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EDITORIAL

We all agree that the general public is not aware of what Occupational Therapy entails. However, people in the profession should feel the duty to be promoters of Occupational Therapy. This should start within our immediate group that is medical and paramedical staff, educators, carers, patients and students. Being a professional does not only mean carrying out assigned duties in your respective department, but also being actively involved in your respective professional body.

Good professional conduct includes being a good clinician, showing responsibility towards own continuing development, being part of an association, and being aware of the local and international professional issues. If we want Occupational Therapy to be a recognised profession we have to make it our duty to inform those around us about our clinical work and about the professional body and its commitments. It is a must that all those in the profession including Occupational Therapy students are aware that our profession has an association, an educational committee and a journal. We should be proud enough of our work to promote it as a profession to our friends and colleagues.

We would like to take this opportunity to congratulate the newly qualified Occupational Therapists and to welcome the first year students.

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Continuing Professional Development: A comparison between Malta and UK. A position paper – Demis Cachia

Introduction

Change is ahead for Occupational Therapists, generated by issues from both outside and inside the profession. Not only is the pace of changing accelerating in the world generally and the health service specifically, but traditional methods of providing care and rehabilitation are being modernised. This presents an exciting challenge and the need to reflect on both individual practice and the practice of the profession as a whole; has never been greater. As professionals we need to be able to respond quickly to changes within market conditions, to client requirements and to the influences of government policies. In this position paper, I will focus on continuing professional development (CPD) and therefore, the concept of lifelong learning will be highlighted. A comparison with the UK will be done since: -

- Being a British colony for many years, Malta is influenced by the UK in many ways including the development of the health care and the educational system,
- Many articles were written in the BJOT and in the "OT News" related to CPD, and
- The English language itself being the second language in Malta.

Personal Feeling and Instance

Following my personal interest to start the European Master's in Occupational Therapy, I felt very disappointed from the lack of support and encouragement received from higher authorities (not by Occupational Therapists). The negative attitudes towards continuing education and the bureaucracy to apply for support led me to write this paper where I claim that compared to the UK, continuing professional development in the Maltese Islands is not being encouraged adequately. Moreover, the importance of lifelong learning is not being recognised.

Definition of CPD

A number of different terms are used to describe the generic activity of maintaining and improving professional

competence, however, in recent years the term Continuing Professional Development (CPD) is being used more within the Occupational Therapy profession. CPD is described as lifelong learning, which enables individuals and teams to "expand and fulfill their potential to the benefit of the patient care" (DOH, 2000). It starts from a baseline of existing knowledge, qualities and technical abilities, which CPD aims to maintain, broaden and develop further. The College of Occupational Therapy (COT 2000b, p36) defines CPD as "the systematic maintenance, improvement and broadening of knowledge and the development of personal qualities necessary for fulfilling professional and technical duties throughout the practitioner's work life". CPD is about having a commitment to a structured approach to learning in order to maintain and develop the personal qualities, skills and knowledge needed for competent performance throughout the working life (Fenech, 2001).

Europe and Lifelong Learning

In the last decade a lot of importance to lifelong learning has been given. In fact the year 1996 was designated as the European Year of Lifelong Learning. In the UK (1998) a Lifelong Learning White Paper was made and in the year 2000 the European Council in Lisbon published a Memorandum on the subject. Also, many articles were published in the BJOT related to CPD.

Unfortunately, only one article was found in the Maltese Journal of OT related to CPD. This does not mean that Occupational Therapists in Malta do not engage in continuing education. In-fact a good number of Occupational Therapists are in possession of a master's degree in OT. However, evidence to this is not being demonstrated due to the lack of publications and awareness on the importance of this matter. This is also because in the Maltese culture, CPD is seen to be more of a personal satisfaction leading to a final reward such as a degree or any other form of accreditation. Nothing or little is gained if one has a master's degree or any other qualification besides the first degree/ diploma, in terms of promotion of financial remuneration.

