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CAOT President-Elect Sue Forwell (left) and Treasurer Maureen Coulthard with Steven Fletcher, Manitoban MP (Charleswood-St. James-Assiniboia) and Health Critic for the Conservative Party during CAOT's 10th year in Ottawa celebrations. **More on page 3**

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CAOT marks decade in Ottawa by unveiling nationwide programs

Tanya Baglole, CAOT Communications Coordinator

CAOT launched two national initiatives during its tenth anniversary celebration in the nation's capital, where more than 70 stakeholders gathered at a wine and cheese reception in late October at the Lord Elgin Hotel.

CAOT President Diane Méthot unveiled the Pan-Canadian Awareness Campaign on Occupational Therapy and Interdisciplinary Collaboration in Primary Health Care. The national initiative aims to accelerate the adoption and practice of interdisciplinary collaboration in primary health care. It also plans to build support for occupational therapy as an essential service where care is provided in homes, workplaces, schools and community settings for mental and physical health and end-of-life care.

Stable, Able and Strong, CAOT's second new initiative, was announced by Dr. Claude Rocan, director general for the Centre for Health Promotion of the Public Health Agency of Canada. This project will develop a support model and component strategies to help seniors who have experienced a fall to maintain or resume active living in their homes and the community.

Addressing a captivated audience, President Méthot said these initiatives reflect CAOT's view of primary health care through health promotion and disability prevention within a cost-effective system. "We are confident our initiatives will advance our common vision of a collaborative primary health care system that values client engagement, a population health approach to health planning, access to the right professional and effective communication among the health professions, and a commitment to continuous improvement," she noted.

Nancy Milroy Swainson, director of the Primary and Continuing Health Care Division, Health Canada, congratulated CAOT for being an "integral partner" and supported its primary health care initiatives. She also spoke about the factors needed to make collaborative care intrinsic to the daily provision of primary health care, such as...

Maureen Coulthard, CAOT board secretary/treasurer, Steven Fletcher, Manitoban MP (Charleswood-St. James-Assiniboia) and Health Critic for the Conservatives, and Paulette Guitard, CAOT Quebec board director, gather to celebrate CAOT's decade anniversary in the nation's capital.

- Evidence to demonstrate that an interdisciplinary collaborative approach to primary health care does improve the quality of care and client health outcomes.
- Greater public awareness of the benefits of an interdisciplinary collaborative approach to primary health care, and what this means to the individual client.
- Tools and resources developed to support health professionals to work more collaboratively.
- Interdisciplinary education at the pre-licensure level so various health professionals can learn from each other.
- Support for the 'champions' of interdisciplinary collaboration in primary health care, to promote the approach among their colleagues. This includes continuing education at the post-licensure level.

"Together, with these initiatives, CAOT is tackling most of these activities. I thank you for your efforts to date and wish you well as you embark on your awareness campaign," she said.

Susan Swanson, CAOT member, and Cindy Moriarty, of Health Canada, Health Human Resources Strategies Division, mingle at the wine and cheese reception held at the Lord Elgin Hotel.

(Left to right) Mr. Jim Karygiannis, Dr. Claude Rocan, CAOT President Diane Méthot and Ms. Nancy Milroy Swainson launch two national initiatives at CAOT's 10th anniversary in Ottawa: the Pan-Canadian Awareness Campaign on Occupational Therapy and Interdisciplinary Collaboration in Primary Health Care and Stable, Able and Strong.

Dr. Rocan discussed how the impact of a fall is well understood by everyone who works in occupational therapy. "The permanent disability, chronic pain and fear of falling can be devastating – physically, financially, and emotionally," he said, noting the "sobering statistics" of falls:

- One third of seniors experience a fall a year.
- Falls are responsible for 70% of all injury-related days of hospital care for seniors.
- Falls are directly accountable for 40% of all seniors' admissions to long-term care institutions.

"That is why I am so pleased to announce federal funding to CAOT for their new project 'Stable, Able and Strong'... This project reflects both the population health and occupational therapy ideals of enabling people to help themselves," he concluded.

The three-year, $300,000 project, funded by the Population Health Fund of Health Canada until June 2008, is sponsored jointly by CAOT and by the University of Ottawa's occupational therapy program.

Jim Karygiannis, parliamentary secretary, Human Resources and Skills Development Canada, who brought greetings on behalf of Minister Belinda Stronach, talked about the valuable contribution occupational therapists make to health care in Canada. He praised CAOT for nurturing occupational therapy students, which he said was critical to the country's future labour market.

"One of the ways to look to the future is doing exactly what the CAOT does so well already – representing so many students of occupational therapy. The skills these young people are learning and the support they are getting through your organization will see them through the challenges ahead. Professional health care organizations that attract and nurture young people, as your group is doing, are critical to the future of Canada's labour market," said Mr. Karygiannis.

In her address, President Méthot also discussed the difficult decision CAOT made to move to the nation's capital, wondering if our "voice" would be better heard by moving closer to the seat of government.

"I am glad to say it was the best decision we could have made. And as a result, we have developed strong partnerships," she said.

Indeed, the room at the Lord Elgin Hotel, a few blocks from Parliament Hill, was filled with representatives from many national organizations.

"'The strength of one and the power of many,'...these [initiatives] are just some of the many fruitful partnerships that have grown from our move to Ottawa a decade ago. We are confident that these are just the beginning of our continued journey with our partners to an improved publicly funded Canadian health system," concluded President Méthot.

Valuable web pages

Pan-Canadian Awareness Initiative on Occupational Therapy and Interdisciplinary Collaboration in Primary Health Care:
http://www.caot.ca/default.asp?pageid=1044
Stable, Able and Strong initiative:
http://www.caot.ca/default.asp?pageid=1385

Telerehabilitation

Occupational therapy beyond borders

Lorna Reimer

Telehealth is defined as "the delivery of health services and education at a distance via the use of communications and information technologies" (CAOT, 2004, glossary). Telerehabilitation is the provision of rehabilitation intervention, education, training and support using technology across distances. Technologies used to support telehealth and telerehabilitation activities encompass a wide range of software and hardware, and wireless, mobile and stationary devices including telephones, videophones, computers, cameras, monitors, speakers, microphones, satellites and wide bandwidth ISDN or Supernet lines to transmit video, digital and audio information. In 1993, Alberta Health and Wellness under the umbrella organization Alberta We//net, established three objectives for telehealth: 1) to improve access to health services for clients and clinicians in remote communities; 2) to support rural and remote clinicians with peer information and continuing professional education; and 3) to improve the efficiency of delivering specialized and expert health services.

It's now 2006. Have we improved access to occupational therapy services for clients in remote communities? Have we supported occupational therapists in rural and remote communities with education and information? Have we improved the efficiency of delivering specialized occupational therapy services? While data likely does not exist to answer any of these questions, currently occupational therapy clinical services, support and education are being delivered across distances. Here are some examples and ideas to consider how you could use telehealth in your practice.

Lorna Reimer, BScOT, MSc is the Director of the Centre of Excellence in Telerehabilitation at the University of Alberta and Glenrose Rehabilitation Hospital, Capital Health. She can be reached by e-mail at: lreimer@cha.ab.ca

Column editors
Lili Liu and Masako Miyazaki

Telelearning

Attending an inservice, lecture or workshop via videoconference is likely the first time most of us experience telehealth. Telelearning, receiving education across distances, is the most frequent and easy to use telehealth activity. Many people can participate in telelearning activities at the same time, from many different sites and communities, and with minimal or no added time and cost for travel. Exposing therapists to telelearning has been shown to improve their comfort level and involvement in clinical telehealth activities as well (Liu, 2000).

Let's focus for a moment on how telelearning could help to meet your specific program or professional development needs. Do you need some expert instruction? Consider "bringing in" a keynote speaker or expert to present via videoconference or the Internet. See if your colleagues in other centres or communities would be interested and could share the costs (even though there are no travel and accommodation costs, anticipate paying a speaker fee and perhaps bridging or long distance fees). Do you have to instruct a class of occupational therapy students on a specific assessment tool? Consider assessing a real client and videoconferencing it to the whole class. Your client will likely find this less intrusive and stressful. For any education activity, planning ahead is important, and doing a practice run when using new technology will help to achieve success.

Teleclinical

Teleclinical activity embodies an episode of care or emulates a patient-provider encounter that would normally take place face-to-face (Aoki, Dunn, Johnson-Throop & Turley, 2003; Currell, Urquart, Wainwright & Lewis, 2000). Teleclinical events can be client-to-clinician, clinician-to-clinician, clinician-to-team, client-to-team, or team-to-team; they can be used for inpatient,

outpatient, or daypatient activities. Teleclinical activity is increasing, but we still have a long way to go to integrate it fully into our daily practice as a routine option for delivering rehabilitation services. Often rehabilitation is thought of as hands on, but actually much is teaching, planning, supporting or coaching. When clients are discharged home after an inpatient stay, family and other care providers often need to learn new ways of caring for and supporting the client. Consider doing some of the planning and teaching via videoconference to involve providers and family from the client's home community as much as possible. When you are working with school and preschool children, include school or daycare staff especially when rehabilitation intervention or equipment is new to those settings. By working together as one large virtual team, everyone can participate, learn from each other, and ultimately identify, prioritize and establish goals and strategies to best meet the needs of clients and their families.

Teleclinical consultation is also very appropriate for outpatients who need specialized services such as seating, assistive technology, and feeding and swallowing. Videoconference or videophone can be used in lieu of face-to-face visits to prescreen clients, and provide complete assessments and effective follow-up. Prescreening gives clinicians the opportunity to meet clients, discuss needs, and prepare for assessment or intervention. Demonstrating equipment can help prepare clients, or gauge their acceptance. Often therapists at a remote site can complete assessments, either partially or fully, with guidance from the specialized teams. This therapist-to-therapist interaction supports capacity building as remote or rural therapists learn new skills to use with other clients.

Telebusiness

Technology can also be used in business and management activities, including conducting meetings, collaborative ventures, and interviews. Recently, when government requested a quick response from an occupational therapy regulatory college, the college was able to link a number of its members from across the province via videoconference to brainstorm and outline the key concerns and information to support their position. In another example, videoconferencing was used to connect expert occupational therapists and university educators to discuss and plan for proposed changes to curricula in clinical neurology.

Benefits

The most obvious benefit of telehealth is the reduction of travel time and costs for clients, families and clinicians, especially to access specialized and tertiary health services located only in larger urban centres (Aoki et al., 2003; Currell et al., 2000). Travel can be a significant undertaking, especially for those who are medically frail or with disabilities who require wheelchair accessible transportation and caregiver or attendant assistance. Telehealth prescreening can improve the efficiency, and reduce the number of face-to-face visits. Team-to-team telehealth communications provide a more complete picture of each client, his or her community, and unique needs and goals to ensure that intervention plans are tailored specifically and thus more likely to be successful. By interacting directly with and supporting the remote therapist or team, specialized teams help to build capacity to carry out interventions and maintain clients in their home communities. Access to professional development opportunities, and mentorship or coaching for remote therapists, also may help to improve staff retention in rural and remote locations.

Limitations

Technology does have limitations, including breakdowns and gremlins. Some staff and clients are uncomfortable with technology and being in front of a camera. Initial cost of lines and equipment are significant, thus making full cost recovery a long-term goal. Without dedicated staff to operate equipment and schedule events, and organizational encouragement and support, most therapists quickly give up on using the technology for more than an occasional inservice or consultation.

Future directions

Occupational therapists engage in telehealth activities to assess clients in remote communities, gain professional knowledge and information, and provide consultation. What do we need to expand telerehabilitation further? Without a doubt, there is a great need for more research and evaluation regarding its effectiveness, and to help us under-

stand what factors contribute to success and what do not (Aoki et al., 2003; Currell et al., 2000). We need more training and education of the current and future workforces, so therapists are knowledgeable and comfortable in participating in telehealth educational, clinical, and professional activities. Ongoing monitoring of utilization, trends, gaps and resources is important for planning program and service delivery changes, and long-term sustainability of the technology and expertise. Development of guidelines and protocols to assist therapists in appropriate and successful telehealth activities are also needed. Future uses to be explored include televisitation, such as linking families and friends in remote communities with loved ones in hospital or hospice, home based telemonitoring, and virtual reality applications.

