me, I would like my presidency to matter to the growth of CAVEWAS and to the evolution of the field, but I cannot do it without you. Author Gordon B. Hinckley said "One of the great ironies of life is this: he or she who serves almost always benefits more than he or she who is served." Stand up and be counted. We need your help now.

Sincerely,

Jennifer Chladny
CAVEWAS President

Jennifer Chladny began working in the field of vocational rehabilitation in 2000 and has been a Registered Rehabilitation Professional (RRP) since 2005 with the VRA Canada. She also holds a Certified Vocational Professional (CVP) designation. Jennifer is the current president of the CAVEWAS Society of VRA Canada.

Dr. Jean Pettifor

1922

2015

Dr. Jean Pettifor, a leading figure in promoting the importance of ethics in clinical psychology and research, passed away at the age of 93. Her passion was for professional ethics in psychology, and one of her proudest achievements was co-authoring the Canadian Psychological Association's Code of Ethics, which has been used as an example and model by psychological organizations around the world.

Jean is remembered by colleagues and friends, here:

Dr. Pettifor was an educator, a mentor, a colleague, a mother, a gardener, a traveller, a writer, an editor, Jean. For me, her most relevant role was that of educator. She taught me, and others, that every situation is unique and that ethical decision-making evolves over time.

The first time I met Jean was when I was a student at the University of Calgary in the late 1900s (Jean would enjoy this reference). The first thing I noticed about Jean was her wonderful hair and the fact she looked more like a favourite grandmother than a university professor globally recognized for her work in ethics. Jean captivated her students with her poignant stories—she made learning a joyful event.

With Jean's passing, I have absolutely no doubt that she has a new role, and I hope she will be looking over me in my role as teacher.

- Arlene Ward

"Ethics are important to everyone, not just psychologists, because ethics guide us in how we relate to other human beings."

– Dr. Jean Pettifor

Once or twice in our lives, we are fortunate enough to meet a person who makes a profound impact on us. This happened to me in 2001, when I attended my first ethics class at the University of Calgary, led by Dr. Jean Pettifor.

From the moment Jean started speaking, I knew something remarkable was happening. She had an extraordinary way of talking about ethics—so wise, so intense, so insightful, yet never arrogant or boastful.

Jean's deep caring and respect for people and the ethics we use to conduct ourselves really resonated with me. I don't know how she was able to transfer information so that it fit into my head and stayed there without any effort from me; I guess this is what it feels like to be inspired!

Jean inspired everyone. She changed the world by changing people and entire professions through her dedicated and never-wavering commitment to ethics. And she did all this with such tremendous humility and grace.

It was a distinct honour to meet Jean and spend time with her. She will be so terribly missed, but her astonishing work will live on forever in all of us!

-Val Lougheed

Thank you, Jean.

VRA Canada's CODE OF ETHICS | Building Trust, Respect, & Integrity

Did you know that VRA Canada has its own Code of Ethics? We do; in fact, our Code of Ethics is one of the 11 components that makes us Professionals by definition.

It is incredibly important for our association to work within the guidelines of a code of ethics, not only for our members but for the clients we serve as well.

A copy of the VRA Canada Code of Ethics can be found on our website, at www.vracanada.com/ethics, along with addtitonal ethics-based resources.

Why do we have a Code of Ethics?

VRA Canada members believe in maintaining a highly ethical relationship with our clients, in accordance, we have established a thorough code of ethics based on four key principles:

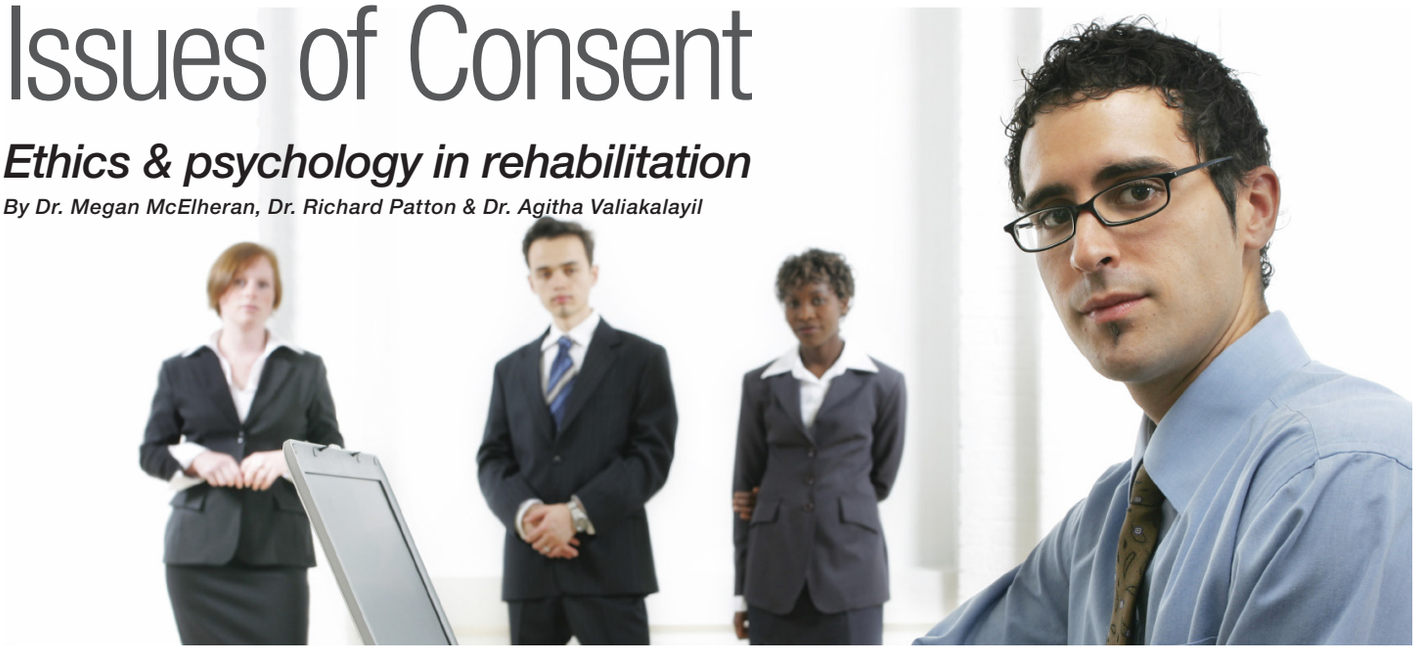
- Respect for the dignity and autonomy of persons
- Responsible caring for the best interests of persons
- Integrity in Professional relationships
- Responsibility to society

Our members maintain the highest levels of professionalism and excellence; our Code of Ethics is the recognized standard for professional practice of vocational rehabilitation in Canada.

Issues of Consent

Ethics & psychology in rehabilitation

By Dr. Megan McElheran, Dr. Richard Patton & Dr. Agitha Valiakalayil



Psychologists receive extensive training in ethics and ethical considerations in the provision of clinical services. Psychologists are trained in numerous models to assist in ethical decision-making; their training is also comprised of core principles, which include responsibility and duty (e.g., legal duty to protect, duty to maintain confidentiality). Identifying responsibilities and duties is one of the most important initial considerations within an ethical decision-making process and is essential to the establishment and maintenance of an effective therapeutic relationship.

This process can become complicated when more than one client is identified, as with third party referrals. It can be difficult to identify and prioritize who the client is, to whom duty is owed, and what level of third party involvement is necessary to satisfy the referral goals and provide the best possible treatment and support to the client. In these situations, there are implications for confidentiality, provision of treatment, and establishment of rapport within the therapeutic relationship to achieve successful treatment outcomes.

