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THE 10th ANNIVERSARY OF

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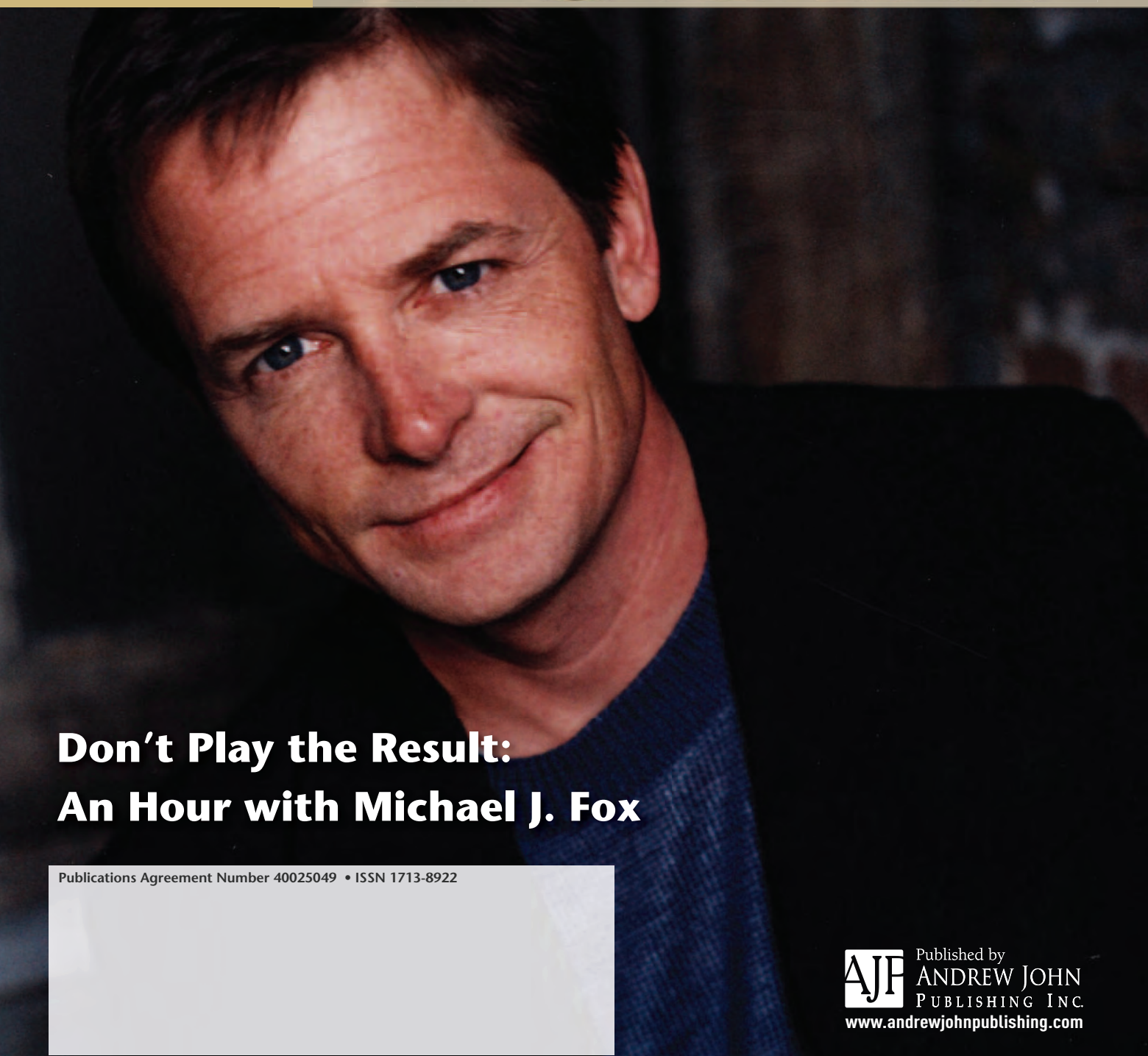

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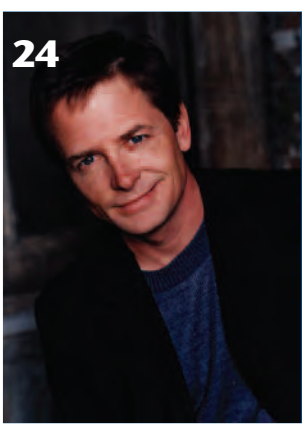

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REGISTRAR'S MESSAGE

It's Been an Eventful 10 Years for *CASLPO Today*

You will find a diverse range of topics of interest covered in this issue of *CASLPO Today*. They include areas such as the role of substitute decision makers; the impacts of the accessibility for Ontarians legislation; Alzheimer patient awareness; mandatory reporting requirements involving members; and updates on Practice Standards and Regulations and the Self-Assessment and Peer Assessment processes. There are also some regular features included, such as: news from OSLA; Regional Education Seminars; lists of College Council and Staff members; a review of recent complaint cases; a list of suspended members; and a summary of items considered at the last College Council meeting in December. We try to make each issue of the magazine as readable and useful as possible, and we always appreciate your feedback. Each issue is also available on the College website at www.caslpo.com.

This year, in fact, marks the 10th anniversary of the magazine's debut back in 2001. To mark this, over the next few issues we will be looking back at some of the major highlights in the magazine's coverage of the regulatory world of the professions of audiology and speech-language pathology. We will also be focusing on some exciting emerging trends and challenges.

The magazine, besides being distributed to the over 3,500 audiologists and speech-language pathologists in the province, is also typically distributed to a select group of interested stakeholders in Ontario, Canada, and the United States. They sometimes comment on articles in the magazine, ask for more information on a given topic, or permission to reprint an article in one of their own membership publications. Recently, the US-based National Council of State Boards of Audiology and Speech-Language Pathology took note of an article we published on ethical practice considerations in the use of social media. As a result, CASLPO has been invited to make a presentation on the topic at NCSB's annual conference this fall.

Our own national organization of provincial regulatory agencies, the Canadian Alliance of Audiology and Speech-Language Pathology Regulators (CAASPR) announced recently that it had applied to the federal government to develop a national competency-based assessment framework. The objective of this initiative, which is similar in scope to that under way in many other regulated health professions, is to improve labour mobility opportunities for audiologists and SLPs and to expedite the labour market integration of internationally-trained and Canadian applicants for registration, through the development of a national competency-based assessment framework for both professions.

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During the course of the three-year project, several approaches will be examined, including: the development of a centralized application and assessment process; setting common standards for entry-to-practice competencies through the development of performance indicators; creating profession-specific language benchmarks in both official languages; developing, testing and implementing an online competency-based portfolio assessment tool to assess and recognize prior learning of internationally-trained applicants; and determining the need for mandatory entry-to-practice examinations for the professions. A national advisory committee, of which I am a member, has been created to oversee work on the project.

I will be reporting in upcoming issues on the work of the advisory committee and the progress being made at various stages of this challenging national project. As well, as mentioned by the president of CASLPO Council, Vicky Papaioannou, in the last issue, CASLPO Council will shortly be approving a new Strategic Plan to guide the work of the College over the next three years. At the moment it is unclear how the CAASPR project will ultimately impact on the work of the College and the work of registered members. However, I can assure you that we will examine all proposals coming from the national level within the framework of the Strategic Plan and the College's commitment to regulating in the public interest and upholding the highest standards of professional and ethical practice.

Brian O'Riordan, Registrar

Update on the Inquiries, Complaints and Reports Committee

By Margaret Drent, Director of Professional Conduct

Since the last update in the fall, 2011, issue of *CASLPO Today*, the ICRC has held nine meetings. One of these meetings was a full meeting of the entire committee; in all of the other cases, the ICRC met as a smaller group, or panel. The *Health Professions Procedural Code*, which is Schedule II of the *Regulated Health Professions Act*, 1991, requires the ICRC to meet in panels to investigate complaints and reports of possible professional misconduct, incompetence or incapacity. The chair of the ICRC selects the members of a panel, which must consist of at least one person from the profession of the member whose case is to be decided. The panel must also consist of at least one public member. The minimum number of members of an ICRC panel is three.

In addition to enabling the ICRC to ensure that it complies with the legislation, meeting in panels has enabled the ICRC to reach decisions more quickly and efficiently. The decisions that the ICRC may make were outlined in the fall, 2011, *CASLPO Today* ICRC update. Below are some highlights of recent decisions.

The mother of an autistic child made a complaint to CASLPO that the speech-language pathologist who treated her child had not communicated with her appropriately; nor was she satisfied with the progress her son had made in therapy using the PECS system (Picture Exchange Communication System). The ICRC decided to take no action in this matter. The speech-language pathologist in question had acted appropriately in this circumstance. Further, the child had made progress in therapy, although the panel acknowledged the frustration that the mother must feel as a consequence of the responsibility associated with having a child with significant communication challenges.

