

Published by the College of Occupational Therapists Ltd
106-114 Borough High Street, Southwark, London SE1 1LB

Published

April 2003

©College of Occupational Therapists Ltd.
ISBN 0-9539375-6-9

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Author Acknowledgments:

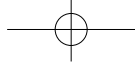
Sarah Cook, Charlotte Munday and Irene Ilott

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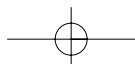
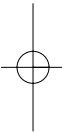
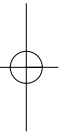
£10.00

This document should be referenced as

Creek J 2003, Occupational therapy defined
as a complex intervention, London, College of Occupational Therapists



This work was commissioned to Jennifer Creek by the College of Occupational Therapists in partnership with the South London and Maudsley NHS Trust. The College wishes to acknowledge the supervision of Sarah Cook and support of Charlotte Munday and Irene Ilott in completion of the research study.



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Foreword

I am pleased to commend this report as the culmination of a collaborative project between the College of Occupational Therapists and the South London and Maudsley NHS Trust.

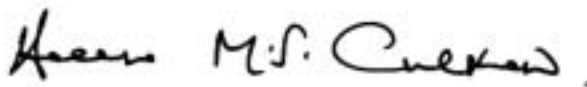
Defining the parameters of occupational therapy as a complex intervention was one of the objectives of the College Business Plan for 2001-2002. The intention was to establish a baseline for describing, defining and researching our interventions and services. The first two phases - theoretical and modelling - from the Medical Research Council's Framework for the Development and Evaluation of RCTs for Complex Interventions Improve Health (2000) were used to delineate the components of occupational therapy and their inter-relationships. To achieve this, the Research and Development Board, in partnership with the South London and Maudsley NHS Trust, commissioned Jennifer Creek to undertake a study of contemporary occupational therapy practice in the UK, with academic supervision from Dr Sarah Cook.

The work is based on a rigorous study of recent UK literature and wide consultation with occupational therapists working in both established and cutting edge areas. The aim was to represent the diversity of contemporary practice. For the first time, we now have an overall description of occupational therapy practice which gives a clear and unambiguous picture of the elements of intervention. We hope that it will be used as the basis for developing programmes of research to investigate the active ingredients of occupational therapy.

The description includes a one-page summary highlighting the scope and unique features of occupational therapy. The central part of the description represents the key elements and visible features of the occupational therapy intervention process that can be researched. This is supported by a section describing factors that the occupational therapist brings to the process, such as knowledge, skills and tools, and the thinking that underpins all actions by the therapist. Finally, there is an overview of external influences on practice, such as the social and policy contexts. Separately and together, these sections capture the subtlety and complexity of the profession today. In particular, they affirm the dynamic nature of the occupational therapy process, occupational therapy reasoning and the therapeutic relationship.

I hope this report will provide the starting point for debate and for further work to test its relevance across the range of specialties. If accepted as a true representation of contemporary occupational therapy, it can be used for many purposes in addition to research. For example, the description could inform the development of national occupational therapy indicators, it might be linked to continuing professional development as the content is derived from experienced practitioners and it could be used in service evaluation.

This report was endorsed by Council in January 2003. The findings are already being used, for example, in influencing the development of the new professional standards for occupational therapy practice and the College's review of the curriculum framework for pre-registration education. I am sure you will find them equally useful.



Helena M S Culshaw
Chairman of Council
2003

1. Introduction

In 2001, a partnership was formed between the occupational therapy department of the South London and Maudsley NHS Trust, represented by Charlotte Munday, and the College of Occupational Therapists, represented by Irene Ilott, in order to commission the writing of a definition of occupational therapy in the UK for the purposes of research.

One of the barriers to carrying out rigorous research into the effectiveness of occupational therapy, including randomised, controlled trials, is the difficulty of identifying what is and is not occupational therapy. Occupational therapists work in a wide variety of fields of practice and service settings, often using disparate intervention techniques. Many of the theories and techniques they use were developed by other disciplines and there can be considerable role overlap within the multi-disciplinary team. Unlike many other team members, occupational therapists do not have any statutory duties. All these factors mean that there is a lack of clarity about the boundaries of the occupational therapist's core role and specialist skills.

In 2000, the Medical Research Council produced a Framework for Development and Evaluation of RCTs for Complex Interventions to Improve Health (MRC 2000). Charlotte Munday felt that this would be a useful guide in beginning to develop a definition of occupational therapy for the purposes of research. She approached Sarah Cook and Jennifer Creek and asked them to undertake the work of producing a definition of mental health occupational therapy.

Concurrently, the Research and Development Board of the College of Occupational Therapists recognised the need for a position statement defining occupational therapy in the UK as a whole, as a basis for research programmes. This work was given priority in the 2001 – 2002 College business plan. Subsequent to the study having been initiated by the South London and Maudsley NHS Trust, the College approached Charlotte Munday to suggest a partnership and a letter of agreement was drawn up.

It was agreed that the study would have two phases. In the first, a definition of occupational therapy in the UK would be produced, which could serve the purposes of research and also be used to inform strategic planning, management, public relations and clinical job descriptions. The second phase of the study would involve testing the definition in the field of mental health practice. The agreed outcomes for the first phase of the study were:

- a simple yet sophisticated re-statement of the parameters of occupational therapy based upon a sound theoretical analysis
- this statement to include what is and what is not occupational therapy, to underpin the development of professional standard setting in the future
- a model of the complex content of occupational therapy practice and the connections between elements which can be used to predict and test the relative contributions of those elements
- a contemporary definition of occupational therapy
- a starting point for the development of consistent terminology to be used in record keeping.

2. Summary of the description

Occupational therapy focuses on the nature, balance, pattern and context of occupations and activities in the lives of individuals, family groups and communities. It is concerned with the meaning and purpose that people place on occupations and activities and with the impact of illness, disability or social or economic deprivation on their ability to carry them out.

