M.J.O.T.

Maltese Journal of Occupational Therapy

Editorial

Dear colleagues,

Let us take this opportunity to thank all who in some way or another, contributed to previous issues of M.J.O.T.

We would like you as participants to be more willing to share your knowledge and experiences in this coming year, to ensure a more regular publication, hopefully on a quarterly basis.

Finally we hope that 1998 will bring with it new opportunities and lots of satisfaction from our clinical work

Editorial Board

In this issue

Issued by Malta Association Of Occupational Therapists.

Issue no. 5 March 1998

Student's Own Perspective of Disability

Julie Mallen Student Occupational Therapist

"Shifting The Balance " is the title for the 21st Annual Conference of the British College of Occupational Therapists. As therapist we are all aware of the need for a balanced lifestyle, in terms of self-care, productivity and leisure, but do we acknowledge and take this on board for ourselves?

I am a part-time Occupational Therapist in my final year at the University of the West of England, Bristol and am due to qualify later this year. I was very privileged to come to Malta on an elective placement during January and February of this year. I spent seven happy weeks at Zammit Clapp Hospital for the care of the elderly near St. Julians. In England, I work in the community assessing the needs of the elderly and disabled people, drawing up care plans to meet their needs, and providing Occupational Therapy aids and adaptations.

My work at Zammit Clapp proved to be an invaluable experience and enabled me to learn how hospital based therapy differs to that in the community, as well as the opportunity to be part of a different culture. I will be always grateful for the welcome and support I received. Whilst at Zammit Clapp, I was asked by Head Occupational Therapist (Cynthia Scerri) , what made me decide to become an occupational Therapist. My reply prompted Cynthia to ask if I would write an article for the Maltese Journal outlining my decision.

In 1986, I was a hotel manager, having previously obtained catering qualifications and had a number of years experience of working in various catering establishments, including hospital catering. I was suddenly taken seriously ill and not expected to live. The problem started with a sore throat which grew worse by the day until I could not swallow and became dehydrated. I also developed a large " boil " on my knee which made walking extremely painful. Within a couple of weeks I had to move back home with my parents so they could take care of me. As ulcers began breaking out all over my body , the doctor began visiting every day but was unable to make a diagnosis.

I was taken to hospital for some tests, and there I stayed for five months. My immune system went into reverse and all internal organs began to dysfunction. This resulted in a need to be on a life support machine for two months, a tracheotomy, an ileostomy (which was reversed 12 months later), and 12 tubes of various kinds. My parents kept vigil by my bedside as they were told every day " spend as much time as you can with her as she probably won't be around in the morning ".

It was the diagnosis of a retired doctor which put me on the long road to recovery, it was at this point specialists could begin appropriate treatment. It was suggested that I had dermatomyositis, a life – threatening muscle wasting disease which also causes inflammation of the muscles, skin and blood vessels. The faithful prayers of members of my church caused a miracle to happen and over two years on intensive physiotherapy, hydrotherapy and occupational therapy, I began to rebuild my life and get back to full health.

