AN INVESTIGATION INTO THE ACTIVITY OF OCCUPATIONAL THERAPISTS WORKING WITH THE ELDERLY MENTALLY ILL

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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The thesis sought to investigate the purpose, nature and efficacy of occupational therapy in health service settings. It was based upon the premise that what occupational therapists do in practice is little understood and poorly researched. Therefore, as well as determining the nature of activity, this research also aimed to understand how the activity of occupational therapists might be influenced. The investigation focused upon the work of occupational therapists with older people with mental health problems, an area of high volume and demand.

Through an examination of the literature on professionalism in health and social care and that concerned with older people with mental health problems, a model of occupational therapy was proposed, underpinned by the research hypothesis. The subsequent research design consisted of four empirical studies; each testing different aspects of the model of occupational therapy activity. As well as measuring the clinical activity of occupational therapists, views of that activity were obtained from the occupational therapists themselves, service users, and representatives from other disciplines also working with older people with mental health problems.

The results of each study were analysed separately in the first instance. The totality of results were then employed to address the overall research aims, and to draw conclusions about the validity of the model of occupational therapy activity. This demanded further analysis of the findings using a critical theory approach to professional behaviour. In light of this, a revised model of occupational therapy activity is presented.

This research enabled the activity of occupational therapists to be fully described for the first time, highlighting both positive aspects and shortfalls. It is has provided evidence of how professionalism in health is driving the activity of occupational therapists. The final chapter presents recommendations for development of a better foundation for occupational therapy activity.

CONTENTS

APPENDICES

TABLES, CHARTS AND FIGURES

LIST OF ABBREVIATIONS

COT	**College of Occupational Therapists**
CPSM	**Council for Professions Supplementary to Medicine**
DoH	**Department of Health**
Dfee	**Department for Education and Employment**
GP	**General Practitioner**
NHS	**National Health Service**
NHS ME	**National Health Service Management Executive**
OT	**Occupational Therapy**
PAMs	**Professions Allied to Medicine**
SSI	**Social Services Inspectorate**

CHAPTER ONE

INTRODUCTION TO THE PROJECT

Statement of the Problem

This thesis is concerned with the work of occupational therapists employed by the health service and based in the premise that what they actually do in practice is little understood and poorly researched Therefore, if occupational therapy as a profession is to maintain, consolidate and advance it's position in the competitive health and welfare market place, it is essential that the purpose, nature and effectiveness of it's practices is exposed to critical scrutiny and understood by both occupational therapists themselves and others outside the vocational group.

Since the idea for this work was first conceived in 1989 and data collection undertaken (1992-1993), the policy thrust towards evidence based practice has accentuated. Use of audit mechanisms and quality assurance activities are now accepted practice within the health service, contributing towards the development of a culture of outcome measurement and cost effectiveness. It must be acknowledged that over the last few years, evidence of effectiveness of occupational therapy has increased, for example the meta analysis of effectiveness of occupational therapy for older people (Carlson et al, 1996); and a range of outcome measures are available, for example the Canadian Occupational Performance Measure (Law et al, 1990) and the Community Dependency Index (Eakin and Baird 1995). However, the extent of evidence still fails to keep pace with demand, particularly in light of most recent Government policy recommendations (DoH 1997a and DoH, 1998a). New legislation further embeds audit and proven effectiveness within clinical practice through the activity of the proposed National Institute for Clinical Effectiveness (NICE). An aspect of the remit of NICE will be to disseminate evidence based clinical guidelines and support audit methodologies at local level.

Occupational therapists work with a wide range of clients in a number of service settings, but for the purposes of this project, investigations were limited to one of the most vulnerable, but frequently encountered user groups; older people with mental health problems. This group are a high priority as there is a growth in the number of older people in society and a consequent increase in demand for resources to cope with their health and social care needs.

> *"...the costs to the NHS of providing services to this increasingly elderly population amounts to between 0.5 and 1 per cent per annum (in real terms) of the total budget of health authorities, a figure conceded by the Government."*
>
> Harrison and Pollitt, 1994, pp. 19.

In light of this high volume and demand, it is not surprising that current policy is also promoting interest in rehabilitation as a means of shortening costly hospital admission and avoiding residential and nursing home care (Nocon and Baldwin, 1998). This is intertwined with concerns about the quality of treatment and care of vulnerable older people. The number of guidance documents and

reports concerned with meeting the needs of older people with mental health problems is evidence of this; for example DoH, (1997b); Barnes, (1997); SSI and DoH (1997a) and SSI and DoH (1997b).

However, if theorists and researchers are to be proved correct, many factors, aside from those stemming from the needs of the user group, will determine the service experienced by older people and their carers; for example style of undergraduate training received by health and social care professionals (Beattie, 1995), the norms and demands of their professional group (Hugman, 1991) and a personal desire for increased status (Guy, 1985). It would appear that professionalism in health and social care is a potentially powerful influence upon the nature of service delivery. On the basis of a trait approach, Wallis (1987a) called occupational therapy an emerging profession, but is this the case and if it is, what exactly is emerging and what are the consequences? Has occupational therapy acquired professional status or is this belief among occupational therapists a case of "the Emperor's new clothes"? Furthermore, how are goals concerned with increasing professionalism reconciled with the needs of older people with mental health problems and their carers? Therefore, in addition to the development and application of robust methods of examining clinical activity (demonstrated through tasks undertaken during the working day), the work described in this thesis also sought to explore the covert as well as overt reasons for the profile of activity which emerges.

The Research Context - a Review of the Literature

This chapter explores the various influences upon the activity of occupational therapists; and in particular the effects of professionalism in health settings set in the context of current policy requirements. A discussion of the needs of older people with mental health problems, and the demands working with this user group places upon occupational therapists completes the picture. The emergent themes from the literature are then synthesised to create a preliminary theory of occupational therapy activity to be tested through empirical research.

What is a Profession?

The terms 'profession' and 'professionalism' are frequently used in discourse, as well as in a wide variety of written material, and are often applied to occupational therapy. However there is no accepted consensus regarding their meaning. The following four alternative interpretations of professionalism were identified by Johnson (1972);

- firstly, it is used to describe changes in occupational groups, for example increase in numbers either due to expansion or the demand for skills to meet needs which have not been previously recognised;
- secondly, it is interpreted through control upon recruitment and practice in a specific occupation;
- thirdly, an occupation adopts certain attributes which characterise professionalism;
- fourthly, the acquisition of professionalisation occurs as a result of the occupational group moving through a sequence of organisational changes.

Johnson draws our attention to the latter two interpretations which describe processes with an end point which some occupations are moving towards and others have arrived at.

Freidson (1977) extracts three alternative explanations for the lack of consensus about the meaning of the word profession:-

1. It is frequently used to compliment self and/ or others.
2. 'Profession' has developed as a historical concept as well as a theory of ideals.
3. Some workers use the term to embrace many occupations in society, whereas others apply it to small number of specific occupations.

Elliott (1980) is of the view that the term 'profession' is used excessively and inappropriately. He makes the following observation;

"Professional and non-professional occupations share many common characteristics. It is difficult to point to a sharp dividing line between the two."

Elliott, 1980, pp. 2.

The indiscriminate use of 'profession' is also observed by Freidson (1977) through listing occupations which claim to have professional status;

"What draws all those occupations together into a single professional stratum is trivial compared to the nature of the differences between many of them."

Freidson, 1977, pp. 22.

Freidson's observation is certainly borne out by the classification of occupational therapy as a profession *allied to medicine* (PAM), which does not appear to serve any overt purpose apart from that of national pay negotiation. During their pilot work on clinical audit in the professions allied to medicine, Normand et al (1991) recognised the joint goals of rehabilitation and fostering of independence across professions grouped as PAMs but also noted;

"..they do not have more in common with each other than they do with medicine and nursing."

Normand et al, 1991, pp. 1

Even where there appears to be agreement between workers about the meaning of profession and professionalism, it cannot be presumed that they used the same understandings of the terms in their work (Freidson, 1977).

To try and develop an understanding of the concepts of profession and the professionalising of occupations, a range of theoretical perspectives have been developed over time.

Theories of Professionalism

An examination of the development of various theories of professionalism gives rise to the following broad groupings:-

- trait theories;
- functionalist theories;
- historical perspectives;
- power theories.

In considering how the activity of occupational therapists can be shaped, the legitimacy of these theories and their application, particularly in health and social care warrants examination.

Trait theories

Early theorists developed and promoted the 'trait theory' to try and explain the complex concept of professionalism. This involved the identification of a number of elements which contribute towards the attainment of professional status; for example, Millerson (1964) used literature available at the time to identify 23 such traits. The most frequently mentioned traits by those propounding this theory are skills located in theoretical knowledge like those acquired through a degree, provision of training and education, testing the competency of members, organisation, and adherence to a professional code of conduct and altruism. Using the trait approach, Etzioni (1969) labelled nursing, teaching and social work as 'semi-professions.' This was derived from the fact that they had acquired some, but not all the traits of professionalism.

"Their training is shorter, their status less legitimised, their right to privileged communication less established, there is less of a specialist body of knowledge, and they have less autonomy from supervision or societal control than 'the' professions."

Etzioni 1969, pp. v

He also observed that the majority of true professions at the time were male dominated while those occupations classified as semi-professions were dominated by female workers.

Later workers (Johnson, 1972; Ovretveit, 1991 and Freidson, 1994) draw our attention to a number of flaws in the trait theory. These include a lack of theoretical underpinning in development of the checklist of traits, that the traits are not mutually exclusive, the lack of identification of causal relationships between traits and the absence of agreement about the relative importance of different traits. Furthermore, in adopting this theory, it is easy to accept the definitions arrived at by professionals themselves, particularly those exemplified in professional codes of conduct (Johnson 1972); for example the Code of Professional Ethics and Professional Conduct for Occupational Therapists (COT, 1995), is published and distributed by the Ethics Committee of the College of Occupational Therapists, without external regulation. Also the traits identified were based on the analysis of relatively few traditional and powerful professional groups, in particular medicine and law.

Johnson (1972) specifically challenged the trait based theory of Etzioni, by arguing that development of the semi professions in health is a consequence of medical dominance;

"The emergence of a succession of subordinate professions auxiliary to medicine in Britain is the history of how physicians have been able to define the scope of new specialised medical roles and cannot be regarded as a hierarchy of semi-professions based upon the inherent potentialities for professionalisation of each occupation, or even a product of the most rationale utilisation of human resources."

Johnson 1972, pp. 35-36.

A variant of the trait theory is the professionalising of occupations through the achievement of various developmental stages; for example, the establishment of training schools, founding of professional associations, protection of the association by law (thereby preventing practice by unqualified individuals) and the adoption of a code of conduct. Wallis (1987b) provides an illustration of this through the accruable landmarks achieved in the move towards professional status of occupational therapy, for example the establishment of training schools, development of standards of entry for training and codes of ethics for practice. Indeed, on this basis, occupational therapists have grounds to be confident about evidence to support their professional status, bestowed by the Council for Professions Supplementary to Medicine (CPSM) in 1960.

"The Professions Supplementary to Medicine Act 1960 bestows the status of a profession on occupational therapy which automatically carried the statutory requirement to regulate professional practice for the protection of clients."

However, Wilding (1982) criticises this theory for describing a passive evolutionary process and not taking into account the dynamics, particularly political, of acquiring professional status. Irvine and Graham (1994) are highly critical of the application of a trait approach to occupational therapy.

"Occupational therapists have searched for status based on the accumulation of 'ticks' against a notional checklist of attributes and have assumed that the position of occupational therapy would change as a function of changes in attributes."

Irvine and Graham, 1994, pp. 14.

They suggest that adherence to the trait theory is at best misdirected and ignores how occupations professionalise. They support this thesis with a number of observations which mitigate against the view that occupational therapy has secured professional status. The first is the difficulties experienced by occupational therapists in describing what they do. Mocellin (1986) likened the differing definitions of occupational therapy to researchers who are continually changing their hypothesis while undertaking a research programme and in 1989, the Independent Commission appointed by the College of Occupational Therapists felt it necessary to develop their own definition, stating that existing definitions were *"too broad and unfocused."* This inability to clearly articulate role feeds the second observation of Irvine and Graham; that of public misperceptions about what occupational therapists do, described as the stereotyped images of craft work and *"do-gooding volunteers"* by Blom Cooper (1989). This can be traced back, in part, to the historical development of the profession which was built upon the curative effect of undertaking craft work. The third point Irvine and Graham raise is the lack of political acumen on the part of occupational therapists. Boyce (1997) suggests that the policy focus upon medicine and nursing, which can be largely attributed to their high economic costs to the state, has allowed much smaller numerical groups like professions allied to medicine (named allied health professions in Australia) to evade attention, with adverse implications.

...the low levels of political activity and organizational infrastructure of the allied health professions, together with their history of relying on the protection of medicine and their lack of attention to strategic level issues, makes them vulnerable to adverse outcomes.

Boyce, 1997, pp. 78

The final argument presented by Irvine and Graham is the general compliance of occupational therapists, which could be gender related. While the interplay between the female orientation of nursing and it's status within a patriarchal paradigm has been explored in depth; for example Witz (1994) and Garmanikow (1978) there has been scant attention paid to feminism on the part of occupational therapy in Britain. The work of Taylor is one exception, but it's appearance in a professional journal means that it is less likely to influence a wider debate.

"An opportunity is presented, following an examination of feminist thought, to question the profession's links with the medical model and objective science."

Taylor, 1995, pp. 173

Through a synthesis of the above arguments, Irvine and Graham (1994) propose that a critical theory approach toward professionalism in occupational therapy is demanded. This takes into account structure, process, power, control and autonomy.

Functionalist theories

Another concept of professionalism related to the trait theory is the functionalist approach. This takes those traits are of direct, practical relevance to society or to the relationship between the professional and client. Proponents of this approach (Barber, 1963 quoted in Johnson, 1972) identified four essential attributes: a generalised and systematic knowledge base, interest being rooted in the community rather than promotion of self interest, existence of codes or ethics to maintain behavioural standards and a system of rewards (both financial and honorary) to denote achievements. This theory emphasises professional authority through superior knowledge. However, critics of this theory point out that systematic knowledge is not always the most important skill within professions like law where a major strength is the ability to interact with clients. Neither is it equivalent across professions like medicine where the skill base developed by practitioners is highly dependent upon medical specialty. Also, it ignores the class, status and power of those carrying out the work (Wilding, 1982). More recently, the rise of consumerism in health and social care settings which promotes partnerships between users and professionals (DoH, 1998b) clearly mitigates against the legitimacy of functionalist theory.

There are questions regarding what constitutes professional knowledge as defined by the functionalist approach and how this is interpreted in relation to occupational therapy, which is founded on the curative effects of occupation.

"The human being can attain enhanced health and quality of life by actively doing things that are personally meaningful and purposeful."

Nelson, 1997, pp. 11.

Nelson suggests that one of the strengths of this purpose is that it is so fundamental. However, in terms of professionalism, '*doing things*' does not fall within the rubric of 'specialist knowledge' with its associated mystic. Through adoption of the word '*occupation*' to explain doing things, rather than '*activity*', Nelson is able to underpin the work of occupational therapists with an academic foundation.

"We are called occupational therapists and the essence of our profession is the use of occupation as a therapeutic method. In contrast the term activity lacks the connotation of intentionality."

Nelson, 1997, pp. 22.

The debate over the use and interpretation of the words occupation and activity continues within occupational therapy (American Occupational Therapy Association, 1993; Ilott, 1995 and Gollege, 1998) raising questions about the purpose it is serving; is it rooted in the quest for greater understanding or the drive for professional status? Furthermore, are the claims of Nelson (1997) that use of the term 'occupation' will aid clarity both within occupational therapy and external to it correct?

The quest for a theoretical framework for occupational therapy is also demonstrated through several models of occupational therapy which have been introduced over time. Tyrrel (1996) quotes the work of Mosey (1981), Kielhofner (1985) and Reed and Sanderson, (1992) as examples of professional practice models. Use of these models has proliferated in recent years and Tyrell suggests that they both enable development of consistency across therapists and provide framework by which occupational therapy can be explained to others. However, evidence does not exist to confirm the claims of Tyrell, and it could also be argued that the real purpose of professional practice models is to mystify the knowledge base, particularly through use of jargon. Furthermore Alexander et al (1985), (a group of occupational therapists from Australia), observed that professional status is more dependent upon how the profession organises itself than upon conceptual and theoretical consensus. A further strategy to bolster specialist knowledge of occupational therapists has been through the concept of 'clinical reasoning.' Through it's own special language, it describes the strategies occupational therapists adopt to analyse, interpret and resolve clinical problems in their work (Fleming, 1991).

Despite these moves to link occupational therapy to academia, specialist knowledge as defined by the functional theorists is confounded by the vocational rather than academic basis of occupational therapists, evidenced through it's diplomate rather than graduate status until relatively recently. During the last ten years, occupational therapy has moved from an exclusively diploma educated profession to one where degree status can be achieved, with a change in location of training from uni-disciplinary, isolated, training schools to placement within higher education establishments. However, admission to established centres of academic teaching and research is limited with most occupational therapy programmes being located within the so called 'new universities.' Furthermore, Williams (1993) suggests that the challenges presented by having the status of a graduate profession need to be confronted if the benefits are to be realised. Placed in the context of professionalism, this suggests that acquisition of graduate status does not immediately equate with improved professional status.

Therefore, if a functionalist theory is applied to occupational therapy, the balance of evidence suggests that there is less substance for claiming professional status than through application of a trait approach.

Historical perspectives

In drawing out theories of professionalisation, both historians and sociologists have interpreted the historical development of professional groups; for example Elliott (1980) examined the development of professions in pre industrial and post industrial Britain to explain how the process of professionalism is linked to social change. He describes living a leisurely lifestyle without necessarily having to work as '*status professionalism.*' This was unimportant in work terms but had high social status. In contrast '*occupational professionalism*' was located in specialist knowledge and work. For the upper classes, state connections were most important with work in the military or government being reserved for the gentry, whereas for the middle classes contact within

the professional grouping was most relevant. The three acceptable professions for middle class gentlemen prior to the industrial revolution were medicine, divinity and law, with a hierarchy existing within each. This association between professions and class status served the purpose of restricting the middle classes. Occupational professionalism started to emerge during the industrial revolution and through a process of social change, it has become indicative of social success. However, as Larson (1977) points out, some of the values of status professionalism have survived within occupational professionalism;

"The modern model of profession undoubtedly incorporates pre-industrial criteria of status and pre-industrial ideological orientations."

Larson, 1977, pp. 5

Much can be learnt about the present position of occupational therapy from it's history. Levine Schemm (1993) explored the development of occupational therapy in America and the United Kingdom, and through this suggested that occupational therapy is underpinned by two different paradigms. The early development of occupational therapy was shaped by the arts and crafts movement. This promoted the production of well designed, hand made goods. The process of craftmanship in itself was believed to have a beneficial and curative effect. Alongside this was another developing ideology which was concerned with a graded therapeutic process, grounded in theories of rehabilitation rather than the satisfaction to be gained from producing a polished artefact.

"Although Casson and American leaders remained dedicated to arts and crafts ideology (in the 1940's), *they began to rely more heavily on patho-kinesiology and scientific reasoning to justify treatment."*

Levin Schemm, 1993, pp. 1086

The early founders of occupational therapy had difficulty in reconciling these two paradigms, and it has been argued that this conflict remains unresolved (Yerxa, 1992), particularly in light of the continuing relationship with medicine. However, if Larson's thesis is applied to occupational therapy, the reasons for this association become clear in that it enables some benefits to be derived from an established status profession, the most overt being the granting of professional status by the Council for Professions Supplementary to Medicine in 1960. This is one of the lynch pins used by occupational therapists as unequivocal proof of their status.

Building upon historical perspectives, Larson (1977) developed the notion of professional markets. The professions had to expand their practice and escape from a rigid system, restricted by social class. This demanded a move away from the old delineators of professional credibility towards a new ideology grounded in legally bound codes of practice and systematic training. Restricting entry to this training served to define those who might be admitted and those who should be excluded. This process or 'social closure' (Weber, 1968 quoted by Lunt, 1997) fostered social privilege as well as professional credibility from the public. Social closure enables the introduction of new professions through exclusion of those without the necessary entry requirements. Once again, a current example which vividly illustrates this is that of occupational science, and it's growth out of, and gradual separating from occupational therapy.

"Occupational scientists occupy a specialist role. They lay claim to a particular knowledge base. This allows them to become members of a higher status group, i.e. the wider academic community. Occupational therapists are excluded from these developments."

Lunt, 1997, pp. 60

Through an analysis of the influence of the labour market upon professionalisation, Friedson (1977) concurs with the following statement by Goode (1960) in that;

"an industrialising society is a professionalising society."

Goode, 1960, pp. 902

Expanding upon this theory of ever increasing professionalisation in Western society, Freidson (1994) observes that the exchange value of an activity defines it as work and the relationship of that work in the market is the delineator of whether the work is an occupation or profession. The capitalisation of society has led to a greater number of tasks being carried out by full time workers which were originally the province of volunteers, thus accelerating the move towards professionalisation of a wider group of occupations. This continuing process is exemplified through the absorption of users and carers into the formal care arena. While acknowledging the importance of the contributions of carers, "Caring for People, (1989a) also sought to capitalise on this unpaid labour force. This increased profile of users and carers in the 1990 Health and Community Care Act placed them firmly on the policy agenda and as a result of their increased interface with formal care services, a new professional group has emerged, that of 'user and carer professionals'. These individuals work with service providers in a number of ways; for example in service planning, research and staff training (Croft and Beresford, 1993 ; Lindow and Morris, 1995). The example of formalised user and carer involvement brings into focus the processes of social closure and professionalism; when do they start to become divorced from the ordinary people they sought to represent?

The importance of supply to meet market demand identified by Freidson (1977) is illustrated through the expansion of occupational therapy. The second world war proved an unexpected watershed for occupational therapy in this country in that it led to a burgeoning demand for rehabilitation skills and a limited training programme for unqualified staff in response. However, Freidson also points out that the professionalising process is dynamic and subjected to fickle societal factors like availability of work and the economic consequences of payment for certain tasks. Moreover, professionalism in capitalist societies is taking on another form where practitioners are controlled by a body of professional elites who exert the technical, administrative and cultural authority enjoyed by professionals in the past; for example the concept of general management in health introduced by Griffiths (1988) exerting it's own control and working to decrease the autonomy of nurses and the professions allied to medicine (Harrison and Pollitt, 1994) Therefore a reverse process of deprofessionalisation can also occur, depending upon market forces. The responses by occupational therapy to recent policy initiatives illustrates the dynamic process described by Freidson. There is no doubt that Community Care policy (DoH, 1990) offered new marketing opportunities for occupational therapists, the most obvious being an augmented role

resulting from community care implementation (Lock, 1994). However, the greatest threats to professionalism of occupational therapy have also arisen from policy initiatives; for example the 1990 reforms introduced the notion of self governing trusts, granting them power and responsibility to manage their own affairs. Consequent to this was fragmentation of occupational therapy as well as other groups through the abandonment of national pay scales by some trusts, dilution of the workforce through generic rather than discipline specific working and the disbanding of professional networks due to the internal market. In 1994, Lloyd Smith tried to foster debate within occupational therapy about how it could withstand the negative influences of the health care reforms and in particular the fragmentation arising from the internal market.

"Occupational therapists often work in very complex situations with people who have multiple needs which cannot always be neatly costed, packaged and sold."

Lloyd Smith, 1994, pp. 43

The 1997 health reforms (DoH, 1997a and DoH, 1998a) promise to place even more pressure on occupational therapy. The internal market is being disbanded, but the concept of self governing trusts is being expanded to that of primary care trusts and more external controls on clinical activity are to be enforced through the National Institute for Clinical Excellence and the Commission for Health Improvement. One of the greatest threats to the status of occupational therapists could lie in an inability to provide concrete evidence of effectiveness. To gain and maintain a foothold in this market place, occupational therapists have to demonstrate the appropriateness and effectiveness of the skill base they possess.

A history of the development of occupational therapy in America (Gritzer and Arluke, 1985) provides a clear illustration of the dynamic process of professionalisation against a backdrop of political and organisational imperatives, increased specialisation of medicine (in this case, rehabilitation medicine) and the parallel professionalising of other associated occupations; for example, physical therapy. However, comparison of the development of occupational therapy in America and Britain, and how policy shapes demand demonstrates the validity of Freidson's view (1994) in that the process of professionalisation is specific to countries and states. While comparative studies are valid, professionalisation of an occupation in one country is not transferable to another. How the process of professionalism differs across international boundaries is exemplified by the introduction of training programmes for occupational therapy in this country and in America. In the United States, the first training course was established within a university. The founder of occupational therapy in this country, Dr Elizabeth Casson (a physician who had observed the developing profession in America), tried to persuade universities to introduce occupational therapy training courses without success. As a consequence, she introduced a private training school in Bristol in 1930. Occupational therapy training was thus established and undertaken in a mix of private establishments, health service run schools, and more latterly in colleges of education for the next fifty years; admission to university being barred until the introduction of degree status over the last ten years. The implications of this have been previously discussed in that, unlike the

development of occupational therapy in America, it denied the development of an academic foundation until relatively recently.

Adopting an historical perspective of professionalism exposes the dynamics underlying the development of professions and maintenance of professional status, and draws attention to the relevance of past and recent policy decisions to current practice. It also confirms that a critical examination of the factors which influence professionalism is more realistic than the application of trait and functionalist theories. However, occupational therapists have largely chosen to ignore this, possibly because it would mean acknowledging that professionalism is an active process which has to constantly be worked at, rather than an end state which can be reached. The constantly changing profile of professionalism is underscored by the forthcoming examination of power theories and their pertinence to health and social care.

Power theories

Theories of occupational control

In 1972, Johnson put forward a theory which is located in the notion of professions exerting control. In common with many later workers; for example Hugman (1991), Freidson, (1977 and 1994), and Irvine and Graham (1994) he suggests that trait and functionalist theories of professionalism are limited in that they do not take into account the control both exerted and experienced by professionals and relationship between practitioner and client. The development of specialist occupational skills creates dependence in those in receipt of those skills; for example users of health and social care services. This has the effect of creating social distance between practitioner and client, increasing the helplessness of the client and creating the potential for professional autonomy. Therefore professionalism can only occur when the occupational group shares wide resources of power, and when the clients provided a large, fragmented source of demand to the extent that they are not able to easily define their own needs and how they might be met; for example people seeking medical help. If occupational therapy in social service settings is considered within this construct, professionalism becomes a real possibility in that need for service seriously outstrips supply (DoH, 1994) and moreover, the users of the service are a disadvantaged, disparate group.

"Professionalism then becomes redefined as a peculiar type of occupational control rather than an expression of the inherent nature of particular occupations. A profession is not then, an occupation, but a means of controlling an occupation."

Johnson, 1972, pp. 45.

Drawing on the American sociological literature, Turner and Hodge (1970) came to a similar conclusion in that occupations should be the focus of analysis using a common analytic framework. This perception is reiterated by Freidson (1994).

"...a coherent and systematic method of analysis is one that requires forsaking an attempt to treat profession as a generic concept and turning instead to formulating a generic concept of occupation within which we can locate analytically the particular occupations which have been labelled professions."

Freidson, 1994, pp. 14

In his examination of power and nursing, social work and the professions allied to medicine, Hugman (1991) favours an examination of the history, structure and ideology of occupations which view themselves as professions. His work is located in the premise that power is both exerted upon and by caring professions, taking into account the organisations within which they work, their relationships with others, including service users and the location of the professional group within wider society.

Freidson (1994) asserts that to accurately examine the process of professionalism, a theoretical approach should be adopted which entails looking at all aspects of service delivery; for example how services are organised, the linkages between professional organisations and the state, how policy is formulated and the group's responses to that policy. Freidson also asserts the importance of concentrating the analysis in the present rather than drawing conclusions from what may happen in the future.

A typology developed by Johnson (1972) to provide a framework for analysis of occupational control consists of the following three groupings;

1. Collegiate control where the worker defines the needs of the client and how they might be met. This builds upon the notion of professional control, more successful in some occupations; for example medicine and law, than others. Consumer choice is weak, service users initiating contact, but the practitioner then deciding when it should be terminated. Collegiate functions geared to maintaining dominance include imposing standards of behaviour both within the workplace and external to it, maintaining one mode of access rather than multiple levels of entry into the occupation, having lengthy training, use of jargon, and maintenance of a code of ethics. The existence of this form of control is not static, as it is easily threatened by external influences like consumer choice and controls introduced by policy; for example the ways whereby the 1990 NHS and Community Care Act sought to achieve control over professionals. This legislation introduced a needs led approach to service delivery which bolstered the power of the service user and their carer, and also sought to limit professional influence through the introduction of general management in place of professional hierarchies. Johnson also maintained that if it remains dominant and confident of it's specialist skills, a profession can contain the potential disruptive influence created through the specialisation of subordinate groups. Another policy initiative mirrors this observation. The introduction of generic workers in health and social care as opposed to input from a range of disciplines has real implications for occupational therapy, already weakened by a shortfall of qualified staff, particularly in less popular specialisms like old age psychiatry. Development of this cheaper source of labour is being fostered through National Vocational Qualifications (Hatchett, 1992; NHS ME, 1993), with the aim being to introduce a sufficiently skilled workforce to meet

needs. Not surprisingly, occupational therapists have not welcomed the introduction of the concept of generic working in health care settings. Mosby (1995) voiced the concerns of occupational therapists in that generic working will be problematic unless staff are able to demonstrate the unique nature of occupational therapy and it's value in patient care.

*"Many (*occupational therapists*) do not know that an occupational therapist can cost approximately 1.25 times as much as his/her nurse counterpart and approximately twice the average housing worker or generic worker."*

Mosby, 1995, pp. 97

The question is whether occupational therapy is sufficiently strong as a profession to withstand these economic implications.

2. Patronage is where the client defines his own needs and how they might be met. This occurs when demand comes from a small relatively powerful group; for example demand for accountancy from corporate businesses. The practitioner has to anticipate what is expected from the customer, thereby decreasing autonomy and placing the emphasis upon local reputation. Recruitment to occupations which fall into this group is through social acceptability; for example shared values (for example that ascertained through recruitment and selection procedures for occupational therapy training) and status, as well as technical ability.

3. Mediation is where a third party mediates in defining needs and how they might be met. While acknowledging a number of forms of mediation, Johnson concentrates upon state control where Government removes the authority to determine the content and subjects of practice and guarantees clients, for example through legal aid and social services. It also enables different societal groups to access the services they provide but Johnson suggests that this is a lesser priority than is controlling practitioners through guaranteed work. Taking the mediation theory of Johnson (1972) and applying it to the caring professions, Hugman (1991) draws our attention to the power bound up in decisions about client involvement; for example who has the power to make referrals and how decisions are reached about the acceptability of the person being referred. Another effect of state mediation is to place decisions about recruitment in the hands of higher education establishments and determine rates of pay through national pay bodies. Wallis (1987a) notes the introduction of state control of occupational therapy in Britain through regulation by the Council for Professions Supplementary to Medicine (which to this day has a number of medical representatives), state administration of student bursaries and the then trade union status of the British Association of Occupational Therapy.

The groupings put forward by Johnson are not mutually exclusive; medicine could be viewed as a collegiate profession but at the same time it is subjected to state control. Occupational therapy exhibits some features of all three groupings. However, this does not signal complacency as a further observation of Johnson is that the resources available to any one occupation will determine the extent of autonomy, and occupational therapists, along with other numerically small disciplines

do not often count in policy terms, in comparison with medicine and nursing because of their lesser resource usage.

Freidson's construct of a profession is that of an occupation which controls it's own work, organised by specific institutions, while embracing an ideology of expertise and service (Freidson 1994). The central tenet of this theory lies in the notion of the prime locus of control being held by the workers themselves rather than by clients or Government. He identifies the common denominators of expertise, credentialism and autonomy across all occupations which have professional status. Within the construct of health, Harrison and Pollitt (1994) identify three co-existing themes of professionalism, which merge to form the whole. The first is concerned with the relationship between the professional and the patient. This assumes that the patient does not have knowledge and consequently has to trust, and be guided by the professional. The public has to be protected from those not qualified to practice and the practitioner is granted autonomy to treat the person without interference. The second is where practitioners seek better terms and conditions of work for themselves. Therefore activity is guided by self interest rather than in the interest of the patient so that autonomy becomes a vehicle for avoidance of managerial control. The final view is grounded in professionalisation as a sociological process, instilled during training whereby the values of the group are instilled.

Much of the critical appraisal of professionalism in occupational therapy that exists originates from America and Australia; for example the work of Alexander et al (1985); Grayson (1993) and Irvine and Graham (1994). Irvine and Graham make the following observation;

"..a process of professionalisation founded on the trait approach comes at a cost to occupational therapy and potentially to its clientele."

Irvine and Graham, 1994, pp. 14.

The costs they describe lie in a failure to acknowledge the political processes which underpin the division of labour in health (Johnson, 1972) and the market place which dictates demand for certain tasks (Freidson, 1994). A further cost lies in ignoring the historical backdrop of professionalism, particularly that which is specific to medicine (Jacob, 1988), and cannot be transferred to occupational therapy.

While various power theories have different emphases, the themes of autonomy and power, the impact of autonomy on relationships with service users and claims to specialist knowledge are consistent themes, warranting more in-depth examination.

The struggle for autonomy in health settings

Freidson (1970) identified two types of occupational autonomy. The first was autonomy by default which occupations achieve either through isolation or through specialisation. The second was socially sanctioned autonomy; for example that enjoyed by the medical profession where autonomy has been achieved, not only from the employing organisation, but also from other doctors. Ovretveit (1985) suggested that professional autonomy in health care is manifested at national, local and

individual levels. At a national level, this is exemplified by the existence of codes of practice, regulation of education and standards of work. At a local level, it is expressed through professional line management and representation of the profession at higher decision making levels. Individual autonomy is demonstrated through freedom to practice independently without interference, and having the power to refuse a referral. However, autonomy can easily turn to dominance. Ovretveit (1985) also identifies two forms of medical dominance. The first pertains to the doctor/patient relationship and the second is concerned with maintaining control over less powerful professional groups like the therapy professions.

Traditionally, professions allied to medicine have had their client group defined for them by the medical profession. Blom Cooper (1989) described the difficulties occupational therapists have asserting their professionalism due to a dependence for referrals upon medical staff in the health service and social workers in the local authority. Their description as a profession 'supplementary or allied to medicine' also contributes to maintenance of a position of subservience in relation to medicine.

"In such circumstances professional advancement of occupational therapists depends upon either courting the dominant profession to acquire its patronage or forming alliances with other professions, similarly placed, in order to try and erect a common platform."

Blom Cooper, 1989, pp.19

Medical control remains, but has lessened to some extent, for example occupational therapists can now work more independently as long as there is ready access to an individual's doctor. However, while overall medical authority over the referral system remains in tact, this concession may be a slight shift on the part of doctors in order to retain control described by Turner and Hodge (1970) within the parameters of the current policy climate.

As health care policy is now demanding integrated, evidence based practice, with the service user at the heart of the process, the desirability of medical autonomy and dominance is being questioned more than ever before (Hunter, 1994). The need for change in the medical profession was somewhat reluctantly acknowledged in a meeting to discuss the core values of medicine, attended by professional leaders (Smith, 1994).

"Doctors cannot swim against the tide and must recognise that this is an age of regulated capitalism in which the consumer is courted and protected, encouraged to be autocratic and persuaded of his or her power."

From a speech by Sir Maurice Shock, reported by Smith, 1994, pp. 1247.

Moreover, while the phenomenon of professional autonomy in health predominantly refers to the medical profession, and many would question it's desirability, particularly for patients, it appears that given the opportunity, other occupational groups would only be too ready to assert their own autonomy. How this is being achieved by other clinical professions is described by Harrison and Pollitt (1994); namely development of professional management hierarchies, with career prospects lying within management, the employment of unqualified assistants to conduct the less interesting,

routine aspects of the job and in the case of nursing, development of clinical expertise which could oppose medicine.

Despite new managerial controls, a challenge to medicine by nurses is articulated through the delivery of a different style of service which is no longer subservient to medicine.

"It is the new focus upon the content of nursing work which more directly challenges the traditional doctor-led model of health care. It does so through an increasing emphasis on a patient centred, care driven model of nurse practice, underpinned by a holistic model of health and elaborated by means of a discursive reworking of the centrality of caring activity as skilled and indeterminate, theoretically informed activity at the core of the new nursing role."

Witz, 1994, pp. 24.

Witz asserts that nurses rather than doctors are in a prime position to respond to the policy driven changes in the health service. However, other research suggests that this is not necessarily the case. The effects of professional status upon the activity of community psychiatric nurses (CPNs) was investigated by Morrall (1997). Freidson's interpretation of worker autonomy as an indicator of status was used to underpin the work. It involved a two year study of the activity of CPNs working in four community mental health teams through the monitoring of 25 new referrals received by each of them. The practitioners were interviewed weekly about the clients being monitored and their treatment and management of each person including inter disciplinary and cross agency working. The complexities of who has the power to refer to who was clearly demonstrated in that CPNs accepted inappropriate referrals from psychiatrists to maintain good working relationships. This compliance had another benefit in that it enabled them to have greater levels of autonomy at other times. Evidence indicated that although the CPNs did not overtly refuse any referrals, they controlled their caseloads through their subsequent activity; for example taking decisions about frequency of contact and discharge. Furthermore, these decisions were largely taken in the absence of supervision or other professional opinion. Morrall concluded that the CPNs had achieved autonomy, but it was not socially sanctioned but by default. He also observed that an arbitrary method of decision taking did not benefit service users.

The drive to acquire control and autonomy is demonstrated through the power occupational therapists readily exert over the unqualified staff responsible to them. Wallis (1987b) comments upon the relatively high numbers of unqualified occupational therapy support staff, placing this in the context of need outstripping demand and the use of these assistants to undertake tasks which do not demand skills acquired through lengthy training. This is a slightly different interpretation to that made by Harrison and Pollitt, who suggest that unqualified staff can conveniently carry out less attractive aspects of the job. Green (1991) undertook a qualitative study of the relationship between occupational therapists and helpers. Her findings support a hypothesis of control, in that occupational therapists sought to limit the power of unqualified staff responsible to them and were preoccupied with their own professional status. Green interpretes her findings within a feminist paradigm;

"...in order to pursue their quest for professionalisation, occupational therapists have unwittingly adopted the male model in which the helpers, although treated with respect and affection are nevertheless women in a 'man's world', the occupational therapists being the go-getters engaged in the 'real work'."

Green , 1991, pp. 55.

The work of Goldie (1977) throws further light on autonomy and power in health settings through research in the setting of a traditional mental hospital. His research involved interviewing 38 psychiatrists, 38 social workers and 27 clinical psychologists about their work, their relationships with other workers and perceptions of mental health problems and treatment methods. From the analysis, he drew the following conclusion;

...it is believed that professions can be differentiated from other occupations by their generally higher salaries, status and legal privileges. The possession of (or seeking after) these and other attributes should not obscure the more fundamental question of how members of a profession attempt to gain and preserve control over the practice of certain activities.

Goldie, 1977, pp. 141

Therefore, Goldie suggests that while autonomy is a key feature of professionalism, within organisations, power is a dynamic concept which shifts. Even though there may be a superficial appearance of unity and autonomy across professional groups, at practitioner level this was not apparent. Acquisition of control by the individual was paramount through the ring fencing of activities. In common with the later work by Morral (1997), Goldie also found that for professions other than medicine, some degree of control was greatly facilitated through overt compliance with psychiatrists. The work of Guy (1985) also points to holes in the notion of professional unity within a mental hospital setting. She conducted a questionnaire survey to members of different professional groups in two mental hospitals to explicate and quantify the preferences which underpin decisions taken by individuals; her theory proposing that preferences are shaped by values as well as the desired goal. Rather than supporting the supremacy of professional unity, Guy found that a number of other variables were more potent. These included the demands of the job, rank rather than profession and the dynamics of the immediate work setting.

Theoretical work and applied research in health care settings all come to the same conclusion. The gaining and maintaining of autonomy is a central concern of all disciplines including occupational therapy with the consequence that it shapes what activity is undertaken and how it is carried out. This is exemplified by the effect of professional autonomy upon the relationship between health worker and service user. Furthermore the desire for autonomy by the individual may override allegiance to their professional grouping.

Professionalism and the caring relationship

In his examination of the power exerted by the caring professions, Hugman (1991) highlighted the uneven balance of power within relationships; for example the lesser value placed upon the views of service users compared with professional goals. All occupations in contact with users of health and

social care profess to be 'caring professions.' However, professions like medicine claim to care about whereas the predominantly female professions of nursing, social work and professions allied to medicine are directly involved in caring for (Hugman, 1991). As direct caring is perceived to be a low status activity, involvement in it can erode the perceived extent of professionalism. Occupational therapists have a different professional ethic to that described by Hugman in that they claim to be enablers rather than direct carers (Stewart, 1994) However, as this enabling is also a direct interaction between clinician and service user, within Hugman's construct this is still a low status activity. A paper by Woodward (1997) discusses the factors influencing caring by nurses. Her analysis entails the application of expressive and instrumental explanations of caring. Expressive caring is an emotional approach to care which involves responding to individual needs. Instrumental caring is an objective method of meeting health care needs where predetermined actions are carried out. While such actions are grounded in skills and knowledge, application of instrumental caring alone can mitigate against an individualised approach. She argues that in the current political and organisational climate, nurses are being encouraged to develop more sophisticated knowledge and technical skills. While this may further personal goals and professionalisation of nurses, it may marginalise expressive caring.

"Without discerning contemplation of the impact of change and counter-measures to preserve the integrity of caring, professionalization may marginalise and disunite the very skill that practitioners claim to profess."

Woodward, 1997, pp. 1003

The conflict of interest described by Woodward has also been observed on the part of occupational therapists in America. Peloquin (1993) noted three factors which place competence above caring; namely a fixation with the health care problem, an emphasis upon protocols and a health care system driven by a business mentality. As the 1990 health reforms were largely derived from American business models of care delivery, it is not surprising that the observations of Peloquin have been replicated in occupational therapy services in this country (Lloyd Smith, 1994).

The need for policy controls upon professional behaviour within the context of the user and professional relationship was raised by Wilding in 1982 prior to the health reforms. He proposed that these controls should include taking service users' knowledge into account, a greater recognition of the rights and needs of users and a greater accountability both to other workers and to service consumers. The effects of Community Care policy has promoted the concept of user empowerment described by Wilding in 1982 by demanding a shift away from a totally professional process to one which actively involves users and carers. Policy (DoH,1990) legislated that this would be achieved through needs based assessment and provision of services to meet needs, rather than individual's needs being professionally defined and fitted into existing services. The drive to centralise the needs of users and carers continues with accompanying legislation; for example the introduction of the Carers Recognition and Services Act in 1995 gave carers entitlement to assessment independent of the person they are caring for. Despite these clear messages, practitioner response is failing to keep pace with the speed of reform. Some of this reluctance will be rooted in

longstanding custom and practice together with lack of clarity about how to reconcile needs based assessment within eligibility for services (Caldock and Nolan, 1994). However, it is also apparent that the drive for professional status also mitigates against a user focus. Harrison and Pollitt (1994) discuss how clinical professions as well as medicine have adopted a professional stance in their relationship with patients; for example deciding the frequency of patient contact. The view expressed by Williams (1993) was that professions allied to medicine have to move away from the medical model of care towards a social or holistic model if they are to respond appropriately to the patient/carer relationship.

Lipsky (1980) proposed that self regulatory behaviour by professionals may serve the purpose of limiting policy which mitigates against service orientated goals. However, through a consideration of the other effects of professionalism; for example autonomy, accountability and professional norms, he came to the conclusion that professionalism does not facilitate a better service for users. The dilemma between meeting the needs of users and carers and furthering professional status is underscored in occupational therapy by Wallis (1987a) who in accord with medical colleagues, acknowledges the importance of the relationship between the occupational therapist and client, but locates it in the context of a challenge on behalf of users;

"A profession cannot afford to be complacent when constantly questioned and challenged by well educated clients...."

Wallis, 1987a, pp. 265

Training of health workers and development of specialist knowledge

The role of training in the instillation of professional values as described by Harrison and Politt, (1994) is discussed by Beattie (1995) through an examination of the training of nursing and medical staff. Bernstein (1971) quoted by Beattie (1995) identified two approaches to curricula teaching. The first he termed the *'collection code'* where students are taught separately and comparison between subjects is discouraged. The second or *'integrated code'* is where active connections between different subject matter is sought. Beattie suggests that both medical and nurse training in the past have adhered strongly to the collection code. In medicine, this has served the purpose of segregating and mystifying professional knowledge. In nurse training, exposure to different versions of nursing reduces learners to a state of uncertainty, obedience and conformity. The purposes this can serve is illustrated through the work of Mackay (1995) which looked at the power exerted by doctors and nurses. She described the patient as a pawn in professional power play. Nurses will be overtly deferential to doctors and dissuade patients from questioning medical decisions for a complex mix of reasons; two examples cited were self protection and inculcation during training. The validity of the theory of nurse training suggested by Beattie was confirmed through the research conducted by Melia (1987) who employs the term *'occupational socialization'* to describe the process by which student nurses are trained and become embedded into the culture of nursing. One of the problems for student nurses identified by Melia is the difference between the ideal taught in training schools and the reality of ward life. The previously reviewed theories of

professionalism underscore the meshing between those occupations which consider themselves to have professional status and the work setting within which they operate; for example Lipsky (1980) puts forward the following hypothesis;

"...the most powerful agent in professional socialization is the work setting. Thus it is the extremely rare newcomer who is able to assert unacceptable or unsanctioned values. The education of new recruits as to what is acceptable, what is appropriate and what will enhance one's career is an extremely powerful determinant of future professional behaviour."

Lipsky, 1980, pp. 204

Therefore, while training might play a part, Lipsky suggests that it is the setting where the individual works which is more potent, explaining the dilemma experienced by the student nurses in Melia's study.

Trait and functionalist theories centralise the importance of the acquisition of specialist knowledge, but application of a more critical approach suggests that this is not necessarily the case. While increasing the level of training to acquire the necessary skills, education also has the effect of increasing understanding by those outside the occupational group and increasing the fragmentation within it. This is observed by Etzioni, a trait theorist;

"....the desire to pass for a higher status group produces pressures which split the group into those closer to the 'passing' limit and those more remote, thus weakening both subgroupings in the societal give and take."

Etzioni, 1969, pp. Vii

The lack of homogeneity within an occupational group which considers itself to be a profession is a further complexity observed by Melia (1987), who underpins her thesis with the concept of segmentation within the nursing profession. A similar conflict can be observed in occupational therapy. The discipline of occupational science arose out of the search for a philosophy to underpin occupational therapy, but it is now developing as a separate professional entity. Lunt (1997) describes the continuing debate about the future of occupational science, which embraces the previously discussed debates about terminology. Some champions of occupational science promote the notion of separation from occupational therapy. The question posed by Lunt (1997) is whether occupational scientists (as they are being called) will pursue higher status through academia while leaving occupational therapists to carry out the lesser status, practical tasks.

Ovretveit (1992) applied the theory of dominance developed by Freidson (1970) to an examination of the management and organisation of localised clinical psychology and physiotherapy services, generalising his findings to other therapy professions, including occupational therapy. He found that professional control through training, qualification requirements for entry into training and state regulation through registration did not support professional autonomy. From his results, Ovretveit postulates that it is how professions are organised and the extent of authority rather than autonomy given to them by the state, by the general public and by service users which are potent factors in determining future survival.

Since 1991, in common with other professional groups, demands have been made upon occupational therapists to research their practice. Although this policy initiative aims to support research and development and promotion of evidence based practice in health and more latterly social care settings, it also feeds into an acquired list of traits upon which notions of professionalism are based. Within a critical approach to professionalism, it also raises questions about the value of specialist knowledge; perhaps it has increased currency in light of most recent health reforms (DoH, 1997a). The value of specialist knowledge in health is supported by Southon and Braithwaite (1998) through a critical appraisal of the effect of health service reforms upon professionalism. They argue that the complexity of tasks undertaken by clinicians are simplified within the policy framework and it also presumes that general managers will have knowledge about different professional groups which they might not possess. Further to this they suggest that professionalism has a part to play which is not being adequately recognised because the tasks being carried out are not fully acknowledged and understood. Southon and Braithwaite suggest that task analysis of the work of professional groups is necessary to unravel the role of professionalism in health.

The importance of specialist knowledge remains unclear; is it merely a demonstration of status or is this a gross simplification of the issues? This thesis is centrally concerned with the work of occupational therapists with older people with mental health problems. Therefore, the previous arguments must be placed in the context of the demands arising from these service users and their carers.

The Demands of Working with Older People with Mental Health Problems

Hugman et al (1997) identify the interplay between policy and health and social care professions and the unrealistic expectations which can result.

"Throughout the history of the welfare state the professions have played a central role. Not only have they been the vehicle through which policy has been implemented in practice, but also their skills and knowledge frequently have come in many instances to be synonymous with the alleviation of health and welfare problems."

Hugman et al, 1997, pp. 10

Older people (and in particular those with mental health problems) present a real challenge for occupational therapy; for example:-

- The problems older people with mental health problems present with both in terms of their complexity, and their often chronic nature.
- The demands these problems place upon the workers concerned, and the skills required to manage them.
- The neglect of older people by policy makers until relatively recently.

The above points will now be explored in more detail.

The complexity of problems

Barnes (1997) suggested that the needs of older people with mental health problem warrant attention from a skilled workforce, particularly for risk assessment, service provision and protection. The requirement for skilled intervention can be attributed to several factors. Firstly, as well as the difficulties associated with ageing, for example increasing physical frailty and deteriorated vision and hearing, older people with mental health problems have to struggle with the consequences of poor mental health. Secondly, older people with mental health problems are a highly heterogenous group. They include people with functional mental health problems like depression; those with dementing illness, for example Alzheimer's disease and people who have had mental health problems for a protracted length of time and grown older. Thirdly, as with older people per se, needs are exacerbated for those who live alone, and those who do not have an informal care network (DoH, 1997b; Barnes, 1997). Therefore, the specific circumstances of each individual also have to be taken into account; for example cultural and ethnic origins and socio-economic circumstances. Finally, the needs resulting from such problems have no respect for the health/social care divide and frequently cross over it, demanding multi disciplinary, multi agency intervention.

The severity of problems encountered by specialist mental health services is exacerbated by inadequate early detection of mental health problems in older people, even when there is contact with primary health care and social care. Banerjee (1993) demonstrated the extent of undetected mental health problems in a group of older people receiving social care. Through the application of standardised measures he revealed a 13.6 per cent undetected incidence of depression and 11.8 per cent incidence of dementia. Banerjee concluded that the training needs of social care staff in this area were not being addressed. A similar problem exists in primary care. The results of a questionnaire survey to GPs by the Alzheimer's Disease Society (ADS, 1995) showed that of the 691 who responded, 71 per cent felt that they were not adequately trained in the management of dementia. The study also involved a questionnaire survey of 2,024 carers. Responses confirmed that detection of dementia by GPs was inadequate; for example carers reported that 36 per cent of people with dementia were not referred to specialist services and in 30 per cent of cases dementia was misdiagnosed as either depression or problems of old age. It can be concluded that by the time the existence of functional mental illness or dementia is confirmed, some kind of crisis is likely to have occurred.

Working with older people with mental health problems also necessitates working with their carers. While the caring role often occurs within families, it can extend to friends and family also. Furthermore, the majority of care is provided for older people by older people (Parker and Lawton, 1994). The research by Levin et al (1994) showed that 40 per cent of 287 carers of older people with dementia were ill or disabled themselves, and over half were spouse carers. Implementation in 1996 of the Carers Recognition and Services Act (1995) gives carers a right to assessment of their own needs provided that the person they are caring for is also being assessed. While there is no entitlement to services following assessment, this Act does signal the beginning of more formal recognition of the contribution of carers. Existing work on the needs of carers promotes the value of

information, home support, day and respite care and advocacy in supporting carers to continue in their caring role (DoH and SS, 1994; Barnes, 1997). Information needs articulated by carers include having an understanding of the illness and its prognosis, knowledge about services and how to access them and responses to situations which are causing anxiety like charging policies for community care.

To work effectively with this user group, occupational therapists and other health workers have to be familiar with, and make appropriate responses to the range of problems stemming from very different mental illnesses. They must also be able to manage the consequences of ageing and physical frailty. Additionally, they must be prepared to work with carers, particularly as contact with secondary mental health services will more than likely have been precipitated by a crisis (Levin et al, 1989). There is no doubt that the specialist skills required to meet these needs are those located within the rubric of professionalism.

The demands placed upon the workers concerned

The need for input from a range of agencies to cope with the problems of mental ill health in old age is being promoted by central Government (DoH, 1997b). It is generally agreed that for older people with complex needs, multi disciplinary and multi agency involvement is essential. The ideology underpinning this method of service delivery is described by Hernan (1994);

"One of the primary arguments for interdisciplinary care addresses the need for treating the 'whole person' instead of having a fragmented focus. Other reasons include preventing duplication of services, providing an efficient method of service delivery, and ensuring prompt access to the expertise of more than one health discipline."

Hernan, 1994, pp. 199-200.

If it works well, the benefits of an integrated approach for service users and carers are evident in that it enables appropriate and timely responses to be made as needs change over time. However, the difficulties working in this manner poses for established professional groups cannot be underestimated for example Rawson (1994) and Mackay et al (1995) discuss the problems arising from perceived and actual professional status, extent of expertise/ knowledge, views of the relevance of that specialist knowledge by other occupational groups and a lack of trust regarding the allegiances of other professional groups. It appears that working in the manner deemed to be most productive for the service user and carer can also serve to erode the foundations upon which professionalism of health and social care workers is built.

