# Report of the Professional Issues Forum on **Access to Occupational Therapy** St John's, NL CAOT Conference 2007

The CAOT Professional Issue Forum on Access to Occupational Therapy was held at the Delta St John's on July 13, 2007.

Improving access to occupational therapy has been one of CAOT's key strategic objectives over the past 10 years. Occupational therapists are concerned about the impact of a growing crisis among many populations that have limited or no access to occupational therapy and opportunities to engage in meaningful occupations. In collaboration with consumers, policy makers, and researchers, occupational therapists are seeking innovative solutions to address the barriers to publicly and privately funded occupational therapy services.

One of the major outcomes of the PIF was to identify a number of strategies that could improve access to health and occupational therapy services.

**Objectives of the Forum were:**

1. Understand the impact of a lack of access to OT services for population needs;
2. Identify issues that impede access to occupational therapy services;
3. Determine innovative and collaborative strategies that will improve access to OT services;
4. Inform the development of a revised position statement and action plan on access to occupational therapy services.

The Forum consisted of panel presentations followed by discussion in a plenary session. The following presentations are available:

1. Regina Casey, PhD Candidate, University of British Columbia. See paper below.
   Access to Occupational Therapy Services in Canada (2007)
2. Judi-Varga Toth, Assistant Director Family Network, Canadian Policy Research Networks (CPRN). http://www.caot.ca/powerpoint/Frontline%20Health.PPT
3. John Maxted, Associate Executive Director, Health and Public Policy
   The College of Family Physician of Canada. http://www.caot.ca/powerpoint/maxted.ppt
   Danielle Hogan, President Newfoundland & Labrador Association of Occupational Therapists. http://www.caot.ca/powerpoint/maxted.ppt

1. **Regina Casey, OT, M.A., Ph.D. Student, UBC**
**Lyn Jongbloed, Ph.D., Associate Professor, UBC**

Introduction

The *Canadian Population Health Initiative Action Plan 2007-2010*, published by the Canadian Institute for Health Information (CIHI, 2006), states that health is largely determined by how we

work, learn, live, and play; in other words by our occupations. According to the Canadian Association of Occupational Therapists (CAOT), "by enabling individuals, groups, and communities to identify, engage in, and achieve desired potential in the occupations of life, their health is improved and enhanced" (2002, p. 1.). Occupational therapists are, however, concerned about a potential crisis among populations that have no or only limited access to occupational therapy.

Access to publicly-funded occupational therapy services is limited by the development of Medicare. Similarly, access to privately-funded occupational therapy services has historically been limited by the development of disability income programs. This paper discusses the impact that lack of access to occupational therapy services has on certain population groups, enumerates factors compounding this lack of access, and identifies factors that impede access to occupational therapy services. It also explores the importance of conducting cost-benefit studies, lobbying insurance companies, and developing innovative partnerships and services that uphold the core values and beliefs of the occupational therapy profession. The authors apply some of theses core concepts in an outline of two services presently being offered in Vancouver.

## Impact of Lack of Access to Occupational Therapy Services on Various Populations

It is difficult to gauge the impact that a lack of access to occupational therapy services has on various populations, as very few studies exist on the subject. Consequently, it may be easier to consider the immense potential contribution of the profession to the health of various populations.

## Occupational Therapy Strengths

Occupational therapists have been involved in delivering client-centred services through occupation to various populations in Canada for over 80 years. Hobson states that, "our professional beliefs and research both demonstrate that engagement in occupation positively affects quality of health" (Canadian Association of Occupational Therapists [CAOT], 2002, n. p.). In her work within the discipline of occupational science, Wilcox (1998, 2006) links the notion of healthy occupations to the *Ottawa Charter for Health Promotion* (World Health Organization [WHO], 1986). According to Wilcox, the *Ottawa Charter* advocates building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services toward the pursuit of health and away from simply curative services. Wilcox (1998) further proposes that the *Charter* is in line with WHO's ambitious vision to "achieve health by all its members" (p. 109). Dr. T. Jarus, the new head of the Division of Occupational Therapy at the University of British Columbia (UBC), expressed similar sentiments. Jarus states that "occupational therapists are transitioning out of the medical model" we are working more with individuals who have social and economic issues and those who are challenged as a result of war, immigration, and family violence "this change is not just semantics" (T. Jarus, personal communication, April 18, 2007). The focus is on improving both quality of life and social determinants of health in order to build healthy communities.