The main aim of occupational therapy is to maintain, restore or create a match, beneficial to the individual, between the abilities of the person, the demands of her/his occupations in the areas of self care, productivity and leisure, and the demands of the environment.

Occupational therapy personnel work with people of all ages, with physical, mental and social impairments and learning disabilities. They work with people who have multiple and complex problems, people with minor coping difficulties and those who are functioning well and wish to maintain and promote their wellbeing.

Ideally, occupational therapy is a partnership between the client and the therapist in which both participate actively, thus increasing the client's responsibility, choice, autonomy and control over her/his care. Throughout the implementation process the therapist listens to and respects the client's and carer's values and aspirations, adapts interventions to meet the client's needs and enables the client and carer to make informed decisions. When the client is unable to exercise autonomy, due to illness or disability, the therapist may make decisions about action on her/his behalf but will continue to work towards increasing client understanding and choice.

The visible aspect of occupational therapy intervention is a series of actions by the therapist that together form a recognisable sequence called the occupational therapy process. At each stage, the therapist combines thinking about the situation, negotiation with the client and negotiation with relevant others in order to determine what action to take within a particular context. Action by the therapist is intended to lead to action by the client or, where this is not possible, action on behalf of the client.

After the initial stage of gathering information about a client, the therapist looks with the client at her/his range and balance of occupations. Having identified where the problems or deficits are, the therapist narrows her/his focus of attention and works on the specific activities, tasks or skills that will remediate the deficit and enable the client to enact her/his occupations more effectively. Where this is not possible, the therapist may adapt the desired activity so that the client is able to carry it out or make changes to the client's physical, cultural, institutional or social environments in order to facilitate occupational performance. The therapist then shifts the focus outwards again to see what effect the action has had on the client's overall pattern of occupations. This shift of perspective happens many times during the period of contact between occupational therapist and client.

The desired outcome of occupational therapy intervention is that the client achieves a satisfying performance and balance of occupations, in the areas of self care, productivity and leisure, that will support recovery, health, well being and social participation.

3. Method of study

Aims

This study seeks to identify:

- the components of occupational therapy intervention
- the defining features of occupational therapy
- the limits of occupational therapy.

Information gathered from the occupational therapy literature has been transformed into a coherently structured description of occupational therapy which is intended for use as the basis for an applied research programme. The desired outcome of the study was a description of what occupational therapy ought logically to be. This can be tested against the reality of occupational therapy practice.

The study did not seek to establish the value of occupational therapy. The assumption was made from the beginning that occupational therapy is of value.

Ontology

An idealist ontology underpins the study. Occupational therapy has no reality independent of the actions and thoughts of occupational therapists. It is constructed by particular people, in particular places, at particular times (Audi 1999, Williams & May 1996)

Occupational therapy has an evolving, historical, social, virtual reality which has been, and continues to be, shaped by social, political, cultural, economic, ethnic and gender circumstances and values (Guba & Lincoln 1994, Schwandt 1994).

Epistemology

An interpretive stance was taken to understanding occupational therapy. All accounts of occupational therapy are socially produced, therefore none can be seen as value-neutral or theory-neutral representations of an independent reality. All such accounts by occupational therapists are equally valid, even when they disagree with each other (Williams & May 1996)

What can be known about occupational therapy is inextricably linked with the relationship between the investigator and the investigated, and the study findings have been mediated by the values of the investigator (Guba & Lincoln 1994).

The social reality of occupational therapy has been understood through an inductive process which sought to construct the wider picture of occupational therapy in the UK from particular accounts (Chalmers 1982). This description has been formulated in such a way that it can be tested against actual practice.

Occupational therapists build on the past to produce a construct of occupational therapy today, in terms of: organisation, beliefs and values, key concepts, goals, domain of concern, knowledge base, roles, tools, core skills, process, outcomes and evaluation.

The current reality of occupational therapy, as constructed by occupational therapists within the context of social, political, economic, ethnic and gender circumstances and values, is described here but it is recognised that this reality will continue to evolve in relation to internal and external developments.

Within the construct of occupational therapy, there is a core of basic assumptions that occupational therapists agree must not be rejected or modified. These are the beliefs and values of the profession (COT 2002). They form a stable foundation from which a research programme for occupational therapy can be developed. Any inconsistency in research findings will lead to the generation of new hypotheses to explain them and not to a modification of this core of assumptions (Chalmers 1982).

Methodology

An ethnographic, dialogic approach was taken to analysing the data in order to construct a description of the shared, social reality of occupational therapy. Dialogue developed between the investigator and subjects through an iterative process of revisiting data sources (Hammersley & Atkinson 1995, Huberman & Miles 1994).

The investigator was part of the process of constructing the reality of occupational therapy, therefore a different investigator would have produced a different description of occupational therapy from the same research process (Altheide & Johnson 1994).

Occupational therapy can be described in terms of its internal elements and not in terms of any external schema. A process of induction, or generalisation by similarity, was used to produce such a description (Chalmers 1982). Different accounts were compared to elicit similarities, consistencies and coherence, as well as contradictions, inconsistencies or elements which have no pragmatic value.

The worth of the final description depends on the degree to which it is internally consistent and harmonious and the extent to which it has evidence utility when applied to research (Audi 1999).