Involvement with this group presents further problems for the staff concerned. Work with older people with mental health problems is complex and demanding and more often results in maintenance of the status quo rather than cure. While being unable to provide a cure has always been problematic, particularly for medicine, this is now reinforced by the current move towards evidence based medicine (Muir Gray, 1997) where demonstrable proof of benefit is the desired outcome. Yerxa, (1992) observed that when cure is not achievable, medical staff scrutinise the role and contributions of other professions. The long term effects of working with a chronic in-patient

population where maintenance rather than cure is the likely outcome is well documented, with the ultimate consequence being staff burnout. This is defined as loss of idealism and purpose experienced by people working in the caring professions (Bailey, 1985; Edlewich and Brodsky, 1980), leading to deterioration in patient care. Previous work has examined the relationship between job satisfaction experienced by clinical practitioners and job performance (Mountain, 1990 and Hoffman and Ingram, 1991). Results suggest that job satisfaction of the workforce has a direct impact upon the quality of the service received by the users of that service. Flett et al (1994) propose a relationship between job satisfaction and availability of ongoing training, which in turn impacts upon the performance of the practitioner. While training can offset the effects of disillusionment with the job, criticism and poor team working is likely to result in poor job satisfaction and poor quality care. Therefore, if they are unsupported in their work, the stresses placed upon occupational therapists and other workers are potentially severe.

The policy neglect of older people with mental health problems

Finally the previously described demands have to be placed within a wider health and social care agenda. Until very recently, older people with mental health problems was a neglected area both in terms of resource allocation and staff recruitment. A mapping exercise of provision conducted in 1997 (Mountain, 1997a) confirmed the inadequacy of services for older people with mental health problems, with service commissioners in some areas prioritising the development of another cinderella service, adult psychiatry. There is no doubt that services for older people with mental health problems have been neglected in favour of higher status acute provision. Thus, it could be argued that working in such a neglected service can further detract from the status of the individual worker.

Emergent Themes

The problem posed by this thesis is what do occupational therapists working with older people do, and why do they do it? To start to address this question, literature has been explored to determine what factors might shape the nature of that activity. This included literature concerned with:-

- professionalism in health and social care, related to occupational therapy;
- policy demands with respect to health and social care delivery and responses on the part of health care workers, including occupational therapists;
- the needs of older people with mental health problems;
- the consequences for staff, of working with a user group who have complex, chronic needs.

Through a synthesis of this literature, three main themes emerged.

The need for a critical appraisal of professionalism in occupational therapy

Existing literature fleshes out concepts of professionalism and describes the effects of the drive for professional status upon health care delivery. Despite this body of knowledge, up to now, the consequences of professionalism upon occupational therapy has only been addressed incidentally,

and it is a neglected area of research. Moreover, the majority of existing work ignores power theories of professionalism in favour of the acquisition of a list of traits as proof of status.

This review has confirmed that a trait approach to professionalism in occupational therapy is fundamentally flawed. While factors like training programmes, codes of conduct and state regulation contribute toward recognition; power and status together with market demand for the services provided are far more potent determinants of status. Therefore, occupational therapists need to move away from defining characteristics, toward a paradigm which seeks to explain the dynamics underlying their relationships with other disciplines, with users of the service, with policy makers and with the general public.

Adoption of a critical theory rather than a trait approach to professionalism demands that occupational therapists examine their achievements and activity in a different light than before, raising some uncomfortable questions. A model concerned with the balance of power across different stakeholder groups within the context of historical and present day influences (including those arising from policy implementation) questions the reality of the professional status of occupational therapists. Two overarching questions emerge from the literature. Firstly how can occupational therapy emulate the development of established groups like medicine given the historical and present day differences between the two disciplines? Secondly, given the enabling role occupational therapists attribute to themselves, how compatible is this with the drive for professionalism?

Professional status and policy demands

Existing evidence highlights the mismatch between aspects of professionalism and the goals of policy. Some demands made by policy are rooted in the desire to create a better service for users and their carers; for example the development of a client centred approach and inter professional and inter agency working (being strongly promoted with respect to older people). However, a second set of demands are overtly concerned with curbing professional behaviour; for example the introduction of general management in health in place of professional line management. In spite of these pressures, there is plenty of evidence of the continued endeavour to improve professional status on the part of medical and clinical occupations. It is also evident that in situations where medicine is pursuaded to relinquish some of it's power, other occupations are all too ready to take that place. This is often rationalised in terms of providing a superior service to that possible through a medical model.

Conflicting influences upon the clinical activity of occupational therapists

The literature confirms that occupational therapists still feel the need to prove their status even though the incompatability of this drive with an approach focused upon the needs of the user emerges from the work on caring and professionalism. This creates conflict for occupational therapists, particularly when one of the claims made by this discipline is that they adopt an holistic approach to treatment and care.

The importance of unraveling the effects of differing demands upon the activity of occupational therapists is confirmed by another body of evidence concerned with the individual in the workplace. The results of empirical research as opposed to theory suggests that a further set of goals concerned with the power and status of the individual in the workplace can shape decision making and activity. This may override the demands of the professional group to which that person belongs. Therefore the desire for status may be a more fundamental human need which has to be satisfied, the professional group being one means to this end.

Conclusions Drawn from the Literature

While this project set out to explore and understand the activity undertaken by occupational therapists, existing literature confirms that this activity does not occur in a vacuum. It can be subject to a potentially large number of influences. Some are clearly necessary and should not be ignored like those created by current policy thinking; some are desirable like maintaining ideology of service; and others have the potential to be adverse, for example the effects of some aspects of professionalisation upon relationships with service users. A synthesis of the literature confirms the tensions that this must create, both for the individual and for occupational therapy as a discipline. However, even though existing work draws attention to this conflict, it does not describe how this is played out in practice on the part of occupational therapists. The next chapter will use the themes drawn from this literature to create a theory of occupational therapy activity to be tested through this research.

CHAPTER TWO

THEORETICAL AND METHODOLOGICAL FRAMEWORKS

Creating a Theory of Occupational Therapy Activity

The themes drawn from the literature in chapter one raise many questions for research, particularly as the activity of occupational therapists in health settings has only received scant examination in the past. Given the themes of conflicting policy demands and personal goals as well as the needs presented by older people with mental health problems and their carers, what are the major tensions experienced by occupational therapists and how are they managed? What are the consequences of these tensions upon their clinical activity, particularly when working with a highly vulnerable user group?

The following aims of this research were identified:-

Firstly; To determine what services occupational therapists, working with older people with mental health problems perform, and the different tasks they carry out;.

Secondly; To explore how worthwhile this activity is from the perspectives of key stakeholders (including the occupational therapists themselves, service users and other key professional groups) taking into account the current health and social care policy framework.

Thirdly; To identify both the overt and covert influences upon the profile of activity which emerges, so that occupational therapists are able to objectively evaluate their work in the future.

Professional confidence

To start to address these aims, a theory of occupational therapy was developed out of the existing knowledge and evidence base.

Within the scope of this work, the term ***'professional confidence'*** is used to describe the range of factors which the literature suggests may influence the clinical activity of occupational therapists. Therefore, these factors might include the skill base a person possesses and clarity about professional role (Southon and Braithwaite, 1998), recognition of their profession at a strategic policy making level (Boyce (1997), acquisition of status and power in the work setting (Goldie, 1977 and Guy 1985) and their job satisfaction (Mountain, 1990). Therefore professional confidence contains a range of intrinsic and extrinsic variables, some of which are likely to conflict.

Primary Research Hypothesis

The primary hypothesis developed from the literature described in chapter one, tested through this thesis is as follows:-

The variables contained within professional confidence will shape clinical judgements and be demonstrated through the tasks undertaken by occupational therapists during their working day. Therefore, the activity undertaken by occupational therapists is symptomatic of their ability to discern between those variables within professional confidence which are both necessary and enhance practice, and those which should be avoided.

The relationships between activity, decision making and professional confidence postulated by this hypothesis are shown in figure 2.1 below.

Figure 2:1 - Occupational Therapy Activity: Initial Hypothesis

This research is designed to identify the range of variables contained within professional confidence and explore their differential effects. Therefore, if the research hypothesis is supported, the following will also pertain:-

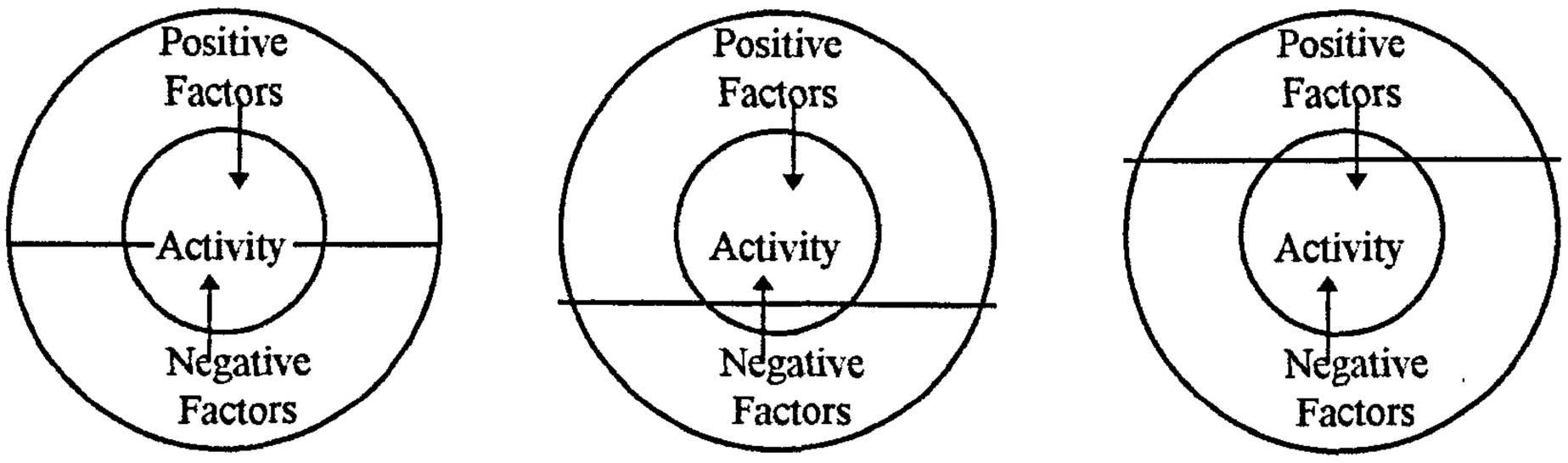
1. The combination of variables within professional confidence will have a direct impact upon clinical judgements.
2. Clinical judgements will underpin clinical activity and determine the quality of service ultimately experienced by the service user and their carer.

Secondary hypothesis one: the combination of variables within professional confidence will have a direct impact upon clinical judgements.

The literature reviewed confirmed that professional confidence will be made up of a large number of intrinsic and extrinsic variables, some of which may conflict; for example meeting the needs of users and carers is unlikely to be compatible with the desire for professional advancement (Lipsky, 1980). The literature also confirmed that it is unrealistic to occupational therapists to entirely abandon the desire for recognition of professional status. However, if the desire for increased status is greater than, for example, the satisfaction to be gained from meeting the needs of users and their carers, clinical activity is likely to be skewed away from the user toward meeting goals concerned with professional advancement. Therefore, as well as the mix of variables contained within

professional confidence, a further aspect of interest is the balance of variables it contains and how this balance can be tipped. If the postulated relationship between professional confidence and decision making is supported, clinical judgements will be shaped by the relative strength of variables within professional confidence. This relationship is illustrated in figure 2.2

Figure 2:2 - Postulated Impact of Balance of Variables in Professional Confidence



Equal Balance: Positive and Negative Variables

Greater Influence: Positive Variables

Greater Influence: Negative Variables

The primary research hypothesis suggests that the mix of variables contained within professional confidence directly influences clinical judgements and resultant activity. Figure 2.2 suggests that if variables like clarity of role, awareness of policy and specialist knowledge predominate, they are likely to lead to sound clinical judgements and result in activity which is centred upon the needs of the older person and their carer. Conversely, if variables like the drive for status and autonomy are stronger, their influence will mitigate against well founded clinical decisions; for example a uni disciplinary approach to treatment and activity, and activity which is geared toward increasing status in the workplace. A predominance of these variables is clearly less likely to result in activity which is located in the needs of the service user and their carer.

Secondary hypothesis two: clinical judgements will underpin clinical activity and determine the quality of service ultimately experienced by the service user and their carer.

The concept of quality in itself is complex and difficult to define because it is located in subjective decisions and will change according to values set by current policy (Kogan and Redfern, 1996). In his construct of quality of medical care, Donabedian (1980) maintains that quality is an attribute that all care will have to a greater or lesser extent.

.....the basis for judgement of quality is what is known about the relationship between the characteristics of the medical care process and their consequences to the health and welfare of individuals and of society, in accordance with the value placed upon health and welfare by the individual and society.

Donabedian, 1980, pp. 79-80

In this study, the construct of quality described by Donabedian, will be judged through the occupational therapy activity experienced by the older people in receipt of the service and their carers. If the primary research hypothesis is supported, professional confidence will ultimately determine the quality of service determined by the service user and their carer. This is illustrated by figure 2.3.

Figure 2.3 - Determinants of Quality Clinical Work

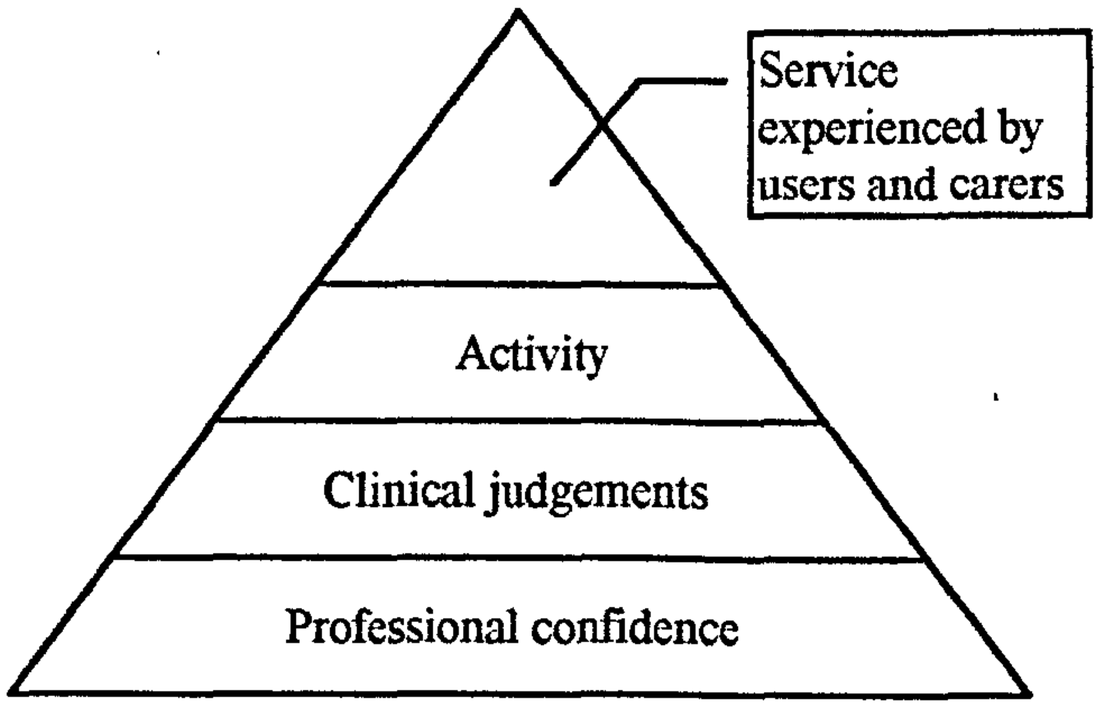


Figure 2.3 proposes that clinical judgements are grounded in professional confidence. Clinical judgements will determine the activity undertaken by the individual occupational therapist. Users' and carers' views of the service will be located in their experiences of this clinical activity. Therefore, professional confidence is pivotal in determining service quality.

Given the evidence which promotes the overriding importance of individual status in the workplace, a key question which will be addressed through testing the research hypothesis is whether occupational therapists behave like the workers in the study of Guy (1985), using their status as a means of personal advancement? Or will they remain deferential to psychiatrists in an effort to retain control over certain tasks (Goldie, 1977 and Morral, 1997)? Alternatively does belonging to the occupational therapy profession help occupational therapists to withstand potentially negative influences which can exist in health care settings and build on positive attributes, thus maintaining an ideology of service, demonstrated through their activity?

Testing the Hypotheses Through a Model of Occupational Therapy Activity

This research is focused upon occupational therapists working in a complex organisation, the health service. A substantial literature (Hugman, 1991; Ovretveit, 1992 and Harrison and Pollitt, 1994) together with personal experience confirm that health settings are a hotbed of conflicting goals and demands. Therefore, while data on activity is readily accessible, in order to interpret the results with respect to the research hypotheses, it must be located within the context of the world where

occupational therapists have to operate. This is substantiated by the views of Turner and Hodge (1970) who promote the links between activity analysis and wider organisational evaluation;

"The analysis of any occupational organization or of categories of persons denoted by any one occupational label can be usefully approached by attempting to identify both the parties (individuals, groups, networks and formal organizations) involved in the carrying out of occupationally related activities and the properties of the activities themselves."

Turner and Hodge, 1970, pp. 49.

A preliminary model of occupational therapy activity was designed to test the hypotheses in the work setting of occupational therapists.

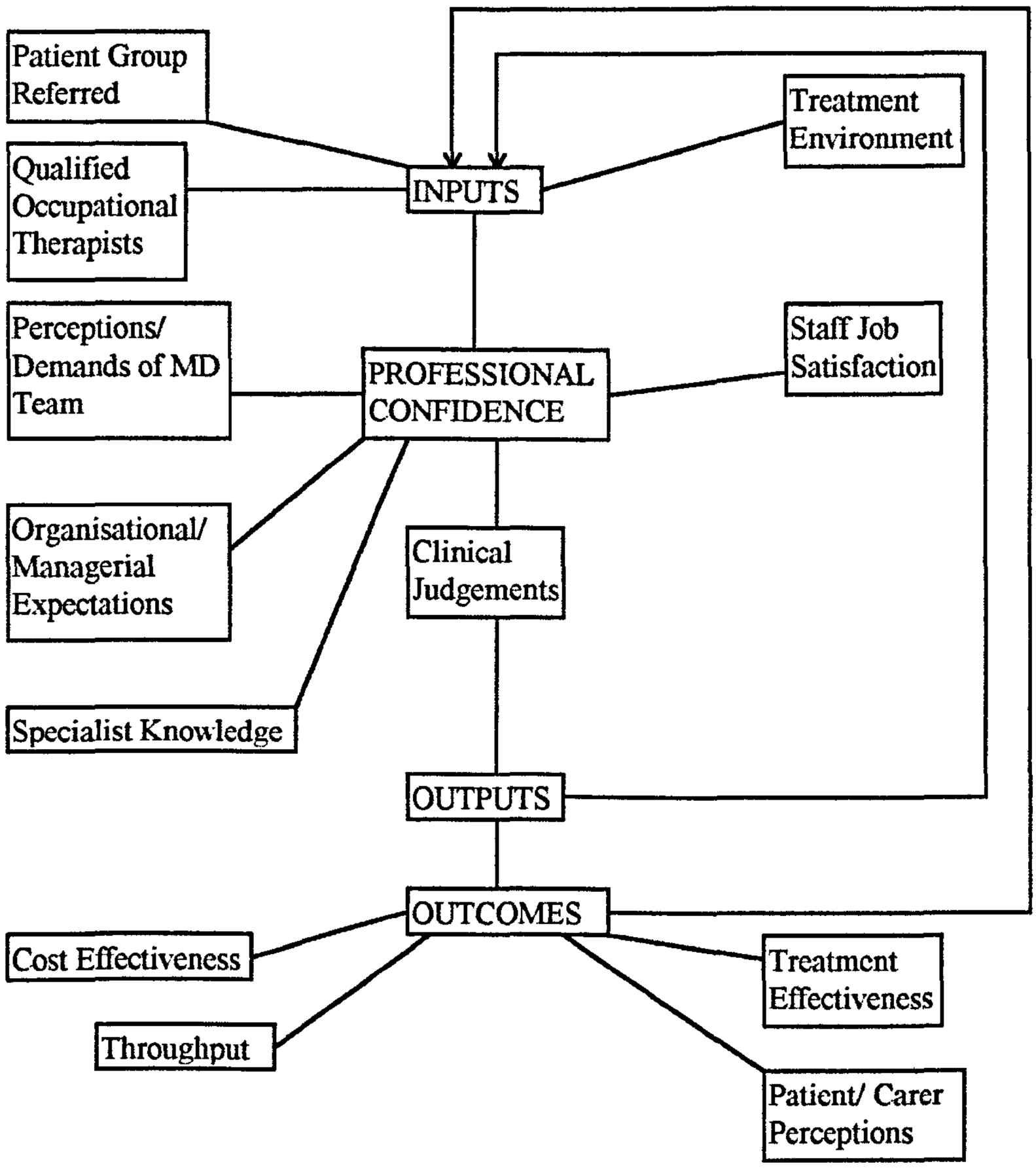
The two main functions of the model were:-

1. To identify what needed to be measured to fully test the research hypotheses.
2. To place occupational therapy activity within a service setting; with research providing an evaluation of the accuracy of the model in terms of the identified variables and the relationships between them.

The system based framework of structure, process, outcome model for evaluation of health services first developed by Donabedian in 1966 (quoted in Donabedian, 1980) was a starting point for development of the model. The proliferation of audit and quality assurance in health care, as well as the focus on quality in this project made this model particularly appropriate (Sale, 1997). In the Donabedian model, *structure* refers to aspects of service provision, for example buildings, equipment and staff to do the work, *process* is the process of service delivery including the interactions between workers and service users, and *outcomes* are the consequences of the interventions. Donabedian stressed the importance of outcome in terms of change in an individual's status, thereby including social and psychological as physical outcomes. The functional relationships between each of the elements is that structure results in process and process leads to outcomes. Kogan and Refern (1996) note the limitations of the Donabedian model in that it concentrates upon the patient/therapist relationship and neglects external influences which all contribute to patient outcomes; for example communication and cooperation and the demands of current policy.

The model developed for the purposes of this project accords with framework suggested by Donabedian, but takes into account the observations of Kogan and Redfern (1996), through acknowledgement of the many internal and external influences upon activity and outcomes. This is achieved through incorporation of the professional confidence/ clinical judgements/ activity hypothesis of occupational therapy activity (figure 2.1). It is shown in figure 2.4

Figure 2.4 - Postulated Model of Occupational Therapy Activity



The model predicts the existence of the following variables and the relationships between them but does not make inferences about their power:-

The identified **inputs** to occupational therapy activity are:-

- ***qualified occupational therapists*** - identified by clinical grading (Basic Grade to Head III)
- ***the patient group referred*** - denoted by age band, sex and diagnosis and including those with functional mental illness as well as those with dementia
- ***the treatment environment*** - the setting where occupational therapy takes place

Drawing upon the literature previously reviewed, it is postulated that the following variables will make up professional confidence:-

- ***application of specialist knowledge*** - the knowledge base possessed by occupational therapists working with older people with mental health problems, together with knowledge of other involved agencies and the demands of policy
- ***job satisfaction experienced by occupational therapists*** - measured and perceived
- ***organisational and managerial expectations*** - exemplified by policy demands

- ***the expectations and demands of the multi disciplinary team*** - views of the team as well as the tasks allocated to occupational therapists

Clinical judgements made in response to a treatment stituation will be shaped by the mix and balance of variables contained within professional confidence

The **output** from clinical judgements is the:-

- ***Occupational therapy received by each service user***
- The **outcomes** of occupational therapy are defined as:-
- ***user and carer satisfaction with the service***
- ***the success of treatment*** - Both measured outcomes and opinions of success
- ***service throughput and cost effectiveness***

Exploring the Model of Occupational Therapy Activity

Research design

A series of four linked studies were designed to examine the model of occupational therapy activity, and through that to test the research hypotheses. Each study had it's own remit with respect to different components of the model.

The specific questions related to each of these studies were:-

Study one

1. How can a valid and reliable method of recording activity be devised?
2. How can staff perceptions of their activity be ascertained?

Study two

1. What activities do occupational therapists working with older people with mental health problems carry out?
2. How does activity vary within the same service and what are the reasons for variance?
3. What are occupational therapists' perceptions of their activity and how does this match actual activity?
4. What are the factors which most influence activity?

Study three

1. How does activity vary across different organisations and what are the reasons for variance?

Study four

1. What impact does occupational therapy have upon older people with mental health problems and their carers?
2. How do other key disciplines view the activity of occupational therapists?
3. In what circumstances is outcome of activity most likely to be positive?

How these questions address the model of occupational therapy activity is shown in table 2.1

Table 2:1 - Investigative Focus of Each Study

Study	Investigative Focus	Research Questions
One	**Clinical judgements + Outputs**	1. How can a valid and reliable method of measuring activity be devised and applied? 2. How can perceptions of that activity be obtained?
Two	**Inputs+ Clinical judgements+ Outputs**	1. How do occupational therapists working with older people with mental health problems spend their time? 2. How does activity vary and what are the reasons for variance? 3. What are occupational therapists' perceptions of their activity and how does this match actual activity? 4. What factors most influence activity?
Three	**Inputs+ Outputs**	1. How does activity vary across different organisations and what are the reasons for variance?
Four	**Inputs+ Clinical judgements + Outputs + Outcomes**	1. What impact does occupational therapy have upon service users and their carers? 2. How do other workers view that activity? 3. In what circumstances is outcome likely to be positive?

Table 2:1 shows that inputs, clinical judgements and outputs are examined across the four studies, this repetition enabling the cross validation of results (chapter seven). The results of the first three studies set the theoretical propositions for the case study (study four, chapter six), the only study to examine outputs and outcomes.

The research approach

Addressing the research questions demanded a combination of qualitative and quantitative methodologies. An essential pre requisite of the project was the development of a valid and reliable method of measuring the activity of occupational therapists. Given that a further stated aim of the project was to gain perspectives of that activity, in-depth interviews were also conducted so that people could express their views in their own terms. Additionally, an existing robust measure of job satisfaction was selected for application (Warr et al, 1979). Given the wide range of methods used during the entire study, details of the selection and application of research methods is provided within the account of each of the four studies.

Table 2:2 summarises the research strategies and methodologies employed in each study and provides detail of the extent of data collection undertaken.

Table 2:2 -Summary of Methods Used in Each Study

Study + start date	Research Strategy or Aim	Method	Application	Data for Analysis
One *Jan'92*	Devising methods of examining activity	Quantitative	Construction of diary	56 pilot diaries
			Validation	29 validations
			Reliability	16 inter-test checks
				2 inter-rater checks
		Qualitative	Pilot interviews	3 occupational therapists
Two *June 92*	Evaluation of Activity	Quantitative	Application of diaries	38 diaries
			Questionnaires	8 returns
		Quantitative	Depth interviews	11 occupational therapists
Three *Nov 93*	Survey of Activity	Quantitative	Application of diaries	9 diaries
Four *June 93*	Case Study	Qualitative	Pilot interviews	4 users
			Depth interviews	9 users + 2 carers
				3 consultant psychiatrists
				3 occupational therapists
				1 day hospital sister
			Semi structured interviews	1 doctor
				2 psychologists
			Telephone interviews	1 social worker
				1 CPN
				2 doctors
				4 home care managers
		Qualitative + Quantitative	Document audit	9 case records

Presentation of Results

The results and conclusions drawn from each study are provided within the account of each. The totality of evidence collected from all four studies is then examined in light of the research aims (chapter seven).

From its inception, this project had high policy relevance, commencing with the audit initiative mandated in the white paper Working for Patients (1989b). However, the pertinence of the findings

are further enhanced by latest Government policy which places quality at the very top of the agenda (DoH 1997a and 1998a). This is the first time that the activity of occupational therapists working with older people has been placed under such scrutiny; the results of empirical research of this activity being reported in chapters three to six. Further to this, the quality of this activity and how it can be enhanced or eroded is drawn out through discussion in chapter seven of the validity of the model of occupational therapy activity. The final chapter (chapter eight) suggests a new theory to underpin occupational therapy practice, located in empirical evidence, drawing out recommendations for future practice in light of this.

CHAPTER THREE

STUDY ONE - DEVELOPING METHODS OF EXAMINING ACTIVITY

Methodological Considerations

The investigative focus of this first study was the clinical judgements made by occupational therapists and their outputs or activity (table 2.1, pp. 35). This involved the development of a method of accurately measuring activity, and means by which perceptions of that activity from the occupational therapists concerned could be obtained. The methods developed during this first study were then applied in subsequent studies to describe the nature of activity as well as well as to determine the reasons for the profile of activity which emerged.

Measuring Activity

The first step in testing the model of occupational therapy activity was the identification of the range of tasks undertaken by occupational therapists working with older people with mental health problems, particularly as this had never been accurately measured before.

"A judgement concerning the quality of that process may be made either by direct observation or by a review of recorded information which allows a more or less accurate reconstruction of what goes on."

Donabedian, 1980, pp. 79

Policy emphasis upon demonstrating effective clinical practice also suggested that as well as having acceptable psychometric properties, the instrument should be developed so that occupational therapists would be able to use it to audit their own activity in the future.

Activity diaries appeared to be the best method of obtaining information about staff activity within the remit of this research project, particularly given the aim of developing a method for occupational therapists to use themselves.

The use of diaries is a recognised method of obtaining information about activity, the format of the diary and subsequent analysis being determined by the nature of the enquiry. They can be used to quantify the range and nature of activity carried out by individuals and have been tailored to specific health service disciplines; for example Lucas and Austin (1984) developed a diary to record nursing activity whereas Smith, (1988) and Whalley Hammel and Bjore, (1994) examined the activity of occupational therapists using diaries.

The respondent can be asked to provide very detailed information which may be free script or recorded under pre determined categories. Two contrasting examples of the application of content analysis of free script diaries have been described by Robinson (1985) and Pharoah (1989). Robinson, (1985) analysed the contents of the diaries of health education officers to identify training needs. "The Care of Elderly People at Home Project" conducted by the Open University in collaboration with the Policy Studies Institute included an analysis of the diary contents of care coordinators to determine the range and extent of support they were offering to older people in their

care (Pharoah, 1989). The work of Kent (1995) and Whalley Hammel and Bjore (1994) illustrate usage of pre coded activity diaries. Kent (1995) described the process whereby detailed coded activity data was being recorded by case managers (including occupational therapists) intensively involved with severely mentally ill people in the community with the aim of identification and quantification of treatment inputs. Whalley Hammel and Bjore (1994) used pre coded activity diary to quantify and weight the time spent in different types of activity by occupational therapists. The purpose was to more accurately reflect the amount of occupational therapy time received by an individual patient.

Diaries as means of obtaining information about activity can be used in projects involving users and carers as well as professionals. Phillips et al (1994) examined the literature regarding the use of diaries as a means of accessing user and carer perceptions in health and social care research, and commented that this is a valuable, but under used methodology. Given the potential of this method, it is therefore surprising that it is not used more frequently. However, use of diaries can be problematic if the researcher does not ensure that they can be used easily and that the resulting data collection is accurate. There are three main considerations.

Firstly, the accuracy of data collected in diaries is wholly dependent upon the willingness of the participants to accurately complete them. If too much detail is requested and completion takes an unacceptable length of time, cooperation can easily be eroded. Lucas and Austin (1984) report on the necessary simplification of the diaries they constructed for use by nursing staff so that they were acceptable to those who were asked to complete them. A complex range of data can only be requested if the respondents are fully involved in the project and have a 'stake' in it's outcome; for example staff involved in the case management project described by Kent (1995) were willing respondents due to their high level of involvement in, and commitment to, the project even though they were asked to continually record their activity in detail.

Secondly, in the case of pre coded diaries, accuracy of the data will also be dependent upon the extent to which the activity categories are comprehensible to respondents and reflect the true range of work being undertaken. Transfer of a method specifically designed for one group of staff cannot be readily generalised to others without modification. It is therefore a cause for concern that a promotional report on a computerised nursing information system developed by management consultants (Greenhalgh, 1989) and piloted in one hundred hospital units claimed that;

"*This* (ward based nursing) *activity sampling format has also been used for all non ward nursing and other health care professionals including community, theatres, PAM's* (Professions Allied to Medicine) *and junior medical staff."*

Greenhalgh, 1989

Thirdly, the application of pre coded diaries to examine workload and practice in clinical settings is commonplace and there are several documented examples of such tools. However, it is less usual to find research employing diaries which has taken into account issues of reliability and validity. The work of Hurst (1993) is unusual in this respect. He critiqued instruments for nursing workforce planning by reviewing a number of studies with respect to validity, reliability and useability. The

staff involved in the intensive care management scheme (Kent 1995) applied audit techniques to examine the accuracy of their diary data. Although Whalley Hammell and Bjore (1994) developed a tool for occupational therapy workload management, they did not demonstrate it's reliability and validity. How considerations of useability and accuracy were taken into account during the development of the activity diary for use in this project are described in the forthcoming sections of this chapter.

Obtaining Views of Activity

In addition to developing a means of measuring activity, a further requirement of this first study was to develop a method of obtaining views of their clinical activity, from occupational therapists. This would enable an exploration of the relationship between clinical judgements and activity, postulated by the primary research hypotheses. Additionally, this dimension of the project would add to the descriptions of clinical activity undertaken by occupational therapists. One of the disbenefits of valid and reliable measurement of activity is that it necessarily simplifies reality. Therefore, adding a qualitative dimension to this project would also reinvest the data with the richness of actual practice.

Qualitative research explores concepts and ideas within a situational context, the analysis of the data leading to the development of theories. Walker (1985) describes qualitative methods thus;

"The techniques are traditionally termed qualitative for they are generally intended more to determine what things exist rather than to determine how many such things there are."

Walker, 1985, pp. 3

This is expanded by Strauss (1987) who describes the grounded theory approach in qualitative analysis developed by Glaser and Strauss in the 1960's as being the development of theory out of the data. The grounded theory approach to analysis has several features. These include theoretical sampling, making comparisons throughout the analysis, and the application of a coding paradigm during analysis.

The value of using qualitative techniques in health care research has been recognised only relatively recently. Phillips et al (1994) acknowledge the value of applying more than one methodology to health and social care evaluation, suggesting that this leads to a more accurate reflection of what occurs. In her brief review of different qualitative methodologies, Robertson (1988) endorses the application of qualitative methods in occupational therapy research in that the meaning and purpose of professional practice cannot be readily translated into quantifiable variables. This view is echoed in respect of nursing practice by Hart (quoted in Hurst, 1993) who asserts that the emotional, intuitive and creative aspects of nursing are not addressed by analysis of activity because they are intangible and therefore not amenable to measurement.

An additional consideration in this project was the numbers of easily accessible subjects. Researching a small profession like occupational therapy can be problematic due to the relatively low numbers involved, particularly if a sub-specialty within the profession is selected for investigation. Use of qualitative methods is a means of producing rigorous research without the

identification of large population samples. However, use of depth interviews to collect data for research purposes is a time consuming, complex task. Vast quantities of data are produced which need to be presented in a cogent manner for the reader. It is therefore an appropriate tool for research but not applicable to everyday practices, as a matter of routine by practitioners. It must also be acknowledged that projects using qualitative methodologies do not negate the need for larger quantitative studies, particularly in light of the generally inadequate research base of occupational therapy.

The qualitative method chosen in this study was the individual in-depth interview, using activities documented in the diaries as a focus for questioning. According to Patton (1982), the depth interview is a research method whereby the interviewer asks open ended questions in a manner which facilitates a full reply from the person being interviewed. This entails careful development of an interview or topic guide grounded in the research questions.

Depth interviews were piloted with occupational therapists as part of the first study, with the intention of conducting similar interviews with occupational therapists during study two, recounted in chapter four.

Undertaking the Field Work

The subsequent field work to develop the quantitative and qualitative methods of examining staff activity were undertaken in the timescales shown in table 3:1. Diary data were collected from occupational therapists working in both medicine for the elderly and psychiatry of old age during March and June, 1992. A pilot in depth interview was tested with occupational therapists working in medicine for the elderly in September 1992.

The following sections of this chapter briefly describe the three data collections shown in table 3:1 and how the data they yielded contributed towards the construction of methods of exploring the activity of occupational therapists.

Table 3:1 - Timescales for Data Collection during Study One

Activity	Specialty Involved	Time of Data Collection
Collecting diary data	Medicine for the Elderly	March 1992
Collecting diary data	Psychiatry of Old Age	June 1992
Pilot interviews	Medicine for the Elderly	September 1993

Developing an Activity Diary: the First Data Collection

Initial Design of the Diary

A free script diary was designed for use during the first data collection (see appendix one). Occupational therapists were asked to describe their own activity in the relevant columns of the diary. Time slots were introduced so that accounts of activity were recorded for each 15 minutes of the working day. One diary was used to collect activity information throughout the working day.

Collecting the Data

The first data collection using these diaries was carried out by five occupational therapists and a student dedicated to the specialty of medicine for the elderly, working from one occupational therapy department based district general hospital (location C).

The aims of the first data collection were:-

1. To explore the potential of diaries for activity data collection.
2. To obtain data about the activities undertaken by occupational therapists working with older people with general medical problems (the second pilot data collection adds the dimension of mental health problems).

The dates agreed for data collection were two successive days during two successive weeks in March 1992. The diary design faults highlighted during the first week of piloting could then be corrected for the second week. To aid accurate completion, diaries were personally delivered the afternoon prior to each day of data collection, and then collected at the end of every day. Data collection resulted in 18 diaries for analysis.

Analysing the Data

Content analysis identified 108 different activities; shown in appendix two.

The following three steps were taken to categorise all the activities. "The Guide Sheet for Mental Health Nursing Activity Analysis" (Hurst, 1991) was used as a reference document:-

1. All 108 activities were roughly sorted under different groupings.
2. The activity groupings were collapsed into 15 discrete activity categories shown in appendix two. The categories are not mutually exclusive; for example a situation where the patient, informal carers and professionals were all present could be recorded three times. The setting in which treatment is taking place is also clarified within the activity category system.
3. Each activity category was allocated a distinguishing code and each of the 108 activities were also encoded. Classification of each activity therefore embraced the category of the activity to which it had been allocated together with its own specific identifier.

Developing an Activity Diary: the Second Data Collection

Ten qualified occupational therapy staff working in psychiatry of old age in one community and mental health trust partipated in the second data collection. This involved occupational therapists based in five locations; A and B were institutions under closure; C, a district general hospital; D and E were hospitals providing a number of discrete functions.

The remit of the second data collection using diaries was twofold:-

1. To substantiate the range of information obtained during the previous data collection by looking at the activities undertaken by staff working with older people with mental health problems as opposed to physical problems.
2. To provide data for the second study, the results of which are reported in chapter four.

Collecting the Data

The time for this second data collection (during June, 1992) was extended to cover the entire working week of each participant, This would enable an examination of tolerance to using the diary, as well as providing more data for analysis.

The format of the activity diary remained the same as that applied during the second week of the first data collection, (see appendix one). The diaries were delivered and collected daily as before from each of the sites to try and ensure accurate and timely completion.

Analysing the Data

Data collection resulted in 38 diaries. Analysis of their contents revealed an extra 28 activities to the 108 identified through the first data collection. The majority of the 28 related to different aspects of assessment and treatment in a community setting (see appendix two). It proved possible to incorporate all these activities into the existing 15 activity categories.

Extensive validity and reliability studies were conducted to examine the robustness of the coded category system, outlined in forthcoming sections of this chapter, and fully described in appendices three, four and five.

A discussion of the analysis of the content of the 38 diaries is given in chapter four, where the activity of staff working in psychiatry of old age and their perceptions of activity are examined.

Validity and Reliability of the Activity Categories

Activities (108 in total) were extracted from the pilot data sets with minimal alteration made to the original documented accounts (see appendix two). These activities were sorted into the previously described 15 categories. It was considered necessary to examine the face and content validity of the activity categories and their contents to establish:-

1. The extent to which interpretation of the grouping of the extracted activities into the 15 categories could be replicated by independent assessors.
2. Identify any activities which required further clarification before they could be categorised successfully.
3. Following agreement regarding placement, allow certain activities to be collapsed within categories.
4. Provide evidence or otherwise of the autonomy of the categories.

Face Validity

Face validity examines whether the items in a measure are acceptable and understandable to the subjects asked to respond to them. Parry and Watts (1989) point out the importance of subjects' understanding of an instrument. However, face validity is a subjective evaluation and is therefore not considered to be a statistical concept.

Content Validity

Content validity ensures that an instrument represents all the concepts it has been designed to measure. Therefore each item in the instrument must be examined for it's relevance (Kerlinger 1988).

Selected Methodology

In some projects which employ activity diaries, asking a matched group of subjects to complete a pilot diary examines the validity of the information obtained as well as highlighting design faults. This methodology is particularly relevant in research where large samples are involved (Gershuny et al 1986). However the small numbers of respondents involved in this study meant that an alternative method had to be found. Validation was therefore examined using the methodology employed by Lavender, (1984); and described by Anastasi, (1976). This involves a number of experts placing each activity into categories. Degree of validity is demonstrated through the level of agreement about placement of categories demonstrated across the experts, and agreement between the experts and researcher. An agreement of 80 per cent was necessary for accuracy based upon the recommendations of Anastasi (1976).

Three validation exercises relating to the categorisation of activities extracted from the first diary data collection and a further validation of the extra activities identified from the second diary data collection were conducted. The results are provided in appendix four.

Minor Alterations/ Collapsing of Activities within Categories

Use of the activity category system to analyse the first two data sets (described in appendix seven and chapter four) indicated that some rewording and collapsing of activities within categories would simplify and improve the categorisation without affecting validity. Minor alterations shown in appendix four were therefore made to the content of the 15 categories following validation and analysis of the first and second data sets.

Finally the activities within each category were reordered into a logical sequence for ease of use.

Conclusions about the Validity of the Activity Categories

The face validity of the identified categories of activity remained acceptable throughout all the validation exercises, in that all the subjects understood and could relate to the categories of activity described. The majority of activities were categorised with agreement of 80 per cent or above. Activity categories with the most consistent content validity; where no more than one activity has been placed in that category with agreement of less than 77 per cent are:-

- Assessment of a patient within a hospital setting
- Patient assessment/treatment within the community
- Communication with other disciplines within the hospital
- Communication with relatives and other informal carers
- General patient contact

The content of the categories relating to administrative tasks, education and supervision consistently caused most disagreement amongst the subjects. Occupational therapists who participated in the validation exercises demonstrated less clarity about the nature of activities which could be considered to be peripheral to patient care.

The total number of activities included in the final categorisation of staff activity was 122. Of the 122 activities identified, 11 failed to be satisfactorily validated throughout any of the validation exercises. Of these 11; two activities were categorised with 67 per cent and 70 per cent levels of agreement and were therefore bordering upon acceptable levels of agreement; two were subsequently reworded. The two reworded items were not validated.

Reliability of the Activity Categories

Reliability tests were undertaken to investigate the extent to which it is possible to accurately record activity using the fifteen devised categories of activity. Two methods of assessing reliability were selected; inter-test reliability and inter-rater reliability.

Inter-test reliability

This estimated the level of agreement between individuals when categorising different activities. Results obtained through application of the Kendal Coefficient of Concordance (Seigel and Castellan, 1988) confirmed that the inter-test reliability of the diary was high and are provided in full in appendix five.

Inter-rater reliability

Inter rater reliability was an integral stage in the development of a pre coded diary. During the initial pilots of the diary method of recording activity, it became apparent that a pre coded diary would be more acceptable to staff who might wish to use the category system to investigate and quantify their own activity. In addition to ease of completion (following a period of familiarisation with the codes), analysis is greatly simplified by the use of diaries. The introduction of codes would also prepare the category system for computerisation. Therefore following validation, and investigation of inter-test reliability, the diaries were redesigned into a pre coded format (see appendix six). Inter-rater reliability was then used to investigate how reliably subjects were able to record their activity using the pre coded diary. The exercise was also useful in providing feedback about the validity of the diary. The extent of agreement between the subject and researcher regarding the occurrence of different types of activity over the working day was examined using the Kappa Coefficient of agreement (Hartmann, 1977).

Conclusions about the Reliability of the Activity Categories

Through inter test reliability, face validity of the pre coded diary format was demonstrated. The occupational therapists who tested the diaries it said that completion was straightforward; and that the diary was discrete in the clinical setting. Additionally, despite a number of methodological considerations described in appendix five, inter-test reliability was adequately demonstrated.

While both tests confirm the reliability of the activity categories, the difference in the extent of reliability between inter-test and inter-observer reliability indicates that a period of familiarisation with the diary might increase the consistency of recording by subjects.

The reliability of the content of the fifteen categories was not investigated. This was beyond the remit of this project due to the large amount of data which would be required. However, it is something which should be pursued in the future.

Activity Analysis Applying the Activity Categories

The development of the pre coded activity diary greatly assisted activity analysis. Through this work, it became evident that a smaller number of categories would be more helpful for quick analysis. It is relevant to note that the classification of nursing activity by Ball et al (1989) reviewed in Hurst (1993) is restricted to four categories of activity; direct or hands on care, indirect or patient related but remote care, associated work or non nursing duties and non productive time; for example personal study.

The 15 categories were therefore collapsed into the following five:-

Direct Patient Treatment

Activities which involve direct assessment and treatment of a patient:-

- Assessment of a patient within the hospital setting
- Treatment of a patient within the hospital setting
- Patient assessment/treatment in the community[1]

Indirect Patient Treatment

Activities associated with direct patient treatment, as well as other activities where patient contact occurs:-

- Preparation for patient assessment/treatment
- General patient contact
- Escorting patients
- Administration related to patient treatment

Communication

Activities where the occupational therapist is communicating with others:-

- Communication with relatives and informal carers
- Communication with other disciplines in the hospital
- Communication with professionals working in the community
- Communication with occupational therapy staff

Education

Activities which involve learning or teaching:-

- Education
- Teaching/supervision

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[1]As health services are increasingly located in the community, it will be necessary to split this activity into two separate activities in future studies.

Other

Activities which are peripheral to patient treatment:-

- Other administrative tasks
- Other

In order to validate the collapsed categories, a final validation study was conducted, identical to those previously described. Agreement about the categorisation of the collapsed categories of activity was high, with 13 of the 15 activity categories were categorised in to the collapsed category with an agreement of 100 per cent. Results are fully recounted in appendix five.

Conclusions about the Collapsed Categories of Activity

The results of the validation confirm that the five collapsed activity categories can be employed for quick analysis. In-depth analysis can be conducted by examining the types of activity occurring within any category, particularly if specific detail is required; for example a therapist might wish to examine the proportion of treatment time they were spending in activities of daily living as opposed to group work or counselling.

Interviewing Occupational Therapists About Their Activity

Pilot interviews regarding perceptions of role, activity and responsibilities were conducted with individual occupational therapists working in the specialty of medicine for the elderly, based at location C. The purpose of these interviews was to examine the relevance and inclusivity of the pilot interview guide and to explore the success of this methodology as a means of obtaining views from staff about their work; thereby complementing the picture drawn by the pilot quantitative diary data collection.

Designing the interview guide

Questions to be addressed by the interview were :-

1. Why is an occupational therapist required to undertake certain activities?
2. What range of skills are used when carrying out the activity?
3. Which activities are considered to be of the most value?

A topic or interview guide defined as a list of relevant areas to probe (Hedges in Walker, 1985), was subsequently developed from these questions. The original intention was to focus upon specific activities documented by each occupational therapist in their diary during the interview. Development of a guide for these interviews firstly involved the identification of a number of key topics. These were identified through the activity described by staff in the activity diaries, the knowledge and experience of the researchers and literature about the role of occupational therapists with older people; for example the paper by Howard, 1987. All relevant questions concerned with each topic were then identified and included in the interview guide.

Organisation of the interviews

Occupational therapists who participated in the first data collection were invited for interview by letter. The diary data collection with this group of staff took place during March 1992; and potential interviewees were sought in September, 1992. Out of the original six subjects, three were available for interview.

Conducting the interviews

All interviews were conducted at the subject's place of work. Although it was intended to conduct them at a venue away from the workplace, time constraints on the part of those being interviewed rendered this impossible.

Despite the initial concerns expressed by one of the interviewees regarding the purposes of the interview, all agreed to have their interview tape recorded. They were very forthcoming and all three interviews resulted in a wealth of information.

Using the Information Gained from the Interviews

1. Modifying the topic guide

The topic guide proved to be appropriate in all respects except for the questions asking occupational therapists to recall specific events that they had documented in the diaries. It was impossible for them to recall specific instances over the time scale involved, and so questions asking for any examples they could recall were substituted.

From the first set of interviews, pertinent issues were raised which were not originally anticipated. These included decisions regarding content of activity, and the philosophy underlying activity. Questions to reflect these aspects were added to the pilot topic guide before application to a larger number of occupational therapists (study four). The final topic guide is appended (see appendix ten).

2. Using the interview data

The three transcripts were used to identify significant themes which featured in the discussions.

The following themes were identified, forming the framework for thematic analysis of subsequent interviews described in study two:-

- Clarity of role
- Training required to undertake certain tasks
- Ownership of tasks
- Contributions by other multi disciplinary team members
- Involvement of the patient and their carers
- Methods of working
- Expressed job satisfaction

It was not appropriate to analyse the contents of such a small number of interviews. However, more detail of the emergent themes are given in appendix seven.

3. Planning further interviews

Results obtained from the first three interviews indicated that data obtained through depth interviews was an effective way of adding to information documented in the activity diaries. It also provided additional detail about the role of occupational therapists, the extent and nature of their working with other disciplines and the clinical judgements which underpin activity. A further set of interviews were subsequently carried out with staff working in psychiatry of old age early in 1993, the results of which are given in chapter four.

Study One: Summary

The remit of this first study was to devise a method of accurately measuring the activity of occupational therapists working with older people with mental health problems and identify how perceptions of that activity might be obtained.

A pre coded activity diary was developed and it's psychometric properties were adequately demonstrated. Moreover the diary would easily lend itself to computerisation and could be used by occupational therapists to examine their own activity.

Additionally, a topic guide whereby occupational therapists can discuss views of their work was successfully piloted.

Following completion of this study, the activity diary was applied in studies two and three and the interview guide in study two, to examine activity and clinical judgements, and explore how clinical judgements are influenced. Further analysis of the findings with respect to the model of occupational therapy activity are provided in chapter seven.

CHAPTER FOUR

STUDY TWO: AN INVESTIGATION INTO THE ACTIVITY OF STAFF WORKING IN PSYCHIATRY OF OLD AGE IN ONE HEALTH TRUST

The aim of this study was to explore the nature of occupational therapy activity and the factors influencing activity, through application of the measures devised during the first empirical study. In so doing the relationship between clinical judgements and activity proposed by the model of occupational therapy activity could be tested.

Research Design

Research entailed the following stages:-

- Analysis of the data collected in activity diaries for the purposes of study one.
- A depth interview with each occupational therapist about their work using the topic guide devised and piloted during study one.
- Application of a valid and reliable job satisfaction questionnaire to all subjects.

During the course of the study, background information was gathered about the services. Features of the psychiatry of old age service in the organisation, and the occupational therapy service dedicated to it at the time of investigation are outlined below.

The patient group served

The service investigated was for people aged 65 years and over with mental health problems. Other patients treated by the service were people under the age of 65 years with a diagnosis of pre-senile dementia. Patients could also have physical illness and/or disability in addition to their mental health problems.

Staff management

All aspects of the service were under the same managerial umbrella, guided by the same occupational therapy manager. The first line of accountability for occupational therapists, not employed in management grades, was through heads of departments directly within their area of work. Therefore, at the time of study, occupational therapy staff were always managed by other occupational therapists.[1]

Work bases

Services were organised from five institutional bases located across the city:-

- Location A; a typical Victorian asylum with an active closure programme.
- Location B; at the time of study this former isolation hospital performed a variety of functions mainly concerning rehabilitation and care of the elderly.

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[1]In April 1994, generic management arrangements were introduced.

- Location C; a district general hospital, with a comprehensive range of services for many categories of patient including older people with medical problems. The occupational therapy service which participated in the first diary data collection were also based at location C.
- Location D; a hospital base for a number of discrete community, in patient and day patient psychiatric services.
- Location E; a hospital providing several different types of service spanning medical and psychiatric care.

Occupational therapists worked within or from all five sites. Areas of work spanned in patients, both acute and long stay; day hospital and community.

Staffing

The qualified occupational therapy staff working within psychiatry of old age at the beginning of June 1992, their base and areas of work are shown in the table below.

Table 4.1 - Occupational Therapists Working in Psychiatry of Old Age, June 1992

Grade	WTE	Base	Area of Work
Head III	0.8	A	Wards
Senior I	0.6	A	Wards
Senior I	0.33	A	Day Hospital
Head III	1.0	B	Wards
Senior I	1.0	B	Community and Day Hospital
Senior II	0.6	B	Day Hospital
Head IV	1.0	C	Community and Day Hospital
Senior I	1.0	C	Community and Day Hospital
Senior II	1.0	C	Community and Day Hospital
Basic Grade	1.0	C	Wards; locations C and E
Senior I	1.0	D	Community and Day Hospital

Undertaking the Field Work

The data collections undertaken during study two are given in table 4.2 below and recounted in forthcoming sections of this chapter.

Table 4.2 - Study Two: Record of Data Collection

Activity	Time of data collection
Collecting diary data	June 1992
Staff interviews	Jan - March 1993
Mail out of questionnaire	March 1993

Analysis of the Diary Data

Qualified occupational therapists working in psychiatry of old age collected activity data using free script diaries (appendix one). The data were firstly used in the development of the pre coded activity diary for self recording of activity. The script was then analysed to describe the nature of the activity undertaken by occupational therapists.

Method of Analysis

Table 4.3 below summarises the data available for analysis.