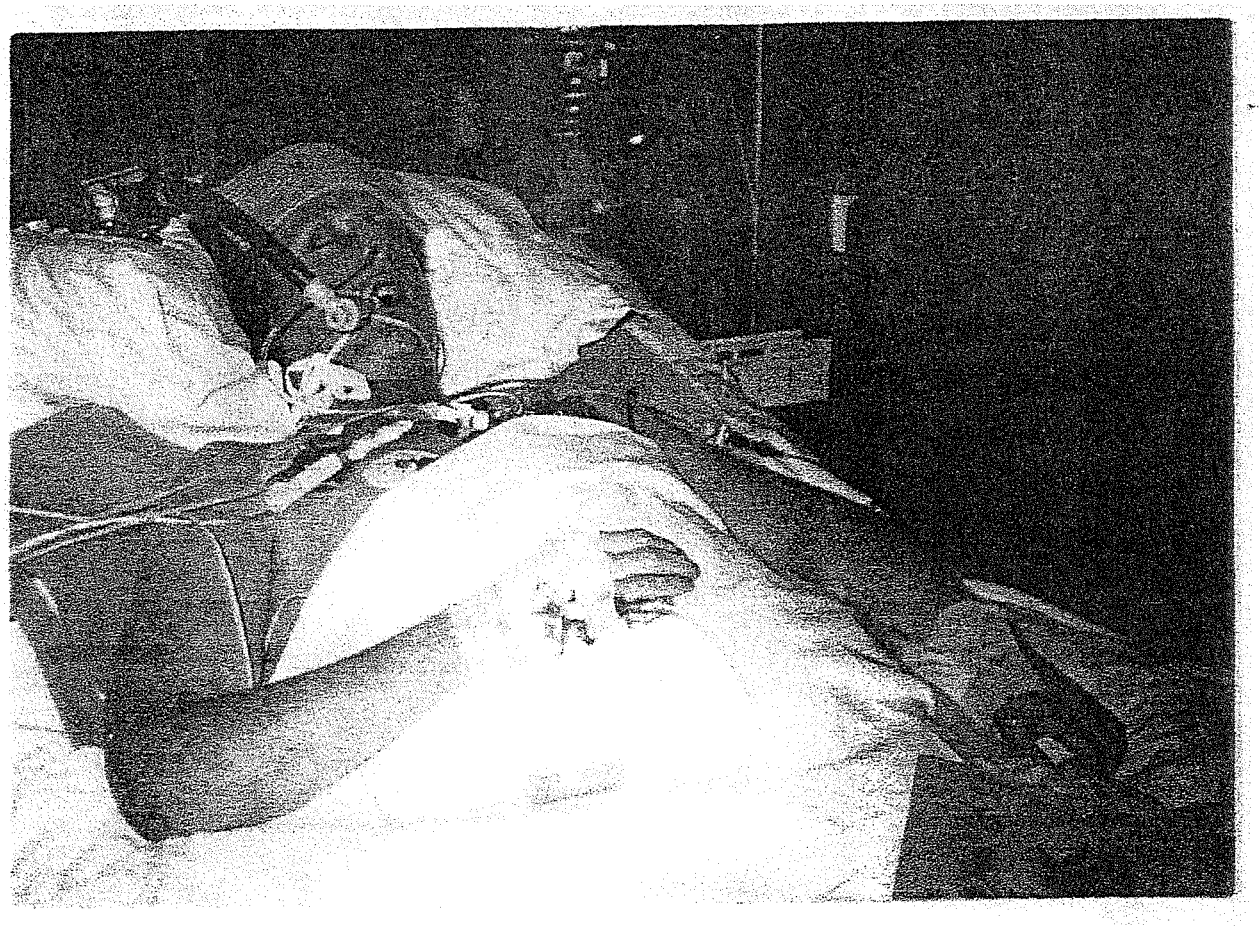
This period of disability really made me ' take stock ' of my life, I certainly needed to ' shift the balance' and reduce my working hours to allow time for leisure activities. For a while I totally lost confidence in myself, the hospital environment had been a protective place, the world outside was big and frightening. I overcame this fear by joining a craft class for disabled people and by undertaking voluntary work with people who had learning disability.

I certainly believe my period of disability has given me an empathy and new understanding into the needs of disabled people. I know what it is like to be fed, washed, dressed and to use a wheelchair. I understand the barriers society creates and the attitude of able bodied people when it comes to dealing with disabled people. It was because of this I realized that I wanted to work with disabled people as I felt I could helped them identify their

needs. In 1990, I was interview for a job as an occupational therapy assistant in social services. The department fortunately saw the potential in me, employed me, and enabled me further my skills and become qualified. Over the last four years they have funded me to take an in-service occupational therapy course. My ambition before I was ill was to open a Devon cream-tea room.

I am now happy with my life and feel I have a lot to offer to others who are going through difficult times.

I fell very privileged that I have been given the chance to carry out formal training. I rest in the hope that in the future I will be able to get the balance right. I now await my results!



Above : **Julie Mallen while she was recovered in hospital.**

An Ordinary Life

Mr.A. Mifsud Departmental Nursing Manager

A fundamental question that has been addressed by parents, service providers and planners when designing services for people with learning difficulties is :

" What are we aiming to achieve?"

Most of us take our homes for granted. A home means something different to each of us, it enhance our lives in many different ways. There is no doubt that most of us would fight, to preserve a nice supportive place we have to control, to protect our identities and our right to have the kind of home we want.

In 1975 the General Assembly of United Nations adopted the Declaration of rights of Disabled Persons, this includes :-

1. Disabled persons have the inherent right of respect for their dignity, they have the same fundamental rights as their citizens of the same age.
2. They have the same civil and political rights as other human being.
3. They are entitled to the measure designed to enable them to become as self-reliant as possible.