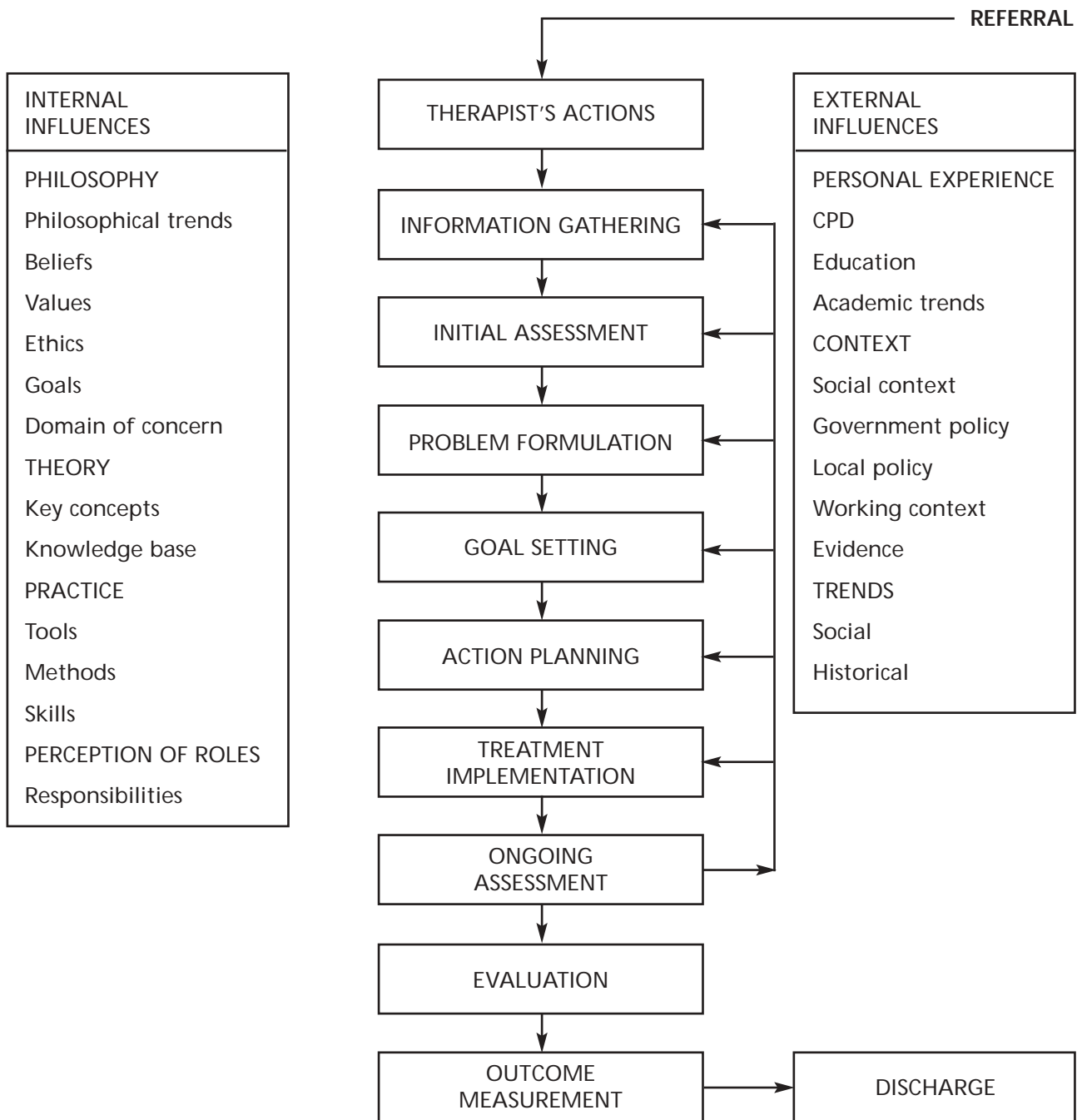
The investigator

In this study, the investigator took the role of a transformative intellectual, an insider who was aware of the possibility of producing a coherent description of occupational therapy from a multiplicity of accounts (Guba & Lincoln 1994).

Method of data collection and data analysis

- 1 Develop a tentative, anticipatory and provisional conceptual framework based on prior theorising about the nature and function of occupational therapy (Figure 1).

Figure 1: Provisional framework for organising data



NB. This framework was modified during successive rounds of data collection.

- 2 Design a data display or displays (conceptual chart) based on the conceptual framework.
- 3 Produce a list of provisional codes based on categories in the conceptual framework.
- 4 Scan volume 64 (2001) of the British Journal of Occupational Therapy, identifying any articles, editorials or opinion pieces which make reference to categories in the conceptual framework. These should be written, or co-written, by a state registered occupational therapist practising in the UK at the time of writing. (Appendix A)
- 5 Read each of the selected papers and highlight any text which refers to categories in the conceptual framework.
- 6 Code the highlighted text.
- 7 Revise the list of codes as necessary.
- 8 Fit the coded data into the data display.
- 9 Revise the data display as necessary to incorporate the data.
- 10 Identify patterns, themes, relationships between variables, common sequences and differences between sub-groups.
- 11 Carry out an interim case analysis to identify any missing or unclear data.
- 12 Scan volume 63 (2000) of the British Journal of Occupational Therapy, identifying any articles, editorials or opinion pieces which make reference to categories in the conceptual framework. (Appendix B)
- 13 Read each of the selected papers and highlight any text which refers to categories in the conceptual framework.
- 14 Code the highlighted text.
- 15 Revise the list of codes as necessary.
- 16 Fit the coded data into the data display.
- 17 Identify patterns, themes, relationships between variables, common sequences and differences between sub-groups.
- 18 Draw conclusions from the displayed data and write up.
- 19 Carry out an interim case analysis to identify any missing or unclear data.
- 20 Identify potential sources of data, for filling in the gaps or clarifying ambiguous categories from references given in data sources, advice from expert informants or a wider literature search. These sources may be: occupational therapy textbooks published in the UK within the past five years; material within the British Journal of Occupational Therapy other than articles, opinion pieces or editorials (such as letters or reports); other occupational therapy journals, newsletters or magazines published in the UK; occupational therapy theses, and other grey literature by occupational therapists produced in the UK. (Appendix C)
- 21 Scan the selected material and highlight any text which refers to missing or unclear data categories or to possible new data categories.
- 22 Code the highlighted text.
- 23 Revise the list of codes as necessary.
- 24 Fit the coded data into the data display.
- 25 Critically analyse the data, seeking consistencies and inconsistencies between beliefs and theories, theories and theories, theories and practice, beliefs and practice.