Panels of the ICRC have considered complaints as well as a Registrar's Report regarding a member's use of the "Doctor title." According to section 33 of the *Regulated Health Professions Act, 1991*, members of certain regulated health professions may use the title "Doctor" when providing health care. Members of CASLPO are not permitted to use the title "Doctor" as a prefix before their name unless the academic institution to which they belong permits them to use the title because they obtained a PhD, and they are using the title in the course of teaching and research (not the provision of health care). In December 2011, the ICRC referred a member of the College to the Discipline Committee as a result of their use of the title. After a member of the College is referred to the Discipline Committee, the legislation as well as the College bylaws require that a notation to be placed in the public register beside their name to this effect. The notation should include a summary of each specified allegation as well as the hearing date(s), once they have been established.
The complainant in a 2010 decision of the ICRC involving a speech-language

Council met on Dec. 9 2011 and the following was discussed:

1. **Auditor's Report and Presentation**
   G. Katchin introduced B. MacKenzie, auditor from Hilborn Ellis Grant LLP, and welcomed him to the meeting.

   B. MacKenzie reviewed the financial statements and updated Council on the recent audit.

   The financial statement and Auditor's report were approved.

2. **Proposal for CASLPO Office Space**
   B. O'Riordan and G. Katchin updated Council on the proposal for CASLPO office space. A lengthy discussion followed. Next steps include providing additional research into CASLPO's space requirements and real estate availability to Council at a later date.

3. **Registrar's Report**
   B. O'Riordan presented his report of recent activities and meetings. Additional items include the following:
   - Nov. 30th meeting with OSLA; future meetings with OSLA will include discussions to organize a joint conference
   - Ad in *Forever Young (FYI)*

4. **Committee Reports**
   Council reviewed the reports from the following committees:
   a) Executive
   - N. Blake clarification on item 6 – that training be given to Council on what the role of Executive involves;
   - R. Lavallee-McNamee inquired as to when Council could expect to be informed of the policy mentioned in item 8 regarding rationale behind who attends which conferences. It was indicated that this will be coming to the next Council meeting.

   b) Registration
   c) Quality Assurance
   d) Audiology Practice Advisory
   - Following the review of the Committee report, M. Drent and J.

Scott reported on the proposal from U of T regarding support from CASLPO for establishing a Master's Program in Audiology.

- L. DeNil provided background information regarding the proposal, which was followed by additional questions from Council to assist with clarification. It was agreed that CASLPO should send a letter of support to the U of T for establishing a Master's Program in Audiology.

e) Speech-Language Pathology Practice Advisory

f) ICRC

- D. Zelisko asked for further clarification regarding the HPARB portion of the report, and M. Drent provided information on this.
- P. Faubert and M. Drent updated Council on the ICRC open cases report.
- B. O'Riordan explained the 150 day time frame for cases and that letters have been given to HPARB for extensions to those files that have gone beyond the allocated time frame.
- C. Bock provided an update on the recent work done by the SCERP Task Force.

g) Patient Relations

5. **PSG on Assessment of Adults by SLPs**
   A. Carling-Rowland updated Council on the progress/process of this document to date. Next steps include sending this document to members and stakeholders for review and comment.

6. **Peterborough Membership Regional Seminar**
   B. O'Riordan and A. Carling-Rowland updated Council on the recent Regional Seminar held in Peterborough. The session was video-taped with the hope to place this video on the website for review by all members as a future e-learning module.

ICRC UPDATE

pathologist asked for a review of the decision from the Health Professions Appeal and Review Board (HPARB). As noted in the fall, 2011 article, HPARB is a body entirely separate from CASLPO and is established by the legislation governing complaints and reports. Unless the ICRC refers the matter to the Discipline Committee for a hearing or for incapacity proceedings, parties to a complaints decision may ask HPARB for a review on the basis that CASLPO's investigation of a complaint was inadequate, or that the ICRC decision was unreasonable. In this circumstance, the ICRC determined that a member of the College had adequately explained the components of a bill to a client. The complainant had signed a document indicating that she understood and agreed with the conditions and terms governing the therapy provided. The ICRC decided to take no action regarding this complaint. In its decision, dated December 14, 2011, HPARB concluded that the CASLPO investigation had been adequate and that the ICRC decision was reasonable.

OSLA UPDATE

OSLA The Ontario Association of Speech-Language Pathologists and Audiologists

Exerting Influence on Behalf of the Professions through Government Relations

By Mary Cook, Executive Director, OSLA

OSLA, as the voice for the profession of speech-language pathologists and audiologists in Ontario, regularly advocates for the profession by representing their needs and their views to government and other stakeholders on a variety of issues. We continue to be a key partner in the Ontario health care system. These are a few of OSLA's recent collaborations:

1. Ministry of Health and Long-Term Care – Assistive Devices Programme Consultation

On January 31, 2012, OSLA audiology representatives participated in a half-day Association group consultation session with the MOHTLC - Assistive Devices Programme (ADP) to review proposed changes to the Vendor Agreement. The new vendor agreement template, according to ADP, will meet ADP's commitment to the Ontario auditor-general and bring the ADP's agreements into compliance with the Ontario government's new *Transfer Payment Accountability Directive (TPAD)*. We were asked to contribute our expertise and identify any knowledge gaps related to the new vendor agreement and its broad-

7. Conference Updates

Updates were given on the following conferences, which were attended by various staff and council members: NCSB, CAA, Canadian Stroke Congress, CNNAR, OSLA Symposium, OHA, ASHA.

Congratulations was expressed to L. DeNil on receiving the fellowship of the Association at the ASHA conference

It was requested that any documentation that is provided to conference attendees be shared with appropriate committees following the conference.

8. CAASPR Update

B. O'Riordan provided an update on the recent activities of CAASPR.

C. Moran questioned why CASLPA does not have a representative on the CAASPR board given that they conduct the national exam.
L. DeNil and C. Moran both expressed their agreement that a proper process needs to be followed as detailed in the RFP process for the hiring of the Project Manager/Executive Director for CAASPR, and as well that certain components (job description, etc.) be created and finalized prior to a decision being made.

Council endorsed the letter written by the Registrar to CAASPR expressing CASLPO concerns with respect to the process of hiring the Project Manager/Executive Director.

9. Procedures for Media Reports

B. O'Riordan asked for feedback on the recent change to providing media reports via e-mail links rather than hard copies in Council meeting packages. Council appreciates and looks forward to continuing to receive the media reports via email links.

10. 2012 Proposed Executive and Council Meeting Dates

The proposed Executive and Council meeting dates for 2012 were approved.

11. Other Business

M. Suddick asked for an update on the status of the Communicating a Diagnosis document. B. O'Riordan noted that an update will be presented to committees in the new year.

12. Evaluator's Report

S. Singbeil reported that today's meeting went well. Council members were prepared; focused on strategic leadership; appreciation to the President for allowing each member to participate in an efficient manner; appreciation to all for using microphones; continued to keep the public interest at the forefront in discussions.

based implementation across all device categories. The outcome of this consultation will guide the government in preparing a new comprehensive agreement package that will be distributed to registered vendors.

2. Submission to HPRAC on the Treatment of Spouses and Mandatory Revocation

All health professional associations, regulatory colleges, and other stakeholders were recently invited by the Health Professions Regulatory Advisory Council (HPRAC) to make a submission on the issue of Mandatory Revocation Provisions and Treatment of Spouses by regulated health care professionals. HPRAC will then determine, based on all the submissions, appropriate recommendations to make to the minister on their findings. This review involves a very complex and sensitive issue.

The current legislation states that if a regulated health professional provides treatment to a spouse there is an automatic revocation of licence to practice in the province for 5 years and a finding of sexual abuse. This legislation was designed to encourage the reporting of sexual abuse by a "patient" and thereby discouraging and eliminating sexual abuse of patients by members of the regulated health professions. The original intent of this regulation is one that OSLA supports. In our submission to HPRAC, OSLA emphatically stated that we support zero tolerance of sexual abuse by anyone in a position of authority, influence, power imbalance and trust. That aspect of the provision should not be changed.

OSLA's position is that the recent interpretation of the sexual abuse provisions by the courts has taken us in an unanticipated direction that imposes draconian consequences on our members that are not necessary to achieve the objectives of zero tolerance, and in fact diminishes its intent when applied to spouses. The mandatory revocation of licence for 5 years should be eliminated and each regulatory College should have the authority to set its own best practices guidelines and disciplinary measures for its registrants based on risk of harm – on a case-by-case basis. It should also be noted that in the RHPA, there is no definition of "patient." Therefore is a spouse a "patient"? Regulated health professionals should have the discretion of treating their spouse, without penalty – unless a complaint is made by the spouse to the College – and until a decision is made, there should not be automatic revocation.

We stated that should HPRAC adopt OSLA's recommendations, the important public policies underlying and informing the colleges on the sexual abuse provisions should not be altered or undermined. If anything the focus of the current provisions will be returned to the real harm that the provisions were drafted to address: the sexual abuse of the general public who are patients.