Table 4:3 - Diary Data Available for Analysis

Grade	Base	Data Collection		No of Events
		Days	Hours	
Head III	A	4	30	179
Senior I	A	4	26	167
Senior I	A	3	13.5	107
Head III	B	4	30	296
Senior II	B	3	19.5	98
Head IV	C	5	37.75	277
Senior II	C	5	36.25	276
Basic	C	5	32.75	269
Senior I	D	5	36.75	291

Analysis of these free script diaries demanded interpretation of the data using the valid and reliable activity categories. Once coded, the data for each subject were analysed by totalling the recorded occurrence for each category of activity in each diary (one diary being equivalent to one working day). The average occurrence of each category of activity for every subject over their working week were then calculated.

Results of Analysis

Results of the analysis of each occupational therapist's activity are summarised on charts 4.1 and 4.2 overleaf. Chart 4.1 gives the results by frequency of the 15 categories of activity (the abbreviations for each of the activity categories are given in appendix two). Chart 4.2 provides an alternative analysis of the same data, illustrating event occurrence by the collapsed categories of activity identified in study one, pp. 47-48.

Chart 4.1

Activity Categories: Incidence of Recorded Activity

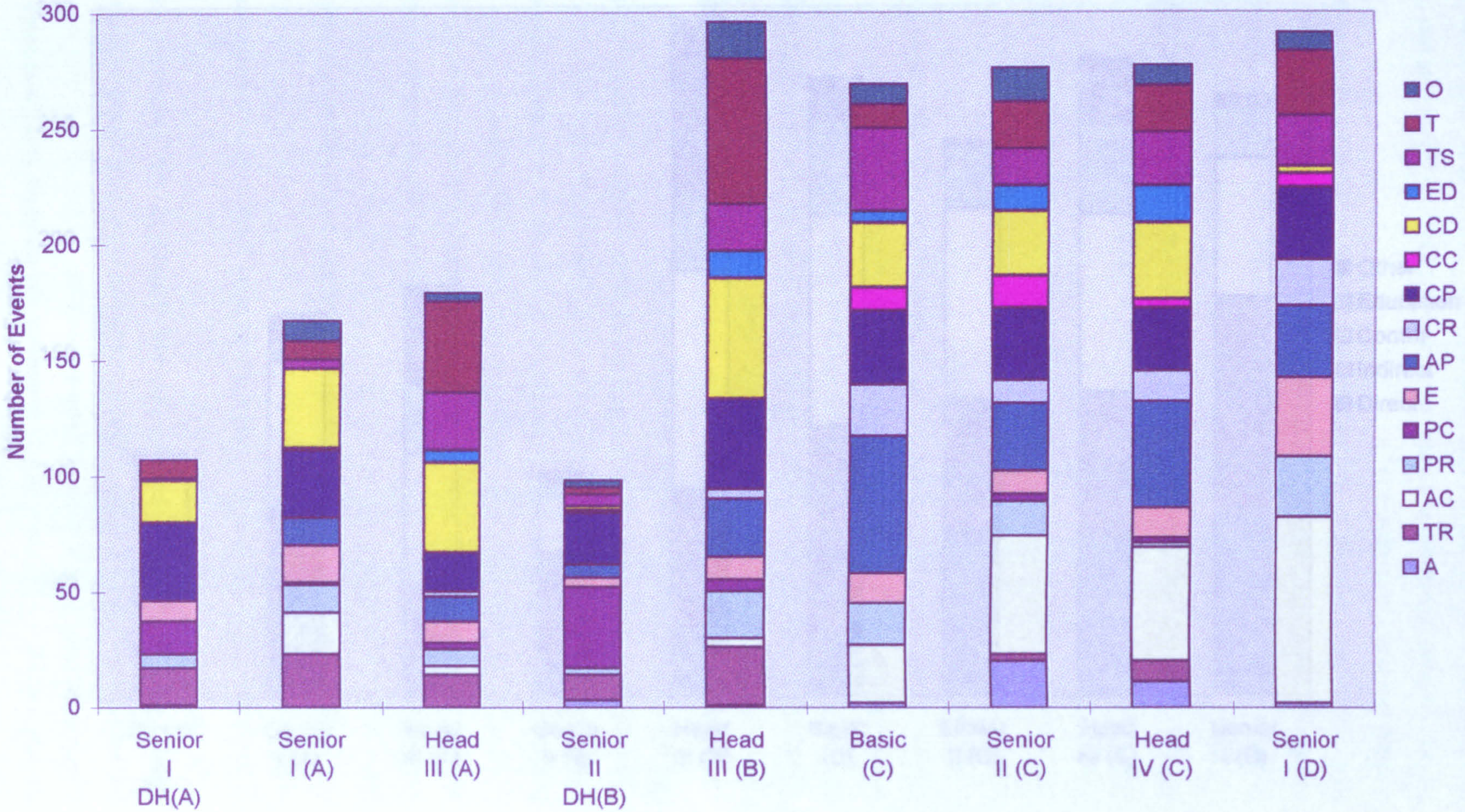
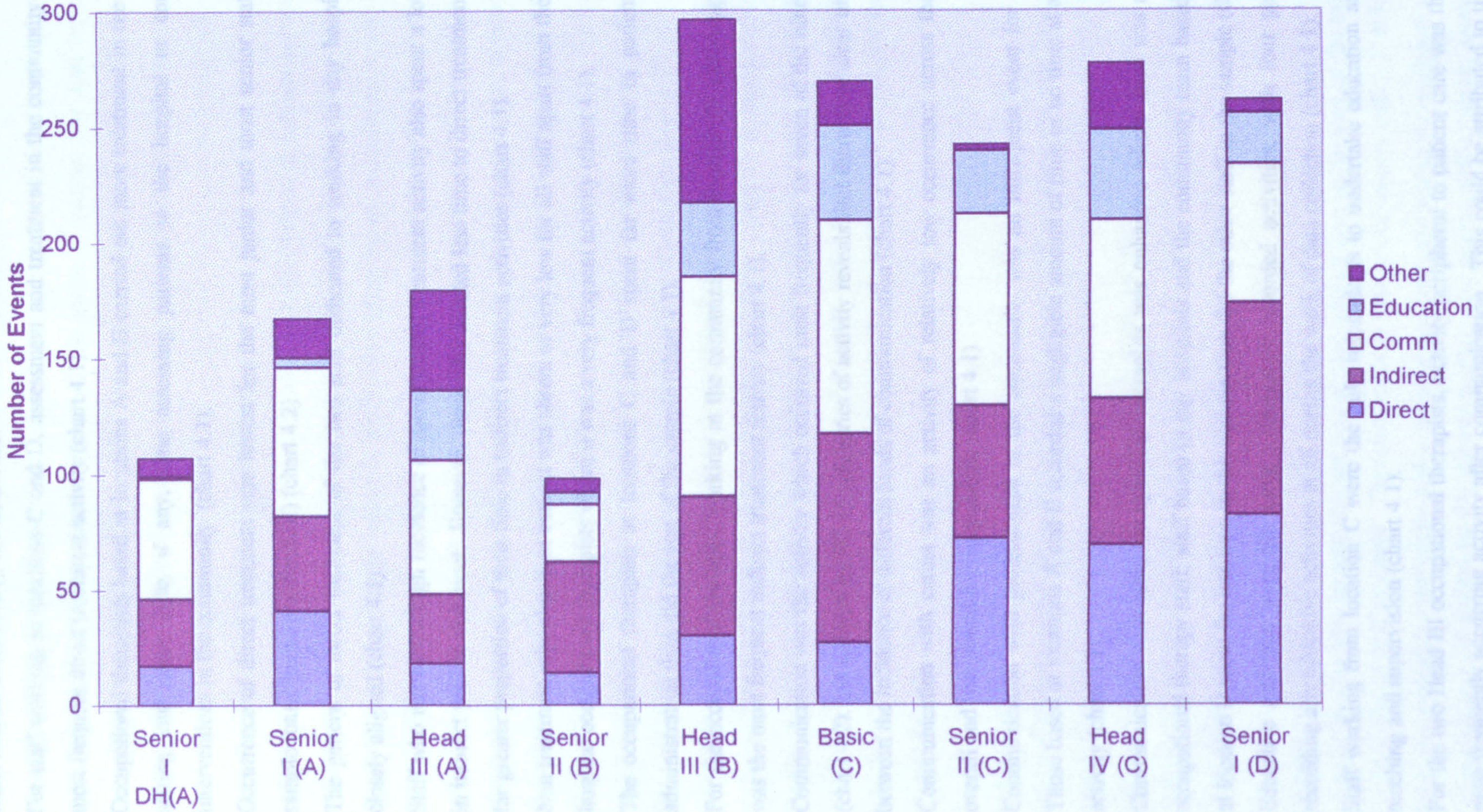


Chart 4.2

Collapsed Activity Categories: Incidence of Events



The main results, illustrated by the charts are:-

- For staff working at locations C and D, assessment and treatment in the community was the most frequent direct treatment activity (chart 4.1).
- Occupational therapists based at locations A and B carried out more treatment in the hospital setting and spent little, if any, time assessing patients in the hospital or conducting interventions in the community (chart 4.1).
- Occurrence of direct treatment was lowest for the most junior and most senior staff in the sample (basic grade and head III) (chart 4.2).
- The pattern of direct treatment of the two staff dedicated to working in day hospitals was closely aligned (chart 4.1).
- Staff who recorded a high incidence of direct patient treatment activity also spent a lot of time in indirect patient treatment. However, those who devoted less time to direct treatment spent a far greater proportion of their time in indirect treatment activities (chart 4.1).
- Non treatment related patient contact was absent or very low for all staff apart from the two day hospital occupational therapists where it was a very frequent activity (chart 4.1).
- The occupational therapists at locations C and D spent far more time in patient related administration than did the rest of the sample (chart 4.1).
- For the occupational therapist working in the community from location D, escorting patients was the most frequent indirect treatment activity (chart 4.1).
- Communication was the activity which occurred most frequently for seven of the nine subjects (chart 4.2), but analysis by the 15 categories of activity reveals that there were clear differences between the incidence of different kinds of communication (chart 4.1).
- Communication with carers was an activity of relatively low occurrence across the sample overall and was absent for three people (chart 4.1).
- Communication with professionals in the community was an infrequent event for all staff. Those based at locations A and B recorded a negligible amount of time or no time at all in this activity (chart 4.1).
- Communication with other occupational therapists was enhanced where there was a core of occupational therapy staff; staff based in day hospitals and the community team based senior I at location D spent far less time in this activity than did the other staff in the sample (chart 4.1).
- Educative activities were the most infrequently recorded activities, with four people not recording any educative activities at all during the week of data collection (chart 4.1).
- Staff working from location C were the only respondents to undertake education as well as teaching and supervision (chart 4.1).
- For the two Head III occupational therapists, activity peripheral to patient care was the second most frequently occurring activity after communication. This could be attributed to time spent in non patient related administration (chart 4.2).

Discussion of the Results

The findings of this aspect of the study only provide a snapshot of activity of the staff who participated. Analysis of these diaries described the nature of activity and also indicated the existence of some tensions underlying activity. Moreover some of the results could not be readily explained. The following themes emerged, and are investigated further in studies three and four.

Organisation and delivery of occupational therapy services

At the time of data collection, the historical location and organisation of services appeared to be major influences upon the style of service being delivered. Individuals who had worked for one health authority prior to reorganisation in April 1991 (those based at locations A and B), were delivering a different style of service to the staff who had previously worked for another health authority (those based at location C). The exception was the member of staff based at location D (previously in the same service as staff at locations A and B). Her activity appeared to be influenced by other, more potent factors; namely having a community remit and being isolated from other occupational therapy staff for most of the time.

Occupational therapists working in institutional settings spent an inordinate amount of time talking to other staff of all disciplines per se but less time treating patients than those staff working from other locations. There are questions about the reasons for this level of communication between staff. Even though the activity of staff based at locations C and D demonstrated a greater community orientation, in that a higher proportion of their work took place in the community, the low level of communication with carers and community based staff was also significant. This suggests that at the time of enquiry the focus of activity for all staff was still the hospital rather than the community.

Patient group referred

The different assessment and treatment settings used by occupational therapists may have been due to demand, though this is not certain. The needs of long stay patients at locations A and B will have undoubtedly determined some of the responses made by the occupational therapy services. Additionally, historical perceptions and expectations of the occupational therapy role in different locations will have played a part in determining the nature of referrals.

Staff numbers and skill mix

Skill mix has to take into account the numbers of support staff working in each of the locations as well as the qualified staff available. The relatively high numbers of support staff (13) at location A presumes less intensive intervention and a maintenance role, reinforcing the notion of a specific style of service to meet patient needs. However, even with support staff available, qualified staff working from these traditionally institutional settings were less concerned with direct treatment activities than those based at other locations. Time spent supervising unqualified staff partly, but not wholely accounts for this. The high level of clinical activity of the Head IV at location C

suggests that presence of support staff need not necessarily compromise the extent of clinical work undertaken by qualified staff.

Treatment to meet needs

Activity at locations A and B appeared to be more aligned to diversion than to active community orientated therapy, particularly in the day hospital settings. There was a preponderance of group work and general patient contact rather than assessment and treatment to meet individual needs.

The low level of communication with carers, by all the subjects, was striking and could be attributed to a range of reasons, for example; office hours of work, no involvement by carers with the patients or lack of awareness of the need to talk with carers and what could be offered by occupational therapy to them.

Education and supervision

The results of the data collection week suggest that the subjects needed to revise their practice, particularly in relation to the imminent implementation of Community Care policy. If practice is to move in line with policy, there would be an inevitable need for participation in a range of educational and supervision activities by all grades of staff.

Conclusions Drawn from the Analysis

Taking the above findings into account, following factors appeared to be shaping the activity of occupational therapists in this study:-

- Service setting; for example whether it was a long stay institution, general hospital or community hospital.
- Location of the occupational therapy service within that setting; for example day hospital, occupational therapy department or multi-professional community team office.
- Proximity to occupational therapists or other members of the multi disciplinary team.

The results also raise the following questions for further investigation:-

- How can qualified occupational therapy staff dedicated to working in a day hospital environment successfully rehabilitate patients if their treatment input, particularly in the community is minimal?
- How worthwhile is the input from the most highly paid staff (head III) if most of their time is spent in activity not directly related to patient care and what is the underlying purpose of such activity?
- Is the most effective service one which directly uses the clinical skills of experienced staff or one which trains and supervises unqualified staff to undertake those activities?
- How important is education and supervision of occupational therapists in fostering change?

How the Occupational Therapists Described Their Activity

Face to face qualitative interviews were undertaken with all eleven qualified occupational therapists employed by the same health trust and working in psychiatry of old age.

Conducting the Interviews

Each subject was invited for interview by letter; cooperation being forthcoming in all cases. Interviews were conducted at a mutually convenient time in a setting of the person's choice. A researcher, with no previous involvement in occupational therapy services, conducted all the interviews, thereby encouraging those interviewed to speak as openly as possible about their role. Development of the topic guide for these interviews and the results of the pilot are summarised in chapter three (the topic guide is shown in appendix ten).

Method of Analysis

The eleven transcripts were analysed by hand. A starting point for analysis was provided by the topic guide as well as themes extracted from the pilot interviews (see appendix seven). The text was coded to identify themes in the manner described by Strauss (1987), themes being identified from the interview data and aggregated across the interviews. Even though the identity of those who took part is easily established it was important to maintain the confidentiality of the content of individual interviews. Therefore, the contributions of specific individuals are not identified in any way.

Results of the Analysis

Validation

Upon completion, the report which is documented below (with the exception of the discussion and summary), was sent to the interviewees for their validation in the manner described by MacPherson and Williamson (1992). Not all the subjects could be located due to moves out of the area, but those who were able to receive the report responded favourably. One of the people contacted asked about recommendations regarding lack of carer contact, but apart from that no other questions were raised.

Analysis commences with an account of the occupational therapists' perceptions of the different dimensions of their involvement in home visiting, domestic assessment, dressing assessment and group work. This is followed by an exploration of views of other less specific aspects of their work including opinions regarding the most important activity, cost effectiveness of the service they offer, training for the job and the philosophy underlying occupational therapy.

How Occupational Therapists Described their Activity

Home visits

A difference of opinion regarding the use of the term 'home visits' emerged. Some people used the expression to cover any visit to a patient in his or her home while others expressed the opinion that

it only referred to the taking home of an in patient prior to discharge to assess functional ability in the home. However, there was overall agreement about the assessment function of a home visit.

> *A normal home visit would be an assessment visit prior to discharge, or to help with actually formalising the assessment of a patient as to whether home was an appropriate place to go or whether we should be looking at residential care instead.*

All but two of the occupational therapists said that they frequently carried out home visits and they took a sizable proportion of their work time. Those who undertook less visits were able to give specific reasons for not being involved in this activity as often. They included allocation of work between staff, and working with long term or day hospital patients.

Aims

Although home visits were carried out to assess the patient at home, more specific aims varied according to the interpreted needs of the patient.

> *The aims behind a visit might be for example to assess somebody's ability to function at home, to assess somebody's attitude to going home - different aims for different cases.*

Other cited purposes were to determine the extent of the care network, examine the need for additional support and to look at leisure and community resources.

> *It's very much focusing on activities and support.*

Emphasis was placed upon the importance of seeing the patient within their own environment. The supposition was made that the patient was more likely to be relaxed while being assessed within their own setting.

> *So we are trying to observe somebody in their own environment, doing very normal activities; whatever they normally do at home.*

In many cases the basic question behind the home visit was whether a patient should return to or remain in their own home. The degree of risk taking and consequent responsibility accepted by the interviewees varied across the group.

This person accepted responsibility for monitoring the patient herself if there was uncertainty.

> *....if I've not been that sure I've erred on the side that I think that they probably will be able to manage...I go and see them during the week...it's always a question of what is an acceptable level of risk...*

An alternative strategy was to pass the patient on to other services.

> *Usually we try to make recommendations; whether that be further treatment in hospital or increased support when they actually go home.*

All occupational therapists said that wherever possible they would spend some time explaining the reasons for going on the home visit to the patient. However they felt that not all patients took in this information; particularly those with cognitive deficits. There was an awareness of the anxiety

which can be generated by the assessment situation but it was assumed by some that by keeping patients less informed about the purpose of a visit, they were sparing them the reality of what it meant.

> *I don't always spell it out in black and white to patients with dementia because you are assessing to see whether they are actually able to function in their own home or whether they need nursing or residential care.*

Ownership of task and skills utilised

There was universal agreement both in their own opinion and in practice, that carrying out home visits was the designated role of the occupational therapist. However, views regarding how this role had been determined varied across the group.

> *...we covered all this in our training - looking at people's functioning and abilities to cope at home.*

> *...partly that's what we've always done and that's been an accepted role...*

There was no doubt that skills in carrying out home visits set occupational therapists apart from their nurses and other colleagues who would not be as concerned with performance of activities. The importance of assessment of functional ability through observing and analysing activity was stressed.

> *The way we work is based in activity and we have training in activity analysis.*

In the majority of cases the task would require the specific skills and training of an occupational therapist, particularly pre discharge home visits which should always be carried out by the occupational therapist.

> *...if I wasn't available? Well they would ask another occupational therapist to do it. If there was no OT available, it wouldn't be done.*

A small number of specific examples of where other professionals had carried out home visits were cited, but the occupational therapist would always be contacted in situations where there were functional problems. Visits by other disciplines were generally for different purposes.

Referrals for home visits

Referrals for home visits came primarily from medical or nursing staff, the main referrers being consultants. They could be given verbally at team meetings or ward rounds and sometimes followed general discussions. However, informal referrals were almost always followed by a written request. It was not usual for the occupational therapist to initiate home visits themselves but most felt that they could suggest it during team discussions. Self referrals for patients or their carers were not expected but it was intimated that on some occasions the impetus for a referral may have originated from the patient. A major factor in patient motivation to make requests was their location at the time. When discussing in patients;

> *...but I don't know that they'd actually see the aim of it. Often people see it as a step nearer going home and that's why they'd ask for it.*

When talking about community patients;

> *The way that it would happen now is they would have to go to their GP and say "Can we have an OT assessment?" People might ask indirectly...and so somebody else would pick that up and pass it on to me.*

Those occupational therapists involved in home visiting said that they would be able to say if they thought that a referral for a home visit was not indicated. However, in practice this occurred very infrequently as most referrals for home visits were seen to be appropriate or were carried out for reasons of '*benefit of the doubt.*' Referrals sometimes had to be redirected to the correct occupational therapy service.

Preparation

In ideal but not always practical circumstances, home visits entailed a lot of preparatory work. Much of this preparation consisted of discussions with the patient and obtaining information from other people.

> *When I do a home visit I always discuss it with the client obviously and their family....because they're usually the person who are caring for them at home...I ring the social services up to find out if they've got any home care or any other community support at home.*

The amount of necessary preparation would increase in situations where the occupational therapist was not allocated to the service from where the referral had originated.

> *....because I don't get involved until the last minute very often, then I'd have to find out a lot of the background from the case notes....through discussion with the nursing staff.*

Occasionally information gathering was supplemented by doing some preliminary functional assessment work with patients in the hospital prior to the home visit.

In addition to collating details of the patient's home circumstances and abilities, the practical aspects of the visit had to be dealt with.

> *You need to find out who's got the key, which can be tricky.*

It was emphasised that dealing with the practicalities can be very time consuming. Even when another professional accompanied the occupational therapist on a joint home visit it was almost always the occupational therapist who was seen to be responsible for coordinating it and organising who should attend. The reasons for this were not clearly articulated, but it was evident that the people we interviewed saw no reason to change their practice.

> *I think really it should be seen as an OT role to organise home visits and to lead them.*

> *Yes it is historical really. I've never thought about it really. But it is a job that we do and do well.*

Involvement of other professionals

Only one of the occupational therapists said that she went on initial home visits alone. This was mainly due to the structure within which she was expected to work; being community based in a team alongside community nurses. She acknowledged that this caused her some concerns especially as policy introduced by the occupational therapy service itself instructed staff not to visit a new patient unaccompanied. The rest of the group took at least one other person with them at all times. A number of reasons were given for this including assisting patients with poor mobility and in the case of in-patients, concerns about refusal to return to hospital. It was evident that no one was willing to challenge policy; particularly as '*anything could happen.*'

Commonly, the person accompanying the occupational therapist was there just as a second person. This tended to be whoever was available; usually an occupational therapy helper or a nurse. In other situations another worker, who might be a helper or a nurse, were invited on the initial visit for specific reasons. In the case of patients who were in receipt of home care, a home care manager might be invited, or a physiotherapist would be asked to accompany the occupational therapist if there were particular mobility problems. The responsibility for deciding on who else to involve was solely that of the occupational therapist.

> *So it's always up to me, the hospital OT to decide.*

Generally when the occupational therapists went on home visits with other professionals, they retained the organisational burden, but accepted that the other discipline's contribution was of equal importance to their own. However, it is relevant to note that this only pertained to an initial assessment orientated visit. There was no mention of occupational therapists undergoing treatment in conjunction with other professionals at a patient's home.

In addition to inviting others on the basis of patient need, other rationales came into operation.

> *I think it's good from the multi disciplinary point of view that you actually go with a nurse, make them understand what you are doing...*

One occupational therapist said that she preferred not to take other professionals who might also want to carry out their own assessments with her on the home visit.

> *....this doesn't tend to work very well with the patient.*

Use of helpers

When occupational therapy helpers accompanied occupational therapists on initial home visits their role was frequently restricted to that of the second person as required by local policy. Four of the people interviewed said that they could be present for a specific reason such as planned involvement in follow-up treatment of a patient. Opinions varied as to whether helpers could or should carry out follow up home visits unaccompanied by a trained member of staff. Three of those interviewed thought that it would be possible to train more able individuals to carry out selected home visits once an initial assessment had been carried out; and that the support staff resource could be employed more effectively. However, the majority thought that it would be inappropriate.

The involvement of carers

It was usual practice to get in touch with a patient's carers before a home visit to obtain relevant information and in some cases explain the reason for the visit. Contact was usually by phone. The needs of the carers were not a rationale for making contact.

> *If the ward know them reasonably well and there doesn't seem to be anything I need to liaise about, I don't necessarily liaise with them.*

One of the people we spoke to had a specific policy to try and involve carers in the actual visit, but the rest pointed out that it was often very difficult to organise for carers to be present at every home visit; for example if they were out at work during the day. There were also occasions where it seemed preferable for carers not to be present. Part of the role of the occupational therapist was to judge what was appropriate in each situation, sometimes deliberately not inviting carers. The patient could be involved in these decisions either directly or indirectly.

> *...obviously whether the patient feels its necessary or important for the relative to be there.*

> *Some patients are unnecessarily dependent upon relatives.*

Carer involvement necessitated a balance being struck between gathering necessary information and limiting interference so that a true picture of the patient's capabilities could be ascertained. No one mentioned assessing the needs of carers.

Reports and documentation

Home visits were always well documented; a written report being produced after each visit which was then widely distributed to other professions.

> *It would go to the consultant, a copy to the ward, a file copy and any other involved agencies like a CPN, a psychologist, or a social worker.*

Reports followed professionally led guidelines and was sometimes supplemented by less formal reporting particularly due to the inevitable time delay in producing written documentation. These less formal methods of reporting were brief summaries in the nursing notes and verbal reports to nursing staff on return from the visit. Even though the occupational therapists took a lot of time and effort in producing reports for distribution to other professionals, it was rare for them to receive similar reports from other disciplines, feedback given tending to be verbal.

It is significant that neither patients nor their carers received copies of the home visit report. All those interviewed said that they attempted to discuss the results of home visits with patients verbally and similarly where carers were involved they were given verbal feedback after the visit. However, the manner in which the concept of carer involvement was being applied in practice was unclear. One person said that she would speak with carers where she had "*direct contact with them.*" The extent of information given to the carer if they were not invited on the visit was not raised during any of the interviews.

Consequences of the home visit

Often home visits with in-patients were carried out to determine whether a person was capable of returning home or not. There was some disagreement across the group we interviewed as to the extent of their responsibility in this. Some thought that the decision was in effect theirs while others felt that their role was to feed information to others who would make a decision.

> *...the consultant that I work for anyway is very influenced by what I say...*

One of the interviewees who worked in a team setting saw the results of a home visit as being one piece of information and other professions would have knowledge from conducting other assessments. Decisions were based on the whole overview of the patient's situation.

Generally the occupational therapists felt that their recommendations were well received and acted upon. If a agreement was reached which went against their advice, there were usually practical reasons for this like limited community resources.

Problems

Overall, home visits were not perceived to be problematic for the staff carrying them out. There were a few exceptions; one of the most cited problem areas being time pressure.

> *The pressure of time - usually referrers wanted a home visit done very quickly, and this went against the OTs wish to spend more time with the patient prior to the visit.*

Occasionally a patient would simply refuse to go, and sometimes relatives would refuse to cooperate. There was also a concern that an in patient on a visit home would refuse to return to hospital, although in practice this rarely occurred.

> *I always have self discharge slips with me, but I've never had to use one yet.*

Transport occasionally proved to be a obstacle. Only two of the interviewees used their own cars for home visits, the rest being reliant upon hospital transport.

Domestic assessments

The terms '*kitchen assessment*' and '*domestic assessment*' were used interchangeably during the interviews, although the latter covered a wider range of activities.

> *.....domestic assessment might encompass other things like laundry or shopping or general household management, cleaning, that kind of thing, whereas kitchen assessment would specifically look at activities in the kitchen.*

Domestic assessments were often an integral component of a home visit. All those interviewed acknowledged that there could be problems in carrying out assessments in the hospital. They doubted the validity of an assessment carried out in a kitchen unfamiliar to the patient, particularly if the patient had organic problems. It was also stressed that the patient was less likely to be

anxious in their own surroundings. If domestic assessments were carried out in the hospital, this tended to be a preliminary activity before a home visit, particularly if problems were envisaged. Those staff who worked in the community as a matter of course were more likely to take a patient home for an initial domestic assessment. However, if any follow up treatment was indicated, it would probably be undertaken in a hospital setting by support staff.

> *I have actually seen them at home and then have asked the support staff to carry on seeing them here* (day hospital) *because by then I already know what's going on at home.*

Aims

The overt aim was to assess function, but an underlying rationale for conducting a domestic assessment was often concerned with safety. Functional ability might include motivation and confidence to carry out the task as well as ability to correctly sequence the different stages of the activity.

> *The activities are usually tailored to meet the needs of the patient.*

Understanding of patients

As with home visits, the occupational therapists said that they attempted to explain the reasons for assessments to patients, but the extent to which patients understood what was happening varied.

> *..other times they were so confused that they wouldn't know.*
>
> *They often see it as being watched and assessed without you even saying so directly.*

There was some realisation that the assessment could be a source of anxiety for patients, success or failure determining return home.

> *...it's sort of seen as a hurdle they've got to get over before they can go home.*

Ownership of task

Domestic assessments were seen as being the exclusive role of the occupational therapist in the same way as home visits.

> *...it is part of our training and it's part of our role in working out somebody's functional skills.*

In light of such definitive statements about training and role it was surprising that access to rehabilitation kitchen facilities were also offered as a rationale for undertaking the task.

> *Because for one thing we've got the facilities there in our department.*
>
> *We're the ones with access to the kitchen and we present ourselves presumedly as the ones with skills in that area.*

The importance of standing back and not interfering was reiterated. It was suggested that other professions are not able to achieve this so successfully.

Other people may step in too quickly and prevent things happening.

Unlike home visits there was a greater acceptance of treatment responsibilities following assessment.

Use of helpers

Only one person was quite definite that occupational therapy helpers should not be delegated the responsibility of carrying out domestic assessment.

It's not fair, they're not trained to do that and it would not be fair to expect them to do so.

All the others expressed some reservations about using helpers in this way; the general opinion being that they could conduct some assessments on selected patients, but would need adequate training and supervision in order to do so. One of the specific problems identified by two occupational therapists was that they would have to interpret the results obtained from the helper into a report to present to other professionals, so this aspect of the task would still involve them.

I think if they were more competent at doing the written work it would help.

Referrals

Several of the people we spoke to said that they tended not to expect specific referrals for domestic assessments and in practice they usually carried them out as one component of a general programme of assessment and treatment prior to a home visit. More general referrals for functional assessment were preferred so that the occupational therapist could then decide upon the necessary actions.

Where explicit referrals were received, they routinely came from medical or nursing staff. In general referrals for domestic assessments were more informal than those requesting home visits.

He (the doctor) would request some sort of functional assessment on a patient.

It might be that other disciplines involved have visited the client at home and there appears to be some kind of problem.

In some situations the occupational therapists felt in a secure enough position to be able to suggest a domestic assessment with a certain patient. Organisational structures within which they worked could facilitate or prevent them from being able to do this.

There were no examples cited of patients and carers directly requesting a domestic assessment but on occasions they were carried out in response to comments made by patients and carers.

They might express concerns...so you would pick it up that way.

Carrying out the assessments

The predominant view from the interviewees was that domestic assessments did not involve an inordinate amount of preparation.

You need to meet with the patient to discuss what they're going to do, so there's preparation in that way. There's not a great deal else.

The group saw that it was up to them to decide upon the content of the assessment according to what they deemed to be appropriate for individual patients.

They vary from making a cup of tea to making a meal and in between as well. It depends what's appropriate for the individual really.

...I check that they can manage a cooker, toaster and electric kettle.

Only one occupational therapist talked about using a specific assessment tool to rate the patient's abilities, the rest relying upon their experience to guide and score the process.

...I usually make the decision as to how far to go on the continuum really...

These assessments were usually conducted on a one to one basis with no other staff present. The only exception to this would be when a student was present in an observational role.

Reports and documentation

Domestic assessments were well documented; written reports, often on customised forms, being produced and distributed to other professionals including the referrer. As with home visits the written results were often preceded by a verbal report, or a summary in the nursing notes. Distribution would be dependent upon the patient's location at the time, but did not extend to the patient and their carers.

That would go probably just within the hospital if it was an in patient.

A written report would go to the community psychiatric nurse, the key worker and the patient's notes.

Reporting back to patients was done informally, but this was difficult if the person had *'done badly.'*

Consequences

One frequent outcome of the domestic assessment was the need for treatment follow up or on-going support.

...if you discover that somebody is incapable of doing what they need to be able to do at home, you need to make recommendations about what's going to happen, what would be a suitable plan of action to enable them to manage at home.

In general it was felt that recommendations were well received by other disciplines. If on-going treatment was recommended, the occupational therapy helper might be called upon. In the case of identified need for on-going support, referrals would be made to home care.

Problems

Most of the problems the respondents identified were concerned with availability of kitchen facilities. This embraced access, quality of the kitchen and use of the kitchen for other purposes.

> *There's only an electric cooker in the ward kitchen ...so it isn't very valuable to do a kitchen assessment with somebody who's used to gas.*

Dressing assessments and practice

The occupational therapists working in elderly medicine stressed that dressing assessment and practice formed a significant part of their work (see appendix seven). However it emerged during these interviews that this group of staff working in psychiatry of old age carried out this activity rarely, if at all. On the few occasions that they had been conducted, it was as a result of comments from relatives.

> *It would usually be some complaint from a relation...*
>
> *It would be one of the patients who was on respite care, who the relatives might have highlighted.*

Assessment was not usually followed by ongoing dressing practice.

> *...you get relations that say the patients can't dress themselves, and actually you find they can if they're given enough time, but their relations are impatient.*

Even though they rarely carried out dressing assessments, all of the people we spoke with did see it as a specific occupational therapy task, and could be an appropriate activity for occupational therapy helpers. Some compared their own attitudes favourably with that of the nurses.

> *Nurses can't see a patient struggling to put clothes on without going to help....whereas an OT would stand back and see if they could manage on their own, or ...suggest a way by which they could manage on their own.*

However, in one work location, both nurses and occupational therapist carried out dressing assessments. This person could not identify differences in the assessments but thought that the subsequent report writing would differ.

> *I would probably put in a bit more detail about what bits they found difficult...*

A number of different reasons were given regarding the rare occurrence of this activity, which they all considered to be a core skill.

> *It's not something we do very often in psychiatry...I think a lot of the patients lived with carers. We don't do it at the moment because of lack of staffing...*
>
> *It may be that we just don't get the referrals.*

Group work

All the occupational therapists interviewed had some involvement in group work; ranging from minimal or spasmodic involvement to group work forming a major use of their time. In addition, several people had a planning and/or supervisory role in groups run by occupational therapy helpers. Two occupational therapists who spent very little time running groups said this was because it restricted their working time unacceptably.

> *...I tend to end up not having time to see other referrals.*
>
> *I've wanted to try to maintain as much flexibility as I could for seeing people in the community.*

Most of the groups were run for in and day patients in institutional locations such as occupational therapy departments or day hospitals. One group was run for a specific number of sessions with the same group of patients, but the rest were less structured. A small number of groups being run by occupational therapy staff included all the patients available in a certain setting; for example all those attending day hospital on a specific day, but more often they were for a sub-group selected from those patients available.

The responsibility for these groups ranged from total autonomy which involved planning, initiating and selecting the patients to a situation where the nature and membership of the group was determined by another professional group, usually nurses. In practice most groups fell between these extremes. However, even where the occupational therapists had little influence in the planning of a group, they were always responsible for the content of each session they led.

Aims and activities

The word '*group*' in the context of occupational therapy practice was an umbrella term for a large variety of different activities.

> *I do relaxation groups twice a week, I do a creative group, I do a men's group...I do a reminiscence group and then I've got a social type group which is more about social interaction between people.*

The aims for each group could be directly linked to the activity or associated with the group processes. A group could sometimes incorporate both aspects.

> *I do a baking group at the day hospital for clients with organic problems...it's a nice social group...you can look at their task performance.*

A group specifically geared towards a community orientation was the leisure group.

> *The aim of the leisure group was really to promote an active healthy lifestyle, to look at community resources that people use, to give them a taste of what kind of activities there are round and about that they could join easily.*

Ownership of task

Since there was apparently a wide range of groups catering for a diverse patient population, it is perhaps not surprising that this aspect of work was not viewed so unequivocally as being the role of the occupational therapist as were home visits and domestic assessments. Groups with similar names and/or aims were apparently being run by other disciplines, especially nurses. This was not voiced as being a concern, although there was reference made to individuals who were judged as having the required qualities to run groups.

> *....the nursing auxiliary here is brilliant, but that's because of personal interest, it's not a core skill.*

The occupational therapists we spoke to felt that involvement in group work was an appropriate use of their time, drawing upon their specific skills and training. They thought that groups run by other professionals would differ from theirs in significant ways.

> *I think she (*a nurse*) wouldn't have set out her aims beforehand.*

It was implied that occupational therapists have been taught to structure groups whereas other disciplines have not. One occupational therapist had to leave nurses to run her groups on the days she was not working. She noted that this had adverse implications.

> *They're not done the way I want them.*

Use of helpers

Occupational therapy helpers frequently ran groups usually, but not always, under supervision. The interviewees had differing perceptions of whether helpers should run groups and how much supervision was needed, influenced in some cases by their knowledge of the skills and abilities of individual helpers; *"it depends upon the helper."*

Allocation of patients to groups

Only in a small number of situations was the membership of a group selected solely by the occupational therapists. It was common for other disciplines to allocate patients to groups often for administrative or practical reasons.

> *One of the sisters at the day hospital sorted people out into groups as to their suitability, abilities their needs and their treatments.*

Even when the occupational therapist was not involved in the original selection of patients, they were consulted about ongoing decisions about the suitability of a group for certain individuals. The most common situation was for allocation to groups to be between the nurses and occupational therapy staff including helpers if involved.

In the case of the leisure group, run jointly by four of those interviewed, referrals to the group were invited from other professionals, and the patients would be subsequently selected for attendance by interview.

Information promoting the group is sent to consultants, wards, community staff and the day hospital...

Self referral by patients to groups was relatively rare but not unheard of. However, it was not encouraged.

....if we thought they were appropriate then yes.

....each person needs to be interviewed for their individual problems and suitability for the group.

Preparation

Preparation for each group varied depending upon its nature. In the case of the leisure group run solely by occupational therapists there was a lot of preparation for each '*course.*'

It's quite a labour intensive group and there's a lot of planning, and you need time to collect referrals and interview referrals....

Only a minority of groups were structured into a fixed number of sessions. Several occupational therapists said they realised the benefits of a fixed number of sessions but found practical difficulties like patient turnover or non attendance at day hospital when trying to organise this type of group.

Involvement of others

In most, but not all groups another member of staff; usually an occupational therapy helper or a nurse was present. Apart from nurses, there was very little involvement from other professional groups. Occasionally a physiotherapist might attend for a specific reason. Some said that they were happy to run groups alone, but others felt that it was important to have two people present, particularly with a group of dementia patients. In all but one case, the occupational therapist took the lead in running the group.

Reporting and recording

Reporting on groups varied from informal and verbal reporting to more structured record keeping. Informal reports tended to be given as the patient was returned to the ward or during team meetings. Written reports might be for general access, and kept within the nursing notes or retained by the occupational therapist in her own notes. Frequently a combination of these occurred, written notes being used as a supplement to verbal reporting. Occupational therapists running the leisure group had developed a report format specifically for that group, and this was the only group for which there was a procedure for reporting back to patients.

In general when records were written up these were made accessible to other members of the multi disciplinary team, but not all the respondents were clear about this.

Once I'd written it down I felt that I'd obviated my responsibility.

Non specific roles

Occupational therapists talked about their involvement in other domains in addition to undertaking practically based interventions. These included forming relationships with patients and boosting their confidence. This was an important aspect of the role of the occupational therapist who worked with continuing care patients. However, she did recognise that other disciplines could undertake this role.

Well, I don't think it's specifically OT...

'*Confidence boosting*' activities might be conducted in group settings or on an individual basis. As part of organising the community orientated leisure group, one small group of occupational therapists had taken on the task of collating community facilities and activities in their area.

The most important activity

Only one occupational therapist found it difficult to identify a specific area of work she considered to be more important than the rest.

> *I think our role is so diverse and we do lots of different activities and it's hard to rank them in order of importance.*

One other person maintained that the general approach taken in the work was more important than any one activity.

The other nine occupational therapists we interviewed felt that the most important area of activity was assessment. Different aspects of assessment mentioned included home visits, domestic assessments and assessment of safety. However, only four of the nine occupational therapists extended this to include treatment following assessment. Furthermore, the nature of treatment they would attempt was not clearly articulated. This lack of clarity is illustrated by the following statements from different interviewees;

> *Well it has been the assessment and treatment of activities of daily living, but in an ideal world we should be doing more other things as well.*

> *Assessing and a certain amount of remedial work following the assessment...the role of helping them achieve what they want to achieve really.*

> *...working as a therapist and again using activities through which you can work out therapies with people.*

Cost effectiveness

Cost effectiveness embraces the efficacy of the service received by the patient and the costs involved in delivering the service.

Ten people felt that the service the patients received, particularly the assessment function was cost effective. Only one occupational therapist said that her work could not be viewed as being value for money as the patients she treated were long stay.

It was apparent that substantiating the notion of cost effectiveness was problematic necessitating the use of vague expressions like "*we do it well*" and *"we're very clear*" and in one case an admission of *"fairly impossible to measure."* One person's view encapsulated the opinion maintained by the group in general in that occupational therapy was the *"the best deal in the Health Service."*

The issue of employment of different grades of occupational therapy staff and resulting salary costs were raised by two people. One person thought that the service was value for money when certain aspects of the work were delegated to unqualified support staff; this delegatory role having potential for expansion. An issue raised by another individual was the differential pay scales for different grades of staff who were carrying out the same activities.

> *..a basic grade is going to do a home visit with a an OT helper just as a Head III will do a home visit with an OT helper. So cost effective wise it's questionable.*

Variation in tasks

One facet of occupational therapy practice illustrated, during this series of interviews, was the wide variation of activity undertaken by staff in different settings. A range of explanations for this role diversity were proposed including the generic nature of the core training;

> *..our training has equipped us to work with people with physical disabilities, learning difficulties or mental disabilities..*

The perceived lack of rigid structure of the occupational therapy role;

> *...because there's often not a role for you, you have to make your own role...*

Finally, the need to tailor services to individual patients;

> *..you just can't assume that a group of people are going to benefit from a certain type of media...You've got to assess it on the individual client's needs and the client group as well.*

It was acknowledged that role variation and resulting lack of clarity about the occupational therapy role could cause problems in relationships with other professionals. However professional agreement regarding the philosophy underpinning the role was considered by some of the respondents to have more relevance.

> *You can't define professionals by what they do, it's the meaning behind what they do...*

Wider role

During the interviews staff were asked if there were some other areas of work that they thought they should be involved in. Some picked out wide areas like use of leisure time, therapeutic and support groups and working with carers of patients with cognitive impairment. Others identified quite discrete tasks like gardening with male patients, and use of validation therapy(a new style of talking to people with dementia where all conversation is given legitimacy instead of being corrected if inaccurate, described by Kitwood, 1992).

The prime reasons given for not expanding role in the desired manner were staffing shortages and resulting prioritisation.

> *...it's because we're short staffed that we're not doing a lot of the things that we could be doing.*

> *...I wonder if I could do more treatment but I have a lack of time....I may be can't do something as intensively.*

There was a realisation that the emphasis on functional assessment limited opportunities for role development into other areas.

> *And the fact because I've made it so clear that the domestic side is what I'll pick up that people don't pick up that I'll do the other stuff as well.*

One person did say that she was unwilling to develop her role further because she sensed that changes were going to occur to the service, and another person recognised that her role with long stay patients was time limited due to new demands upon a scarce occupational therapy resource. She identified the potential training role for occupational therapists.

> *I think it is important for OTs to be involved in training of individuals who are going to provide a service for this client group using the OT approach.*

Appreciation by other professionals

There was a general feeling amongst the occupational therapists we interviewed that their role was appreciated by the other professionals with whom they worked, even if this was only expressed in a negative context when the work could not be done. The expression '*valued*' was frequently reiterated

> *I mean it's valued because there's usually an outcry if for whatever reason, something can't be done...*

When questioned about being appreciated while working in the day hospital one person was convinced that she was "*welcomed with open arms.*"

The question of the ways in which the occupational therapists saw themselves as being valued is important. This could be in the context of providing information for the multi disciplinary team, for example when talking about home visits;

> *..it is an important piece of treatment and information that is needed by the team and recognised.*

However, there was uncertainty expressed by some that this appreciation might not be universal. Some consultants were viewed as being "*supportive,*" but this did not always extend to other staff. Furthermore, it was thought that the full potential of the occupational therapy role might not be acceptable to other professions.

> *I think it's valued within too narrow a band really.*

The historical legacy of occupational therapy, as an entertainment source, could get in the way of full exploitation of potential and in some circumstances there was still an expectation of provision of

an activity programme from other disciplines. However the people we spoke to did accept responsibility for misconceptions of their role.

> *..but I think we should perhaps have made an effort to get the real truth across.*

Although there was a desire to be more proactive in order to shape working patterns, it was difficult to influence change. One person said that she only received referrals if she attended meetings, commenting ruefully that unless she attended, referrals were more likely to be made to the community psychiatric nurse.

> *....we are getting referrals because we are at the meetings and we say 'we could be doing that.'*

Another person spoke about feeling uncomfortable when suggesting changes.

> *So if the patients don't need home visits and specific kitchen assessments then the demands aren't usually made on us.*

There was a recognised requirement to inform other professionals about their role.

> *...if we rely on referrals we then have to educate the referrers as to how we can be most effectively used.*

Despite reservations, all the people we spoke to felt able to make suggestions about their involvement and initiate referrals for occupational therapy services. Once referrals were received they saw determining the level and type of activity as being their responsibility. Nevertheless, this autonomy appeared to be curtailed by the influence of other professions upon role and activity.

Problems of working in the multi disciplinary team

The organisational structure within which the occupational therapists were working at the time we interviewed them had the potential for causing problems. All the staff we spoke with worked in some sort of multi disciplinary team; for example a consultant led team or a day hospital team. The extent of allegiance to the team varied. On some occasions this could lead to a clash between the demands of the team and those of the professional hierarchy. Difficulties could be exacerbated by isolation from other occupational therapists at their work base. In practice, few major problems had arisen, but there was awareness of the potential for problems.

> *....I try a bit of diplomacy....when we go off for courses and things they get a bit irritated...I always give the sister plenty of warning.*

In day hospital settings there could be problems caused by the nursing staff trying to control the activity of the occupational therapists.

> *My analogy in a way is OT and nursing is like a good marriage...but there is always one with whom the buck has to stop...*

Described coping mechanisms included acceptance of the nursing hierarchy and skilled manoeuvres to encourage dialogue and discussion. In team settings difficult issues were concerned with multi

disciplinary cohesion. For those based in an occupational therapy department there was a sense of relief that they did not have to confront these issues.

Philosophy underlying occupational therapy treatment

It was claimed by a previous group of interviewees working in medicine of the elderly that occupational therapists are the only professional group who work *holistically* although more recently other professions have adopted the term. During these interviews this word was explored, both to clarify its full meaning and it's relevance in the work of occupational therapists. One notable finding was that although all the occupational therapists were able to give a definition of the term, only one used it voluntarily before it was specifically raised.

The initial definition given tended to be simplistic;

> *Treating the whole patient.*

> *Looking at every area, looking at the patient as a whole. Treating the person as a whole person, not as a disease or disability.*

When asked to expand upon this, the people we interviewed illustrated their understanding of the term in a range of ways. They talked about looking at how one problem affects other areas of functioning and how they take lifestyle into account.

In terms of the importance this group of occupational therapists attached to the concept in their work, five people said that they did accept this philosophy and definitely incorporated it into their work;

> *...it's something one automatically does.*

However, not all the subjects had this perception, particularly those staff attached to multi disciplinary teams. They were more aware of their involvement being restricted to certain areas of a person's lifestyle;

> *I think it's a bit of a myth...I don't think we'd need a multi disciplinary team if occupational therapists were holistic.*

The view was expressed that it can be inappropriate for an occupational therapist to treat all the problems a patient might present with;

> *I don't think it's always our role to treat everything.*

Observations were made regarding the increasing use of the term by other professions and that an holistic approach should be a goal of all health workers anyway. Those interviewees who were working more closely with other professions than they might have done in the past were aware that they had to demonstrate effectiveness in a more definitive manner.

> *....so I think that we just need to concentrate on what skills we've got and what we can offer people and help people most effectively.*

Finally, the issue of professional justification resulting from increased role blurring was raised. One person observed that every profession thought that they should be able to do everything and that different disciplines are;

> *...trying to grab as many skills to claim for themselves.*

She felt that occupational therapists were also behaving like this and added that the comparatively small professional numbers had always necessitated justification of role.

Training

Although the interviewees who trained several years ago found it difficult to recall what they had learnt whilst training as opposed to what had been learnt during subsequent practice, there was general agreement that their professional training had prepared them to some extent for the tasks that they carried out. Assessment activities, activity analysis and group work were specifically mentioned. However, the importance of post qualification *'learning on the job'* was stressed.

> *I think you definitely get more proficient as you go along and pick up more.*

> *....the nitty-gritty is learnt while you're on the job.*

One person extended this to say that experience of life was a necessary supplement to occupational therapy training.

Another issue raised was the inevitable changes in treatment techniques since qualification and the requirement to keep updated through practice. Some of the group identified particular aspects of their work which they felt had not been covered adequately during training. These included working within a multi disciplinary team particularly where occupational therapy had not got an established role and being exposed to '*real*' dilemmas where resources cannot always match treatment recommendations. No one talked about changing role in response to policy.

Discussion of the Interview Findings

These interviews revealed a wide spectrum of activity and experience across staff employed by the same organisation to work in the same specialty. The analysis uncovered certain threads and questions which warrant further consideration both by this specific service and the profession of occupational therapy as a whole. This is reinforced by the striking similarity in themes extracted from the interviews held with staff working in psychiatry of old age and those of the occupational therapists working in medicine for the elderly, suggesting that clinical judgements were underpinned by a common philosophy (see appendix seven). Furthermore, themes revealed through this analysis complement the findings of the quantitative data analysis, confirming the interplay between clinical judgements and activity.

Organisation of work

Traditionally, occupational therapists employed to work in a hospital have used an occupational therapy department both as a working venue and a base. However, the change of focus to community orientated multi professional work demands a stronger alignment to the multi disciplinary team both in terms of methods of working and work location. During these interviews some staff still expressed a preference for the security of a hospital located occupational therapy department base, greater involvement with the multi disciplinary team being perceived to be problematic, for example eradicating the autonomy of the therapist.

Professional status and multi disciplinary working

In addition to maintaining a preference for being with other occupational therapists, the interviewees sometimes expressed an inflexible attitude towards sharing tasks with different professional groups. There was an underlying tension between maintaining a distinct skill base and informing other members of the team. That occupational therapists still waited in the main for referrals to be made to them by other staff rather than taking the initiative themselves is indicative of a lack of meaningful multi disciplinary work.

Clarity of role and ownership of tasks

There is no doubt that those tasks viewed as being the role of the occupational therapist were undertaken efficiently and there was a genuine desire to provide a good service. As with the previous group of staff interviewed during the pilot, the unequivocal opinion of this group of subjects was that functional assessment is the core function of occupational therapy. Treatment following assessment was a less central function of qualified staff and more likely to be delegated to support staff. Some tasks like organising home visits were maintained as an exclusive role of the occupational therapist even though the time they took compromised the capacity to develop new roles.

Overall, there was strong adherence to professionally introduced policy; for example being accompanied on an initial home visit and extent of documentation required following assessment and treatment.

Despite the limitations upon role and the service led responses that they all described, five of the people we interviewed claimed to be working holistically, taking into account all aspects of a person's needs. Moreover, it was the staff who did not work so often in multi disciplinary settings who said that this was an accurate description of the way they worked.

Extending the skill base

The picture presented by the interviews is muddled. On the one hand subjects were keen to extend their skills, but on the other there was little awareness of the need to change the status quo. There was a genuine belief that the existing service was valued by other professions and represented value for money. Moreover, the security of a customary role rooted in demands from other professions

alongside the reassurance provided by familiar activity was severely limiting horizons and the development of a meaningful presence in the multi disciplinary team.

Assessment of needs and the user/carer focus

There were clear indications that the activity of the staff interviewed was not being appropriately influenced by the imminent implementation of Community Care policy. Involvement of users and carers was only transitory, and focused around 'one off' assessments of the patient. These assessments were usually professionally determined and keeping colleagues informed was a central theme throughout. The people we spoke with informed hospital based professional colleagues of the results of their activity far more rigorously than staff working in the community or the people in receipt of their service. Reports were not written for the consumption of users and their carers.

Although occupational therapists might make contact with patient's carers with regard to specific activities like home visits, there appeared to be little routine contact with carers. The one exception was the occupational therapist working on the continuing care ward. However this contact was reportedly social and did not result in the carers making any requests from the occupational therapy service, even though there were always some patients admitted for respite care. It is evident that patient and carer requests were not expected and could be viewed as being undesirable, the implication being that patients would adopt a passive role in assessment and treatment.

Assessment of carer needs was not a consideration and community located treatment follow up was limited, resulting in a service which was only responsive to needs which could be met by resources known to the occupational therapists rather than taking account of the full range of needs of the individual and how these might be met. The only exception to this was the community based leisure group, where the leisure needs of each participant were discussed with them.

Training requirements

Like the staff interviewed who worked in medicine for the elderly, post qualification skills were acquired and developed through practical experience of clinical practice rather than through formal education. Although there was some awareness of the shortcomings of this strategy, it was not challenged.

Use of unqualified staff

The presence of helpers in a service was perceived to be a "mixed blessing." The interviews exposed unclear opinions regarding their role and the extent to which unqualified staff should be given sole responsibility.

How those interviewed perceived their work raises the following questions for further examination in studies three and four:-

- How can occupational therapists working in health care make a successful transition into the community and what help do they require to achieve this?
- Why is assessment activity prioritised?
- What are the positive aspects of occupational therapy practice which should be maintained and valued, and what should be abandoned?
- What changes need to occur to reinforce a user and carer orientation in occupational therapy practice?

Measuring the Job Satisfaction of Occupational Therapists

It was hypothesised through the theoretical model (chapter two) that the job satisfaction of occupational therapists would influence professional confidence, thus shaping the service experienced by users and carers. Therefore, the aim of this aspect of the research was to accurately measure the job satisfaction of occupational therapists participating in the study.