- 26 Produce a first draft of a description of occupational therapy as it is today, based on the data but modified to improve internal coherence and pragmatic value.
- 27 Send the first draft to a small number of occupational therapists working in different fields of practice (Appendix D). Ask them to comment on whether or not they recognise it as a description of occupational therapy, it captures the unique features of the profession, it fits their own field of practice and there is anything they would like to add or to take out of the description.
- 28 Use the comments from the pilot group to clarify any aspects of the description which are ambiguous, fill in gaps and add new data categories.
- 29 Form a reference group to comment on the second draft of the description. This group should include occupational therapists working in different fields of practice and different geographical regions of the UK (purposive sampling). It should also include occupational therapists working in new or marginal areas of practice who will test the boundaries of occupational therapy (extreme case sampling). (Appendix E)
- 30 Ask the reference group to comment on whether they recognise the description as occupational therapy, whether or not it captures the unique features of the profession, if it fits their own field of practice and if there is anything they would like to add or to take out.
- 31 Use the comments from the reference group to clarify any aspects of the description which are ambiguous, fill in gaps and produce a final description.

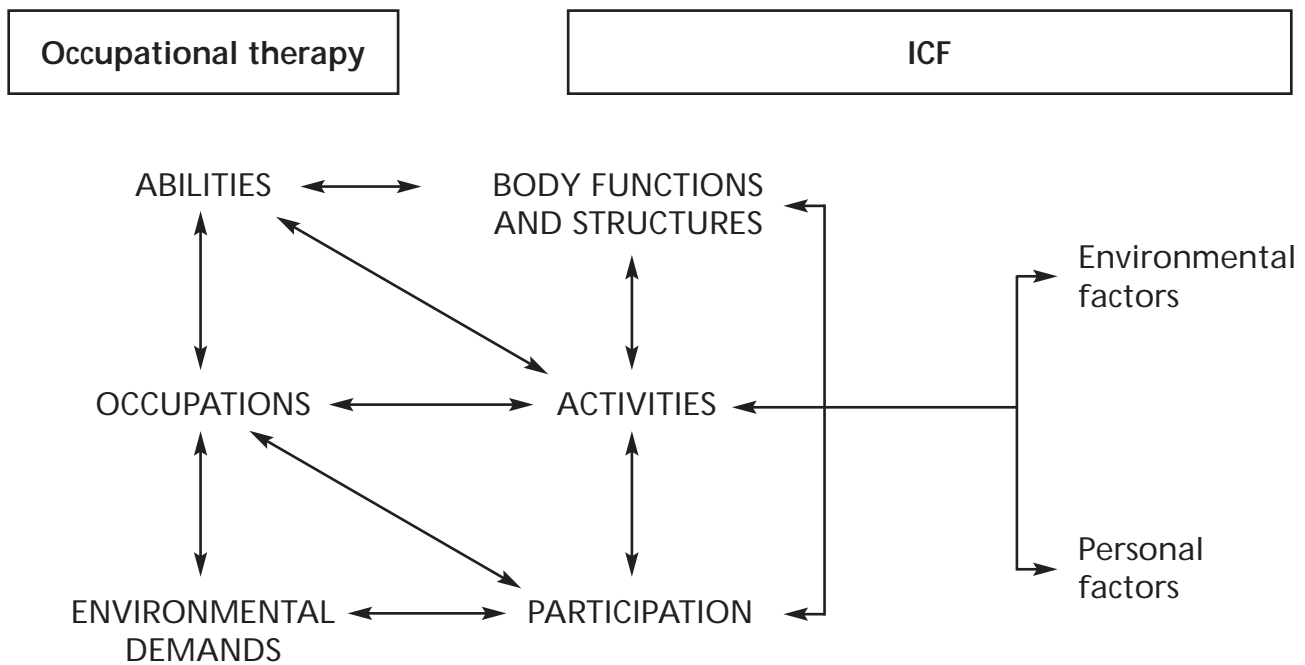
4. Description of occupational therapy

Occupational therapy can be described as a complex intervention because it is in concord with the definition laid down by the Medical Research Council (MRC 2000, p1). That is, occupational therapy comprises ‘a number of separate elements which seem essential to the proper functioning of the intervention although the “active ingredient” of the intervention that is effective is difficult to specify.’

The description given here is based on an analysis of recent occupational therapy literature in the United Kingdom. It identifies the elements of occupational therapy: therapist, client, context, environment and therapist’s actions, and describes how these elements relate to each other. The description applies to the work of the occupational therapist with individuals or groups but it is acknowledged that occupational therapists also act as consultants, providing advice and training within organisations.