## Factors Influencing the Need for Greater Access

Trends in disability statistics indicate that as the population increases, there is a corresponding

rise in the number of people who have disabilities, and a comparative ration of people with disabilities living below the poverty line (Human Resources Development Canada [HRDC], 2002). However, according to Wolfson & Rowe (2005), there are uncertainties regarding disability numbers and the severity of illnesses that these individuals may experience. Nevertheless, the fact that we are living longer and the increase in numbers of people with disabilities, will mean increased need for occupational therapy services that enable people to do the activities that are important to them (CAOT, 2004, 2005; Canadian Occupational Therapy Foundation [COTF], 2004-2007).

Specifically, the number of healthy seniors (individuals 65+) will increase by 2.6 million between 2001 and 2021 (Wolfson & Rowe, 2005). Fafard (2006) believes that people 65+ will seek health care services earlier and remain in care longer, thereby utilizing a large proportion of the health care budget. Fafard also notes that these consumers of services will be increasingly egocentric, demand better timelines, choice and quality regarding service delivery, and be more open to trying complementary non-western approaches to health care.

It is proposed that Canada¡¦s economy loses $33 billion annually in direct and lost productivity as a result of mental health illnesses and addictions. Further, WHO (1986) predicts that depression (the fourth-leading cause of disability and premature death in the world) will be the leading cause of workplace disability by 2020 (Mood Disorders Society of Canada, MDSC, 2006). Sadly, according to the MDSC the unemployment rate among people with serious mental illness is 70-90%, leading to an increased need for occupational therapy services. Interestingly, in 2005, of the $300 million allocated to health promotion and disease prevention by government, 1.5% went to mental health, 30% to diabetes care, and 19.8% to cancer care (MDSC, 2006)

According to Dr. L. Duxbury, professor, School of Business, Carleton University (whose work was recognized with the Canadian Workplace Wellness Pioneer Award in 2002), Canada is facing a skilled workforce shortage (Dr. L. Duxbury, personal communication, March 9, 2007; CAOT, 2005) in both private and public services. In British Columbia for instance, approximately 40 occupational therapists graduated last year. A recent report advises that the number of graduates should be doubled to 80 in order to address ¡§the current generalized shortage of occupational therapists "the third highest number of paramedical vacancies" in BC (CAOT and British Columbia Society of Occupational Therapists [BCSOT], 2007, p. 6). When occupational therapy positions remain unfilled due to lack of graduates, these are often filled by professionals from other disciplines, thereby decreasing the numbers of occupational therapists employed in the system. Therefore, for a number of reasons, a shortage of occupational therapists may coincide with the increased need for occupational therapy services, compounding the lack of access.

Factors that Impede Access to Occupational Therapy Services

Access to occupational therapy services is strongly shaped by the way in which Medicare developed in this country, as well as by the regulations found within the legislation regarding which services are fundable. The following two sections examine factors that influence funding and, consequently, access to publicly- and privately-funded occupational therapy services.

Publicly-funded Occupational Therapy Services

Medicare consists of publicly-funded hospital and physician programs and services (Evans, 2000). The provinces/territories administer the programs. The *Canada Health Act* (1984) stipulates that in order to receive federal funds, provinces/territories have to ensure that health care services are accessible (no financial barriers), universal (everyone is covered), comprehensive (covering all medically-necessary hospital and physician services), portable, and publicly administered (Health Canada, 2002). Approximately 70% of health care financing comes from public sources and 30% from private sources (CIHI, 2005).

Medicare covers physician- and hospital-based services. Provinces/territories may offer other services, but they are not required to. Similarly, hospitals are not required to offer occupational therapy services, but many do. The obligation of jurisdictions to provide services has been the subject of some debate in the courts. For instance, in the Auton vs Government of British Columbia case, (Supreme Court of Canada, 2004), parents of autistic children in BC argued that the government should fund behavioural services for their children at home. The Supreme Court disagreed with their argument, saying that provinces/territories had the right not to offer non-core services. This same argument can be applied to occupational therapy services. Occupational therapy is not recognized as an essential medical service.