The importance that the European Union (EU) and its members gives to Lifelong

Learning will surely encourage Maltese policy makers to take action in this regard. Also due to the fact that Malta will soon be a member in the EU such matters cannot be ignored anymore. In-fact it is expected that in the year 2003 a Health Care Professions Act will be adopted while the Malta Specialist Accreditation Committee will be set up.

CPD and OT

East (2000) states that, it was no longer possible to consider OT as 'common sense. He stressed that a theoretical base of OT specific knowledge, informed by skilled clinical reasoning, was critical for the continuing development of practice. Since the Occupational Therapy service relies increasingly on the ability to respond quickly to the market change, the clients' requirements and the influences of policy makers, the need to change and to foster innovation in both the clinical and educational setting is of utmost importance. Therefore, the need to update knowledge, gain new skills, reflect on daily practice and the need to be accountable and competent can only be achieved through continuing professional development. CPD is likely to promote a happier and more motivated workforce who will deliver healthcare more effectively (Castle, 1996).

Types of CPD

CPD may take many forms. The reason behind the following explanation is to demonstrate that it is not just the completion of a course that may lead to any form of accreditation. Alsop (2000) provided a list of possible activities in which individuals might engage in for CPD. These can be divided into formal and informal modes of learning.

Formal learning includes formal studies such as those leading to an MSc, a BSc, an MA and a Diploma. Participation in workshops, research, conferences, lectures, study days, writing articles, and presentation of a paper are also forms of formal learning.

Informal learning may include chairing of meetings, enhancing existing capabilities, facilitating others' learning, secondments, developing new skills, introducing change, presenting papers, coaching and mentoring others, private study with general reading, accessing

clinical databases, the Internet and fieldwork education.

Comparison between Malta and the UK

Professional competence (PC)

In the past, a qualification was seen as a licence to practice that lasts for a lifetime whereas competence decays and does not last forever (Eraut, 1994). CPD will no longer be optional, and sooner or later Occupational Therapists will need to be ready with their portfolios to demonstrate their efforts in CPD and their ongoing competence to practice (Alsop, 2002). Research studies (Watkins 1992, Henwood 1994) suggest that competency regresses in the years following initial qualification, with a half-life of 2-5 years, before being superseded by new developments or becoming obsolete (Henwood 1994). Ashton (1992) argued that professional knowledge could be outdated in less than 5 years post-qualification; hence there is a need for individuals to engage in education activities that will keep them informed on new developments.

PC has been defined as "an ability to perform the tasks and roles required to the expected standard (Eraut, 1998, p32) and as "the outcome of thoughtful self-directed professional development activities " (Crist et al, 1998, p729). Day (1995), suggested that competence was the possession of the necessary skills, knowledge, attitudes, understanding and experience required to perform in professional and occupational roles to a satisfactory standard within the workplace. It could therefore be argued that PC is a perishable commodity and that the acquisition of initial registration qualifications is only the first step towards continuous learning and attainment of knowledge, where 'education is a lifelong process' and the 'professional, a lifelong learner' (Watson 1985).

Breines (1998), emphasised the importance of continuing education and self- evaluation in order to maintain professional status and enhance professional image. In the UK, the Health Act (1999) has paved the way for measures that will require all health professionals to account for their CPD in order to demonstrate ongoing

competence in the professional field. In the UK, the Code of Ethics and Professional Conduct for Occupational Therapists (COT, 2000a) states that:

5.1.1 *"All members of the OT profession have an individual responsibility to achieve and maintain their level of PC and to be aware of current legal issues affecting their practice".*

5.4 *'Occupational Therapists shall be personally responsible for actively maintaining and developing their personal PC, and shall base service delivery on accurate and current information in the interests of high quality care'.*

5.4.1 *"Occupational Therapists shall undertake CPD".*

5.5 *'All occupational therapists have a professional responsibility to participate in the education of occupational therapy students, particularly in the area of fieldwork education'.*

5.6 *'Occupational therapists shall promote an understanding of, and research into OT'.*

The College of OT in the UK, (2001) set a minimum standard on one half-day each month for all OT personnel for CPD quality enhancement activities, scholarship and research (Ilott & White, 2001). The same College is responsible for monitoring the competence of Occupational Therapists or their fitness to practice. On the other hand, the Code of Professional and Ethical Conduct for Occupational Therapists in Malta (Council for the Professions Complementary to Medicine, 2002) states that:

Statement 4 *"As a professional group, Occupational Therapists are committed to provide the best possible service to patients.....).*

Statement 7.2 *"Occupational Therapists should be accountable for his/ her work".*

Statement 7.5 *"With reference to his/her profession, every reasonable opportunity should be taken to sustain and improve knowledge and PC".*

Statement 7.6 *"Additional training/ support when he/ she perceives the need"*

The MAOT statute, article 2.2. states that "Occupational Therapists should aim to establish and maintain professional standards in the practice of OT". The COTEC code of Ethics state that "Occupational Therapists should participate in professional development through lifelong learning and to apply acquired knowledge and skills in their professional work".

A major difference between the two countries exists on how professional competence can be achieved. Although it is clearly stated in the UK codes that competence can be achieved through lifelong learning, in Malta this remains very unclear. No specific statement mentions how competence can be achieved. Therefore, I strongly feel that such a statement needs to be included, which would then strengthen statement 4 and 7.5 of the Maltese Code of Ethics.

Legal issues

No references in the Maltese Code of Professional and Ethical Conduct mentions legal issues related to professional competence. On the other hand, in the UK, the same Code clearly states that OT's should be aware of legal issues if professional competence is not achieved. This clearly shows major differences between the two countries where in Malta professional competence is not being reinforced by legal issues. Rather it is still a free choice for individuals to be engaged in.

Responsibility

The issue of responsibility refers to the question of who should be responsible in making sure that healthcare professionals, in this case Occupational Therapists are being involved in CPD in order to provide the best quality of service. Is it the Occupational Therapist's personal responsibility to be engage in continuing education? While in the UK Occupational Therapists are practically forced to carry out CPD (statement 5.4.1) in-order to keep the OT license, in Malta further education is still a personal decision of whether or not he/ she decides to do so. Therefore, in Malta if an Occupational Therapist does not feel the need to undertake CPD then it is not illegal. This means that while in the

UK, Occupational Therapists are obliged to carry our further education, in Malta it is the individual's decision and responsibility to engage in life long learning is based on personal motivation and willingness.

Moreover the College of Occupational Therapists and Health Professional Council (HPC) in the UK are responsible to monitor competence and fitness of practice. While such a College does not exist in Malta, to my knowledge it is the role of the Board for the Professions Supplementary to Medicine (BPSM) in Malta, which aims to monitor competence and fitness to practice. However, this is only stated on paper and it is not being reinforced. The need to have a responsible body is vital in making sure that all healthcare professionals, including Occupational Therapists, maintain and /or improve professional standards. However, in my opinion it should also be the Occupational Therapists' responsibility to be involved in CPD as is mentioned in the Code of profession in Malta (statement 7.5) and in UK codes 5.4.1.

Getting back to work

Following a career break such as parental/ maternity leave, the need to have a re-training period to gain/ refresh new knowledge and skills in my opinion is essential. While in the UK, the COT has developed what is called a 'Return Pack'., to date, in Malta, reduced hours of work and assistance to children (in a few places exists only). No specific program exists for those who want to go back to the working life. One is assumed to be competent and knowledgeable enough to re-start work immediately with no need to follow a training period. This clearly shows the lack of support the Department of Health (Malta) is giving to these persons. Moreover, the importance to be competent at work is taken for granted.

Funding for CPD

There is no automatic right to be funded in order to carry out further education. This seems to be unfair, especially in the UK where every individual is expected to carry out CPD. In Malta, the DH in line with the Manual Staff Developments section offers training initiative schemes to all healthcare employees. Individuals who want to

follow a continuing education programme can apply for 'paid study leave'. This means that a released period is given (with full pay) in order to carry out such programmes. A contract between the two parties is signed where the applicant is bound to work a stipulated period of time with the DH following the course completion. Although the MAOT aims to establish and maintain professional standards in the practice of Occupational Therapy, no funds are available to support its members. Therefore, very minimal support/ funding exists for practising Occupational Therapists. Most of the courses have to be paid by the applicant him/herself through special loans taken from local banks.