As psychologists, ethical clinical practice is guided by training in clinical decision making, understanding and using empirically supported treatment approaches, and consulting with sources such as the Canadian Code of Ethics for Psychologists, Standards of Practice, and relevant legislation (e.g., Health Information Act) to balance these numerous and sometimes competing interests. In practice, this process can be challenging to navigate and requires willingness to engage in ongoing dialogue with all relevant parties, and continuing reflexivity about how clinical practice can be improved with regards to consent.

The establishment of a strong therapeutic alliance (or working relationship) is necessary to create the open and collaborative atmosphere required to facilitate progress in therapy. Establishing rapport early in the process, and engendering trust throughout treatment, are crucial to strengthening this working alliance. Clients require a certain level of comfort and safety with the therapist to discuss personal, and often difficult, psychological issues. As such, clarifying concerns relevant to consent in the context of third party involvement involves balancing the needs of the client (e.g., to privacy, confidentiality), with those of other stakeholders (i.e., insurance companies, employers, other professionals involved in treating the client—physical therapy, occupational therapy, etc.) who are involved in the rehabilitation process.

> *"Creating a therapeutic environment that is open and transparent engenders trust"*

Clients may understandably be concerned about what information about themselves may be shared with others, and how this may impact their livelihood, or access to benefits. These issues can make it challenging for the client to establish or maintain trust in the treating therapist. Psychologists endeavor to ensure that clients understand what information may be released, to whom, and the reasons for providing this information throughout the treatment process as part of the informed consent process. Creating a therapeutic environment that is open and transparent, and demonstrating a willingness to discuss emerging concerns, engenders trust and can offset potential misunderstandings about how information is shared.

What has emerged from our understanding of the unique circumstances surrounding third party consent is that there is a need for specific adaptations within the clinical service delivery context. There are three main clinical adaptations we understand to be consistently required:

1. The informed consent process must be modified. In standard clinical care, the informed consent process occurs between the psychologist (or other mental health professional) and his or her client(s). When providing psychological service as part of a rehabilitation process, the consent process must be broadened. Ethical service delivery insists that clients understand the exact nature of how information will be shared, what information will be shared, and his or her rights to privacy within this arrangement. As a result, the process required is lengthier, and must involve more specific questioning to ensure that clients understand third party involvement.

2. Consent is bi-directional. Within a standard psychological service delivery arrangement, the psychologist and client

review issues related to informed consent relative to their working relationship. With third party involvement, an additional step is recommended—ensuring that the third party agrees to the terms of consent. It is recommended that providers of mental health service consult with the referring party from the rehabilitation organization to ensure they are in agreement with the terms of consent. Ensuring from the outset that there is understanding regarding what information will be shared, and that all parties agree, mitigates the potential for conflict or misunderstanding after treatment has begun.

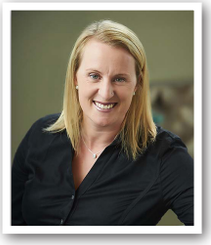
As an illustrative example, a client recently had concerns regarding the involvement of his rehabilitation consultant in his psychological treatment. As part of the informed consent process, it was necessary to discuss his concerns related to the degree of detail that would be provided to his rehabilitation team. The initial therapy session therefore became a process of discussing what kinds of information would be shared with his rehabilitation consultant. In order to ensure all parties were agreeable to this arrangement, an extra process of having him discuss his concerns directly with his rehabilitation consultant was organized so that they could together agree to the limits that would be established relative to the details of information that would be shared. Following their conversation, and a conversation the psychologist had with both parties to confirm this agreement, therapy was able to progress.

3. Consent is dynamic. It is important to recognize that issues understood at the outset of psychological treatment may become illuminated to a greater degree as therapy progresses. There is always the possibility that new information will emerge that may or may not be relevant to the rehabilitation program. Therefore, it is essential to remember that consent is dynamic, and often issues related to consent need to be re-visited throughout the treatment process and with the rehabilitation team. Recognition of this possibility enhances the probability that consent-related issues will be addressed before conflict develops.

As another illustrative example, this issue was recently confronted when a client disclosed issues related to domestic violence that resulted in her being repetitively injured. These injuries were aggravating the chronic pain that disabled her from being able to work, and that had necessitated her being absent from her job. The immediate concern in this instance related to the safety of the client; risk management interventions were put into place. A discussion in therapy regarding the sharing of the abuse she had suffered with her rehabilitation consultant occurred, in which the client decided for herself that she would inform her provider of the abuse and the injuries she had been suffering. Her rehabilitation consultant was then able to provide her with extra support relative to her safety plan, and helped her to determine how to negotiate financial issues relative to her benefits as the client worked to leave the abusive relationship. This is an example of how all practitioners, including the rehabilitation consultant and the psychologist, can work collaboratively to support the healing and recovery of clients.

The above principles have emerged through our work as psychologists with clients engaged in rehabilitation programs. These are important and complex considerations we regularly make in our work with rehabilitation clients, having come to recognize how the process of consent is unique when third parties are involved.

APPROVED



Dr. Megan McElheran is a Clinical Psychologist with WGM Psychological Services in Calgary, AB. She completed graduate training at the Stanford University clinical psychology consortium, where she obtained specialized training in the treatment of PTSD. She continues to focus on work with first responders, and her clinical practice involves work with active-duty members of the Canadian Forces, the RCMP, and local firefighters. She completed a TEDx speech in 2011 related to Trauma, Change, and Resilience.

Dr. Richard Patton obtained MSc and PhD degrees in Clinical Psychology from PGSP-Stanford Psy.D. Consortium, California. Patton also earned a BSc Psychology, MA Cognitive Psychology, and a certificate in Applied Behavior Analysis from University of Manitoba. He specializes in treating anxiety, depression, and PTSD.

Dr. Agitha Valiakalayil earned her PhD in Clinical Psychology from the University of Saskatchewan. She has also earned a Master's degree in Psychiatry, and undergraduate degrees in Biology and Psychology, from the University of Alberta. Her areas of clinical interest include mood and anxiety disorders, trauma, interpersonal difficulties, assertiveness, self-esteem, and stress management.

Points to Ponder

Ethical use of technology in vocational rehabilitation settings

By Dr. Deirdre Pickerell, CHRP, GCDFi & Dr. Roberta Neault, CCC, CCDP, GCDFi

We live and work in a world increasingly influenced by, and integrated with, information and communication technology (ICT). Whether it's via cable, satellite, or mobile networks, we are more connected than ever. According to one recent study, Canadians are amongst the biggest users of the web (1), on average spending more than 36 hours a month online. Social media seems to be the biggest draw with approximately 50 per cent of Canadian Internet users on Facebook every day (2). Canadians' use of Twitter is also expected to increase 2.5 times faster than Americans' use (3). Employers, including human resource professionals and recruiters, are also embracing technology. Peter Harris noted in a 2015 article for Workopolis (4) that "45 per cent [of employers] are researching potential candidates using social media" and what employers find can be the difference in whether a candidate gets hired or not. Of course, it isn't just social media; between 50 to 70 per cent of employers are using web-based employment applications (5) and both training and counselling are now being offered online (6; 7). However, studies have shown that many of those working in career and workforce development have been slow to embrace technology (8).