Selection of a Suitable Rating Scale

The rating scale selected for use was developed by Warr et al (1979) to examine job satisfaction of blue collar workers. The job satisfaction scale (scale 5) is one of eight different scales developed by Warr et al for diagnostic and evaluative use.

The scale is quick and easy to use, and has since been successfully applied to care staff working in residential homes for the elderly (Wilkin et al 1985) and to nursing staff working on continuing care wards for patients with dementia (Mountain et al 1990 and 1994).

Format of the Rating Scale and Method of Application

The job satisfaction scale consists of sixteen items related to *intrinsic* and *extrinsic* aspects of job satisfaction. Each variable is measured on a seven point ordinal scale ranging from extremely dissatisfied to extremely satisfied. There is also a category for not answered.

The job satisfaction schedule was posted to 11 staff in March 1993 following interviews with them about their work.

Reasons for the poor return

Even though the questionnaire was anonymised, three of the eleven subjects did not return it. Explanations for the low response rate could be poor memory or the occupational therapists feeling that the material was too sensitive. However, all staff participated in an equally probing interview about their role and perceptions of their work with no resistance from anyone. This therefore raises questions about the applications of alternative methodologies in health care settings and the quality of results that might be forthcoming from their application.

Results

The eight cases were examined initially in relation to reported and overall job satisfaction.

The subject scores for *reported* and *overall* job satisfaction were calculated using the seven point ordinal scale for each variable in the manner indicated by Warr et al. The midpoint score for *overall* and *reported* job satisfaction, and the scores obtained for each subject are given in table 4:4. Overleaf.

Table 4:4 -Overall and Reported Job Satisfaction Scores

	Overall	Reported
Midpoint Score	60	5
Subject Scores		
1	73	5
2	63	5
3	69	5
4	86	6
5	51	3
6	77	5
7	58	4
8	72	5

The scores for the other two sub-scales of reported job satisfaction were calculated in the same manner. These are given in Table 4:5 below.

Table 4:5 - Sub-scales Scores of Overall Job Satisfaction

	Intrinsic	Extrinsic	Working Conditions	Employee Relations	Job itself
Midpoint Score	28	32	20	20	20
Subject Score	34	39	27	19	26
	29	28	24	18	23
	33	36	25	19	26
	41	45	29	28	32
	25	26	20	14	18
	37	42	25	25	28
	30	28	21	18	20
	31	41	29	21	20

Subjects with a summated score greater than the midpoint of each scale were satisfied whereas subjects scoring less than the midpoint score were dissatisfied. Subjects obtaining a score equivalent to the midpoint of the scale were neither satisfied nor dissatisfied. A finer analysis of extent of satisfaction and dissatisfaction was not possible due the small numbers involved. Job satisfaction and dissatisfaction by scales is summarised the table 4:6 overleaf. This shows that the majority of subjects were satisfied on all scales of job satisfaction apart from *employee relations* job satisfaction where more subjects were dissatisfied.

The table shows that the results obtained for overall and reported job satisfaction are very similar. Furthermore, the same two subjects were dissatisfied or neither satisfied nor dissatisfied on both scales.

Table 4:6 - Job Satisfaction/ Dissatisfaction by Scales

Job Satisfaction Scale	Subjects Satisfied	Subjects Dissatisfied	Subjects Neither
Overall	6	2	0
Reported	6	1	1
Intrinsic	7	1	0
Extrinsic	5	3	0
Working Conditions	7	0	1
Employee Relations	3	5	0
Job itself	5	1	2

The score which reflects overall job satisfaction is that obtained from the analysis of the first 15 items in the measure. Te results show that six of the subjects were satisfied overall and two were dissatisfied. It was predicted that there would be no difference between the results of overall job satisfaction and those obtained by computation of the two subscales of job satisfaction.

To test this hypothesis, the chi-square test for one sample was applied to the results shown in the above table. This test examines the extent of agreement between the obtained responses and expected responses. The expected responses were six satisfied and two dissatisfied.

The results shown in Table 4.7 were obtained when the statistical test was applied to the two job satisfaction subscales.

Table 4:7 - Results of Application of Chi-Square one Sample Test

Scale	chi square (df=1)	Significance
Intrinsic	**0.667**	**ns**
Extrinsic	**0.667**	**ns**
Working Conditions	**2.330**	**ns**
Employee Relations	**6.000**	**0.001****
Job Itself	**0.222**	**ns**

The results given in the above table demonstrate that for all sub scales apart from *employee relations* job satisfaction, the obtained results equate to those expected, in that no significant difference existed between overall job satisfaction and four of the five subscales of job satisfaction. However, staff are significantly dissatisfied with employee relations ($p=<0.01$) compared with their *overall* job satisfaction.

Discussion of the Results

The results were affected by the rate of non return of the questionnaire; the reasons for which have already been discussed.

At the time that the occupational therapists were asked about their job satisfaction, two events had occurred which may have contributed to feelings of dissatisfaction across the group with respect to employee relations. Firstly, the directly managed unit had applied for trust status, which had been accepted. The unit became a trust one month after this survey. Personal and professional anxieties were widely expressed across the organisation at this time. The implications of this new management arrangement could not be comprehended as it was uncharted territory for everyone. Secondly due to vacancy this particular group of staff had not been responsible to a middle manager (area occupational therapy manager) from April 1991 to August 1992. It had been necessary for the staff to organise themselves. This had been a difficult task as they had previously worked in two different health districts. The area occupational therapy manager for psychiatry of old age commenced work in August 1992. By the beginning of 1993, after a period of observation and assimilation, managerial decisions had been taken, resulting in changes geared toward changing he style of service being delivered. Observed changes included the move of a senior member of staff from location B to location A and development of new posts for qualified members of staff as support staff left the organisation.

At the time of enquiry, the subjects were having to cope with a lot change at an organisational and professional level. Implicit in the professionally led changes was the message that the previous service had not been entirely satisfactory and there was a need for a more responsive, community based service.

Relating The Findings From The Three Aspects Of Investigation To The Research Questions

This study was concerned with exploring the model of occupational therapy with respect to inputs to activity, the clinical judgements made by occupational therapists and the nature of the activity itself (or outputs). Four research questions specific to this study were identified (table 2.1, pp. 35). How the findings of this study address the research questions is described below.

1. What activities do occupational therapy staff working with older people with mental health problems carry out?

Interviews with occupational therapists revealed that they were undertaking a wide range of activity and described it's many facets. Underpinning this activity was clear agreement across the group regarding the role and responsibilities of occupational therapy with older people with mental health problems. However, both the results of the interviews and the analysis of the diary data suggested that occupational therapy had not moved sufficiently into the community. Even when interventions were conducted in a community setting, the hospital remained the central focus for exchange of information and decision taking; health and social care staff in the community being consulted only on rare occasions.

2. How does staff activity vary within the same service and what are the reasons for variance

Analysis of the diary data showed that staff located in institutional settings had a different pattern of work to those staff working in settings where more of a community orientation was encouraged. Staff based in what were closing long stay institutions were more inclined to limit their clinical interventions to the hospital base and spend a greater proportion of time in communication with other staff in the hospital and other activity not directly related to patient care. It was striking that the two staff working in day hospital settings spent most of their time in activities with patients which were not orientated toward either assessment or treatment. Despite these clear differences which appeared to be directly linked to treatment setting, the interview data showed that there was general assent across the whole group with regard to what an occupational therapy service for older people with mental health problems should offer.

3. What are the occupational therapists' perceptions of their activity, and how does this match actual activity?

Due to issues of confidentiality, it was not possible to link the activity of specific members of staff to their interview data. Certain findings in the diary data were mirrored by what the subjects said during the interviews. These included lack of involvement of carers in assessment and treatment and learning on the job rather than devoting time to education and supervision. There were also some areas of dissonance between measured activity and the views held by occupational therapists; for example, even though assessment was viewed as being the predominant activity by nine occupational therapists, treatment within the confines of the hospital was greater in institutional settings A and B, with six of the 11 people interviewed working in those settings.

4. What are the factors which most influence staff activity?

The results of analysis of diary data suggest that greatest overt influence upon activity was the base from which staff were working. However, despite the differences in service delivery derived from treatment location, during interview all subjects were in general agreement about their role and responsibilities, indicating the existence of other influences upon activity.

Referrals made to the service inevitably shaped the nature of activity. However, as the predominant method of receiving referrals was from other disciplines, the type of referral received could be attributed, at least in part, to the expectations and perceptions of the occupational therapy service by those making the referrals.

At the time of enquiry, despite organisational and managerial changes which were beginning to take place, job satisfaction with clinical aspects of the work remained high and the adverse consequences of poor job satisfaction upon activity were not apparent

Study Two: Summary

The results indicate that service location is a potent factor in shaping the nature of the occupational therapy service. Therefore where an occupational therapy service is based warrants appropriate thought and planning.

The findings also signify that there is an urgent requirement for occupational therapists to examine their own activity. This requires a fresh consideration of familiar practices in light of prevailing policy requirements; for example needs based assessment, and by taking the user and carer perspective more fully into account. Moreover, there appear to be other factors, aside from treatment setting which are shaping clinical activity. These are fully investigated in chapter seven.

CHAPTER FIVE

STUDY THREE: SURVEY ACROSS THREE DIFFERENT HEALTH LOCALITIES

The aim of this study was to examine the similarities and differences in activity of qualified occupational therapy staff working in the same specialty but in different health districts. This aim was underpinned by the research question articulated in chapter two; 'how does staff activity vary across different organisations and what are the reasons for variance?'

Selection of the Study Areas

The original project design involved applying a reliable and valid measure of staff activity across three health districts in the Yorkshire Region (see chapter three). However, health districts were radically changed in April 1991. The table below provides details of health districts in Yorkshire, and populations served for each district. (Source- 1991 census provided by Leeds Health Care).

Table 5:1 - Populations Served by Current Health Districts

Health District	Population
Bradford	**457344**
East Riding	**500889**
Leeds	**680722**
North Yorkshire	**702761**
United Health (Scunthorpe, Goole)	**357151**
Wakefield	**310915**
West Yorkshire (Dewsbury, Huddersfield, Calderdale)	**564712**

The table illustrates the wide areas served by the 'new' health districts and the variance in population sizes.

Preliminary investigations, prior to commencement of data collection, confirmed that a comparison across services within different health districts would not satisfy the requirements of the research. Therefore, three occupational therapy services for people with mental health problems were selected for investigation on the basis of:-

- Population size
- Locality
- Status of the parent organisation
- Comparable numbers of occupational therapy staff
- The service being for people aged 65 years and over

Using the above criteria, occupational therapy services for psychiatry of old age in three health locations were selected; locations X, Y and Z. Locations X and Y were part of the same health district, while location Z was in a separate health district Each of the localities encompassed a mixture of urban and rural environments. Two of the three occupational therapy services operated

within NHS self governing trusts. Location Y was still a directly managed unit but was in the process of re-applying for trust status. All three occupational therapy services employed comparable numbers of staff at the time.

The managers for each service were contacted and arrangements were made to visit them to obtain information about the nature of the service and explain the project. It was not possible for the researchers to personally oversee the data collection due to the geographical locations of the study sites. Consequently, it was essential to obtain commitment and cooperation. The visits also served the purpose of introducing staff to the activity diary and explaining how to complete it.

The staffing in each of the three services at the time of enquiry is appended (appendix nine).

Data Collection

Data collection in all three areas took place Monday to Friday of the week beginning Monday 13th December. The correct number of pre coded diaries were posted to the subjects before the week identified for data collection and the completed diaries were subsequently returned in the post

Data collection resulted in 11 data sets, each data set containing a record of activity for the working week of the subject who completed it. Diaries that did not reflect the time span of a typical working week for the subject were not used. As a consequence, there was less data available than expected, with nine data sets available for analysis.

Table 5:2 summarises the grade and work location of occupational therapists who took part in the data collection; and amount of data submitted by each individual, illustrating the variance in amount of data submitted.

Table 5:2 - Summary of Data Available for Analysis

Grade	Location	Data Collection		Number of events
		days	hours	
Senior I	**X**	**4**	**29.75**	**121**
Senior II	**X**	**3**	**32.25**	**129**
Basic Grade	**X**	**5**	**35.50**	**201**
Senior I(i)	**Y**	**2.5**	**18.75**	**199**
Senior I	**Y**	**2**	**13.50**	**69**
Senior II	**Y**	**4.5**	**32.75**	**140**
Head III	**Z**	**5**	**35.75**	**264**
Senior I	**Z**	**4.5**	**33.50**	**338**
Basic Grade	**Z**	**5**	**36.75**	**254**

Results of Analysis

Data were analysed by:-

1. Totaling the recorded occurrence of each category of activity for every diary
2. Calculating the average occurrence of each category of activity for each occupational therapist.

Summary of the main findings

The findings are summarised in the same manner as in chapter four. They are given in charts 5.1 and 5.2. overleaf. Chart 5.1 gives the results by frequency of each of the 15 categories of activity for each person. Chart 5.2 provides an alternative analysis of the same data in that it illustrates the occurrence of events by the collapsed categories of activity.

Chart 5.1

Activity Categories: Incidence of Recorded Activity

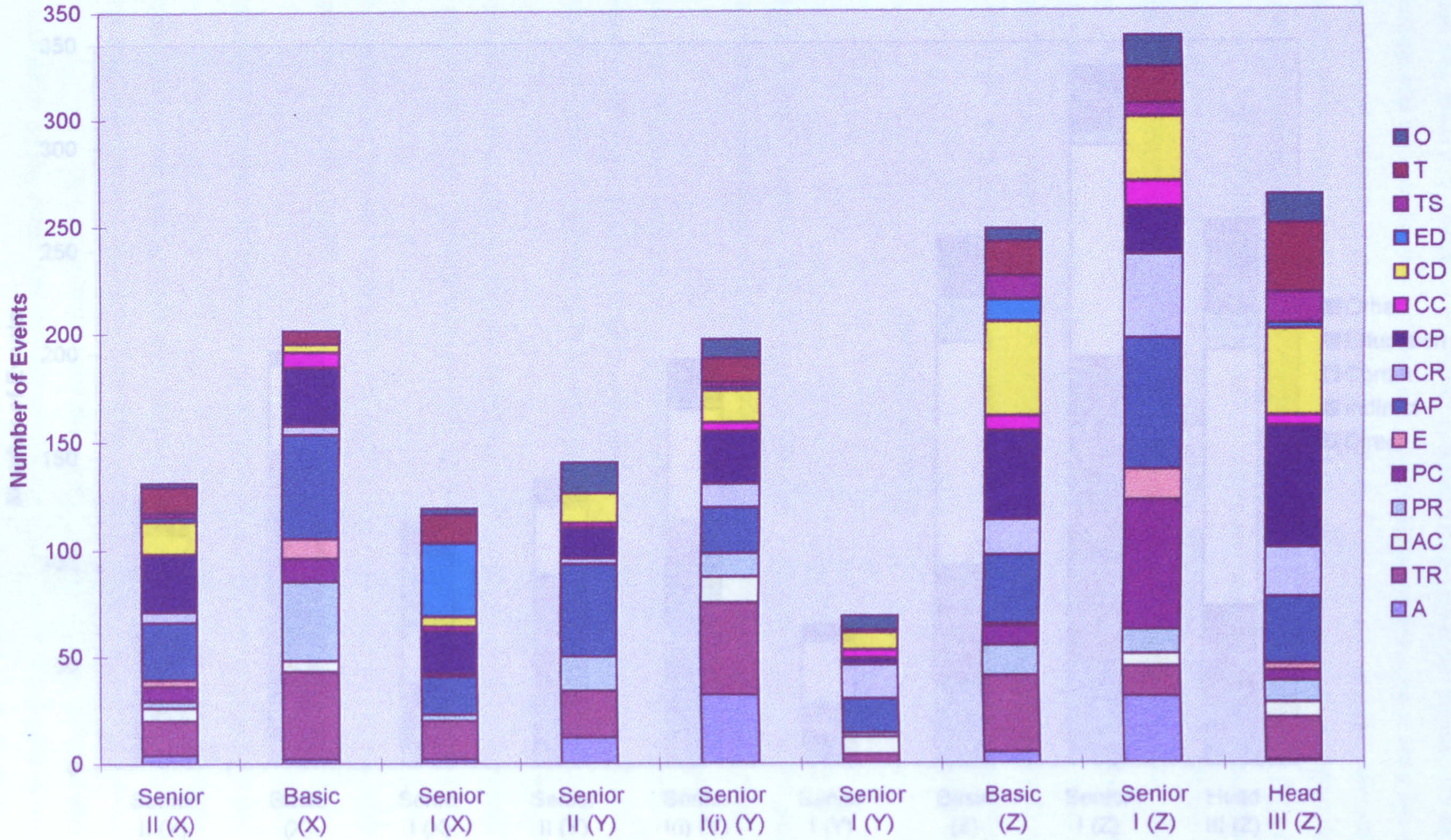
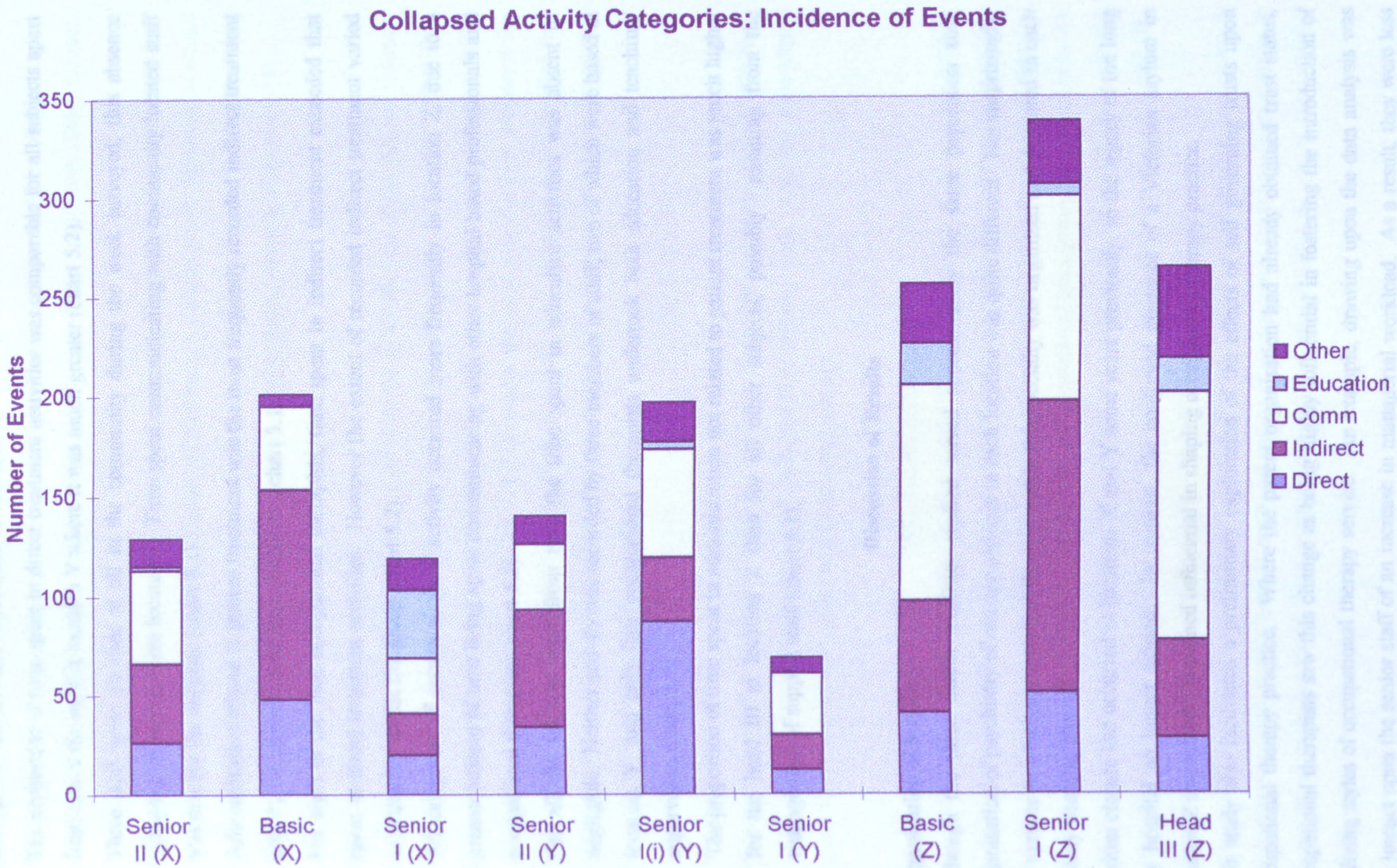


Chart 5.2


Collapsed Activity Categories: Incidence of Events
Number of Events
350
300
250
200
150
100
50
0
Other
Education
Comm
Indirect
Direct
Senior II (X)
Basic (X)
Senior I (X)
Senior II (Y)
Senior I(i) (Y)
Senior I (Y)
Basic (Z)
Senior I (Z)
Head III (Z)

The main points drawn from the charted results are:-

- The proportion of time spent in direct treatment activities was comparable for all subjects apart from one of the staff in location Y where it was much greater (chart 5.2).
- Three staff spent no time at all in the community during the week surveyed; this absence occurring across all three locations. Time spent communicating with community located staff was rare for the majority (chart 5.1).
- Administration related to patient treatment was the most frequently recorded indirect treatment activity for all staff in all three locations (chart 5.1).
- For eight of the nine occupational therapists, time spent in indirect treatment exceeded that spent in direct treatment activities. However the extent of recorded indirect treatment varied considerably across the group (chart 5.2).
- All categories of communication activity occurred more frequently in location Z, due to a greater amount of time being spent communicating with other hospital based professionals and occupational therapists (chart 5.2).
- For all the subjects apart from two, the time spent in educative activities was absent or negligible. Neither activity was recorded by three members of staff; two of which were based at location Y, and only four occupational therapists undertook both education and teaching/ supervision (chart 5.1).
- The proportion of time spent in administration not related to patient treatment was much higher for the head III at location Z than for all other subjects, possibly resulting from the management of support staff (chart 5.1).

Discussion of Results

Organisation of services

Although the three health localities studied served approximately the same population size, organisation of psychiatry of old age services in each location was quite different. Not surprisingly, the manner in which occupational therapy within this specialty was organised and delivered in each locality was also diverse.

Asylum closure had occurred in locations X and Y some years previously, so the legacy of the long stay hospital no longer existed. In contrast, the continued existence of a Victorian asylum in location Z undoubtedly remained influential in shaping occupational therapy practice.

This study also facilitated a preliminary exploration of the effects of self governing trusts upon occupational therapy practice. Where the parent organisation had already obtained trust status, occupational therapists saw this change as being highly influential in fostering the introduction of differing styles of occupational therapy service. An example, drawing upon the data analysis was the impact upon the senior staff of an increase in managerial workload. As a result, they were less engaged in clinical activity.

Staff numbers and skill mix

At the time of enquiry, the occupational therapy staffing levels in all three localities were no higher than the national average of 0.27 total established WTEs per 1,000 population (Blom Cooper, 1989).

A different occupational therapy skill mix existed in each area. The evidence from this study does not provide evidence of clinical activity of qualified staff being related to grade. However, in accord with the findings of study two, the most senior member of staff based in an institutional setting (head III at location Z) spent an inordinate amount in peripheral and communication activities.

Education and supervision

The low levels of educative activities which were recorded by all but one of the subjects warrants further investigation as it suggests that even junior staff were learning 'on the job' rather than receiving supervision or spending time updating practice. The reasons for this can only be a matter of speculation. One explanation may be that historically the service has always supported it's acolytes; custom and practice as 'benign neglect' or 'sink and swim' being the norm. Another may be that as a result of recent administrative changes, senior staff were not able to offer supervision due to an increasing focus upon management.

Treatment to meet needs

Staffing levels in all three localities were barely adequate, and unlike the service described in study two, there were no occupational therapy staff dedicated to community work. Activities were largely restricted to the hospital base rather than community settings.

Study Three: Summary

The limited scale of this study does not enable definitive conclusions to be drawn; the findings raising yet more questions, which need to be explored in further research. However, there is little doubt that location of occupational therapy services were significant in influencing organisation and style of service delivered. Moreover, the flattening of hierarchical management structures in health trusts was resulting in senior staff having to accept more managerial responsibilities. It also supports the findings of the previous study in that apart from at the most senior grade (head III), skill mix did not influence the activity process and clinical output.

Although the Blom Cooper enquiry into occupational therapy (1989) recommended an increase in qualified staffing and an acceleration in the relocation of occupational therapists from hospital to community settings, neither of these recommendations had been fulfilled in any of the localities studied.

The specific questions which arise out of this study are:-

- What effects were the health service reforms having upon professional identity?
- Given the increasing fragmentation of services, how should the work of occupational therapists be supervised?
- How many staff are necessary to run an effective community orientated service; and of what grades?
- Are head III staff cost effective?

The findings are discussed further in chapters seven and eight and used to test the model of occupational therapy activity.

CHAPTER SIX

STUDY FOUR - OCCUPATIONAL THERAPY WITHIN A MODEL OF SERVICE DELIVERY

Introduction

The final study explored the impact and outcomes of occupational therapy within a model of service delivery from a range of different interests; and also tested the validity of conclusions drawn from the preceding three studies.

This study is of particular importance in the context of the overall project. A rich literature already exists on formal and informal care networks of older people (Wenger, 1984; Sinclair et al, 1990; Challis and Davies, 1986). Nevertheless, this is the first time that occupational therapy practice with older people in this country has been placed under such close scrutiny from the perspective of the service user. Furthermore, enabled the model of occupational therapy activity to be tested with respect to inputs, clinical judgements, outputs and outcomes.

Selected Methodology

Meaningful service evaluation has to take account of all those with a stake in the occupational therapy service as they will contribute to the experiences of, and decisions taken by the older person and their carer. Therefore, case study methodology was considered to be most appropriate research strategy, in that it entails a multi-dimensional approach to data collection to capture different perspectives (Kellaher et al in Peace, 1990).

There has been much controversy about the merits or otherwise of case study as a research method. Academic debate has resulted in the grounding of case study research in rigorous methodologies (Platt in Burgess, 1988; Hamel et al, 1993 and Yin, 1994). Yin (1984, quoted by Platt in Burgess 1988) defines case studies as:-

"an empirical enquiry that investigates a contemporary phenomenon within its real life context when the boundaries between the phenomenon and the context are not clearly evident and where multiple sources of data are used."

Platt in Burgess, 1988, pp. 4

It is a method of gaining insights into complex unstructured problems which often occur within organisations (Easton, 1992), enabling an in-depth approach to be used which is not possible in other forms of evaluation research (Phillips et al, 1994). Data collection can embrace both quantitative and qualitative methodologies.

There are different opinions regarding the design of case studies and their purpose. Platt (in Burgess 1988) depicts the functions of case studies as being twofold; rhetorical and logical. The rhetorical function allows the researcher to use illustrative material to describe real life situations. On the other hand, the logical function is embedded in hypothesis testing through empirical evidence, and produces results which are generalisable. This notion is exemplified by Layder (1993) who describes two polarised methods of social research strategy; that of research to test

theories and research concerned with theory construction. A project does not have to exclusively adhere to one or the other methods and can embrace a mix in the manner described by Platt. Yin (1994), a psychologist who has specialised in case studies of organisational processes and written extensively on the subject, grounds his case study work in the generation of theory. He is clear that case studies give rise to theory and not statistical generalisation, a common mistake being a lack of distinction between the two.

Study design and associated methods of analysis require careful attention in the planning stages of a project. Yin states that theory building in case study design should always precede data collection, and that case studies should have the following five components Yin (1994):-

1. The research questions.
2. The study propositions or in the case of an exploratory study, it's stated purpose.
3. It's unit of analysis; for example an individual, service or organisation.
4. Logic linking the data to the propositions.
5. Criteria for interpreting the findings.

Lack of generalisability from one or a small number of cases is a frequently quoted limitation of the method. This is due to a lack of understanding regarding how the results can be generalised from case studies, particularly as an important aspect of the method is the retention of the individuality of the case. However, if a theory is generated prior to data collection, this is the means by which the results can be generalised.

Methods of Case Study Analysis

The foremost strength of the case study method is the collection of data from several different sources to illuminate the research questions. Thornton (1990) states that;

"presenting data from multiple sources adds to the descriptive force of the study by maximising the descriptive angles to the relevant feature."

Thornton, 1990.

However, this also results in difficulties in analysis (Hamel et al, 1993; Yin, 1994). In a classic work on sociological research, Denzin, (1970) points out that any research project is subject to researcher bias in the form of methodologies selected, sampling strategies, the timing of the research and how the results are interpreted. Use of several research methodologies and researchers in the same study will assist in eliminating bias that occurs when only one methodology is applied by a single researcher.

Associated with different case study designs are alternative methods of analysing case study data. One term frequently used to describe analysis of multiple sources of data is 'triangulation.' Triangulation is described by Fielding and Fielding (1986) thus;

"The basic procedure is to check links between concepts and indicators by using other indicators. This does not complete the test. Even if results match, there is not guarantee of actual inference."

Fielding and Fielding, 1986, pp. 24

Denzin (1970) identifies four types of triangulation; '*data triangulation,*' '*investigator triangulation,*' '*theoretical triangulation'* and '*methodological triangulation.*' Data triangulation involves the application of a range of different methodologies to the same study. Furthermore, data collection methods can be applied to the same situation at different times in different places and/ or in the presence of different people. Investigator triangulation means that several researchers are employed, thus decreasing researcher bias and increasing observational reliability. Theoretical triangulation has two main forms. One method is where a small set of study hypotheses developed from what is already known guide the data collection as in other forms of empirical study. Data is collected from multiple sources to confirm or refute the hypotheses. Alternatively, the researcher can develop his own propositions and theory, only relevant to the data to be analysed. Data triangulation, investigator triangulation and theoretical triangulation can all be applied to the same study. Methodological triangulation embraces two methods; '*within method'* and '*between method.*' Within method involves the researcher using one methodology and employing several strategies to examine the data set. Between method triangulation combines dissimilar methods to measure the same unit of analysis. Consequently, linking data in case studies means more than simple comparison of results. Kellaher et al in Peace, (1990) discuss the appropriateness of data triangulation in relation to studies which seek to investigate the complexities of input, process and outcome. Triangulation is promoted by situations like the presence of a multi disciplinary team where a range of different viewpoints will emerge.

Fielding and Fielding (1986) suggest the following methods of triangulating data:-

1. Aggregating data from different sources to explore different themes.
2. Looking at areas where data from different sources is in conflict.
3. Looking at results from different sources to contribute to the formulation of arguments.

Using the work of Fielding and Fielding (1986), Kellaher et al in Peace (1990) define outcomes of triangulation as findings which confirm the study propositions (confirmatory evidence), findings which do not substantiate the propositions (discomfirmatory evidence) and circumstantial evidence as results which emerge out of the study which were not grounded in study propositions, but are of major consequence.

Yin (1994) describes two alternative strategies for analysing the evidence produced in case studies. The first is use of the theoretical propositions to guide the analysis. The second is the development of a descriptive framework within which to describe the case, for example a working day. Underpinning these two strategies are three main methods of analysis; 'pattern matching,' 'explanation building' and 'time series analysis.' The method selected will be reliant upon the nature of the study. Pattern matching involves comparing a pattern arising from empirical investigation with a hypothesised one. Explanation building involves analysis of the case study by building an explanation of the case with the goal of developing ideas for future studies. Time series analysis compares patterns across a number of data collections over a period of time.

The application of triangulation to a project described by Kellaher et al in Peace 1990 involved a secondary data analysis using the results of a large quantitative study to provide the foundation for analysis of four case studies. Yin (1994) has termed this method '*case survey*'; stating that;

"*The case study is a relevant technique where the research objective is explicitly that of secondary analysis.*"

Yin, 1994, pp. 123

Method of analysis selected for this study

Design and analysis of this study incorporates data triangulation, investigator triangulation and theoretical triangulation as defined by Denzin (1970). Theoretical propositions were developed specifically for this study based upon the evidence produced from the first two studies, as well as the existing body of knowledge in the area. The pattern matching method of theory building (Yin, 1994) was thought to be the most appropriate mode of analysis. This involves the stating of study propositions prior to the commencement of the study. The unit of analysis was defined as the occupational therapy service within a model of service delivery. A series of research questions underpin the propositions.

Multiple sources of data concerning the occupational therapy service were collected by two researchers. The potential biases of the lead researcher were tempered by the observations of the second researcher, a social scientist with no previous exposure to the area under investigation.

Study propositions

Using findings from the first two studies, the literature reviewed and the lead researcher's knowledge of the practice of occupational therapy, the following theory was constructed, to be tested by the application of the case study method:-

Occupational therapists working with a community orientation are more responsive to patient needs. However working in this manner creates more challenges for the therapists themselves.

This breaks down into the following propositions:-

- The impact of occupational therapy upon users and their carers is enhanced when interventions are carried out in the community.
- Working in a multi disciplinary team augments the effectiveness of occupational therapists even when there is blurring of the distinct occupational therapy role.
- Working in the community increases the range and scale of occupational therapy responsibilities.

The resulting research questions, derived from the study propositions are shown in table 6.1 on page 102. Table 6.1 also identifies methods of data collection.

Table 6.1: Case Study Design and Methodologies

Theoretical Propositions	Key Research Questions	Data Collection Methods
Service Benefits ***The impact of occupational therapy upon users and carers is enhanced when interventions are carried out in the community***	• What are users and carers experiences of occupational therapy? • In what circumstances are benefits likely to be greater for users? • In what circumstances are benefits likely to be greater for carers? • How do other professionals view occupational therapy?	1. Qualitative interviews with service users and carers 2. Interviews with occupational therapists about their treatment of each user interviewed 3. Interviews with other key professionals 4. Case note audit
Multi disciplinary team working ***Working in a multi disciplinary team augments the effectiveness of occupational therapy even when it results in blurring of the distinct occupational therapy role***	• What commitment do occupational therapists make to the multi disciplinary team? • What are the problems for occupational therapists of multi disciplinary team working and what are the benefits? • How are referrals made to the occupational therapy service? • What interventions are conducted by occupational therapists as part of the multi disciplinary team? • To what extent do occupational therapists work alongside other agencies?	1. Audit of occupational therapy documentation 2. Interviews with other key professionals 3. Interviews with occupational therapists about their treatment of each user interviewed 4. Case note audit 5. Qualitative interviews with service users and carers
Responsibility ***Working in the community increases the range and degree of occupational therapy responsibilities***	• How do occupational therapists respond to the expressed needs of service users? • Which multi disciplinary team members are identified as key workers? • What are the expectations of other professionals	1. Qualitative interviews with service users and carers 2. Interviews with occupational therapists about their treatment of each user interviewed 3. Interviews with other key professionals

Research Design

The following sequential research design was developed:-

1. Identification of one field work area in the health trust previously involved in study two.
2. Liaison with key personnel working in the field work area prior to the commencement of data collection; that is, the occupational therapy staff as well as other members of the multi disciplinary team.
3. Collection of data regarding the occupational therapy service from several identified sources in order to explore the questions underlying the study propositions (see table 6.1).
4. Data triangulation to address the research questions and in so doing examine the validity of the study propositions.

The Selected Case Study Area

On the basis of the available information, the service offered by the staff based at location C and working in the services provided from location E was identified. At the time occupational therapists were responsible for providing a service to the day hospital which had recently moved from location C to location E; in addition to taking referrals from community locations in the east of the city. The reasons for selecting this area were:-

- More than one qualified member of staff were providing the service.
- Stable staffing profile during the previous year.
- Comparatively high level of activity.
- Occupational therapy service geared towards treating patients in the community.
- For the purposes of this study, the model of service delivery under investigation will be referred to as the community model.

Following identification of the area, permission was sought to interview patients from each of the three consultants responsible for the day hospital and identified community patches in the community model (identified as consultants A, B and C). Meetings were also conducted with the senior nurse responsible for the day hospital and three occupational therapy staff who were to participate.

The different strands of enquiry were conducted in the following manner:-

1. Identification of a maximum of 12 older people with functional mental health problems who had recently received occupational therapy.
2. A depth interview with each identified service user and where possible their carer to ascertain opinions about the service received. (see appended interview topic guide, appendix ten).
3. A description of the general activity of the occupational therapists in the field work area including referral and methods of documentation.
4. Identification of other health and social care professionals involved in the care of each older person interviewed, including those who had made the referral to occupational therapy.

5. Interviews or questionnaires to other identified with respect to the processes involved in referral of a patient to occupational therapy; and the expected and perceived results of occupational therapy intervention.

The forthcoming sections in this chapter recount the results obtained from each strand of investigation. The totality of results are then examined in light of the research questions to examine the validity of the case study hypothesis.

How the results of the case study relate to the overall aims of the project and the model of occupational therapy activity is discussed in chapter seven.

First Strand of Enquiry - Interviewing Service Users

Methodological Considerations

A key element of the case study was to ascertain service users' views of the occupational therapy service they had received. The method of choice was that of individual depth interviews[1] with people who had recently received or were still receiving occupational therapy.

In a publication which examines different methods of obtaining opinion from service users on behalf of a health authority, Bond (1993) looked at the importance of establishing why the views of service users are being sought and the issues involved in obtaining their views. Points to consider include those of confidentiality, clarity of purpose, feedback to the respondents and the resources necessary to undertake the consultation. Although the publication was aimed at informing purchasers of heath care, some of whom will have had little research experience, it does provide a useful checklist. When deciding upon the most appropriate method of enquiry, the relatively high resource implications of qualitative methodologies must also be considered.

The particular issues inherent in interviewing older people are described by MacPherson et al (1986). They considered the problems of interviewing people aged 75 years and over during a qualitative study which sought to explore user involvement in decisions about formal care arrangements. The researchers recorded their views following each interview. They concluded that problems of interviewing older people for research purposes are *"amplified"* and therefore it is crucial to establish optimum conditions for the interview. The issues highlighted by MacPherson et al (1986); for example the requirements for written as well as verbal appointments and the need to maintain a flexible informal approach were carefully considered in the undertaking of the interviews. MacPherson et al (1986) also stress that a pertinent view can be obtained in the majority of cases for this extra effort.

The Pilot Study

Four pilot interviews were conducted with a sample of older people prior to interviewing a cohort of service users for the case study. They were intended to highlight any problems in undertaking such interviews, and enable the topic guide to be checked and modified.

Older people for the pilot interviews were sought from a similar service to that chosen for the case study so that the issues covered in the topic guide would be of equivalent relevance. The interviews all took place during May 1993, the same researcher conducting all four interviews. The topic guide is shown in appendix ten, and results of analysis the pilot interviews with four older people are given in appendix eleven.

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[1]See chapter three, methodological considerations, for an explanation of depth interviews

General Issues Highlighted by the Pilot Interviews

1. The topic guide proved adequate and was therefore retained in it's original form apart from the addition of a question relating to the range of services arranged for the older person.
2. Photographs proved to be a necessary prompt. It would have been very difficult to proceed with the interviews otherwise. An understanding of the treatment a person had received also proved useful for prompting and guiding the discussion appropriately.
3. Being interviewed in the day hospital itself may have increased interviewee compliance as the interviewees were aware of staff moving around outside the interview room due to the glass panels in the door. The person interviewed in her own home was more forthcoming about the treatment she had received. Although she was generally more communicative, the venue for the interview may have contributed.
4. Time scales between involvement in treatment and interview were important. One person became confused over a series of treatment episodes. If treatment had been ongoing when the interview occurred, confusion may have been less.
5. Tape recording the interviews did not present any problems.

Implications of Analysis of the Pilot Interviews

As well as substantiating the methodology for further interviews, several questions emerged from analysis of the pilot interviews:-

- Why do elderly people opt into or out of treatment, and what are the reasons for this?
- When should help be offered at the expense of independence?
- What are the reasons for lack of patient involvement in planning overall treatment?
- What are the outcomes of day hospital activity?

Following the four pilot interviews, nine older people who had recently or were still receiving occupational therapy were selected for interview about their experiences of the service operating from location E. The interviews were conducted over a three month period from the end of June to August 1993.

Background information

Summary information on each person interviewed is shown in Table 6:2 overleaf.

All those interviewed were female and aged 65 years or over. All were living independently in the community at the time of interview, six living alone, two with partners and one had her son living with her. Four of the people interviewed were accommodated in some form of sheltered housing at the time.

In addition to having a complex association with psychiatric services, four people had severe physical problems which affected their functional ability and had resulted in treatment from other specialist services. The extent of the networks of care for each person are shown in a further section

in this chapter, all the available evidence demonstrating that the extent of psychiatric and social care needs of all the older people were complex.

Table 6:2 - Summary of Information Available about the Older People Interviewed

Name	Date of Birth	Psychiatric Diagnosis	Living Circumstances
Mrs LF	25.09.22	MD Psychosis* (depressed)	lives with partner
Mrs KA	09.02.23	MD psychosis (depressed)	son lives with her
Mrs DB	26.12.27	anxiety, depression	lives with husband
Mrs EC	24.10.11	depression	lives alone
Mrs SF	08.08.15	MD psychosis (depressed)	lives alone
Mrs MR	18.08.25	alcoholism, epilepsy, overdose	lives alone
Mrs BP	10.07.12	MD psychosis (depressed)	lives alone
Mrs HW	11.06.23	depression	lives alone
Mrs DW	15.12.23	anxiety, agoraphobia	lives alone

* Manic Depressive Psychosis

Procedures for the interviews

Each interview was conducted using the topic guide previously devised for the pilot interviews (appendix ten) in the person's own home, using photographic prompts of the occupational therapy staff, including support staff. Additionally, it was possible to talk with the two husbands who were also carers.

The interviews taped and subsequently transcribed. Analysis was carried out using "The Ethnograph", a computerised package for qualitative analysis (Seidel et al, 1995). Ethnograph allows the coding procedure in qualitative data collection to be computerised, aggregation of the coded data being one of the resulting procedures. It also enables the input of biographical details on each respondent. For this set of interviews, use of the package was limited to the coding of text. Computerisation did speed up the process of analysis considerably.

Results of Data Analysis

Themes extracted from the data complemented those extracted from the pilot data set. However as this group of older people were far more forthcoming about their personal and social circumstances than the people interviewed for the pilot and as the majority were still receiving active occupational therapy treatment, they had less trouble recalling events. Nevertheless, photographic prompts proved invaluable in identifying members of staff.

Individual circumstances

Expressed problems and associated feelings

The problems older people were coping with spanned physical illnesses, the issues associated with ageing and mental health difficulties. Four of the people we spoke with specifically described their problems in terms of the physical illnesses and how this had affected their mental state. Those people who had been admitted to hospital with serious physical illness all remembered their experiences in detail.

> *Since I've been ill - I had cancer - I haven't been very well with that; and I would say I've more or less spent about a year in hospital, you know in stages. When I came out nobody medically seemed to talk too much about things and I got really depressed and didn't want to go out at all.* (Mrs KA).

Mrs EC was waiting for an operation and this was a major preoccupation as a previous similar experience had been very traumatic. She had also suffered a mild stroke to which she attributed some functional problems.

> *Well, I had a slight stroke, a mild stroke and it upset my balance. I was going with a stick you know...I began to lose my memory a little bit...*

Mrs DB suffered from severe emphysema which she linked with her mental health problems;

> *They say it's a vicious circle; the chest is bad and I'm depressed and the panic attacks come on and its a case of breaking that circle..*

Mrs BP also had a stroke and also described her problems exclusively in terms of a range of functional problems like dizziness, poor mobility and a tendency to tire easily.[2] Mrs MR had a longstanding physical disability for which she should have been wearing a leg caliper. This caused on going distress.

Some of the problems raised were the frustrations of trying to maintain independence in the face of physical illness and increasing frailty.

> *I shall be glad when I can go to the shops, its a nuisance when you can't do your own shopping.* (Mrs BP).
>
> *On Sunday I tried to open a little of salmon. I've about five tin openers and I couldn't open it, so I couldn't have salmon for my tea.* (Mrs EC)
>
> *It's the vaccing; I can't push it up and down* (Mrs KA).

In addition to increased difficulty in carrying out activities of daily living, the effects of age and infirmity touched other areas of the women's lifestyles; for example ability to undertake lifelong interests. Mrs HW could not continue her hobbies due to poor hand mobility.

> *I love sewing, knitting and crocheting but I can't do any more.*

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[2]It is significant that there was no reference to stroke in the case notes of Mrs EC and Mrs BP.

Similar frustrations were described by Mrs BP;

> *...my eye infection means I can't see very well for sewing which was always a very big thing with me.*

Mrs EC "*loved dancing*" but she was no longer able to go due to her physical problems.

Mental health problems formed only part of the spectrum of difficulties described and the significance placed on this aspect of overall health varied considerably. However, overall the mental distress described was severe, as would be expected from a group of people who had received formal psychiatric care. Difficulties expressed were physical and psychological symptoms of depression, anxiety and associated panic attacks and general lack of confidence in situations outside the home.

Mrs HW described herself as being awfully depressed and fearful of the way she was feeling.

> *...when I did first start going to this clinic I was in a bad way and I did feel like committing suicide.*

It was sometimes difficult for the interviewees to describe what they had, or were still experiencing.

> *...this is the bogey - its so difficult for me to come and start doing things normally.* (Mrs SF)

> *I'll say it's a mystery illness.* (Mrs LF)

The consequences of mental health problems like loss of confidence and lack of motivation were frequently difficult to reconcile. Respondents used words like "*lazy*" and "*guilty*" to describe their behaviour.

> *....I think I'm lazy. I don't know what it is because God, I've never been lazy in my life.* (Mrs SF)

Mrs HW said she felt "*guilty*" because of her inactivity and said that previously she was "*never still.*"

Several of the women found that familiar, necessary activities like cooking were difficult to undertake because of the way they were feeling. Therefore in addition to the increased difficulties of maintaining independence due to physical factors, mental health problems also affected ability to care for oneself.

> *At one stage I did think that I; well I got to the stage where I couldn't cook.* (Mrs MR)

Clearly they were challenged in their attempts to maintain independence by physical illness and mental ill health alongside the ageing process. However, there was an acknowledgment of how previous experiences and opportunities can influence coping abilities. In some cases current problems could be attributed to specific lack of preparation or opportunity in earlier life; for example not learning to drive or not having had time to develop a social life. Two people described more pervasive problems which had left them not able to cope more generally. Mrs KA had experienced a very hard life as a single parent and thought that some of her current difficulties stemmed from having to "*bottle everything up*" when she was younger. The effects of bereavement had a profound

effect upon Mrs SF who had experienced a close relationship with her husband. They had worked and enjoyed a social life together; his death rendering her unprepared for a life alone.

Housing

Another set of problems which were referred to were those generated by the lack of suitability of their environment in light of increasing infirmity; for example not being able to climb hills to get to the shops or lack of local shops.

> *..I can't get into town, only to these few shops around here.* (Mrs LF)

A move to more easily maintained accommodation could be triggered by the advent of increasing infirmity alongside bereavement. The two interviewees with partners had remained in accommodation of long standing. Mrs LF discussed the problems of accessing local shops but as she was not living alone, coping was still possible. Mrs SF was still living in the house she shared with her husband for over thirty years. However, they had been so involved in their own life as a couple, she was quite isolated from the neighbourhood.

Four of the people we spoke with had moved into accommodation with a warden. Of these four, three were widowed and Mrs MR was no longer living with her husband. A widow for many years, Mrs EC mentioned that the reason why she had moved into warden assisted accommodation was because she had been burgled six times at her previous house. Only Mrs MR who was in a quandary over her housing needs discussed her accommodation at any length.

> *I felt as if I wanted to go into a 24 hour care place, but then I decided that I couldn't completely give up my independence, you know. I just like this here, I can do my own thing, I can cook my own meals.*

Nevertheless, living in accommodation designed for the elderly did not guarantee a better quality of social life. Even though she was living in sheltered accommodation, Mrs EC felt lonely.

> *They're quiet in these flats, there's no interchanging.* (Mrs EC)

Family and friends

Of the nine people we spoke to, two were living with partners and six had children of their own. All had been married. Those with children included one respondent who lived with her husband. During the interviews, discussions about families were inextricably linked with care being received from various family members.

For the two women with partners, their problems had resulted in a heavy reliance upon their spouses for both physical assistance and emotional support. Mrs DB was aware of the burden this placed upon her husband.

> *...I don't care how well you get on, you can get under one another's feet...I like him here because I like the company but he must get a bit fed up sometimes.*

In contrast, Mrs KA whose son had moved in to live with her felt clearly unsupported.

> *...I've got a family but I don't think they understand really.*

Those women with children all described being visited and obtaining varying degrees of assistance. However expectations of assistance from children were generally not taken for granted; and reliance placed upon sons was less than that expected from daughters, a finding which has been echoed in larger scale studies; for example the work by Qureshi and Walker, (1989).

> *My daughter often comes in on a Tuesday, my son just drops in when he can find the time.* (Mrs BP)

Mrs KA gave a complex set of reasons for the lack of assistance from one of her sons.

> *...before they were both working and now they've got the baby. And he has his own job and to make more money he has another job at night, because now he's buying his house and now his wife's stopped working and they have the baby.*

Mrs SF was heavily supported by her two daughters, having contact and assistance from them five days out of seven.

Although Mrs MR had a large family she was clear that she did not want her family to care for her out of a "*sense of duty.*" She also inferred that staying with members of her family limited her independence.

Mrs LF and her partner were supported by a niece from her husband's family, but Mrs LF did not have any family contacts of her own.

> *..a niece and her husband live just up there and they go shopping for us, which helps enormously. I have a niece and a nephew but I don't know where they are.*

It appeared that the two widows who had not had children had to be more independent.

> *You see I have no family of my own unfortunately and it's very rare that anybody comes.* (Mrs HW)

It transpired during the interview that Mrs HW did receive more help from other family members than she was willing to concede to. As Mrs HW was without children or partner and therefore did not relatives with strong obligations, she may have perceived the available help to be from an unreliable source. It was evident from the interviews that those women without close relatives were in a far more vulnerable position regarding availability of help.

The extent to which other relationships; for example those with neighbours and friends had moved towards that of providing practical care and emotional support varied across the group. Type of residence or length of time spent living there did not appear to influence the care networks in this sample of elderly people. Mrs SF was helped very significantly by her daughters and just met her friends when she attended the day centre or by telephone contact. However, she did not get any help from her neighbours even though she had lived in the same house for many years.

Mrs EC relied upon the church for emotional support, help from family being severely restricted by lack of close relatives. She was in the position of having to rely upon her own coping abilities in the majority of circumstances, particularly as she described herself as "*about the fittest*" in the sheltered housing development where she lived. Mrs DB depicted all her neighbours as either *"all gone or elderly"* so that apart from her husband and family there was no one else to call upon.

For Mrs BP and Mrs KA the situation was clearly that of older people looking after other older people. Mrs BP had helpful friends and neighbours in the sheltered housing complex where she lived.

> *I have a neighbour further up who brings me lunch and things like that. The warden's very good. She'll go and fetch my pension or prescriptions.*

Most of the older people we interviewed were highly reliant upon family, friends and neighbours for practical and/or emotional support.

Independence skills

Even though reliance on others by all the subjects was high, four of the people we spoke to were determined to maintain certain skills and interests in the face of illness and frailty. Mrs BP resolved not to return to hospital even though it had been recommended. Her lifestyle had clearly been curtailed by her illness but she was determined to manage.

> *I can't walk much now but I do go down the road to get a bit of exercise. But I'm not very good really. I'm doing a bit outside in my garden but that's about as far as I get, apart from cooking my meals.*

Even when daily living did prove problematic, there was a determination to retain some independence and for some this entailed the development of alternative strategies; for example using taxis to get about. Mrs EC described engaging a mobile hairdresser. Both Mrs EC and Mrs HW reluctantly accepted a lower standard of housework.

In contrast, Mrs DW took full advantage of the help that was available accepting meals on wheels in preference to cooking for herself. She did not go out at all apart from to the day hospital. Mrs SF was overwhelmed by her feelings of depression and found being independent very difficult. She also found her feelings inexplicable, as "*she had worked all her life.*"

A major problem area was leaving the house. Five of those interviewed found going out unaccompanied problematic.

> *If I do go out I go shopping with my sister.*
> (Mrs HW)
>
> *...sometimes I like to walk to that gate and I change my mind. If somebody's with me I'd probably go further.* (Mrs KA)
>
> *I'm not prepared to go on my own.* (Mrs SF)

The two subjects living with partners were only prepared to go out accompanied by them. Mrs DB also had a motorised scooter to enable her to go out.

With such a small group of interviewees the range of reasons why one person develops coping strategies and another does not cannot be fully drawn out. However the four people who were more determined to maintain a level of independence all lived alone in contrast to the two living with partners who relied heavily on help from them. For these two ladies with partners, it appeared that the knowledge that someone was there to help all the time meant that maintenance of independence skills was less critical than for those coping alone.

Leisure and recreation

The distressing effects of infirmity upon ability to undertake lifelong pastimes have already been described.

Only one of the women was actively trying to expand her social life, the effort of trying to retain an existing lifestyle being challenging enough for the others Mrs MR was considering voluntary work suggested by the occupational therapist as her social life had become very restricted over a long period of time by her mental health problems. For the other eight people we spoke with it was a case of trying to maintain some level of familiar activity. Church was an important feature of social life for Mrs EC and Mrs BP. Mrs KA attended bingo arranged by the church one a week. Mrs SF got some pleasure from her caged bird, but for her, and several other people we spoke to, television appeared to be the major source of entertainment. Mrs HW also mentioned that the opportunities for leisure and recreation in earlier life had been somewhat limited by work.