Through the University of Malta (UOM), educators/ teachers have been funded to gain further qualifications. This happened in our profession in order to be able to open a degree course. This is supported by WFOT standards that state that educators' qualifications should normally be at least one level higher that those of graduates of the programme. Therefore, it is clearly stated that the UOM is supporting its lecturers to improve their qualification standards. Moreover, every year full time educators have access to free books, and the purchasing of information technology such as computers and software items. On the other hand, practising staff is being hindered from these benefits in that there are only two full time posts in a team of nine lecturers and financial support from the University is only given to full time employees. Part time lectures have to pay for their own CPD.

This also shows a discrepancy between the two areas of practice. Also, the fact that continuing education program within the University are very limited and none are related to our profession, the university itself is hindering qualified staff in gaining new knowledge and to further their qualifications. Action programmes developed by the European Union (EU) like Socrates II, Leonardo Da Vinci and EQUAL should be taken into consideration by Occupational Therapists. These programs are funded by EU through the European Social Fund. Although applications for such programs may take long and some are complicated to fill, such an opportunity

should be taken to enhance lifelong learning for Maltese Occupational Therapists.

Portfolios

Chambers Concise Dictionary (1991) defines a 'portfolio' quite simply as a collection of papers. Brown (1995) defined portfolio as "a private collection of evidence which demonstrates that continuing acquisition of skills, knowledge, attitudes, understanding and prospective. It is both retrospective and prospective, as well as reflecting the current stage of development and activity of the individual".

Portfolio is a dynamic tool that indicates change over time and the creator's hopes and plans for the future. This support what Redman (1994) suggested that *"a portfolio is a living, growing collection of evidence that mirrors the growth of its owner*". Therefore, it is not only aimed to demonstrate achievements. It should present an evolving collection of material and observations that constantly relates the past to the present and the present to the future. A portfolio enables the learner to become more reflective, to be able to recognise strengths and limitations and become more aware of the learning they have achieved (Brookfield, 1995).

It is anticipated that evidence to CPD will be needed for maintaining state registration (Craik, 1997). In the UK, the Code of Ethics and Professional Conduct for Occupational Therapists (COT, 2000) 5.4.2. state that: *"each occupational therapist is responsible for maintaining a portfolio detailing CPD".* In an article published on the OT News, Grooves (2001) said that: *"any one of us could be asked to submit our CPD Portfolio to an official body in support of our request for annual renewal. Any one of us could be stuck off the Register and deemed not competent to practice if we cannot prove otherwise".* In fact what Grooves said came into effect last October where the Health Professions Council (HPC) made it clear that Occupational Therapists are expected to demonstrate their continuing competence.

In Malta once registered in the BPSM, you will not get expelled from the registration list if one fails to show evidence for continuing education as

only the curriculum vitae is needed. Action against the individual can be taken if unprofessional conduct and conviction for criminal offenses are made. Therefore, at present there is no need for health care workers to have a portfolio.

However, this issue was and is still being discussed by OTEC and by the MAOT. In fact, 2 workshops on CPD have been already organized and I am sure that further debate will be going on. Also Occupational Therapists who want to work outside the Maltese Islands will need to be ready to show their portfolio. Therefore, I feel that all Occupational Therapists should be ready with their portfolio, as this issue will soon be discussed in higher authorities.

Conclusion

Research studies, statutes, and other literature clearly show that lifelong learning will improve competence, which will also help in gaining new knowledge and skills. However, there is still a discrepancy between what is written and every day reality. Although lifelong learning is quite a new concept, the need to start developing support and initiatives for Occupational Therapists in the health care arena is of utmost importance. Health authorities and other bodies including the health care system, Department of Health, and national associations are not supporting enough individuals who want to carry out further education. The need to upgrade laws and reinforce present ones is felt. Occupational Therapists in Malta need to further develop this aspect of the Service. This would lead to a better quality of care to both our clients and society itself. Therefore, with an increase in support and by giving more opportunities, OT services and professional competence would surely be maintained and improved.