The use of ICTs within vocational rehabilitation also seems inconsistent and unclear. McGuire-Kuletz and Froehlich (9) found that 67 per cent of the vocational rehabilitation professionals surveyed were using social media within their professional practice; in that same research, however, they acknowledged the lack of written guidelines and/or training around ethical usage. Conversely, Ipsen, Goe, and West-Evans (10) found that "counsellor access to social media is limited in many agencies," noting concerns around confidentiality and privacy, ethical issues, and a lack of understanding of how to integrate social media into professional practice. In a publication for the US-based National Career Development Association in 2015, Julia Panke Makela (11) provided a comprehensive overview of ethical considerations in integrating social media into career services.

> *"50 to 70 per cent of employers are using web-based employment applications"*

The increasing popularity of ICTs, including the assumption that it is an accepted communication method, has an impact on the work of vocational rehabilitation professionals—whether or not they choose to integrate technology into their practice. Barros-Bailey and Saunders (12) provided a brief historical overview of ethical considerations related to technology use in vocational rehabilitation settings—for almost 20 years now, this has been an important discussion within the sector. Similarly, McGregor and Radman (6; 13) discussed ethical considerations in eRehabilitation. Using VRA Canada's Code of Ethics (14) as a framework, this article highlights points to ponder when using (or choosing not to use) technology.

Section 1 – Professional Relationships is focused on how vocational rehabilitation professionals interact with clients. Technology has the potential to both help and hinder the development of professional relationships. For example, to involve family and/or significant others (1.4), technology that facilitates video-conferencing (e.g., Skype) may be helpful and a tool familiar to family members. However, publicly available tools such as Skype do not have the privacy and security features required by many confidentiality agreements and privacy protection laws (6). This results in an ethical dilemma: using the tool facilitates accessibility and inclusion, not using the tool protects privacy and confidentiality.

Within this same section, Point 1.8 of the Code relates to dual relationships which, of course, are to be avoided whenever possible. However, social media sites (e.g., Facebook, Twitter, LinkedIn, Instagram) can blur the boundaries, especially in instances where the account holder has limited control (i.e., Twitter users can follow anyone). It is widely accepted that LinkedIn is the social media platform for business relationships but less clear how individuals may be using Facebook. Therefore, an ethical dilemma may involve deciding which invitations or "friend requests" to accept under what circumstances, and why. Will welcoming a client into your LinkedIn network open up job leads? Might you inadvertently find yourself in a dual relationship by joining the same LinkedIn group or "liking" the same Facebook page?

Section 2 – Confidentiality is, understandably, a huge area of concern when it comes to technology-assisted communication, especially when using ICTs not specifically designed for secure and confidential transmissions or storage. On one hand, technology has many

benefits, allowing us to connect literally anytime and anywhere. This, of course, can strengthen professional relationship and enhance services. In just seconds, an email or fax can transmit a signed document or information that a client has given you permission to release; mailing the same document may result in a lengthy delay. Despite this efficiency, however, most email services cannot be considered secure—either during transmission or upon receipt (i.e., there is always a question of who might see an email or a fax when it arrives). However, even "snail mail" goes astray and although it comes in an envelope there is no guarantee that someone unauthorized won't open it.

Section 3 – Professional Responsibility is another area where use of technology can be a double-edged sword. Email communications or recorded online meetings (with the client's permission, of course) can be shared with supervisors to facilitate helpful coaching and feedback, supporting monitoring effectiveness (3.8), and consultation about ethical issues (3.9), or about client needs (3.23); similarly, technology can provide better access to supervision, especially for vocational rehabilitation professionals who are self-employed, working in remote locations, or faced with their own mobility challenges. However, confidentiality and privacy issues remain a concern. Becoming comfortable with technology can also facilitate access to continuing education (3.10), for vocational rehabilitation professionals as well as their clients. Research in the career development sector, however, has revealed a general reluctance to learn online (8). An important point to ponder, then, is: How might your own views on technology be impacting the choices you are offering your clients, or your ability to critically evaluate the viability of an e-learning program that interests them?

Section 4 – Advocacy is an area where technology offers great opportunities within the vocational rehabilitation context. This fits with accessibility within your own practice (4.4) as well as advocacy for reduced barriers to access throughout the community and specific educational facilities, service providers, or workplaces (4.5 and 4.6). However, reluctance to meet online, lack of understanding about virtual workplaces, or distrust of e-learning opportunities may impact your ability to effectively advocate for clients or meet their identified needs. Social media, previously discussed, is also a powerful advocacy tool. Another point to ponder, therefore, is: How might you more effectively integrate social media into your professional practice?

Section 5 – Evaluation, Assessment, & Interpretation is another area where technology has had a significant impact in recent years. Points to ponder here include whether or not you are using the most valid and reliable assessment tools available, how you are administering and interpreting assessment results, and, if you are administering assessment tools remotely, how you can ensure that the individual you intend to test is the one actually sitting at the computer Also, technology can facilitate quality assurance within your own programs and services through the use of Internet-based surveys, virtual focus groups, feedback links on your website, and even something as straightforward as picking up the phone to follow up.

"Technology has the potential to both help and hinder the development of professional relationships"

Section 6 – Business Practices is another technology-infiltrated area. A point to ponder is: Have your own business practices incorporated relevant technologies to enhance efficiency, accessibility, and excellence? Consider all forms of technology, from your website (to what extent is it following the latest accessibility principles?), to your phone and email systems, to the technology-assisted physical components of your office location (including signage, buzzers, doors, and elevators). A relevant excerpt from this section of the Code cautions that professionals "take precautions to ensure their potential biases, professional competence, and limitations of their expertise do not lead to or condone unjust practices" (14). Reflect on whether your personal biases for or against some technologies, or lack of comfort and competency with technologies, might be impacting your ability to offer just and effective services.