One key development, the creation of the Centre of Excellence in Telerehabilitation, a collaborative partnership between the University of Alberta and Capital Health, Edmonton, will aid in pursuing these opportunities and needs. The first of its kind in Canada, the Centre will bring together best practices, research, education and support in telerehabilitation for clients, educators and health workers from urban, rural and remote areas across Alberta and beyond. The Centre is designed to provide support, information and services, creating a seamless integration of telerehabilitation options, while bringing clinical rehabilitation expertise to those who need it. Further information can be found at: http://www.capitalhealth.ca/AboutUs/OurOrganization/AreasofService/Rehabilitation/Telerehab/default.htm

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OTDBASE celebrates 20th anniversary

"Like Christmas and a Lolly Shop and Winning the Lottery"

Laura van Iterson

It's 2006; do you know where your occupational therapy textbooks are? How many occupational therapists can find their textbooks, let alone make the claim that they have made a database of them? Marilyn Conibear, OT(C) can. She did so twenty years ago. And she didn't stop there! She asked herself the ambitious question, "Wouldn't it be something if a database could be created of occupational therapy journal literature?"

She thought of occupational therapists isolated from medical libraries, remembering what it had been like to work in Moose Jaw without access to occupational therapy literature. And then, wonderfully for the rest of us, she took the initiative to create a database of occupational therapy journal literature with what she had: copies of the *Canadian Journal of Occupational Therapy* and the *American Journal of Occupational Therapy*, all the while carefully indexing every article with a concern for "occupational therapists' clinical way of thinking".

And now? Now she enjoys hearing occupational therapists around the world rave about her invention! On the web site you'll read, OTDBASE is...

> "Like Christmas and a lolly shop and winning the lottery![1]"
>
> "...very user friendly and comprehensive."
>
> "...one of the vital databases to utilize for OT research."

This year marked the 20th anniversary of OTDBASE's inception, yet how many CAOT members know what a rich resource it is? As is often the case with our Canadian home-grown successes, we don't catch on to them until they've made it big in the outside world...

And indeed, it was not until trying to do occupational therapy research while based in France that this Canadian occupational therapist found simplicity in the form of a tool spelled OTDBASE. For the first time without access to CINAHL, or MEDLINE databases, I read about OTDBASE on the CAOT web site. OTDBASE is easy to access by internet from the CAOT web site and is free for CAOT members. OTDBASE allows me to search by keyword or topic and provides abstracts of articles from 22 different occupational therapy journals and practice magazines from 11 different countries. The journals accessed by OTDBASE come from Canada (*CJOT, OT Now*); the USA (*AJOT, OTJR, OTMH, POTG, POTP, OTHC, OTP*); England (*BJHT, BJOT, OTI*); Ireland (*IrJOT*); Germany (*E & R*); Sweden (*SJOT*); Australia (*AOTJ, JOS*); New Zealand (*JOPOT, NZJOT*); South Africa (*SAJOT*); Israel (*IJOT*); and Taiwan (*WFOTB*)[2]. The list is growing. For example, I have approached the French journal Ergothérapies about being indexed via OTDBASE and the editor of the Indian Journal of Occupational Therapy has agreed to have it included.

Non-CAOT members will find OTDBASE at www.otdbase.org. As the purpose of OTDBASE is to expose as many occupational therapists as possible to the international occupational therapy literature, it is economical. Many national occupational therapy associations, such as CAOT, offer access to OTDBASE for their members, at a rate that does not exceed one dollar per member per year. For others, the price of a first year subscription is $50 USD for individuals, $200 USD for a small group, $400 USD dollars for an institution.

OTDBASE brings the knowledge of occupational therapists around the world to our fingertips with the click of a mouse. Now if only someone could help me find my first year anatomy notes!

[1] Quote from feedback section on OTDBASE by JC - University (Australia) student

[2] Full journal titles are available on OTDBASE.

The Ottawa Hospital Occupational Therapy Orientation Manual: A tool of convergence

Renée Gauthier and Rachel Gervais

The Ottawa Hospital came into being on April 1, 1998 through the fusion of the Ottawa Civic Hospital, the Ottawa General Hospital and the Riverside Hospital. With its 1,130 beds, the Ottawa Hospital is one of the largest teaching hospitals in Canada, offering full health services to more than 1.5 million residents of Eastern Ontario. The clientele's needs in the area of occupational therapy services are filled by 45 occupational therapists, approximately 33 full-time equivalents. The Ottawa Hospital has gone through profound changes over the last six years, renewing its culture, mission and vision while maintaining its tradition of compassion.

Occupational therapists have had to make major changes to adapt to their new corporate environment. Following the initial merger in 1998, three occupational therapy departments were brought together under the administration of a single chief. The provision of occupational therapy services has gone from a department structure to a decentralized program structure. At the time of the merger there were, for example, three different policy and procedure manuals, a situation contrary to the new common vision of the Ottawa Hospital, dividing the staff in their daily work. The occupational therapists on-call, who had to work on different campuses and in a variety of programs, required training that was both wide-ranging and detailed to assimilate and apply the complex procedures for each site.

Our first action was to create the Occupational Therapy Professional Practice Committee made up of members from all the campuses, representing acute and sub-acute care and inpatient and outpatient services in mental and physical health. The objectives of this committee were to standardize professional practice and to make occupational therapy interventions more coherent. This standardization and coherence made it possible to ensure better continuity of services among the various programs and the three campuses. In addition, we wanted to facilitate transfers between job positions at the different campuses and adjust training periods to match the availability of supervisory resources. We also hoped to encourage a feeling of belonging and increase job satisfaction in the mega-hospital by promoting the exchange of ideas and inspiring a sense of identity and professional competency.

The first corporate action to improve the sense of belonging and enhance our standards of professional practice was to develop an orientation manual in occupational therapy. This manual, divided into eight sections, now serves as a reference tool and common starting point by detailing the practice of occupational therapy at the Ottawa Hospital.

About the authors

Renée Gauthier is a physical medicine occupational therapist at the general campus of the Ottawa Hospital, and Rachel Gervais is Chief of Occupational Therapy and Therapeutic Recreation — a full-time manager supporting the professional practices of occupational therapists. Rachel may be reached by e-mail at: rgervais@Ottawa-hospital.on.ca

The eight sections

1. Introduction to occupational therapy at the Ottawa Hospital

Governs the practice of occupational therapy within the corporation; explains the raison d'être of the orientation manual for current and newly hired employees; provides an orientation checklist; confirms the implementation of a model of practice that favours the uniformity and continuity of services throughout the entire hospital.

2. Information specific to the department

Provides specific information on the discipline, including our mission and annual objectives, the lists of the clinical teams in occupational therapy, and task descriptions; includes the schedule of

Within the organization, we project the image of a professional group with a concern for cohesiveness and uniformity...

meetings and presentations, and the information contained in the common directory for the discipline, accessible to everyone on all three campuses through the Ottawa Hospital intranet system.

3. Clinical protocols
Specifies the processes in occupational therapy, for example the sources of references, the criteria for prioritizing the patient list, guidelines for assessment, intervention, planning discharges, and the transfer of patient care in occupational therapy to another department and/or another campus.

4. Record keeping
Explains how to fill in the forms approved by the Occupational Therapy Professional Practice Committee from initial assessment to discharge; lists the commonly-used abbreviations.

5. Workload report
Explains the statistical requirements in occupational therapy at the Ottawa Hospital and how to record the data.

6. Supervision of students
Clarifies the requirements for participation in the training of students and clarifies the roles and responsibilities during student internships.

7. Rehabilitation assistants
Refers the occupational therapist to the guidelines of the College of Occupational Therapists of Ontario and discusses the assignment of service components to rehabilitation assistants.

8. Performance assessment
Describes how the performance of an occupational therapist is evaluated at the Ottawa Hospital.

Writing a manual which combined the procedures, forms and practices from all three campuses took several months. Once it was developed, the manual was presented to all the members of the occupational therapy staff at a retreat. During this retreat, we discussed highlights of the manual, established a uniform vision and gained the support of all the occupational therapists and rehabilitation assistants. Following the retreat, everyone agreed to begin reviewing our internal operating methods and to adopt a common initial occupational therapy assessment form in order to facilitate the work of temporary occupational therapists when they are redeployed within the organization according to needs.

The orientation manual has been more than a tool to help with the training and education of temporary and on-call occupational therapists. It has served as a catalyst for the review of the program for performance assessment, as well as for the development of a common approach to the supervision and delegation of tasks of assistants. The manual encourages inter-campus experience for staff, and encourages team spirit and better communication within the discipline and with the hospital as a whole. For example, during the process of conversion to electronic medical files, the organization was able to determine our record-keeping needs since they had already been explained in the manual. Our common starting point facilitates exchanges with our new partners, the University of Ottawa Heart Institute and the Rehabilitation Centre. Within the organization, we project the image of a professional group with a concern for cohesiveness and uniformity, and a group which has re-examined its processes to align with the new corporate vision of the Ottawa Hospital.

We have also discovered advantages from a clinical perspective. Adopting a common practice model for occupational therapy (in our case, the Canadian Model of Occupational Performance (CAOT, 2002)) has stimulated reflection, encouraged inter-campus discussions, enhanced interventions and aligned occupational therapy practice. By using a single initial assessment form, we can be sure that the client receives a continuity of services through better inter-campus communication.

For readers who wish to initiate a similar project and who are working in newly merged organizations, we suggest the following: The first step is to identify the situation that you want to change. In retrospect, before beginning this work we neglected to define clearly the problem situation upon which we wished to act. Absorbed as we were by the rapid pace of clinical demands, our objective was essentially to facilitate the transfer of patients between campuses. Along the way, we realized that the manual was enhancing

The introduction of a suggestion box gave all the occupational therapists a chance to express their views, and to think about and influence the process.

networking and diversifying the opportunities for learning in occupational therapy, thus improving daily practice in occupational therapy and visibility.

The adherence of occupational therapists to the project was not ensured in the initial phase, since each campus operates autonomously. Staff are reluctant to change an established system that is working well; therefore any extra work generated by the restructuring of the hospital was seen as a negative. In an attempt to counteract the reluctance to change, the professional practice committee frequently consulted the whole group as the manual was being developed. The introduction of a suggestion box, where all ideas were permitted and dealt with anonymously, gave all the occupational therapists a chance to express their views, and to think about and influence the process. This preliminary reflection by the occupational therapists was a valuable step to have in place prior to discussions with the full group.

The *Ottawa Hospital Occupational Therapy Orientation Manual* is constantly being revised by the Occupational Therapy Professional Practice Committee since it reflects a dynamic, ever-changing process. Over the last two years, it has become an indispensable resource to support a more standardized approach in occupational therapy and promote uniformity of practice on every campus. The exercise of its implementation has permitted us to share our resources and validate our processes. The manual and its development have proven to be an excellent tool to promote the convergence of professional practice in occupational therapy in a newly restructured hospital environment.

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The National Fieldwork Placement Service: Next steps

Bonny Jung, McMaster University & Huguette Picard, Chair of ACOTUP

Life is full of changes that inspire us to strive for excellence. What worked for us yesterday and even today may not be what is best for the future.

Since the 1960s, the CAOT provided national fieldwork coordination support to the occupational therapy programs across Canada. For over four decades CAOT's responsibility for this task was a testament to their commitment to the membership and to the future of the profession.

In 2001, CAOT re-prioritized their goals as a professional association and decided to discontinue management of the Fieldwork Placement Service (FPS) as of 2003. In the absence of an alternate service provider, McMaster University assumed the task of operating the FPS in the summer of 2003 on a trial basis with direction and support from the Association of Canadian Occupational Therapy University Programs (ACOTUP). McMaster University made improvements and updates to the FPS with a vision to address the needs of the future. However, in 2005 it was decided that the existing FPS system was not viable due to changing fieldwork trends in the national landscape and rising costs.

ACOTUP has been considering alternative arrangements for the administration of the FPS for some time. A decision has been made. Through its secretariat operated by Megram Consulting Services Limited, ACOTUP will provide a national placement service as of January 2006. Now that more information is available on the policies and procedures of this updated service, Megram, on behalf of ACOTUP, has begun to contact sites to initiate targeted recruitment for placements occurring in the first few months of 2006. Megram hopes to develop a solid partnership with Canadian sites and to continue the excellent relationship that was established between fieldwork placement providers and the FPS-McMaster. ACOTUP would like to take this opportunity to thank the people at FPS-McMaster for their hard work in providing resources and professionalism in supporting the national placement service from January 1, 2003 until December 31, 2005.

If you have any immediate inquiries we encourage you to contact your affiliated university fieldwork coordinator for more information regarding the status of the placement system.

Declarative title: Systematic review of the literature concluded that there is an evidence base for occupational therapy interventions with people aged 60+ living independently in the community.

Summary of Steultjens, E. M. J., Dekker, J., Bouter, L. M., Jellema, S., Bakker, E. B., & van den Ende, C. H. M. (2004). Occupational therapy for community dwelling elderly people: A systematic review. *Age and Aging, 33,* **453–460. (Prepared by Cary Brown, CAPs Advisory Group Member).**

Research Question/Objective: To determine whether occupational therapy improves or maintains outcomes for community dwelling people who are 60 years and older.