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Occupational Therapy The German Way - Joseph Busuttil

A recent visit to Germany as part of the management component of the European Union Leonardo Programme gave me the opportunity to observe at close quarters how our profession is conducted at a major psychosocial hospital, as well as at a university undergraduate course.

The Zentrum for Psychiatrie Soziale Rheinblick in Einchberg has a catchment area of 400,000 inhabitants in Wiesbaden and the Rhinegau region. The hospital has around 400 beds with sections for young people, adults, the elderly, as well as a forensic area. There is also a day centre in Wiesbaden.

Occupational Therapy (or Ergotherapie, as our profession is called in Germany as well as in a number of European countries), is carried out in one major building, as well as in a number of OT departments situated in the wards of the major areas. The German OT's stress the activity base of the profession. Besides the activities of daily living, they also carry out various techniques in the rehabilitation programme like information technology and clerical work; art and pottery; silkscreen printing; woodwork and cane work. What I found interesting is that there are no technical staff to help out in these techniques, but the OT's themselves have a solid technical background which enables them to guide and supervise patients in these activities.

While on a visit to the OT university course at the Europa Fresenius Fachhochschule in Idstein, I could understand why German OT's are so well versed in technical activities. Besides the usual academic curriculum, the facility has a number of workshops for the activities mentioned above, as well as for others like leather work and bookbinding; it is here that the OT students get their intensive technical training (incidentally, three of the Idstein OT students have recently been in Malta for a lengthy practicum as part of their course).

Talking to leaders of the OT profession in Germany, one becomes conscious that the profession there is not without its problems. There are financial cuts in the

health service, which means that some OT posts are being cut in various hospitals. There is also high OT unemployment rates in Germany. The problem stems from the fact that there are more than 160 OT higher educational establishments in the country, with the result that there is overproduction of therapists. I was told that this figure must come down to around 60 teaching facilities so that the unemployment problem could be tackled successfully.

Overall, it was a very stimulating visit and a learning experience, during which I could not help but recall the poet's words that: "Absence of Occupation is not rest; A mind unoccupied is a mind distressed."

PARENTS' PERCEPETIONS OF O. T. SERVICES, AS MEASURED BY THE MEASURE OF PROCESSES OF CARE (MPOC) - MAUREEN SPITERI

(Dissertation submitted in partial fulfilment of the requirements for the Degree of Bachelor of Health Science (Hons) O.T.)

Introduction

Over the past twenty years, there has been a dramatic change in the nature of service delivery for children with disabilities and the parent-service provider relationship. As opposed to the traditional professional-directed style of child-centred care, a new approach is now opted for, referred to as Family-Centred Care (King et. al, 1999).

Family-Centred care is a philosophy and method of service delivery for children and their parents, which emphasises a partnership between parents and service providers. This philosophy of care is based on a number of important concepts including:

- parents are the ones who know their children best and they want the best for their children;
- all families are different and unique;
- the child's functioning is the result of the supportive family and community context. Hence the child is affected by the stress and coping of other family members (King et. al, 1998; Rosenbaum et al, 1998)

Literature Review

Occupational therapy literature promotes a family-centred care approach, as clients are part of a family structure (Mattingly & Lawlor, 1998). This is especially true in paediatric care, since children do not operate in a vacuum and hence successful intervention requires sensitivity to the perspectives of the parents (Cohn, Miller, & Tickle-Degnen, 2000; Hinojosa & Kramer, 1993). Providing family-centred services requires practitioners to understand what the behaviours, events, persons and institutions mean to those who participate in them (Cohn & Cermak, 1998).

Paediatric literature provides evidence that parents of children with chronic

disabilities such as cerebral palsy not only suffer increased stress and burden as a secondary consequence of their child's condition (Sloper & Turner, 1993), but also have an increased risk of social and mental health problems (King, Rosenbaum & King, 1996). Recent studies show that there is a relationship between aspects of caregiving and parental distress (King et al., 1999; Sloper 1999; Miller et al., 1992).