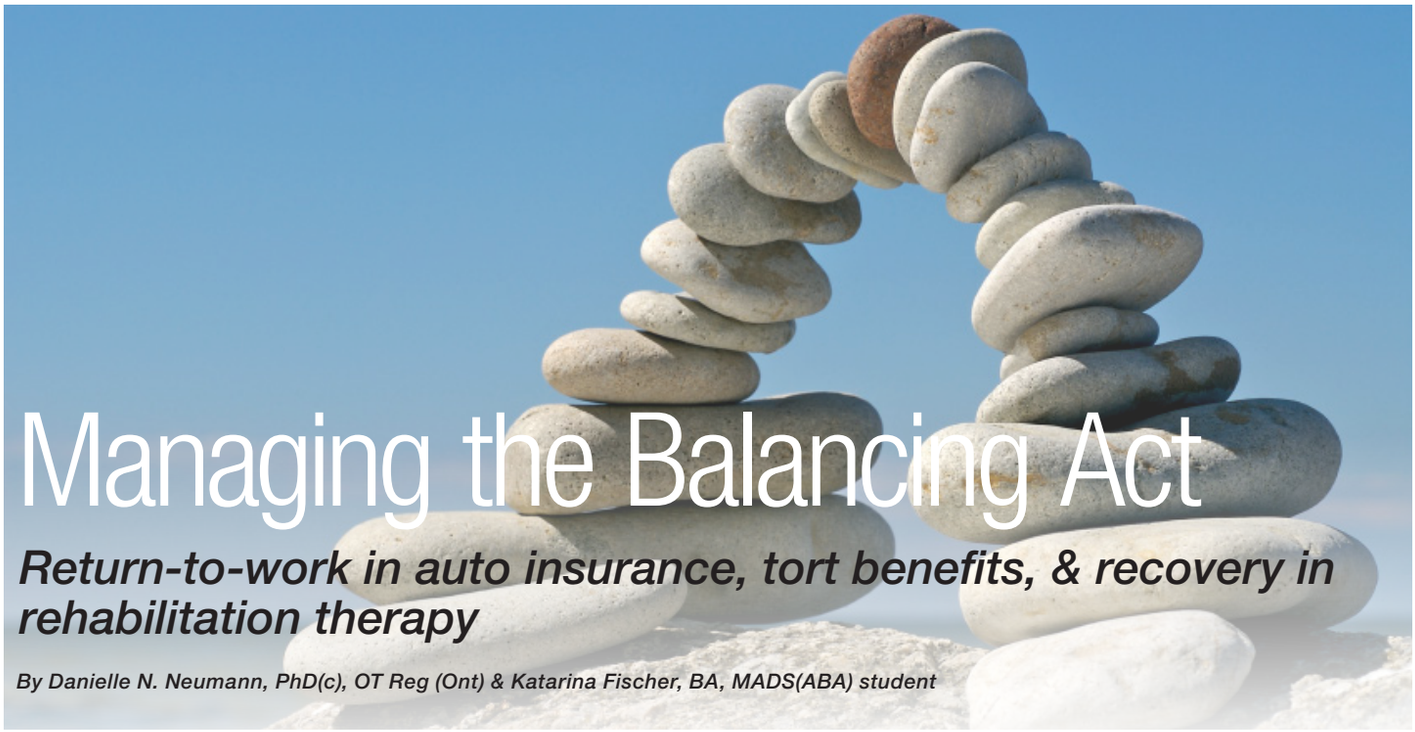
Section 7 – Teaching, Training, & Supervision has already been addressed to a certain extent in the preceding sections. Points to ponder here include: Are you comfortable integrating emerging technologies into your teaching, training, and supervision roles? And, if not, how you might build both comfort and competency? Facilitated e-learning courses, webinars, YouTube videos, dedicated LinkedIn groups, and TED Talks can easily reach employees, colleagues, students, supervisees, and clients in remote locations (assuming Internet is available). Live (synchronous) sessions can be recorded for later viewing or listening, stretching professional development budgets and ensuring consistent training opportunities as new members join the team.

Section 8 – Research & Publication is the final section of the Code and it, too, has been impacted by technology. There are overlaps here with roles previously mentioned (e.g., teaching, training, and advocacy) but also additional considerations in terms of conducting ethical research and disseminating research results in ways that will have the greatest impact. In the research methodology section of the Code (8.1), for example, researchers are called to ensure that their literature reviews are comprehensive; it's inconceivable in our current global knowledge-based society that such research wouldn't include, at least in part, a search of online publications and databases. Research collaborations may begin through social media, and research results may be shared back to those same groups, as well as written up in blogs; e-zines; association e-newsletters; or peer-reviewed academic journals, most of which are now online. Of course, confidentiality remains a huge concern and it's imperative that published results not reveal any identifying information.

In many of the scenarios presented here, it can be challenging to balance diverse ethical principles while incorporating emerging technologies into the day-to-day work of vocational rehabilitation professionals. Employing an ethical decision model can help identify and evaluate a viable solution. Longer term, ethical codes will need periodic updates and agencies will need to introduce and/or re-evaluate policies to ensure that ethical use of emerging technologies facilitates high quality, accessible, and efficient client services.

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

Authors Deirdre Pickerell (2014 winner of the Stu Conger Award for Leadership in Career Development and Career Counselling) and Roberta Neault (Gold Medal and Diamond Pin for Leadership in Career Development recipient) lead Life Strategies Ltd., an award-winning, project-based organization with a long history of service to the career development and vocational rehabilitation community. Both teach courses, present workshops and webinars, and write on ethical practice within career and workforce development, and are avid users of social media.



Managing the Balancing Act

Return-to-work in auto insurance, tort benefits, & recovery in rehabilitation therapy

By Danielle N. Neumann, PhD(c), OT Reg (Ont) & Katarina Fischer, BA, MADS(ABA) student

Case Study: *Seven years ago, 25-year old Jillian was involved in a car accident. While waiting to turn left at a light, the car that she was driving was struck from the side by a vehicle that ran a red light. Her vehicle sustained significant impact on the front driver's side, and secondary impact on the rear driver's side. Immediately following the accident, Jillian experienced headaches, vertigo, loss of consciousness, neck pain, left shoulder pain, and left hip pain. She was later diagnosed with post-concussive syndrome, several spinal compression fractures, myofascial pain in the left neck and trapezius area, and acute post-traumatic stress disorder. She has not returned to driving, despite completion of a driving assessment and subsequent training sessions. She has not returned to work as a child and youth worker, and she has had several unsuccessful attempts to return to university, where she had previously been completing her undergraduate degree in psychology. Over the past seven years, she has engaged in a range of therapeutic interventions with more than 20 different therapists, including independent evaluations by medical and rehabilitation professionals. She has gained more than 130 pounds since the accident, and currently spends the majority of her day in bed or in her recliner, at her parents' home. At the age of 32, she is severely depressed and relies on her parents to support her with her basic activities of daily living. Jillian hopes that her settlement will work out in the near future, so that she can "get on with her life."*

As an occupational therapist providing vocational rehabilitation that is funded through the auto insurance sector, Jillian's story is all too familiar. My clients have endured a great deal of hardship and occupational change as a result of their injuries, and often they have previously engaged in therapy with goals for recovery and overcoming barriers to achieving maximal quality of life. I am often faced with the dilemma of attempting to provide rehabilitation services to clients who wish to delay return to work in favor of maximizing the effects of their disability until a settlement is received. Reaching a settlement usually takes years, and at some point, many clients stop engaging in therapy. For some clients, this is because there is an undeniable emotional and psychological toll associated with unnecessary delays in the resolution of tort claims (1). Delayed judicial attention to the effects of an injury is associated with exacerbating the injuries of plaintiffs, and has enormous impacts on their psychological health (2; 3).

For other clients awaiting a tort decision, they experience psychological effects because they are anxious about losing benefits. The literature is not kind to these clients; a quick search of the terms "malingering," "disability syndrome," "compensation-seeking," "extreme exaggeration," and "assumed illness" will lead to several case studies that describe clientele like Jillian in a negative light (4; 5; 6; 7). As a therapist, it is sometimes easy to identify these clients—one client told me explicitly—"I don't want to volunteer right now, my lawyer wants me to wait until my court case is done." But not all clients are as forthcoming with the truth—some clients may demonstrate behaviours and cues that indicate this way of thinking, without explicitly letting you know. As a therapist charged with the responsibility of assessing functional ability and engagement, this can be a tricky situation to navigate. Questions that come up include:

- How do you trust your client, the rehabilitation team (including the lawyer), and/or your own judgment when assessing the validity of situations where the client is not engaging in therapy?
- Who is my client here? How is it that the personal injury lawyer is hiring me to provide the service (of rehabilitating the client), but seems to be advising the client not to engage in my therapy?
- Is my professional opinion being "bought" in these situations?

This article will draw on the larger research literature base, information from lawyers, and published case studies to examine a sample of situations in order to offer some clarity for rehabilitation professionals. The authors offer a set of a "clinical cues" from the occupational and behavioral analysis perspectives in order to help vocational rehabilitation professionals consider the client context and develop a roadmap for ensuring that they are preserving their professional integrity while also respecting client autonomy and performing their expected duty as a rehabilitation professional in their specific field.