Methodology: Systematic review.

Data sources: Electronic databases (MEDLINE, CINAHL, EMBASE, AMED, and SCISEARCH), the Cochrane Controlled Trials Registry, and the libraries of two Dutch health professions' institutes. Hand searching of reference lists and contacting published experts in the field. The search was conducted in 2002, and with earliest search dates ranging from 1966 to 1985 (depending on the database).

Study selection: Inclusion criteria for articles included in the review: (a) efficacy studies (randomized control trials (RCT) and non RCT); (b) studies evaluating occupational therapy interventions; (c) primary or secondary outcomes related to functional ability, quality of life and falling; and (d) full length articles.
Studies that were multidisciplinary were excluded because they did not directly address the question of occupational therapy intervention. The researchers included studies where the intervention was carried out by another discipline but was considered to fall within the role of occupational therapy.

Data extraction: The studies were sorted into five distinct intervention categories consistent with International Classification of Functioning, Disability and Health (ICF) categories: (1) training of sensory-motor functions; (2) training of cognitive functions; (3) training of skills; (4) advice and instruction regarding the use of assistive devices; and (5) counseling of primary caregiver. A sixth category was comprehensive occupational therapy (when all five categories were part of the intervention).

The authors compared standardised mean differences (a statistical technique that allows for comparison of data between studies where different outcome tools are employed) but, because of the highly diverse nature of the studies, data were not pooled in a meta-analysis.

Quality ratings: The methodological quality of the selected articles was evaluated against a total of 19 criteria: internal validity (11 criteria), statistical (2 criteria) and descriptive (6 criteria). All criteria were scored as 'yes', 'no' or 'unclear', and studies were rated as 'high quality' if they met a minimum of 6 internal validity, 1 statistical and 3 descriptive criteria. The criteria were modified for studies that did not follow a controlled design, thus resulting in 7 internal validity, 4 descriptive and 2 statistical criteria. Studies were rated as 'of sufficient quality' if they met a minimum of 4 internal validity, 2 descriptive and 1 statistical criteria.

Results: Seventeen studies met the inclusion criteria. One study looked at comprehensive occupational therapy, 3 studies reported occupational therapy interventions targeting caregivers of people with dementia, and 13 studies involved advice and/or training for assistive devices. Six of the 12 controlled clinical trials were rated as high methodological quality. Two of the 5 'other-designed' studies were rated as having 'sufficient strength', and the remaining studies achieved a rating of 'low' methodological quality. 'Strong evidence' for increasing functional ability was found for the occupational therapy intervention of advising about assistive devices as part of a home hazard assessment program. The evidence base for

structure abstract continued

providing assistive devices in combination with skills training for reducing falls in the elderly, and for the efficacy of comprehensive occupational therapy on function, social participation and quality of life, was found to be limited. The evidence for the efficacy of providing caregiver education as a technique to maintain independence in persons with dementia was rated 'insufficient'.

Authors' conclusions: A strong evidence base exists in the literature for provision of advice and training in assistive devices as part of a home-hazards assessment designed to increase function. A degree of evidence also exists for the effectiveness of interventions in functioning, social participation, quality of life and reduced incidence of falls for community dwelling elderly persons. More research targeting people with specific conditions and their caregivers is required.

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What is a systematic review?

Lori Letts, CAPS Column Editor

This CAP addresses evidence from a systematic review that was conducted by Steultjens and her colleagues. In thinking about how to use this evidence in practice, it may be useful to review the definition and features of a systematic review. The Glossary of Terms in the Cochrane Collaboration[1] defines a systematic review as "a review of a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise relevant research, and to collect and analyse data from the studies that are included in the review. Statistical methods (meta-analysis) may or may not be used to analyse and summarise the results of the included studies." Generally, a systematic review is intended to evaluate the strength of evidence for specific interventions. The term systematic is used to emphasize the systematic approach to literature searching. Systematic reviews gather evidence from primary research studies (such as randomized controlled trials) which have been designed to evaluate the effectiveness of the intervention in a specific clinical context or with a specific population.

The value of a systematic review lies in its ability to review the strength of the evidence from several primary studies to give an overview of the evidence related to the intervention. Systematic reviews are becoming increasingly common in occupational therapy. Therapists can use the results (a) to help them guide decision-making with individual clients about whether or not an intervention has strong evidence to support it (or to refute its effectiveness), (b) to help them in program development, and (c) to respond to queries about the effectiveness of their interventions.

Like all research, systematic reviews need to be critically appraised. The types of issues to consider are the clarity of the review question, the search strategies used, the inclusion/exclusion criteria applied, the methods to pool or analyse data, and the conclusions based on those results. If you are interested in more information about understanding or critically appraising systematic reviews, some relevant sources include:

Critical Appraisal Skills Program
10 questions to help you make sense of reviews
http://www.phru.nhs.uk/casp/casp_s.review_tool.pdf

Oxford Centre for Evidence Based Medicine
Critical Appraisal Worksheet for Systematic Reviews of Therapy
http://www.cebm.net/worksheet_overview.asp

Article on Systematic Reviews
Greenhalgh, T. (1997). Papers that summarize other papers (systematic reviews and meta-analyses). *British Medical Journal, 315,* 672-675.
http://bmj.bmjjournals.com

[1] Version 4.2.5, p. 45. Available at:
http://www.cochrane.org/resources/glossary.htm

Commentary on Steultjens et al. 2004

Lynda Dunal, Bianca Stern, Sharon Faibish and Alanna Weill

As today's occupational therapy clinician endeavours to integrate evidence based care within a client-centered approach, he or she is often challenged with negotiating the ever-growing amounts of rehabilitation literature. Systematic reviews can present a logical and ordered way of tackling this flood of information (Law & Philp, 2002). Steultjens et al. conducted a systematic review of the literature to summarize current best evidence to determine if occupational therapy improves or maintains outcomes for community dwelling people who are 60 years and older.

Systematic review process

The authors employed a systematic and transparent methodology, and delineated their search strategy methods in locating the studies used and the databases accessed. In addition, they identified selection criteria for inclusion, the classification of five specific intervention categories, the population of interest, and the interventions and outcomes measured. They also identified the types of research designs and a scoring system that rated methodological quality. The supplementary material is very helpful in understanding the systematic review. Therapists interested in reviewing the article would benefit from accessing the supplementary material as well. It is interesting to view the supplementary material and realize that a study of 6 case studies is rated as high methodological quality while two randomized controlled trials (RCTs) of caregiver interventions are rated low quality. This occurred because more and stricter criteria are applied in evaluating the RCT, even though some criteria cannot readily be applied to community-based intervention studies conducted in rehabilitation, e.g. blinding allocation. Many systematic reviews classify studies based on levels of evidence rather than categorizing them as RCTs and other designs, as has been done here. The results were summarized according to a best evidence synthesis framework and analyzed according to the five intervention categories. They used a statistic called the standardized mean difference (SMD) to compare data across studies, since different outcome measures were used for outcomes such as falling and functional abilities. SMD is one approach to determining effect size, which is the estimate of how effective an intervention is. It is challenging to interpret the SMD statistic, since it tells you the number of standard deviations between two means (the treatment and control group), but doesn't help you to determine if those differences are clinically important. The best-evidence synthesis adopted is an attempt to pool information about the evidence, both its quality and its quantity. Strong evidence requires consistent, statistically significant findings in outcome measures in at least two high quality RCTs. Evidence from one high quality RCT is considered to be limited evidence, even though that evidence might be readily usable by clinicians in practice.

Applying the results to practice

It was difficult to make comparisons between the population samples and settings in the review and our local practice situation due to, for example, missing demographic information. Although the categories of interventions seemed similar, more information was required to determine if the findings could be applied in our local setting. We would need to acquire the original studies in order to make those judgements.

Steultjens et al.'s review presents a number of challenges related to the application of its find-

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The conclusion that "occupational therapy interventions for community dwelling elderly people results in positive outcomes" (p. 453) is an important message to convey to our clients and funders.

ings, both to the individual clinician's level of skill in knowledge translation and to the larger occupational therapy professional community. For the practicing clinician, this review can be challenging to understand if one is not familiar with the intent of this type of research and data analysis, and/or one does not have access to the supplementary data mentioned in the article. Also, there can be a tendency to view the review's rigorous processes of distilling evidence as reductionistic. The authors' conclusions may seem disheartening or even surprising if one is left thinking that this is all the existing evidence. After all, we know, and the authors of the systematic review agree, that effective occupational therapy is not simply about supplying assistive devices. Steultjens et al.'s review question casts a broad net that resulted in a mixed bag of interventions and outcomes. This type of study offers limited information to front-line practitioners about how he or she can effectively incorporate and apply best evidence into everyday practice. However, clinicians can use such reviews as a source of information about other studies they may want to review. For example, the authors note that there is limited evidence on the effectiveness of a comprehensive occupational therapy intervention because they only identified one high-quality RCT. Clinicians offering or proposing comprehensive occupational therapy interventions would be wise to be familiar with that single study. Furthermore, several studies of multi-disciplinary interventions were excluded from the review. Occupational therapists involved in multi-disciplinary teams may be quite interested in exploring those articles.

Are we asking too much from this systematic review? We want it to be more useful to the practicing clinician. Is this a flaw of the review or a limitation in the nature of the research that was examined? Our initial reaction of disappointment with this study's findings may not necessarily be the fault of the study. What it doesn't tell us is in fact what it is telling us – namely, that our profession is in the midst of growing its body of knowledge, its evidence, and that occupational therapy intervention outcomes are not easily measured. It spurs us to reflect upon whether we might be neglecting to capture the true essence of occupational therapy outcomes related to occupation, occupational performance, and occupational engagement by focusing on the broader outcomes of functional ability, social participation, and quality of life. The review also speaks to the challenges of implementing methodologies such as the RCT within community settings. For example, the review cites three community-based caregiver interventions that are all rated as low quality. This leads to questions about whether the quality ratings used are appropriate in evaluating clinical trials of occupational therapy interventions conducted in community settings.

An online discussion of this CAP will be held from January 23 to February 3, 2006.

Visit the CAOT web site and click on Critically Appraised Papers on the home page. We look forward to your participation.

Key message

Despite its limitations, it is still worthwhile to disseminate the review's findings to consumers, professionals, key funders and decision makers. If positioned correctly, policies can be reviewed, in relation to this evidence, especially those policies related to occupational therapy interventions for community dwelling older adults. The conclusion that "occupational therapy interventions for community dwelling elderly people results in positive outcomes" (p. 453) is an important message to convey to our clients and funders. Also, the results of this review, although quite broad in nature, can serve as a springboard for further clinical reflection and to highlight future research needs, such as studies aimed at examining other occupational therapy interventions provided to community dwelling older adults using outcomes that speak to improving occupational performance.

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The occupational therapy workforce in Canada

Claudia von Zweck, CAOT Executive Director

In May 2005, CAOT initiated the Workforce Integration Project for International Graduates in Occupational Therapy with funding from the Government of Canada's Foreign Credential Recognition Program. An initial step of this project was to conduct a review of available information regarding the occupational therapy workforce in Canada. This review was necessary to understand the context for occupational therapy practice in Canada. Highlights of the findings of this review are outlined below.

Education

Approximately 725 students graduate from Canadian occupational therapy university education programs annually. Occupational therapists educated in Canada currently receive a bachelor's or master's degree as an entry level credential. Beginning in 2008, only master's-level programs will be eligible for CAOT accreditation. The majority of Canadian university programs have now implemented curriculum changes to confer a Master's entry-level credential (ACOTUP, 2004).

The number of occupational therapists in Canada with advanced degrees is increasing. In 2004, over 13% of occupational therapists who were members of CAOT had advanced degrees, including 104 occupational therapists with a doctoral degree (CAOT, 2005).

Almost one in ten occupational therapists in Canada who are members of CAOT received their entry level education outside of Canada. Most of these internationally educated occupational therapists are living in the provinces of Ontario and British Columbia (CAOT, 2005).

Roles

In 2004, almost 90% of occupational therapists who were CAOT members were working in roles with occupational therapy clients. Many occupational therapists however also balance multiple roles in their practice. Fifty per cent of CAOT members acted as consultants, 20% had management roles and 7% were involved in research. Five per cent of CAOT members were academic faculty (CAOT, 2005).