3. Meeting with the Ministry of Education – SLPS in Education Interest Group

On February 3 OSLA met with representatives of the Ministry of Education, Special Education Policy and Programs Branch, to discuss among other topics, the Speech and Language Advisory Committee/Demonstration Sites and any additional follow up from the Deloitte Report, Full-Day Learning, and the *Supporting Oral Language Development (SOLD)* resource guide. We also presented to the ministry staff OSLA's recent School Services Survey which outlined four key themes; ongoing need for speech and language services for Ontario students; concerns regarding policies and guidelines governing speech and language services for school age children; transition to school for students with speech and language needs; and services for students with complex needs. We are looking forward to the opportunity to continue to build a better working relationship with ministry staff and to collaborate on issues that impact our members in the education sector and our ultimate goal – to improve and increase school SLP and audiology services for students in Ontario.

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FAQs about the Self-Assessment and Peer Assessment Programs

By Carol Bock, Deputy Registrar and
Alexandra Carling-Rowland, Director of Professional Practice and Quality Assurance

The Quality Assurance (QA) Program at CASLPO is based on the principle that lifelong learning and practice evaluation are essential to continuing professional competence resulting in quality service to the public. Each year, 250 members are randomly selected to submit their Self-Assessment Tool (SAT) online, and from the 250, 30 are randomly selected to participate in the peer assessment process. Both the SAT and peer-assessment focus on four areas: description of your practice, evaluation of your Professional Practice Standards, formulating Learning Goals, and acquiring Continuous Learning Activity Credits (CLACS) to help realize your goals. As we roll out the process each year questions arise:

Why Me?

A: Luck of the draw! Every year 250 members are randomly selected to submit their Self-Assessment Tool (SAT) by an outside information technology service.

I submitted my SAT In 2008, I have been asked to submit it again, is that right?

A: Some members will inevitably be randomly selected from the pool more than once. When you complete your SAT your name is removed from the pool for three years. Consequently, a member who was selected in 2008 to submit their SAT would be taken out of the pool for 2009, 2010, and 2011. They are back in the pool for selection in 2012 and therefore could potentially be selected for this year.

Can I count continuing learning activity credits (CLACs) that are not related to my goals?

A: No. All Learning Activities must be connected to a Learning Goal. However, you can add to your goals so that your Learning Activities do relate. Your Learning Goals are not set in stone and can be revised at any point to include learning opportunities when they arise and to address practice demands as they change.

Do I need to submit anything with my SAT?

A: No, you do not need to submit evidence when you send in your SAT online. Write the learning activity summary in the box provided, fill in your CLACs (one hour equals one CLAC) and pull down from the menu the type of learning activity; presentations, self-study, clinical guidance etcetera.

How are those members who are peer assessed selected?

A: The 30 members who are selected for the peer assessment are selected from the 250 who must submit their SAT. However, the 30 members are selected **before** CASLPO receives their SATs so there is no possibility of selecting the members for peer assessment based on how they filled out their SAT. It is completely random. Once selected for a peer assessment, though, the member is then removed from the general pool for 5 years.

How is a peer assessor assigned to me?

A: You are matched with the peer assessor based on several factors, including, area of clinical practice, potential conflict of interest or bias, geographical proximity, and the preferred time for assessment. Once the best match is made, you will be provided with the name of your assessor, usually through e-mail. You will be granted one veto opportunity, as stipulated in the Quality Assurance Regulation. Once you accept the peer assessor, then the College informs the peer assessor and provides them with the necessary contact information.

Once I have submitted my package of evidence for the peer assessment is there any opportunity to change or add to it?

A: You cannot add or change the evidence once it is submitted to CASLPO. If you are submitting electronically, you will find that the SAT online is temporarily closed for you or if you are sending in hardcopy evidence, nothing is accepted past the due date. However, sometimes members cannot include evidence for all the indicators due to the fact that some types of evidence are not amenable to copying or scanning and uploading (e.g., videos, materials that are three dimensional, etc.). For this reason, it is perfectly acceptable to demonstrate the evidence when the peer assessor makes their site visit. It is preferable to have as much evidence submitted in advance. However, in order to make the site visit more efficient and valuable for the member.

Will the peer assessment focus on my clinical skills directly?

A: No. Because the peer assessment process does not include observing members with patients/clients it is not possible to evaluate this aspect of your practice. Primarily the assessment is

limited to document reviews and conversations with you, the member. Although some aspects of your evidence and your knowledge of the practice standards will reflect to some degree your clinical practice, this process does not attempt to evaluate your clinical skills directly.

Summary

The Self-Assessment Tool and peer assessment process are designed to enhance your practice and are best viewed at an opportunity to develop professionally. However, it is not unusual to feel some apprehension or uncertainty. If you have any questions at any point in the Quality Assurance process or if you would like the benefit of speaking with other members who have been through the process, do not hesitate to contact Alex Carling-Rowland at 416-975-5347, toll-free at 1-800-993-9459 extension 226 or via e-mail at acarlingrowland@caslpo.com

Mandatory Reporting – Frequently Asked Questions

By Margaret Drent, Director of Professional Conduct - January 2012

Members often ask the College about their obligations in regard to "mandatory reporting." This term refers to legal obligations to report terminations of employment, sexual abuse, and other issues to the College. These obligations are described in the *Health Professions Procedural Code*, Schedule II of the *Regulated Health Professions Act, 1991 (RHPA)*. Some questions and answers on this topic appear below.

I am an employer and a member of CASLPO. I have just terminated a staff member. Do I have to report this to CASLPO?

A: Yes. Section 85.5(1) of the *Health Professions Procedural Code*, Schedule II of the *Regulated Health Professions Act*, 1991, provides that a person who terminates the employment or revokes, suspends or imposes restrictions on a member for reasons of professional misconduct, incompetence or incapacity must file a report with the Registrar within thirty days of the termination.

Can I submit my report by e-mail?
A: Yes, although please note that e-mail is not secure. The College tries to avoid using e-mail wherever possible as part of the reports process. Sometimes, however, for reasons of time, e-mail may be the most efficient way to work.

I have decided not to renew the contract of an SLP who works for me. I do not employ SLPs permanently; rather, they work on contract. do I have to report this to CASLPO?

A: Yes, but only if you decided not to renew the contract for reasons of professional misconduct, incompetence or incapacity. The intent behind the mandatory reporting provision quoted above is to ensure that the College is made aware that a person has been terminated, or that their contract has not been renewed due to their professional misconduct, incompetence, or incapacity. Therefore, the employment arrangement between the employer and the employee is not important. What is important is to make the College aware that there has been a change in the employment arrangement because of professional misconduct, incompetence, or incapacity.

I have decided not to renew a contract because the SLP in question violated a non-competition agreement with me. I do not see a reference to non-competition agreements in the Professional Misconduct regulation. Do I have to report this decision not to renew the contract to CASLPO?

A: Yes. If you are uncertain about the existence of professional misconduct, incompetence, or incapacity, set out the details in your reporting letter. The Registrar will review this information and decide what to do.

What happens with the mandatory reports that I file with the College?
A: The Registrar reviews all mandatory reports of termination received and decides whether there are reasonable and probable grounds to believe that there has been professional misconduct, incompetence, or incapacity. If the Registrar is of this view, he will ask the Inquiries, Complaints and Reports Committee to review the matter. If the ICRC is in agreement with the Registrar, the ICRC will approve the appointment of an investigator. The investigator will then contact the person who filed the mandatory report to speak to them as part of the investigation. *However, because of the confidentiality rules in the RHPA, the College may not be able to provide any additional information, depending on the outcome.*

I am not a member of CASLPO, but I manage SLPs and audiologists. Do I have to file mandatory reports?

A: Yes. Section 85.5 of the *Health Professions Procedural Code*, Schedule II of the *RHPA*, includes "a person who terminates the employment…"

Can the employee sue me if they find out that I filed a mandatory report with CASLPO?

A: No. Section 85.6 of the *Health Professions Procedural Code* provides that no action can be instituted against any person for filing a report in good faith under section 85.5 of the *Code*.

What happens if CASLPO finds out that I did not file a mandatory report?

A: In theory, you could be fined following a provincial offences prosecution. Section 93(1) of the *Health Professions Procedural Code* provides that every person who contravenes s. 85.5(1) is guilty of an offence and on conviction may be ordered to pay a maximum $25,000 fine. In addition, if you are a member of the College, you may be investigated for failure to comply with the RHPA.

I was convicted of driving while impaired. Do I have to inform the College?

A: Yes. The *Health Professions Procedural Code* requires members to disclose to the College if they have been convicted of an offence. Please note that this does not mean that a notation will be placed in the public register to this effect. The information will become public only if the matter is referred to the Discipline Committee, and that Committee takes action.

I think that one of the people who works for me has an incapacity issue. Do I have to inform the College?

A: Yes, if you terminate or suspend them for reasons of incapacity (see above). If you are a "facility operator," which is an undefined term in the law but which may include private offices or multidisciplinary clinics, and you have reasonable grounds to believe that a practitioner who practices at the facility is incompetent or incapacitated, you must report this to the College.

Please note that "incompetence" means that the member's professional care of a patient displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that the member is unfit to continue to practice or that the member's practice should be restricted. "Incapacity" means that the member is suffering from a physical or mental condition or disorder that makes it desirable in the interest of the public that the member's certificate of registration be subject to terms, conditions or limitations, or that the member no longer be permitted to practice. In both cases the issue must be sufficiently serious that it requires that restrictions be imposed on the practice of the member (examples include mentoring, monitoring, suspension, or limitation in scope of practice).