The Client Perspective

Initially following an injury, clients tend to be

highly motivated to resume engagement in meaningful occupations such as returning to work, volunteering, as well as activities of everyday living that require physical function. This desire to resume engagement in everyday activities, as well as improve overall functioning, may often be challenged by the fear that one's successful rehabilitation within these previously assumed roles and occupations may result in the potential rejection of their claim (4). As a result, "pain behaviours," characterized by either a conscious or non-conscious focus on the pain experienced by an individual are often demonstrated with "an effort to legitimize their injury and themselves when under the stress of facing an adversarial system" (8). Hanson-Mayer (5) refers to these injury-related behaviours in which clients may engage as a combination of coping mechanisms. Coping is demonstrated as a means of both reconciling the client's newfound, consequent disability and functional limitations, while subsequently securing a potential solution (greater compensation) to these life-altering effects. This prolonged period of disability is described within literature as an incongruent, and, at times, increasingly exaggerated representation of post-injury symptomology, due to the stress associated with obtaining the maximum amount of compensation possible (5; 4).

A behavioural perspective regarding these "coping mechanisms" refers importantly to the social contexts and environments in which treatment occurs (9). Often, the pain behaviours, as compared with recovery-focused behaviours demonstrated by clients throughout the therapeutic process are maintained by socially mediated reinforcers, such as the social attention garnered from family members, other health care providers, the treating rehabilitation therapist, as well as the lawyers involved with the respective claim (10). Importantly, this engagement in pain behaviours (despite an individual's current level of functioning) is contingent upon the presentation of socially mediated reinforcement that confirms the debilitating and life-altering effects associated with a client's respective condition post-accident/injury. It is the presentation of this socially mediated reinforcer that may arguably be immediately reinforcing and increasing the occurrence of pain behaviours demonstrated throughout the therapeutic process, while the receipt of compensation acts as a delayed reinforcer that influences the increased occurrence of this behaviour. Further, as these pain behaviours are reinforced, recovery-focused behaviours that include engagement in everyday activities such as work, volunteering, and leisure activities may be extinguished as a result of discontinued positive reinforcement contingent on the occurrence of these recovery-focused behaviours (10). As a result, we ultimately may see an increase in pain behaviours that disrupt the rehabilitative process, in addition to a simultaneous decrease in 'rehabilitation-focused behaviours' that would otherwise promote and support the rehabilitative process.

"Reaching a settlement usually takes years, and at some point, many clients stop engaging in therapy"

The Lawyer Perspective

Many clients erroneously believe that their legal case is over if they return to work, or demonstrate that they are enjoying new roles or activities while living with the effects of a disability; however, personal injury lawyers stress that this is not the case (11; 12). If a rehabilitation therapist has been hired by the lawyer to provide assessment and rehabilitation services, the lawyer expects that the therapist will demonstrate informed and objective assessment in order to provide strong and credible evidence regarding the functional abilities of the client, so that their position is supported if the case does move to the court environment. Unreasonably missing time from work and other productive roles can hurt a claim, while attempts to return to work suggest a good work ethic and draw attention away from the secondary benefits associated with a tort claim (8). While the literature indicates that there is a strong belief that legal representation is a deterrent to returning to work and previous function (8); closer analysis of the larger evidence base suggests that severity of injury—and subsequently, length of time away from previous occupations—is a more reliable predictor of return-to-work. For example, if a client is away from work because of an injury for:

- 20 days, the chance of return to work is 70 per cent
- 45 days, the chance of return to work is 50 per cent
- 70 days, the chance of return to work is 35 per cent (13)

Litigation does not often correlate with an improvement in reported psychological or physical symptoms (14); in fact, health status often deteriorates as a result of decreased access to costly rehabilitation services following settlement.

In short, lawyers suggest that it is in the best interest for clients/claimants to fully engage in therapy. If a client has demonstrated reasonable effort to resume previous roles and activities, has engaged in therapy, and has not been successful—they can expect that this will demonstrate an increased impact on their quality of life, resulting in an increase in benefits. Conversely, if a client is not attempting to engage in therapy then it is perceived as malingering and compensation-seeking behaviours, subject to prolonged scrutiny.

The Therapist Perspective

Vocational rehabilitation professionals have a duty to their association and to their respective colleges to apply ethical frameworks to solve ethical situations, to demonstrate professional integrity, to practice in a client-centred manner (despite third-party involvement), and to protect the client's best interest (15). In the world of rehabilitation, we are very much aware that "early intervention" of best practices regarding incurred injury is always associated with optimal outcomes. The "client" who received priority consideration in ethical situations regarding vocational rehabilitation is always the injured person, the shared client between lawyers and therapists/counsellors. Vocational counsellors must demonstrate accountability to the code of ethics outlined by their profession, and must always practice in a manner that represents the best interests of their clients. At times, this may mean that the therapist needs to address clinical cues that a client may not be acting in his/her own best interest with regards to intentional engagement in therapy. The therapist must be poised to identify and intervene regarding clinical cues.

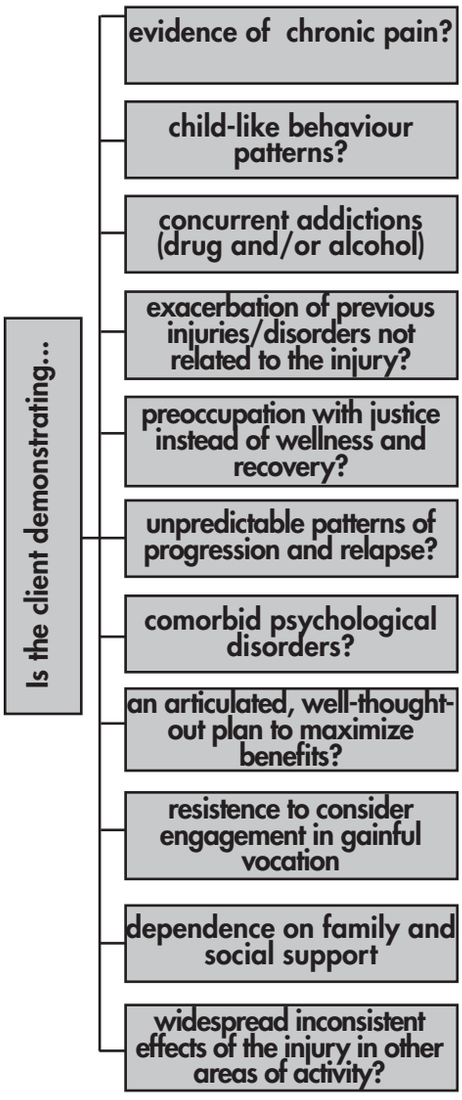
Rehabilitation therapists, counsellors, and other professionals involved in the vocational rehabilitation process are uniquely skilled to provide a wide variety of services to individuals with disabilities. While the roles and functions that are assumed by the rehabilitation professional will vary depending on their core profession and the industry in which service is delivered, the underlying goals are shared: we all work in a client-centered approach to engage the injured client in rehabilitation in order to enable them to return to meaningful vocational pursuits.

Clinical Cues

The therapeutic relationship assumed between a therapist and client may be influenced by a number of client-demonstrated behaviours that

affect the level of engagement, as well as the ultimate success of the therapeutic process. The therapeutic relationship, within this case, faces a sort of push and pull between therapist and client, in which the "push" to establish and regain functional abilities with respect to occupations that are meaningful to the client, meets a sort of resistance, or "pull" from the client to fully engage in the therapeutic process. This push-and-pull relationship may further be characterized by behaviours and attitudes that reflect a client's preoccupation with the award and amount of compensation that is ultimately believed to be proportionate to the pain and suffering they have experienced (5; 4). In this case, the client begins to view the therapist as a threat to their goals for compensation, and they adopt a disability-oriented lifestyle that is characterized by an inconsistent pattern of engagement and relapse, and an increasingly evident preoccupation with pain and security. Figure 1 lists several cues that are consistent with a client who has adopted a disability-oriented lifestyle focused on prioritizing compensation over recovery.