Supply

Over the past decade, the supply of occupational therapists in Canada increased faster than population growth, with an average of 31.1 occupational therapists per 100,000 population, an increase from 26.0 in 1998 (Canadian Institute for Health Information [CIHI], 2004). Despite this increase,

(Left to right) CAOT Executive Director Claudia von Zweck, Kurt Davis, of the Canadian Society for Medical Laboratory Science, HRSDC Minister Belinda Stronach and Richard Lauzon, of the Canadian Association of Medical Radiation Technologists, in Halifax as the federal government announces over $1.6 million in funding for programs, including the CAOT's Workforce Integration Project, to help integrate immigrants and foreign-trained Canadians into the workforce.

Recent changes will allow only occupational therapists with Master's entry level degrees to write the U.S. certification exam (National Board of Certification in Occupational Therapy, 2005).

the supply of occupational therapists in Canada continues to significantly lag behind many European countries such as the United Kingdom, Belgium, Sweden, and Denmark that report between 43 and 105 occupational therapists per 100,000 (Council of Occupational Therapists for European Countries, 2005).

The average age of occupational therapists in Canada is reported to be 36 years and over 90% are female (Human Resources and Skills Development Canada [HRSDC], 2005a). Within this young workforce, maternity leaves of absence are common. In addition, the rate of part-time work among occupational therapists varies in different provinces from 20 to 46% (HRSDC, 2005a; New Brunswick Department of Health and Wellness, 2002; Schroeder et al, 2005). These factors influence the productivity of the workforce. A New Brunswick report confirms that despite public-sector occupational therapy workforce increases, the average number of hours worked fell (New Brunswick Department of Health and Wellness, 2002).

Upcoming retirements are expected to reduce the available workforce for educational faculty (Ontario Hospital Association, 2003), and many occupational therapists appear to leave the profession after 20 to 30 years. Without a defined career ladder within the profession, many occupational therapists who are working in roles that do not involve contact with clients, such as managers, researchers and educators, fail to retain their titles as occupational therapists (Province of Nova Scotia, 2001).

Health system changes may interfere with job satisfaction and retention of occupational therapists. In 2002, CAOT members reported their greatest practice problems were related to their work environment, including facing unrealistic workloads with a lack of staff, resources and professional recognition (von Zweck, 2003). Occupational therapists also face decreased job security, particularly when entering the profession (HRSDC, 2005).

During the 1990s, many new graduates moved to the U.S because of higher compensation and recruitment incentives, but migration later fell. However, it may again increase, as American occupational therapy demand is expected to rise due to population aging. Recent changes will allow only occupational therapists with Master's entry level degrees to write the U.S. certification exam (National Board of Certification in Occupational Therapy, 2005). Very few master's level entry education programs exist outside of the United States and Canada.

Distribution

The distribution of occupational therapists varies greatly among provinces, ranging from 36.8 occupational therapists per 100,000 population in Quebec to 20 per 100,000 in Saskatchewan (CIHI, 2004). In addition, most occupational therapists reside in more heavily populated areas resulting in a lower per capita distribution of occupational therapy services in rural areas (HRSDC, 2005).

Occupational therapists consider employment stability, jobs for partners, and family proximity when selecting where to live (Mitchell, 2003; British Columbia Health Human Resources Advisory Committee, 2002). Occupational therapists are attracted to positions offering variety, good working relationships, mentoring for newer graduates, education and realistic workloads (Jenkins, 1991).

Population health need, measured in terms of the rate of disability within each province, does not appear to explain variations in the distribution of occupational therapists in Canada. Disability rates for adults and children reported in the 2001 Participation and Activity Limitation Survey were lowest in Quebec, with highest rates in the provinces of Nova Scotia and Saskatchewan (Statistics Canada, 2002).

Human resource planning documents suggest using support workers to improve access to occupational therapy (Atkinson & Hull, 2001; New Brunswick Department of Health and Wellness, 2002; Newfoundland and Labrador Health Boards Association & Department of Health and Community Services, 2003). CAOT members in provinces with fewer occupational therapists reported higher support personnel use (CAOT, 2005).

The distribution of occupational therapists and populations served in Canada appear most influenced by funding availability. For example, few occupational therapists work in community set-

Last September several Canadian occupational therapists attended the European Network of Occupational Therapy in Higher Education Conference (ENOTHE) in Vienna, Austria. From left to right: Anne Carswell, ENOTHE Executive Director Hanneke van Bruggen, Claudia von Zweck and Elizabeth Townsend. CAOT Executive Director Claudia von Zweck attended to gain information regarding ENOTHE's tuning project which will develop standard learning outcomes for occupational therapy education in Europe. These standards may make it easier for occupational therapists emigrating from Europe to meet Canadian practice requirements.

tings in provinces such as Nova Scotia and Newfoundland that do not provide publicly funded home care services (CAOT, 2005). As a result of public funding limitations, occupational therapy services are reimbursed, more and more, by private sources of payment. Over 50% of CAOT members reported in 2004 that they receive private funding for their services. Although occupational therapy is usually not funded by extended health insurance plans, a number of payers provide reimbursement for occupational therapy services such as auto and disability insurers, worker's compensation and corporate businesses (CAOT, 2005). The broader payer base for occupational therapy reflects the move of the profession into new areas of practice such as disability management, universal design and assistive technology. Self-employment among CAOT members rose from 3% in the early 1990s to 27% in 2004 (CAOT, 2005). Almost one third of members in British Columbia and Ontario were reported to be self-employed. This shift occurred at a time when significant health system reforms were introduced that integrated provider organizations, created program management organizational models and increased privatization of health services, particularly in the rehabilitation sector. Many formerly hospital-based occupational therapy services were shifted to the community. As a result, the majority of members of CAOT now work in the community rather than traditional institutional health care settings (CAOT, 2005).

Demand

A review of labour market information and workforce studies indicates a strong demand for occupational therapists across Canada, with shortages across Canada, particularly in rural areas. Some urban areas such as Halifax and the Lower Mainland of British Columbia report full-time jobs are less available to occupational therapists entering the workforce. The aging population, advances in technology, greater emphasis on quality of life issues and better recognition of the value of rehabilitation are expected to drive demand for occupational therapy services in the future. Although limited growth is anticipated in the public sector, opportunities in private practice are expected to rise (HRSDC, 2005).

Summary

Existing shortages and the continued expected growth in demand for occupational therapists reinforce the importance of the work of CAOT on human resource planning for occupational therapy, including promoting the workforce integration of international graduates in occupational therapy. Internationally educated occupational therapists who come to work in Canada play an important and growing role in meeting service demands for occupational therapy in Canada. The next phase of the Workforce Integration Project involves interviews with international graduates as well as other stakeholder groups to examine factors that serve as barriers or facilitators for working in Canada as an occupational therapist. The final report on the findings will be available in fall of 2006. For more information, please contact Pamela Burnett Hicks, Workforce Integration Project coordinator at pburnett@caot.ca or (800) 434-2268, ext. 244.

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on Your behalf

CAOT meets with Active Living Alliance for Canadians with a Disability

In August 2005, the author met with National Partnerships Manager Chris Bourne of the Active Living Alliance for Canadians with a Disability (ALACD) to review our shared vision of promoting active living for all Canadians with a disability, and to explore partnership opportunities. CAOT supports the mission and vision of ALACD. Their core vision is "a society where all Canadians lead active and healthy lives". Both ALACD and CAOT recognize the importance of promoting the positive influence of activity on health and well-being to individuals of all abilities, in every community. CAOT proposes to work with ALACD to this end by sharing resources, participating in projects of mutual interest, and disseminating information to CAOT members.

Like CAOT, ALACD has representatives in all provinces and territories. We agreed that the initial focus of our partnership should be to promote education about occupational therapy and ALACD philosophies and initiatives, and facilitate linkage between regional occupational therapy and Active Living Alliance representatives. This process will educate the occupational therapy community about ALACD resources that are available to assist clients in making physical activity a regular part of their lives.

For example, ALACD has a Speakers Bureau. Speakers are available to promote active living and share personal stories which can inspire diverse audiences. The ALACD Youth Exchange and Ambassador Program provides opportunities for Canadian youths, aged 14 to 17, to travel to Ottawa. These youths are presented with a wide range of opportunities for active living and also learn about cultural diversity. In addition, they are encouraged to develop leadership qualities and share their experiences while promoting active living opportunities in their home communities.

ALACD offers a wide range of printed and on-line resource materials designed to educate and encourage Canadians with disabilities to become more active, to facilitate inclusion and participation at all ability levels, and to promote awareness among service providers and communities of their obligations to offer opportunities for everyone. These resources may be used by individuals, groups, service organizations, businesses, teachers, health and fitness professionals, communities and agencies at municipal, provincial and federal levels.
Some of the resources and tools available through ALACD include:

- The ALA Newsletter, *Activate Yourself.*
- *Moving to Inclusion: Active Living Through Physical Education – Maximizing Opportunities for Students with a Disability.* This resource binder contains educational booklets that outline strategies to facilitate inclusion of students with different disabilities, including amputation, physical awkwardness, cerebral palsy, multiple disabilities, those who use a wheelchair, intellectual disabilities, visual impairment, hearing problems or deafness. One pamphlet reviews skiing for students with a disability.
- *Moving to Inclusion: Equipment Manual* includes strategies to adapt physical activity, provides information regarding inclusive equipment options, and provides examples of inclusive games and sports.
- The ALACD website, www.ala.ca, offers a Disability and Wellness Information Centre. This is a free on-line service that offers extensive information on healthy, active living opportunities for people with disabilities. A search engine allows users to locate programs and events available across Canada.

I would like to encourage all occupational therapists to learn more about the ALACD, and about how to link our clients and communities to ALACD resources to promote inclusive active living. Please feel free to e-mail me for more information at: laurieot@camccool.ca. *–Laurie Warren*

Highlights from the CAOT November 2005 Board of Directors meeting

Tanya Baglole, CAOT Communications Coordinator

A CAOT Board of Directors meeting was held in Calgary from November 25-26. Before the meeting, the board hosted a member reception where President Diane Méthot presented the new CAOT strategic plan. An annual board evaluation meeting was also held to review governance structure and practices.

Highlights of the board meeting results include:

World Federation of Occupational Therapists (WFOT)

- The required qualifications and duties of the CAOT delegate and alternate delegate to the WFOT will be revised to ensure the needs of both WFOT and CAOT are met.
- The board asked the WFOT delegate to request that the WFOT definition of occupational therapy be reviewed to ensure the description is inclusive of all populations served by occupational therapists.
- The board supported in principle increased financial support for the operations of the WFOT. Board members recommended the development of a business plan and accountability measures to retain equity and fairness among all member countries.

Other business

- The Canadian Institute for Health Information provided a presentation on their Primary Health Care Indicator Development Project. Following the presentation, board members provided feedback for consideration in the further development of the indicators.
- Upon recommendation of the Policy Audit Committee, the following revised policies were approved:
  - Ends Policies.
  - General Finance.
  - Co-sponsorship and Endorsement.
  - Cancellation/Non-sufficient Funds.
  - Complimentary Registrations.
  - Occupational Therapy Month.
  - CAOT Delegation to the WFOT.
  - Ethical Statement for CAOT publications.
- A report on the 2005 Professional Issue Forum on the Canadian Framework for Ethical Occupational Therapy Practice was received. The ethical framework document will be revised for publication on the CAOT web site in 2006.
- Revised position statements on the topics of home and continuing care and primary health care were approved and will posted on the CAOT web site.
- The Board endorsed the *Principles and Framework for Interdisciplinary Collaboration in Primary Health Care* and the *Canadian Collaborative Mental Health Charter*, two documents developed in consultation with CAOT in national primary health projects. In addition, the following other documents were endorsed:
  - 2005 National Children's Alliance Brief to the Finance Committee.
  - HEAL position statement on Potential in Pan-Canadian Health Human Resource Policy and Planning.
  - Joint Statement on Physical Punishment of Children and Youth.
  - Framework for a National Strategy on Palliative and End-of-Life Care.

Budget and finances

For the 2004-2005 fiscal year, the board received a favourable unaudited year-end financial report. CAOT received surplus revenues due to higher than expected attendance at Conference 2005 in Vancouver, sales from publications and savings in National Office expenses. With these surplus revenues, the board approved the following projects:

- Professional Issues Forums at Conference 2006 on the topics of Research Without Borders and Dysphagia.
- Development of a proposal for a qualifications recognition process for support personnel.
- Canadian Journal of Occupational Therapy strategic planning meeting.
- Validation and development of indicators for the *Profile of Occupational Therapy Practice in Canada*.
- Evidence-based practice workshops.
- Certification examination plain language translation project.

On your behalf

CAOT projects

Canadian Collaborative Mental Health Care Project (CCMHC)

The Canadian Collaborative Mental Health Care Project has been funded through the national envelope of the Primary Health Care transition fund from January 1, 2004 to March 31, 2006. Work continues in the following four primary areas:

- An analysis of the current state of and knowledge regarding collaborative mental health care.
- The development of a charter committing partner organizations to working collaboratively.
- The development of specific strategies for the implementation of collaborative care.
- Dissemination of the findings of the project, including working with provincial, federal and territorial governments to facilitate their implementation.