The move from the more traditional model of hospital – based care to ordinary life provision requires changes in attitudes not only by the general public but also by those involved in the care process. Such changes cannot be assumed to occur naturally, but require specific programs of preparation , coaching and support.

So that such services are tailored to the individual preferences, strengths and needs of the users, within the context of the least restrictive environment , the following objectives should be met :-

a. new skills be acquired so that they enhance the ability to cope with normal social envi ronment.
b. to engage in a wide range of ordinary activities to practice and consolidate skills that have been acquired.
c. to engage in a full range of home – making activities and household duties.
d. join in as many community base activities as possible.
e. use local facilities whenever possible.
f. be involved in all decisions affecting their lives.
g. modify disruptive behaviors that limit or deny access to ordinary activities.

The services should be offered in such a manner that are appropriate to the person's age and that they respect his dignity. To achieve this, individuals require opportunities for informed choice and autonomy over their own lives, which may involve taking defined risks.

One natural consequence of increased opportunities for ordinary living and for encouraging people with learning difficulty to make their own decisions, is that they will be exposed to the hazards of daily living.

Staff will also be placed in the potentially difficult situation of being involved in making decisions that will actively introduce an element of risk into the person's life . It is important that the staff feel confident that, providing they act in a professional and competent manner, their employer will support them, should incidents occur.

It is therefore crucial that risk – taking guidelines are prepared and agreed at the highest level of management, otherwise life planning is likely to be severely restricted in its scope.

These should include :-

a. degree of risk – prevention is better than cure, therefore predicting possible harm is the first step towards preventing it.
b. monitoring – it is wise to use past experience, but if this is not available, rather than not doing anything at all, one should test out the situation with careful monitoring.
c. priority of objectives – one must not weigh the degree of risk involved with the importance of the objective. The word caution is never to be forgotten.
d. decision-making – shared decision–making can never be emphasized enough. Once a decision is taken, everybody involved has the responsibility to implement it faithfully, until it is again reviewed.

It is towards these aims that the Learning Disabilities Training Unit (L.D.T.U.) at Mount Carmel Hospital was opened more than a year ago, in May 1996. A lot of work and dedication has been put in this project during and before this period. especially by the Occupational Therapist of the Psychoaeducational Department. Infact the whole O.T. department helped and encouraged us in this venture. But I'm afraid we are lacking the support one expects from other agencies and government departments.

If we really want a better life for persons with a learning difficulty residing in MCH , all of us must support such initiatives. If these people are not given a chance to live an ordinary life in the community, we will be just wasting time and money.

It is the community (all of us) who years ago put these people in MCH, now it is the duty of the community to help in every way possible so that, with dignity not charity , they are helped to find their way back where they rightly belong.

News From Abroad :

New European Show To Have Strong Focus On The Expanding Homecare Market.

A new Eropean " Trade Only " show , with the focus solely on Homecare is to take place on 1st-3rd April 1998 in Luxembourg. Bringing together exhibitors and visitors from the most European countries and from many others areas of the world, Medtrade Europe is being launched by Semco Productions. emco are the organisation that, over the past 18 years, has developed one of the worlds largeat Homecare events in the USA, which this year in New Orleans attracted 40, 00 visitors and a range of 250, 000 homecare products.

The aim of Medtrade Europe is to attract the key decision makers, purchasers, specifiers and advisors of homecare equipment and services, by providing them with new and interesting products, many of which will be on show from the very first time in Europe, along with useful educational seminars. already companies from China, Taiwan, Hungary, Germany, U.K. France, Belgium and U.S.A. have confirmed their intension to exhibit at the show.

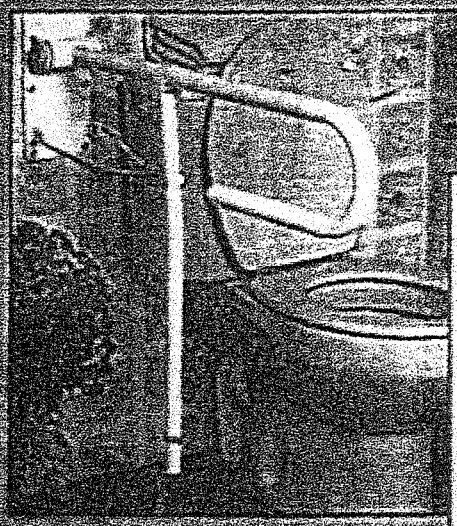
Frank Lievens, Joint Managing Director of the new show is confident that their is a real need for a more focused homecare event. " Homecare provision in the USA is far more advanced than in Europe at the present time" says Frank " However, we are positive that European Homecare product and services will develop in much the same way, particularly with the universal need for reduced hospitalisation costs, creating a great number of new and exciting opportunities for product providers, professionals, advisors, and homecare services. Our aim is that the new Medtrade Europe Show becomes the central meeting and learning place for the European Homecare market in the future" .