Perceptions of interventions from professions and agencies other than occupational therapy

Social care

Forms of social care mentioned were all practical and included home care services, housing wardens and in one instance provision of aids to daily living by social services.[3] The pattern of care provision was not dissimilar to that already exposed by larger studies in that practical care provided by families decreased the amount of support offered from social care agencies. Mr and Mrs B had requested several services but nothing had materialised. Mr B gave vent to his frustration;

> *The social services were a wash out. They promise you so much...we'll get somebody to help your cleaning, we'll get somebody to sit with her so you can go out, but nothing at all, nothing.*

Mrs KA implied that a service had been withdrawn since her son had come to live with her but she would not enlarge upon this.

> *Well, I used to have; before my son came, but he's not very good at cooking but still; I had a home help.*

Mrs SF paid privately for help with her home and garden. Mrs MR did not receive any practical care but was living in sheltered accommodation.

The remaining five people received social services home care. Frequency of the home care service ranged from weekly to once a fortnight and time allocated for each visit was also variable. Tasks undertaken by the social services home care staff were in the main shopping and collecting of pensions. There was a resigned acceptance of this limited role.

For those older people living in sheltered accommodation, the role of housing wardens was viewed in the main to be to that of surveillance. The warden where Mrs EC was living visited daily to see if she was alright whereas Mrs BP's warden used the intercom daily with one weekly visit. Another

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[3]Day centre attendance is referred to in the context of day services.

aspect of the warden's job was that of facilitating socialisation amongst the residents.

Attendance at day services

Five of the people we spoke with had attended the day hospital at some time and two were still attending at the time of interview. However, Mrs HW was due to be discharged. The only person who claimed not to have benefitted from attendance was Mrs DB who started going immediately prior to be admitted as an in-patient (possibly in an attempt to prevent admission) and then while still resident in the hospital.

> *I went twice and then I landed up in hospital. They sent me down from there (the ward) but I was really poorly so I didn't want to go. They said it would do me good, but I was in such a state that I was turfed back upstairs.*

The other four described favourable experiences of attendance. The day hospital offered a secure, social environment. Activities described were predominantly social; for example quizzes, games and recreational cookery. They appeared to enjoy being timetabled in this way by the nursing staff and occupational therapy helpers.

> *..on a morning we have keep fit and then go onto discussions about different things and then it's dinner time and then after dinner we have a quiz, sometimes bingo. They're very nice there.* (Mrs DW)

As with the older people interviewed during the pilot, it was evident that a social disposition was required for the user to benefit from day hospital attendance.

Those who had been discharged from the day hospital or expected to be in the near future expressed regret about this.

> *There was always somebody on hand if anybody was upset or anything. Also the doctor would see you every so often.* (Mrs KA)

Mrs HW was clearly very worried about her impending discharge from the day hospital;

> *...they think that I'm alright but unfortunately in my own heart I know that I'm not.*

In preparation for discharge, day centre attendance was could be suggested. Mrs EC and Mrs KA had both started to attend day centre and it had been suggested to Mrs HW. Mrs KA's first experience of day centre was unfavourable, but she had found an alternative which was more acceptable. Although Mrs SF had not attended day hospital, she did go to the Jewish Day Centre.

Experiences of in patient psychiatric care

Eight of the nine interviewees had been admitted for in patient psychiatric care in the recent past. Some people like Mrs DB wished to speak at length about their experiences of in patient care. For others it was a confusing time which they would rather forget. Interventions recalled while in hospital included making contact with the occupational therapy and physiotherapy staff, undergoing relaxation sessions and commencing day hospital attendance.

The older people had difficulty in making sense of what had occurred during the admission. Mrs SF could recall key dates readily but could not recall the time she had spent hospital for her mental

health problems, and even though she was hospitalised over an extended period of time, talked very little about it. She did admit that she found it very hard "*coming out.*" Difficulty in recalling in-patient care was also expressed by Mrs LF;

> *I can't remember going into hospital or being admitted, but they say I was ill when I went in and the doctor told me I was in a bad way when I went in but I can't remember.*

Mrs DB still could not rationalise her behaviour during admission;

> *You see I was like this in S* (location E), *I was terrible. I didn't go to the toilet for three days, I wouldn't go to the toilet, I wouldn't go into the bedroom. Well, when I say I wouldn't; to me I couldn't, at that time.*

Mrs BP remembered the time she spent in hospital in terms of having to prove that she was still capable of living in the community.

Interventions from other professions

The subjects talked about a number of other health care professions involved in their treatment and care in addition to occupational therapists. They also included staff of importance to them who they had seen in the past. Those mentioned included medical staff, psychologists, community psychiatric nurses and physiotherapists. From the descriptions of interventions undertaken by various disciplines it appears that professional roles had been blurred in some respects, different disciplines undertaking a range of interventions. Mrs SF and Mrs KA had been treated at home by psychologists. For Mrs SF this was continuing whereas for Mrs KA, occupational therapy was substituted for psychology. Mrs HW, Mrs BP and Mrs MR had received physiotherapy in the past for their physical problems.

The introduction of a different profession could be in response to expressed need. As Mrs MR was undecided about her future living arrangements she had been visited by a social worker. She had also attended a psychotherapy centre briefly but decided that it was not for her.

Only Mrs EC could recall having been visited by a community psychiatric nurse who talked with her and helped her sort out her bathing problems.

The common denominator across the group was medical intervention in that at the time of interview as everyone had an out patient appointment with a psychiatrist, and were under the care of their GP. Mrs MR expressed some dissatisfaction with the constant change in medical personnel;

> *...you might just get used to one and then you have another one come.*

Occupational therapy interventions

Perceptions of reason for referral to occupational therapy

The people we spoke to had been referred to occupational therapy in a number of different ways. Their awareness of and involvement in the process extended from discussions with the referrer about their opinions before referral was pursued, to no awareness at all about the referral prior to contact being made by the occupational therapist. Perceptions of referral was undoubtedly influenced by the recollections of each individual, and their status at the time. However, certain patterns did emerge from these interviews, and the importance of explanation on the part of the referrer became

apparent. That those people who were better informed about how they had been referred knew more about the reasons for referral is not an unexpected finding.

Only three of the respondents recalled a discussion taking place about being referred. In two cases they took place before discharge from an in patient setting. For Mrs MR this took place with her doctor;

> *I was asked and I agreed.*

In the case of Mrs DB, discussions took place with ward staff prior to her discharge home.

> *When I came out of S....my charge nurse said she would get someone to follow me up when I came out, if that would suit me because I was in quite a long time and it was time I was coming home. So I said "Yes that would be fine" and so she said "I've got A to come out to you, would you like a word with her over the phone?"*

Mrs KA first had contact with the occupational therapist while attending the day hospital but she had been fully informed about the referral by a psychologist who was also treating her at the time.

For Mrs BP the first treatment sessions with the occupational therapist were arranged while an in patient. She had no recollection of the referral process.

Mrs EC, Mrs HW and Mrs DW had been attending the day hospital at the time of the referral and presumed that it had been arranged by the nursing staff, as no other explanation was given.

> *It must be the hospital.* (Mrs EC)
>
> *They do it with everybody.* (Mrs HW)

The two remaining older people were referred whilst out patients and both appeared to be slightly bemused about why referral to an occupational therapist had been arranged.

> *I thought she was sent from the welfare.* (Mrs SF)
>
> *...I just received the letter or phone call from them.* (Mrs LF)

Treatment regimes

Some of the people we spoke with were still being seen by the occupational therapist when we interviewed them and expected this to continue for some time whereas others did not expect any further visits.

There was a marked dichotomy in the group, in that five were in receipt of quite intensive occupational therapy and the remaining four had only experienced brief involvement with the service. There was no discernable difference in stated severity of physical and psychological problems across the two groups.

The people who had received only brief occupational therapy input were those who had most difficulty recalling events and people concerned with their occupational therapy treatment. It was easy to confuse the roles of different staff they had contact with in the absence of sustained intervention; for example nurses and occupational therapists were wrongly identified several times. Mrs HW commented;

> *You see so many people don't you...they tell you their names and that, oh my God there's loads of them. They come and they go so quickly.*

For the people who received brief intervention, reasons for occupational therapy involvement were easily clouded by experiences of hospitalisation or day hospital attendance.

Mrs BP had contact with the occupational therapist while she was still in hospital, and was then followed up by the same person accompanied by an occupational therapy helper once she returned home.

> *She actually came to see me at the hospital and questioned me.*
>
> *Oh the day I came home she came to see me.*

Mrs BP had a long interview while in hospital *"about my childhood"* and was also asked to make a meal. She was less clear about the home based interventions during the two subsequent home visits. She recalled being asked if she would like to attend day centre and being questioned about her interest in certain home based recreational activities.

> *I think she did ask me if there was anything that I wanted to do, and I didn't quite, because at that time I'd just come out of hospital and I didn't feel like doing anything.*

Mrs DW was seen by the occupational therapist during her attendance at day hospital, where she expected to make a meal. However, this never took place and her cookery experience in the day hospital was limited to the baking group run by the occupational therapy helpers. She was subsequently visited at home, but could give no reasons for the visits.

Mrs HW described attending the baking group run by occupational therapy helpers at the day hospital, and later being visited twice at home by a qualified occupational therapist and another person who she did not know. She was interviewed and then invited to be interested in craft activities in the home, follow-up being carried out by the second person (presumedly an occupational therapy helper).

Mrs EC also received brief occupational therapy intervention following a period of hospitalisation. The aim of occupational therapy intervention appeared to be establishing if she was able to go out independently, this being successfully achieved on one trip.

In contrast, the five people who had experienced more intensive occupational therapy recalled their treatment and the reasons for it without difficulty.

Although Mrs LF said that she had forgotten *"quite a lot of things"* she was very clear about her occupational therapy treatment programme.

> *For ten weeks she said it would be. Every other week.*

This also involved an occupational therapy helper, a long term aim being that of taking a bus journey. As Mrs LF was living with her partner he was inevitably involved in the plan of treatment.

> *Oh, they talk to him, listen to him when he's talking.*

Mrs KA first encountered the occupational therapist who was to treat her in the community during an attendance at the day hospital. Community based treatment was then commenced, a lot of the responsibility for carrying it out being delegated to an occupational therapy helper. This was still

on-going when we spoke with Mrs KA. She talked about a range of interventions including relaxation therapy, visits to day centres following discharge from the day hospital and trips into the local community with support from the occupational therapy helper.

Mrs SF had been seeing the occupational therapist at home over an extended period of time. Treatment was planned to continue but the member of staff involved was due to change. Involvement had been quite intensive and Mrs SF had clearly built up a relationship with the occupational therapist treating her. Treatment in this case focused upon cooking in the home and the associated tasks of shopping.

> *Well, we started off doing cooking, and baking and things like that. Then she took me to town. She took me out shopping and we went to Headingley.*

Mrs SF recounted the plan of treatment where her trips into the community were to be supported but unaccompanied.

> *...we went together on a bus, and then she was going to do it where I go on a bus to town and she follows on with her car.*

Although Mrs SF had been in hospital for a long period of time she did not recall receiving any occupational therapy treatment until she returned home.

The most intensive level of involvement was being received by Mrs DB, one of the two people living with a husband. When we spoke with her, ten sessions of counselling had just commenced. Prior to this, treatment had involved various strategies to cope with and overcome panic attacks, and encouragement to increase activity within the home.

> *She 's suggested all sorts of things.*

Mr B was not involved in the counselling sessions.

> *In the beginning he used to sit in and if he wanted to put his two cents in...then she would listen, and then suggest. But mainly it's me....*

It became clear during the interview that Mr B used the time when his wife was occupied as a period of respite from caring for her.

Mrs MR had a different style of treatment to the rest of the group in that she was attending the occupational therapy department at location C as an out-patient, treatment there taking the form of pottery and cookery groups. She had previously been a member of the out patient leisure group run by the occupational therapy service. Although the groups were run by different staff members, the occupational therapist still met Mrs MR to discuss her progress, help her to cope with anxiety and assist her in making appropriate decisions about her life. Contact had been maintained during an admission to hospital.

Role of unqualified occupational therapy staff

All nine interviewees had received some input from other members of staff or students associated with the occupational therapy service.

Mrs DW thought that the occupational therapist had been accompanied by some students when she was visited.

Mrs MR joined the pottery and baking sessions run by an occupational therapy instructor when she attended the occupational therapy department at location C for out patient sessions.

The other seven women had experienced some degree of contact with occupational therapy helpers in the community. The manner in treatment was delegated to support staff has already been described, their role being the undertaking of practical activities like accompanied trips into the community and relaxation and cookery sessions, rather than counselling.

> *She doesn't discuss, H, she doesn't discuss anything...she's been walking me about.*

Only Mrs EC, one of the women who had received brief intervention did not know why the occupational therapist had been accompanied by a helper when she was visited at home.

As with the pilot interviews, the role of helpers in the day hospital was less clear and easily confused with teaching or nursing.

> *I thought she was something to do with Domestic Science.* (Mrs DW)

Mrs HW described the role of occupational therapy helpers in the day hospital as assistants to the nursing staff and could not see how their job differed.

> *Well, she helps the staff. She joined in when we were doing exercises and sometimes group therapy and then they have quizzes...*

Perceptions of occupational therapy

Not surprisingly, the five people who were receiving more intensive input had formed a relationship with the staff involved and showed greater awareness of the reasons for the treatments they were undergoing. Mrs MR regarded herself as being part of the process rather than in receipt of care.

> *She wants my ideas.*

Mrs SF was clearly concerned about an impending change of therapist and the effects this might have. When talking about going on the bus;

> *She realises I couldn't do it. I'm not used to doing things on my own.*

Treatment was viewed by those in receipt of longer term intervention as being personalised to their needs.

> *..they wanted to see what they could do, and prepare me for doing things, seeing to things, looking after myself and that.* (Mrs LF)

The time spent with each person over time enabled information to be provided as described by Mrs DB;

> *....she explained all about the panics, why they're caused in a sense and also that there's nothing that can cure them but I can learn how to cope with them myself.*

It also permitted treatment goals to be extended.

> *She's completed what she's done, but I think she thinks I could do more, not depend upon people for me to go out there and walk up and down.* (Mrs KA)

Mrs DB's husband also considered himself to be informed and involved in treatment.

> *She's programmed her so far, now she's stopped that programme, and she's on to something else.*

Of the four who had brief interventions, less specific reasons for treatment were given, like Mrs HW;

> *They do it with everybody, more than not I've heard them say they've had a visit from them.*

And Mrs EC;

> *...she just comes and chats.*

Mrs BP was frightened of having to return to hospital and saw the occupational therapist as being influential in such a decision, particularly as she had commenced assessment and treatment as an in patient.

> *....when I came home that day she thought I ought to go back. She wanted me to go back to hospital.....I didn't have to go back into hospital, they thought I'd managed to make a meal so I'd probably be alright.*

Fear of being made to return to hospital may have resulted in reluctance to become involved in the treatment process once home, and being asked a lot of questions was resented.

> *She's been here about twice. I don't know why she come the second time. She didn't stop very long. She asked me how I felt, if I felt alright.*

Two of those interviewed had encountered occupational therapists previously, but only in an informal context. No one talked about any previous assessment or treatment episodes.

> *Well, I'd an idea through going to hospitals so much.* (Mrs HW)

> *...as far as I knew it was only taking these classes at the hospital; that's what I thought the therapists were for, completely for that.* (Mrs MR)

Mrs BP clearly got her initial perceptions confused with physiotherapy.

> *....I just presumed it was these exercises I'd done at the hospital.*

Benefits of occupational therapy

One of the benefits reiterated by the majority of those we spoke with irrespective of amount of involvement was the awareness that someone was interested and concerned for their welfare.

> *....because it shows they are trying to help you, you're not just left to carry on.* (Mrs HW)

> *I don't think it's changed my life as such but it's helped me to know there's somebody helping me. You get to look forward to them coming.* (Mrs LF)

> *...you know there's someone out there concerned about you and that's half the battle.* (Mrs DB)

Mrs MR made it clear that the difficulties of trying to cope alone in the community particularly after a period of hospitalisation could not be underestimated.

When you come out of hospital you start getting panicky again because of all the things you cut yourself off from and to know that you've got this link is very good.

There were also benefits expressed in being able to talk things over with someone.

It takes you out of yourself having someone to talk to. (Mrs MR)

The quality of the relationship with the individual therapist was integral to perceived benefits, as expressed by Mrs DB;

She gives me the feeling that she wants me to get right for me.

Compliance with the treatment regime

The majority of those interviewed said that they did not feel pressurised by the occupational therapy treatment and were able to refuse aspects which they did not feel able to undertake. However, refusal was usually in the context of a response to an imminent event rather than being expressed when treatment was being planned. Mrs LF described her reaction to planned trips into the community.

Well, H's been happen once or twice...and I've just said "Oh I don't think I can manage it today."

Mrs SF knew that there were plans for her to practice using buses independently but she was not going to agree when the time came;

No, I shan't do that.

The effect of non compliance was perceived by Mrs BP to be of great significance when she was receiving occupational therapy as an in patient. She talked about the opinions held by the patient group when she was an in patient regarding the consequences of refusal to acquiesce.

Well, they said you went to the kitchen to make a meal, if you passed you could go home, but if not you'd have to go and do it again, stay in hospital.

As Mrs BP was very keen to return home it is not surprising that she did not want to refuse.

I was under the impression that you've got to do this meal up there or you didn't get out.

Some of the questions asked during the initial interview were also a cause for concern for Mrs BP. However, this was not reiterated by the other people we interviewed who were generally of the view that information gathering carried out by the occupational therapist had not been intrusive.

....I didn't feel invaded or anything. (Mrs MR)

Discussion of the Interview Findings

Although this sample of users was small, information gained about informal care and lifestyle of older people echo many of the themes elucidated by existing pieces of rigorous research. Work on the care networks of older people (Wenger 1984) found that living with a carer renders delivery of services less likely. The marginal amount of support available to extremely vulnerable people has

been described by Ellis (1993). Furthermore, the results of these interviews provide a valuable insight into the experiences of older people as consumers of an occupational therapy service and assist in illuminating some of the issues identified during the pilot.

It is evident that the attitudes and past lifestyles of the older people together with their illness and social circumstances all contribute towards overall ability to be able to cope. Although the experiences of each individual will colour perceptions, key themes emerged which warrant further consideration and investigation.

Extent of problems experienced by the older people

The results of these interviews graphically illustrate the cumulative effects of physical and mental ill health in older age. Maintaining independence and a reasonable lifestyle in the face of increasing infirmity is extremely problematic. The addition of mental health problems only serve to exacerbate existing difficulties and dependence upon others, quality of life being severely eroded in some instances. Despite prevailing problems there was a determination on behalf of the majority to retain some level of independence. This was particularly crucial for those respondents who lived alone with less help from family.

Health and social care provision

As the people we spoke with had a complex range of problems, a wide variety of health and social care professionals were involved. However, from the descriptions of the services they had previously and were currently receiving, it appeared that the manner in which care was being delivered was often restricted to certain patterns. One example is attendance at day hospital where the regime described by subjects during this set of interviews and the pilot interviews focused upon socialisation. Therefore to experience benefit, it was necessary to be sociable. In addition day centre attendance could be prescribed as a result.

It appeared that practical forms of care were extremely restricted for all apart from the one person who could afford to pay for care. For those reliant upon social services provision, there were difficulties in obtaining the services that they really wanted, leading to resigned acceptance.

Referral to occupational therapy services

The extent of problems faced by this group of older people were pervasive and should not be underestimated or trivialised by service providers. However, the interviews highlighted a distinct lack of regard on behalf of service providers in some circumstances. The manner in which patients were referred to the occupational therapy services was not always adequately considered by either referrers or the therapists themselves. This finding leads to further questions regarding referral and take up of other services apart from occupational therapy.

The interviews demonstrated the significance of the management of the referral process in shaping the success or otherwise of subsequent activity. Those who had been 'prescribed' assessment and treatment without their knowledge and involvement felt at best uninvolved and at worst on trial. In

contrast those who were given information and allowed some degree of decision making felt more in control and were more receptive. The timeliness of referral was also an important factor. Referral perceived to be stemming from other services like day hospital or in patient care had different implications for the patient to referral from other sources.

Patient involvement in treatment

The effect of poor referral methods could be ameliorated if the occupational therapist subsequently took the time to develop a relationship with the older person. Confusion and concern about the purpose and outcomes of treatment was greatly reduced if not extinguished if the older person felt that they were in partnership with the therapist over their treatment. Having a full understanding of the reasons for referral and the treatment plan was influential in determining extent of cooperation. However, those who had been referred to occupational therapy for quick assessment remained disadvantaged and in one case fearful throughout. The belief among the patient group was that assessment was a test that could be passed or failed with consequent outcomes. Occupational therapists clearly need to become more sensitised to the major effects upon the patient of this type of involvement.

Type of intervention

Although brief occupational therapy intervention may be necessary in some cases, the problems which this form of involvement causes and the greater benefits of intensive work with an individual are explicit from these interviews. The people we interviewed had all got very complex needs which could not be satisfied by 'one off' contact. One worker fulfilling a number of roles rather than a series of workers all undertaking specific tasks might therefore be considered in complex cases. All the people we spoke to had extensive care networks which should have been investigated and in some cases tapped for treatment to be most effective.

Choice of treatment venue

The descriptions of both qualified and unqualified occupational therapy intervention provided by the subjects suggest that treatment was less effective in hospital settings than in community settings. The older people generally enjoyed the social atmosphere of the day hospital and could recall the activities carried out by the occupational therapy helpers However, as with the users interviewed for the pilot, they confused the role of the occupational therapy helpers believing them to be either teachers or adjuncts to the nursing staff. The roles of both qualified occupational therapists and helpers were more meaningful to the individual when treatment was conducted individually in community settings.

The themes drawn out of these interviews are taken forward in the overall synthesis of the case study findings.

Second Strand of Enquiry -Administrative Procedures Used by Occupational Therapists

Occupational therapists participating in the case study were asked to share their methods of note keeping. The purpose of this was to provide evidence of the extent or otherwise of multi disciplinary working, locate any theories or standardised methods used in assessment and treatment, and explicate the extent of sharing with other occupational therapists.

Methods of recording patient information

Each occupational therapist had a loose leaf file containing records of all their ongoing cases.

This contained:-

1. Initial referral card/sheet.
2. A copy of the consultant's report to the GP; this accompanied the initial referral if the consultant was requesting an occupational therapy assessment.
3. Ongoing notes.
4. Records of any assessments carried out.
5. Copies of reports to consultants; for example home visit reports.

Ongoing notes:-

One member of staff was using a method of note keeping which entailed identification of problems and methods of resolving those problems. The head occupational therapist thought that one other member of staff might also use this method, but wished to point out that it was not standard procedure.

Assessments:-

Each occupational therapist decided which, if any standard assessments were appropriate. Two assessments were mentioned; a schedule developed locally by occupational therapists working in one of the Adult Psychiatric Day Hospitals, based on an American model; the Kielhofner Model of Human Occupation (Kielhofner and Nicol, 1989) and the Clifton Assessment Procedure (Pattie and Gilleard 1979). Assessment schedules were not used with demented patients.

Home Visit Reports:-

Although there was no standard form, the head occupational therapist said that they appeared to follow the same format.

Records on Groups:-

These were completed for each patient in response to a checklist and kept in the nursing notes.

Monthly records:-

There were several statutory data collection sheets which had to be completed at the end of each month. These included Korner data collection (Meacham, 1986) and information on activity conducted with patients of GP fundholders for the trust's Contracting Department.

Conclusions Drawn from the Recording Methods of the Service

The method of note keeping indicated that each occupational therapist was working autonomously in that:-

1. The occupational therapy working notes were not shared with other professionals, from the same or from other disciplines apart from group work notes placed within the nursing files. As each occupational therapist maintained her own file of on-going cases, notes were not generally shared within the occupational therapy department.
2. Restricted access to working notes was substantiated by the head occupational therapist's lack of knowledge about how her staff were completing them.
3. Valid and reliable methods of assessment and measuring outcome were not considered to be appropriate.
4. There was an acknowledged lack of standardisation regarding note and report writing.

Third Strand of Enquiry - Further Information About the Older People Interviewed

In addition to the previously described interviews, two further sets of information were collected about each of the nine older people interviewed. These were:-

1. The psychiatric history of each older person and their treatment and care, documented in their case notes.
2. Details of the occupational therapy assessment, treatment and outcomes through individual interviews with the occupational therapists responsible for treating each older person.

Collecting the Data

Information provided in the case notes

Case notes were examined to extract:-

- brief demographic details and social circumstances;
- diagnosis, psychiatric history and relevant medical history;
- treatment received and by who;
- practical and social care received and by who.

Full information extracted from the case notes of each person is given in appendix twelve and used to construct care diagrams for each of the older people interviewed. Three examples of care diagrams are provided later in this section (see figures 6.1a to 6.3c, pp. 129-131). The remaining six are shown in appendix twelve.

Accounts of occupational therapy treatment from the occupational therapists involved

Two of the three occupational therapists were interviewed about their treatment of each individual, it's progress and success factors. (A series of prompt questions given in appendix ten were used by the interviewer). Written treatment plans were referenced during each discussion. All these interviews apart from that concerning Mrs SF were conducted after we had met with the older people.[1] All interviews were taped and transcribed.

The information from these interviews are recorded in full in appendix twelve. A summary of the themes extracted from the interviews is given below together with relevant comparisons of the therapists views and those expressed by the older people.

Perceptions of problems experienced by the patient

Two of the occupational therapists interviewed placed the problems of the people they treated almost exclusively within a model of psychiatric illness and it's consequences; for example, functional or social restrictions. Only one person had a more holistic view of the problems of the four people she had treated; referencing life events like bereavement and physical problems.

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[1] The interview with Mrs SF was delayed due to a hospital admission.

Aims of treatment

Treatment of the perceived problems was almost exclusively directed at improvement in functional ability, and increasing participation in leisure activities. For seven of the nine older people, this entailed treatment being conducted at home or in their locality. Treatment methods used extended beyond an activity orientation to anxiety management and improvement of coping strategies for those patients being treated over a longer period of time.

Frequency of treatment

The descriptions of frequency of treatment provided to these individuals by the therapists concerned correlated with those provided by the older people themselves.

Although Mrs MR described the benefits of occupational therapy during interview, the senior II occupational therapist said that she had failed to attend for treatment in the majority of instances and had been extremely elusive.

Success of treatment plan

Treatment was not described as successful for those patients who had been seen for brief interventions. For Mrs EC, treatment was considered to have achieved something from the patient's viewpoint, but relapse was thought to be likely.

Patients who received treatment for a longer period of time were as difficult to treat, but it was possible to spend a greater amount of time building up a relationship with each person. Treatment in each case had to be adjusted several times to accommodate the shifting needs and circumstances of the patients, but there appeared to be more of a willingness and capacity to be able to do this.

Other involved professionals

Working with other professionals was only discussed in relation to four patients overall. The majority of other professions cited were hospital based, the involvement of community based staff being mentioned for five of the older people.

Appropriateness of the referral

Referral to occupational therapy was viewed as being appropriate in eight out of nine cases. However, both the senior II and senior I occupational therapists stated that treatment of their patients could have been conducted by other members of the multi disciplinary team. Being a key worker for Mrs MR made the referral appropriate rather than a need for the skills of an occupational therapist.

Conclusions

The views of the occupational therapists matched that of the older people in that brief intervention was perceived to be both unsatisfactory and unsuccessful. Working more intensively with patients demanded a move away from the traditional occupational therapy role into areas which could

involve other members of the multi disciplinary team. In addition more responsibility was described; for example being a key worker and arranging admission. This was in contrast to the brief involvement where the results of intervention were merely passed on to other members of the multi disciplinary team. However, those interviewed appeared to have difficulty acknowledging the totality of needs a person can present with. This restricted view was compounded by professional autonomy which appeared to exist in the majority of treatment situations.

Comparing Differing Perceptions of the Care Networks of the Older People Interviewed

Development of the care diagram

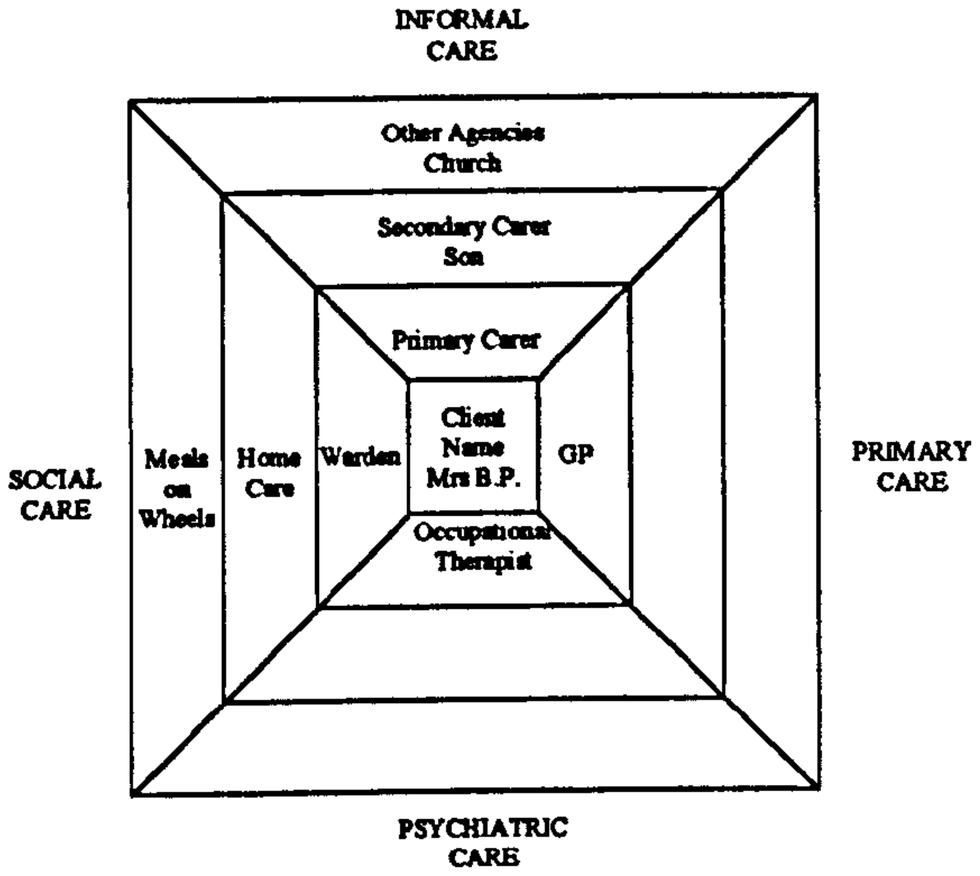
A method of visually displaying the care network for each person was devised for the purposes of this research. The 'care diagram' is a quadrant with each of the four sides representing a different type of care. The subject is placed at the centre of the quadrant. The position of the carer in relation to the subject denotes the importance of the relationship; thus a carer closest to the centre of the quadrant represents a highly significant relationship whereas one placed further out is of less consequence. The date when the information was obtained is also recorded. This is particularly important as care networks will change over time in line with shifting needs.

Use of the care diagram

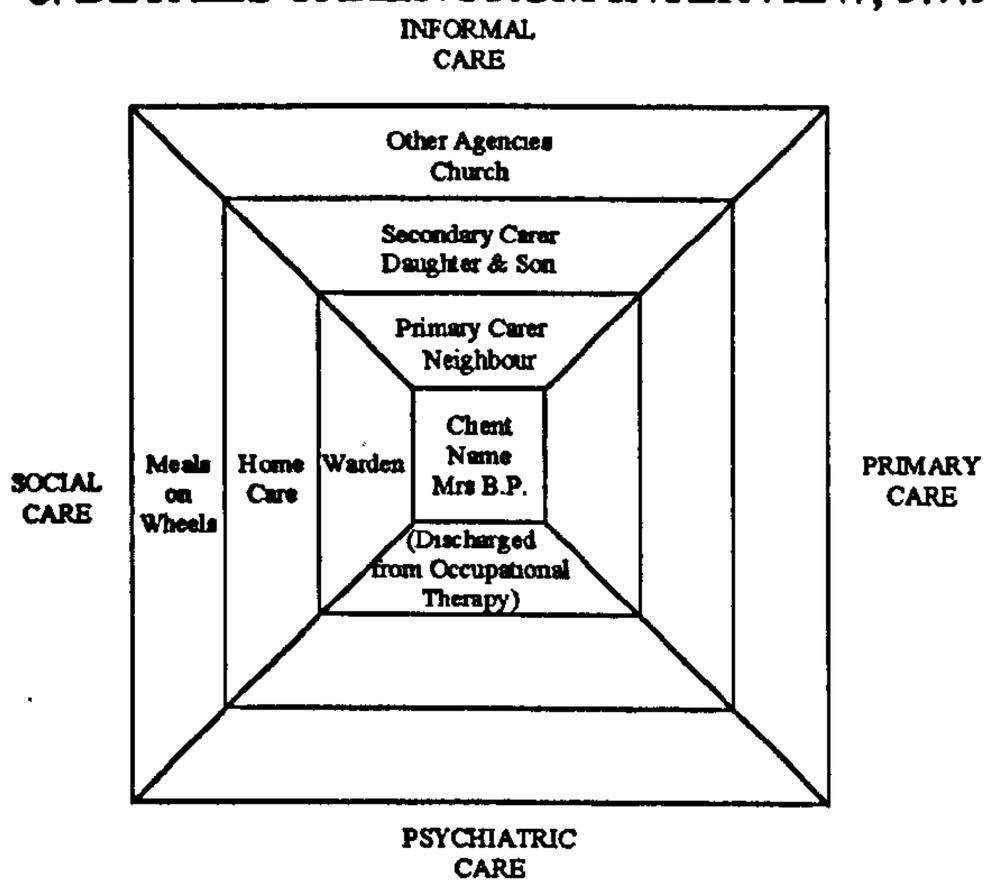
Three diagrams were drawn for each older person; the first based on information taken from the case notes, the second drawn from the interviews with occupational therapists responsible for their treatment and the third from the perspectives of the older people themselves. Three examples of are provided overleaf; illustrating perceptions of the care networks of Mrs BP, Mrs DW and Mrs KA.

Figures 6.1a-c
Patient Mrs B.P.

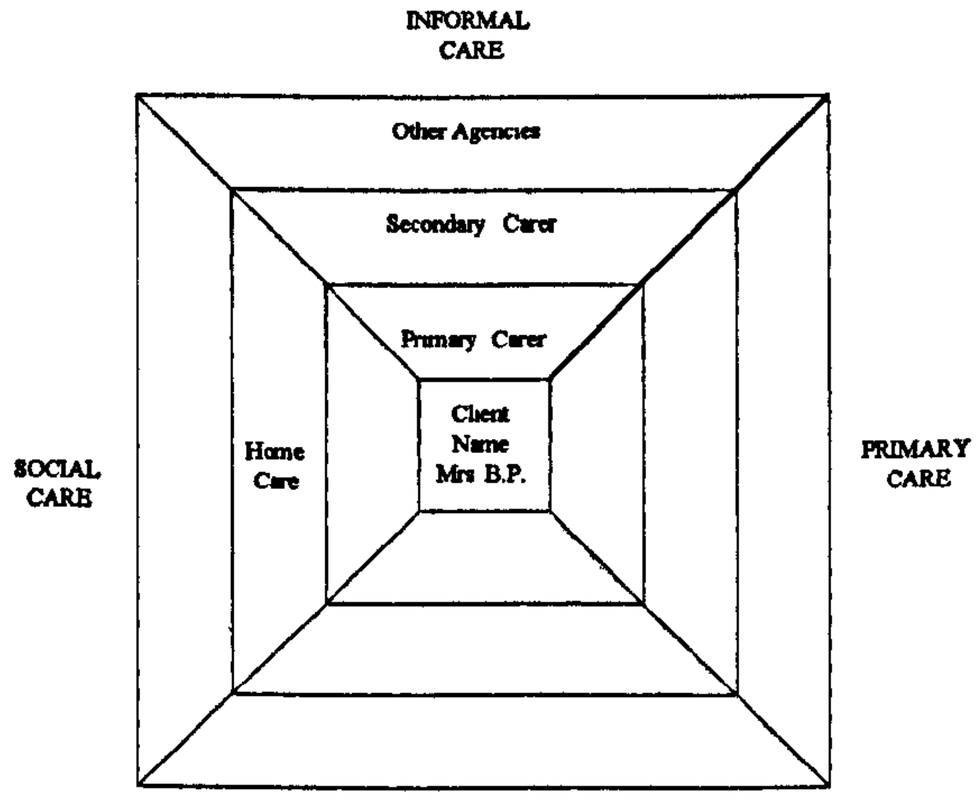
a. DETAILS TAKEN FROM THE CASENOTES, 20.8.93



b. DETAILS TAKEN FROM INTERVIEW, 5.7.93

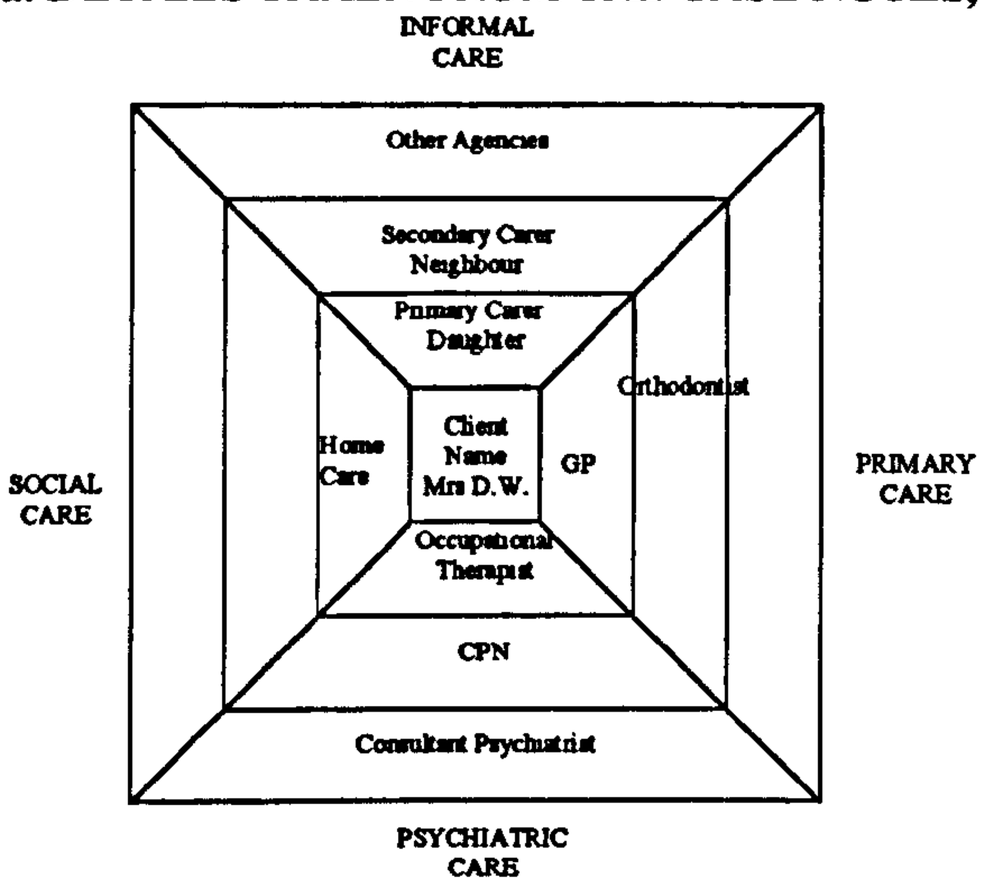


c. DETAILS TAKEN FROM INTERVIEW WITH OCCUPATIONAL THERAPIST, 13.8.93

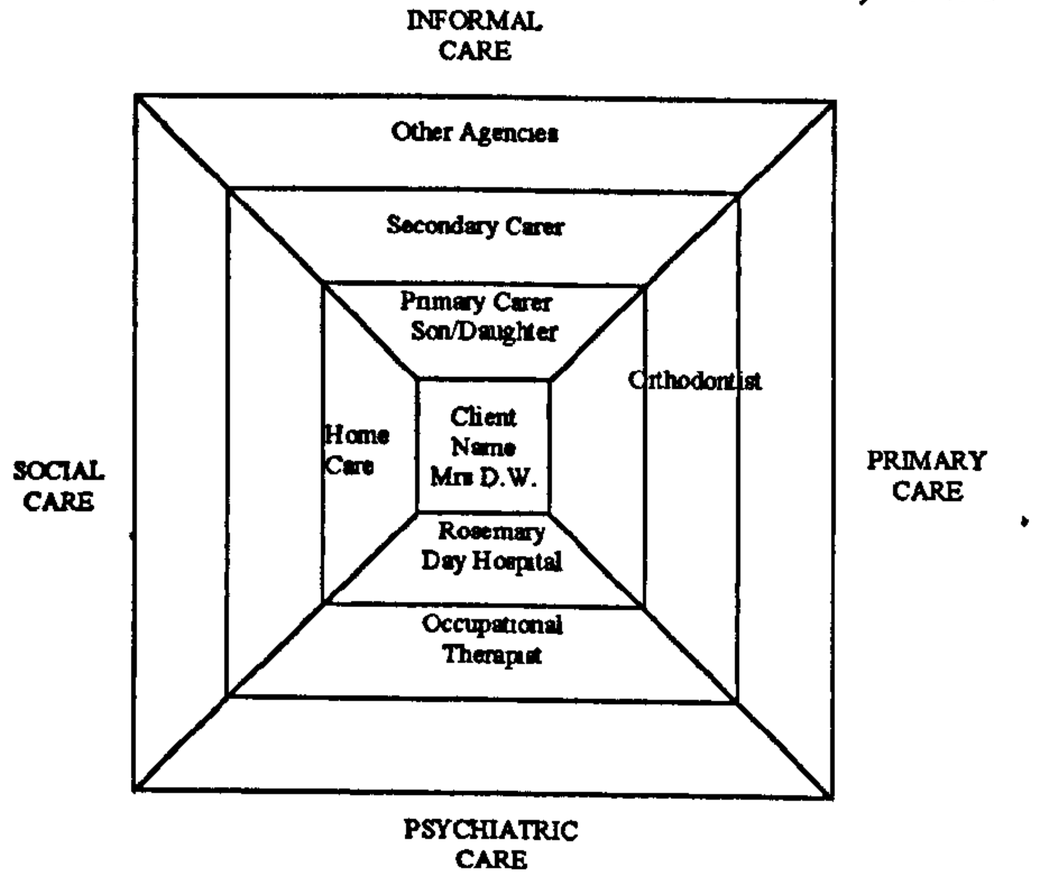


Figures 6.2a-c
Patient Mrs D.W.

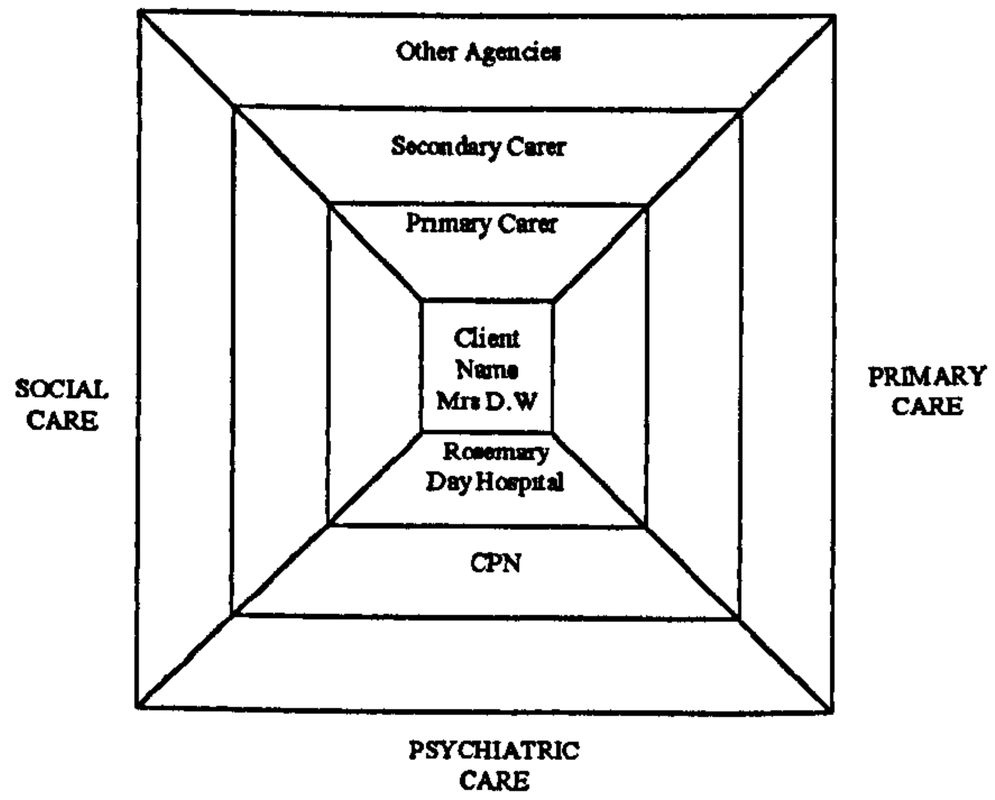
a. DETAILS TAKEN FROM THE CASE NOTES, 20.8.93



b. DETAILS TAKEN FROM INTERVIEW, 4.8.93

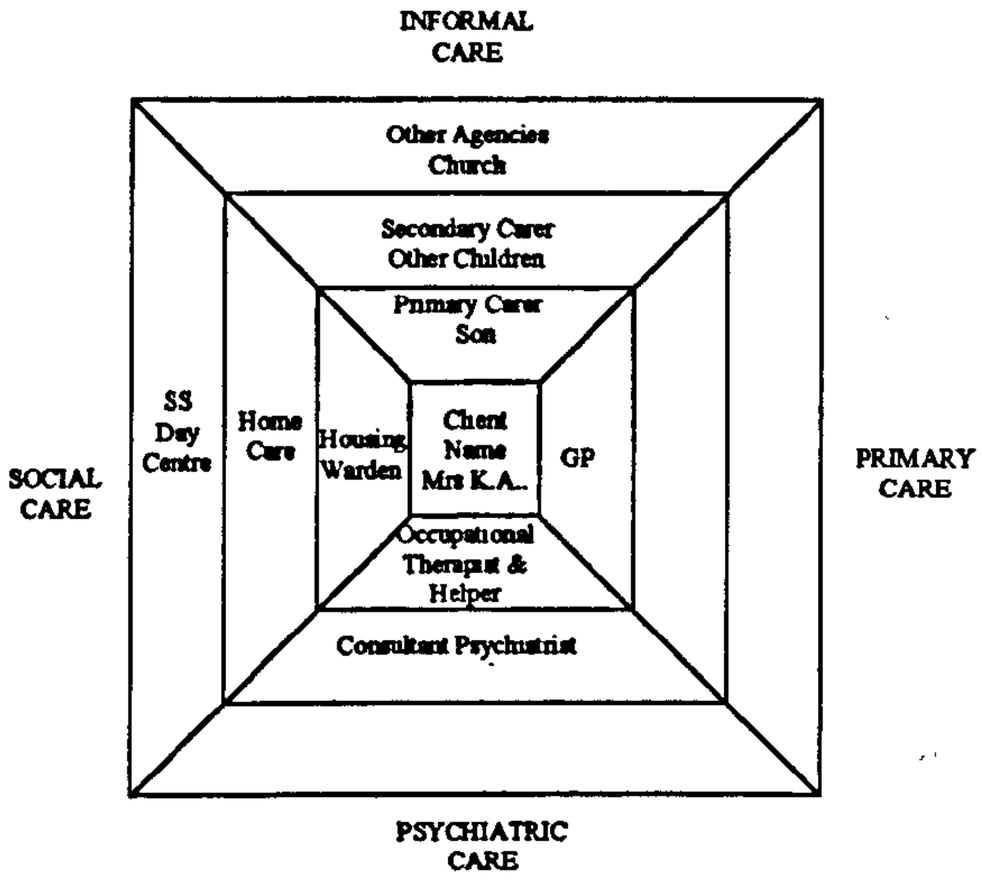


c. DETAILS TAKEN FROM INTERVIEW WITH OCCUPATIONAL THERAPIST, 13.8.93

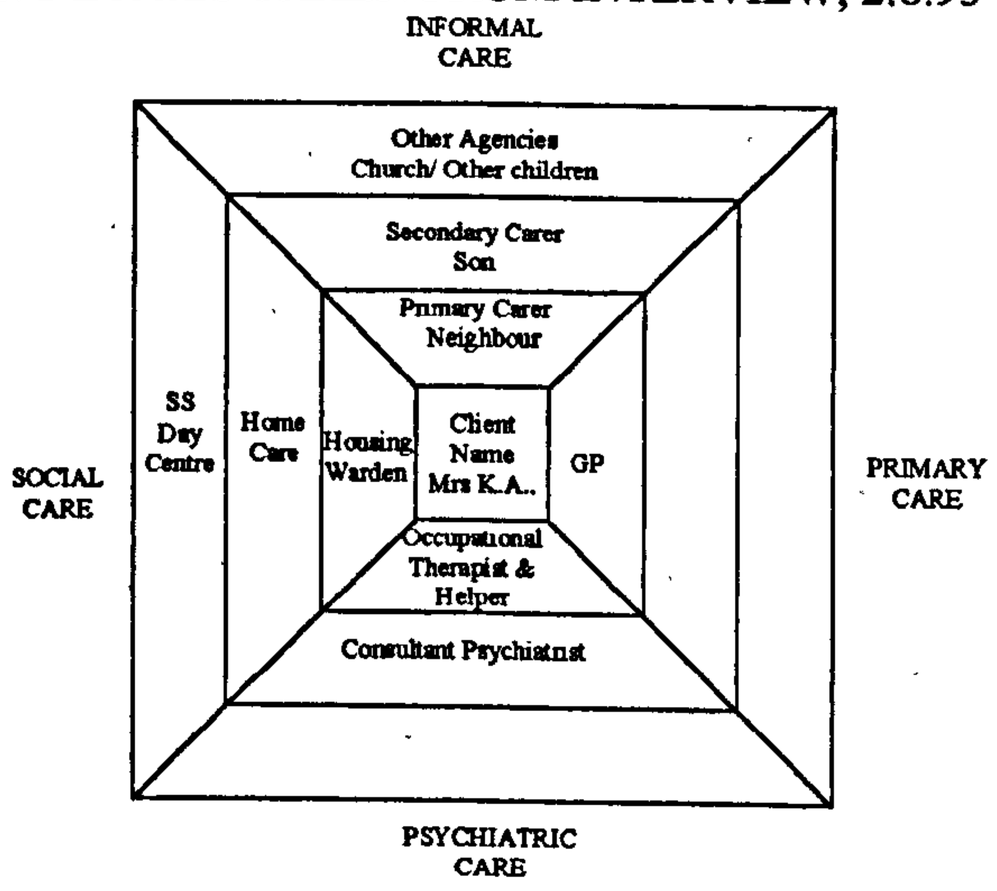


Figures 6.3a-c
Patient Mrs K.A.

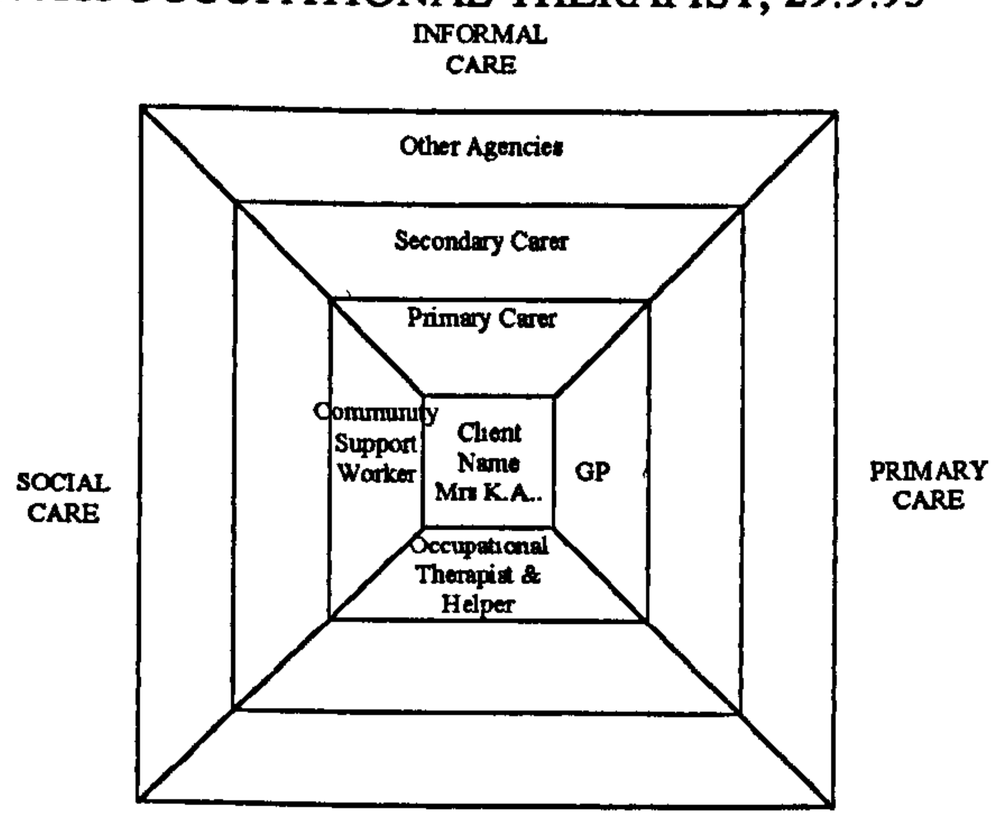
a. DETAILS OF CARE TAKEN FROM CASE NOTES, 20.8.93



b. DETAILS TAKEN FROM INTERVIEW, 2.8.93



c. DETAILS OF CARE TAKEN FROM INTERVIEW WITH OCCUPATIONAL THERAPIST, 29.9.93



Responses to Need: Summary of Findings from the Care Diagrams

The care diagram is a useful method of visually illustrating complex networks of care[2]. It can also be utilised to look at care networks from different viewpoints or keep track of networks when rapid change occurs like that triggered by a major event like hospital admission.