CAOT board directors have conducted member forums in 16 cities throughout Canada and have received feedback on the Canadian Collaborative Mental Health Charter. Darene Toal-Sullivan is the CAOT representative on the Canadian Collaborative Mental Health Care Project. Dr. Terry Krupa is the CAOT volunteer representative.

Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) initiative

The EICP initiative is funded by Health Canada's Primary Health Care Transition Fund. The objective of EICP is to encourage health professionals to work together in the most effective and efficient way to produce the best health outcomes for patients and for providers. The EICP Initiative has engaged primary health care providers, governments and Canadians in a national effort to create a framework for change and innovation in primary health care. EICP has followed an ambitious research agenda designed to gain new insights into successful primary care models in both urban and rural settings. The project is also planning to develop practical tools to encourage inter-disciplinary collaboration and a supportive policy and regulatory environment. The initiative has developed a set of guiding principles and a framework for collaboration that will inspire health care providers and governments to ensure that Canadians have access to the right professional and the right services, at the right time.

As with the mental health project, CAOT board directors received feedback at members' forums on the principles and framework.

The principles will be addressed in the CAOT standard documents such as the *Profile of Occupational Therapy Practice in Canada* and new versions of the academic accreditation standards.

Health Canada Population Health Fund: Falls Prevention Initiative, Tools for Living Well Project

This project which was completed in March 2004 continues to generate interest from occupational therapists and consumers. The Tools for Living Well (TFLW) toolkit was posted on the www.otworks.ca web site in September 2004 in addition to other fall prevention resources developed by the project. Between April and August 2005, the toolkit was downloaded 2,891 times, in addition to downloads of other project resources. Mary Lou Boudreau, former manager of the TFLW project, provided a presentation on the sustainability of this initiative at an injury prevention conference in Halifax in November 2005.

National Human Resources Database Project

This project is coordinated by the Canadian Institute of Health Information (CIHI) and is directed toward the development of supply-based databases of information for five health professions. The project was initiated first for the occupational therapy profession. The project began in February 2005 with the establishment of a working group with representation from CAOT, all occupational therapy regulatory organizations and CIHI. Claudia von Zweck represents CAOT on this project. A trial of the collection of the data elements that will be included in the new database will be undertaken in 2006 with full implementation in 2006-2007. The first annual publication of data from the occupational therapy database is planned for November 2007.

Occupational Therapy Best Practice Project

This project, which is being led by Dr. Susan Rappolt, University of Toronto, will develop clinical practice guidelines for facilitating individuals' return to productive occupations following traumatic soft tissue injuries of the neck and back. CAOT's involvement will consist of endorsing the process and framework for the development of clinical practice guidelines (CPGs), promoting member involvement in the development of CPGs, identifying key stakeholders to participate in the project, and disseminating research knowledge and other project outcomes to our members including publishing of CPGs in the Canadian Journal of Occupational Therapy and on the CAOT web site. Dr. Susan Rappolt and a graduate student are in the process of developing a survey of CAOT members' knowledge, attitudes, beliefs and skills in implementing clinical practice guidelines. The results of the professional issue forum on clinical practice guidelines will inform the development of the survey tool. The survey is the second major activity related to CAOT involvement in clinical practice guidelines development.

On your behalf

CAOT • ACE

Population Health Fund: Stable, Able and Strong project

In August 2005, CAOT and the University of Ottawa Occupational Therapy Program received $299,000 from the Population Health Fund, Public Health Agency of Canada for the Stable, Able and Strong project. This project will develop a post-fall support model and component strategies for seniors who have experienced a fall to enable them to maintain or resume engagement in meaningful activities in the context of home and community. A community development model using senior volunteers will be used to enable seniors to create post-fall support services. Principles of peer learning will be used to address the emotional and social sequelae of falls through the development of self-help support groups and resource collections. Seniors will lead post-fall support groups to provide inspiration and motivation for seniors who have experienced a fall. Resource collections will be developed and shaped by community needs to provide information to seniors, caregivers and health professionals regarding post-fall supports, including community services, activities and assistive devices. The existing resources from the Tools for Living Well project and the Go for It manual will be incorporated into the collections. Pilot testing of the Post-Fall Support Model will occur in three sites across Canada and will address both anglophone and francophone populations.

Initial work on this project has involved development of position descriptions, committee terms of reference and the project critical path. Mary Lou Boudreau has been hired as project manager, and Sandra Wittenberg will provide administrative support. A Project Advisory Committee has been developed and will meet for the first time in January 2005. A literature review of the current state of knowledge and practice in post-fall support is in progress. A logo for the project is currently under development.

Population Health Fund: Canadian Falls Prevention Curriculum

CAOT provided a letter of support for the application of this project in 2004. This project has received funding from the Population Health Fund. CAOT will be involved with the project by assisting in participant recruitment for the pilot testing of the curriculum, reviewing curriculum content and format for appropriate target audiences, and helping to disseminate the final curriculum. Darene Toal-Sullivan will be the CAOT contact for this project.

Workforce Integration Project

The Workforce Integration Project is an initiative funded by the Foreign Credential Recognition Program of the Government of Canada. The overall purpose of the project is to examine barriers and facilitators for internationally trained occupational therapists entering the Canadian workforce. The collected information will be used to formulate recommendations in consultation with stakeholder organizations for further action to reduce barriers to workforce integration for internationally educated occupational therapists.

The initial meeting of the Project Advisory Committee was held in June 2005 to promote understanding of the goals, objectives and rationale for the Workforce Integration Project, obtain input regarding the issues and factors to be investigated in the Project, and gain assistance for gathering information for the project. Members of the Project Advisory Committee include representatives of ACOTUP, ACOTRO, PAC and the National Union. Two internationally educated occupational therapists practicing in Canada are on the Committee. CAOT representatives on the Committee include Claudia von Zweck and Pamela Burnett Hicks (Project Coordinator).

A literature review was undertaken to examine issues related to the workforce integration of international graduates in occupational therapy. To collect information for the project, a written survey was sent to all internationally educated occupational therapists working in Canada, and telephone interviews are currently underway with representatives of occupational therapy regulatory organizations, university education programs and provincial associations. Claudia von Zweck also attended the European Network of Occupational Therapy Educators Conference to obtain information regarding the work of European countries on developing competency standards for education in occupational therapy. Face-to-face interviews with international graduates are planned for 2006.

National coalitions

Active Living Coalition for Older Adults

The Active Living Coalition for Older Adults (ALCOA) is a partnership of 24 national/provincial/territorial organizations having interest in the field of aging and active living in Canada. CAOT is a roundtable member of ALCOA, whose mission is to encourage older Canadians to maintain and enhance their well-being and independence through a lifestyle that embraces daily physical activities. ALCOA submitted the following two project proposals to their new funding source, the Public Health Agency of Canada - Healthy Communities Division.

The Pan-Canadian Healthy Living Strategy is a federal/provincial/territorial (F/P/T) initiative that

was launched in September 2002 to improve overall health outcomes and to reduce health disparities and the burden of chronic disease on the health system by addressing the common preventable risk factors - physical inactivity and unhealthy eating. The membership project is directed towards strengthening ALCOA's membership base to enable the coalition to meet its strategic objectives and achieve sustainability. As it stands, ALCOA's funding ceases on March 31, 2006.

ALCOA is working with the Osteoporosis Society of Canada and Fifty-Plus (formerly CARP) to develop a calendar to encourage residents of Canada to make physical, social, mental, emotional and spiritual activities a priority - despite osteoporosis or their age. The calendar was unveiled in November 2005 during Osteoporosis Month, and is available through ALCOA. Darene Toal-Sullivan represents CAOT on the executive of ALCOA.

Canadian Alliance on Mental Illness and Mental Health (CAMIMH)

CAMIMH is a network of national mental illness and mental health organizations representing a unique coalition of consumer, family, community and provider organizations that was founded in October 1998. A major project for CAMIMH has been the development of a new Call for Action, which is the National Action Plan for Mental Illness and Mental Health in Canada. This policy document is presently in a draft format. It is hoped that the cochairs of the Council of Health Ministers will sign-off on this document.

CAMIMH was also responsible for coordinating Mental Illness Awareness Week October 3-10, 2005. CAOT supported MIAW by including promotional posters with the September Occupational Therapy Now mailing. Diane Méthot is the CAOT representative on CAMIMH.

Canadian Patient Safety Institute (CPSI)

CAOT became a voting member of the CPSI in July 2005. CPSI is a newly formed organization at arm's length from governments, system stakeholders and regulatory bodies, and is committed to providing a leadership role with respect to patient safety issues. CPSI was formed in response to the report *Building a Safer System*, prepared from a national forum on patient safety that recommended the establishment of a Canadian Patient Safety Institute. To achieve its objectives, CPSI collaborates with governments and national organizations, and provides advice on effective strategies to promote leading practices and raise awareness among stakeholders, patients and the general public about patient safety.

Canadian Working Group on HIV and Rehabilitation (CWGHR)

The Canadian Working Group on HIV and Rehabilitation (CWGHR) is a national non-profit organization which promotes innovation and excellence in rehabilitation in the context of HIV, through research and education. The project, Interprofessional Learning in Rehabilitation in the Context of HIV: Stakeholder Capacity Building through Development of New Knowledge, Curriculum Resources, and Partnerships, was supported by CAOT, and work began in February 2005.

As a first step for this project, CWGHR is developing a compendium of material and resources on HIV and rehabilitation as well as interprofessional education. Any articles or materials in this area can be forwarded by e-mail to the project manager, Gillian Bone, at gbone@hivandrehab.ca. Dr. Debra Cameron from the University of Toronto represents CAOT on the Advisory Committee for this project.

HEAL

The Health Action Lobby (HEAL) is a coalition of national health and consumer associations and organizations dedicated to protecting and strengthening Canada's health care system. In October 2005, HEAL and the G4 (Canadian Medical Association, Canadian Nursing Association, Canadian Pharmacy Association and the Canadian Healthcare Association) held its first annual summit with health policy officials to discuss the status of health human resources development and to position strategically these groups to assist Health Canada in moving this agenda forward. HEAL has developed a position statement on health human resources capacity which is aligned with CAOT's position. HEAL promoted the messages in the position statement at the summit.

The Chronic Disease Prevention Alliance of Canada (CDPAC)

The Chronic Disease Prevention Alliance of Canada is a networked community of organizations and individuals who share a common vision for an integrated system of chronic disease prevention in Canada.

In the federal government budget in March 2005, $300M was announced for the Public Health Agency of Canada for Healthy Living and the Prevention of Chronic Disease. Consultations in each province and territory were held to develop public health goals for Canada. The results had not been posted at press time. CAOT is looking for a member to volunteer as the CAOT representative for CDPAC.

Mental Health Support Network of Canada (MHSNC)

The MHSNC, a network of 12 health organizations, was launched October 10, 2001 in response to the events of September 11, 2001, to provide trusted advice, education and support to the public and the professional community during times of disasters, terrorism and emergencies. After the tsunami disaster, a core group of MHSNC members met to revise the four brochures in the *Coping with Stress*

series developed post 9/11. The brochures now address reactions to stressful events in a more generic fashion without reference to a specific event. These brochures are also available on the PHAC Office of Emergency Preparedness, Planning and Training web site (http://www.phac-aspc.gc.ca/cepr-cmiu/oepptdmupf/index.html).

National Literacy and Health Program

The NLHP was established by the Canadian Public Health Association and is now funded by the National Literacy Secretariat, Human Resources and Skills Development Canada. NLHP is a partnership of 27 national health associations including CAOT. A meeting of the NLHP has not been held since the conference, Staying the Course, Literacy and Health in the First Decade, October 17-19, 2004. Darene Toal-Sullivan is the CAOT representative on NLHP.

Quality End-of-Life Care Coalition

The Quality End-of-Life Care Coalition believes that all Canadians have the right to quality end-of-life care that allows them to die with dignity, free of pain, surrounded by their loved ones, in a setting of their choice. The Quality End-of-Life Care Coalition of Canada (QELCCC) has developed and submitted to Minister Ujjal Dosanjh a request for $20 million for a long-term, sustainable, nationally funded strategy for palliative and end-of-life care in Canada. The framework document highlights why a national strategy is needed, what it would encompass and who needs to be engaged to ensure a national strategy is meeting the end-of-life care needs of Canadians. Overall the framework is very comprehensive and visionary in its direction. It has been reviewed by the CAOT representative to the QELCCC, Cynthia Stilwell from Nova Scotia. Cynthia has strongly advocated for occupational therapy to be identified as one of the professions to be included in development of interdisciplinary collaborative skills in end-of-life care.