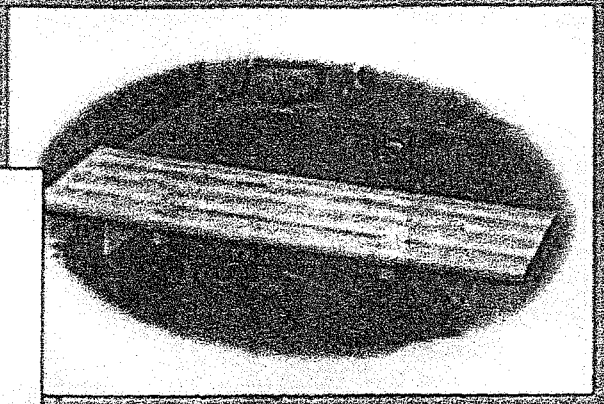
The Laximbourg Exhibition and conference facilities are just five mintues from the airport and motorway networks, providing the new show with first class accomodation. For a full information and registration pack about Medtrade Europe including details of low cost travel and hotels and the interesting free educational seminars on offer simple ;

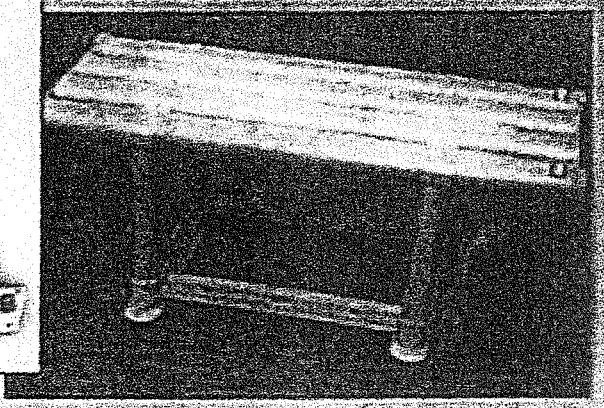
Fax to: *The Belgian Office on + 3222697953 or Tel: + 3222698456*