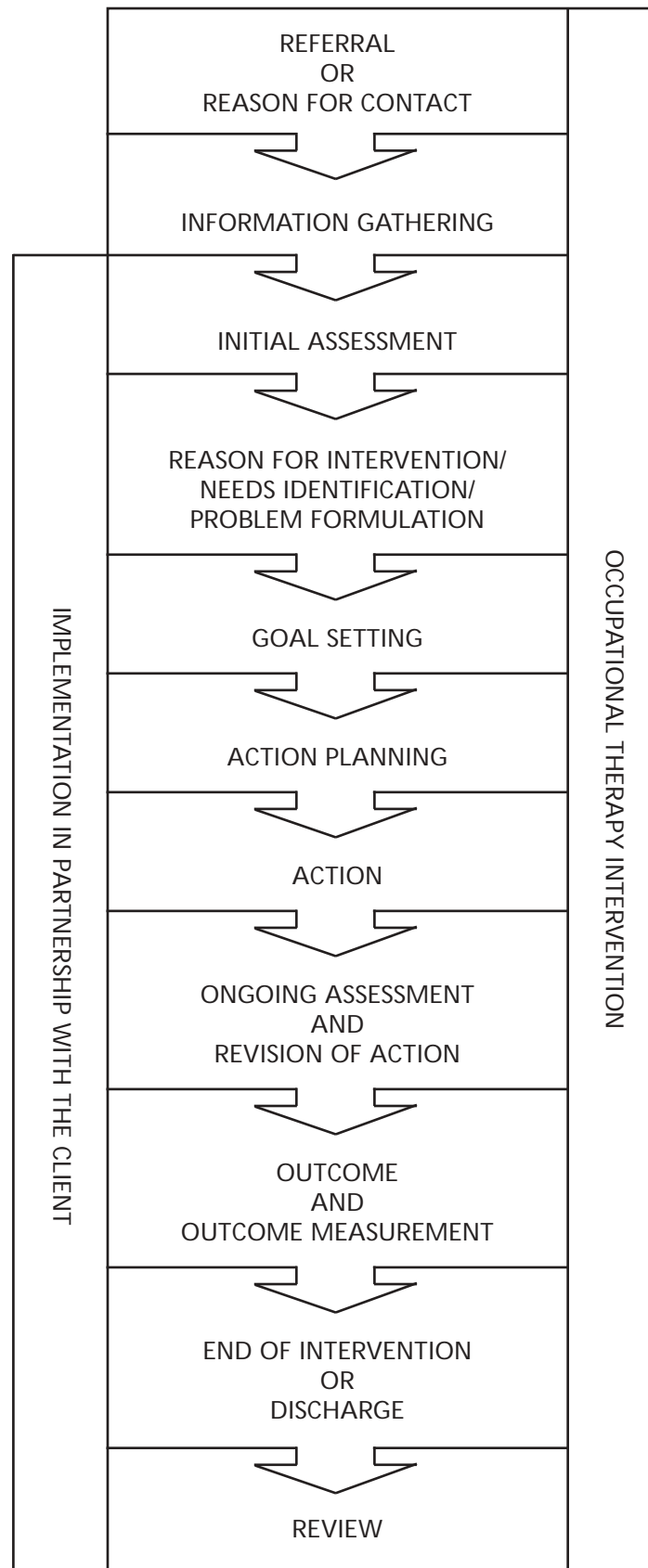
The main aim of occupational therapy is to maintain, restore, or create a match, beneficial to the individual, between the abilities of the person, the demands of her/his occupations and the demands of the environment, in order to maintain or improve the client’s functional status and access to opportunities for participation. Maintenance or improvement of function takes place within the context of the client’s illness, disability or other limitations. The activities of occupational therapists fit comfortably within the framework of the International Classification of Functioning, Disability and Health (ICF) (WHO 2001) (Figure 2). The ICF describes health domains and health-related domains and is intended to be descriptive of all people, not just those with illness or disability.

Figure 2: Occupational therapy and the ICF (WHO 2001)



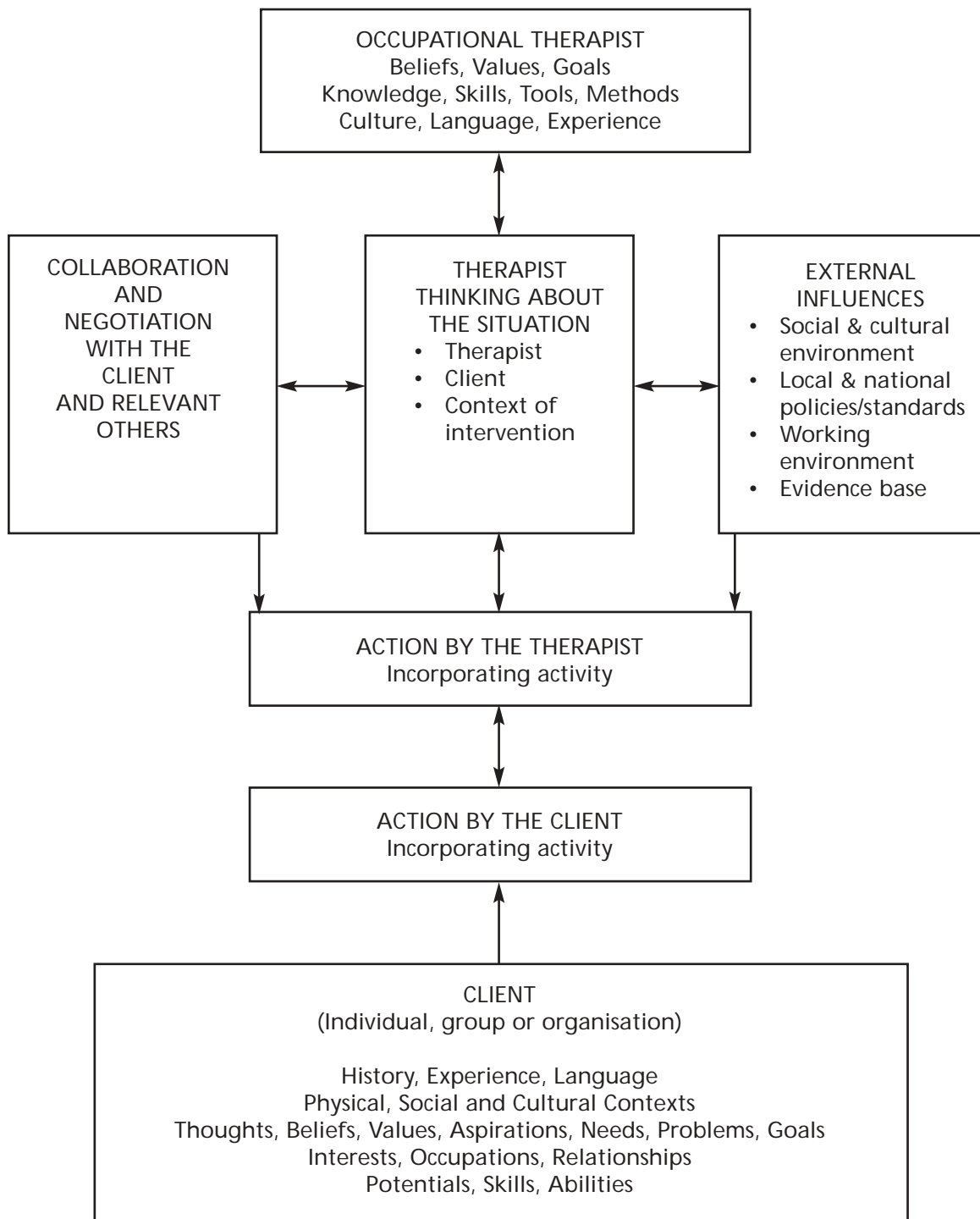
The visible aspect of an occupational therapy intervention is a series of actions by the therapist that together form a recognisable sequence called the occupational therapy process (Figure 3). The first two actions by the therapist, referral and information gathering, and the last action, review, are not usually carried out in partnership with the client. The other eight actions by the therapist initial assessment, problem formulation, goal setting, action planning, action, ongoing assessment and treatment evaluation, outcome measurement and discharge take place in collaboration with the client and, within medical settings, are called treatment implementation. In non-medical settings, the term *treatment* is not usually used to describe what the occupational therapist does.