I am a CASLPO member. I have just been let go by my employer because of budget cuts. My employer told me that s/he has informed the College. What happens next?

A: The Registrar will review the information in the reporting letter to determine if the matter should be referred to the ICRC. If there is insufficient information in the reporting letter, staff will contact the employer to follow up. If the Registrar decides to bring the matter before the ICRC to ask for approval of an investigation, you will be contacted by the investigator. The matter would be referred to the ICRC only if the reporting letter indicated that their might be professional misconduct, incompetence, or incapacity.

I have a question that has not been answered above. Whom should I contact?

A: You can call Margaret Drent, the Director of Professional Conduct, at (416) 975-5347 extension 221, or toll-free at 1-800-993-9459.

College Changes That Will Affect Your Practice: Regulations, Bylaws, and Practice Standards Update

By Carol Bock, Deputy Registrar

It is important to keep abreast of changes that will affect your practice. When regulations, bylaws, practice standards and guidelines (PSG) and Position Statements (PS) are in circulation, it is your opportunity to provide Council with feedback. When any of these documents are published you are then required to adhere to them. Here is an update as of January, 2012:

In development

- PS on Use of Support Personnel by Audiologists
- Advertising Regulation
- Conflict of Interest Regulation
- Professional Misconduct Regulation

In circulation

- PSG on Assessment of Adults for SLPs

Awaiting ministry approval

- Quality Assurance Regulation
- Registration Regulation
- Records Regulation

Recently published

- PS on Disclosure of Test Materials and Data
- Proposed Records Regulation, 2011

Addressing Hearing Loss is Important for Patients with Alzheimer's Disease and their Caregivers

By Marilyn Reed, Audiology Practice Advisor, Baycrest Geriatric Healthcare System

The link between age-related hearing loss and cognitive impairment has been well established through over 30 years of research, and recent findings have caused a resurgence of interest in this relationship.

When functioning optimally, auditory and cognitive processing together enable us to receive and perceive multiple acoustic signals superimposed upon each other (such as when we are listening to conversation in a noisy restaurant) so that we can extract meaning from the cacophony of sounds around us almost effortlessly.

The interaction and co-dependence of cognition and sensory systems allows us to perceive the world around us, to comprehend, communicate, to learn, and to share thoughts and ideas. Our ears enable us to hear, but our brains enable us to use what we have heard for specific purposes.

Impairments of hearing and cognition both increase markedly with age such that the majority of those over 75 years of age have hearing loss and about 20% have cognitive impairment. Since both hearing and cognitive impairment are highly prevalent in older adults, it is reasonable to expect that dual impairments would be common. However, these conditions seem to combine in ways that we are only beginning to understand. Hearing loss is more prevalent in those with dementia (90% of cases) and recent studies of those with mild cognitive impairment (MCI) have found that their performance on tests of auditory processing is worse than that of controls. In addition, epidemiological studies have shown that hearing loss and the ability to understand speech in noise are predictive of the future manifestation of dementia.

Audiologists, psychologists, neuroscientists and others (including those at Baycrest) are exploring the interactions between sensory and cognitive processes in healthy aging and in those with dual impairments, and what we learn should have a positive impact on patient care.

Because research has provided strong evidence that hearing impairment contributes to, or accelerates the progression of symptoms of cognitive decline in older adults, hearing health care is an important component in the larger context of healthy aging.

Studies have also shown that the use of interventions such as hearing aids can help individuals with Alzheimer's disease, and yet these individuals are much less likely to receive attention for their hearing needs. As well as helping patients hear better, we can also help to alleviate the burden of caregivers by reducing problem behaviours and facilitating communication.

A comprehensive hearing assessment should be part of any Alzheimer's diagnosis because interventions for hearing loss may not only help to maintain communication and social interaction, but might also help to stave off or slow down the manifestation of symptoms of dementia.

Staff Contact Information

Due to Canada Post requirements, CASLPO's mailing address must now include "Box 71" as seen below.
Mailing Address: CASLPO, 3080 Yonge Street, Suite 5060, Box 71, Toronto, Ontario, M4N 3N1
Telephone: 416-975-5347 or 1-800-993-9459 (Toll-free in Ontario only) Fax: 416-975-8394

Name	Title	Ext	E-mail
Brian O'Riordan	Registrar	215	boriordan@caslpo.com
Carol Bock	Deputy Registrar	227	cbock@calspo.com
Margaret Drent	Director of Professional Conduct	221	mdrent@caslpo.com
Colleen Myrie	Director of Registration Services	211	cmyrie@caslpo.com
Gregory Katchin	Director of Finance & Operations	217	gkatchin@caslpo.com
Alexandra Carling-Rowland	Director of Professional Practice & Quality Assurance	226	acarlingrowland@caslpo.com
Carol Lammers	Executive Assistant to the Registrar	214	clammers@caslpo.com
Camille Prashad	Program Assistant (Registration Services)	213	cprashad@caslpo.com
Julie McFarland	Program Administrative Assistant (Corporate)	210	jmcfarland@caslpo.com

What You Need to do to Comply with the Accessible Customer Service Regulation

This article was written by People Access, a division of Excellence Canada, formally known as the National Quality Institute.

Providing accessible services for people with disabilities is not just good practice, **it is now the law**. In June, 2005, the Ontario Legislature passed the *Accessibility for Ontarians with Disabilities Act (AODA)*. Under this legislation, five standards were developed setting out requirements on accessible customer service, information and communication, transportation, employment and the built environment which deals with building, entranceways, parking etc. The first standard on accessible customer service is now in force. The information below will help you understand what you need to do to comply.

Who Needs to Comply? Is My Organization Included?

All organizations and businesses that operate in Ontario and have at least one employee must comply. The only organizations that do not need to comply are unincorporated sole practitioners and organizations run entirely by volunteers. If you are a sole practitioner but your incorporation documents name you as an employee of your company, you need to comply. Even if you only have part time or part year employees, you still need to comply. One way of looking at it is, if your organization issues T4s, you need to comply.

When Do I Need To Comply?

January 1, 2012 is the date that all organizations in the private or non-profit sector must be in compliance with the accessible customer service standard. Organizations in the broader public sector such as hospitals, universities and municipal governments were required to comply by January 1, 2010.

I Don't Have "Customers." Are You Sure This Applies To Me?

The government chose the word "customer" as shorthand to refer to anyone that an organization provides with goods and services. Students, patients, and clients are all included under this term.

What Do I Need To Do?

There are eight requirements that apply to all organizations with one employee or more.

1. Establish a set of policies, practices and procedures on how you and your employees will provide goods and/or services to customers with disabilities.

2. Allow customers with disabilities to use personal assistive devices e.g., hearing aids, wheelchairs, walkers, oxygen tanks, to access your services and/or goods

3. Communicate with a person with a disability in a manner that takes into account his or her disability

4. Train all staff to provide accessible customer service. The regulation is clear that it isn't just front-line staff but also management that must understand how to provide accessible customer service. You must also train volunteers and contractors if they will be acting on your behalf with patients, clients or customers.

5. Allow people with disabilities to bring a guide dog or service animal with them to your premises, unless otherwise prohibited by law. For example, animals are not allowed by law in a restaurant kitchen or an operating theatre in a hospital.

6. Permit people with disabilities who require a support person to bring that person with them. If you charge a fee, your organization can decide whether to waive or lower the fee for the support person.

7. Provide notice when facilities or services that people with disabilities rely on to access your goods or services are temporarily disrupted.

8. Establish a process for people to provide feedback on how you provide goods and/or services to people with disabilities.

Organizations and businesses with 20 or more employees will also need to file regular compliance reports. These are on-line checklist reports that are quick and easy to complete. If your organization has 20 or more employees, the government will be sending you instructions on how to complete your compliance report. Organizations and businesses with 20 or more employees are also required to prepare written policies, practices and procedures. Smaller organizations and businesses need to develop such policies, practices and procedures and communicate them to all employees, but don't have to have them written down.

What Will Happen If I Don't Comply?

The government is hoping that most organizations and businesses will see

the benefits to them of providing accessible customer service in terms of providing more effective service to all their customers or clients, gaining loyalty, and attracting new clients or customers. Therefore the emphasis is on education and support to help organizations come into compliance. If your organization is found to be out of compliance either through a complaint received, through your submitted report or through an audit, the government will first attempt to provide the support and information you need to come into compliance. You may also be issued a director's order detailing when and how you must comply. You may be levied an administrative monetary penalty. While the emphasis is on helping organizations to come into compliance, **there are serious penalties for organizations that commit an offence under this legislation by refusing to comply with a directors' order, preventing an inspector from inspecting your premises or submitting a false report. If an offence is committed, your organization may be fined up to $100,000 a day, and/or an individual responsible for the offence may be fined up to $50,000 a day.**

Where Can I Learn More?

You can go to www.accesson.ca to view the legislation and the accessible customer service regulation and to access the tools that the government has developed to help you comply.

How Can I Get Started So I Will Be In Compliance In January, 2012?