Fig 1. Clinical cues to identifying the compensation-focused client



Evidence-based Interventions

The best way to cope with an injury is to minimize its effect on functioning. For clients like Jillian, as identified within the case study, the injury has often permeated every facet of their daily lives, and the client begins to live a life that is defined by the disability. In order to understand the effect that the injury has had on the client's lifestyle, it is important that the rehabilitation professional explores both the history of the injury, and the current context of the resultant disability. Consistent with a cognitive-behavioural approach, evaluating the client's thoughts, beliefs, and concerns about the injury and perceptions regarding its impact on returning to work, as well as resuming other meaningful occupations within everyday life, provides a strong basis for understanding the client's motivations for engaging in the behaviours that have been noted (8). Effective, client-centred and empathetic communication is key to this role—ask the right questions and explore the client's perception in a comprehensive manner. Consider the following:

- What occupations, roles, activities have been affected?
- What are the client's current interests? Have they changed post-injury?
- What is the client's current physical, psychological, and pain state?
- How long has it been since the accident and how have circumstances changed?
- Did the client like their previous job? Did they love it? Are they motivated to return? Why or why not?
- Can the client actually return to their previous vocation, or is retraining necessary?
- What are the barriers to returning to work, as experienced/perceived by the client?

Following initial exploration, the authors recommend that you seek consent to consult with other members of the rehabilitation team and the client's support team to explore further. You may find that consulting with the lawyers, previous therapists, the other (current) therapists on the team, and the client's social support network will lend insight into the motivation and lifestyle of the client. The next step is then to assess the clinical cues that you have identified, as necessary—using the best practice tools that are recommended for your role and profession.

Following these areas of exploration, the best practice recommendations for all professions tend to be grounded in an empathetic, client-centred approach that appreciates the complex connections between psychological and physical impacts of injury at the level of the person, the social and cultural environment, and the valued activities and vocations in which the client is engaging. Interventions should be focused on enabling lifestyle changes so the client can overcome a preoccupation with a disability-oriented lifestyle, and instead adopt a recovery-focused lifestyle that does not discredit the injury, but is also not grounded on the injury. Techniques that are effective include motivational interviewing (16), transtheoretical models of intervention that are based on the stages of change (17), coaching, mindfulness/relaxation, and cognitive-behavioural therapy (CBT). The therapist should ensure that they do not attempt to discredit the client's understanding of the source of the pain (i.e. if the client believes there is a physical source, do not attempt to discredit this understanding while explaining the psychological sources that could be contributing to the experience).

In order to successfully engage in vocational rehabilitation programmes, it is further understood that the client must begin to build a new routine of daily activities and behaviours that are not grounded around the injury. Achievement of control around their basic environment and symptoms can lead clients to feel motivated to become more self-directed in goal attainment around vocational activity.

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

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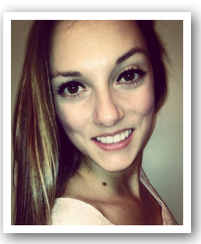


Katarina Fischer is an occupational therapist assistant and is currently pursuing a Master of Applied Disability Studies with a specialization in Applied Behaviour Analysis at Brock University. She also works as an Instructor Therapist with the Quinte Assessment and Treatment Group providing intensive behavioural intervention (IBI) training with children who have a diagnosis of Autism Spectrum Disorder (ASD). She can be reached at kf14sj@brocku.ca.

How to Be an "Expert" Expert

Tips for an expert witness

By Wendy Moore Mandel & Deanna Gilbert

The determination of the legal disputes that arise out of complex personal injuries has become more and more dependent upon the observations and opinions of health care practitioners. Therefore, the ability of health care practitioners to communicate their observations and opinions in the legal arena is vitally important to all patients who are unfortunately involved in a serious injury case.

An "expert" in a legal case is someone who is considered to have special skill, knowledge, training, or experience, such that their observations and opinions will assist the ultimate decision maker (a judge or jury) in adjudicating a legal case.

Often, treating health care practitioners are eager to help their injured patient but are unfamiliar with what may be involved. Equally, independent health care practitioners might be keen to assess the plaintiff for litigation purposes, but are reticent about ultimately having to testify in court. The goal of this article is to provide potential medical expert witnesses with some (brief) insight into what may be involved in the process.

Procedure in a personal injury legal case is governed by a set of rules called the Rules of Civil Procedure (the "Rules"). There are two primary Rules which govern the contents of expert reports: Rule 4.1 and Rule 53.03.

Rule 4.1 sets out the duty of an expert. It provides that an expert must:

- provide an opinion that is fair, objective, and non-partisan
- limit the scope of his or her opinion evidence to that which is within the scope of his or her expertise
- otherwise assist the court as may be reasonably required to determine an issue

The Rule further confirms that the expert's duty to the court overrides any obligation to the person by whom the expert was retained.

Rule 53.03 describes (among other things) the information that must be contained in the report. Expert's reports must include:

- the instructions provided to the expert
- the nature of the opinion being sought
- the opinion and, where there is a range of opinions, an explanation about why the opinion falls within that range
- the reasons for the opinion, including any assumptions, research conducted, and/or document relied upon
- a signed Acknowledgement of Expert's Duty form (Form 53)

The more persuasively the expert can express his or her opinion, the more assistance that opinion will be to the plaintiff. However, it is important to keep in mind the fine line between being persuasive and being partisan. If an expert crosses the line into advocacy, less authority is given to the expert's opinion. In a worst case scenario, the judge may bar the expert from testifying at trial entirely.

It is critical for health care practitioners to understand the burden of proof required in the legal realm. In civil/tort cases, the plaintiff is required to prove his/her case "on the balance of probabilities" or that it is "more likely than not". 100 per cent medical certainty is not required—51 per cent probability is. The "more likely than not" burden applies not only to establishing the cause of the plaintiff's injuries, but also to any losses that have been incurred to date. The legal language and corresponding burden of proof is less when proving future losses. The plaintiff need only prove that there is a "real and substantial risk or possibility" of a future event or loss. The use of the proper legal language in a medical report is important.

Some health care providers are called upon to give expert evidence in their capacity as a treating professional; others are hired specifically to assess a plaintiff and provide an opinion solely for the purpose of the litigation. Our courts often struggled with how to accept evidence from treating health care practitioners, when their record keeping and report writing was not completed for use in a legal case and therefore has not complied with the Rules.

In a recent decision of the Ontario Court of Appeal, the court considered the use of opinion evidence provided by treating health professionals who had not provided a Rule 53.03 compliant expert report and clarified the circumstances under which a treating health care professional may testify at a trial without having complied with the Rules. In the case of Westerhof v. Gee, the court concluded that a witness with special skill, knowledge, training, or experience who has not been retained by a party to the litigation may nonetheless give opinion evidence without complying with Rule 53.03, where:

1. The opinion to be given is based on the witness' observation of or participation in the events at issue
2. The witness formed the opinion to be given as part of the ordinary exercise of his or her skill, knowledge, training, and experience while observing or participating in such events

Health care practitioners who are called upon to give expert opinions in a plaintiff's case are often reticent about discussing the formation of their opinions with counsel. In January 2015, the Ontario Court of Appeal released its decision in Moore v. Getahun, which answered many practical questions about how lawyers and

expert witnesses can interact in the preparation of expert reports and when preparing experts for giving evidence at a trial. In the decision, the Ontario Court of Appeal provided considerable guidance about how lawyers and expert witnesses should interact and about the extent to which communications or draft reports are subject to disclosure to the opposing side. Very specifically, the Court of Appeal explained:

> *It would be bad policy to disturb the well-established practice of counsel meeting with expert witnesses to review draft reports. Just as lawyers and judges need the input of experts, so too do expert witnesses need the assistance of lawyers in framing their reports in a way that is comprehensible and responsive to the pertinent legal issues in a case.*

Consultation and collaboration between counsel and expert witnesses is essential.