The powerful influence that parents exert on the developmental gains of their children, has been well-documented (Hinojosa & Anderson, 1991). Hence there is a profound need to involve parents in their child's treatment (McCall & Schneck, 2000). Thus paediatric occupational therapy intervention does not focus solely on the child, but must also target parents. To achieve this, occupational therapists must be cognisant on the parents' expectations, since, if these are not met, the parents' perceptions of occupational therapy services may be affected. In turn the latter may limit the beneficial effect of occupational therapy services for the child (McCall & Schneck, 2000). Similarly Hinojosa and Kramer (1993), state that it is the family and not the therapist who has the true power, and hence it is only the former who can facilitate or sabotage the intervention process. These authors remark that when the occupational therapist does not consider the important people in the child's environment, the intervention may be inappropriate. They stress the fact that intervention should be conducted in the human context of the child's life; otherwise the treatment is not aimed at the whole person.

There are two possible ways of investigating the nature of the service delivery offered to parents and their children. One way is to investigate the perceptions of the professionals (McBride et al., 1993). However a number of authors agree that the ultimate evaluation of implementation of family-centred care lies in the perception of parents (Carrigan, Rodger & Copley, 2001; King, Rosenbaum & King, 1996; Mahoney, O'Sullivan & Dennebaum, 1990; McBride et al., 1993). Mahoney, O'Sullivan & Dennebaum (1990), report that the only way that services can ascertain that they are truly providing family-centred care is, if the parents

themselves perceive that they are receiving the kinds of services that family-centred care entails. Whilst according to Carrigan, Rodger and Copley (2001), only by obtaining the views of parents can one identify gaps in the existing services. Similarly King, Rosenbaum and King (1996), imply that the receivers of a service are the only true source of information about what type of care is actually received.

Methodology

Although various studies have been carried out to investigate parent's perceptions of family-centered care, and the nature of service delivery (Carrigan, Rodger & Copley, 2001; King et al., 2000; King et al., 1998; King, King & Rosenbaum, 1996; King, Rosenbaum & King, 1996; King, Rosenbaum & King, 1997; Mahoney, O'Sullivan & Dennebaum, 1990; McBride et al., 1993) all of these studies are foreign. Consequently there are no studies that have investigated the local situation. Hence the aim of this study was to examine the parents' perceptions of the extent to which occupational therapy services within a national health service are delivered in a family-centred manner. This will enable occupational therapists to become more aware of the parents' viewpoints and hence ameliorate service provision. Ultimately this information may lead to the provision of more effective occupational therapy services to serve the children and family members more effectively.

Parents' perceptions were tapped using an already validated questionnaire; the Measure of Processes of Care (MPOC) by King, Rosenbaum and King (1995). It is a 56-item measure of parents' perceptions of service providers' behaviours. It contains five scales: enabling and partnership; providing general information; providing specific information about the child; co-ordinated and comprehensive care for the child and family; and respectful and supportive care. The general format of an item is 'To what extent' does a particular behaviour happen. Parents use a 7-point response option to record their answers. Scales are then calculated by averaging the scores of all items on a scale. No overall MPOC scale is calculated. This likert rating of statements, allows comparisons across studies (McNaughton, 1994).

SCALE NAME	NO OF ITEMS	EXAMPLE OF AN ITEM
		To what extent does the OT that works with your child...
Enabling & Partnership	16	....provide opportunities for you to make decisions about treatment?
Providing General Information	9	...have information available about your child's disability (e.g., its causes, progress)?
Providing Specific Information	5	...provide you with written information about what your child is doing in therapy?
Co-ordinated & Comprehensive Care	17	...look at the needs of your 'whole' child (e.g., mental, social) instead of just the physical needs?
Respectful & Supportive Care	9	...treat you as an individual rather than as a 'typical parent of a child with a disability?
Total	**56**	

Table 3.1.

MPOC – 56 Scales (modified from King, Rosenbaum & King, 1995)

Since the questionnaire (MPOC), was administered in the form of a structured interview, the 7-point response option was printed in a large font so that the participants have a visual image and not simply a mental one. Except for three interviews that were carried out in English, all the other interviews were done in Maltese.

The MPOC was developed with extensive input from parents and is based on aspects of care that parents view as important. It has sound

psychometric properties (King, Rosenbaum & King, 1995).