People Access, a division of Excellence Canada devoted to helping organizations in different sectors plan and implement the legislated AODA standards is a one-stop source of free and low-cost products, services, resources and tools to help you meet the upcoming deadline.

Go to www.peopleaccess.ca or www.accessibilityconsultants.ca to learn more about what they provide.

New Members for 2011

By Colleen Myrie, Director of Registration Services

The College of Audiologists and Speech-Language Pathologists of Ontario welcomed the following new members between January 1, 2011 and December 31, 2011:

Audiology

Reg. No.	Name
5592	Sara Alberni
5569	Nadine Anis
5243	Parviz Ashtari
5597	Patricia Auger
5634	Diane Allison Barons
5739	Noliwé Béké
5583	Amita Nitin Bhise
5731	Jason Matthew Cheung
5632	Marco Coletta
5645	Bonnie Samara Cooke
5655	Julie-Anne Marie Coyne
5723	Nancy A. Ethier
5705	Carolyn E. Falls
5656	Tessa N. Forrester
5641	Mira Gojmerac
5702	Lisa Michele Hiller
5680	Heather Marianne Jessome
5631	Jennifer D. Karpicke
5650	Miriam Anne Kolacevic
5570	Manoj Kumar
5684	Carmen S. Lee
5604	Veronica A. Lopes
5626	Rebecca Jane Malcolmson
5429	Eirini Mihanatzidou
5593	Mahsa Mosstaghimi-Tehrani
5620	Monika A. Nazair
5683	Jennifer A. Nicholson
5772	Paige Marie Pierozynski
5603	Chantale Wendy Pirouet
5575	Isabelle-Anne Pleau
5756	Robert William Quelch
5725	Natacha Racette
5692	Jean-Grégoire M. Roveda
5591	Joelle Séguin
5532	Karthu Sivasankaran
5578	Kristen Patricia St. Louis
5741	Stephanie Autumn Stacey
5625	Angela M. Weaver
5663	Ann Mary Hughena Webber

Speech-Language Pathology

Reg. No.	Name
5728	Elizabeth Jean Adam
5590	Anna Ammoury
5691	Anna Nirukshi Arulampalam
5511	Danielle E. Bailey
5652	Shruti Balagopal
5585	Lakshmi Nisha Balakrishnan
5753	Stephanie Lynn Barraco
5567	Emily Elise Barrett
5644	Jennifer Rae Bateman
5646	Meghan Danielle Belair
5715	Valérie A. Bélanger
5018	Nicole Deborah Belitzky
5707	Joanne Amy Berbrayer
5757	Shona Elizabeth Blatch
5711	Joanne A. Bourdon
5640	Caitlin Emily Elizabeth Brown
5676	Erin Elizabeth Broxterman
5736	Rachel Bryan
5538	Megan Bullock
5740	Rebecca Elaine Bullock
5647	Carly Ann Cermak
5383	Angela Chan
5581	Emily Siw-Li Chan
5709	Hilary Eleanor Cochrane
5730	Jennifer Marie Coleman
5568	Laura B. Conway
5751	Leah M. Craig
5690	Jessica Pearl Davenport
5653	Alyssa M. DeAbreu
5660	Erica M. Deegan
5488	Jessica Diamantopoulos
5662	Carla DiGironimo
5729	Silvia D'Onofrio
5622	Laura Catherine Downey
5549	Glynnis Elizabeth Du Bois
5706	Sarah Ducasse
5722	Sarah Kristen Dupuis
5582	Thanya Lakmini Duvage
5618	Sarah Rose Ettorre
5506	Andrea Lilian Fewster
5774	Patrick W.C. Fothergill
5608	Jillian Ruth Fraser
5628	Stefanie Anne Gabbott
5696	Melissa Leanne Gagnon
5565	Amy L. Geleyn
5648	Michelle Lisa-Marie Gennaro
4921	Denitsa Velkova Getsova
5654	Robyn Lana Goldberg
5571	Natalie Gousteris
5719	Stacey Alana Greenberg
5639	Sarah Grund
5747	Marie-Eve Haché
5754	Safia Aminmohamed Haji
5726	Maude Hallée
5199	Catherine L Hambly
5697	Katherine Patricia Harder
5580	Rachel Ann Hess
5714	Beverley Roxane Ho
5745	Matthew Ross Hoftyzer
5712	Sarah Elizabeth Fumiko Hori
5398	Carrie Anne Hughes
5615	Amy Patricia Husk
5693	Kathryn L. Ingebrigtsen
5579	Kathleen Anne McLean Jackson
5701	Melissa V. James
5694	Piotr Wieslaw Jankowski
5742	Natalie Renee John
5623	Emma R. Johnson
5687	Hilary Kaine
5586	Tova G. Kalkstein
5686	Katherine Grace Kovler
5614	Amanda Lauren Kropf
5677	Larissa Rosanne Kusyj
5717	Joelle Renée Labute
5382	Shoshana E. Lantos
5704	Dulcinea Isadora Lau
5699	Vanessa Marie Leblanc
5682	Tyler Phillips Levee
5775	Ruth Levin
5612	Amanda Katherine Libenson
5750	Helen Livshits
5698	Rebecca Grace MacAlpine
5600	Lauren Anne Mackonka
5552	Kaitlyn Marie MacPherson
5718	Alishia Lynn Mannix
5769	Catharine Rose Marosszeky
5637	Andréa Sophie Martin
5557	Stephanie Faye Mathias
5743	Alecia Sari McFarlane
5087	Erin Patricia McSweeney
5764	Peter Medeiros
5594	Danielle Anne Michelin
5395	Tracy Rose Morgan
5605	Diane Louise Mulholland
5716	Kristen Murphy
5659	Erin Kathryn Murray
5560	Kristen Leah Narducci
5588	Victoria Michelle Nevill
5681	Mallory Elizabeth O'Leary
5642	Alyson Nicole Osborne
5390	Melissa A. Oziel
5619	Jenna Ilyse Pace
5463	Tammie Lynne Paquette
5633	Fahmida Pardhan
5724	Amanda Parker
5732	Katy Lorraine Patterson
5738	Tijana Pejcic
5584	Jason Pineo
5733	Lilah H. Podolsky
5598	Sabrina Polimena
5630	Alexandra Carly Politewicz
5657	Nicole E. Pounds
5587	Mana Camellia Pourvahidi
5636	Lauren Carly Reznick
5685	Nicole Theresa Richard
5627	Brittany L. Rickard
5737	Stephanie Ann Salvatore
5678	Alyssa D. Schwartzentruber
5606	Madeline Dawn Shiah
5649	Dana A. Skowronek
5617	Lindsay N. Sorrell
5748	Tamara Rose Stein
5643	Sarah Patricia Strathy
5700	Erika Amanda Stupka
5607	Tegin N. Suddaby
5735	Anne-Marie Danielle Talbot
5589	Leah Kathryn Taylor
5566	Katie Natalie Thompson
5635	Heather Anne Tice
5556	Allison Anne Tonkin
5360	Nadia E. Torrieri
5638	Alison M. Turner
5710	Breann Y. Van Moerkerke
5624	Marianne Ward
5776	Sarah Anne Wesseling
5616	Lena Jeanne Williams
5713	Rosemary A.T. Wilson
5689	Ashley Tennille Witzel
5695	Lorraine L.H. Wong
5602	Yana S Yunusova

Reaching Compliance with the Accessible Customer Service Standard of the AODA: Clarifying the Role of the Regulatory Colleges

The first standard under the *Accessibility for Ontarians with Disabilities Act*, 2005 (AODA) is now in force. All organizations with one employee or more in the private and non-profit sectors must comply with the Accessible Customer Service Standard by January 1, 2012.

To help our colleges and members meet this compliance date, several colleges in the federation of Ontario health regulatory colleges are now part of an Advisory Committee organized by the People Access Division of the National Quality Institute. CASLPO is one of these colleges. The purpose of this committee is to help inform and support organizations and practitioners in the health care sector to comply with this standard. To clarify the role the colleges play in helping members reach compliance with this standard, we have listed below what responsibilities appropriately fall within the role of the colleges and will be supported through this Advisory Committee, what is not included in the college role, and some additional opportunities available.

It is important to understand that colleges are required as employers to be compliant with the Accessible Customer Service standard by January 1, 2012. Many of those practitioners registered with individual colleges may also need to be compliant by January 1, 2012. It is also very important to note that it is the government, not the colleges or associations, who will be monitoring and enforcing compliance with these regulations and legislation.

What's in Scope for Colleges

The primary role for colleges in supporting their members' compliance is as information conduits. Members are being supported by

- Information about the and the regulations to raise awareness.
- Connections to existing free and low-cost resources.
- Links to relevant websites.
- Links to continuing education.

What's Not in Scope

- Colleges are not the educators and trainers, although they can provide links to training for members.
- Colleges are not the regulators and don't have to ensure that members are compliant.
- Colleges do not monitor or carry out enforcement of standards under the AODA.

Opportunities for Colleges

Through the advisory committee organized by the National Quality Institute to raise awareness among health care practitioners, colleges have opportunities to help members excel in providing accessible service by making available

- Links to members who are champions in providing accessible services.
- Role modeling examples, tools and suggestions.
- Other data on engagement around accessibility and compliance.
- Access to opportunities for recognition sponsored through the National Quality Institute through decals, awards and lists of compliant organizations which will be produced and made available through the Institute.