Other activities

Mainstreaming Health Human Resources Innovations Conference (MHHRI)

In view of Health Canada's key interest and role in health human resource policy and planning, Dalhousie University's School of Public Administration (SPA), with support from Health Canada, brought together major stakeholders for a national conference to discuss and analyze strategies relating to innovative health human resources deployment practices in Canada. The conference's primary goals were the sharing of information on innovative deployment practices across the country, the examination of criteria for success, and the determination of best practices for potential application in other jurisdictions. Donna Klaiman attended this conference on behalf of CAOT.

Conference outcomes were intended to enable the dissemination of potential blueprints for innovative practices to be implemented in other jurisdictions and to be studied further by the academic community. The final report will be disseminated for further discussion when available.

Health Council of Canada

Created as a result of the 2003 First Ministers' Health Accord on Renewal, and following the recommendations of the Romanow and Kirby Reports, the Health Council of Canada is mandated to monitor and report on the progress of health care renewal in Canada. Chaired by Michael Decter, the 26 councillors were named by the participating provinces and territories and the Government of Canada. Their expertise and broad experience includes the areas of community care, aboriginal health, nursing, health education and administration, finance, medicine and pharmacology.

The Health Council of Canada strongly believes that the health care renewal goals established by the First Ministers cannot be achieved without a collaborative and coordinated approach to resolving the complex issues of health human resources. To this end, the Health Council convened a health human resources summit, Modernizing the Management of Health Human Resources in Canada: Identifying Areas for Accelerated Action, on June 23, 2005 in Toronto. The meeting brought together educators, professional organizations, researchers, regulators and front-line workers to address and initiate dialogue and examine solutions and success stories. In preparation for the Summit, the Health Council staff conducted an environmental scan of current views on health human resource issues in Canada http://hcc-ccs.com/news_summit05.asp Specifically, the scan:

- identifies the key policy positions of stakeholder organizations and governments related to four theme areas (education and training, scopes of practice, workplace issues and health human resource planning);
- highlights the solutions proposed by stakeholders and governments; and
- explores the range of gaps between identified problems and the proposed solutions.

CAOT was represented at this summit by Donna Klaiman. The final report of the summit will be disseminated for further discussion when available.

National Network of Libraries for Health (NNLH)

NNHL is a coalition of organizations interested in the development of a system that will ensure that all health care providers in Canada have equal access to the best information for client care. The system will be designed to fit the Canadian health care model and fill in information gaps inherent in a complex

health delivery system. NNLH is sponsored by the Canadian Health Libraries Association (CHLA). Claudia von Zweck attended a stakeholders' meeting of NNLH in June 2005. At this meeting a high level of support was received from the meeting participants, including representatives from health professional associations, the Public Health Agency and the Canadian Institute for Scientific and Technical Information (CISTI). CHLA has therefore issued a request for proposal for the development of a proposal for a national health library.

"Rock this Joint" Summit on Standards for Arthritis Prevention and Care

Catherine Backman represented CAOT at the Summit on Standards for Arthritis Prevention and Care held in Ottawa, November 1-2, 2005.

Wait time management

Nearly 150 participants attended the Taming of Queue II conference in Ottawa to discuss, debate, analyze and share experiences with issues relating to wait time management and reduction. The symposium gathered a broad mix of government representatives, health policy analysts, health professionals and stakeholder organizations in an effort to assess the progress being made, the challenges that still exist, the latest research developments and the future plans for wait time management.

Wait time management is not considered simply a doctor-patient issue. It is related to many problems in the health system, ranging from inadequate human resources planning to more effective primary health service delivery and the lack of interdisciplinary collaboration as it pertains to the client. The debate continues; however this is obviously a politically driven agenda and the federal/provincial/ territorial governments are looking for a very practical fix without having to agree to a major health reform strategy.

Health policy

The First Ministers Health Accord is a 10-year plan that included commitments to establish targets by December 15, 2005 for the training, recruitment and retention of health professionals. HEAL members attended a joint event, marking the one-year anniversary of the Accord, and called on political leaders to step up action to meet the deadlines set out in the 2004 health plan. At this time last year the First Ministers committed to benchmarks and targets to increase the number of health professionals working in the system. Health professional organizations are wondering what happened to the commitments to work together and the promised engagement between political leaders and health care professionals. In addition, an Ipsos Reid survey conducted prior to the event indicated that a majority of Canadians (54%) polled said they are less optimistic about the future of health care services in their community than they were one year ago. While there is a willingness on the part of professional organizations to work with government, very little action is taking place.

To develop support for greater access to occupational therapy services in Canada, CAOT launched the Pan-Canadian Awareness Campaign on Occupational Therapy and Interdisciplinary Collaboration in Primary Health Care on October 20, 2005.

Health Human Resources (HHR)

HHR is seen as an urgent requirement by several agencies who want a comprehensive, coordinated national human resources strategy. Without an effective national health human resources strategy, the investments and plans to improve access to and modernize Canada's health care system will not be realized. It is a very slow process with very little feedback on the government's activities.

CAOT continues to work on projects directed toward improving health human resources planning in occupational therapy. These projects include the Human Resource Database Project and the Workforce Integration Project in addition to the EICP and CCHMI primary health care projects. CAOT representatives also attended meetings and conferences relating to health human resources, including Modernizing the Management of Health Human Resources in Canada: Identifying Areas for Accelerated Action, sponsored by the Health Council of Canada and the Mainstreaming Health Human Resources Innovations Conference.

CAOT will also submit a proposal to Health Canada to develop a Case Management and Distribution Framework building on our first March 2005 project, Best Practices in Case Management and Distribution, in March 2005. This will be submitted for funding under the Health Canada Health Human Resources Strategy, and one of the primary initiatives to come out of the 2003 First Ministers' Accord on Health Care Renewal.

Social policy

Future CAOT plans for government relations activities will examine the area of social and economic policy. It is anticipated that there may be opportunities to align CAOT activities to promote access to occupational therapy with policies that support the development of worker productivity and capacity building for a sustainable knowledge-based economy. A report regarding government priority areas in social and economic policy and potential CAOT initiatives will be provided for discussion at the June 2006 CAOT board meeting.

CANADIAN OCCUPATIONAL THERAPY FOUNDATION

To fund scholarship and research

Upcoming competitions

February 28

Critical Literature Reviews	2 x $5,000
COTF Research Grants	2 x $5,000, 1 x $3,000
Isobel Robinson Historical Research Grant	$2,000
Joanne V. Cooke and Associates Qualitative Research Award	$1,500
Roulston Innovation Award (academic institutions to indicate interest to COTF)	

March 1

Ontario Society of Occupational Therapy (OSOT) Presentation Award	$1,000
OSOT Multi-Disciplinary Presentation Award	$1,000

March 31

Marita Dyrbye Mental Health Award	$500

April 1

Society of Alberta Occupational Therapists (SAOT)

SAOT Research Award	$500
SAOT Research Education Award	$500
SAOT Research Presentation Award	$500

For details and application forms, see the Grants section at www.cotfcanada.org.

Art Ability art auction

The second Art Ability auction took place on October 19, 2005 at the Steam Whistle Brewery in Toronto. COTF raised funds at this event through ticket sales, art work purchases and alcohol sales.

2005 COTF Annual Report

The 2005 COTF Annual Report will be posted on the COTF web site (www.cotfcanada.org) in March. Please visit the web site for regular updates.

2006 COTF Grants Program

The COTF Board of Governors approved a grants program for 2006, after consulting with the University Liaison Group. Thank you to the University Liaison Group for reviewing the program and offering feedback.

Type of Grant	Name	Amount
Research	COTF Research Grant (2 x $5,000)	$10,000
Research	COTF Research Grant	$3,000
Research	Isobel Robinson Historical Research Grant	$2,000
Research	Critical Literature Reviews (2 x $5,000)	$10,000
Research	Joanne V. Cook and Associates Qualitative Research Award	$1,500
Subtotal		**$26,500**
Scholarship	CIHR ($11,000 matched by COTF)	$22,000
Scholarship	Thelma Cardwell	$2,000
Scholarship	Goldwin Howland	$2,000
Scholarship	Invacare	$2,000
Scholarship	Master's (4 x $1,500)	$6,000
Scholarship	Doctoral (2 x $3,000)	$6,000
Subtotal		**$40,000**
Other	Janice Hines	$1,000
Other	Marita Dyrbye	$500
Subtotal		**$1,500**
TOTAL		**$68,000**

COTF Board of Directors. Back row (L to R): Michael Bilas, Deb Cameron, Bradley Roulston, Sangita Kamblé (Executive Director), Andrew Ksenych, Paul McFarlane. Front Row (L to R): Nick Sawrantschuk, Karen Yip (Treasurer), Diane Méthot (CAOT President), Sandra Bressler (President) Tamra Ellis (Vice President)

November 2005 COTF Board Meeting

The COTF Board of Directors met in Toronto on October 21. The Board welcomed three new governors: Michael Bilas, Andrew Ksenych and Nick Sawrantschuk. The board will be developing a fundraising plan for its next meeting. For more information, please contact Sangita Kamblé at skamble@cotfcanada.org or visit the COTF web site at www.cotfcanada.org.

New award

The J.V. Cook and Associates Qualitative Research Award is offered for the first time in 2006. Joanne V. Cook retired from the University of Western Ontario in June of 2005. A retirement party was held in her honour. She requested that a donation be made to COTF that could be used for an award in her name and her associates – her students. The research grant is in the amount of $1,500 for studies involving issues of occupation that exclusively use the strategies and analytic techniques of qualitative research. These criteria therefore exclude survey questionnaire studies, even if they have one or two open-ended questions. Also excluded would be structured, closed-end interview questionnaires that use counts of responses for analysis.

Erratum

In the last issue's column, the article: Isobel Robinson Historical Research Fund, an error was made in the date. Isobel graduated with her BA from McMaster University in 1966, not 1996.

Your support counts!

COTF sincerely thanks the following individuals, companies and organizations for their generous financial support during the period of September 1 to October 31, 2005. COTF will acknowledge donations received after November 1, 2005 in a future issue.

Marte Bachynski
Sue Baptiste
Marlene Beaty
Giovanna Boniface
Ann Booth
Jane Bowman
Deb Cameron
Donna Campbell
Canadian Association of Occupational Therapists
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CAOT Endorsed Courses

CO-HOSTED WITH CAOT

June 1-3
CAOT 2006 Conference. Evidence and occupation: Building the future. Montreal, Quebec. Tel: (800) 434-2268, ext. 228; e-mail: conference@caot.ca.

ENDORSED BY CAOT

September-April
1. Modern Management, 2. Continuous Quality Improvement for Health Services and 3. Risk Management and Safety in Health Services. (All distance learning). Contact: Cheryl Teeter, Canadian Healthcare Association, 17 York St., Ottawa, ON K1N 9J6. Tel: (613) 241-8005, ext. 228; www.cha.ca.

April 5-9, 2006
Certificat A-One (Arnadottir Occupational Therapy – ADL Neurobehavioural Evaluation). Centre Hospitalier de l'Université de Montréal (CHUM). Contact: Elaine Vachon, Tel: (514) 890-8000, ext. 14124; Fax: (514) 412-7221; e-mail: chum_aone@yahoo.ca

June 9-10, 2006
Evaluation and Treatment of Visual Perceptual Dysfunction in Adult Brain Injury: Part I. Wascana Rehabilitation Centre, Regina, SK. Provider: Regina Qu'Appelle Health Region. Instructor: Mary Warren MS, OTR. Contact: Peggy Bacon, Tel: (306) 766-5613; Fax: (306) 766-5595; e-mail: peggy.bacon@rqhealth.ca

ONGOING

Myofascial Release Seminars Myofascial Release I, Myofascial Release II, Fascial-Pelvis Myofascial Release, Cervical-Thoracic Myofascial Release, Myofascial Unwinding, Myofascial Mobilization, Paediatric Myofascial Release. Various Canadian and U.S. dates. Instructor: John F. Barnes, PT. Contact: Sandra C. Levengood, Myofascial Release Seminars, 222 West Lancaster Avenue, Paoli, PA 19301. Tel: (800) FASCIAL (327-2425); Fax: (610) 644-1662; e-mail: paoli@myofascialrelease.com; www.myofascialrelease.com.

WEB-BASED DISTANCE EDUCATION

Acquire an Expertise in Driving: Evaluation, Adaptation & Retraining. Bilingual Program. Dates: September-December; January-April; May-August;. Provider: School of Physical and Occupational Therapy at McGill University. Contact: Isabelle Gélinas, PhD, 3654, Promenade Sir-William-Osler, Montreal, QC H3G 1Y5. Tel: (514) 398-4514; Fax (514) 398-6205; e-mail: isabelle.gelinas@mcgill.ca.