Application of the care diagram to data obtained in this study revealed the need for all professionals to be more aware of the work of other involved agencies and the totality of care received by the older people they were treating. There was a clear need for greater coordination across health and social care agencies and for individual workers to listen to the views of the older person and their carer.

More specifically, the following points emerged:-

- All disciplines contributing to the case notes had a one dimensional view of informal care and family responsibilities, and documented their own interpretation of care received without checking with the patient. Workers made the often erroneous assumption that family were the most important formal carers. The information gained from the interview with each the older person revealed a more complex care network than did the other sources of information with reference being made to a greater number and range of care providers.
- The occupational therapists in relating their treatment plans for each subject tended not to refer to other involved agencies or informal carers involved in care of the person
- The amount of care, and in particular social care, the older people received was relatively low and did not reflect their complex needs. However, those older people who lived alone received more formal care overall than those who lived with others.
- Primary care did not assume significance with perceptions on the part of all interviewees rarely extending beyond the individual's GP.

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2 The care diagram was used by Leeds Community and Mental Health Trust to identify care received by people with severe mental illness from the perspective of the professionals involved and the patients themselves as part of a patient centred approach to care.

Final Strand of Enquiry - Perceptions of Occupational Therapy by Other Professionals

The interdependency which always exists between different care providers is exacerbated when the user group have complex needs like all the older people interviewed. The care diagrams illustrate the extent of professional and informal care each person was receiving, adding weight to the view that their needs necessitated a range of interventions by different service providers over an extended period. The quality, efficacy and appropriateness of the service experienced by the service user and their carer will be dependent upon the ability of these different professional groups to work together cohesively. Consequently, an exploration of opinions of the occupational therapy service by other related professionals working within and alongside the case study area was an essential dimension of the case study.

Care diagrams were used to identify other relevant services and workers.

Individual representatives from the professions shown in table 6:3 were asked to give their opinions about the occupational therapy service they had contact with.

Table 6:3 - The Professionals Interviewed and Method of Interview

	Professional Group	Numbers Interviewed	Methodology Used
Medical	Consultants	3	Depth Interviews
	Junior Medical Staff	3	Telephone Interviews Face to face structured interview
Community Social Care	Home Care Managers	4	Telephone Interviews
Community team	Psychologists	2	Telephone Interview
	Community Nurse	1	Telephone Interview
	Social Worker	1	Telephone Interview
Day Hospital Nurses	Day Hospital Sister	1	Depth Interview
	Day Hospital Nurses	1 return	Questionnaires

The line of enquiry focused upon the overall service offered by the occupational therapists rather than specific individual involvement.

As the consultant psychiatrists and day hospital sister were considered to be key informants in their role as service gatekeepers, they were interviewed in depth using the methodology described in chapter three. Telephone interviews proved to be a successful method of interviewing the majority, capturing the views of a diverse range of individuals within the limited resources of the project. Frey

(1989) points out the benefits of this approach which includes saving time and costs by cutting out the travelling time to the interviewee. However, he does point out the requirement for good preparation. Therefore, a semi structured series of questions were formulated beforehand and notes were taken during each interview.

After consideration it was felt to be beyond the remit of this project to contact general practitioners. Considering the ever increasing profile of primary care services, and the need for all professions, including occupational therapy to ensure that GPs are well informed about their skills, this was an unfortunate omission. And some work specifically in this area will undoubtedly be necessary in the future, particularly given the increasing policy focus on primary care and the future development of primary care trusts (DoH, 1997a).

The following same lines of questioning were pursued across the whole sample:-

- contact with occupational therapists;
- referral to occupational therapists;
- perceptions of the role of occupational therapists;
- the interface of each professional group with occupational therapists.

In preparation for interviewing consultant psychiatrists, an interview topic guide was devised (appendix ten).

Results of the Interviews

A summary of the findings are provided here and full accounts of the interviews described in appendix thirteen.

1. Home Care Managers

Themes extracted from the interviews

- The contributions of occupational therapy were universally valued.
- Home care managers were far more familiar with social services employed community occupational therapy services than hospital based services.
- Expectations of occupational therapists by home care had increased due demands arising from community care implementation, and the extension of their own role.
- Occupational therapists were failing to appreciate the implications of community care policy in terms of their own activity and that of home care; for example, not communicating the results of assessments.
- The relationship between home care and occupational therapy was not equal; in the majority of cases home care managers would not expect to refer to occupational therapists.
- The quality and quantity of information received by home care from all hospital sources was generally inadequate.

2. The Multi Disciplinary Community Team

The work of Ovretveit (1987) was employed to determine the nature of the multi disciplinary team which existed in the community model. He suggests that there are four different models of multi disciplinary team. The model which best fits the teams working within the community model is described by Ovretveit as a "*core and extended team.*" This is where there is a core of full time workers from one or two professions and an extended team comprised of professionals with part-time involvement. The whole team is managed by a team leader.

In the community model, there were three multi disciplinary teams; one for each consultant. The membership of the three teams overlapped for some professions. The different professional groups had varying degrees of commitment to team working; for example social workers, psychologists and community psychiatric nurses were fuller team members than occupational therapists or junior medical staff. Even though social workers are employed by social services, their hospital base and place in the multi disciplinary team was a greater influence upon their work. The work of each team was managed overall by the consultant medical staff. The aggregated views of the multi disciplinary team workers therefore embrace those from social work, psychology, community psychiatric nursing and the clinical assistant with a community remit.

Interviews with the consultants were considered separately due to their greater range of responsibilities.

Themes extracted from the interviews

- Difficulties due to recruitment and retention of occupational therapists were mentioned by all
- Patterns of referral to and from occupational therapy varied for each profession.
- Reasons for referral were frequently dictated by the known interests of individual occupational therapists.
- All professions were able to identify a clear role for occupational therapists; the described role extending beyond assessment into therapeutic treatment on a longer term basis.
- Views were expressed that the skills of occupational therapists were not being used appropriately.
- The occupational therapists were carrying out joint visits with social workers only, even though other professions viewed this as desirable.
- The quality of relationship between individuals was significant in dictating the extent of inter disciplinary working.

3. The Day Hospital Team

The day hospital team were those staff whose job involved spending a dedicated amount of time in the day hospital.

The problems inherent in obtaining information by any other method than by that of direct contact were demonstrated by the poor return of questionnaires from the day hospital nurses, with only one return.

Themes extracted from the interviews and questionnaire

- As with the community team, difficulties due to recruitment and retention of occupational therapists was mentioned by all those questioned.
- Opinions regarding the role and benefits of day hospital based occupational therapy varied, but there was general agreement about the value of interventions within the patient's home.
- An occupational therapist might only be accepted by the day hospital team if he or she was willing to be directed by the nursing staff and participate in the activity regime whereas the view of medical staff was that this was a waste of occupational therapy skills.
- That the service would improve if staffed properly was a view held by all those questioned apart from the day hospital sister
- Given the staff dynamics expressed through the interviews, and the widely differing views of how patient needs should be met, it was unlikely that any one member of staff would be able to fulfil such a role.

4. The Consultant Psychiatrists

As Table 6.3 shows, three consultant medical staff were interviewed. At the time of interview, each consultant was working from the same base at location E, each having responsibility for a number of patients attending the day hospital in addition to a community patch and in patient beds. Their role as overall managers of the multi disciplinary community team has already been mentioned.

All interviews were taped and transcribed. The content of the interviews was subsequently examined for common themes and differences. Full results are appended (appendix thirteen).

Themes extracted from the interviews

- Each of the consultants had a different working pattern and expected other staff to adapt to this.
- Difficulties were expressed again due to poor retention of staff. Although there was some awareness of recruitment problems, little or no allowance was made for this.
- All three consultants were dissatisfied with what they perceived to be the preference of occupational therapists to be attached to venues rather than to teams.
- The notion of staff based in a community team and following patients through the system was strongly maintained by all three consultants.

- It was evident that consultant involvement with the day hospital was very limited.
- Occupational therapists have to be prepared to educate consultants about their role and demonstrate value for money, if they are to be fully included.

Discussion of the Interview Findings

Although some of the difficulties expressed with the occupational therapy service might have served a purpose in rationalising more pervasive problems in the community model overall; certain issues raised and reiterated by different professional groups warrant serious consideration.

Problems resulting from poor recruitment and retention of staff was the common thread running across all the interviews. However, as the current activity of occupational therapists was also questioned by many of the people that we spoke with, it is doubtful that adequate staffing would be the universal panacea. A clear example was provided by the discussions with home care managers. It was evident that if occupational therapists were to effectively extend their role into the community existing staff needed to gain a better understanding of the Community Care Act (DoH, 1990) and their responsibilities within implementation of the new legislation.

The findings also indicated that changes in occupational therapy practice were required. The message regarding the benefits of longer term involvement in the community rather than short term assessment was echoed by many of the people we interviewed with strong arguments for its instigation. This change in practice would be stimulated by greater commitment to multi disciplinary working. This shift in role was perceived to be highly desirable by the majority of those interviewed.

A high degree of disparity regarding the optimum role of occupational therapists was expressed by the day hospital as opposed to the rest of the multi disciplinary team, including the consultants. The community based multi disciplinary teams and consultants preferred occupational therapy staff to be team orientated, this still being an innovative way of working for many occupational therapists. However, this conflicted with the stated requirements of the day hospital staff. Traditionally occupational therapists have worked alongside nursing staff in day to day activity and it seems that a movement away from this type of involvement to a more autonomous, community orientated approach was causing problems. The day hospital sister in particular felt that the place of the occupational therapist was still in assisting in the provision of an activity programme in the day hospital led by nursing staff. Overall, fuller membership of the community multi disciplinary team was viewed positively by the majority, with less support for attachment to venues including the day hospital and hospital based occupational therapy department.

Drawing Together the Findings From the Case Study

The results are now combined to look at the totality of evidence, and whether it supports or refutes the theory underpinning this case study. Clearly having multiple sources of confirmatory evidence improves the validity of the overall results. However, Yin (1989) states that;

"even if one variable does not behave as predicted, your initial proposition will have to be questioned."

Yin, 1989.

The validity of each of the study propositions are examined through the extent to which this research has addressed the research questions articulated in table 6.1

Study proposition one: the impact of occupational therapy upon users and their carers is enhanced when interventions are carried out in the community

What are users and carers experiences of occupational therapy?

The range of interventions described by the older people interviewed and the occupational therapists focused, in the majority of cases, upon the maintenance and improvement of independence skills in the community. Interventions were geared toward maintaining social networks and self care by encouraging activities like use of community resources, cookery and leisure activities. Some on-going treatment was carried out by unqualified staff under the supervision of the occupational therapist. Interviews with occupational therapists and with service users and their carers suggested that physical needs of the older people were rarely taken into account, with the focus being almost exclusively upon mental health problems.

In what circumstances are benefits likely to be greater for users?

Interviews held with service users indicated that involvement in the referral process and an understanding of the reasons for referral were more likely to lead to favourable outcomes. Those older people who had not been involved in the referral process either did not understand why they had been referred or were concerned about the implications of referral, in one case being fearful of the consequences of failing an assessment. However, these interviews also suggested that even if management of the referral process was poor, the occupational therapist could overcome this by spending time building a relationship with the patient. In the case of referrals for rapid assessment, this was not possible and the patient remained disadvantaged. Not surprisingly the recipient was less likely to be cooperative in situations where prescribed treatment did not match their wishes. Service users who were being treated over a longer period of time were able to plan their treatment with the occupational therapist. However, this was not a guarantee of cooperation and success, confirmed through the interviews with occupational therapists.

For people being treated on a longer term basis, treatment could extend beyond the traditional occupational therapy role into areas like anxiety management and counselling. Moreover, those receiving treatment over a longer period of time were able to fully describe what they were receiving

and the reasons for it. In contrast, those who received brief interventions easily confused the role of the occupational therapists with that of other professionals, exacerbated by their experiences of occupational therapy in the day hospital and in patient settings.

Several strands of enquiry reiterated the benefits for users of longer term occupational therapy in community settings. In the majority of instances, this necessiated following the person post discharge into the community. It was evident that for treatment to be meaningful, both user and carer views must be heard with treatment both matching their perceptions of need, and taking account of shifting needs over time.

How do other professionals view occupational therapy?

Several workers from a range of disciplines raised the value of home assessments carried out by occupational therapists to examine coping abilities of the older person, and through this provide information for other professionals. However the requirement to move away from hospital located activity based treatment and short term assessment to longer term involvement in the community was also emphasised. The benefits of a longer term, cooperative approach to treatment is supported by the perceptions of occupational therapists. Situations where treatment was more intensive and the patient was fully involved in the process were more satisfying for the therapist than those where referral was for a quick assessment to provide information for other members of the multi disciplinary team. Moreover, where treatment was more flexible to meet the changing needs of the individual, a greater range of interventions were employed The potential for adopting a more comprehensive role was described by some; for example the CPN thought that occupational therapy had an important role in lifestyle changes after retirement and the one of the psychologists saw advantages in occupational therapists training other, less qualified staff to undertake practical aspects, carrying out more of a psychotherapeutic role themselves.

In what circumstances are benefits likely to be greater for carers?

Where there were co-resident partners, carers perceived themselves to be involved in the treatment process. However, the extent to which this occurred, merely because they were in situ, is difficult to ascertain. Non resident carers were not involved in the treatment process. It is significant that one of the carers used occupational therapy intervention as a period of respite for himself, in preference to being involved in the treatment process. The occupational therapists did not make reference to meeting the needs of carers in their descriptions of treatment.

Study proposition two: working in a multi disciplinary team augments the effectiveness of occupational therapy even where it results in blurring of the distinct occupational therapy role

What commitment do occupational therapists make to the multi disciplinary team?

This research confirmed that working with older people with complex needs demands a move away from one-off specific occupational therapy assessments to longer term generic involvement with

individuals and their carers. Moreover, to be most successful, greater collaboration with both health and social care professions is required, and occupational therapists, along with other disciplines must be prepared to relinquish some of their professionally managed systems. At the time of research this clearly was not occurring.

The consultants agreed that occupational therapists need to be full members of the multi disciplinary team, and were dissatisfied with their perceived attachment to occupational therapy departments rather than to teams. This was echoed by individuals from other professional groups. Continued adherence to the professional group rather than to the multi disciplinary team was demonstrated through maintenance of an occupational therapy base despite pressure from a number of quarters (including the professional line manager) to adopt a team location. Also, record keeping was a personal matter, the lack of standardisation in note and report writing across the group confirming individual ownership of work. In tandem with other professions, evidence provided by the care diagrams confirmed that occupational therapists were not involving other health and social care professions adequately in their treatment plans.

What are the problems for occupational therapists of multi disciplinary team working and what are the benefits?

In community settings a different opinion of role and responsibilities emerged to that of hospital based staff. The need for assertion of a distinct professional role was emphasised. To be successful members of the multi disciplinary team, some workers thought that occupational therapists would have demonstrate their distinct skills and be prepared to stand their ground with other team members. This contrasted with expectations of the day hospital team, where it seemed that it would be counter productive to disagree with the opinions of the day hospital sister.

The benefits of a increased involvement in community work were described as being a greater involvement both in terms of joint working with other professions and further development of the occupational therapy role. Several of those interviewed stated that they would welcome more joint working with occupational therapists.

How are referrals made to the occupational therapy service?

Methods of referral were described by the other professions, the older people themselves and illustrated through the documentation maintained by the occupational therapists. Two distinct types of referral were identified; those for intensive treatment and referrals for rapid assessment. In three cases, service users were able to recall a discussion taking place with them about referral to occupational therapy. The remaining six people could not recall being informed about the referral at all. This embraced all those who were involved in either in patient or day services at the time.

Occupational therapists maintained written records of referrals to the service, including copies of consultant letters, indicating a formal referral mechanism. However, several professionals mentioned making referrals to occupational therapy over the telephone.

A variety of reasons for referral to occupational therapy were mentioned by the representatives of the other disciplines interviewed. However, for the members of the multi disciplinary team and consultants there was no doubt that the personality and interests of the occupational therapists were highly influential in determining both referral rate and type of referral. The consultant with an occupational therapist in his team made all referrals himself. Similarly, referrals by the day hospital team were sorted and monitored by the sister in charge in her position of service gatekeeper. Home care staff expected referrals to be made by occupational therapist, personal contact enhancing that process. The extent to which referrals were made to hospital based occupational therapists by home care was less clear.

What interventions are conducted by occupational therapists working as members of the multi-disciplinary team?

Service users described a whole variety of different interventions. For seven of the older people interviewed, interventions in their home or locality embraced a move away from an activity focus to behaviour therapy and counselling.

By the time the consultant psychiatrists were interviewed, only one had an occupational therapist attached to their team. They all saw appropriate interventions as those where the home situation is complex. There was a difference of opinion between consultants about the patient group that occupational therapists should be most involved with. One thought that involvement should be predominantly with people with dementia, whereas another expressed the view that it should be with functionally ill patients.

Two of the occupational therapists described working closely with psychologists in treating two specific patients. Liaison with other staff apart from the consultants were only mentioned in passing. The move to a more generic role was described in situations where community based treatment was longer term.

To what extent do occupational therapists work alongside other agencies?

The lack of reference by occupational therapists to other service providers in treatment was illustrated by the care diagrams drawn from descriptions of their treatment interventions. The occupational therapists in relating their treatment plans for each subject rarely referred to other services external to the hospital or informal carers involved in care of the person. This deficit is highlighted by the disparity between the care diagrams drawn from the service users' accounts of their care network and those drawn from the occupational therapists descriptions of their treatment.

Study proposition three: working in the community increases the range of and degree of occupational therapy responsibilities

How do occupational therapists respond to the expressed needs of service users?

More intensive involvement inevitably results in more demands being placed upon the therapist. This is in contrast to the recreationally focused work alongside other staff in the day hospital, and

one off assessments of functional ability where other professions are left to find the solutions to any problems uncovered. When longer term intervention was indicated, the occupational therapists demonstrated their ability to be able to respond to a greater range of needs and to change their treatment interventions as appropriate. They extended their role to meet these needs; examples are the intensive follow up of Mrs MR embracing a range of different responsibilities, and arranging hospital admission for Mrs KA when she was in crisis. However, the neglect of problems stemming from physical ill health was a common thread running across all treatment plans.

From, discussions with home care managers, it is also evident that successful community working cannot be divorced from the requirements that current policy places upon practitioners; necessitating changes in practice. The increased role of community occupational therapy anticipated by other professions has already been described.

Which multi disciplinary team members are identified as being key workers?

There was only one instance where an occupational therapist stated that she was a key worker for one of the people interviewed. The social worker interviewed expressed the view that key working by occupational therapists would be unlikely due to their involvement in assessment to provide information. In contrast one of the consultants specifically talked about the desired role of occupational therapists as key workers.

What are the expectations of other professions?

The majority of professionals interviewed to felt that in order to work successfully in the community, the occupational therapist has to be prepared to make longer term commitments to individual patients. The desirability of joint assessments were cited by several professions, and it was notable that in situations where a working relationship had been established with other team members, skill sharing and blurring of professional boundaries occurred. The consultant psychiatrists were in favour of follow up of patients through the system by one person rather than patients being passed around professionals. The major disparity regarding the role of occupational therapists was between the day hospital and the rest of the multi disciplinary team. The community based multi disciplinary team and consultants preferred occupational therapy staff to be team orientated, whereas the day hospital sister saw occupational therapy as a component of the day hospital routine, within the remit of her responsibilities.

Circumstantial Evidence which Emerged during the Study

Evidence not related to the case study research questions also emerged during the study. Kellaher et al (in Peace 1990) term this '*circumstantial evidence.*'

The case study highlighted issues concerned with the overall role and function of other health and social care professions apart from occupational therapists. Concepts of patient orientated, multi professional working were alluded to by all health based professionals consulted. However, working methods described did not bear this out. Meeting user and carer needs appeared to be poorly

developed across all professions. Use of care diagrams revealed the tenuous relationships between those involved in providing care and the recipients. Furthermore, case note documentation showed a failure to listen to user and carer views. Service provision was still grounded in certain assumptions; for example; those living with someone else would have a lesser requirement for services, and relatives provide informal care rather than neighbours and friends.

Testing the Case Study Theory

The case study theory is;

Occupational therapists working with a community orientation are more responsive to patient needs. However working in this manner creates more challenges for the therapists themselves.

This case study confirmed the validity of this theory.

Evidence to support treatment outcomes in community settings was not clear. However, results from several strands of enquiry confirmed that the process of occupational therapy is most likely to be viewed favourably by the majority of service stakeholders when occupational therapists are members of a multi disciplinary team working in the community with people on a longer term basis. Nevertheless, findings also revealed that treatment outcomes cannot be guaranteed through this process, with the optimum outcome in most cases being maintaining the older person for as long as possible in the community, rather than achievement of any health gains. Tangible benefits for the service user were largely derived from the treatment process itself, and the knowledge that someone was concerned for their welfare.

There is clearer evidence of the new problems and challenges that community working places upon the staff involved. Even though all the older people interviewed were seen at some time by an occupational therapist at home, the study uncovered different degrees of community working and attachment to community multi disciplinary teams on the part of occupational therapists.

The challenges presented by this way of working include skill sharing across disciplines and the need to develop a wider, and in some cases, generic role. A hightened awareness of Community Care policy is essential, as is the need for strong assertion of personal and professional skills within the multi disciplinary team.

Through interviews with the day hospital team, the difficulties that any single handed person would have working in that hospital based setting were revealed. Developing a role which did not confer with the views of other more established disciplines would be highly problematic. Therefore it can also be deduced that hindrances and challenges exist for occupational therapists wherever they locate their work. The problems of working in the community appeared to be more concerned with application of skills, having up to date knowledge and the ability to network with a range of agencies. In the hospital setting, problems were located in power battles with other professionals and traditional views of role.

On balance, the available evidence suggests that working in the community should be more attractive to occupational therapists in that it enables them to demonstrate and expand skills the have to the benefit of service users and their carers without being sidetracked by inter disciplinary friction. If this is so, then why was some reluctance to adopting this changed role on the part of occupational therapists? Skills can be updated in line with new requirements, but it appeared that more fundamental, unstated problems were restricting the development of a community role. The next chapter, looks at the findings of all four studies in light of the overall aims of this project. Through a critical appraisal of the findings, the reasons for this reticence is explicated. Finally, the results are used to test the model of occupational therapy activity.

Study Four - Summary

- Results obtained from the four strands of enquiry confirmed the validity of the case study hypothesis.
- Evidence also indicated that all health professionals needed to develop a greater awareness of the complex needs of older people with mental health problems and be prepared to spend more time listening to users and their carers.
- Occupational therapists, along with other involved professionals, were largely ignoring the totality of needs older people were presenting with.
- Even though working in the community appears more attractive to occupational therapists, other, unstated obstacles appeared to be limiting development of this role.

CHAPTER SEVEN

THE ACTIVITY OF OCCUPATIONAL THERAPISTS AND THE INFLUENCES UPON THAT ACTIVITY

The aims of this chapter are to examine the totality of results obtained from the four empirical studies; firstly in light of the original research aims and secondly to test the accuracy of the model of occupational therapy activity. The chapter concludes with an acknowledgment of the limitations of this project, thereby informing future work in this area.

Recommendations stemming from the conclusions drawn here are raised in the final chapter of this thesis, chapter eight.

Achieving the Research Aims

Results pertaining to the first two aims (the profile of activity, responsiveness to the policy framework and stakeholder opinions of the occupational therapy service) have been previously discussed at length in studies two, three and four. To avoid repetition, a summary of the findings and how they address the first two aims of this research aims is provided below. The third aim; identification of the reasons for activity has not been raised in previous chapters and is therefore discussed in depth, with emergent themes being used to test the model of occupational therapy activity.

Aim One: To determine the services occupational therapists, working with older people with mental health problems perform, and the different tasks they carry out

This was achieved through the construction and testing of a valid and reliable pre coded diary to measure the activity of occupational therapists working with older people (study one). The resulting diary has robust properties and is simple to use by practitioners during the course of their working day. Furthermore, the results can be easily analysed. It's usage has the potential to help occupational therapists to meet the requirements described in the Government's Consultation document "A First Class Service" (DoH, 1998a); for example the identification of quality practice, establishing clinical standards to promote quality and auditing practice against these standards.

Application of the diary and analysis of the data confirmed that occupational therapists working with older people with mental health problems were engaged in a wide range of clinical and non clinical activity (fully described in studies one, two and three). This included treating patients in a variety of hospital settings as well as in their homes and their community; undertaking work related to patient care, like preparing for treatment sessions and escorting patients; communication with other workers and with carers; education and teaching as well as supervision of subordinate staff; and finally a number of tasks, for example staff administration, which were peripheral to patient care. Qualitative interviews held with occupational therapists in study two revealed that while inability to articulate purpose is a frequently cited problem of occupational therapists, clinical practice was clearly grounded in strong beliefs which bridged different service settings. These

beliefs embraced an ideology concerned with enabling through the application of practically based interventions together with strong agreement about the exclusivity of certain roles and responsibilities; for example the organisation and execution of home visits, domestic assessments and dressing assessments.

In addition to explicating the nature of activity, this project also revealed how clinical activity is frequently interrupted and side tracked by alternative aims and demands; for example, studies two and three showed how staff working in traditional institutional environments were influenced by the many inherent problems and historical methods of service delivery which had been established over the years in those settings. Working in the community led to a different set of treatment aims and priorities (study four) and should have allowed more clinical freedom, but prevailing attitudes still reinforced work within, and allegiance to, the parent institution. This has the effect of limiting communication with community workers and cross agency working.

Aim Two: To determine how worthwhile is this activity from the perspectives of key stakeholders, taking into account the current health and social care policy framework

Occupational therapy was viewed favourably by the majority of workers from other disciplines interviewed during this research. In view of job vacancies at the time, there were some justifiable complaints about poor recruitment and retention of staff. Erosion of the extent of service provision and lack of inter disciplinary working was attributed to inability to retain a stable core of occupational therapists. However, the greatest level of dissatisfaction noted in study four was rooted in the resistance of occupational therapists to being located within the multi disciplinary team. Considering their preoccupation with maintaining a valid position in the team through their activity (demonstrated in studies two and four), this persistent refusal to relinquish the departmental base was contradictory.

The extent of true multi disciplinary working on the part of any member of health service staff interviewed during this project, irrespective of discipline, was minimal. Joint working across professional groups was most likely to take place between two members of staff. Such arrangements appeared to be nurtured by the quality of the relationship between the individuals concerned. Given the pre-requisites for joint working within health, it is easy to understand why activity involving external agencies would be problematic. Working across agencies demands ability to share, not only with health service colleagues but workers from agencies where a different culture will prevail. The service users' views of occupational therapy are recounted in chapter six and appendix eleven. The overt compliance of older people was highlighted; they were reluctant to directly voice any disquiet. However, this compliance was tempered by covert resistance if treatment did not match either their needs or expectations. This took the form of either refusing to cooperate at the time of treatment, even if a prior agreement had been made; or complying in the treatment setting with no intention of changing habits at home. Therefore, occupational therapy could only be worthwhile for service users in situations where their full range of needs were uncovered and responded to. Study

four confirmed that for service users, occupational therapy treatment conducted in community settings was a the best use of the resource.

This project also demonstrated the potential for better deployment of the unqualified workforce, particularly in light of the complaints about staffing levels. Study four demonstrated that occupational therapy helpers were able to undertake a wide range of activity in the community if allowed to by the qualified staff. However the majority view expressed by occupational therapists was that helpers had a limited skill base. This was clearly translated into restrictions upon their activity.

Studies two and four revealed poor awareness of current policy by occupational therapists and a lack of knowledge of their responsibilities within the legislative framework, particularly with respect to needs based assessment and treatment to meet assessed needs. There was little comprehension of any requirement to change established practice as it was felt that it already fulfilled policy requirements. This work showed that while this was the perception, it fell far short of reality. Thus, assessment and treatment opportunities were being missed, information was not being passed on to community workers who would have benefitted from it, and treatment was less meaningful for users and their carers. One reason for this lack of awareness of new policy demands was the tradition of learning on the job as the prime means of gaining experience. When the 1990 NHS and Community Care act was implemented, the changes in practice it demanded was unchartered territory for all. Therefore learning could only occur through training, or by reading the many guidance documents; for example DoH and SSI 1991 and DoH, SSI and SWSG (1991). By the time the research results were fed back to the participants in 1996, there was a greater level of insight into the importance of policy upon practice, but questions remain about the how practice has changed in light of this.

Through this research a method whereby occupational therapists can obtain an accurate record of their own activity has been developed, and it's application may identify need for changes to practice. However, analysis of qualitative interview data from a range of stakeholders proved to be a more powerful indicator of where the need for changes might lie.

Aim Three: To identify both the overt and covert influences upon the profile of activity

Descriptions of activity and accounts of the 'worthiness' of the activity undertaken by occupational therapists fails to explain certain observations; for example the preference for involvement in assessment rather than treatment activity on the part of occupational therapists and the minimal difference in range of clinical activity observed across different grades of staff in studies two and three. Therefore, further, more fundamental questions remained about the nature as well as the balance of underlying influences upon activity. What causes occupational therapists to undertake the activities described previously?

The need to explore both the overt and covert influences upon activity demanded further examination of the research findings. Irvine and Graham (1994) propose that a critical theory

approach to professionalism in occupational therapy will include an examination of structure, process, power, control and autonomy. Therefore, the activity data were further analysed through adoption of a critical theory approach to professional behaviour described in chapter one. The study design enabled activity to be placed in the context of:-

- Relationships with other disciplines in various workplace settings where occupational therapist practise.
- The impact of professional behaviour upon service users and their carers, particularly as this project was concerned with the assessment and treatment of one of the most vulnerable groups; older people with mental health problems.
- The implementation of major changes in health and community care policy and the impact of these changes upon occupational therapists.

A further, extremely enlightening source of information was provided through a seminar held in 1995 for occupational therapy staff who had participated in the project, (Mountain and Moore, 1996); their responses to the results of the activity analysis giving further weight to the body of evidence.

Adopting a Critical Theory Approach to Professional Behaviour

Findings are presented under three headings which accord with the paradigm of structure, process, power, control and autonomy proposed by Irvine and Graham (1994).

1. Relationships between occupational therapy and other disciplines

The findings from this project suggest that the service being received by the service users was being compromised by the continued battle for power and autonomy on the part of all health professionals; exemplified though the interwoven processes of referral, decision making, recognition of expertise, and extent or otherwise of inter disciplinary and inter agency working.

Referral routes

The referral routes described in this thesis underscored the dominance of medicine over occupational therapy and other clinical professions, despite the moves towards a community orientation and the requirement this places upon staff to accept wider responsibility for the older people in their care (study four). A complex layering of who can refer to who was exposed; for example medical staff primarily made decisions about referral to occupational therapy (and other disciplines) in line with their overall clinical responsibility for patient care. In some circumstances this power was delegated to other members of the multi disciplinary team; usually nurses in day to day charge of a clinical area. It was also significant that home care organisers did not presume to make direct referrals to occupational therapists employed by the hospital even though they are in a prime position to uncover the needs of older people living at home and trigger referrals to specialist services as appropriate. There are questions about whether referrals from home care would be

welcomed by occupational therapists. In common with the observations of Hugman (1991) this project revealed a clear protocol regarding who had the right to refer and to whom. Moreover, the routes which people took to access the occupational therapy service demonstrated that methods of client referral were not always properly considered, bringing into question the real reasons for certain decisions being taken. Were they in the interest of the service users or serving other purposes? The significance of the referral process was illustrated during this study through the debate which occurred between day hospital nurses before allowing referral to occupational therapy to go ahead. The depth of this discussion gave some indication of the power associated with such decisions. Studies by Mackay (1995) and Morral (1997) both suggested that nurses seek the approval and sanction of doctors in order to achieve secondary goals. In this study of occupational therapy, a similar phenomenon was observed in that occupational therapists placed great emphasis on the need for, and desirability of, medical approval. If they did not work within the medically defined protocol, patients might be referred to other disciplines instead and their position would become precarious. Occupational therapists realised that they had to tolerate referrals from nursing staff as they were gatekeepers of a clinical area, particularly when responsibility for referral to occupational therapy had been delegated to nurses by doctors. Nevertheless, it was evident that this was a situation which was not easy to for them to reconcile. Therefore, in common with the work of Morrall (1997), this project showed that acceptance of referrals was likely to be located in the gains to be made from fostering a relationship with the referrer rather than the needs of the person being referred. This sheds light on the limitations placed on referrals from other sources like home care, where no overt status gains were to be made.

An important dimension of the process for occupational therapists was the acceptance of referrals for rapid assessment with the purpose of providing information for the rest of the multi disciplinary team, and in particular the consultant. Paradoxically, particularly when a referral was concerned with assessment, occupational therapists were more than ready to hand the problem back to the medical staff once they had carried out the prescribed work, with treatment opportunities being missed. Where referral was less formal; for example in the majority of group work settings, occupational therapists had little control over who attended even though they were responsible for the content of the session; the feeling being that this compromised both the status and effectiveness of the activity. Once again, this lack of power could be traced back to not having authority over a designated clinical area. The one example in this study where occupational therapists had challenged the system was through the establishment of the community based leisure group described in studies two and four. The referral criteria for this group was defined by the occupational therapists themselves and they had direct control, both of composition and content of the group. This had proved to be a successful venture with complementary comments being made from staff from a variety of backgrounds, including medicine. Participants stated that they derived benefit from attending and the occupational therapists themselves enjoyed running the group. In this situation the gamble of breaking away from the system had paid dividends. Such a venture would benefit from further study of clinical and cost effectiveness; for example did the group help to

maintain participants in the community and how does this kind of intervention compare with day hospital attendance?

Decision making, autonomy and power

One of the themes extracted from the consultant interviews was the requirement for occupational therapists to be more assertive. Implicit in this was that if they were not, they would be marginalised in the team. Obtaining sanction from other members of the multi disciplinary team, and in particular the consultant was therefore perceived as being important in maintaining a valid position in the team and maintaining a respectable workload. However, this arrangement had clear drawbacks. With doctors maintaining overall control over the referral process, how could staff from other clinical disciplines operate in a truly autonomous manner? This was not exclusive to occupational therapy; there were tensions observed in other professional groups, rooted in perceptions of power and decision making abilities in relation to medicine.

One of the policy decisions operationalised through the 1990 NHS and Community Care Act was to involve doctors in management, thereby capitalising on their skills and status while controlling their behaviour (Hunter 1994). This led to the introduction of the clinical directorate model of management described in study three. At the time of this study, professional line management of occupational therapy had been disbanded in some locations in favour of a directorate model of management. The consequence of this was that those who were previously at the apex of the occupational therapy hierarchy were being asked to undertake tasks of a more generic nature by general managers. The extent of data collected in this project did not enable further explication of the effects of a general management model upon activity. However, it did show that where the professional hierarchy remained in tact, its power was striking; for example staff interviewed did not question local policy determined by the professional leader, even when this conflicted with the demands of the multi disciplinary team and was a source of annoyance to the consultant (study four). Once again, the security obtained from the professional group predominated over multi disciplinary working. Following completion of the research, the occupational therapists who participated were asked about the role of the most senior staff in their service (Mountain and Moore, 1996). While fear of erosion of professional line management was universally voiced, reasons for retaining the hierarchy reflected a degree of confusion about the need for lead occupational therapists. A range of roles were put forward, for example promotion of development work, supervision of junior staff and routine staff management. It is relevant that the findings of the research did not support the development and supervision role in the majority of instances. Some thought that retention of head grades protected clinical staff from managerial responsibility while another suggestion was that head grades should be more involved in clinical work by delegating routine administration to an administrator.

Within their own sphere of influence, the behaviour of occupational therapists mirrored that of their medical colleagues. Beattie (1995) employs the metaphor 'tribalism' to explore how boundaries between the different health professionals have been drawn. While this phenomenon has been

frequently applied to medicine (Hunter, 1994), this study raised the notion of tribalism in occupational therapy with several examples of marginalisation of other professions and adherence to rigid professional stances by the occupational therapists in this study, illustrated by what occurred once a referral had been received. This is an important insight which while alluded to in theoretical work, has not been demonstrated through occupational therapy research in this country before. Occupational therapists wielded their own controls in several ways. One way was to limit the contributions of other team members; for example once the need for a home visit had been identified and agreed, the occupational therapists was prime organiser and executor even in the presence of another professional. Thus, control was maintained over designated tasks (Goldie, 1977). Another way was to underplay the potential of the contributions of other team members by claiming that the task would not be done as well by others. This stance was maintained even when occupational therapists did not have sufficient resources to undertake the task themselves; for example the idea that nurses could be trained to undertake dressing assessments was an anathema to all the occupational therapists interviewed. Yet another strategy was to limit the powers of the unqualified staff responsible to them, in the guise of responsible professional behaviour. The observations of power exerted over this group confirms the views of Harrison and Pollitt (1994) in that unqualified staff were given tasks which were perceived to have lower status; for example treatment following assessment. Moreover, while some of the limitations upon the activities of helpers were necessary and rational, this project showed that others were not; for example the consensus across those interviewed that helpers are not trained to carry out assessment (and implicitly cannot be trained to do so) and that they are not able to contribute to written records as they lack competence in written work.

A further parallel can be drawn with the behaviour of medical staff in that occupational therapists were observed to be largely autonomous from each other, particularly with respect to clinical decision making. They maintained a method of notekeeping which was not shared, and extent of supervision was generally low apart from that provided to very junior and unqualified staff. Certainly at senior level and above, controls upon the nature of activity appeared to be minimal, apart from the limits set in some domains by professionally led policy decisions. Therefore while seeking support from members of the same group, unlike nurses who are trained to work in a team, the preference was for independent working methods where individual practitioners do not question the working methods of colleagues. However, these working methods located largely in custom and practice are about to be challenged. The new policy recommendations (DoH, 1997a and DoH, 1998a) will question clinical practice on the part of all health disciplines through the clinical guidelines to be set by the proposed National Institute of Clinical Excellence (NICE). This will demand that clinical activity meets quality criteria identified by NICE, and furthermore, proof of effectiveness will be demanded before new treatments can be introduced. Changes required to meet the challenges of this policy are discussed in chapter eight.

Perceptions of status in the working environment

The results of this project concur with the finding of research conducted in Australia by Boyce (1997) in that there are policy factors outside the clinical care domain which are proving instrumental in determining the extent of power and autonomy experienced by health professionals; for example changing lines of managerial accountability, and working across agencies. In particular, Boyce notes the moves to replace professionally driven resource allocation with managerial decision making, thus increasing accountability for activities. Additionally, the devolvement of decision making to clinical units bring the contest for resources outside the professional arena and closer to the patient interface. Boyce notes that in Australia this problem was being overcome by allied health professionals in Australia (which includes occupational therapists) becoming allied to one another. While this movement has resulted in concerns over retaining control over specified area of work, it has also improved chances of direct participation at strategic policy making forums. In Britain, a similar phenomenon can be observed in that representation by individual professions allied to medicine at a strategic level is marginalised by larger and more powerful disciplines. This then has the effect of reducing influence when policy is implemented; for example Primary Care Groups introduced through "The New NHS" (DoH, 1997a) are largely concerned with GPs and community nursing, with far less acknowledgement of the role of other professions.

If adoption of a critical theory of professionalism is applied rather than a trait approach, the findings of this research suggest that occupational therapists were struggling with the notion of professional status. There was little evidence to support Freidson's theory (1994) of staff controlling their own work; they remained largely reliant on the medical profession both for work and approval. While an ideology of expertise and service did emerge, this was being compromised in a number of ways; for example activity being motivated by other professionals rather than the needs of users and carers and a desire to satisfy the needs of the multi disciplinary team as a way of maintaining some sense of status. Control certainly did not lie with the occupational therapists themselves.

Possession and acknowledgment of, specialist knowledge and expertise

Within a trait construct of professionalism, one of the defining features of acquiring professional status is the existence of specialist skills and knowledge. So did occupational therapists demonstrate such expertise through the activities they carried out?

There is little doubt that some of the activity occupational therapists were engaged was valued by a variety of colleagues within the hospital, home care organisers, users of the service and their carers. However, occupational therapists themselves placed far greater store upon recognition from other hospital based disciplines, and in particular medical staff. Work with older people with mental health problems is complex and demanding and more often results in maintenance of the status quo rather than cure. While being unable to provide a cure has always been problematic, particularly for medicine, this is now reinforced by the current move towards evidence based medicine (Muir Gray, 1997) where demonstrable proof of benefit is the desired outcome. Yerxa, (1992) suggests that

when cure is not achievable, medical staff scrutinise the role and contributions of other professions. If this is the case, then the occupational therapists in this study were placed in the position of having to demonstrate their worth with a client group where needs are complex and curé is less likely.

A key question was why treatment was apparently a lower status activity compared to assessment. Application of a critical theory approach to professionalism can answer this question where a simple analysis of staff activity cannot. The lesser significance placed upon treatment was evidenced by the greater involvement of helpers in this activity, whereas they were largely prevented from carrying out assessments. The reassurance occupational therapists derived from providing the multi disciplinary team with information and having recommendations acted upon by other team members has already been raised. Thus certain activities, and in particular short term assessment were valuable currency in maintaining status. Being asked to undertake rapid assessment was therefore translated by the staff in the study as recognition of their specialist knowledge and expertise, even for those occupational therapists working from institutional locations where demand for assessment was less, the emphasis being upon social and recreational activity. In light of this, it is not surprising that occupational therapists fiercely defended their role as experts in functional assessment, and neglected other dimensions of their skill base, even when they did not have the resources to meet demand and others might be trained to carry out aspects of the work (Mountain and Moore, 1996). Discussions about the research findings confirmed the confusion and lack of rationale which existed, with the view also expressed that greater participation by unqualified staff would limit the role of the qualified occupational therapist to that of assessor only! These tensions extend beyond the occupational therapists interviewed during this project. Perceptions of occupational therapists as facilitators of rapid discharge has been bolstered by policy which promotes care in the community, alongside ever increasing financial constraints upon health trusts. Occupational therapists have responded to assessment role necessary for the facilitation of "quicker and sicker discharges" (Sutton, 1996). The pressures this causes was described by an occupational therapy manager during discussion of the research findings (Mountain and Moore, 1996). She was clear that the overriding goal in the acute trust she worked for was obtaining successful discharge so that patient throughout was maintained. Occupational therapists were obliged to get the patient home both safely and speedily. This functionally orientated role is in opposition to that described by some occupational therapy academics; for example Nelson, 1997.

> *....we need to resist the temptation to redefine ourselves with every new trend in health care. We are not rehabilitation professionals - we are occupational therapists whose mission is much more basic and enduring than even the rehabilitation movement. Nor are we functional therapists or functional outcomes therapists. The term function is reflective of the mechanistic, business orientated climate of these times.*
>
> Nelson, 1997, pp. 22

Maintaining the purpose described by Nelson while satisfying the demands of management demands is clearly problematic, particularly in light of the status to be derived from carrying out a role which others perceive to be important.

It must be stressed that occupational therapists were not alone in protecting what they perceived to be their exclusive contribution. The behaviour of day hospital nurses towards occupational therapists, doctors to occupational therapists and occupational therapists to other members of the multi disciplinary team all support Goldie's thesis of 1977. This proposes that a fundamental goal for practitioners is gaining and keeping control over certain activities. Such activities might include overseeing the work of other disciplines; for example in the day hospital, nurses tried to control the activity of occupational therapists, with the threat of lack of acceptance if compliance was not forthcoming. In turn occupational therapists controlled the contribution of the unqualified staff responsible to them.

There was a failure to acknowledge the potential that exists in providing training to others, as discussed by one of the psychologists interviewed. As it was, a predetermined agenda of training was given to unqualified occupational therapy staff where there was direct control over their activity, but not extended to any other groups.

The awareness voiced by some occupational therapists interviewed during study two, that assessment was limiting development in to other areas was a reflection of the position they found themselves in. One rationale put forward was that short staffing had led to this concentration upon assessment. While this is not an unreasonable statement (given the demand for rapid discharge) activity analysis also revealed that for the majority of occupational therapists less time was spent in clinical activity than in other categories of activity like communicating with other staff. Through adoption of a critical theory approach, it was apparent that threats to their professional status were causing occupational therapists to draw heavily upon the values and knowledge learnt during their pre-registration training and limiting development in to other, more interesting aspects. If this were not so, then a greater delineation between the activity of different grades of occupational therapists would have emerged during activity analysis, due to expertise being developed with experience.

2. The Impact of Professional Behaviour Upon Service Users and Carers

In 1990, Mayers suggested that occupational therapy has a unique philosophy which includes involving clients in all decisions which affect them. Work in Canada has promoted this ideal through the development of client centred guidelines for practice (CAOT, 1993). However the findings of this work suggested that this philosophy, if it ever existed in reality, was being compromised for a variety of reasons. How can occupational therapists legitimately centralise the needs of users and carers if they are also concerned with enhancing their professional status? Furthermore, study four clearly showed that even though the older people referred to the occupational therapy service also had problems stemming from physical ill health, occupational therapists tended to concentrate on mental health problems almost exclusively. Therefore, the philosophy of holism was not played out in practice.

Hugman (1997) describes some of the dilemmas which can compromise a philosophy like that which exists in occupational therapy; for example, professions have to be convinced of the benefits

of a partnership relationship with clients and while different groups have different interpretations of caring, all claim to care. In the case of older people with mental health problems, the user movement evidenced in mental health and physical disability remains less of a threat to professional decision making. While this easier is for clinicians to cope with on a day to day basis, it does not challenge entrenched values and practices, making it more difficult for professional groups to become aware of the impact they have upon service users and make necessary changes.

Despite overt compliance with assessment and treatment regimes, it was apparent that service users did opt in and out of activities, making last minute decisions not to cooperate, in the case of out patients, by not attending or by going along with treatment without any intention of changing behaviour. It is interesting to note if a user was only referred for short term assessment, the relationship between occupational therapist, the service user and their carer would be brief and it would not be necessary to confront some of the more difficult, intractable behaviour some older people with mental health problems can exhibit. Was this one of the reasons why occupational therapists were keen to hand back the patient to the multi disciplinary team once they had carried out the assessment? Further research is indicated to determine whether this is indicative of a need for further training or due to other factors.

In her research which looked at the power exerted by doctors and nurses, Mackay (1995) described the patient as a pawn in professional power play. Nurses will be overtly deferential to doctors and dissuade patients from questioning medical decisions for a complex mix of reasons; two examples cited were self protection and inculcation during training. While this study did not overtly replicate the findings of Mackay, discussions with both occupational therapists and service users did not question decisions made by doctors, or their authority. Furthermore, the activities undertaken by occupational therapists played out this compliance. Even though rapid assessment was not helpful for users and not fulfilling for occupational therapists (study four) it was carried out, usually because doctors had requested it.

Evers et al (1994) suggest that effective inter professional working considers older people and their carers as participants in inter professional work rather than passive recipients, drawing upon their expertise, both of the illness and of the service system. Discussions with service users, carers and occupational therapists during this study revealed that the occupational therapists took decisions about the extent of information they gave to users and carers, choosing not to inform at times. Unfortunately, this did not take account of the anxiety which can arise from lack of information; or the knowledge possessed by the users and carers that they could draw upon; for example older people's descriptions of their care networks (study four). Even one of the most innovative examples of occupational therapy practice, the leisure group, was not user orientated in that decisions about admissions and discharges were taken by staff alone. A worrying aspect of the study was that occupational therapists did not appear to be fully aware of the power they had over service users and it also did not occur to them that they were not involving users and carers adequately. How this power can be translated into authority (Ovretveit, 1992) and therefore used positively through a partnership with users and carers is raised in chapter eight. The findings from the case study (study

four) accorded with work by Twigg and Atkin (1994) who examined the experiences of carers of a range users of health and social care services. Twigg and Atkin observed that;

"Carers come into the orbit of an occupational therapist by virtue of the domestic location of their work, but they tend to be incorporated into their practice only to a limited degree."

Twigg and Atkin, 1994

The case study found that occupational therapists were unlikely to seek out carers, involvement being restricted to those who they met when they visited the older person at home. During the presentation of the findings of the research to participants in 1995 (Mountain and Moore, 1996), occupational therapists were asked to consider how they involve service users and much contact they ought to have with carers. The following questions about user involvement encapsulate the extent of the problem which existed;

"How much should you listen to the service users accounts and who do you believe?

To what extent is a patient able to express an objective view?

Can we believe the patient's view of their care network?"

Mountain and Moore, 1996, pp. 47.

With respect to carer involvement, mixed views were expressed, with some people seeing benefits in enhanced carer contact whereas others were of the opinion that the existing extent of contact was adequate. This omission was not exclusive to occupational therapists; evidenced by the lack of congruence between the views of professionals and service users regarding formal and informal care networks (study four). On a more positive note, Evers et al (1994) cite a number of factors associated with beneficial experiences on the part of older service users and their carers. These include longer term relationships with professionals and developing a shared understanding and joint strategies to problem solving. This study demonstrated the benefits of longer term treatment for service users and that this role could be fulfilling for occupational therapists. Unfortunately, as previously described, it was not considered to be a status activity and was a lesser policy priority.

3. Responses to Policy Driven Changes in Health and Social Care Delivery

Current policy is strongly promoting multi disciplinary, cross agency working, particularly in the case of older people with complex needs (NHS ME, 1998). Therefore, to address the question of responsiveness to policy, the extent to which these goals of integrated working were being achieved is examined.

Multi disciplinary working

Irvine and Graham (1994) suggest that attaining professional status is of importance to occupational therapists because of a desire to create unity at a time when their work is increasingly becoming more specialised and they are having to work in isolation or within community teams. In chapter one, questions were raised about the impact on the change of location of occupational therapy training from uni disciplinary, isolated sites to higher education institutions. Has this facilitated the introduction of multi professional education in any way? At the time of data collection (1992-

1993), some occupational therapists were finding working within a health located multi disciplinary team to be problematic and there was greater allegiance to members of the same discipline. They perceived team working as being a threat to their autonomy and sought support and security from each other. It is not surprising that they were largely resistant to being dispersed from a departmental location while the benefits of remaining in close contact were such.

The consultants interviewed all said that they would prefer a greater adherence to the multi disciplinary team by occupational therapists. However, this might be construed as having greater adherence to them as leaders of the teams. A question for a further research is whether the need to be with members of the same discipline is replicated by occupational therapists working outside the health service; for example in private practice or local authority settings. Is multi disciplinary and cross agency working more of a possibility in the absence of medical leadership?

While occupational therapists largely accepted the established referral routes, they were clearly less accepting of perceived interference with their clinical activity on the part of other disciplines. A salient observation by Evers et al (1994) was that the inability of any service, no matter how good, to meet the needs of all users can be confused with need for improvement to inter professional working and caring services. Therefore, the previously discussed frustration arising from the intractable problems older people with mental health problems present with can be blamed on poor team working. On a more optimistic note, the research highlighted that where close working relationships between individual team members had been fostered, inter disciplinary work was successful and it was possible for occupational therapists to use a wider repertoire of skills to the benefit of service users. However, in situations where other professionals were perceived to be a threat, these benefits were not realised and occupational therapists retreated to a limited range of assessment activity and tended to work in isolation. How this cycle might be broken is discussed in chapter eight.

Inter agency working

At the time of this project, the multi disciplinary team as interpreted by occupational therapists comprised of themselves, nurses, psychologists, social workers accommodated in the hospital and doctors. The interviews with this range of disciplines in study four confirmed that this was the general understanding. The concept of multi disciplinary working had not extended to include community workers; for example primary care and home care. There was a noticeable lack of referrals across the health/ social care divide and absence of cross agency working. The reasons for poor communication with other disciplines, particularly with workers in community settings is of particular relevance, given the benefits of multi disciplinary cross agency working for the client group concerned. Through her work on older people with mental health problems who live alone, Barnes found that collaborative working can improve communication between workers and with users and carers, improve the quality of care received and make effective use of existing resources.

"Like books supported by bookends, the care of an older, mentally ill person alone can collapse if either side of the support is missing. To maintain this support, a flexible response from both types of services (health and social services) *was felt to be crucial."*

Barnes, 1997, pp. 1997.

However, Mackay et al (1995) note that more effective resource use has resulted in questions being raised about the rationales underpinning division of labour in hospital settings and caused a shift of emphasis from health to social care in the community. Working in the community also blurs established lines of accountability. Thus, the benefits of collaborative and cross agency working is a double edged sword for hospital located workers in that it questions established methods of working. Even though occupational therapists may have been be less than satisfied with their position, at least it was familiar territory. If staff behaviour is placed within this context, it is not surprising that occupational therapists spent far less time talking to community based staff as opposed to those working in hospital (studies two and three). It would be interesting to look at whether the converse is true; does working with hospital based disciplines have a similar effect upon community based workers? In occupational therapy, the question is extremely pertinent as occupational therapists work for both health and social services. This project has demonstrated the gains to be made from a strong allegiance to the same group, but does this allegiance extend across different organisations?

This critical appraisal of the research findings is now used to examine the accuracy of the research hypotheses, and to test the model of occupational therapy activity.

Using the Research Findings to Test the Research Hypotheses

The primary research hypothesis postulated that the mix of variables within *professional confidence* underpin clinical judgements and are demonstrated through subsequent activity. Further to this, the hypothesis proposed that professional confidence is comprised of a large number of variables. Some are concerned with the knowledge base of the individual, and others are rooted in the how occupational therapists perceive themselves and are acknowledged by other workers.

This findings of empirical research supported the hypothesis in that a range of variables demonstrably influenced clinical activity of occupational therapists. These included the needs of the users and their carers, the demands of other members of the multi disciplinary team as well as the limitations they enforced, treatment setting, policy demands arising from within the employing organisation as well as from Government, and a desire for status and recognition. Therefore the existence of a large number of variables within professional confidence is confirmed and their impact upon clinical activity has been illustrated.