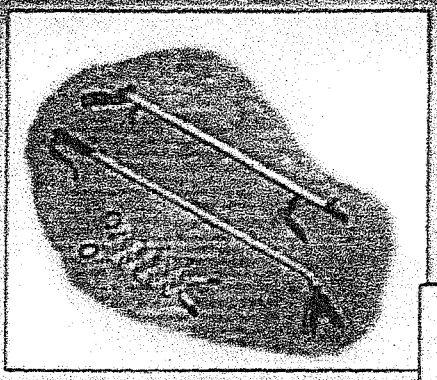
David N. Russell

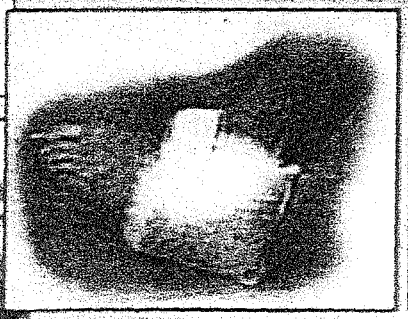
A hundred ways to make your life easier

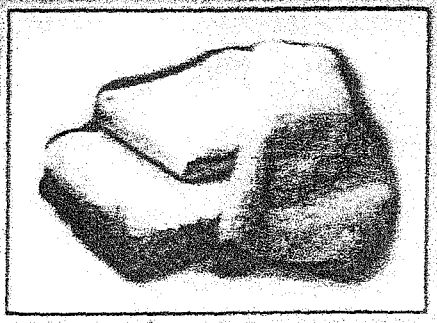


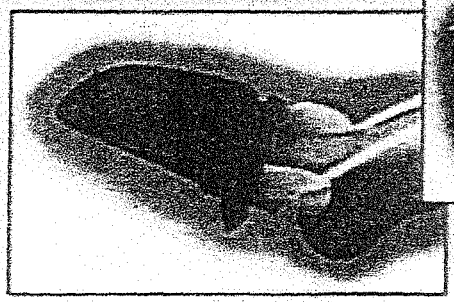


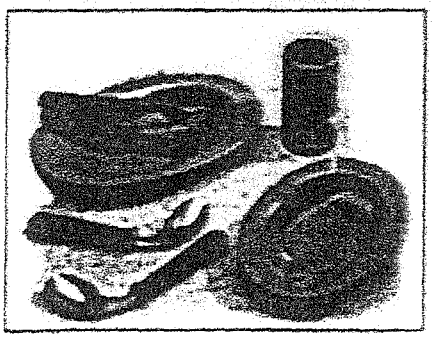


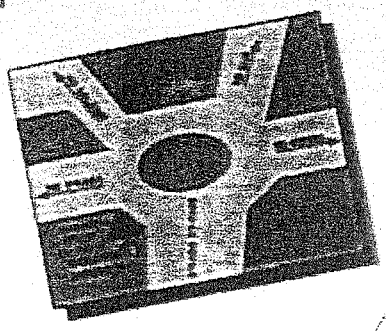












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The Canadian Occupational Performance Measure

Doriette Bonello Sen. O.T.

The Canadian Occupational Performance Measure (COPM) is an individualized measure designed for use by Occupational therapists to detect change in a client's self-perception of Occupational Performance over time. The COPM. :-

* identifies problem areas in occupational performance,
* evaluates performance and satisfaction rela tive to those problems areas; and
* measures changes in a client's perception of his/her performance over the course of occupational therapy.

The COPM is designed to measure changes in self-perception of occupational performance among clients with a variety of disabilities and across all developmental stages.

CLIENT – CENTERED THERAPY

Client – centered occupational therapy refers to practice in which clients are the central focus. This means considering their needs and wishes; and taking into consideration their experiences and knowledge.

A client – centered approach requires the therapist to actively seek and structure opportunities for clients to have real choices. Five key concepts are considered as essential to O.T. client – centered practice :-

1] The worth of the individual as an active participant in the therapeutic process.
2] A holistic view of the individual as requir ing meaningful occupation in all aspects of life.
3] The therapeutic use of activity/ occupation as a medium of change.
4] A developmental perspective which recog nizes changes as a process related to life stages; and
5] Optimal occupational performance in self-care, productivity and leisure, produced by an individual's meaningful integration of spiritual , sociocultural and mental perfor mance components within the context of environmen tal conditions.

MODEL OF OCCUPATIONAL PERFORMANCE

The Occupational Performance frame of reference is used to organize the treatment process for the psychsocial client. The theory contends that an individual must preserve a balance of activities in their daily life in order to stay healthy and perform his/her life roles.

The areas of work, self-care, and leisure are considered performance skills that acquired through developmental learning and practice. The purpose of O.T. is to help clients achieve their maximum degree of independent living. O.T. treatment is based on improving performance skills in gradual steps, in order to attain as much independence as possible. The stages of treatment are progressive activities which build a foundation of acquiring competence.

The first stage used adjunctive methods, the second stage consists of enabling activities, while the third is purposeful activities. These activities must have a meaning to the client for there can be no therapeutic value in an activity unless it is meaningful to the client. The last stage, resuming occupational performance roles, permit the client to fulfill necessary tasks of work, self-care, and leisure (Pedretti and Pasquinelli, 1990)

FEATURES OF THE COPM

- Is based on an explicit model of O.T.
- Encompasses the occupational performance areas of self-care, productivity and leisure as primary outcomes.
- Recognizes the performance components as essential to the process of occupational performance.
- Incorporates the roles and role expectations of the client.
- Considers the importance of performance areas to the client.
- Measures client – identified problems.
- Incorporates re-assessment of the identified problem areas.

- Focuses on the client's own environment thereby ensuring the relevance of the problems to the client.
- Considers the client's satisfaction with present performance.
- Engages the client from the beginning of the O.T. experience.
- Increases the client's involvement with the therapeutic process.
- Can be used with all developmental levels.
- Supports the notion that clients are responsible for their health and their therapeutic process.
- Permits the client and the therapist to identify and deal with everyday issues.
- Permits the evolution of the use of purposeful tasks and activities.
- Allows for input from members of the client's social environment if the client is unable to answer on his/her own.