The effects of a child with a neurodevelopmental disorder such as cerebral palsy on family life may produce different demands to those of a child with, for example, conduct disorder, as well as different medical and paramedical needs (Sloper & Turner, 1993). Hence for the present study, families of children with cerebral palsy were chosen, as it is assumed that a study of one diagnostic group would reveal consistent issues being confronted by these families.

In this study the target population consisted of the parents of children with Cerebral Palsy that were currently receiving occupational therapy treatment at the Child Development and Assessment Unit in St. Luke's Hospital. Hence the study took place at the Occupational Therapy department at the Child Development and Assessment Unit (CDAU) in Saint Luke's hospital, in Guardamangia, Malta. The researcher carried out the structured interview with 17 parents of children with cerebral palsy. Two parents participated in the pilot work while 15 participants took part in the main study. Therefore, the two parents that were used for the pilot work were not included in the main study. One of the mothers refused to participate, whilst two other children stopped attending for occupational therapy and hence were not considered as appropriate candidates.

Findings

The findings indicate that parents view Occupational Therapy services as being relatively family-centred. The information from the present study is comparable to information collected in similar studies (King et al., 2000; King et al., 1998; King, King & Rosenbaum, 1996; King, Rosenbaum & King, 1996; King, Rosenbaum & King, 1997).

The parents in the current study indicated that the Occupational Therapy Department was doing well with respect to the interpersonal aspects of service delivery, but that the provision of information was a relatively weak area. As in other studies ((King et al., 2000; King et al., 1998; King, King & Rosenbaum, 1996; King, Rosenbaum & King, 1996; King, Rosenbaum & King,

1997), parents reported that the provision of general information was the aspect of family-centred service that was least well done. Hence it seems that the interpersonal aspects of service delivery are being done well; and it is only the services that are influenced by system level issues, such as Providing General Information, that are not on the same standards.

Conclusion

The Occupational Therapy service under study should strive to improve the provision of information so as to provide services in a truly family-centered manner. A family-centered approach to service delivery leads to parental satisfaction, which is associated with increased adherence to home treatment programs for their children. In turn this is associated with better physical, behavioural and social outcomes for children (Carrigan, Rodger & Copley, 2001; King et. al,, 1999; King, Rosenbaum & King, 1996; Rosenbaum et. al., 1998). Research also shows that when parents receive family-centered services, they are less likely to experience feelings of distress and depression (King et. al, 1999). Being satisfied with services and seeing services as family-centered are not only important outcomes in their own right, but they are associated with a host of other outcomes for both children and parents.

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BEHAVIOUR QUESTIONNAIRE TYPE A

Adapted from 60 seconds Stress Management.

Many times, stress symptoms are the direct result of Type A behaviour. Unless we become aware of our own Type A traits, recognising stress symptoms and linking then to stress sources can be very difficult. The following quiz is designed to give you an idea of your own behavioural type. Read each statement carefully and then circle the number corresponding to the category of behaviour that best fits you. (1 = Never, 2 = seldom, £=Sometimes, 4= Usually, 5= Always). When you finish, add up all the circled numbers. A key at the end of the quiz will explain what your total score means.