The Court of Appeal also recognized that preparation of a case for trial requires an umbrella of protection that allows counsel to work with experts while they make notes, test hypotheses, and write and edit draft reports. The Court of Appeal further held that draft reports need not be disclosed and the notes and records of any consultation between experts and counsel need not be disclosed—even if the expert is going to be called as a witness at trial. However, the claim of protection (i.e. litigation privilege) cannot be used to shield improper conduct. If there are reasonable grounds to suspect that counsel communicated with an expert witness in a manner likely to interfere with the expert witness' duties of independence and objectivity, the court can order disclosure of such discussions.

When a legal case must be decided by a judge or jury, the ability of the medical expert (both treating health care professionals and litigation—hired health care professionals) to communicate their observations and opinions to the trier of fact is crucial. The expert must be well-briefed for trial. Expert briefings should include:

1. A review of the duty of the expert, in order to prevent the appearance of advocacy
2. A review of all the records that may be relevant to the expert's opinion
3. A review of helpful and hurtful legal language
4. A review of the theories and themes of the case
5. A review of the facts in the case, especially if those facts have been relied upon for any assumptions or conclusions
6. A review of other expert opinions in the case, both corroborating and conflicting
7. A review of any authorities (e.g. textbooks), which may be put to the expert in cross-examination
8. A review of any flaws in the expert's report that become apparent with the fullness of time, more evidence, and intensive trial preparation
9. A review of the contents of the expert's file, which may have to be brought to court

A persuasive expert witness at a trial will:

1. Speak slowly and clearly
2. Look at the trier of fact when answering questions
3. Use simple language (wherever possible)
4. Be responsive to questions
5. Consider using visual aids

Finally, in order for the expert's testimony to be both permitted and preferred, it is vital that the expert's report must be compliant with Rule 53.03. The expert must also be aware of the boundaries the court will impose upon the expression of their opinions, as well as be aware that his/her counsel has consulted about the preparation of the report and the presentation at trial.

APPROVED

Called to the Ontario Bar in 1995, Wendy Moore Madel is a partner at Thomson, Rogers. Her practice is exclusively personal injury and medical malpractice cases, acting on behalf of seriously injured people and their families. Among others, Wendy has lectured for the Neurological Rehabilitation Institute of Ontario and to health care providers in both hospital settings and at academic conferences. Wendy has been identified as a leading practitioner in the area of personal injury law by LEXPERT® and was selected by her peers for inclusion in The Best Lawyers in Canada® in the field of personal injury litigation.

A member of the Law Society of Upper Canada since 2008, Deanna Gilbert's practice is devoted to helping people who have been seriously injured as a result of motor vehicle accidents, slip and falls, medical malpractice, and assaults. She represents a wide range of clients of all ages, sex, and race, across the province of Ontario. She has had precedent-setting cases; has authored a number of papers; and has lectured at many legal and health care-related conferences. Deanna is also a Co-Chair of the Volunteer Committee for the Brain Injury Society of Toronto, and has volunteered for the Feed the Hungry program operated by the Law Society of Upper Canada. Deanna holds a Certificate of Proficiency in French.

Wellness Centre

More & More, Less & Less

The defining ethic in the modern workplace can be interpreted as "More, Bigger, Faster." More information is available to us than ever before, and the speed of every transaction has increased exponentially, prompting a sense of permanent urgency and endless distraction. We have more clients to please, more emails to answer, more phone calls to return, more tasks to juggle, more meetings to attend, more places to go, and more hours we feel we must work to avoid falling further behind. It's exhausting!

The technologies that make instant communication possible anywhere, at any time, speed up decision making, create efficiencies, and fuel a truly global marketplace. But too much of a good thing eventually becomes a bad thing. Left unmanaged and unregulated, these same technologies have the potential to overwhelm us. The relentless urgency that characterizes most corporate cultures undermines creativity, quality, engagement, thoughtful deliberation, productivity, and ultimately performance. We *believe* we understand the health effects.

All this furious activity exacts a series of silent costs: less capacity for focused attention, less time for any given task, and fewer opportunities to think reflectively and long term. When we finally get home at night, we have less energy for our families, less time to wind down and relax, and fewer hours to sleep. We return to work each morning feeling less than rested, less than fully engaged, and unable to focus. It's a vicious cycle that feeds

"Too much of a good thing eventually becomes a bad thing"

on itself. Even for those who still manage to perform at high levels, there is a cost in overall satisfaction and fulfillment—not to mention work-life balance. The idea of more, bigger, faster generates value that is narrow, shallow, and short-term. More and more, paradoxically, leads to less and less.

No matter how much value we produce today—whether it's measured in dollars or closed client files—it's never enough. We run faster, stretch out our arms further, and stay at work longer and later. We're so busy trying to keep up that we stop noticing we're in a Sisyphean race we can never win.

Think about the following questions in relation to your own life: What is the cost of this lifestyle to you or the way you're working? How truly engaged are you? What's the impact on you, those you work with and those you love? What will the accumulated toll be in 10 years if you're still making the same choices?

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

Is unethical behaviour insurable?

The greater good of society is best served when individuals have as little incentive as possible to act unethically in combination with appropriate disincentives. As such, the insurance industry does not facilitate first party insurance protection for those who intentionally commit wrongful professional acts or criminal acts that harm a third party. If you are successfully sued alleging that you intentionally wronged a client for personal gain, even if the act is not criminal per se, your Professional Liability policy will not respond. For example, a key client from whom you source the majority of your income has contracted you to assess a third party individual's state of being to determine if they are ready to return to work. You purposefully omit key information in your report that would otherwise contravene your assessment that the individual is ready to return to work. Down the road you are sued alleging professional negligence that harmed the assessed individual and the plaintiff lawyer successfully proves that you purposefully omitted key information motivated by the belief that you were garnering the favour of your client as a "profitable" associate. In such a situation your insurance company would deny payment for damages on your behalf and demand reimbursement for the legal expenses incurred defending you.

This Policy does not apply to any Claim based upon, arising out of, or attributable to:

a. Any dishonest, fraudulent, or criminal act, error or omission by any Insured

b. Any wilful violation by any Insured of any law, statute, ordinance, rule, or regulation

c. Any Insured gaining any profit, remuneration, or advantage to which said Insured was not legally entitled

However, this exclusion does not apply to:

i. Claim Expenses incurred in defending Claims alleging the foregoing conduct until there is a judgment, final adjudication, adverse admission, or finding of fact against the Insured as to such conduct at which time the Insured shall reimburse the Insurer for Claim Expenses incurred up to that date

ii. Any Insured who was neither the author of, nor an accomplice to, the foregoing conduct

What if I am sued alleging that I acted unethically in regards to how I delivered my vocational rehabilitation services, however, the facts and evidence indicate that I did not?