Two secondary research hypotheses were derived from the primary hypothesis. The first postulated that the balance of variables within professional confidence dictate the nature of activity. The range of positive and negative factors within professional confidence, exposed through critical appraisal of the research findings are summarised in figure 7.1 overleaf

Figure 7:1 - Positive factors (shown black) and Negative factors (shown grey) within Professional Confidence

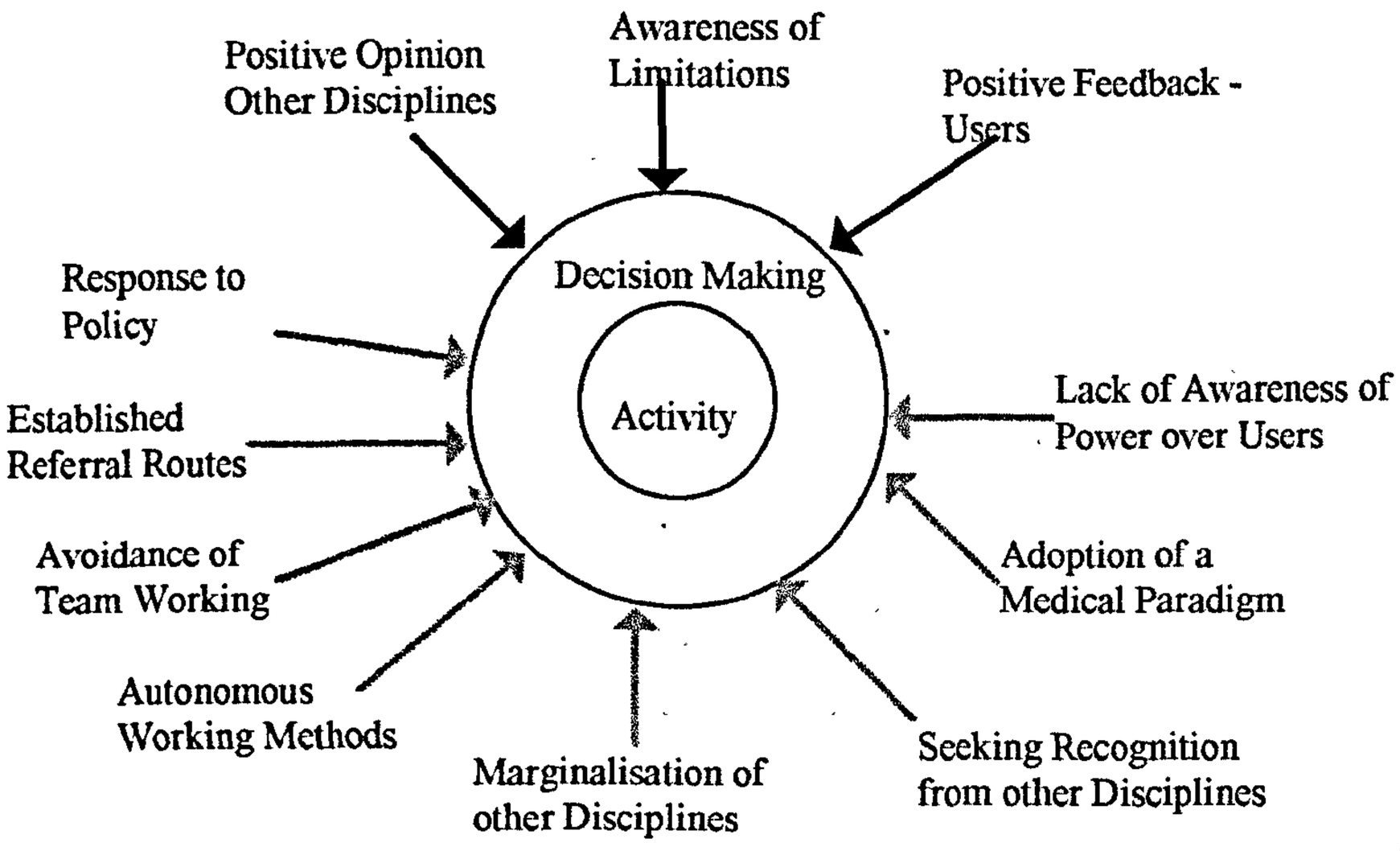


Figure 7.1 shows that clinical activity was determined by a greater weighting of negative as opposed to positive variables within professional confidence. Certain of the findings remained unequivocal across all the occupational therapists who participated in this research, despite a wide variance overall in measured activity. These included clinical autonomy, (from other occupational therapists as well as from different disciplines), a preference for working within a medical paradigm and a fierce protecting of certain tasks from interference by other disciplines. Positive factors which have emerged from the research included the feedback provided by service users about the benefits of longer term contact as well as views of the potential of occupational therapy provided by some representatives from other professional groups. A further positive aspect was that some occupational therapists were aware of the inadequacies of some aspects of their practice, and identified the need for change. The demands of policy created mixed messages for occupational and is a clear illustration of how various influences compete and affect clinical decisions. It is unfortunate that policy is fostering demand for rapid assessment and discharge due to shortage of acute hospital beds. This project has shown that this activity is not in the interest of users and their carers, but it could have been balanced by other policy requirements which promote a user centred approach; for example needs led assessment and provision of services to meet assessed needs. At the time of data collection, just prior to community care implementation, occupational therapists believed that their practice already met policy requirements. This lack of awareness combined with demand for rapid assessment negated the positive aspects of policy for the user and thus the overall effect of policy upon clinical judgements was negative.

The term 'professional confidence' suggests a positive approach, but adoption of a critical theory approach to the findings of this project highlighted the adverse effects of some aspects of professional confidence upon the clinical judgements made by occupational therapists. The desire

to satisfy the demands of other disciplines predominated, with the needs of users and their carers being less powerful. Thus, judgements underpinning activity were skewed towards goals concerned with professional status in the immediate workplace.

The other secondary hypothesis tested through this research is that clinical judgements will underpin clinical activity and determine the quality of service ultimately experienced by the service user and their carer (chapter two, figure 2.3). Results of this project confirmed that a prime determinant of service quality for service users and carers is the clinical activity they experience. Those service users and carers who received longer term treatment were more satisfied than users who experienced short term assessment. However, this work also revealed the pervasive effects of treatment environment upon professional confidence and ultimately upon clinical activity. One of several examples demonstrated through this research is the day hospital, where occupational therapists and their support staff were expected to run leisure and recreational groups. Treatment setting dictated demand for occupational therapy, and fostered certain expectations both by the multi disciplinary team and by service users. Given the traditional methods of service delivery which predominate in day hospitals for older people, undertaking clinical activity which does not conform with what is expected is difficult particularly in circumstances where the individual is the only occupational therapist. From a review of the evidence base concerning service options for older people with mental health problems (Mountain, 1997) came to the following conclusion;

"....the problems if creating a climate of change in an existing institutional setting (which day hospital represents) cannot be underestimated."

Mountain, 1997, pp. 4

The powerful influence of the treatment environment also explains why occupational therapists were reluctant to relinquish a departmental base, where they had greater control over extraneous environmental influences. Unlike doctors and nurses, occupational therapists did not have control over a clinical area, they were vulnerable if the treatment setting was not sympathetic to their work. Therefore, the hypothesis was only true in part, as treatment environment was found to be an overriding influence upon professional confidence, ultimately impacting upon the quality of service received by service users and carers. Therefore, true picture, reflected in figure 7.2, overleaf is more complex than was postulated.

Figure 7.2 - Revised Determinants of Quality Clinical Work

The implications of figure 7.2 for new service developments located are raised in chapter eight.

The Validity of the Model of Occupational Therapy Activity

As the model of occupational therapy activity is underpinned by the primary research hypothesis; this aspect of the model suggested in figure 2.4, chapter two is also supported, in that professional confidence influences clinical judgements and ultimately clinical activity.

The model proposed that four groupings of variables make up professional confidence;

- The perceptions and demands of the multi disciplinary team.
- Organisational and managerial demands.
- Specialist knowledge applied to those referred for treatment.
- Job satisfaction.

The range of factors within professional confidence, extrapolated through this research is shown in figure 7.1. Each of these factors can be placed within the above groupings; for example:-

1. The impact of organisational demands both from within the occupational therapy management structure and from the wider health care setting, played out by policy requirements.
2. The powerful influence of the multi disciplinary team, and in particular doctors, upon clinical judgements.
3. The importance of knowledge located in the needs of older people

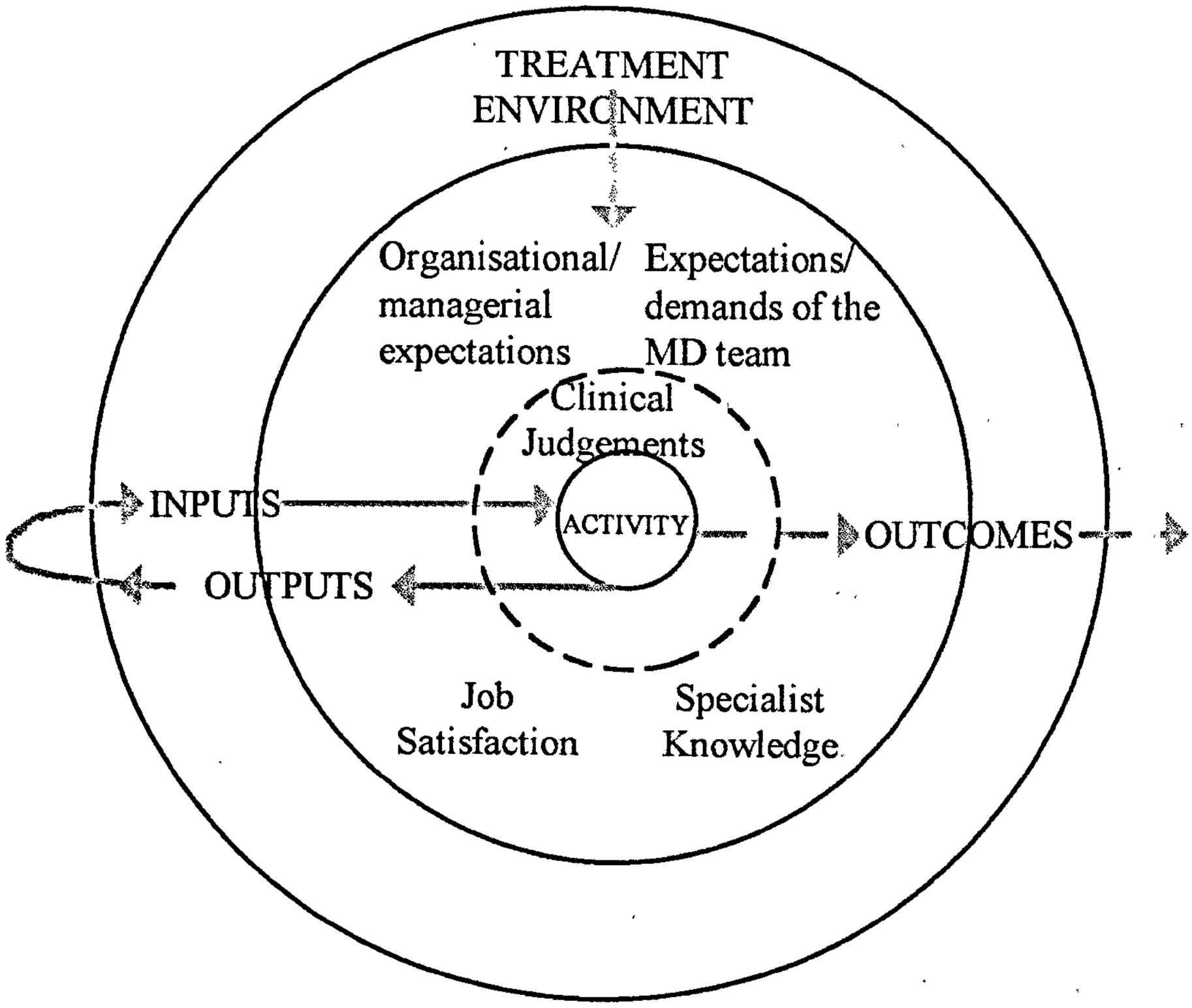
What is less clear is the effect of job satisfaction upon professional confidence. Measurement of job satisfaction did not yield satisfactory results due to the small number of questionnaires available for analysis (study two). Implicitly, it appears that job satisfaction was being gained from a number of sources; for example from status obtained through the job and from contact with service users. Organisational unrest was a negative influence upon job satisfaction (study two). While it has not been possible to explicate the relationship between job satisfaction and professional confidence through this work, job satisfaction is a provenly powerful influence upon activity (Mountain et al

1990 and 1994), and it is therefore retained within the revised model of occupational therapy activity.

The purpose of the model of occupational therapy activity was to locate the activity of occupational therapists within the context of a work setting. The term 'treatment environment' could be applied to a number of conditions; for example the occupational therapy department, the home of a service user where treatment occurs, the day hospital or the institutional setting of the hospital. In the original model (figure 2.4, chapter two), treatment environment was defined as an input into the treatment process. However, this project determined that, rather than being a treatment input, treatment environment is an independent variable with the power to influence all other variables identified within the model. Treatment environment could shape both the nature and patterns of referral and the demands placed upon the staff concerned and ultimately the quality of service. This is illustrated in figure 7.3 overleaf.

The original model conferred with the Donabedian model of structure, process and outcome. However, the previously recounted research findings showed that observed results of occupational therapy (for example results of assessment) rather than the outcomes of that activity (for example reports of benefit from service users and carers and measured improvement in health) were likely to generate more referrals. Therefore the flow of activity illustrated in the original model did not reflect the reality of occupational therapy with older people with mental health problems as measured treatment outcomes are rare.

Figure 7:3 - Revised Model of Occupational Therapy Activity



While acknowledging the power of the treatment environment upon activity, figure 7.3 also suggests a dynamic model where change can occur. The necessary changes, and how they might be brought about are raised in the final chapter of this thesis.

Implications of the Methodologies Used During this Project

On completion of this project it was important to reflect upon the lessons learnt during the research process, particularly in light of the results and their consequences for occupational therapists. Furthermore, as research is a comparatively new discipline for occupational therapists, a critique of this project can inform future research and development activity. There are also questions about how research results can be disseminated most appropriately to all those with a stake in occupational therapy services.

1. Lack of funding to support the project

A content analysis of the main professional journal for occupational therapists in this country, the British Journal of Occupational Therapy (Mountain, 1997b) confirmed that most research into occupational therapy is conducted by individuals within their workplace. In common with the majority of existing research, resources available for this work limited sample sizes and restricted the work to one Health Region. Therefore, the representativeness of data collection and generalisability of the results need testing in other locations. Given the powerful messages for occupational therapists that this work has uncovered, further work to validate the diary for more extensive use would be a good investment.

2. Project staffing

This project questioned research being undertaken by occupational therapists for occupational therapists. Two researchers were involved; the lead researcher was involved in occupational therapy management, (but not of the services under investigation) at the time of field work. Project funding provided the finance to employ a second part-time researcher to undertake some aspects of data collection under the direction of the lead researcher. She was a social scientist with no previous experience of occupational therapy services. Although the lack of availability of another research occupational therapist was a matter for initial regret, this did not remain the case. It soon became evident that involvement from a worker outside the profession improved the quality of the research. By viewing the subject area with an objective eye unencumbered by professional ideology, the social scientist questioned many of the professionally held but unsubstantiated beliefs of the research occupational therapist; for example the interpretations placed on key activities like home visits. However, the dynamics of professionalism described in chapter one, and in particular social closure as a means of identifying a professional group, demanded other insights from the researchers. The occupational therapy researcher was able to locate the research in the context of the perceptions and understandings of occupational therapists, which someone outside the professional grouping would not have been able to do.

3. The practitioner as a researcher

At the time of field work (1992-1993) the lead researcher was an occupational therapy manager. The challenges presented by management of the research process, necessitating maintenance of an

objective viewpoint, soon became evident. Despite strict adherence to confidentiality and anonymous reporting of the results, some practitioners involved in the research process were uneasy. There were concerns expressed about what the findings might reveal, exacerbated by the position of authority of the lead researcher in what is a small profession. To manage this confounding factor, a deliberate strategy was adopted whereby the second researcher carried out, under supervision, all qualitative interviews with occupational therapists.

This project has shown that research approach has to be carefully considered, particularly when the activity of others, for example practitioners or service users and their carers, is placed under scrutiny. Action based research is a method whereby the locus of power can be shifted from the researcher to the group being researched. This methodology demands a partnership between researchers and those being researched, with research results being shared throughout the course of the project. This level of involvement can diffuse anxiety as well as ensuring that recommendations located in the results can be implemented as rapidly as possible. Now that the primary research has been completed, this model could be usefully applied to future research into the activity of occupational therapists ; for example testing the validity of the model of occupational therapy activity applied to occupational therapists working in local authority settings.

4. Research design and choice of research methods

There are problems researching a small profession. Numbers are limited from the outset and become further reduced when a sub-specialty within the profession is selected for specific investigation. Qualitative research is a rigorous methodology which does not rely upon large population samples. Additionally, this type of methodology enables exploration of the more intrinsic elements of clinical practice, not readily accessible through quantification. Use of both qualitative and quantitative methodologies meant that the aims of this research could be examined from several perspectives. Also, common themes emerged across the four studies, enabling the cross validation of results.

The benefits of this approach are clear in that it has allowed service quality to be articulated by service users and their carers, as well as creating a measure for occupational therapists to use to examine their own activity. However, other research approaches should be considered if the work described here is to be extended to occupational therapists working in other settings and specialities,

5. Dissemination of the Findings

Since the Department of Health Research and Development strategy was first introduced in 1991, there has been increasing emphasis upon dissemination as a crucial component of the research process, so that research results can be translated into practice. This concern was demonstrated by a funded programme of research to evaluate methods of implementating of research findings in the health service (DoH, 1995). The importance of effective research dissemination and implementation is now underscored by the policy led demand for evidence based practice (DoH 1997a and DoH, 1998a).

The writing of a thesis does not enhance the dissemination of research results, and the researcher was aware of the length of time it took for practitioners to receive any information from the project (at least two years). Publication of the findings will be extended to reach a wide readership, so that they add to the body of existing knowledge and to academic debate. Taking into account the value of action research in enabling timely implementation of results, a recommendation for the future is that dissemination of a large project should be conducted throughout it's duration, rather than upon completion only.

To date, dissemination of the results of this work to occupational therapists has included seminars, a conference paper presented at a national event and a published report (Mountain and Moore, 1996). This mix of dissemination methods has proved successful in reaching a wide group of occupational therapists beyond those who were directly involved in the research. In the oral presentations to occupational therapists, a two way communication process was established whereby the researchers verbally reported the research results, questions from the audience were invited and discussions of the implications for practice were facilitated. Documenting the results in a report for widespread distribution proved more challenging, as questioning and clarification of the results can only take place through correspondence with the authors. It was therefore important to give careful consideration to how the written results might be interpreted by the readership, particularly those outside the profession of occupational therapy. In light of this, a two pronged dissemination strategy will be implemented; one aimed toward occupational therapists and another at the wider health and social care community. Further dissemination of this work to occupational therapists will raise the need for changes to practice in light of new methods of treatment and care of older people with complex needs. It will also examine how measurement of clinical activity through the instrument devised during this project can contribute toward the requirement for evidence of effective practice. Several of the findings of this project question the methods being adopted by all workers involved with vulnerable people; for example the often erroneous interpretation of care networks. These aspects of the study will be disseminated through outlets to reach a wider audience.

CHAPTER EIGHT

LOOKING TOWARD A BETTER FOUNDATION FOR OCCUPATIONAL THERAPY ACTIVITY

This research enabled the activity of occupational therapists to be fully described for the first time, highlighting both positive aspects and shortfalls. It is has provided evidence of how professionalism in health is driving the activity of occupational therapists. Furthermore, through exploration of the nature of that activity and what influences it, a model of occupational therapy activity has been validated, which could be generalised to occupational therapists working in a range of health settings. Further research is required to explore applicability of that model to occupational therapists in local authority settings, voluntary organisations and private practice, and in new systems of care delivery which span the health /social care divide.

Although the project concentrated upon one profession, the results, particularly of study four demonstrated how change is required on behalf of a range of health care professions. It would be easy to incriminate occupational therapy for a number of deficiencies which also pervade other disciplines. The lost opportunities for service users described in this thesis is the responsibility of all those involved in their treatment and care, particularly given the vulnerability of the client group concerned.

Unfortunately, rather than confirming status, the results of this work reveal the damaging effects of pursuing professionalism upon occupational therapy, both for individual practitioners and well as for occupational therapy as a discipline. While it is clear that occupational therapists cannot avoid professionalism in health and social care, their ability to discriminate between desirable aspects of professional behaviour and those which should be avoided was certainly flawed. In light of the results, alongside changes in delivery of health and social care, occupational therapists are advised to critically examine and consider changes to aspects of their work.

This chapter draws out where change is required, the tensions underlying making necessary shifts in practice and how positive factors within professional confidence might be fostered so that change can become a reality.

Identifying the Necessary Changes

Through analysis of the activity of occupational therapists, and adoption of a critical approach to the profile of activity which emerged, factors which influence clinical decision making have been uncovered and reported in chapter seven. The findings from this project revealed a less than desirable situation in that the common denominator straddling all four groupings of variables within professional confidence was the need to demonstrate professional status. This relentless desire frequently skewed decision making away from the needs of the service user and their carer. The most pertinent example is the prioritisation of short term assessment by occupational therapists.

This occurred because other disciplines, and in particular doctors frequently requested this activity, and consequently it was considered to be a source of improved status as discussed in chapter seven. Moreover, the desire for recognition from the activity was such that it was fiercely protected from perceived external interference; for example by marginalising the contributions of other disciplines and unqualified support staff. Unfortunately such actions, rather than leading to increased status, tended to erode it. Assessment frequently entailed handing the problem back to medical staff with a report of findings, rather than being followed with treatment to meet needs uncovered through the assessment process. Therefore it had limited value, both for other workers trying to solve the complex needs of older people with mental health problems and for the service users themselves. Recognition of worth from service stakeholders; (other professions and the users of the service themselves) was reduced in these circumstances. This research identified the vicious cycle created by the desire for increased status, illustrated in figure 8.1

Figure 8:1 - Effects of the Drive for Status and Power Upon Activity

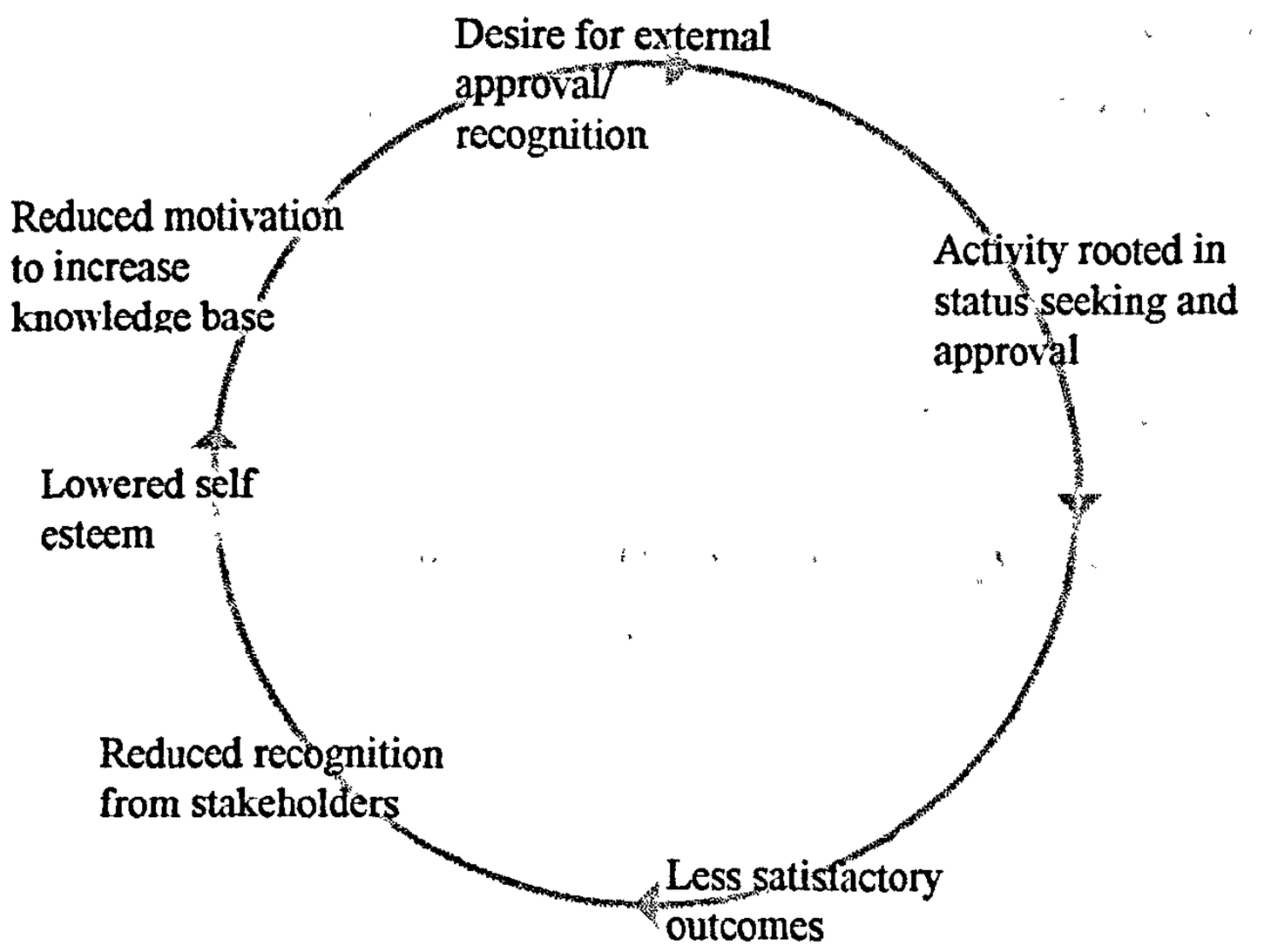


Figure 8.1 shows that activity rooted in status seeking and approval does not meet the needs of older people with complex needs, or assist other workers in meeting those needs. This leads to less than satisfactory outcomes for service users and their carers, and reduced and short term recognition from other disciplines. The effects are to reduce job satisfaction and erode self esteem. This decreases motivation to extend personal knowledge base and expertise, feeding the need for more reassurance from external sources. Substantial changes have to be brought about if this cycle is to be reversed.

A key question posed in chapter two was concerned with positive aspects of professionalism upon behaviour. Does belonging to the professional group help occupational therapists to withstand

potentially negative influences and build on positive attributes, thus maintaining an ideology of service which is demonstrated through their activity? If this is so, then belonging to the occupational therapy profession will reverse the cycle shown in figure 8.1 The findings of this work showed that agreement about activity was striking even when occupational therapists worked in different organisations and in different specialties. Therefore, congruence across the group was high. However, rather than being beneficial and promoting positive factors within professional confidence, this sense of belonging was counterproductive. It was a means of retreat at best; demonstrated through the strong desire to retain a departmental base, thereby controlling extraneous factors arising from the environment. At it's worst, this behaviour supported invalid and outdated practice like the desire to maintain helpers in a subservient, prescriptive role. Furthermore, the strong consensus regarding the content of occupational therapy assessment and treatment across people working in different locations suggested that this stemmed from training and/ or the professional body. The research by Guy (1985) drew conclusions about the greater importance of attaining personal rather than professional recognition in the workplace, with professionalism merely providing a means of achieving a place on the promotional ladder. The findings of this work were different to that which has preceded in that belonging to the occupational therapy profession was a means of protection against adversity in the workplace, thereby fostering the cycle in figure 8.1 rather than reversing it.

Individual occupational therapists, occupational therapy educators and the professional body will have to work hard to reverse the negative cycle shown in figure 8.1. The cycle of activity which is recommended through this research and needs to be tested is shown in figure 8:2.

Figure 8:2 - More Desirable Influences upon Activity

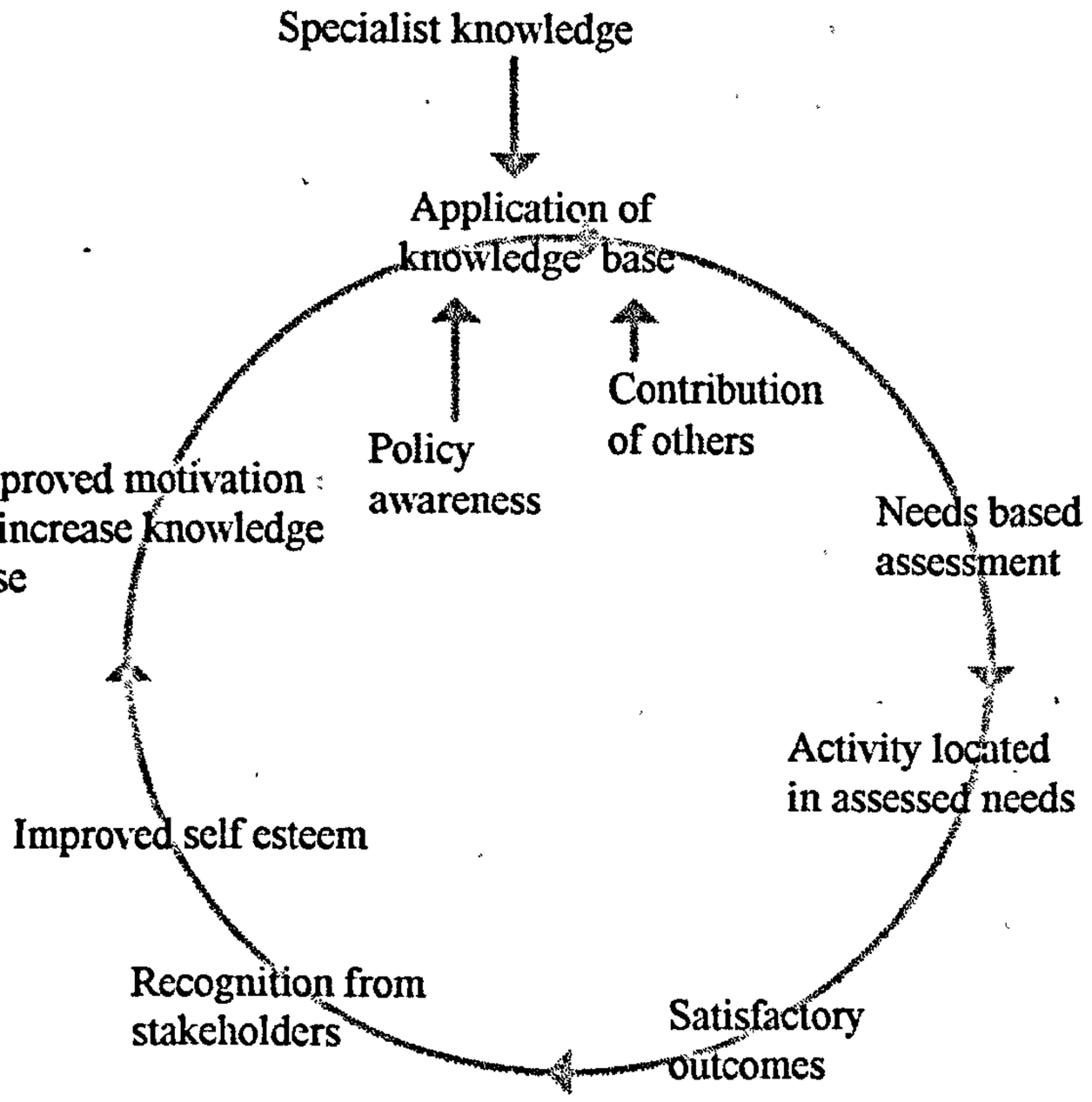


Figure 8.2 suggests that professional confidence should be grounded in a specialist knowledge base, alongside a robust understanding of policy requirements and a clear comprehension of the contributions of other workers across a range of agencies. This combination of skills and knowledge on the part of the individual occupational therapist is more likely to lead to assessment and treatment which directly meets the needs of the user and their carer, and appropriately involves other agencies. If treatment is responsive to needs, it is more likely to result in satisfactory experiences and outcomes for service users. This will lead to greater recognition from all stakeholders, thus reinforcing self esteem and job satisfaction. The motivation provided through good job satisfaction is more likely to lead to the individual building upon their knowledge base. Therefore, to promote quality activity, located in the needs of service users and carers while at the same time obtaining recognition in the workplace and good job satisfaction, the following are required:-

- application of a body of expertise;
- policy awareness at practitioner, organisational and national levels;
- knowledge of the contributions of others from the same and other agencies.

How the results of this research can be taken forward, taking into account the many demands which will stem from the treatment environment is now described

Strengthening the Positive Factors within Professional Confidence: Recommendations for Action

Improving Policy Awareness

This project confirmed the need for occupational therapists to abandon a wish list of traits as a means of proving their status. The results suggest that because occupational therapists have constructed professionalism in simplistic terms, this has restricted their 'political awareness.' Adopting a critical approach to professionalism would enable occupational therapists to be more aware of changes (particularly those rooted in policy decisions), the opportunities and threats presented by such changes and develop strategic responses at practitioner, organisational and national levels as described by Ovretveit (1985).

Developing a strategic response to policy

There is no doubt that occupational therapy has lacked influence at a strategic level due, in part, to their numerical size and relatively small use of resources against medicine and nursing (Harrison and Politt, 1994). The occupational therapists who participated in this study reflected the position of their profession in a broader context. They perceived themselves to have little influence, both in their immediate work environment and in the wider health and social care community. Furthermore, their knowledge of policy and how practice needed to change in line with current thinking was poor. A stronger presence by key occupational therapists and the professional body in decision making forums would certainly provide a foundation for increased confidence.

With respect to the Australian health care system, Boyce (1997) argues that allied health professions (the Australian equivalent of professions allied to medicine) need to become allied to each other to withstand the effects of change and provide a greater voice at the policy making level. Furthermore, there has to be development of an adequate infrastructure to support clinicians. A stronger presence by key occupational therapists and the professional body in strategic decision making forums in Britain would help to raise the profile of occupational therapists in this country. To achieve this, a similar strategy as the one described by Boyce is strongly recommended. The greater voice arising from representation through the alliances with other professional groups would have a more substantive influence at policy making level. Some of these partnerships have already been formed; for example through the Joint Therapies Research Group which includes representatives from physiotherapy, occupational therapy and speech and language therapy. This group provides a joint view at strategic level and seeks to engage policy makers concerned with research and development. Other partnerships have been established to look at clinical issues; for example the College of Occupational Therapists contributed toward development of Clinical Guidelines for Management of Imminent Violence published by The Royal College of Psychiatrists (1998).

This research recommends that these alliances are strengthened and extended through the activity of the professional body. A current example where the College of Occupational Therapists should be proactive is in respect to the 1997 White Paper. The infrastructure to support policy implementation is being put in place; for example membership of the National Institute for Clinical Excellence is being determined and the advisory groups for the national health service frameworks have been appointed. The College should be forming relationships with other key professions so that they can influence operationalisation of the 1997 White Paper. This necessitates more political awareness than before.

As well as shaping policy implementation, increased awareness at the top would also facilitate dissemination of policy decisions to managers and clinicians through the professional network. The occupational therapists in this study appeared to have avoided the many Department of Health guidance documents on implementation of community care. While there are no guarantees, thorough dissemination by the professional body may have reached some occupational therapists who failed to obtain the necessary information through other routes, and it would certainly emphasise the importance to occupational therapists of certain policy decisions.

Awareness of policy at local levels

The Blom Cooper report of 1989 implied that the transition for occupational therapists from a hospital based service to one with a community orientation would be a natural step, but this was not demonstrated by the research findings. If occupational therapists are to extend their role into the community it is imperative for them to gain a better understanding of policy, their responsibilities within implementation of any legislation and develop new roles and practice as appropriate. At the time of data collection (1992-early 1993) the community care policies legislated in the 1990 NHS and Community Care Act were about to be actioned. The occupational therapists interviewed were

totally unprepared for these changes and thought that existing practice would do. This combination of lack of knowledge together with complacency is a dangerous mix. The research showed that this disadvantaged service users and their carers, and led to lost opportunities to demonstrate worth on the part of occupational therapists. Since 1993, policy has moved on, demanding further changes to established methods of service delivery. There is a focus on cross boundary care delivery, and inter agency working, particularly for vulnerable user groups with complex needs (Leathard, 1994). The question this raises is whether occupational therapists are appreciating the need for current policy led changes to service delivery and acting appropriately.

The responsibilities of the professional body in delivering these messages in an effective and timely manner has already been raised. A further set of responsibilities lie with occupational therapy educators. Pre registration occupational therapy training must reinforce the need for policy awareness and also teach practice in line with current policy. Lack of knowledge of policy uncovered during this research spanned recently qualified occupational therapists as well as established practitioners. Moreover, there is little point emphasising a uni professional view point when policy is dictating that practice must move toward a multi professional focus. In order to deliver training in line with the world in which occupational therapists have to operate, educators must ensure the adequacy of their knowledge base and effectively impart this to future occupational therapists. Moreover the multi professional training opportunities presented by relocation of many training occupational therapy schools into further education establishments should be exploited. Multi professional undergraduate education has many proven benefits; for example it encourages broader perspectives and common frames of reference, improves communication and understanding across disciplines and helps to avoid tribalism (Areskog, 1995).

The final responsibility lies with the practitioners themselves. Responsibility for continuing professional development (CPD) currently lies with the individual practitioner. However, the current review of the PSM Act may mandate CPD for occupational therapists and another policy initiative Lifelong Learning" (DfEE, 1998) is promoting the need for continuing education at all stages of life. There is no doubt that the described strategy of learning on the job was not serving the educative needs of occupational therapists and left them inadequately prepared for the shifts in practice which were to occur. There was a clear need for training to facilitate a change of focus, and given the increasing array of available opportunities, occupational therapists are failing in their duty of care if they do not both acknowledge their need for further information and training and take action as appropriate.

Developing a Body of Specialist Knowledge

How professionalism can distort the clinical activities undertaken by occupational therapists has already been discussed. Furthermore, interviews with occupational therapists suggested that when threatened, they tended to retreat into a narrow repertoire of activity, which would have been learnt during pre registration training. Nevertheless, occupational therapists who participated in this project did have skills which were valued by others. The questions raised by this research is how

can occupational therapists both extend and apply their skills more appropriately. The steps which should be taken to achieve this are described below.

Disengaging from a medical paradigm of professionalism

Their relationship with doctors was undoubtedly one of the main predicaments for occupational therapists who participated in this study. They were emulating features of medical professionalism; for example clinical autonomy without having real control over their own work (Freidson, 1994). Little progress appears to have been made since 1989 when Blom Cooper observed that reliance upon others for referral was preventing development of professional status. The results of this research also suggested that there were benefits for other hospital based disciplines if the status quo were maintained. If occupational therapists spent their time concentrating on trying to meet an unachievable aim of a medical construct of professionalism then they presented less of a real threat to other staff groups. However, by undertaking activities which they perceived to be meeting the needs of the hospital based multi disciplinary team, and in particular medical staff, occupational therapists were completely invalidating their position in the wider arena of community care where they could have a central role to play. One example of is by providing a bridge between hospital and home. This is crucial, particularly for older people who have been hospitalised as they are highly likely to return home less independent than before (Mistiaen et al, 1997). There is an increased likelyhood of unplanned readmission to hospital, particularly if support and rehabilitation are not forthcoming (Williams and Fitton, 1988; Gautam et al, 1996). Furthermore, the effectiveness of this role would increase through partnerships with social services occupational therapists. Examples of what this wider role could entail are:-

- Needs based assessment and identification of services and treatment to meet assessed needs. This would mean spending more time with the older person, accepting their views of their care networks and needs (Godfrey and Moore, 1996). Occupational therapists claim to be enablers (Stewart, 1994) and could therefore have a key role in holistic assessment of need and identifying care and rehabilitation to meet those needs.
- Continuing rehabilitation programmes commenced in hospital when the older person returns home (Nocon and Baldwin, 1998).
- Making assessments of carers needs and responding as appropriate. This could include providing information, emotional support and teaching practical coping strategies so that the person being cared for is able to maintain as much independence as possible (Barnes, 1997).
- Liaising with the primary health care team so that the continuing needs of the older person are fully conveyed, particularly upon discharge. Clear routes of communication with the primary health care team must be maintained so that any future problems can be rapidly acted upon before a crisis is reached (DoH, 1997a).

If this role was taken forward, recognition for a job well done would come from a range of sources. Overall clinical responsibility has to remain with the responsible medical officer, and a relationship

must be maintained given established referral routes. Nevertheless, if occupational therapists are mature practitioners, this will not dictate the nature of their practice. Some occupational therapists would state that they are already carrying out all the duties described above. The main difference between what is recommended and what this research uncovered lies in the extent to which the views of the older person and their carer were listened to and taken seriously. A new role would also entail working collaboratively with other agencies in the community, particularly the primary health care team.

Undertaking practice which matches the requirements of community care policy

The development of practice in line with policy complements the previously described role which acknowledges medical priorities, but is not dictated by doctors. It also reinforces the requirement for awareness of policy at a local level. Responsiveness to the wide range of needs users and their carers present with is one of the cornerstones of community care policy. While it is widely acknowledged that this ideology is compromised by a concentration upon a medical construct of treatment and eligibility criteria for social care (Caldock and Nolan, 1994), the philosophy of enabling people to remain in the community remains in tact. This project clearly showed that users and carers were able to receive great benefit from occupational therapy when the occupational therapists were acting with their interests at the core of activity rather than those of other professional groups, including their own. It is most regrettable that the staff in this study did not listen more carefully to their own judgments and those of the people they sought to rehabilitate. The desirability of longer term, community located treatment, which demands user centred responsiveness and communication with a far wider range of formal and informal carers was unequivocal. Moreover, there were indications that moving away from a hospital focus to community care would enable more creative methods of client centred working. The one example given during this research was the community based leisure group, demonstrating the potential which undoubtedly existed. The new policy requirements for cross boundary care delivery will further test the abilities of occupational therapists, but if health and social services occupational therapists are able to pool their expertise and resources, it could also be an asset (Herbert and Mort, 1997).

Providing training

During an interview with a representative from another discipline, the view was expressed that occupational therapists should train others to undertake clinical work rather than always being direct care givers themselves. This comment was very insightful, given the current high profile of rehabilitation and the consequent increase demand for staff with those skills. Intermediate care is a new service concept with incorporates both convalescence and care across health and social care boundaries. A review of the literature concerned with intermediate care (Mountain, 1997c) confirmed that if this style of service proliferates, demand for occupational therapy cannot possibly keep up with supply. Therefore, if they are to maintain their position in the market place,

occupational therapists would be strongly advised to become involved in training generic rehabilitation workers to carry out on going rehabilitation in community settings.

Providing evidence of effectiveness

Another aspect of current policy which would help to identify and confirm specialist knowledge in occupational therapy is the requirement to ground clinical practice within existing robust research evidence. The occupational therapists in this study did not consider whether the interventions they protected as being their specialist role were beneficial. This unproven optimism regarding the benefits of occupational therapy is no longer adequate in the prevailing climate of demonstrable effectiveness and value for money. This need is ever more pressing given the implementation of the 1997 White Paper in 1999, which will demand that clinical practice matches clinical guidelines set by the proposed National Institute for Clinical Excellence. Thus, increasing evidence of clinical effectiveness and improving implementation of existing evidence is set to become a top priority for all clinical professions. Occupational therapy is currently supported by a patchy evidence base, and the evidence which exists needs to be drawn together. The 1997 White paper places some responsibility for this upon the professional body. However, practitioners and managers also have to learn to seek evidence of effectiveness to support their practice. This will be a hard experience for some as undoubtedly it will necessitate the abandoning of some established practice is shown to be of little or no value. However, through identification of the evidence base, occupational therapists should also build upon a proven body of knowledge. This will strengthen professional confidence and therefore the appropriateness of clinical activity.

Developing a stronger research base

This project has confirmed that there is a need for larger scale, adequately funded, rigorous research into occupational therapy, in addition to small localised studies. Multi disciplinary research can be more appropriate with respect to certain research questions. However, as the skill base of occupational therapy is so poorly researched and need for evidence does not match demand, there is a requirement for participation in professionally based as well as multi disciplinary projects.

The Culyer report (1994) aimed to foster quality research within hospital and community health settings. Implementation in 1995 of the recommendations in the Culyer report is encouraging more research activity at middle management and practitioner levels in health provider units. However, there are questions concerning the successful marrying of research with other, established duties. The results of analysis of activity data showed that occupational therapists were spending a minimal amount of time in activities which would promote a culture of enquiry in the workplace. Pas Coburn (1993) identified a number of factors which can foster the undertaking of occupational therapy research in clinical environments. These were a work environment committed to using evidence based practice, undertaking research which complements the clinical role, research training, both formal and informal and access to administrative support. There are questions about whether a change of culture has taken place over the last few years in occupational therapy, and

whether the infrastructure described by Pas Coburn exists. It is the responsibility of occupational therapy managers as well as general management to try and create an environment which encourages research. This will reap direct benefits for the organisation as quality research is rewarded financially.

Occupational therapy training schools will also have to demonstrate more involvement in rigorous research activity, possibly by employment of researchers dedicated to occupational therapy research. A greater impetus from the academic institutions would greatly assist practitioners in gaining the necessary skills, provide a role model for occupational therapists.

Better Deployment of the unqualified workforce

The occupational therapists who participated in this study did not use support staff to best advantage. Indeed, results suggest that a times they were being used to bolster notions of status on the part of the qualified staff. Their presence in day hospital settings highlighted the waste of resource. in that they pacified nursing staff but service users thought they were teachers. The work of Dockrell and Wilson (1995) looks at how community care policy has fostered the employment of unqualified staff both due to task reallocation and the mixed economy of care. How demands for staff to work in rehabilitation settings in the community will also inflate this workforce has already been raised. Therefore, occupational therapists must accept that the unqualified staff previously accountable to them alone could have a wider, more autonomous role to play in the future. Rather than imposing a hierarchy of control, this will necessitate a more flexible approach which acknowledges individual strengths and contributions in community settings.

Effective inter disciplinary working

"It is clear that professional isolationism is neither acceptable nor appropriate and if maintained will not meet the challenges that health and social care continue to face."

Cole and Perides, 1996, pp. 62.

One of the most important messages from the literature is that inter disciplinary working is not an automatic process, particularly for those working with the complex needs of older people with mental health problems. It has to be worked at and one which occupational therapists in common with other disciplines will have to work at during all phases of their working life. All the professionals interviewed in this study had to cope with the demands of working with each other as well as with older people. The absence of a shared philosophy of care and paucity of working across disciplines except where friendships had been forged was evidence of the problems which pervaded the multi disciplinary team. Moreover, there was a noticeable absence work with other service providers. As the thrust of current policy is promoting inter disciplinary and cross agency working, particularly with older people with mental health problems (Barnes, 1997 and DoH, 1997b) uni disciplinary, uni agency practice will become a thing of the past. The need for multi professional training to cope with the inevitable tensions is clear. The pervasive effects of treatment

environment upon clinical activity discussed in chapter seven underscores this need. In the new constructs of health and social care delivery, treatment settings which span the health and social care divide are unchartered territory for all. Established relationships between professional groups will have to change in response to demands from new treatment settings. This is a prime opportunity to create a healthier working environment, but it can only be achieved if the requirement for team building and training on behalf of all workers is recognised.

Summary of Recommendations for Action by Occupational Therapists

This research has revealed many aspects of occupational therapy practice which need to change. It has also shown that responsibility for change lies with the professional body, occupational therapy educators and managers as well as clinicians. Occupational therapists are not totally at fault for their lack of influence; the power of the treatment environment has been demonstrated, and this is rarely under their direct control. However the revised model of occupational therapy (figure 7.3) illustrates the many aspects which occupational therapists can take action upon, thus strengthening their professional confidence and the effectiveness of clinical practice. Occupational therapists would be advised to test the accuracy of the cycle of activity proposed as being desirable (figure 8.2) by making the changes described in this chapter.

Recommendations for Further Research

The results of this research are important, both from the perspectives of occupational therapists as well as from that of the wider professional community. Its prime aim was to describe the activity undertaken by occupational therapists. However, given the links between what occupational therapists do and the wider organisational health and social care world, that activity is symptomatic of a far greater agenda which extends beyond the occupational therapy profession.

The relevance of further work to test the validity of the revised model of occupational therapy activity (figure 8.3) in alternative treatment settings has already been raised, and given the patchy research base which underpins occupational therapy, it is vital that this work is pursued.

This project has also raised wider questions for services for vulnerable older people. The results described in this thesis together with the overall paucity of research in to services for older people with mental health problems signals the need for research and development in a wider context. While the service delivery changes demanded by policy are undoubtedly beneficial, the difficulties which pervade existing provision and permeate all disciplines are clear. Avoiding replication of old problems in new service models, while at the same time promoting best practice demands further research as well as dissemination of evidence which already exists into practice. This should include work to determine optimum service configurations to meet the needs of older people and their carers, and the steps which need to be taken to ensure seamless care delivery across health, social services and other care providers.

Concluding Comments

The previous assumption that the profession of occupational therapy would have a protected future in their role as facilitators of independence is being challenged by the current health and social care climate. The following prediction by Goble in 1989, one of the recognised occupational therapy academics in this country, proved to be accurate;

"The Health Service Review entitled Working for Patients highlights the fact that professionals must withstand critical analysis from many sources and that occupational therapists must clearly identify their product"

Goble, 1989, pp.351

This research has provided evidence of the clinical activity of occupational therapists working with older people with mental health problems. Critical analysis of that activity described in this thesis shows that the drive for professional status can override the needs of users and their carers. Recommendations arising from this work demonstrate the extent of change which is required before occupational therapists are able to identify both their product and their worth.

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APPENDIX ONE

DIARY OF WORK ACTIVITY

NAME.....

GRADE.....

WORK LOCATION.....

HOURS WORKED PER WEEK.....

TODAY'S DATE.....

ACTUAL HOURS WORKED DURING THE DAY.....

TIME	WHAT WAS YOU MAJOR ACTIVITY?	WHO WERE YOU WITH?	WHERE WERE YOU?	WHAT EQUIPMENT DID YOU USE?	ANYTHING ELSE YOU DID AS WELL
8.00					
15					
30					
45					

APPENDIX TWO

List of Staff Activities Extracted from the First Diary Data Collection

1. Filing patient records
2. Non specific activity with patient records
3. Washing up
4. Inviting a patient to participate in occupational therapy treatment
5. Writing a patient case study
6. Discussing treatment recommendations with carers
7. Arranging patient treatment with other hospital based disciplines
8. Making recommendations to community based staff
9. Sitting with patients
10. Using reality orientation therapy
11. Teaching/ supervising activities of daily living e.g. dressing, personal hygiene, meal preparation
12. Obtaining information from other hospital based disciplines
13. Advising carers
14. Reading work related articles
15. Non specific liaison with other occupational therapy staff
16. Staff management (re non clinical issues)
17. Updating records/ case notes/ writing reports
18. Preparing for a patient group
19. Assessing the suitability of a patient's home
20. Obtaining information from a patient
21. Supervising clinical work of junior occupational therapy staff
22. Discussing home circumstances with a patient
23. Obtaining information from carers
24. Issuing equipment to a patient
25. Measuring for aids/ adaptations in a patient's home
26. Giving support and reassurance to a patient
27. Preparing for assessment of activities of daily living
28. Assessing a patient's need for aids/ adaptations whilst at their home
29. Making drinks for patients
30. Completing activity diary
31. Collecting a patient from the ward for occupational therapy
32. Reading nursing/ medical notes
33. Answering the telephone
34. Walking back to the department
35. Running a therapeutic group for patients
36 Giving a patient assistance with personal washing
37. Discussing plans/ progress/ outcome of treatment with community based staff
38. 'On the job' teaching to other staff
39. Using the telephone
40. Discussing plans/ progress/ outcome of treatment with other hospital disciplines
41. Preparing documentation regarding management issues
42. Supervising clinical work of occupational therapy students
43. Collecting referral cards
44. Teaching students
45. Loaning occupational therapy equipment
46. Assessing a patient's activities of daily living e.g. dressing, personal hygiene meal preparation
47. Undertaking general administrative tasks within the occupational therapy department
48. Obtaining advice/ information from other occupational therapy staff
49. Adapting clothing for a patient
50. Obtaining assistance from carers
51. Non specific patient discussion with other hospital based disciplines
52. Discussing problems with a patient's carers

53. Appraising student progress
54. 'On the job' teaching to students
55. Organising timetables for students
56. Non specific discussion with students
57. Completing Korner returns
58. Tidying the department
59. Completing order for aids/ adaptations to social services
60. Delivering reports
61. Making referrals to other disciplines in the hospital
62. Returning equipment to the occupational therapy store
63. Relaying telephone calls
64. Planning own work load
65. Supervising clinical work of occupational therapy helpers
66. Making referrals to community based staff
67. Advising other hospital based disciplines
68. Receiving telephone messages
69. Non specific liaison with community based staff
70. Receiving clinical supervision
71. Attending multi disciplinary meetings apart from ward rounds, case conferences
72. Obtaining equipment required for patient treatment
73. Walking to wards
74. Planning/ discussing treatment with a patient
75. Organising clinical work timetables with occupational therapy helpers
76. Preparing educational material
77. Counselling a patient
78. Making arrangements for a home visit
79. Helping a patient to the toilet
80. Discussing research
81. Waiting
82. Making a patient feel more comfortable/ positioning a patient
83. Attending birthday parties
84. Demonstrating the use of equipment to a patient
85. Giving feedback to occupational therapy staff on meetings attended
86. Assessing a patient's mental well being
87. Assessing a patient's need for aids/ adaptations
88. Discussing treatment standards
89. Carrying out an initial interview with a patient
90. Adjusting equipment for a patient
91. Discussing training issues
92. Teaching/supervising mobility e.g. walking, transfers, stairs
93. Talking with patients
94. Discussing plans/ progress/ outcome of treatment with other occupational therapy staff
95. Meeting new patients
96. Assessing a patient's mobility e.g. walking, transfers, stairs
97. Travelling to/ from a patient's home
98. Planning care programmes with carers
99. Planning discharge with a patient
100. Assessment/ discussion of a patient's mobility within their own home e.g. walking, transfers, stairs
101. Returning a patient to the ward
102. Attending ward rounds, case conferences
103. Observing a patient during another treatment
104. Non specific liaison with other hospital based disciplines
105. Assessment/ discussion of a patient's activities of daily living within their own home e.g. dressing, personal hygiene, meal preparation
106. Demonstrating equipment to carers
107. Communicating with occupational therapy staff about patient treatment/ clinical work load

108. Non specific liaison with carers

Additional Staff Activities Extracted from the Second Diary Data Collection

1. Assessment/ monitoring of mental state in the community
2. Interviewing a patient in a community setting
3. Assessment/ treatment of functional/ coping abilities in the community
4. Routine administration related to self e.g. time sheets, travel claims
5. Non clinical housekeeping tasks
6. Attending a non clinical occupational therapy meeting
7. Attending a clinical occupational therapy meeting
8. Assessing the safety of a patient in their home/ in the community
9. Escorting patients to/ from community venues
10. Undertaking specific treatment with a patient in hospital
11. Restraining a patient
12. Greeting patients
13. Preparing patient treatment programmes
14. Undertaking diversional activities with patients
15. Liaison with voluntary services in the hospital
17. Taking patients to/ collecting patients from transport
18. Preparing documentation for clinical meetings
19. Chairing an occupational therapy meeting
20. Chairing a multi disciplinary meeting
21. Helping patients to use community facilities
22. Teaching other professionals
23. Preparing/ collecting information about community facilities/ activities for patients
24. Discussing community support available with a patient
25. Undertaking specific treatment with a patient in a community setting
26. Counselling a patient in a community setting
27 Attending a non clinical multi disciplinary meeting
28. Clearing up after assessment/ treatment

Categorisation of Staff Activities

Assessment of a patient within the hospital setting
Any form of patient assessment carried out in the hospital setting. Unless an assessment is documented as being conducted elsewhere, assume the assessment to be hospital based.