APPLICATION OF THE COPM

1. The COPM is the best used during an interview type session. The style of interview is usually individual to each therapist.
2. Probably the most effective method is to engage in a conversation with the client in a relaxed and uninterrupted environment.
3. Before discussing occupations with the client, the process of the COPM should be explained.
4. The outcome of the COPM should also be explained during the assessment .
5. The COPM allows for a re-assessment. This should be able to tell the therapist the progress the client has made in his occupational performance and his perception of it.
6. It is not necessary for the clients to identify problems in all areas of occupational performance. However, it is important to review each area to ensure that all occupational performance problems are identified.
7. Scoring ; Importance rating are designed to identify problems for intervention. During the actual administration of the measure the client should choose up to five problems that are most pressing. These are often problems that are rated highest in importance.
8. Questions are also asked about performance and satisfaction. The initial numeric scores do not have inherent meaning by themselves. The change in scores between assessment and re-assessment is the clinically important score.

EVALUATION

1. The COPM is easy to translate, apply, understand, explain, and to score.
2. Helps to formulate a care plan.
3. It is not necessary to use it before your care plan.
4. Can be used as one of your targets.
5. Using the COPM encourages the roles of the therapist as a facilitator and as an advisor.
6. It puts a varying degree of responsibility onto the client depending on his/ her mental state.
7. It does depend on the motivation of the client to take a degree of responsibility to change.
8. It also depends on the client's rational perception of his/her own occupational performance.
9. It also depends on the client's motivation to better his state of occupational performance.

References:

1. *Canadian Occupational Performance Measure. CAOT Publications 1994.*

2. *O.T. Guidline for Client-Centered Mental Health Practice. CAOT Publications 1994.*

3. *Quik Reference Manual. O.T. Students San Jose University of California*

CANADIAN OCCUPATIONAL PERFORMANCE MEASURE

CLIENT NAME : AGE : *24 years*

GENDER : *Male* ID# :

DATE OF ASSESSMENT : *30/4/97*

PLANNED DATE OF REASSESSMENT: *28/5/97*

DATE OF REASSESSMENT : *16/7/97* THERAPIST NAME : *Mrs. D. Bonello*

FACILITY/ AGENCY : *Day Centre Qormi* PROGRAMM : *Day Programme*

STEP 1
IDENTIFICATION OF OCCUPATIONAL PERFORMANCE ISSUES

To identify occupational performance problems, concerns and issues, interview the client, asking about daily activities in self-care, productivity and leisure. Ask clients to identify daily activities which they want to do, need to do or are expected to to do by encouraging them to think about a typical day. Then ask the client to identify which of these activities are difficult for them to do now to their satisfaction. Record these activities problems in Steps 1A, 1B or 1C.

STEP 2
RATING IMPORTANCE

Using the scoring card provided, ask the client to rate, on a scale of 1 to 10, the importance of each activity. Place the ratings in the correspo - nding boxes in Steps 1A, 1B, or 1C.

STEP 1A : SELF – CARE

IMPORTANCE

Personal care ; _____ | |

_____ | |

Functional Mobility ; _____ | |

_____ | |

Community Management ; _____ | |

_____ | |

1A : PRODUCTIVITY

Paid / Unpaid Work ; Full Time Employment | 10

Household Management ; Cookery | 6

Play/School ; _____ | |

IC : LEISURE

Importance

Quite recreation : _____ | |

Active recreation : Going out | 10

Socialization : _____ | |

Initial assessment :			Reassessment	
Occupational Performance Problems:	Performance 1	Satisfactory 1	Performance 2	Satisfactory 2
1. Going out	3	2	8	8
2. Job	3	2	7	8
3. Cookery	3	6	3	6

Scoring .	Performance Score 1	Satisfaction Score 1	Performance Score 2	Satisfaction Score 2
Total performance or satisfaction scores / Total Scores = # of problems	= 3	= 3.3	= 6	= 7.3

Change in Performance = Performance scores 2 [6] - Performance Score 1 [3] = [3]

Change in Satisfaction = Satisfaction scores 2 [7.3] - Satisfaction Score 1 [3.3] = [4]

- Focuses on the client's own environment thereby ensuring the relevance of the problems to the client.
- Considers the client's satisfaction with present performance.
- Engages the client from the beginning of the O.T. experience.
- Increases the client's involvement with the therapeutic process.
- Can be used with all developmental levels.
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Marketing the Occupational Therapy Professional in Malta

J. Chetcuti B.A. (Hons.), Dip. O.T., S.R.O.T.

This article is a brief version of an assignment presented for the module entitled Management of Occupational Therapy as part of the MSc programme for Occupational Therapy at the University of East London.