Members Currently Under Suspension

By Colleen Myrie, Director of Registration Services

As of February 3, 2012, the following CASLPO members are currently under suspension for failing to pay their annual fees for 2011/2012 in accordance with section 24 of the Health Professions Procedural Code:

Name	Reg. No.	Profession	Name	Reg. No.	Profession
Nadine Elizabeth Ewanchyshyn	(1394)	Speech-Language Pathology	Tracey Lynn Prevost	(3025)	Speech-Language Pathology
Joseph F. Henne	(1577)	Audiology	Bradley C. Miller	(3279)	Audiology
Esther Ruth Naiberg	(1993)	Speech-Language Pathology	Tammy Lynn Morris	(3461)	Speech-Language Pathology
Dianne Jay Roebuck	(2189)	Speech-Language Pathology	Seema Shah	(3998)	Audiology
Shann Wishart	(2518)	Speech-Language Pathology	Shannon Michelle Miller	(4331)	Audiology
Ling Zhang	(2709)	Audiology	Kimberly Rose Bauerly	(5220)	Speech-Language Pathology

Communication Access: Improving Accessibility for People with Communication Disabilities

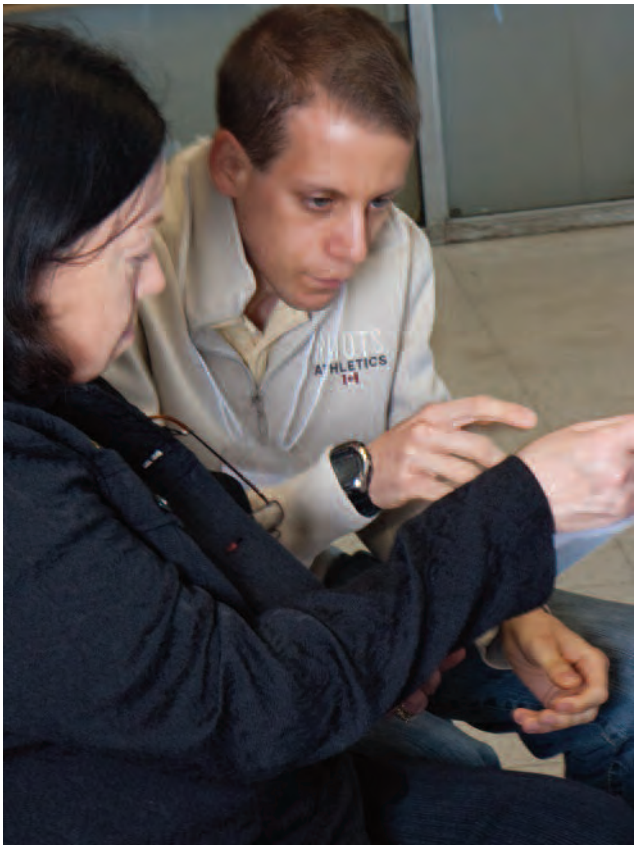
By Barbara Collier, Reg. CASLPO
Executive Director
Augmentative Communication Community Partnerships Canada

People who have communication disabilities (CDs) have the legal right to access goods, services, health care, and education and employment opportunities that are equal in quality to people who do not have disabilities. These rights are protected by legislation within the Canadian Charter of Rights and Freedoms, and in Ontario by the Human Rights Commission and the Accessibility for *Ontarians with Disabilities Act* (AODA 2005). The AODA gave rise to the current customer regulations (2008) and the integrated accessibility regulations (2011) which include accessibility regulations to information and communications. The purpose of these regulations is to provide "rules" that organizations have to follow to identify, remove and prevent barriers to accessibility[1] so that people with disabilities can have full and equal access to their goods and services. There are specific timelines and obligations for private and public sector organizations in terms of implementing accessibility policies, procedures and practices. For details, see the website of the Accessibility Directorate of Ontario (ADO).

Accessibility laws, when appropriately defined and enforced can be powerful tools to address the inequitable situation experienced by many people with disabilities. Legislation can increase awareness of the barriers and requirements of people with disabilities; provide clarity on the obligations of organizations providing services and result in inclusion in training programs and enhanced resource development. There is ample evidence that laws in other countries have increased awareness and access to Braille, sign language, curb cuts, and other accessibility accommodations. People with CDs, however, present with needs that are less understood than other disability groups and who can experience major barriers when communicating with businesses and organizations in their communities.

Over the past 3 years, Augmentative Communication Community Partnerships Canada (ACCPC) provided input to ADO in the development of Ontario's regulations. Some of the resulting recommendations are in the final integrated accessibility regulations (2011). It is important to know about and take advantage of these features in this legislation as they can potentially improve accessibility for people who have communication disabilities. For example, the regulations state that staff in organizations must consider a person's disability when communicating with them, allow the use of assistive devices, and support persons and provide accessible text, print and e-communications.[2] However, like other accessibility regulations, Ontario's regulations tend to focus on the needs of people with limited mobility (e.g., building codes) and people who are deaf, hard of hearing, blind, visually impaired or deaf-blind (e.g., alternate format requirements, captioning, sign language interpreters etc.). The communication access requirements of people with CDs are not addressed in ways that are meaningful for most people with CDs. For example, there are no clear directions for community personnel on how to communicate face-to-face or over the telephone with consumers who have CDs. The result is that many people whose speech is difficult to understand and/or have difficulty understanding spoken language continue to experience major barriers and compromised services within their communities.

Central to the inadequate inclusion of people with CDs in existing legislation



is the fact that the communication disorders community has not yet provided a clear description of the accessibility requirements of people who have CDs. While there is significant documentation on communication barriers and supports for individuals who have specific communication disabilities (e.g., aphasia, TBI, people who use augmentative and alternative communication) in specific contexts (e.g., health care, justice, emergency services) much of the literature focuses on the individual supports required from trained assistants whose role is to facilitate communication between a person with a CD and an unfamiliar person. The need for individual communication accommodations, including the use of a communication assistant (support person) is a core principle of accessibility for people with CDs. However, the person with whom the individual is communicating plays a different role than a communication assistant and therefore has different responsibilities. These responsibilities need to be clearly defined and reflected in the legislation if people with CDs are to have their rights recognized and protected.

What is Communication Access?

To begin the process of describing communication access, ACCPC, with a funding contribution from Human Resources and Skills Development Canada (2009-2012), conducted a national survey in which they asked people with CDs, families, and service providers to tell us about their accessibility barriers and the accommodations they require in order to have equal access to goods and services within their communities. Over 250 people responded representing a diverse range of communication disabilities and diagnostic groups across Canada.[3] It is important to note that many of the respondents used some form of augmentative and alternative communication either as their primary mode of communication or to clarify speech when not understood.

Not surprisingly, most of the barriers they reported relate to the person with whom they are communicating. They reported that people ignore them; do not know how they communicate; talk to the person with them about them; restrict their communication to answering yes and no questions and do not give them sufficient time to communicate their messages. They experience these barriers in face-to-face interactions, at meetings and public events and especially over the

telephone. Many people reported difficulty reading and handling print, text materials, and navigating websites. They also reported challenges with writing activities such as completing forms, taking notes, and signing documents. These barriers occur across all sectors of the community and most notably when communicating with government agencies, health care, disability and emergency settings, transportation, stores and restaurants.

In terms of accessibility accommodations, each respondent described their individual accommodations needs; however, there were a number of overarching themes. Based on the survey and common principles embedded in human rights legislation, people with CDs expect businesses and organizations to:

- Be respectful.
- Speak to them in ways they understand.
- Accept the communication methods that they think are most effective.
- Follow their instructions about how to communicate with them.
- Give them sufficient time to communicate their messages.
- Make an effort to understand their messages.
- Give them opportunities to share their ideas and opinions as well as answering questions.
- Ask how they want to communicate over the telephone and if they want alternatives to the telephone.
- Give them accommodations they may need at meetings and public events.
- Give them text, print and electronic information in ways they can handle, read, and understand.
- Give accessible forms, and any assistance they may need to take notes and sign documents.

For people with CDs, these themes have personal subtexts and accessibility lies in the details of these subtexts. Please visit our website for examples of how people with CDs can personalize and take advantage of these principles. For example, the right to expect to use one's preferred communication methods means that a person may choose to use one or more methods to communicate such as speech, writing, gestures, sign language, a communication display, or a device. The person may also choose to use a sign language interpreter, a translator, or someone to support them communicating. In essential services (e.g., health care or legal setting) where the person may not have someone to assist with communication, the individual can expect the organization to secure services to support them to communicate.

Communication Access Resources

Based on research, ACCPC has developed a number of online resources about communication access. These include:

- E-learning modules for businesses and organizations at http://www.communication-access.org. This online resource has 8 modules containing video segments of people with different communication profiles, downloadable resources and an optional quiz. Domains include communication accommodations for face-to-face interactions, telephone, meetings, reading and writing.
- Expectations for accessibility for people with CDs http://www.communication-access.org/p/rights_expectation.
- Communication access booklet http://www.communication-access.org/p/resources.
- Web links for communication access within other contexts http://www.communication-access.org/p/links.