Figure 3: The occupational therapy process



For the more experienced therapist, the occupational therapy process is not linear. At each stage, the therapist combines thinking about the situation, negotiation with the client and negotiation with relevant others in order to determine what action to take within a particular context. The context of the intervention modifies the occupational therapy process and the therapist's thinking, negotiation and action. Action by the therapist is intended to lead to action by the client or action on behalf of the client. (Figure 4)

Figure 4: The elements of the situation



In certain contexts, such as health promotion and disease prevention, the occupational therapist does not follow the process with an individual client. The occupational therapist's skills and knowledge are translated into action targeted at particular groups of people.

The occupational therapist brings to the process her/his beliefs, values, culture, language, goals, knowledge, skills, tools, methods and experience.

The elements of the situation taken into account by the therapist include the therapist her/himself, the client and the context of the intervention.

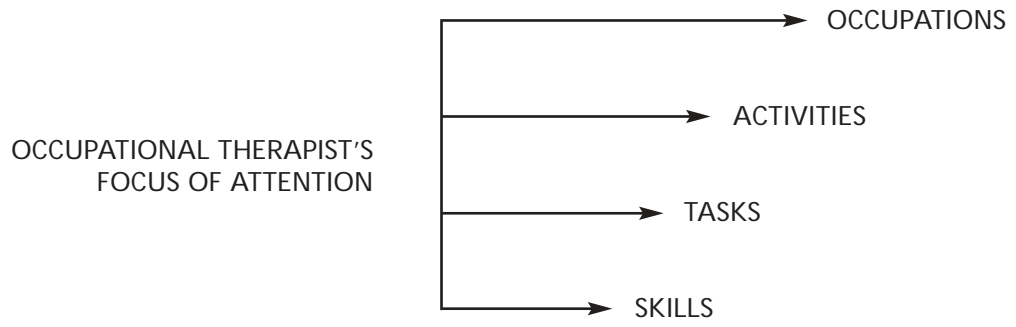
Occupational therapists call the people who use their services 'clients', 'patients', 'service users' or 'individuals'. Each of these terms is in common usage within particular service settings. The term 'client' is used throughout this document. The client may be an individual, a group of people (such as client and carers, for example) or an organisation. The client brings to the therapeutic encounter her/his own physical, social and cultural context, history, language, goals, values, beliefs, occupations, abilities, potentials, interests, skills, aspirations, experience, thoughts, relationships, needs and problems.

The context of an intervention includes: the wider social, cultural, political and economic environments; national and local policies and standards; guidelines and care pathways; local norms and procedures; the immediate working environment, and evidence of effective practice. The working environment includes: physical, financial and human resources; colleagues; managers; hierarchies of power; attitudes; expectations; team goals, and the amount and type of support available.

The treatment environment may be a health or social care setting, the client's own living environment or workplace, a community-based venue, school, nursery or other setting. It consists of the physical surroundings, the other people around and their attitudes. The therapist seeks the most appropriate environment for intervention, then monitors and manipulates these elements to overcome any disadvantages of the setting, to provide varied and selected stimulation and to achieve a range of goals.

During the occupational therapy process, the therapist shifts her/his focus of attention from occupation, to activity, to task, to skill and back again (Figure 5). S/he starts by looking at the client's range and balance of occupations, both current and expected future occupations. Having identified where the problems or deficits are, s/he focuses inwards and works on the activities, tasks or skills that will remediate the deficit and enable the client to enact her/his occupations more effectively. Alternatively, the therapist may make environmental modifications to facilitate occupational performance. The therapist then shifts the focus outwards again to see what effect the intervention has had on the client's overall pattern of occupations. This shift of perspective happens many times during an intervention, often without the therapist's conscious awareness.

Figure 5: Shifts of perspective during intervention



The occupational therapy process

Occupational therapy intervention is a process of collaboration and negotiation between the therapist, client and carer in which the client is helped to identify her/his problems and/or goals and to find effective ways of dealing with them. Assessment, problem formulation, goal setting, action planning, action, treatment revision, outcome measurement and discharge actively involve the client and can, therefore, all be seen as aspects of treatment implementation (Figure 3).

Referral or reason for contact

The occupational therapist accepts referrals which s/he deems to be appropriate and for which s/he has the resources. It is the duty of the occupational therapist to obtain enough information on which to base a decision about the appropriateness of the referral. If the minimum standards for intervention cannot be met, the therapist declines the referral or refuses to initiate assessment and treatment. Priority is given to clients who have occupational needs and who are judged to be at an appropriate stage for the kind of occupational therapy available. Occupational needs may be in the areas of self-maintenance, productivity and/or leisure. The client may have extensive and complex needs requiring intensive, long-term intervention or may require only limited occupational therapy input.