DALHOUSIE SERIES

January-April 2006
Advanced Research Theory and Methods for Occupational Therapists (OCCU 5030). Instructor: Dr. Brenda Beagan

Community Development for Occupational Therapists (OCCU 5042). Instructor: Dr. Loretta de Rozario

Program Evaluation for Occupational Therapists (OCCU 5043)
Instructor: Debra Boudreau

Contact: Pauline Fitzgerald, School of Occupational Therapy, Dalhousie University, Forrest Bldg., Room 215, Halifax, NS B3H 3J5. Tel: (902) 494-6351; e-mail: p.fitzgerald@dal.ca.

NIDMAR COURSES 2006

Effective Disability Management Programs (Module A). Dates: on-line Jan. 9-15; March 27-April 2.

Legislation and Disability Management (Module I). Dates: on-line May 8-14.

Workers' Compensation and Return to Work (Workshop Module J). Dates: on-line TBA.

Insurance and other benefits (Module L). Dates: on-line Jan. 16-22; Sept. 1-16.

Disability Management in Unionized Organizations (Module N). Dates: on-line Feb. 13-19.

Disability Management from a Human Resources Perspective (Module P). Dates: on-line Feb. 27-March 5.

Marketing and Education in Disability Management and Return to Work (Module U). Dates: on-line Feb. 5-11; May 8-14.

Information Management (Module V). Dates: on-line Feb. 20-26.

Job Analysis (Module E). Dates: on-line March 6-12.

Provider: National Institute of Disability Management and Research (NIDMAR). Contact: Heather Persons, NIDMAR, 830 Shamrock Street, Suite 202, Victoria, BC V8X 2V1. Tel: (604) 736-2578; Fax: (604) 733-2519; e-mail: Heather.Persons@nidmar.ca.

Graduate Certificate Program in Rehabilitation Sciences (University of British Columbia and McMaster University). Five required courses offered Jan.-April & Sept.-Dec. each year include: Evaluating Sources of Evidence, Reasoning and Clinical Decision Making, Measurement in Practice, Developing Effective Rehabilitation Programs, and Facilitating Learning in Rehabilitation Contexts. Courses eligible for online masters programs at both universities. Information: www.rehab.ubc.ca or www.fhs.mcmaster.ca/rehab/

Graduate Program in Post-Secondary Studies (Health Professional Education). Memorial University of Newfoundland. Centre for Collaborative Health Professional Education and Faculty of Education. Tel: (709) 737-3402; Fax: (709) 737-4379; e-mail: edugrad@mun.ca.

For more information about CAOT endorsement, e-mail education@caot.ca or Tel. (800) 434-2268, ext. 231

Don't forget to look for the teaser in the next issue!

Occupational therapy then: Stories from our past

Lynn Cockburn, Judy Friedland, Jane Davis, Mary Clarke, Barry Trentham, Catherine Brackley, Sue Baptiste and Heather McDonald

The history of occupational therapy in Canada is filled with fascinating stories of courage, insight and determination. To bring our history to life, members of the Occupational Therapy History Interest Group at the University of Toronto and the CAOT Archives Committee will be writing and editing a regular column introducing these stories and other interesting information. The column will provide a short 'teaser', followed by a link taking readers to the CAOT web site containing more detailed information.

This column is a joint initiative of the Occupational Therapy History Interest Group at the University of Toronto and the CAOT Archives Committee. The membership of the University of Toronto group includes individuals involved in collecting, maintaining, and examining archival and historical occupational therapy materials. Some of our members originally belonged to the CAOT Archives Committee; the group has since evolved into one whose goals are to generate interest in and to offer occupational therapy researchers and practitioners a platform for exploring the history of occupational therapy. We are hoping other interest groups of this type will start across Canada. Developing our understanding of the history of the development of occupational therapy across Canada will assist in the ongoing exploration of our professional identity, provide insight into how the profession is evolving, and assist in leaving a richer historical record for generations to come.

Our group hopes that this column will spark a greater interest in the history of occupational therapy. We encourage occupational therapy practitioners and researchers from across Canada to participate by contributing pieces of interest, submitting articles, locating and archiving important historical texts and artifacts, and sharing untold stories. Since we believe there is an urgent need to document our early history, we would like to begin by focusing on the period from around 1900 to 1950. Please e-mail your entries to Sue Baptiste: baptiste@mcmaster.ca.

OT Then Teaser...

To discover the identity of this occupational therapist and more history, visit OT Then on the CAOT web site.

This occupational therapist was among the first in Canada to study occupational therapy. She practised in Canada from 1919 to 1922 and then her career as an occupational therapist took her to the United States from 1922 to 1943. During that time she wrote a book on weaving, which stands today as the basic book of weaving owned by most handweavers in North America. It has been revised and updated three times.

Was it the analytic approach to the task of the mechanics of weaving, learned in her practice of occupational therapy, that allowed her to create such a durable classic — one that, 60 years later, remains relevant? — *Catherine Brackley*

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Welcome to the Meeting Room for the Pan-Canadian Awareness Campaign on Occupational Therapy and Interdisciplinary Collaboration in Primary Health Care

Thanks for joining our team. Our purpose is to advance health reform that embraces interdisciplinary collaboration and recognizes how essential occupational therapy services are in primary health care across Canada.

We hope your lobbying efforts are going smoothly. Please use this meeting room to access any resources you may need. For example, you can download a sample letter for government officials or download fact sheets. (The sample letter is a Microsoft Word document. Simply fill in the relevant names, addresses and print it on CAOT letterhead. Please do not change the content of the letter as we want to ensure that a consistent message is sent across the country.)

We are holding training sessions on the following dates:

Dec. 6, 2005 1-2pm EST
Jan. 12, 2006 1-2pm EST
Feb. 14, 2006 1-2pm EST
March 9, 2006 1-2pm EST
April 6, 2006 12-1pm EST
May 11, 2006 12-1pm EST

If you are interested in attending, please contact Stephanie Smith or call (800) 434-2269, ext. 231.

Quick links

The Kit
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Our Purpose
President's Address
Terms of reference for volunteers
Volunteer registration form
Message board
References

Message Board

You will find the latest news and notices to help with your local lobbying efforts. Please feel free to post any material that you think will help fellow team members.

Reports

To help track our progress, kindly submit a brief report after each meeting you attend. Complete the attached form - that will be updated shortly - or use your own format. Please include:

- Your name, date of meeting, location
- Candidate(s) present
- Parties represented
- Information delivered
- Outcome of meeting
- Your thoughts - what went well, what could be improved, what further resources you need

Please remember that the CAOT is non-partisan and requests that you do not engage in public debates of a partisan nature while representing our association.

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Stable, Able and Strong

Stable, Able and Strong is a project sponsored jointly by the Canadian Association of Occupational Therapists (CAOT) and the University of Ottawa, Occupational Therapy Program. The project is funded by the Population Health Fund, Health Canada from September 2005-June 2008.

Stable, Able and Strong will develop a support model and component strategies for seniors who have experienced a fall to enable them to maintain or resume engagement in meaningful activities at home and in the community. Research has demonstrated that health and well-being are influenced by the ability to engage in life's occupations. Withdrawal or changes in occupation can lead to increased dependency, lack of confidence and depression (CAOT, 2003). Seniors who have experienced a fall are at risk for subsequent falls and a decrease in engagement in activities of daily life or occupations. **Stable, Able and Strong** will address fear of falling, and personal, environmental, and activity-related risk factors for subsequent falls, and strategies to safely resume daily occupations.

A community development model using senior volunteers will be used to enable seniors to create post-fall support services. Peer learning principles will address the emotional and social sequelae of falls through the development of self-help support groups and resource collections. Seniors will lead post-fall support groups to provide inspiration and motivation for seniors who have experienced a fall. Resource collections, which will build on information from the 2001-2003 CAOT Tools for Living Well Project will be developed to provide information for seniors, caregivers and health professionals regarding post-fall supports. A peer-leader manual will also be created to enable communities and seniors to develop post-fall support groups. Pilot testing of the support model will occur in three sites across Canada. The model, manual and resources will be disseminated to community partners, regional, provincial and federal organizations. For more information, please contact Mary Lou Boudreau, project manager.

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Critical Appraisal Skills Programme (CASP)

making sense of evidence

10 questions to help you make sense of reviews

How to use this appraisal tool

Three broad issues need to be considered when appraising the report of a systematic review:

- **Is the study valid?**
- **What are the results?**
- **Will the results help locally?**

The 10 questions on the following pages are designed to help you think about these issues systematically.

The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions.

You are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

The 10 questions are adapted from Oxman AD, Cook DJ, Guyatt GH, Users' guides to the medical literature. VI. How to use an overview. JAMA 1994; 272 (17): 1367-1371

Screening Questions

1. Did the review ask a clearly-focused question? ☐ Yes ☐ Can't tell ☐ No

Consider if the question is 'focused' in terms of:

- *the population studied*
- *the intervention given or exposure*
- *the outcomes considered*

2 Did the review include the right type of study? ☐ Yes ☐ Can't tell ☐ No

Consider if the included studies:

- *address the review's question*
- *have an appropriate study design*

Is it worth continuing?

Detailed Questions

3 Did the reviewers try to identify all relevant studies? ☐ Yes ☐ Can't tell ☐ No

Consider:

- *which bibliographic databases were used*
- *if there was follow-up from reference lists*
- *if there was personal contact with experts*
- *if the reviewers searched for unpublished studies*
- *if the reviewers searched for non-English-language studies*

4 Did the reviewers assess the quality of the included studies? ☐ Yes ☐ Can't tell ☐ No

Consider:

- *if a clear, pre-determined strategy was used to determine which studies were included. Look for:*
  - *a scoring system*
  - *more than one assessor*

5 If the results of the studies have been combined, was it reasonable to do so?

☐ Yes ☐ Can't tell ☐ No

Consider whether:

- *the results of each study are clearly displayed*
- *the results were similar from study to study (look for tests of heterogeneity)*
- *the reasons for any variations in results are discussed*

6 How are the results presented and what is the main result?

Consider:

- *how the results are expressed (e.g. odds ratio, relative risk, etc.)*
- *how large this size of result is and how meaningful it is*
- *how you would sum up the bottom-line result of the review in one sentence*

7 How precise are these results?

Consider:

- *if a confidence interval were reported. Would your decision about whether or not to use this intervention be the same at the upper confidence limit as at the lower confidence limit?*
- *if a p-value is reported where confidence intervals are unavailable*

8 Can the results be applied to the local population? ☐ Yes ☐ Can't tell ☐ No

Consider whether:

- *the population sample covered by the review could be different from your population in ways that would produce different results*
- *your local setting differs much from that of the review*
- *you can provide the same intervention in your setting*

9 Were all important outcomes considered? ☐ Yes ☐ Can't tell ☐ No

Consider outcomes from the point of view of the:

- *individual*
- *policy makers and professionals*
- *family/carers*
- *wider community*

10 Should policy or practice change as a result of the evidence contained in this review? ☐ Yes ☐ Can't tell ☐ No

Consider:

- *whether any benefit reported outweighs any harm and/or cost. If this information is not reported can it be filled in from elsewhere?*

Critical Appraisal Worksheet for Systematic Reviews of Therapy

Are the results of this systematic review valid?

Is it an overview of randomised trials of the treatment you're interested in?	.
Does it include a methods section which describes:	
...finding and including all the relevant trials?	.
...assessing their individual validity?	.
Were the results consistent from study to study?	.

Are the valid results of this systematic review important?

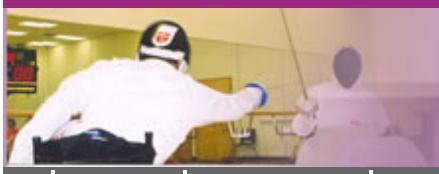
Translating Odds Ratios to NNTs

Can you apply this valid, important evidence about a treatment in caring for your patient?

Do these results apply to your patient?	
Is your patient so different from those in the trial that its results can't help you?	.
How great would the potential benefit of therapy actually be for your individual patient?	
Method I: **f**	Risk of the outcome in your patient, relative to patients in the trial, expressed as a decimal:_____ NNT/f = _____/____ = _____ (NNT for a patient like yours)
Method II: **1 / (PEER * RRR)**	Your patient's expected event rate if they received the control treatment, PEER:_____ 1 / (PEER*RRR) = 1/_____ _____ (NNT for a patient like yours)
Are your patient's values and preferences satisfied by the regimen and its consequences?	
Do your patient and you have a clear assessment of their values and preferences?	.
Are they met by this regimen and its consequences?	.