Occuaptional Therapy was formally established in America early in the twentieth century. Much progress has been made throughout the years outlining its particular objectives albeit gradually (Young, Quinn, 1992). The changes that occurred reflect the ever changing world in which we live. Occuaptional Therapy emerged in early history from a common belief held by a small group of people . Reilly (1962) places common belief into a hypothesis as follows *'that man, through the use of his mind and will, can influence the state of his own health.'*

The history of Occuaptional Therapy in other countries namely Canada, Australia and Britain parallels that of Occupational Therapy in the United States in many ways. Therapists the world over seek increased public recognition for their contribution to the health of the population. It is a well known fact that greater recognition will entail increased accountability and the need for research to validate theories underlying practice and account for effectiveness of services.

The introduction of Occuaptional Therapy in Malta started with the recruitment of foreign therapists (British) in 1955 and continued to develop with the engagement of the first Maltese therapists in 1974. For this purpose Maltese candidates were selected in 1970 and sent to England for training in 1971. The first two male Maltese therapists were appointed in October 1974. More Occupational therapists joined in 1982 after training in the United Kingdom. It was not until 1984 that the first locally organized course of training in Occupational Therapy was established (Busuttil, 1986). Courses are currently being held by the Institute of Health Care, University of Malta with an ever increasing demand for occupational therapists.

The Maltese attitude towards health is largely based on the medical model. For all ailments there is a cure to be sought at the local doctors. There are no shortages of doctors in Malta where they work either in a local community clinic or else privately.

It is only in the last decade that the value of other professions has been appreciated. It is a common occurrence for Occupational Therapists to feel disheartened by the fact that few people know what an Occupational Therapist does. Whilst understanding that Occupational Therapy is not the only profession with this dilemma, it is vital that therapists dedicate some responsibility to establish the image of Occupational Therapy to the 'target market' i.e. the public and amongst other professions. Occupational Therapists should be clear regarding their specific roles in assessment, treatment, rehabilitation, promotion and maintenance of health.

There is a need to be confident when discussing areas of practice. There is a need to accept and outline the limitations that exist in occupational therapy as in all professions (Maslin, 1991).

Marketing was once thought inappropriate to use in health care. However, it is emerging as an important aspect of delivery of health care services, including Occupational Therapy over the world . Marketing techniques can be applied to the Maltese situation to improve valid recognition amongst other professions and increase public awareness.

Marketing as defined by Kotler (1976) is *'the set of human activities directed at facilitating and consummating exchanges.'* Butler (1991) describes marketing as both an activity and a business philosophy whilst Rodgers (1974) views marketing as primarily concerned with the creation, presentation and communication of what a firm has to offer. The firm's activities are therefore exposed to public criticism. Marketing Occupational Therapy will aim to present what the profession has to offer (e.g. restoring an individual to an independent lifestyle through adaptations within the home) and communicate its aims and values in a creative way.

Occupational Therapists in Malta consist in the vast majority of therapists working in the public sector. The health service in Malta is provided free of charge to all Maltese citizens.

We therefore are concerned with "relationship marketing" i.e. non-profit seeking marketing in the form of marketing communications and public relations.

Occuaptional Therapy can be marketed on two counts, firstly to other persons in the health services and secondly to the general public. For all intents and purposes we shall refer to persons in the health services (consultants, doctors, physiotherapists, social workers etc.) and the general public as customers.

Hart (1987) describes how any organization needs to develop a strategy. Prior to applying any form of strategy it is important to get to know the customers and the markets in which the service operates.

It is important to note that consumers vary in age, sex, class, occupational and geographical region. To market Occuaptional Therapy, it is therefore vital to understand and develop an awareness of consumer behavior (Butler,1991). Successful marketing begins with preliminary market research. Since marketing aims at satisfying the customer, it is important to stay in touch with the need, wants and preferences of the consumers (Jacobs, 1987). Rather than designing services and then looking for customers, the reverse occurs in marketing the Occuaptional Therapy service. The market needs to be looked at and potential customers listened to and then services are designed to match their needs and desires (Kotler, 1983a).

Implementation of a plan

As a starting point, a weekend seminar needs to be organized for all Occupational Therapists in Malta by the professional body of Occupational Therapists.

The aims of this seminar will include:

1. To highlight the problem of lack of recognition or awareness of what Occuaptional Therapy is by the public and other health care professionals.
2. Explain the importance of a mission statement and aim at establishing one for Occuaptional Therapy to encompass all areas of practice in Malta.
3. Brainstorm different marketing strategies that can be employed.
4. Formulate different groups to focus on specific themes or areas.
5. Brainstorm & formulate a plan for funding.
6. SWOT Analysis i.e. strengths, weaknesses, opportunities and threats.