In some settings, clients are not referred. The occupational therapist works assertively to engage people in need who are considered likely to benefit from intervention.

The occupational therapist may refer a potential client to another service provider if the needs of the individual are not within the boundaries of her/his professional competence or if s/he cannot accept the referral for any other reason. The person making the original referral is informed of this.

If a potential client has to be placed on a waiting list, ideally the occupational therapist informs both her/him and the referring agency and advises them of the likely length of waiting time.

The therapist includes details of referral to and registration with the occupational therapy service in the client's records, if appropriate.

Information gathering

The occupational therapist gathers enough information about the situation to be able to determine whether or not the referral is appropriate and to support effective intervention. This includes information about the client's medical history, occupations, needs, strengths, goals, support networks and risk factors, and is gained from the client's carers, members of the multidisciplinary team, case notes, the therapist's general observations and more detailed assessment.

The therapist records information, including personal details, history and current involvement with services, in the client's records.

Initial assessment

The initial assessment is the means through which the therapist gathers specific information about a client's functioning in order to identify the factors which impact on her/his functional ability, occupational performance and health. This is called functional assessment, functional analysis or performance analysis. The information is used to guide intervention and to predict risks. If the intervention is going to involve further contact between the therapist and client or carer, the initial assessment may be prolonged in order to build rapport and trust.

On first meeting the client, the occupational therapist introduces her/himself, asks the name by which the client wishes to be known, and her/his preferred language, and explains why the assessment is being carried out. The therapist obtains verbal or written consent to intervention from the client or carer prior to starting a formal assessment.

Assessment is in the areas of self-maintenance, productivity and/or leisure and in the physical, cognitive, intrapersonal and interpersonal skill domains. It includes consideration of the client's abilities, strengths, limitations, developmental level, needs, expected social and physical environments and support systems, and the amount and type of assistance needed. The therapist also assesses the client's feelings, attitudes, interests, goals, personal history, past experiences, cultural practices, work status, housing status and degree of knowledge and understanding. Where possible, present levels of functioning are related to past patterns of occupation and the expectation of future patterns of occupational engagement.

The occupational therapist communicates the results of assessments to colleagues and, in turn, takes account of the findings of colleagues so that assessments are not duplicated.

During the initial assessment, the therapist and client judge whether or not the client would benefit from occupational therapy and begin to develop a therapeutic relationship. The client is involved throughout the assessment process as far as possible, having some control over both what information is gleaned and how it is elicited. The therapist is flexible, adapting the assessment activity when necessary, providing appropriate support and jettisoning a task if it is creating undue problems or difficulties. The occupational therapist respects the client's right to refuse further occupational therapy intervention.

The therapist uses assessment methods which are appropriate to her/his own abilities and to the client's needs and situation. These include:

- interacting informally with the client
- observing activity in the client's own living, working or social environments or in the clinical setting
- setting the client specific tasks
- carrying out standardised tests
- interviewing clients and carers
- asking questions and discussing the situation informally.

The therapist records the results of all assessments, including any decision not to continue the intervention made by the client or, in cases where the client is not able to make the decision, an advocate. Assessment results have a shared ownership between the client and the therapist. The client may withhold consent for these results to be shared with others.

Reason for intervention/needs identification/problem formulation

Occupational therapists formulate the desired outcomes of their interventions as goals, problems and/or needs. This formulation leads to planned action to reach the goal, solve the problem or meet the need.

Occupational therapy is concerned with the impact of illness, disability or environmental factors on an individual's ability to carry out her/his desired activities and occupations. The occupational therapist organises assessment information in such a way that s/he is able to build an understanding of the client, identify problems with activities and occupations and set priorities for action. Problem formulation requires that the therapist, client and, where appropriate, carers or family establish a relationship in which they are able to engage in mutual exploration and interpretation of what the problems are, where they are located, what the desired outcomes of intervention are and what might realistically be achieved. The process of negotiating goals and problems can be therapeutic in itself.

Complex problems require analysis from a variety of perspectives and theoretical frameworks and, in some cases, more than one way of formulating a problem is applicable. The therapist formulates problems at different levels, as occupational imbalance, occupational performance deficits, activity limitation, task performance problems or skills deficits. When problems have been identified and priorities for action agreed, the therapist records them, including any needs and objectives which cannot be met with the reasons for this.

Goal setting

The occupational therapist expresses the goals of intervention in terms of occupational performance, as targets to be reached, problems to be resolved, needs to be met or aims to be achieved. Goals are adjusted to the client's needs and performance and the occupational therapist may be concerned with the direction of change rather than with defined and measurable outcomes. The goal may be to help a client come to terms with relapses, deteriorating or restricted functioning and/or the need for life-long medication. It may include the client accepting physical and/or emotional support. An initial goal may be for the client and/or carer to become more aware of what their needs are so that they can engage more actively in the intervention process.

Whenever possible, the client and/or carer participate actively in negotiating goals, reviewing the available options for action and setting priorities. The client and therapist decide what is reasonably achievable from an intervention in the time available. If the client has difficulty expressing what s/he wants, initial goals will be tentative or vague, based on the therapist's perception of the client's abilities and needs, or may focus on enabling the client to make decisions and/or express needs and wants.

Priority is given to setting goals that address the most basic or underlying problem, or what the client perceives to be important, or a problem which family or care staff see as overshadowing all other aspects. In an acute setting, these are often the only goals that are set. In settings where the therapist and client are in contact for a longer period of time, the therapist usually advises the client to start with small goals on the way to achieving a longer term goal. They could agree to set initial goals to deal with problems which have easy solutions in order to build trust and confidence. They could also agree that, although a problem exists, intervention is unnecessary or would not be beneficial, or that the problem cannot be entirely resolved.