Access to publicly-funded occupational therapy services is also affected by the way in which hospitals are funded. A block payment system is used to reimburse health service provision. A hospital, for example, is reimbursed a particular amount of money based on historical funding patterns. The amount of money it receives does not depend on the number of patients treated or the quality of services provided (Horton, 2007). The amount of money allocated for occupational therapy services (and therefore the volume of services) in hospital and community settings, depends largely on the volume of services historically provided in each setting, and the skills of the occupational therapist and rehabilitation managers to lobby hospital management or the regional health authority for additional funding (Jongbloed & Wendland, 2002).

In the 1960s and early 1970s, most health services were hospital-based. Later, more community-based services developed for people with mental illnesses as well as those with physical disabilities. Provinces/territories are required to offer hospital and physician services, yet have an option about whether or not to offer community- or home-based services, including occupational therapy services.

Access to occupational therapy services in long-term care facilities is greatly influenced by legislation. Long-term care facilities provide care for those unable to live independently even with community support services, and those who require 24-hour nursing services. Payments to long-term care facilities are based on a resident based needs formula and cover nursing care, food, and accommodation costs. Legislation governing extended care facilities requires more occupational therapy services than legislation governing intermediate care facilities; the resident/occupational therapist ratio however, remains substantive (Jongbloed & Wendland, 2002)

Privately-funded Occupational Therapist Services

Opportunities for occupational therapists to engage in private practice are closely linked to the

way in which various disability income programs have developed over time Jongbloed & Wendland, 2002). Over the last 80 years, various income replacement programs have been added to existing programs. The income that people with disabilities receive if they cannot work is strongly influenced by the cause or origin of their disability: Veterans Affairs Canada offers coverage to veterans; provincial/territorial Workers¡¦ Compensation Boards offer coverage to those who became disabled at work; those injured in motor vehicle accidents are covered by motor vehicle insurance. Workers¡¦ compensation, motor vehicle insurance, and private insurance operate on insurance principles. Generally, individuals injured on the job and covered by workers¡¦ compensation or other insurance receive more benefits and a greater range of services than those who become disabled in other ways. Thus, people whose disability occurred at work or in a motor vehicle accident, or who are wealthy and can pay for occupational therapy, have greater access to private practice occupational therapy than other people with disabilities (Jongbloed & Wendland, 2002).

These organizations, as well as lawyers, employ occupational therapists, usually on a contract basis, to assess the functional abilities of people injured at work or in car accidents and to provide intervention. The percentage of occupational therapists working in private practice rose from 4% in 1989 to 25.6% in 2005 (CAOT, 2006). (It is important to note that membership in CAOT is voluntary and does not include all occupational therapists in Canada. However, CAOT and its provincial/territorial affiliates represent more than 10,000 occupational therapists and 1,100 students [CAOT & BCSOT, 2007].)

Suggested Considerations to Deal with Access to Occupational Therapy Services
It seems clear that in order to deal with access to occupational therapy services, the profession¡¦s biggest challenge is to increase financing for occupational therapy services. Three actions must be undertaken: 1) we must articulate the costs and benefits of our service in rational ways; 2) we must advocate and lobby for services, and 3) we must develop innovative models of service delivery and partnerships.

Documenting the costs and benefits of our services means articulating service outcomes in terms of cost and value-added components such as: quality of life, increase in role contribution and or satisfaction, decrease caregiver stress, and effects on the Canadian economy. As a profession, we are still in the early stages of this enormous endeavour. We, as a profession, need to be able to articulate the economic value of occupational therapy service delivery. Rigorous economic evaluation studies both the outcome and cost effectiveness of services in order to balance outcomes against costs. This data can then be used to strengthen the profession's capacity to lobby with provincial and federal governments.