Call for Action

While existing Ontario accessibility regulations contain some useful items that can improve access for people with CDs, our professions need to provide input to future revisions and updates of the ADO and AODA regulations in order to ensure that they reflect the needs of people with CDs. At this time,

we can play an important role in supporting people with CDs in learning about their rights and negotiating their accessibility needs. We can educate businesses and organizations, and get involved in local accessibility committees. We can start by being leaders within our own organizations. This means having policies and practices to ensure that all staff in our workplaces, know how to do the following:

- Interact respectfully with people with CDs.
- Communicate effectively with people who have different communication profiles.
- Assist people with CDs in understanding what is being said.
- Communicate over the telephone with people who have CDs or provide alternative options to the telephone.
- Accommodate people with CDs at meetings, public events, conferences and presentations.
- Provide appropriate and timely access to text, print, and paper-based reading materials.
- Make websites and social media accessible.
- Provide accessible forms and supports for writing.
- Negotiate and provide authorized signature accommodations.

Learn more about these accommodation areas on the e-learning modules at: http://www.communication-access.org.

To receive and contribute to updates on communication access, send your name and email address to accpc@sympatico.ca.

References

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Don't Play the Result: An Hour with Michael J. Fox

By Sherry Hinman

When Michael J. Fox addressed the 2,000-strong audience at HealthAchieve 2011, he began by telling us he had a dual agenda: to talk about health care issues and entertain. And he delivered on both counts.

Fox is a celebrated actor, best known for his television roles in *Family Ties*, *Leo and Me*, and *Spin City*, as well as his roles in such classic films as *Back to the Future* and *The Secrets of My Success*, which garnered him several Emmys and Golden Globe Awards. It was not until his life went "skidding sideways" that he became the face and name for Parkinson's disease.

Fox was diagnosed with early-onset Parkinson's disease in 1991. "At 29 years old, it was like a bomb went off," he told us. "I got a second opinion, a third opinion, a fourth opinion." This was after a year of experiencing, and attempting to explain away, the symptoms. "I woke up to find a message in my hand," he said. "My pinkie was trembling. I put it up to a hangover. DTs? Who gets DTs in one finger?"

Fox said one of the most important lessons he ever learned was from his father: Don't play the result. "It means, don't act as though you know what's coming, like the pie in the face. So you have to live in the moment."

It would be another seven years before he disclosed his diagnosis to the public. "I kept up the façade. I couldn't trust the audience to play the result. I didn't think they'd think it was funny if I was sick."

But once he did reveal his diagnosis, he said, it increased the conversation and the awareness. By virtue of who he was, it became more acceptable to have the disease. One woman told him she didn't feel embarrassed when she told people she had Parkinson's. "People would say to her, 'Oh, like Michael J. Fox.' "

That's when it sank in that he had the ability to inspire. And, in 2000, that realization led to his creation of the Michael J. Fox Foundation for Parkinson's Research. In a 2008 *New York Times* article, "Taking Science Personally," the author wrote, "[The Michael J. Fox Foundation] has managed to become, in its short seven-year life, the most credible voice on Parkinson's research in the world." In 2010, the foundation "funded over $39 million in targeted Parkinson's research…"

"The foundation was going into business to go out of business," Fox said of their purpose. As he spoke of the foundation's work, you could sense his frustration. "We don't have a department of cures," he said. "It's no one's priority. Why is treatment so expensive? Why is it so challenging? Biology is hard. We don't know the cause. $100 billion a year is spent on drug discoveries in America. We need to spend the money more effectively."

The Michael J. Fox Foundation is also active in Canada. It has received support from Canadian researchers, who have been actively involved since the foundation was created. It officially registered as a Canadian charity in 2009 and has funded over $10 million in Canadian research.

Throughout his talk, Fox's speech was well controlled. He spoke quickly, and twisted his head to the side every so often, but it would take a trained ear to detect the vocal strain it took to address the crowd. It wasn't always the case that he could speak so well. Those who have heard Fox speak during television interviews and other public addresses are used to seeing his writhing head and arm movements, and hearing the characteristic volume, pitch and rate difficulties associated with Parkinson's disease.

In a 2002 interview with NPR, he talked about his dyskinesias. "Well, actually, I've been erring on the side of caution – I think 'erring' is actually the right word—in that I've been medicating perhaps too much, in the sense [that] ... the symptoms ... people see in some of these interviews that [I] have been on are actually dyskinesia, which is a reaction to the medication."

Speaking without medication, he went

on to explain, would be even worse, because of the Parkinson's symptoms. "There's a kind of a cluttering of speech and it's very difficult to sit still, to sit in one place. You know, the symptoms are different, so I'd rather kind of suffer the symptoms of dyskinesia..."

When asked about the dyskinesias in a Q & A following his keynote address, he confirmed that they have diminished. "I have less dyskinesias now. I'm on a cocktail of drugs."

One of the reasons Fox is able to accomplish so much despite his disease is his extraordinary optimism. When talking about his second book, *Always Looking Up: The Adventures of an Incurable Optimist*, he jokingly said he told his wife, Tracey Pollard, "I'm never going to finish my book on optimism."

But he thrives on the positive aspects of having his disease. In his latest book, *A Funny Thing Happened on the Way to the Future*, he wrote, "Because Parkinson's demanded of me that I be a better man, a better husband, father, and citizen, I often refer to it as a gift. With a nod to those who find this hard to believe, especially my fellow patients who are facing great difficulties, I add this qualifier it's the gift that keeps on taking ... but it is a gift."

Sometimes it was difficult to tell if he was being serious or funny, and sometimes, as in his description of Parkinson's as a gift, it was likely both at once. But he also entertained us with his pure wit, as promised.

Those who know Fox's story might be aware that he once dreamed of a career in hockey. One time, he had the fortune of meeting former NHL player, Bobby Orr, considered by many to be the greatest hockey player of all time. Their meeting was just before a game and it was noisy. Orr said something to him but he couldn't hear it. At the end of the period, Orr invited him onto the ice. Fox was star-struck and couldn't believe it when he found himself able to deke around Orr and shoot the puck though his legs and into the net. Afterward, he realized what Orr must have said before the game: "At the end of the period, I'll let you put the puck between my legs."

Canadian audiences love a Canadian story, and we ate this one up, along with several others. He gave us all his Twitter username and anyone checking Twitter just prior to the talk, would have seen this post from @realmikefox: "About to speak at @HealthAchieve. Nice to be back in Canada where hockey is king & the syrup comes from trees."

But his best stories packed a powerful punch. In one, he told of a story he read about a Mozambican woman who was about to give birth during a terrible flood. The flood became so severe that she had to climb a tree to save her life, and when the moment came, she had no choice but to give birth while still in the tree. Soon after he read this story, one of Fox's daughters complained to him about something that was difficult to do. "A woman had a baby in a *tree*!" he told her, and it then became a family joke to say that line whenever anyone complained about accomplishing a difficult task.

First the humour; then the punch. If ever there was an example of someone who took on a difficult task with optimism and grace, it is Michael J. Fox. And in true Fox style here is one further story about what it was like when he learned he had Parkinson's. "It's like standing in the middle of the road with your feet set in concrete. You know the bus is coming but not when. It's a true case of 'don't play the result.' The next years were the best years of my life."

Sherry Hinman is a freelance writer and editor. She is also a professor in the Communicative Disorders Assistant Program, Durham College; worked clinically as an SLP for fourteen years; and served three years on the CASLPO Council.

Working Effectively with Substitute Decision Makers: Consent and the Law

By Alexandra Carling-Rowland Ph.D. Reg. CASLPO,
Director of Professional Practice and Quality Assurance

Every SLP and audiologist wants to develop a productive working relationship with Substitute Decision Makers (SDMs); these include the partners, parents, family members, and significant others in the patient/client's life. However, frequently we interact with these individuals at a vulnerable time. Parents are worried that their child's speech, language and hearing skills are not developing as they should, and whether this signifies a greater problem. Partners are dealing with the shock of their loved one having a stroke or traumatic brain injury and the resulting loss of communication. People are coming to terms with a medical diagnosis with significant implications to their loved one's quality of life.

Families are trying to make the best decisions for their child or adult family member, but they can also come to us with other issues and stresses in their personal lives, which can cause pitfalls as we negotiate what is best for the child or adult we serve. Parents or adult family members do not always agree with each other or with our recommendations. However, Ontario has two different pieces of legislation governing consent to treat, and consent to collect, use and disclose personal health information, and it has institutions which can help us to overcome more extreme situations and guide us in our dealings with SDMs.

Consent to Treatment

The legislation governing consent to treatment is the *Health Care Consent Act* (1996). The *Act* obliges us to obtain informed consent. It requires the health professional to give the individual reasonable information regarding treatment, including the risks and benefits, and an opportunity to ask questions and have them answered to the individual's satisfaction. The *Health Care Consent Act* refers to "treatment," but allows for service providers to apply the legal tenets to screening and assessment. CASLPO, in 2007, determined that members must obtain informed consent for all screening and assessment as well as treatment services.