The therapist records clearly the client's assessed needs and the objectives of intervention, even when the decision is taken not to work towards all the client's goals. It is sometimes not possible to treat all the problems identified in an assessment, for reasons of safety, professional knowledge or ethics. When resources do not permit a comprehensive treatment programme or intervention, the therapist identifies and records the objectives that have to be achieved in order to maintain a minimum level of satisfactory and safe service to clients and carers.

Action planning

Action planning is a collaborative endeavour between the therapist, the client, the carer and the treatment team to devise a unique solution that meets the needs of this individual under this specific set of circumstances. The client is not the recipient of a ready-made solution but is an active participant in the formulation of a new one. The action plan specifies the approach to be used and the actions to be taken by the therapist and client towards solving identified problems or reaching agreed goals. Interventions are usually designed to meet more than one goal or to develop more than a single set of skills.

Each intervention programme is highly individualised, taking into account the client's skills, problems, needs, environments, preferences, interests, motives and past experiences, as well as a wider social, political and cultural heritage. Where possible, the client selects or agrees the mode of intervention. Other influences on the choice of intervention include the therapist's style of working and preferences, as well as factors external to the client-therapist relationship.

When activities are the main therapeutic media, the action plan involves selecting activities for their potential to engage client interest, participation and enjoyment and for their potential to be adapted to meet treatment objectives. Throughout the intervention, activities are graded or sequenced to maintain client interest and therapeutic potential.

When environmental adaptation is the main therapeutic approach, the therapist has to negotiate suggested changes to the client's environment from a clear understanding of the dynamics of the household, workplace or other setting and to make alterations flexibly over time, as and when circumstances change. The therapist may also negotiate the introduction of employed carers to improve the client's functional capacity and quality of life or to relieve carers.

The occupational therapist keeps a record of the wishes of the client/carer, together with her/his own aims, plans and actions. The therapist needs to document clearly any risk

decisions taken to ensure that, should an adverse event occur, the reasons for taking that particular risk can be clearly identified.

Action

The occupational therapist works in partnership with other professionals, community workers or volunteers and refers clients to, or consults with, other service providers when additional knowledge and expertise are required. S/he works collaboratively with the client and, if appropriate, with the carer so that control over the intervention process is negotiated and shared. If the client or her/his advocate refuses treatment, this must normally be respected. There is an element of risk taking involved in respecting the client's choices and the reasons for all decisions are documented.

Intervention usually involves engaging the client in activities which have been analysed, selected, adapted, graded and sequenced to achieve therapeutic goals. Activities can be used to develop or maintain skills or adapted so that the client is able to perform them with her/his existing skills. The occupational therapist carries out activities with the client or discusses the activities that the client will carry out in other settings. Grading and sequencing activities allow the therapist to adjust precisely and increase incrementally the demands on the client so that s/he continues to develop skills while still experiencing success.

Intervention sometimes involves adapting the client's physical and social environments, either by arranging for structural alterations or by introducing support workers, in order that the client is able to carry out her/his activities of choice with minimum risk.

Treatment media are often the normal activities of selfcare, leisure or work, creative activities, educational activities or environmental modification. The therapist selects media on the basis of which can best fulfil the aims of treatment, have most meaning for the client, make the best use of existing resources and fit in with the overall programme of intervention the client is receiving.

Ideally, the client will take most of the required actions, although there is often the need for some action by the therapist and others on behalf of the client. The therapist will sometimes teach another person to carry out the action plan, providing supervision appropriate to the level of competence of the person carrying out treatment and retaining responsibility for the client.

The therapist becomes a tool for treatment through the therapeutic use of self. S/he ascribes her/his own meanings to what the client is doing, therefore, to balance this, s/he asks the client what an activity means to her/him and listens to her/his stories without making judgements. The meaning of a therapeutic activity is not necessarily fully developed from the beginning of the intervention but may be constructed through the performance of the activity and the ongoing discussion between the therapist and client during the occupational therapy process.

The therapist records the process and results of the intervention, using these notes to ensure that the treatment plan is moving towards its target. The client may request access to these records.

Ongoing assessment and revision of action

Assessment and evaluation are ongoing throughout treatment in order to measure progress towards previously agreed goals and to ensure that what is being done is effective.

The therapist observes changes in performance, or asks the client if s/he feels any progress has occurred, or uses specific assessments according to need. S/he assesses the same performance at intervals, using a standardised measure or taking the individual's previous performance as the baseline. The physical and social environments in which a person lives and works are an integral part of continuing assessment.

The occupational therapist modifies or changes interventions in response to the evaluation of assessment findings. S/he evaluates and reassesses her/his involvement with a client when treatment does not progress in the anticipated or desired manner. When someone other than the occupational therapist carries out the occupational therapy programme, the therapist remains responsible for making adaptations to the programme as required and for the outcome of the plan.

The therapist records assessment results, including outcomes and further action required. Unmet needs are always recorded. The therapist gives timely feedback of assessment results to the team

Outcome and outcome measurement

The intended result of a programme of intervention is to achieve the agreed goals, therefore, the goals can be expressed as desired outcomes. Outcomes should relate closely to the client's social, psychological, emotional and cultural needs in relation to occupational performance.

Ideally, the therapist and client work together to:

- establish a baseline from which to measure change
- agree realistic, desired outcomes
- define those outcomes as observable and measurable items of performance
- implement treatment for an agreed period
- carry out the same assessment again
- review goals and, if appropriate, revise desired outcomes.

If it is not possible to involve the client in negotiating realistic outcomes, the therapist may base expected outcomes on the results of the initial assessment.

Change is measured by comparing assessment results before and after intervention. In clinical practice, it is not usually possible to know the extent to which change was brought about by the occupational therapy intervention, especially if the client is receiving input from several professionals.

The therapist records when outcomes have been achieved. When outcomes are not achieved, the therapist records this for the purposes of service review and development.