The outcome of the seminar is to leave with a campaign which can be worked on within specific groups. Five teams could be organized where the first four teams make up the promotional mix i.e. advertising, promotion, public relations, personal selling and fund raising.

The explanations and lists given below for each area are just some ideas which can be applied to the Maltese situation and are not meant to be comprehensive or conclusive.

Advertising aims at attracting the attention of the consumer and creating interest to stimulate the continued use of the product. Effective advertising can be achieved if a competitive message is targeted to the right people and often enough to have an impact on the target audience.

Timing is also very important, so campaigns are mounted when the target audience are in the mood to try the product.

The following advertising methods may be successful in the local Maltese situation:

1. Brochures / Fliers on occupational therapy aims and objectives.
2. Leaflets for patients on a variety of conditions
3. Posters in departments or central places in the hospital or community centre.
4. Web page on computer.
5. Advertisements in the local newspaper/ magazines/ professional magazines & journals.
6. Television broadcasts/radio slots.
7. Short video that can be used for the press or other events.
8. An audio cassette

Promotion is most effective when used in conjunction with advertising. It consists of providing a number of short-term incentives to purchase the service. Methods such as bonuses coupons are inappropriate to Occuaptional Therapy since we are mainly dealing with a free health service where we wish to increase awareness. Contests and sponsorships may be an effective way to promote Occupational Therapy with either cash, travel or book prizes or bursaries.

Public relations means attracting the publics attention. An important aspect of publicity is that it is free and objective and has more credibility. Jacobs (1987) suggests that a key to success requires a well-executed media relations programme. This involves becoming acquainted with the media, establishing a rapport, being accessible and responsible and easy to work with. Public relations methods suitable for Occuaptional

Therapy can include:-

1. Writing in local editorials.
2. Writing articles for newspapers and magazines (e.g. a series on hints and advice for different groups of illness).
3. Involvement in television documentaries and discussion programs.

4. Participation in radio programs.

5. Publicity in the form of press releases/news following events such as: conference, study mornings and participation in a fair;

6. Holding open days.

7. Compilation and production of slides, photos and library resources.

8. Sending wall charts and visiting schools.

Personal Selling involves personal communication. Possibilities in this area suit occupational therapists and include:-

1. Talks at University/college/student guest lectures.

2. Participation in Health fairs and exhibitions.

3. Serving on boards or committees with other health professionals.

4. Participating in continuing education programs with other health care professionals.

5. Organizing study mornings, conferences and seminars.

6. Organizing a publicity week e.g. occupational therapy week or fair.

Fund raising can include:-

1. Organizing a lottery/raffle.

2. Organizing a fund raising dinner.

3. Seeking out sponsors from major suppliers of equipment for leaflets/exhibition stands/ brochures/ study days etc.

4. Revenue from selling diaries, pens, notebooks, T-shirts and sweatshirts following competitions.

5. Organizing a cake/jumble/car boot sale.

6. Payment for study days/ entrance to fairs.

The success of the fund raising schemes and the amount of money generated will effect the whole marketing campaign. Each of the other teams will be given a budget or materials to utilise during the various campaigns.

Conclusion

The campaign needs to be monitored at various stages. Reports from each team can be sent to central body for analysis. The impact of the campaigns on the image and awareness of occupational therapy need to be followed through a follow-up survey and an evaluation seminar after approximately six months. Occupational therapy offers promise of an improved quality of life for our clients especially those with chronic diseases and disabilities. It also makes a valid intellectual contribution to the university. Although marketing is a relatively new sphere within health care it can provide professions with strategies to increase recognition and methods to improve their overall image. An effectively designed marketing campaign will ensure that occupational therapy achieves its proper place in the eyes our patients, educational arena, the work sphere and amongst other health care practitioners.

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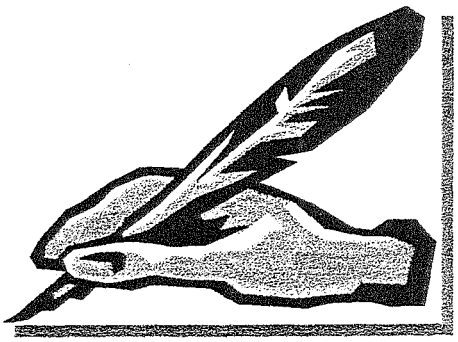

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