MacDonald (2006) in a recent "environmental scan of the economic literature" concludes that general problems for this under-researched area for occupational therapists include: small sample sizes, lack of control groups, a focus on the practitioner rather than specific interventions, and poor cost tracking for services. In the area of fall prevention (an area that produces rich outcome data), only 8% of the literature incorporates economic analysis (Gillespie as cited in MacDonald, 2006). In the area of early discharge after stroke (another strong research area), it appears that research design has impeded the ability to statistically demonstrate significant financial benefits. MacDonald recommends further financial

investigation in the less well-developed areas of return to work, driving assessments, development disabilities, and traumatic brain injury where occupational therapists are the key service providers. He also recommends attaching a dollar amount to both pre-existing and new studies, and advocates for the profession to encourage and support these activities. MacDonald unfortunately fails to mention the need for developing costing measures for health promotion interventions (such as community participation activities geared at promoting healthy occupation or mental health interventions). Elaborating cost measures concerning these specialist areas is complex and may require the development of new tools.

How do we advocate for the necessary access to occupational therapy services? Dr. Jarus proposes that participation in occupation is a human rights concept; we need to educate the public on how we can positively influence the life of persons whose participation may be restricted. She advises that we need to begin by exposing our students to community service models and first-hand experiences (Dr. Jarus, personal communication, April 18, 2007). Occupational therapists are providing services in both the private and public domains.

Community research and participation action research are two powerful and promising modes of delivering services in keeping with the *Ottawa Charter* and may beg further investigation and support by the profession.

Strategies to lobby insurance companies should continue. It may be useful to highlight successes in service delivery in insurance companies such as the Insurance Company of British Columbia and the Workers Compensation Board in order to market occupational therapy services. Further lobbying may be useful with private insurance companies that do not list occupational therapy as a covered service.

In the area of publicly-funded services, efforts may best be targeted at the health authority level, where both the funds and the power to make decisions are concentrated. The health authority will be receptive if it detects efficient service delivery and outstanding managers such as Kim Calsaferri, Occupational Therapist and Manager of Rehabilitation and Recovery Services and Family Involvement at Vancouver Community Mental Health Services (VCMHS).

More common today are partnerships with private industry firms (such as pharmaceutical companies) and various granting agencies. These collaborations are a way to fund and sustain programs. Occupational therapists may serve their clients well by looking at how they can ethically and safely collaborate with various stakeholders (both public and private) in new ways to create powerful, reciprocal relationships that allow Canadians increased access to occupational therapy services. A recent document released by The Conference Board of Canada (2007) demystifies issues of liability for partnership development. The report proposes that each regulated health profession have its own liability insurance and only practice within the realm of competence or scope of practice, and that each program is responsible for its own risk management strategies.

New Practice Models that Uphold the Core Values and Beliefs of the Occupational Therapy Profession

This next section will briefly outline innovative practice models or approaches in two services

presently being offered in British Columbia. Strengths, challenges, and lessons learned will be highlighted.

Gastown Vocational Services (GVS), Vancouver and Burnaby, BC
A section of the Vancouver Community Mental Health Services (VCMHS) is described as a 'promising practice' by Human Resources Development Canada (HRDC, 2002). Gastown Vocational Services (GVS) provide vocational/educational programs to youth and adults who live in the lower mainland and have a mental health disability. The program was established in 1991 and assists participants to reach their volunteer, educational, and employment goals. The program offers one-to-one and group support for participants.