Children

Parents are the joint and equally ranking SDMs for a child, and they both have to give consent to treatment on behalf of their child. However, if only one parent attends an initial screening or assessment you can accept one parent consenting for both, if you think the consent is being given in good faith. In other words, when you ask if the absent parent is in agreement with your course of action, and there is nothing leading you to believe that this is not the case, you can proceed and document that consent was obtained.

Treatment Scenarios and Practice Advice

The following are typical scenarios encountered by members:

What do I do when the separated parents of a child I am treating are in conflict and it seems that they do not agree with each other on principle? They take turns in bringing the child to therapy and now one of them is saying that they cannot bring him. I am really worried that the child, who has significant needs, will suffer.

If you are working with parents who are divorced or separated and only one parent has custody, then that custodial parent is the SDM, and will provide consent for you to screen, assess, and treat the child. In this situation, the "access parent" does not have the right to consent, or otherwise, to his or her child's therapy, even if he or she stipulates that he or she does not agree with the assessment or intervention plan.

If the parents are separated or are divorced and have joint custody, then both parents must give consent to screen, assess and treat. What should members do if both parents do not agree with and consent to an intervention plan? Unless you receive consent from both custodial parents you cannot proceed with your intervention. If you feel that the communication well-being of the child is at risk, and parental agreement seems remote, then you should consider contacting the Office of the Public Guardian and Trustee (OPGT). The OPGT has a Treatment Decision Unit, staffed by consultants who consider themselves to be "decision makers of last resort." On contacting them, you will be assigned a consultant according to your geographic area who will discuss all of the options with you first, before making

a decision on behalf of the child.

OPGT contact information: Tel: (416) 327 -6683, Toll Free: 1-800-366-0335
Website:
http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/

I am currently seeing a teenager who wants to end therapy. His parents do not agree with his decision. He would benefit from further intervention (he is very dysfluent), but I can see that he really wants to stop.

The *Health Care Consent Act* does not specify an age at which an individual is able to consent, or withdraw consent, to treatment. Whether a child can in fact withdraw consent depends on whether he or she understands the relevant information and appreciates the reasonably foreseeable consequences of his or her decision. When providing service to an older child who does not want to pursue therapy, against parental wishes, try to negotiate a solution. Potential solutions might include a break in therapy and re-evaluation at a later date, or agreed upon time-specified blocks of therapy. If the parents persist, and the teenager is capable of making a decision to withdraw consent to treatment (he or she has the ability to understand relevant information and appreciate the reasonable foreseeable consequences of a decision or lack of decision), then you should seek advice from your manager, an ethicist, or your employer's lawyer.

Adults

An elderly patient who is in our Complex Continuing Care unit has been designated Nil Per Os (NPO) because of severe swallowing difficulties. This was agreed to by one of her adult children. The other adult children disagree with the decision and they are threatening legal action.

Adult patients or clients have the right to give or withhold consent to treatment. The adult maintains this right even if there is a Power of Attorney for Personal Care (POA) or a SDM identified on the medical record, and even if another health care professional has found the adult lacking in capacity for a previous decision. The *Health Care Consent Act* directs health professionals to presume that the individual has the capacity to give consent. If, however, you suspect that the individual does not have the capacity to provide informed consent, then you must evaluate his or her capacity. Capacity is defined in the *Health Care Consent Act* as the ability to understand relevant information and the ability to appreciate the reasonably foreseeable consequences of the decision or lack of decision.

Should the adult require an SDM to consent to treatment, because of a lack of capacity, then the highest ranking individual on the list provided by the Ministry of the Attorney General is selected. The list is as follows:

1. a court appointed guardian;
2. the person named in the Power of Attorney for Personal Care;
3. a representative appointed by the Consent and Capacity Board;
4. the spouse or partner;
5. the adult child or parent;
6. brother or sister;
7. any other relative by blood, marriage or adoption; or
8. the Office of the Public Guardian and Trustee.

If two equally ranking people (two or more adult children) fail to agree, and consent to treatment is not obtained, and the health care team have failed in their efforts to resolve the situation, you can contact the Treatment Decision Unit of the OPGT. As with the previous scenario, you will be assigned a consultant according to your geographic area and all options will be discussed before they make a decision on behalf of the adult.

Sharing Personal Health Information

The *Personal Health Information Protection Act (PHIPA)* (2004) governs the collection, use and disclosure of personal health information. PHIPA outlines the parameters regarding the individual's right to consent, to withhold or withdraw consent to said collection, use and disclosure of information.

I am an audiologist practicing in a private clinic. Recently, a father came to the clinic asking for information about his young child's hearing assessment. This father is separated from the mother who has full custody of the child. Am I allowed to give him the information?

Young Children (0-12 years)

When working with young children, the parents are joint Substitute Decision Makers (SDM) and are both entitled to the health information you generate in the form of reports, treatment goals, recommendations, etc. This right to information does NOT change, even if the parents are separated or divorced, and one of them does not have custody. In the course of your practice, you can be presented with a variety of legal parenting scenarios: joint custody, sole custody and access, and court-determined parallel parenting plans. With all of these situations both parents are allowed access to health information regarding their child and can request to see their child's record. According to the *IPC's Order P-1246* (1996), the *Children's Law Reform Act* and the *Divorce Act* affords an "access parent" the right to "be given information as to the health, education and welfare of the child." This would include information from audiology and speech language pathology screens, assessments and intervention. However, if there is a court order prohibiting a parent from receiving information, then that order must be followed. You should request to

see the court order to determine precisely what information can and cannot be shared, and then document the details in the child's record.

I am a SLP providing outpatient voice therapy to a client who is 14 years old. This client has shared personal information with me (nothing to do with abuse) and has asked me not to tell his mother. What should I do if the mother asks?

Teenagers (13-18)

PHIPA provides some flexibility regarding the interpretation of matters relating to this age group. It acknowledges that there are circumstances where individuals have the right to withhold consent to share their personal health information with their parents. For example, a fourteen-year-old girl seeking information regarding safe sex might not want this to be shared with her parents. If the teenager shares personal information with you in a therapy session, and the parent later questions you about it, you will have to use your professional judgement regarding the disclosure of such information. If you have any doubts, contact the Information and Privacy Commissioner for advice.

IPC contact Information: Telephone: (416) 326 3333, Toll free 1(800) 387 0073 Website: www.ipc.on.ca

I work in a hospital and have been referred a patient for a swallowing assessment. When I went to read the patient's chart it had "Lock Box" written on the front. What does this mean?

Adults

Adults have the right to give, withhold, or withdraw consent to collect, use and disclose personal health information. The adult maintains the right to decide even if there is a Power of Attorney for Personal Care (POA) or a SDM identified in the medical record. If an adult decides that his or her information cannot be shared, the term "lock box" is frequently used, in other words, the information is "locked." This may mean, for example, that the patient is willing to give and allow you to use information but not share that information with others, including members of the health care team; or, all/some family members are excluded from accessing the information. It is essential that you know exactly what information can and cannot be used and disclosed. Further information on the Lock Box can be found on the IPC Fact sheet: http://www.ipc.on.ca/images/Resources/fact-08-e.pdf

The right to decide on how personal information is collected, used or disclosed is lost if that adult is found lacking in capacity. We recommend that SLPs and audiologists take the time and use resources to ensure that patients/clients understand the consent process and have an opportunity to communicate their wishes with regard to the degree to which their personal health information can be collected, used and

disclosed. If an adult does not have the capacity to decide, the SDM makes the decision on the adult's behalf.

In previous articles in *CASLPO Today* you have referred to the Office of the Information and Privacy Commissioner of Ontario. What is this office?

The Information and Privacy Commissioner of Ontario (IPC) is an officer of the Legislative Assembly of Ontario that acts independently of government to uphold and promote open government and the protection of personal privacy in Ontario. The IPC has responsibility for three acts: The *Personal Health Information Protection Act (PHIPA)*, the *Freedom of Information and Protection of Privacy Act (FIPPA)*, and the *Municipal Freedom of Information and Protection of Privacy Act (MFIPPA)*.

The IPC's mandate is to

- independently review the decisions and practices of government organizations concerning access and privacy;
- independently review the decisions and practices of health information custodians in regard to personal health information;
- conduct research on access and privacy issues;
- provide comment and advice on proposed government legislation and programs;
- review the personal health information policies and practices of certain entities under *PHIPA*; and
- help educate the public about Ontario's access, privacy and personal health information laws and related issues.

As health care professionals we want the best for the patients or clients we serve and fostering good relationships with SDMs is frequently part of that service. If you have a good understanding of the legislation governing the two types of consent, and know where to go to seek advice, patient autonomy can be preserved and the best interests of your patients/clients can be maintained. If you have any further questions regarding this area of practice, please contact me at CASLPO: Alex Carling Rowland, Director of Professional Practice and Quality Assurance, telephone: 416 975 5347 extension 226, e-mail acarlingrowland@caslpo.com

Bibliography

Health Care Consent Act (1996)
Information and Privacy Commissioner of Ontario
Office of the Public Guardian and Trustee
Personal Health Information Protection Act (2004)
The Consent and Capacity Board

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