Additional Notes:

Therapy|Diagnosis|Prognosis|Harm/Aetiology|Systematic Reviews



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Interested in joining the active living movement? Does your organization believe in the importance of active living for Canadians with a disability? Become an ALACD partner today!

Click here to learn how to become an ALACD partner.

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Not sure where to start? Try selecting one of the following options. Don't forget to click Go!

I'm looking for... Go!

ACTIVITY FACT SHEETS

- **Want to get active?**
- **Don't know where to start?**

Use our Interactive Activity Search tool

or go to the Activity Fact Sheet page.

STORY OF THE WEEK

Dare To Get Out There!

It can be a challenge to keep active during the winter, especially when you're home-schooled! Our family found a perfect solution at the YMCA.

more ...

PARTNERS

For a full list of our Partners click here.

Today's featured partner is:

Active Living Coalition for Older Adults

view ...

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Welcome to the Canadian Occupational Therapy Foundation

What's New

2006 Grants Program

Deadline: February 28, 2006

COTF Research Grants *(2 x $5,000 and 1 x $3,000)*
Critical Literature Review Grants *(2 x $5,000)*
Isobel Robinson Historical Research Grant *($2,000)*
Joanne V. Cook and Associates Qualitative Research Award *($1,500)*
Roulston / COTF Innovation Award *(please contact COTF)*

Deadline: March 31, 2006

Marita Dyrbye Mental Health Award *($500)*

Deadline: September 30, 2006

Doctoral Scholarships *(2 x $3,000)*
Master's Scholarships *(4 x $1,500)*
Thelma Cardwell Scholarship *($2,000)*
Goldwin Howland Scholarship *($2,000)*
Invacare Scholarship *($2,000)*
Janice Hines Memorial Award *($1,000)*

Deadline: October 15, 2006

CIHR Doctoral Fellowship *($22,000)*

TD Bank Financial Group Scholarship in Rehabilitation-Related Research for Graduate Students with Disabilities

An initiative between Toronto Rehab and TD Financial Group has been announced. The scholarship will be for $20,000, and fields of study must relate to rehabilitation but are not limited to any particular discipline and, for example, may include rehabilitation sciences, health administration, and engineering. Please note that candidates do not have to be enrolled at the University of Toronto. International candidates may apply. Please visit: http://www.torontorehab.com/documents/TRITDScholarshipannouncement.pdf

2006 CAOT Conference

The 2006 CAOT Conference will be held in Montreal, Quebec from June 1-3, 2006. COTF will be hosting the following sessions:

1. Being Successful in Research - Grants Related Session

Upcoming Grant Deadlines:

February 28, 2006

1. COTF Research Grants
2. Critical Literature Review Grants
3. Isobel Robinson Historical Research Grant
4. Joanne V. Cook and Associates Qualitative Research Award
(Application form and guidelines forthcoming in January. For information, please contact swittenberg@cotfcanada.org)
5. Roulston / COTF Innovation Award
(Please contact skamble@cotfcanada.org)

2. Lunch with a Scholar with Helene Polatajko as the Scholar
3. Silent Auction in the Trade Show
4. Annual General Meeting

Please visit the web site for updates as they become available.

CIHR - Small Health Organizations Partnership Program

COTF will be partnering with CIHR for three years to offer a doctoral research award in the amount of $22,000 *(one award of $22,000 each year)*. The competition deadlines are October 15, 2005, October 15, 2006 and October 15, 2007. For more information, please contact Sangita Kamble at skamble@cotfcanada.org or visit http://www.cihr-irsc.gc.ca/e/28169.html.

2nd Annual Art Ability Show

The Art Ability Show was held on Wednesday, October 19 from 6-9 p.m. at the Steam Whistle Brewery Gallery in Toronto. Thank you to those of you who attended to support COTF!

2005 Research Scholarship Competition

Congratulations to the winners!

Community OT Grant - Lynn Shaw *($5,000)*

Critical Literature Reviews - Debbie Laliberte Rudman, Lori Letts, Lili Liu (*$5,000 each)*

COTF Research Grant - Claire Dumont *($5,000),* Annette Rivard *($2,000)*

COTF Searching for Mystery Donors

Missing a receipt for your donation to the Foundation? Click here to investigate.

CHA Releases Vision for Health System

Click here to download the **joint vision statement (**English and French).

CHA, together with its colleagues from the Canadian Medical Association, Canadian Nurses Association, Canadian Pharmacists Association and Health Action Lobby, have released a joint vision statement on the future of the health care system entitled: **Meeting the health care needs of Canadians**. This statement is designed for Canadian voters as they prepare to cast their ballot on January 23, 2006.

How do we improve patient safety and quality care? Find out what we can do now at the organizational, provincial/territorial, and national levels to move us toward improved patient safety.Version française

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National Roundtable on Health System Effectiveness

Hosted by CHA

Summary Report expected in early 2006

National Healthcare Leadership Conference
June 12th and 13th, 2006
Victoria, BC

Join your colleagues at the largest national gathering of health system leaders to hear the key issues debated by leading experts. Click here to be redirected to the conference website.

Program details will be available in December.

The National Advisory Council on Aging (NACA) fully endorses the findings and policy recommendations contained in CHA's Policy Brief, *Stitching the Patchwork Quilt Together: Facility-Based Long-Term Care within Continuing Care – Realities and Recommendations*. Click here for NACA's official **Statement of Support** (English and French) and **news release** (English and French).

In the above-noted Brief, CHA describes some of the problems facing long-term care facilities in Canada, and proposes a policy framework aimed at addressing these problems so that long-term care systems across Canada can be flexible enough to meet regional realities, while delivering comparable services. Click here for information on how to order this publication.

Stitching the Patchwork Quilt Together: Facility-Based Long-Term Care within Continuing Care—Realities and Recommendations, PB #5

Anthology of Readings in Long-Term Care, 4th Edition
edited by Marion Stephenson and Eleanor Sawyer

This latest anthology includes the most recently published Canadian articles on long-term care in one handy reference. Compiled from journals and magazines published after 2002, we've tied these readings to our popular textbook Continuing the Care: The Issues and Challenges for Long-Term Care, Revised Edition.

Also available!

The Road to Eden North: How Five Canadian Long-Term Care Facilities Became Eden Alternatives

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enhancing environments for wellness & occupation

"Designing for Inclusion"

November 25th 2005

Click for more information...

NEW!

New Funding Program! A CIHR Graduate Training Program for Rehabiliation Scientists interested in Quality of Life Research. **QLP**

Paralympic Double Medal Winner!
Elisabeth Walker, Paralympic double medal winner, and Occupational Therapy student returned to McMaster for an evening of celebration on November 12, 2004. Accompanied by her mother, Johanna and father, David, Elisabeth was greeted with rounds of applause and cheer, during a special reception held in her honour, by Peter George, President and Vice-Chancellor, and Mary Law, Associate Dean (SRS). For more on the celebration, click here!

Rehabiliation Science Faculty Member wins Nathalie Barr Lectureship by the American Society of Hand Therapists
Read More!

McMaster Named Canadian Research University of the Year!
See Story Here

Rehabilitation Science Faculty Win Awards

Course-based Online Masters Program

School of Rehabilitation Science Establishes Endowment Fund to Support Students in Need of Financial Aid

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Mary E. Black

One of the first occupational therapists in Canada

"I was born with crafts, among people accustomed to doing things with their hands."

Mary E. Black was one of the pioneer occupational therapists in Canada who studied, developed and practiced in the early 1920s. She spent most of her professional career in the United States. It was during her 21 years across the border that she wrote a definitive book on weaving. This book has become a durable classic; it has been revised and updated three times. Owned by most handweavers in North America, it is regarded as the bible of weaving. Perhaps it was the analytical approach - which Mary E. Black learned in her practice of OT - that guided her in the mechanics of weaving to produce a book that has remained relevant for over 60 years.

Born Sept. 18, 1895, in Nantucket Island, Massachusetts, she was educated in Wolfville, Nova Scotia, and early on showed an aptitude for craft work. She taught herself as a child to weave a "coarse and crude mat" from marsh grass. Mary graduated from Acadia Ladies Seminary in 1913. In 1919, she took an occupational therapy course in Montreal. Run by the federal government, the goal was to train ward aides for the Soldiers Civil Re-establishment (SCR) program.

Mary E. Black had a long and varied career, training in Nova Scotia and continuing to practice throughout the United States. She began as a ward aid in Dartmouth, NS, helping soldiers who were returning from the war to reintegrate into society. Her career also led her to instructing student nurses in OT at the University of Michigan. Then she returned to Nova Scotia in the 1940s, bringing an OT perspective to her work with handcrafts, for example, while directing a program for the provincial government.

Practice areas

1919-1920: SCR ward aid at Nova Scotia Hospital in Dartmouth
1921-1922: organized and conducted OT program for civilian patients
1922-1923: lectured on psychiatry and crafts at Boston State Hospital in Blue Hills, Mass.
1923-1932: organized and directed OT program, instructed student nurses in OT procedures at State Hospital in Traverse City, Mich.
1932- 1939: organized and directed OT and Industrial Therapy programs at Michigan State Hospital in Ypsilanti; instructed student nurses in OT from the University of Michigan, Ann Arbor
1939- 1943: re-organized OT and set up program that valued OT for patients in specialized environments at Milwaukee Sanitarium in Wanwatosa, Wisc.; worked on manuscript for *Key to Weaving*
1943- 1945: organized and directed handcrafts program for the Nova Scotia government in Halifax

1956-1960: co-owner of Shuttle Craft Guild in Bedford, NS, published the *Shuttle Craft Bulletin*

Mary E. Black conducted extensive research in early developmental OT. Research for her most influential book, Key to Weaving, originated from material she collected while working as an OT at Michigan State Hospital in Ypsalanti, when a fellow OT requested weaving information for a patient. Mary E. Black spread out patterns and information she had and decided to write a book about weaving. In 1941, while approaching Bruce Publishing Company, of Milwaukee, to accept a book on knitted doll's clothes written by her sister, the publisher said what he really wanted was a textbook on weaving. In 1943, she presented this manuscript, but due to the lack of paper because of World War II, it was not published until August 1945.

Books

Key to Weaving (1945): published by Bruce Publishing Co. Milwaukee, Wisc.
About 65,000 copies sold by 1979
Weaving for Beginners (1953): compiled by request for the federal department of Physical Education; published by the Canadian government.
Sett and Weaving of Tartans (1954): published by Lily Mills Co. Shelby, NC
You Can Weave (1974): published by McLelland and Stewart

Publications

1925-1955: wrote many articles on various phases of OT and handcrafts, published in OT bulletins, *Family Herald*, *Weekly Star* and *Handcraft* bulletins

1938-1943: assistant editor of the *American Journal of OT*

1942: wrote chapter on OT Treatment for the Acutely and Chronically Ill Neuropsychiatric War Casualty

1943-1960: edited and wrote much of the material for *Handcrafts*, the bi-monthly bulletin of the Handcrafts division, department of Trade and Industry

---

Mary E. Black's most profound influence on the community occurred during the 12 years she served as the director of the Handcrafts division of the department of Industry and Publicity, which later became Trade and Industry. From 1943 to 1955, she used a community development approach, helping people to help themselves. Drawing from her OT background, she encouraged people to learn to make "simple and useful things" with excellent workmanship and good colours. She provided resources, education and showed how to improve quality and marketability. During this time and subsequent years, she was consulted nationally and internationally and received many honours for her contributions.

Lasting evidence of Mary E. Black's influence on society is her *Key to Weaving*. If you mention her name to any North American weaver, most will have a copy of her book on their shelves. It remains the basic "bible" for technique and problem solving for weaving issues. Drawing on her OT background, she was able to analyze the tasks and present the information in clear, concise terms so that her book and name has stood the test of time.

Throughout her career, Mary E. Black was actively involved in OT associations, frequently holding official positions, such as the president of the Michigan OT Association from 1936-1938. She also actively participated in many handcrafts and arts associations in the United States and Canada. However, she will long be remembered for starting weaving guilds locally in Halifax, provincially, with the Atlantic Society of Handweavers, and finally collaborating nationally in 1948, to form the Guild of Canadian Weavers. In 1949, she was the honorary president of the national guild.

Mary E. Black died on Feb. 11, 1988.

Resources

Wendy Landry, professor at the Nova Scotia School of Art and Design
Public Archives of Nova Scotia
Joyce Chown, co-owner of the Shuttle Craft Guild in Bedford, NS

Bibliography

Autobiographical Resume: Mary Ellouise Black: 1980
Biography of Mary E. Black: Wendy Landry
New Key to Weaving: Mary Black (O.T.R)