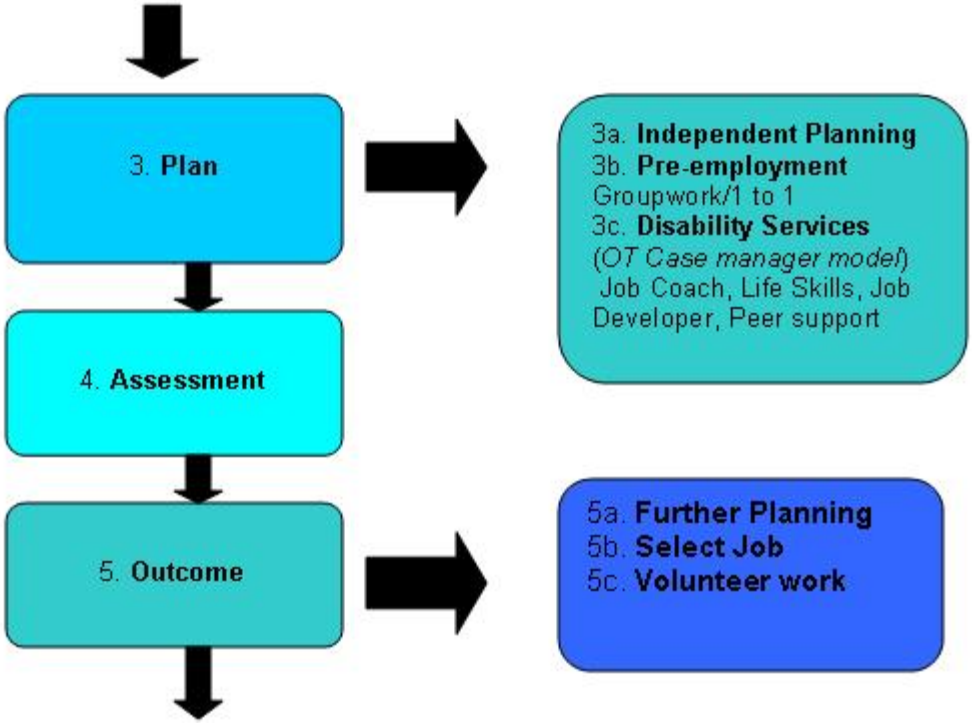
This innovative program is managed by Mariella Bozzer, an occupational therapist, and is unique: it a public service, accommodates private clients, and is a "performance-based" service (the program obtains funding only if participants attain specific results). Partners include: the Ministry of Health (33% of the budget), the Ministry of Employment and Income Assistance (45% of the budget), the Ministry of Children and Family Development (11% of the budget), and private revenue (e.g., insurance companies and Worksafe BC) (6% of the budget).

The working budget is approximately $1 million; the program serves approximately 600 clients per year at two locations, and employs an interdisciplinary team of 22. The model for this program (primarily a rehabilitation case management model) offers an individualized approach to client-centered service delivery. The following diagram represents which clients can expect to obtain services at GVS.

Service Flow at GVS (VCMHS)

1. **Intake**

2. **Client accepted**




6. **Summary Report**

When asked about the challenges of the program, Bozzer reveals that constant collaboration and accountability regarding partners results in the continued quest to measure and respond to partner satisfaction and service quality. Every six months, partners are formally asked to give feedback to the program. "Without that feedback you cannot know the quality of the service you are providing" (M. Bozzer, personal communication, April 18, 2007).

The big challenge is managing change well (Manion, 2005). A change is often driven by performance outcomes. Specific challenges come from integrating performance needs with designing and implementing recovery-orientated services. A recent example was the need to redesign a program that although was working well, did not meet the performance needs of funders. The issue was resolved by integrating the program into another existing employment program to create a "blended service delivery model." Only by truly understanding and buying into the necessary reorientation was staff able to manage this change. Bozzer notes that this was not an easy process. She also reflected that this kind of service delivery is not suitable for all employees as some individuals have difficulty adjusting to new ways of doing business. The fact that contracts are renewed every three years requires extensive paperwork (proposal writing and administrative organization). Bozzer also noted that the added complexity of competing for funding every three years in an already competitive market is challenging.

Benefits
Bozzer cites increased funding sources and an opportunity o create a diverse program as important benefits. She says she is proud to be able to offer clients a variety of individually-tailored, flexible, seamless services to clients. The program operates on best practices and provides increased choice for consumers and families.

Lessons Learned

There is an understanding that the pace is fast in this environment. However, Bozzer is quick to advise: "Don't try to change too fast as it will blow up in your face "ensure people are adjusting to the change or there will be no buy in." She also admits that business acumen is imperative to the success of the program: "I have become very proficient at costing out services ... and knowing where to put financial resources ... we also have learned to negotiate for up front money to initiate planning services and do the 'readiness piece' for clients. There is a drive to keep a pulse on how clients' needs change, and in order to accommodate the needs, services will fluctuate. We need to be able to respond to these changes on a month by month basis; for instance, one month we may need extra job coaching service, while another month it may be a decrease in life skill services" (M. Bozzer, personal communication, April 18, 2007).