If the allegations are not criminal in nature and specific to professional negligence, your policy should respond to provide a legal defense if your Professional Liability policy has a "duty to defend" clause. A "duty to defend" clause obligates the insurance company to pay for your legal expenses even if a lawsuit is meritless. Or, if the lawsuit has some merit, however, it is revealed that you *unintentionally* omitted key information when assessing a client that results in a negligent assessment, your insurance policy should respond to pay damages or a settlement up to the limit of your policy's limit of liability.

This Policy does not apply to any Claim based upon, arising out of, or attributable to:

a. Any dishonest, fraudulent, or criminal act, error or omission by any Insured

b. Any willful violation by any Insured of any law, statute, ordinance, rule, or regulation

c. Any Insured gaining any profit, remuneration or advantage to which such Insured was not legally entitled

However, this exclusion does not apply to:

i. Claim Expenses incurred in defending Claims alleging the foregoing conduct until there is a judgment, final adjudication, adverse admission or finding of fact against the Insured as to such conduct at which time the Insured shall reimburse the Insurer for Claim Expenses incurred up to that date

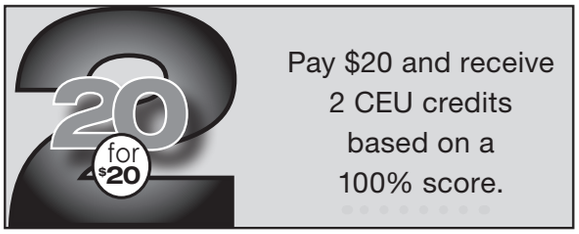
ii. Any Insured who was neither the author of, nor an accomplice to, the foregoing conduct

What if I am criminally charged alleging an illegal activity such as defrauding a third party of funds?

The vast majority of Professional Liability insurance policies provide no coverage whatsoever for these situations. There are some rare insurance policies in the marketplace such as the Professional Liability policy supplied to VRA Canada members that provides insurance money for legal defence costs incurred regarding criminal matters on a reimbursement basis (subject to a $100,000 limit of liability). This means that if you are in a position to successfully defend yourself regarding a criminal allegation, you will be reimbursed your legal expenses when the matter is settled. Again, this is a very rarely supplied coverage in the Canadian insurance industry and is a valuable benefit of VRA Canada membership if one opts for insurance through the VRA Canada member group plan.

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. When a health care provider makes a diagnoses or chooses a course of treatment, those decisions are 100% beneficial and risk-free.
   A: True
   B: False

2. How many employers are now said to be using web-based employment applications?
   A: 30-50%
   B: 50-70%
   C: 45-55%
   D: 85-90%

3. What are the three main clinical adaptations required surrounding third party consent?
   A: Consent is temporary, amendments must be made in person, consent must be given by at least two parties
   B: Rights to privacy, understanding of how information is shared, consent can't be rescinded
   C: Process must be modified, consent is bi-directional, consent is dynamic
   D: None of the above

4. Clients awaiting a tort decision may experience psychological effects and anxiety about losing benefits.
   A: True
   B: False

5. Who said "Integrity is doing the right thing and knowing nobody's going to know whether you did it"?
   A: Oprah Winfrey
   B: Henry Paulson
   C: Eleanor Roosevelt
   D: Winston Churchill

6. Case studies are not a good way to demonstrate how ethical issues may be analyzed.
   A: True
   B: False

7. When allocating resources to clients, what should you assess?
   A: Impact of the decision on others
   B: Impact of the decision on the system
   C: Impact of the decision on society
   D: All of the above

8. Which field has been slow to adopt technology when it comes to employment searches/postings?
   A: Counselling
   B: Law
   C: Career and workforce development
   D: Retail and service industries

9. What term is associated with the characterization of conscious or non-conscious focus on pain in an individual?
   A: Pain association
   B: Pain qualifications
   C: Pain management
   D: Pain behaviours

10. An expert witness' duty to the court does not override any obligation to the person by whom the expert was retained.
    A: True
    B: False

11. What set of second order principles has sprung from the guiding principles of medical ethics?
    A: Confidentiality and privacy
    B: Subjectivity and time
    C: Capacity and effort
    D: Record keeping and anonymity

12. What is one of the most important things to consider within an ethical decision-making process?
    A: Duties and responsibilities
    B: Stakeholders and reputation
    C: Practices and considerations
    D: Commitments and obligations

13. A client's legal case ends when he or she returns to work.
    A: True
    B: False

14. Why is consent before treatment important?
    A: It doubles as a contract of employment between you and the client
    B: It serves as a reference point should conflicts arise during treatment
    C: To provide protection in case of litigation
    D: To establish respect and trust with the client

15. For how long has "ethical considerations in technology" been an important discussion in vocational rehabilitation?
    A: 5 years
    B: 10 years
    C: 15 years
    D: 20 years

16. Why do codes of ethics have sections dedicated to vocational assessment?
    A: To establish dedicated practices for dealing with ethical complaints
    B: To demonstrate legal recourse
    C: To provide reference material for other manuals/guidebooks
    D: To keep historical record of previous conflicts

17. When a client is away from work due to injury for 70 days, what is their chance of return-to-work?
    A: 75%
    B: 60%
    C: 50%
    D: 35%

18. What is critical for health care practitioners to understand in the legal realm?
    A: Advocacy
    B: Burden of proof
    C: Partisanship
    D: Appeal parameters

19. In vocational rehabilitation, what areas of practice receive the most ethical complaints?
    A: Privacy/confidentiality
    B: Informed consent/choices
    C: Conflict of interest
    D: All of the above

20. Which of the following is a clinical cue of a compensation-focused client?
    A: Evidence of chronic pain
    B: Concurrent addiction
    C: Dependence on family and social support
    D: All of the above
    E: None of the above

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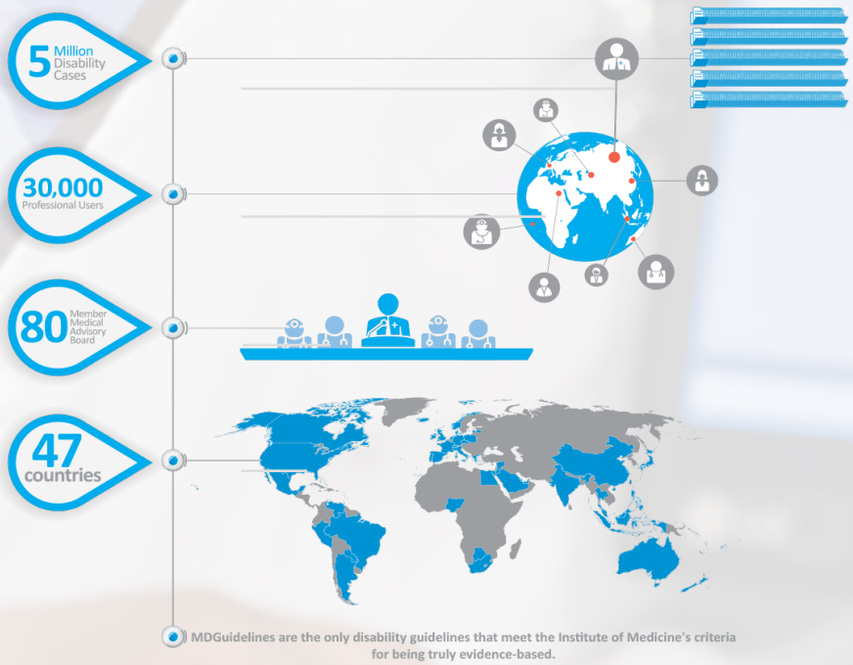

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