1. I become angry or irritated whenever I have to stand in line for more than 15 minutes.
   1 2 3 4 5

2. I handle more than one problem at a time.
   1 2 3 4 5

3. It's hard finding the time to relax and let myself go during the day.
   1 2 3 4 5

4. I become irritated or annoyed when someone is speaking too slowly.
   1 2 3 4 5

5. I try hard to win at sports or games.
   1 2 3 4 5

6. When I lose at sports or games, I get angry at myself or others.
   1 2 3 4 5

7. I have trouble doing special things for myself.
   1 2 3 4 5

8. I work much better under pressure or when meeting deadlines.
   1 2 3 4 5

9. I find myself looking at my watch whenever I'm sitting around or not doing something active.
   1 2 3 4 5

10. I bring work home with me.
    1 2 3 4 5

11. I fell energised and exhilarated after being in a pressure situation.

1 2 3 4 5

12. I feel like I need to take charge of a group in order to get things moving.

1 2 3 4 5

13. I find myself eating rapidly in order to get back to work.

1 2 3 4 5

14. I do things quickly regardless of whether Ii have time or not.

1 2 3 4 5

15. I interrupt what people are saying when I think they are wrong.

1 2 3 4 5

16. I'm inflexible and rigid when it comes to changes at work or at home.

1 2 3 4 5

17. I become jittery and need to move whenever I'm trying to relax.

1 2 3 4 5

18. I find myself eating faster than the people I'm eating with.

1 2 3 4 5

19. At work, I need to perform more than one task at a time in order to feel productive.

1 2 3 4 5

20. I take less vacation time than I'm entitled to.

1 2 3 4 5

21. I find myself being very picky and looking at small details.

1 2 3 4 5

22. I become annoyed at people who don't work as hard as I do.

1 2 3 4 5

23. I find that there aren't enough things to do during the day.

1 2 3 4 5

24. I spend a good deal of my time thinking about my work.

1 2 3 4 5

25. I get bored very easily.

1 2 3 4 5

26. I'm active on weekends either working or doing projects.

1 2 3 4 5

27. I get into arguments with people who don't think my way.

1 2 3 4 5

28. I have trouble "rolling with the punches" whenever problems arise.

1 2 3 4 5

29. I interrupt someone's conversation in order to speed things up.

1 2 3 4 5

30. I take everything I do seriously.

1 2 3 4 5

The minimum score is 30, the maximum 150. The breakdown by personality type is as follows:

Score	Personality Type
1000-150	Type A
76-99	Type AB (Average)
30-75	Type B

If your score was 75 or below, you're a Type B person. You pretty much take life as it comes and usually don't allow problems and worries to dominate your life.

If your score was in the range of 76-99, you're part of a majority who has some Type A and some Type B characteristics. For the most part, you probably know how to relax and aren't very aggressive or competitive. You do however, take some things seriously and, in certain situations, like to be active, competitive, and productive. You need to see which Type A traits you have and decide whether or not they're affecting your health and lifestyle.

If your score was 100 or above, then chances are you're a Type A person and you need to work on your attitudes, behaviour, and priorities before you become seriously ill.

INSTRUCTIONS TO AUTHORS

(Adapted from British Journal of Therapy and Rehabilitation and NAPOT by Ruth Bondin)

Articles should be between 1,200 and 1,800 words, and may be in the form of reviews (e.g. literature or equipment); research reports (especially based on work undertaken for a bachelor's or Masters degree), case studies and particular techniques and activities; and both local and international work experiences.

Title

The title of the article should be concise and clear. The name of the author together with his/her titles.

Short Introduction

This should be between 50-60 words in length. It is designed to develop the reader's interest and to tell them broadly about the article.

Headings

Please use headings and subheadings. Headings should be in uppercase bold and subheadings in lowercase bold.

Tables and Illustrations

Tables and illustrations are a help to the readers. Tables and illustrations should be numbered consecutively, in order of their first citation in the text. If a figure has been published previously, acknowledge the original source.

Conclusion

Your conclusion should be brief and logically ordered. Identify gaps in Knowledge and suggest future initiatives.

References

In the text:

- Use the name and the year (Harvard) system for reference in the text: 'As Green and Smith (1998) have shown....' As already reported (Green and Smith 1998)...
- For three or more authors print the first author's name followed by *et al* eg 'As Green *et al* have shown...'
- When several references are cited simultaneously, the order should be chronological.
- The total number of references should not exceed 15.

In the reference list:

Arrange references alphabetically by the first author's name.

Print the names and initials of all authors.

The sequence for a journal article is:

Author(s); year; title; journal; volume; first and last page numbers.

The sequence, layout and punctuation for books are

Personal Author:

Laidler P (1994) *Stroke Rehabilitation: Structure and Strategy*. London: Chapman & Hall.

Editor:

McCarty, G T (ed) (1992), *Physical Disability in Childhood*, Edinburgh: Churchill Livingstone

Abbreviations.

Abbreviations should be defined at their first mention