According to Jennifer Glasgow, occupational therapy team leader at GVS, the occupational therapy case management approach is a key to the success of the program. "It is what makes the wheels turn around here." Mariella and Jennifer agree that with this model of service delivery, it is possible to have the right person for the right job at the right time to provide an efficient effective service (Canadian Institute for Health Information, 2006). Glasgow adds that without the focus on occupation and a true understanding of the impact on clients with disabilities, clients would not get the ¡§quality best-fit service¡¨ and the service could fail as a result (J. Glasgow, personal communication, April 18, 2007).

Unfortunately, last month GVS was unsuccessful in renewing its contract with the Ministry. This outcome demonstrates the need to develop occupational therapy competencies such as critical thinking, innovation, and change management critical to the operational success of these kinds of innovative partnership models.

Why Weight Program

The Why Weight Program is a Vancouver Community Mental Health Services (VCMHS) program partnered with a pharmaceutical company, Eli Lilly, in order to finance programming geared to promote healthy lifestyles and occupations for persons with mental illness. It is an innovative program, initially coordinated by Rene Corbett, occupational therapist. Regina Casey, co-author of this paper is the current coordinator of the program and is employed six hours per week. The role is primarily to coordinate services and promote collaboration between partners and those delivering service. Developing resources for the program is also key as is collecting and disseminating outcome data. This data will be utilized in considering next steps when the project funding is terminated in January 2008.

The program replicates the successful John Pendlebury model from Britain (Pendlebury, Bushe, Wildgust, & Holt, 2007) and was established just over one year ago via a grant application. Eli Lilly invited grant applications for up to $100,00 per project. The entire Eli Lilly Wellness Education Fund was available throughout Canada and comprised of $2 million. Grant applications were reviewed by an independent body; key requirements were that projects be sustainable after the two years of funding, collaborative in nature, relevant to the Eli Lilly mission for the fund (wellness education and involvement in related occupations). VCMHS was successful in securing $70,000 over the two-year period. Why Weight core programs are managed by seven different mental health teams and employ six peer contractors at $11.00 per

hour. These contracted positions are often a beginning for individuals who have not been working for long periods.

Programming includes group sessions on goal setting, learning about nutrition, fitness, and food preparation. Engaging in physical exercise, support, and a weekly weigh-in are key components of the bi-weekly service. For many, the support offered by their peers allows individuals to engage in occupations they otherwise would decline. A manual was developed with content information that can be utilized after the program is complete. A competition was launched for a logo that would be used for wellness programming throughout the system.

Notably, Eli Lilly's name is not used in any advertising. Eli Lilly has requested broad information about the project (how many groups, how many individuals are attending) at the end of the two-year period. The letter of agreement for the contract included: "Of course, the approval of your application imposes no obligation, expressed or implied, with the respect to the mention, prescription, use, or support of Lilly products." Additionally, it was important to both partners (Eli Lilly and VCMHS) that the identity of program participants remain anonymous.

Challenges arising from developing such a program include working collaboratively with new and divergent partners, and forging change within an existing system. Some staff in the organization did not wish to partner with a private company for fear of being ethically compromised. These issues required that project leaders be attentive to staff concerns and focus on project successes (Kotter, 1996). Another challenge was that this program was intended to be multidisciplinary; rehabilitation staff and peer contractors, however, are carrying out the majority of the work. Identified systemic barriers regarding the project, highlighted the system's issue of access to services to non-team clients; these in turn demonstrated a need to provide services to clients who are not officially part of the specific teams (who at present automatically have access to the program). For instance, staff needed to be creative so that clients attending the Early Prevention and Intervention Program received access to the services of larger teams. Another issue is that those who receive mental health services from a private psychiatrist or family physician will not have access to this program at this time.

Benefits

It was felt the 'timing was right' for this project, as there has been a significant focus in wellness in mental health service delivery over the past couple of years (R. Corbett, personal communication, April 21, 2007). A recent publication on this project has attracted interest from groups in Halifax, Hamilton, and Vernon. According to Corbett, the project has already effectively demonstrated the need for a health promotion approach to service delivery and the initiative fits the current recovery orientated approach to care in mental health. The project has served to build the capacity within the system and has helped to generate new collaborators in the larger system. An example was given regarding dietitians who have identified a gap in nutrition services to persons with a mental health issue within the system. "Dialogue with dieticians has resulted in funding for a research dietician to determine a potential role on a mental health team" (R. Corbett, personal communication, April 21, 2007).

## Lessons Learned

Knowledge of change management (Bridges, 2003; Kotter, 1990, 1996; Senge, 1990) is essential for this kind of change within a system. The existence of champions, an understanding of organizational culture, and the support of management is needed. An important lesson learned was that the outcome was more positive than initially forecast. Initially, it was hoped that five teams would be involved; instead, there are seven teams participating. There was some flexibility in the budget that allowed for a resource fund to be developed for participants. Feedback from clients includes an appreciation for increased participation in healthy occupations and the development of a wider network of supports.

When asked for words of wisdom to share with others who are interested in developing a similar project, Corbett suggests: "Clarify expectations and go one step at a time" (R. Corbett, personal communication, April 21, 2007).

## Conclusion

As a health profession, we are not alone in struggling to learn to sustain what we have and to plan for building what we want in the future. Dialogue and involving stakeholders will be important. The goal may be for small, cumulative, positive changes that are focused on a clear vision for the future.

CAOT has begun the process of identifying current best practice competencies through the revision of the Profile of Occupational Therapy Practice in Canada (CAOT, in progress 2007). In terms of core competencies as a profession, we are now placing more emphasis on developing skills for roles in leadership, community development and involvement/participation, systems thinking, economic analysis of interventions, collaborative practice for client-centred care, family involvement, action learning/critical thinking, and workplace wellness.

CAOT (2005) anticipates that in the future the "demand for health services will continue to exceed the money available" (p. 3). This paper has illustrated and upheld CAOT's claim that "It is not wise to assume that the distribution of resources that has evolved historically is either efficient, equitable or appropriate in future health services" (CAOT, 2005, p. 3). A challenge for the profession is to reflect on how we can finance service delivery in new and creative ways, and understanding that more is not necessarily better.

We have described two collaborative partnerships that occupational therapists in British Columbia have formed with government and private organizations in order to provide services to clients with mental illnesses. Duxbury adds to this sentiment by saying that we need to plan for the future, not just redesign the past (Dr. L. Duxbury, personal communication, March 9, 2007). As a profession, what models or values can we extend to help improve and finance the Canadian population¡¦s health? For further information on developing collaborative partnerships, please refer to the Canadian Collaborative Mental Health Initiative ([CCMHI], 2006).

Possible useful resources to innovation are presented by two recent Canadian documents. The first document, entitled The Principles and Framework for Interdisciplinary Collaboration in Health Care (Enhancing Interdisciplinary Collaboration in Primary Health Care [EICP], 2006), encourages health professionals to work in more collaborative, innovative ways in order to

provide more efficient and effective services to clients, patients, and families. The second document is the Charter produced by the Canadian Collaborative Mental Health Initiative ([CCMHI], 2006), which dovetails with the work of the EICP and is focused specifically on mental health service delivery. (Of note, CAOT was an active partner in developing both documents.)

Interestingly, from a more global perspective, the sentiment of developing collaborative, innovative, and efficient practice, though not new, is shared by the National Institute for Mental Health (NIMH) in England in its recent publication *New Ways of Working for Everyone: An Implementation Guide* (NIMH, 2007). The publication proposes new ways of working together that are centred on ensuring that the most skilled member of a team is the one responsible for delivering an intervention based on client need. The person who is most skilled on the team should be the person to deliver the intervention which based on client need.

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2. Judi-Varga Toth - view her Powerpoint presentation
http://www.caot.ca/powerpoint/Frontline%20Health.PPT

3. John Maxted- view his Powerpoint presentation http://www.caot.ca/powerpoint/maxted.ppt

4. Danielle Hogan- view her Powerpoint presentation
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