Treatment of a patient within the hospital setting
Any form of occupational therapy treatment carried out in the hospital setting. Unless treatment is documented as being conducted elsewhere, assume the treatment to be hospital based.

Patient assessment/ treatment within the community
Any form of occupational therapy assessment or treatment documented as being conducted in a community setting.

Preparation for patient assessment/ treatment
Any activity necessary before assessment/ treatment can commence.

General patient contact
Contact with patients which is not assessment or treatment oriented.

Escorting patients
Activity not part of assessment or treatment which help a patient to move around the hospital.

Communication with relatives and other informal carers
Contact, meetings and discussion with the patient's 'significant others.'

Communication with other disciplines in the hospital
Contact, meetings and discussions with hospital based professionals other than occupational therapists.

Communication with professionals working in the community
Contact, meetings and discussions with community based professionals.

Communication with occupational therapy staff
Contact, meetings and discussions with occupational therapy staff.

Education
Educative activities which do not involve patient contact or clinical supervision.

Teaching/ supervision
Activity involving student supervision, supervision of clinical skills or teaching.

Administration related to patient treatment
Administration directly related to clinical activity.

Other administrative tasks
Administration not directly linked to clinical activity.

Other
Activities which do not relate to any of the other categories.

Content of Staff Activity Categories (Final Version)

A - Assessment of a patient within the hospital setting
A1 Inviting a patient to participate in treatment
A2 Carrying out an initial interview with a patient
A3 Asking a patient for information
A4 Assessing a patient's mobility, e.g. walking, transfers stairs
A5 Assessing a patient's activities of daily living e.g. dressing, personal hygiene, meal preparation
A6 Assessing a patient's need for aids/ adaptations
A7 Assessing a patient's mental state

TR - Treatment of a patient within the hospital setting
TR1 Teaching/ supervising mobility e.g. walking, transfers, stairs
TR2 Teaching/ supervising practice of activities of daily living e.g. dressing, personal hygiene, meal preparation
TR3 Planning discharge with a patient
TR4 Running a therapeutic group for patients
TR5 Undertaking specific treatment with a patient
TR6 Giving support and reassurance to a patient during treatment
TR7 Counselling a patient during a treatment session
TR8 Using reality orientation therapy
TR9 Demonstrating the use of prescribed equipment to a patient
TR10 Issuing equipment to a patient
TR11 Adjusting equipment for a patient during treatment
TR12 Making a patient feel more comfortable/ positioning a patient

AC - Patient assessment/treatment within the community
AC1 Interviewing a patient in a community setting
AC2 Assessment/ monitoring of mental state in the community
AC3 Assessment/ discussion of patient's activities of daily living within their home e.g. dressing, personal hygiene, meal preparation
AC4 Assessment/ discussion of patient's mobility within their own home e.g. walking, transfers, stairs
AC5 Assessing a patient's need for aids/ adaptations whilst at their home
AC6 Measuring for aids/ adaptations in a patient's home
AC7 Assessing the suitability of a patient's home
AC8 Assessment/ treatment of functional/ coping abilities in the community
AC9 Assessing the safety of a patient in their home/ in the community
AC10 Counselling a patient in a community setting
AC11 Undertaking specific treatment with a patient in a community setting
AC12 Helping patients to use community facilities

PR - Preparation for patient assessment/ treatment
PR1 Preparing for a patient group/ individual session
PR2 Obtaining equipment required prior to patient assessment/ treatment
PR3 Preparing for assessment of activities of daily living
PR4 Making arrangements for a community visit
PR5 Collecting referral cards prior to the commencement of assessment/ treatment
PR6 Planning/ discussing treatment with a patient
PR7 Meeting patients informally before assessment/ treatment
PR8 Reading clinical notes
PR9 Preparing patient treatment programmes

PC - General patient contact

PC1 Greeting patients
PC2 Talking with patients
PC3 Sitting with patients
PC4 Attending social events for patients e.g. birthday parties
PC5 Making refreshments for patients
PC6 Giving a patient assistance in the absence of assessment/ treatment
PC7 Undertaking diversional activities with patients
PC8 Restraining a patient

E - Escorting patients
E1 Collecting a patient from the ward for treatment
E2 Returning a patient to the ward
E3 Escorting a patient around the hospital
E4 Travel associated with a specific patient or group of patients
E5 Escorting patients to/ from community venues
E6 Taking patients to/ collecting patients from transport

CR - Communication with relatives and other informal carers
CR1 Planning treatment with carers
CR2 Obtaining information from carers
CR3 Obtaining assistance from carers
CR4 Discussing treatment plans/ recommendations with carers
CR5 Advising carers
CR6 Discussing problems with carers
CR7 Demonstrating equipment to carers
CR8 Non specific liaison with carers

CP - Communication with other disciplines in the hospital
CP1 Referring patients to other hospital based disciplines
CP2 Arranging patient treatment with other hospital based disciplines
CP3 Discussing progress/ outcome of patient treatment with other hospital based disciplines
CP4 Obtaining information from other hospital based disciplines
CP5 Advising other hospital based disciplines
CP6 Attending multi disciplinary clinical meetings
CP7 Attending non clinical multi disciplinary meetings
CP8 Chairing multi disciplinary meetings
CP9 Non specific patient discussion with other hospital based disciplines
CP10 Non specific liaison with other hospital based disciplines
CP11 Liaison with voluntary services

CC - Communication with professionals working in the community
CC1 Referring patients to community based staff
CC2 Discussing plans/ progress/ outcome of treatment with community based staff
CC3 Making recommendations to community based staff
CC4 Non specific liaison with community based staff
CC5 Checking that patients receive community services

CD - Communication with occupational therapy staff
CD1 Communicating with other occupational therapy staff about patient treatment/ work load
CD2 Discussing plans/ progess/ outcome of treatment with other occupational therapy staff
CD3 Obtaining advice/ information from other occupational therapy staff
CD4 Giving feedback/ information to other occupational therapy staff
CD5 Non specific liaison with other occupational therapy staff
CD6 Attending a clinical occupational therapy meeting
CD7 Attending a non clinical occupational therapy meeting
CD8 Chairing occupational therapy meetings

ED - Education
ED1 Reading work related articles/ documents
ED2 Personal study
ED3 Preparing educational material
ED4 Discussing research
ED5 Discussing training and education issues

TS- Teaching/ supervision
TS1 Teaching students
TS2 Appraising student progress
TS3 'On the job' teaching to students
TS4 'On the job' teaching to other staff
TS5 Planning/ supervising work of students
TS6 Planning/ supervising work of junior occupational therapy staff
TS7 Planning/ supervising work of support staff
TS8 Non specific discussion with students
TS9 Receiving supervision

AP - Administration related to patient treatment
AP1 Updating records/ case notes/ writing reports
AP2 Completing Korner returns
AP3 Filing patient records
AP4 General administration involving patient records
AP5 Completing order for aids/ adaptations to Social Services
AP6 Telephone calls re clinical issues
AP7 Planning own work load
AP8 Preparing documentation for clinical meetings

T - Other administrative tasks
T1 Loaning occupational therapy equipment
T2 Telephone calls - general
T3 Answering the telephone
T4 Preparing documentation regarding management issues
T5 Administration related to routine management of staff
T6 Audit/ quality assurance activities
T7 Routine administration related to self e.g. time sheets, travel claims
T8 Miscellaneous non clinical administrative tasks

O - Other
O1 Walking to wards
O2 Walking back to the department
O3 Clearing up after assessment/ treatment
O4 Non clinical housekeeping tasks
O5 Waiting
O6 Travel not specific to a patient

APPENDIX THREE

Activities which Failed First Validation	Description for Second Validation
** = activities which when reworded produced an agreement of 80 per cent and above	
Non specific activity with patient records	General administration involving patient records**
Writing a patient case study	Writing a patient case study for educative purposes
Staff management (re non clinical issues)	Administration relating to routine management of staff**
Obtaining information from a patient	Obtaining information from a patient before commencement of treatment
Giving support and reassurance to a patient	Giving support and reassurance to a hospitalised patient during treatment**
Completing activity diary	Completing activity diary for research purposes
Giving a patient assistance with personal washing	Giving a hospitalised patient assistance with with personal washing in the absence of assessment/ treatment**
Discussing home circumstances with a patient	Discussing home circumstances with a patient during hospital based treatment
Using the telephone	Administrative use of the telephone
Collecting referral cards	Collecting referral cards prior to the commencement of assessment/ treatment**
Loaning OT equipment	Arranging for others to loan OT equipment by completing the necessary administration
Adapting clothing for a patient	Adapting clothing for a patient for treatment purposes
Organising timetables for students	Organising timetables of field work education for students
Tidying the department	Tidying the department to maintain an orderly workplace
Completing order for aids/ adaptations to Social services	Completing paperwork necessary to order aids/ adaptations from Social services
Delivering reports	Delivering written reports on patient assessment/ treatment
Making referrals to other disciplines in the hospital	Referring patients to other disciplines in the hospital**

Returning equipment to the store	Returning equipment/ materials to the OT store following loan or use during treatment
Relaying telephone calls	Giving telephone messages to other staff members
Making referrals to community based staff	Referring patients to community based staff
Receiving telephone messages	Receiving telephone messages from other staff members
Obtaining equipment required for patient treatment	Obtaining equipment required prior to patient assessment/ treatment**
Organising clinical work timetables with occupational therapy helpers	Discussing timetables of clinical work with occupational therapy helpers
Counselling a patient	Counselling a patient during a treatment session**
Helping a patient to the toilet	Escorting a patient to the toilet in the absence of assessment/ treatment
Making a patient feel more comfortable/ positioning a patient	Making a patient feel more comfortable/ positioning a patient during treatment
Attending birthday parties	Attending social events for patients e.g. birthday parties**
Assessing a patient's need for for aids/ adaptations	Assessing a patient's need aids/adaptations whilst in the hospital**
Discussing treatment standards standards	Discussing treatment standards for audit and quality assurance
Adjusting equipment for a patient	Adjusting equipment for a patient during treatment**
Discussing training issues	Discussing training and education issues**
Meeting patients	Meeting patients prior to assessment/ treatment
Travelling to/ from a patient's home	Travelling to a patient's home for a home visit/ home assessment
	Returning to the hospital from a home visit/ home assessment
Observing a patient during another treatment	Observing a patient during another treatment for educative purposes
Demonstrating the use of equipment to a patient	Demonstrating the use of prescribed equipment to a patient**

Breakdown of the Categorisation of each Activity which failed the Second Validation

Writing a case study for educative purposes	60% Education 40% Teaching/ supervision
Obtaining information from a patient before the commencement of treatment	40% Assessment in hospital 60% Preparation for assessment/ treatment
Discussing home circumstances with a patient during hospital based treatment	40% Assessment in hospital 60% Preparation for assessment/ treatment
Administrative use of the telephone	10% General patient contact 40% Other administrative tasks 30% Patient related administration 20% Other
Arranging for others to loan OT equipment by completing the necessary administration	40% Other administrative tasks 60% Patient related administration
Adapting clothing for a patient for treatment purposes	20% Treatment in hospital 60% Preparation for assessment/ treatment 20% Other
Organising timetables of field work education for students	30% Education 20% Teaching/ supervision 50% Other administrative tasks
Tidying the department to maintain an orderly workplace	60% Other 10% Other administrative tasks 20% Preparation for assessment/ treatment 10% Not scored
Completing paperwork necessary to order aids/adaptations from Social Services	50% Other administrative tasks 40% Patient related administration 10% Other
Delivering written reports on patient assessment/ treatment	10% Communication with other disciplines 70% Patient related administration 20% Other
Returning equipment/ materials to the OT store following loan or use during treatment	30% Patient related administration 20% Other administrative tasks 50% Other
Receiving telephone messages from other staff members	50% Communication with OT staff 30% Other administrative tasks 10% Communication with other disciplines 10% Not scored
Giving telephone messages to other staff members	70% Communication with OT staff 10% Other administrative tasks 10% Communication with other disciplines 10% Other

Referring patients to community based staff	70% Communication with community based professionals 30% Patient related administration
Discussing timetables of clinical work with OT helpers	60% Communication with OT staff 40% Teaching/ supervision
Escorting a patient to the toilet in the absence of assessment/ treatment	60% General patient contact 40% Escorting patients
Making a patient feel more comfortable/ positioning a patient during treatment	70% Treatment within the hospital 20% General patient contact 10% Preparation for assessment/
Discussing treatment standards for audit and quality assurance	40% Communication with OT staff 20% Education 20% Teaching/ supervision 20% Other
Meeting patients prior to assessment /treatment	70% Preparation for assessment/ treatment 30% General patient contact
Travelling to a patient's home for a home visit/ assessment	20% Assessment/ treatment in the community 20% Preparation for assessment/ treatment 20% General patient contact 10% Escorting patients 30% Other
Returning to the hospital from a home visit/ home assessment	10% Assessment in the community 30% General patient contact 10% Escorting patients 50% Other
Observing a patient during another treatment for educative purposes	20% General patient contact 20% Education 20% Teaching/ supervision 20% Communication with other disciplines 20% Other
Completing activity diary for research purposes	60% Other administrative tasks 30% Education 10% Patient related administration

Activities which Failed Second Validation	Description for Third Validation
** = activities which when reworded produced an agreement of 77 per cent and above	
Writing a case study for educative purposes	Personal study **
Obtaining information from a patient before the commencement of treatment	Taking a history from a hospitalised patient Asking a hospitalised patient for information
Completing activity diary for research purposes	Completion of data collection forms (merged with Korner data)
Discussing home circumstances with a patient during hospital based treatment	Discussing home circumstances/ lifestyle with a hospitalised patient
Administrative use of the telephone Giving telephone messages to other staff members Receiving telephone messages from other staff members	Telephone calls; (general) ** Telephone calls re clinical issues **
Arranging for others to loan OT equipment by completing the necessary administration	Arranging for OT equipment to be loaned**
Adapting clothing for a patient treatment purposes	Adapting clothing for a patient following for ADL assessment
Organising timetables of field work education for students	Timetabling students
Tidying the department to maintain an orderly workplace	Keeping the department tidy**
Completing paperwork necessary to order aids/ adaptations from Social services	Administration related to loan of equipment from Social services **
Delivering written reports on patient assessment/ treatment	Delivering patient reports
Returning equipment/ materials to the OT store following loan or use during treatment	Returning equipment/ materials to the OT store
Referring patients to community based staff	Making referrals to professionals working the community **
Discussing timetables of clinical work with OT helpers	Discussing work schedules with OT helpers
Escorting a patient to the toilet in the absence of assessment/ treatment	Escorting a patient to the toilet

Making a patient feel more comfortable/ positioning a patient during treatment	Repositioning a patient during treatment **
Discussing treatment standards for audit and quality assurance	Audit/ quality assurance activities
Meeting patients prior to assessment and treatment	Meeting patients informally before assessment/ treatment
Travelling to a patient's home for a home visit /assessment	Travel in connection with a specific patient or group of patients
Returning to the hospital from a home visit/ assessment	Travel not specific to a patient **
Observing a patient during another treatment for educative purposes	Observing a patient receiving other treatments e.g. physiotherapy

Activities Successfully Categorised During First and Second Validations but not The Third

Activity	Percentage Agreement 1st/2nd validations	3rd validation
Inviting a patient to participate in OT treatment	100	70
Measuring for aids/adaptations in a patients home	100	70
Issuing equipment to a patient	80	50
Collecting a patient from the ward for occupational therapy	90	64
Obtaining advice/direction from other OT staff	100	70
Non specific discussion with students	80	63
Planning own work load	80	67
Receiving clinical supervision	80	67
Planning discharge with a patient	80	70

Breakdown of the Categorisation by Subjects of each Activity which failed Third Validation

Asking a hospitalised patient for information	70% Assessment in hospital 30% Preparation for assessment/ treatment
Taking a history from a hospitalised patient	70% Assessment in hospital 30% Preparation for assessment/ treatment
Discussing home circumstances / lifestyle with a hospitalised patient	60% Assessment in hospital 30% Preparation for assessment/ treatment 10% Missing
Completion of data collection forms	60% Other administrative tasks 40% Patient related administration
Adapting clothing for a patient following ADL assessment	30% Treatment in hospital 30% Preparation for assessment/ treatment 10% Patient related administration 20% Other 10% Missing
Timetabling students	10% Communication with OT staff 40% Teaching/ supervision 50% Other administrative tasks
Delivering patient reports	20% Other administrative tasks 60% Patient related administration 10% Other 10% Missing
Returning equipment /materials to the OT store	50% Patient related administration 30% Other 20% Missing
Discussing work schedules with OT helpers	40% Communication with OT staff 50% Teaching/ supervision 10% communication with other disciplines
Escorting a patient to the toilet	50% General patient contact 50% Escorting patients
Audit/ quality assurance activities	70% Other administrative tasks 20% Patient related administration 10% Education
Meeting patients informally before assessment/ treatment	30% Preparation for assessment/ treatment 60% General patient contact 10% Missing
Travel in connection with a patient or group of patients	10% General patient contact 30% Preparation for assessment/ treatment 10% Escorting patients 40% Other 10% Missing

Observing a patient receiving other treatments e.g. physiotherapy	20% General patient contact 20% Education 20% Teaching/ supervision 20% Communication with other disciplines 20% Other

Breakdown of the Categorisation by Subjects of each Activity which failed Final Validation

Interviewing a patient in a community setting	50% Assessment/ treatment in the community 40% Preparation for assessment/ treatment 10% General patient contact
Routine administration related to self e.g. time sheets, travel claims	50% Other administrative tasks 50% Patient related administration
Non clinical house- keeping tasks	60% Other 30% Other administrative tasks 10% Patient related administration
Preparing documentation for clinical meetings	67% Patient related administration 22% Preparation for assessment/ treatment 11% Communication with other disciplines
Helping patients to use community facilities	70% Assessment/ treatment in the community 20% General patient contact 10% Preparation for assessment/ treatment
Teaching other professionals	50% Teaching/ supervision 30% Education 20% Communication with other disciplines
Preparing/collecting information about community facilities for patients	40% Preparation for assessment/ treatment 30% Communication with professionals in the community 10% Communication with other disciplines 20% Patient related administration
Discussing community support available in the community with a patient	40% Assessment/ treatment 20% Preparation for assessment/ treatment 20% General patient contact 10% Communication with professionals in the community 10% Treatment in hospital
Clearing up after assessment/ treatment	50% Other 30% Patient related administration 10% Preparation for assessment/ treatment 10% Other administrative tasks

Summary of Solutions to Unclassified Activities

Activity ***Adapting clothing for a patient***
Problem This activity proved problematic to the therapists, mainly because few if any carry it out. Staff involved in the validation exercise pointed out that only the unqualified member of staff ever carried out this type of activity.
Solution Removed from list.

Activity ***Observing a patient receiving other treatments***
Problem This activity was recorded once by the student who participated in the first data collection.
Solution Removed, as the category system only pertains to the activity of qualified staff.

Activity ***Taking a history from a hospitalised patient***
Problem This description of activity together with the activity *'Asking a hospitalised patient for information'* were formulated from the original activity *'Obtaining information from a patient before the commencement of treatment'* in an attempt at better clarification. However the results still did not reach the accepted criteria.
Solution 'Asking a *hospitalised patient for information information'* was retained. *Taking a history from a hospitalised patient'* was removed. The lack of validity of the activity is recognised.

Activity ***Discussing home circumstances with a patient***
Problem Results of validation did not reach the accepted criteria.
Solution Excluded from list as this activity can be embraced within *'Asking a patient for information.'*

Activity ***Timetabling students***
Problem This activity was never satisfactorily categorised despite several attempts at clarification, possibly as many clinical supervisors would view this as being an integral part of student supervision, an activity already included.
Solution Inclusion in the activity *'Supervising clinical work of students'*; the reworded activity being *'Planning/ supervising clinical work of OT students.'*

Activity ***Discussing work schedules with OT helpers***
Problem The lack of agreement over the placement of this activity reflects confusion over whether it is day to day communication or teaching.
Solution The activity was excluded from the final list as it is an integral part of the existing activity *'Supervising clinical work of OT helpers.'*

Activity ***Returning equipment/materials to the OT store***
Problem This describes clearing up at the end of patient treatment.
Solution This is a peripheral activity which can be subsumed within the activity of *'Keeping the department/ base tidy.'*

Activity ***Delivering patient reports***
Problem It appeared that delivering reports by hand was idiosyncratic to the service first studied.
Solution Excluded as in the majority of services patient reports would sent by the postal system and not by hand.

Activity	***Audit/ quality assurance activities***
Problem	70 per cent of staff rated this activity in *'Other administrative tasks.'* The difficulty staff had categorising this activity reflected the fact that it had not yet become an integral feature of the work of clinical staff.
Solution	It was retained in the list of activities where the majority of staff categorised it. Doubts regarding it's validity must be acknowledged, but this activity will have increased relevance in the future.
Activity	***Meeting patients informally before assessment/ treatment***
Problem	This item was categorised into *'Preparation for assessment/ treatment'* with agreement of 67 per cent
Solution	It was left in the list of activities within *'Preparation for assessment/ treatment'*; acknowledging lack of agreement.
Activity	***Escorting a patient to the toilet***
Problem	This activity was classified by 60 per cent of the sample into the category *'Escorting patients.'*
Solution	The activity described is very specific, and was therefore generalised to *'Escorting patients around the hospital.'*
Activity	***Completion of data collection forms***
Problem	This activity is a combination of what were two separate items on the original list; *'Completing activity diary for research purposes'* and *'Completing Korner returns.'* It is interesting to note that during the first validation the activity *'Completing Korner returns'* was successfully categorised (80 per cent agreement), whereas the new activity showed a 60/40 split between patient and non patient related administration.
Solution	*'Completing Korner returns'* was placed back in the list of activities. *'Completion of data collection forms'* was removed.
Activity	***Travel in connection with a specific patient or group of patients***
Problem	The categorisation of this activity caused great confusion. One of the staff involved commented that "travel is just travel." Staff successfully agreed on the placement of *'Travel not specific to a patient.'* The lack of agreement over patient related travel is difficult to overcome. There are many reasons why travel might be undertaken in relation to patients which explains the lack of agreement.
Solution	The activity was reworded so that it reads *'Travel associated with a specific patient or group of patients.'* It has been included in the category *'Escorting patients.'* It is interesting to note that the definitions of travel included in the third validation were extracted from the diary devised by a research team at Warwick University to measure the activity of multi disciplinary teams working with head injured patients.
Activity	***Preparing/ collecting information about community activities for patients***
Problem	The activity was interpreted in four different ways by the subjects.
Solution	Excluded as the activity can be placed within existing activities e.g. *'Preparing for a patient group/ individual session.'*
Activity	***Discussing community support available with a patient***
Problem	The activity was interpreted in four different ways by the subjects.
Solution	Excluded as the activity can be subsumed within other activities depending upon the nature and context of the conversation.

Activity	***Teaching other professionals***
Problem	The subjects categorised this activity into *'Education,' 'Communication with other disciplines'* and *'Teaching/supervision.'*
Solution	Excluded as the activity can be subsumed into other activities in each of the above categories.
Activity	***Non clinical house keeping tasks***
Problem	Placed in '*Other*' category by 60 per cent of subjects.
Solution	Retain otherwise activities like plant watering and locking up cannot be categorised.
Activity	***Preparing documentation for clinical meetings***
Problem	Placed in the correct category by 67 per cent of subjects.
Solution	Retained as this type of activity will become more prevalent with implementation of community care.
Activity	***Helping patients to use community facilities***
Problem	Identified as assessment/ treatment in the community by 70 per cent of subjects.
Solution	Retained as this is an important aspect of work.
Activity	***Routine administration related to self e.g time sheets, travel claims***
Problem	Half the subjects categorised the activity as *'Administration related to patient treatment'* and half as '*Other administrative tasks.*'
Solution	The activity was placed in '*Other administrative tasks'* with acknowledgement of it's lack of validity.
Activity	***Clearing up after assessment/ treatment***
Problem	There is still confusion over the exact nature of this task. It needs to be in the categorisation as staff insist that it is an integral part of the work.
Solution	It was placed in the category '*Other*' where the majority categorised it with acknowledgement of it's lack of validity.

Minor Alterations to Final Activity Descriptions

1. 'Hospitalised' and 'whilst in hospital' were removed from the descriptions of activities in categories *'Assessment of a patient within the hospital setting'*; *'Treatment of a patient within the hospital setting'* and *'General patient contact.'*

2. The activity 'Planning care programmes with carers' was reworded to read *'Planning treatment with carers.'*

3. The activity 'Giving a hospitalised patient assistance with personal washing in the absence of assessment/ treatment' was reduced to *'Giving a patient assistance in the absence of assessment/ treatment.'*

4. The activities 'Attending ward rounds/ case conferences' and 'Attending multi disciplinary meetings apart from case conferences' were collapsed into one activity *'Attending multi disciplinary clinical meetings.'*

5. The activity 'Preparing for a patient group' was extended to *'Preparing for a patient group/ individual session.'*

6. The activity 'Reading nursing/ medical notes' was reduced to *'Reading clinical notes.'*

7. The activity 'Giving feedback to other OT staff on meetings attended' was altered to *'Giving feedback/ information to other OT staff.'*

8. References to 'OT students' were reduced to *'Students.'*

9. References to 'OT Helpers' were changed to *'Support staff.'*

10. Activities describing 'Planning/ supervising clinical work' were reduced to *'Planning/ supervising work.'*

11. The activity 'Receiving clinical supervision' was reduced to *'Receiving supervision.'*

12. 'Non specific administrative tasks' was reworded to *'Miscellaneous non clinical administrative tasks.'*

13. The activity 'Undertaking general administrative tasks in the OT department' was excluded as this is embraced in the activity *'Miscellaneous non clinical administrative tasks.'*

14. The activity 'Making arrangements for a home visit' was extended to *'Making arrangements for a home/ community visit.'*

15. The activity 'Making drinks for patients' was reworded to *'Making refreshments for patients.'*

16. The activities 'Tidying the department' and 'Washing up' have been removed as they can be subsumed within the activity *'Non clinical housekeeping tasks.'*

APPENDIX FOUR

Validation of the Staff Activity Categories

Undertaking the First Validation Exercise

Firstly, all 108 activities extracted from the first diary data collection were arranged in random order (see appendix two).

Ten occupational therapists working in general physical medicine at location C were recruited to participate in the validation. They spanned all qualified grades and had not been previously involved in the project.

Each person was provided with the list of the 108 activities and the 15 categories of activity together with a definition for each category (appendix two) and completion instructions; see below.

A meeting was held with participants beforehand to reiterate the instructions, particularly the importance of not collaborating with colleagues during the exercise, and to distribute the required material. The information was collected approximately two weeks later; the time span expressed as being realistic by the subjects. I arranged to collect the data personally.

Instructions for Participants in Validity Checks of Activity Categories

1. You will find in your pack five pages of listed staff activities derived from accounts of work undertaken by occupational therapists working in geriatric medicine. They are headed *'staff activities for final validation.'*

2. You will also find another four separate sheets headed *'activity categories one to fifteen.* The categories have been identified as a result of examining documented staff activity. A brief explanation of each category is provided.

3. You are to assign each of the 108 listed activities to **ONE** of the activity categories using the information provided about the categories, so that the accuracy of my category system can be tested.

4. When you have decided upon the category for an activity please list it under the relevant category.

5. Please try to ensure that a code is provided for each activity, and that you do not allocate an activity to more than one category.

6. Please do not collaborate during this exercise as that will falsify the results.

I appreciate that this will involve a considerable amount of time and effort. May I thank you in anticipation of your participation.

Gail Mountain.

The following observations were made during discussion when the data were collected:-

- The inclusion of extra sheets to list the activities they placed in each category was cumbersome. Most staff had written the numbers relating to each activity against the activity categories instead of writing activities down for comparison with each other.
- Extreme difficulty in categorising one or two of the activities was expressed; for example the wide variety of reasons why an individual may use the telephone or travel.

Results

The results obtained from each person were charted under each activity category so the extent of agreement could be demonstrated.

I decided that an agreement of 80 per cent was necessary for accuracy based upon the recommendations of Anastasi (1976).

Of the 76 activities placed in the same category as that of the researcher, 68 had been placed with an agreement by eight out of ten subjects or more (Table 4.1a).

Table 4.1a - Extent of Agreement between Subjects and Researcher (n=108)

Agreement (per cent)	Frequency
<60	31
60	2
70	7
80	11
90	16
100	41

There was agreement of 80 per cent and above for the placement of a further five activities which differed from my placement (Table 4.2a).

Table 4:2a - Agreement between Subjects of Activities Placed Differently to the Researcher

Agreement (per cent)	Frequency
60	6
70	2
80	3
90	1
100	1

The five activities placed with high agreement by participants in a different category to that of the researcher were subsequently re-categorised in accordance with the results obtained from the subjects.

Therefore, of the original 108 activities, 73 were successfully placed with an agreement of 80 per cent and above and 35 were not successfully placed.

Undertaking the Second Validation Exercise

The 35 activities which had failed to be successfully validated were extracted from the list. The most obvious reason for lack of agreement regarding placement of an activity was a lack of clarity in it's description. Each of the 35 activities were reworded so that the nature of the activity might be more easily understood. This resulted in a list of 36 activities as the original activity relating to travel to and from home visits was split into two activities. The reworded descriptions are given in appendix three, page ?6

The ten occupational therapists who participated in the first validation were asked to take part in a further validation exercise by placing these 36 reworded activities into categories. All instructions remained as before.

Results

The results of this second validation are given below in table 4.3a

Table 4:3a - Extent of Agreement Between Subjects and Researcher (n=36)

Agreement (per cent)	Frequency
<60	13
60	6
70	6
80	5
90	3
100	3

Employing the same criteria used for analysis of the first validation (agreement of 80 per cent and above), 11 of the 36 activities were successfully categorised. There was agreement of 80 per cent and above between the subjects over the placement of a further two activities which differed from the categorisation made by the researcher.

Therefore, out of the 109 activities, 86 had been successfully categorised and 23 had not after two validation exercises.

The categorisation by subjects of each of the activities which failed validation is shown in appendix three.

Undertaking the Third Validation Exercise

A third validation exercise was then conducted with a different cohort of occupational therapists. They all worked at another acute services trust in the same city; eight in different aspects of physical medicine and two in liaison psychiatry. They had no previous knowledge of the project.

The purpose of the third validation was the following:-

1. To cross validate with the results obtained from the first and second validations.

2. To successfully categorise the 23 activities which had not been validated.

Each of the 23 activities which had not been successfully validated was again reworded (changes documented in appendix three). The activity diary being used during the National Traumatic Brain Injury Study (Health Services Research Unit, Warwick University, 1992) was used for guidance in re-phrasing some of the activities. A revised list of 109 activities was produced for the third validation. The methodology was identical to that used before, the subjects being asked to place each activity into the most appropriate category.

Results

Several visits were necessary to obtain all 10 returns. This was explained by a bout of staff sickness. The activities which were reported to cause most difficulty were mostly those which had already been mentioned by the first group of staff; for example travel, adapting clothing, escorting to the toilet. One person said that she found it difficult to make objective decisions about the nature of activities; tending to directly interpret the activity within the context of her work. For example, *'sitting with patients'* caused problems as she related this to the sorts of assessments she might be doing whilst sitting with a patient.

Unfortunately, not all the activities were categorised. This occurred where respondents had undertaken the validation exercise on more than one occasion, resulting in missing values for 16 activities. Another error occurred when one occupational therapist placed an activity in two different categories.

Table 4:4a shows the agreement between subjects on all 109 activities. Where missing values occurred the percentage response is based upon the total number of activities categorised, resulting in an acceptable level of agreement being 77 per cent and above. It can be seen that there was agreement of 77 per cent and above for 81 activities. A further 10 activities scored 70 per cent agreement.

Table 4:4a - Extent of Agreement Between Subjects during the Third Validation (n=109)

Agreement (per cent)	Frequency
<60	9
60	1
63	2
64	1
67	5
70	10
77	7
80	17
90	25
100	32

Four activities were placed with agreement of 77 per cent and over differently to the researcher, and they were therefore reclassified accordingly. It is unclear why the second cohort viewed *'Filing patient*

*record*s' differently to the first as this activity was categorised with a high level of agreement. This activity was left in the category where the first group had placed it.

The nine activities successfully categorised by the first group, but without adequate agreement by the second group, are given in appendix three.

Table 4:5a shows the percentage agreement between the subjects for the 23 activities which had not previously been validated. Where missing values occurred the percentage response is based upon the total number of activities categorised. Due to missing values, as a result of subject error, an agreement level of 77 per cent and above was accepted as before.

Table 4:5a - Extent of Agreement between Subjects and Researcher (n=23)

Agreement (per cent)	Frequency
<60	0.7
60	2
67	2
70	3
77	3
80	1
90	3
100	2

Therefore, taking an agreement level of 77 per cent and above as being acceptable, 14 activities were still not validated.

The breakdown of the categorisation by the subjects of each of the 14 activities which failed validation is given in appendix three.

On the basis of discussions which took place with staff during the validation exercises, and deductions made as result of data collection, solutions regarding the 14 non validated activities are fully documented in appendix five. This shows that of the 14 non validated activities, nine were removed and five retained, three in their original form, two reworded. One activity from the original list was placed back in the categorisation. Therefore at this stage the categorisation of staff activity consisted of 101 activities sorted into fifteen categories.

Extension of the Categorisation of Staff Activity

When the contents of the diaries recorded by the staff who participated in the second data collection were analysed there were 28 extra activities identified which had not been recorded by staff working in medicine for the elderly (see appendix two). The majority related to different aspects of assessment and treatment in community settings. These 28 activities could be readily absorbed into the fifteen categories of staff activity but they also required validating.

Another ten qualified staff of varying grades working for the same community and mental health trust in a range of specialties were asked to categorise the 28 activities into the 15 categories using the same methodology as before. The subjects had not previously been involved with the project. Only nine completed data sets were returned, another subject being subsequently recruited. The results obtained are given in Table 4.6a

Table 4:6a - Extent of Agreement during Validation of Activities Extracted from Second Diary Data Collection

Agreement (per cent)	Frequency
40	2
50	4
60	1
67	1
70	1
80	5
89	1
90	3
100	10

It can be seen from the table that 19 activities of the 28 were successfully validated using a criterion of 80 per cent agreement and above. One was categorised by the subjects with 80 per cent of the subjects in a different category to that identified and was re-classified accordingly.

Of the eight activities which were not satisfactorily validated; six did not embrace direct patient contact. The breakdown of the categorisation by the subjects of each of the activities which failed validation is given in appendix three. As before, on the basis of discussions which took place with staff, and deductions made as result of data collection, problems and solutions regarding the eight non validated activities are recorded in appendix three. Of the eight non validated activities, three were removed and five retained with acknowledgment of their lack of validity.

APPENDIX FIVE

Reliability of the Staff Activity Categories

Reliability of the categorisation of staff activity was undertaken to investigate the extent to which it is possible to accurately record activity using the fifteen devised categories of activity. Two methods of assessing reliability were selected; inter-test reliability and inter-rater reliability.

Inter-Test Reliability

Inter test reliability was applied to estimate the level of agreement between individuals when categorising different activities.

Method

Four occupational therapists were each asked to independently code the same four diaries using the category system without any collaboration between them using the coding sheet shown overleaf. The subjects spanned the professional grades. The diaries to be coded were extracted from the first data collection. Selection of the diaries was on the basis of grade of staff who had completed them; so that one was the account of the head III, one of the senior II and two of basic grade staff. Apart from grade, the diaries were randomly selected. There was 100 per cent return.

Results

Statistical reliability checks were subsequently undertaken to investigate the extent of coding agreement between the subjects for each diary. The test used in this instance to determine inter-test reliability between a number of different assessors was the Kendal Coefficient of Concordance (Seigel and Castellan, 1988). This test was applied to the total scores obtained by the four raters for each activity category in the coding system.

The results are given in Tables 5.1a-5.4a

NAME OF RATER..... DATE COMPLETED.....

NUMBER OF DIARY..... WORKED HOURS CODED.....

Tick once for each documented incidence of the activity **Total**

A1 ☐☐☐☐☐☐☐☐☐☐ ☐

A2 ☐☐☐☐☐☐☐☐☐☐ ☐

A3 ☐☐☐☐☐☐☐☐☐☐ ☐

A4 ☐☐☐☐☐☐☐☐☐☐ ☐

A5 ☐☐☐☐☐☐☐☐☐☐ ☐

A6 ☐☐☐☐☐☐☐☐☐☐ ☐

A7 ☐☐☐☐☐☐☐☐☐☐ ☐

TOTAL PATIENT ASSESSMENT IN HOSPITAL SETTING ☐

A1 ☐☐☐☐☐☐☐☐☐☐ ☐

A2 ☐☐☐☐☐☐☐☐☐☐ ☐

A3 ☐☐☐☐☐☐☐☐☐☐ ☐

A4 ☐☐☐☐☐☐☐☐☐☐ ☐

A5 ☐☐☐☐☐☐☐☐☐☐ ☐

A6 ☐☐☐☐☐☐☐☐☐☐ ☐

A7 ☐☐☐☐☐☐☐☐☐☐ ☐

A8 ☐☐☐☐☐☐☐☐☐☐ ☐

A9 ☐☐☐☐☐☐☐☐☐☐ ☐

A10 ☐☐☐☐☐☐☐☐☐☐ ☐

A11 ☐☐☐☐☐☐☐☐☐☐ ☐

A12 ☐☐☐☐☐☐☐☐☐☐ ☐

A13 ☐☐☐☐☐☐☐☐☐☐ ☐

TOTAL PATIENT TREATMENT IN HOSPITAL SETTING ☐

Table 5.1a - Inter-Test Reliability of Diary A

Rater	1	2	3	4
Activity category				
A	**0**	**0**	**0**	**0**
TR	**1**	**1**	**1**	**1**
AC	**1**	**1**	**4**	**4**
PR	**0**	**0**	**1**	**0**
PC	**0**	**0**	**0**	**0**
E	**1**	**0**	**1**	**0**
CR	**0**	**0**	**5**	**0**
CP	**2**	**2**	**5**	**2**
CC	**0**	**0**	**0**	**0**
CD	**0**	**1**	**2**	**0**
ED	**0**	**0**	**0**	**0**
TS	**6**	**2**	**3**	**2**
AP	**3**	**4**	**3**	**3**
T	**4**	**2**	**5**	**4**
O	**0**	**0**	**0**	**0**

Coefficient of concordance (W) = 0.8257; p = <0.01

Table 5.2a - Inter-Test Reliability of Diary B

Rater	1	2	3	4
Activity category				
A	**6**	**4**	**6**	**4**
TR	**3**	**4**	**4**	**5**
AC	**0**	**0**	**0**	**0**
PR	**4**	**2**	**5**	**3**
PC	**0**	**0**	**0**	**0**
E	**0**	**0**	**0**	**0**
CR	**2**	**2**	**3**	**2**
CP	**4**	**3**	**3**	**3**
CC	**0**	**0**	**0**	**0**
CD	**3**	**4**	**5**	**3**
ED	**1**	**0**	**1**	**0**
TS	**0**	**0**	**0**	**0**
AP	**10**	**7**	**8**	**6**
T	**1**	**2**	**0**	**2**
O	**0**	**0**	**0**	**0**

Coefficient of concordance (W) = 0.9343; p = <0.01

Table 5.3a - Inter-Test Reliability of Diary C

Rater / Activity category	1	2	3	4
A	1	1	1	1
TR	3	3	3	3
AC	0	0	0	0
PR	1	1	2	1
PC	2	0	2	2
E	2	1	2	2
CR	1	1	3	2
CP	4	0	4	5
CC	1	1	1	1
CD	1	1	0	
ED	0	0	0	0
TS	0	0	0	0
AP	9	4	8	7
T	0	0	0	1
O	0	0	0	0

Coefficient of concordance (W) = 0.8133; p = <0.01

Table 5.4a - Inter-Test Reliability of Diary D

Rater / Activity category	1	2	3	4
A	1	1	1	1
TR	3	3	3	3
AC	0	0	0	0
PR	2	2	2	3
PC	0	0	0	0
E	0	1	0	0
CR	1	1	0	1
CP	3	3	3	4
CC	0	0	0	0
CD	2	2	4	2
ED	0	0	0	0
TS	0	0	0	0
AP	6	7	8	6
T	1	0	0	1
O	2	0	1	1

Coefficient of concordance (W) = 0.9087; p = <0.01

It can be seen from tables 5.1a-5.4a that the inter-test reliability for each diary coded was high; p = <0.01 in all cases.

Inter-Rater Reliability

Following validation, and investigation of inter-test reliability, the diaries were redesigned into a pre coded format (see appendix six).

Inter-rater reliability was used to investigate how reliably subjects were able to record their activity using the pre coded diary. The exercise was also useful in providing feedback about the validity of the pre coded diary.

Method

A member of staff completing a pre coded activity diary was observed by another individual for one complete working day. The observer recorded the subject's activity in situ, using the pre coded diary format. This exercise also enabled the face validity of the pre coded diary to be examined.

The subject and observer were not allowed to discuss the coding of activities, but the observer was allowed to request clarification regarding different aspects of any activity prior to coding.

The extent of agreement between the subject and researcher regarding the occurrence of different types of activity over the working day was examined using the Kappa Coefficient of agreement. A Kappa value of 0.6 and above indicates a satisfactory level of agreement (Hartmann, 1977).

In order to code a broad range of activity, the inter-rater exercises were carried out for two working days using different grades of staff as subjects.

Limitations of the methodology

- One of the observers was not an occupational therapist. This led to some problems of interpretation of the activity of the member of staff being shadowed.
- The second observer was a student occupational therapist who had only spent a few weeks training Lack of knowledge resulted in problems of interpretation.
- Although the reliability exercise was completed twice, the category *'Communication with Carers'* remained unobserved.
- A period of diary familiarisation was not built in to the exercise, which may have improved accuracy.

Results

Face validity of the pre coded diary format was demonstrated. The occupational therapists who used it said that completion was straightforward; and that the diary was discrete in the clinical setting.

The Kappa Coefficient over the two reliability exercises was computed using the formula

$$K = \frac{P(A)-P(E)}{1-P(E)}$$

Where P(A) is the proportion of time that the raters agree and P(E) is the proportion of time that the raters would agree by chance.

The total number of instances of recorded activity for both observer and subject for the two days was 131.

The distribution of observations (Cj) made between observer and the subject is shown in Table 5.5a

Table 5.5a - Inter-Rater Reliability : Distribution of Recorded Activity

Activity category	Cj
A	21
TR	26
AC	20
PR	23
PC	12
E	10
CR	0
CP	22
CC	8
CD	2
ED	5
TS	46
AP	27
T	6
O	4

There were 75 instances where the subject and observer agreed upon the coding of an activity. There were another 14 activities which were coded by both subject and observer, but they allocated the activity different codes. Another 32 activities were coded by either subject or observer, but no corresponding activity was coded by the other.

Despite the previously described methodological considerations, when the Kappa coefficient of agreement for the 131 events was calculated, K = 0.61, an adequate level of agreement.

Validation of the Collapsed Categories of Activity

Following validation and reliability checks, the 15 categories of activity were collapsed into five for easy analysis. Ten occupational therapists working for the health trust previously involved in the second diary data collection were recruited to undertake the validation exercise, The methodology used was the same as that employed to validate the content of the fifteen categories of activity. Eight returns were obtained, but only seven could be analysed as one had been incorrectly completed. The results of the validation are shown below in Table 4.6a.

Table 4.6a - Validation of Five Collapsed Activity Categories

	subject						
activity	1	2	3	4	5	6	7
A	DPT	DPT	DPT	DPT	DPT	DPT	DPT
TR	DPT	DPT	DPT	DPT	DPT	DPT	DPT
AC	DPT	DPT	DPT	DPT	DPT	DPT	DPT
PR	IPT	IPT	IPT	IPT	IPT	IPT	IPT
PC	IPT	IPT	IPT	IPT	IPT	IPT	C
E	IPT	IPT	IPT	IPT	IPT	IPT	IPT
CR	C	C	C	C	C	C	C
CP	C	C	C	C	C	C	C
CC	C	C	C	C	C	C	C
CD	C	C	C	C	C	C	C
ED	E	E	E	E	E	E	E
TS	E	E	E	E	E	E	E
AP	IPT	IPT	O	O	IPT	IPT	IPT
T	O	O	O	O	O	O	O
O	O	O	O	O	O	O	O

DPT = direct patient treatment C = communication

IPT = indirect patient treatment E = education

O = other

It can be seen from Table 4:6a that 13 of the 15 activity categories were categorised in to the collapsed category with an agreement of 100 per cent. Furthermore, the subjects agreed with my placement of the categories. The activity category '*general patient contact'* was placed in the collapsed category of '*indirect patient treatment'* by six out of seven subjects (85.7 per cent

agreement). *'Administration related to patient treatment'* was placed in *'indirect patient treatment'* by five of the seven subjects (71.4 per cent agreement).

It was thought that *'communication with relatives and other informal carers'* might prove difficult to validly place in one collapsed activity category as it could be interpreted as being indirect treatment or communication. However, all subjects placed it in *'communication.'*

APPENDIX SIX

INSTRUCTIONS FOR COMPLETION

All work related activity, both **clinical and managerial,** must be recorded in the way described below.Please do not record meal breaks or describe any non-work related activity.

For **each hour of your working day** describe **fully**:-

1 Your **major activity;**

2 **Who** you were doing it with (identify people by role rather than name e.g. patient, physiotherapist, social worker);

3 **Where** you were doing it

4 Any **equipment used;**

5 Any other information you would like to provide;

6 Anything else you did.

Any information you provide will remain confidential

ACTIVITY RECORD FOR OCCUPATIONAL THERAPISTS WORKING WITH THE ELDERLY

NAME .....

GRADE .....

BASE .....

COMPLETING THE DIARY

Before using this diary, familiarise yourself with the appended activity codes.

1. Complete the details on the front cover.
2. Record time duties commenced for each day.
3. At the end of **each 15 minutes**, record all activity using the codes at the back of this diary, eg if you have been assessing a patient's mobility at home, record AC4 in the first column. If this was followed by discussion of problems with relatives/carers in the same 15 minutes, record CR6 as well. Some activities can occur at the same time, eg assessing a patient's mobility with a student present would be recorded as A4 and TS3. Try to be as inclusive as possible.
4. Record all activity that takes place during each 15 minutes even if the activity commenced in the previous 15 minutes.
5. Do not record time spent off duty, eg meal breaks – leave time blank.
6. At the end of **each** working day, record time duties finished.
7. Record any comments on the relevant sheet at the back of the diary.

Division of Psychiatry and Behavioural Sciences in Relation to Medicine
University of Leeds, 15 Hyde Terrace, Leeds 2.

DATE OF DIARY……LOCATION

TIME DUTIES COMMENCED……MONDAY

TIME	CODED ACTIVITY
8.00-8.15	
8.15-8.30	
8.30-8.45	
8.45-9.00	
9.00-9.15	
9.15-9.30	
9.30-9.45	
9.45-10.00	
10.00-1015	
10.15-10.30	
10.30-10.45	
10.45-11.00	

TIME	CODED ACTIVITY
11.00-11.15	
11.15-11.30	
11.30-11.45	
11.45-12.00	
12.00-12.15	
12.15-12.30	
12.30-12.45	
12.45-1.00	
1.00-1.15	
1.15-1.30	
1.30-1.45	
1.45-2.00	

Activity Categories

A **Assessment of a patient within the hospital setting**
Any form of patient assessment carried out in the hospital setting

TR **Treatment of a patient within the hospital setting**
Any form of occupational therapy treatment carried out in the hospital setting.

AC **Patient assessment/ treatment within the community**
Any form of occupational therapy assessment or treatment documented as being conducted in a community setting.

PR **Preparation for patient assessment/ treatment**
Any activity necessary before assessment/ treatment can commence.

PC **General patient contact**
Contact with patients which is not assessment or treatment orientated.

E **Escorting patients**
Activity not part of assessment or treatment which help a patient to move around the hospital or community.

CR **Communication with relatives and other informal carers**
Contact, meetings and discussion with the patient's 'significant others.'

CP **Communication with other disciplines in the hospital**
Contact, meetings and discussions with hospital based professionals other than occupational therapists.

CC **Communication with professionals working in the community**
Contact, meetings and discussions with community based professionals.

CD **Communication with occupational therapy staff**
Contact, meetings and discussions with occupational therapy staff.

ED **Education**
Educative activities which do not involve patient contact or clinical supervision.

TS **Teaching/ supervision**
Activity involving student supervision, supervision of clinical skills or teaching.

AP **Administration related to patient treatment**
Administration directly related to clinical activity.

T **Other administrative tasks**
Administration not directly linked to clinical activity.

O **Other**
Activities which do not relate to any of the other categories.

A - Assessment of a patient within the hospital setting

A1 Inviting a patient to participate in treatment
A2 Carrying out an initial interview with a patient
A3 Asking a patient for information
A4 Assessing a patient's mobility, e.g. walking, transfers stairs
A5 Assessing a patient's activities of daily living e.g. dressing, personal hygiene, meal preparation
A6 Assessing a patient's need for aids/ adaptations
A7 Assessing a patient's mental state

TR - Treatment of a patient within the hospital setting

TR1 Teaching/ supervising mobility e.g. walking, transfers, stairs
TR2 Teaching/ supervising practice of activities of daily living e.g. dressing, personal hygiene, meal preparation
TR3 Planning discharge with a patient
TR4 Running a therapeutic group for patients
TR5 Undertaking specific treatment with a patient
TR6 Giving support and reassurance to a patient during treatment
TR7 Counselling a patient during a treatment session
TR8 Using reality orientation therapy
TR9 Demonstrating the use of prescribed equipment to a patient
TR10 Issuing equipment to a patient
TR11 Adjusting equipment for a patient during treatment
TR12 Making a patient feel more comfortable/ positioning a patient

AC - Patient assessment/treatment within the community

AC1 Interviewing a patient in a community setting
AC2 Assessment/ monitoring of mental state in the community
AC3 Assessment/ discussion of patient's activities of daily living within their home e.g. dressing, personal hygiene, meal preparation
AC4 Assessment/ discussion of patient's mobility within their own home e.g. walking, transfers, stairs
AC5 Assessing a patient's need for aids/ adaptations whilst at their home
AC6 Measuring for aids/ adaptations in a patient's home
AC7 Assessing the suitability of a patient's home
AC8 Assessment/ treatment of functional/ coping abilities in the community
AC9 Assessing the safety of a patient in their home/ in the community
AC10 Counselling a patient in a community setting
AC11 Undertaking specific treatment with a patient in a community setting
AC12 Helping patients to use community facilities

PR - Preparation for patient assessment/ treatment

PR1 Preparing for a patient group/ individual session
PR2 Obtaining equipment required prior to patient assessment/ treatment
PR3 Preparing for assessment of activities of daily living
PR4 Making arrangements for a community visit
PR5 Collecting referral cards prior to the commencement of assessment/ treatment
PR6 Planning/ discussing treatment with a patient
PR7 Meeting patients informally before assessment/ treatment
PR8 Reading clinical notes
PR9 Preparing patient treatment programmes

APPENDIX SEVEN

Results of the Analysis of Data from Staff Involved in the first data collection

Analysis of the Diaries

The main reason for collecting data from staff working in medicine for the elderly was to produce a list of activities from which a categorisation of activity could be developed. It was also a pilot of the diary method of collecting staff activity data.

A slightly different group of staff participated in data collection during each day of the data collection. Details of those involved are given below.

Table 7a - Summary of Data Available for Analysis Following Data Collection

Grade	Data Collection Time Span		No of Events Recorded
	Days	Hours	
Head III	2	14.25	122
Senior II	4	29.0	220
Senior II(i)*	3	21.25	156
Basic Grade	2	15.5	119
Basic Grade(i)*	3	21.0	167
Student	4	22.0	143

* For purposes of identification

It can be seen from Table 7a that diaries were comleted by six different individuals over the four days. This resulted in 18 data sets. Only two therapists completed the diaries for all four days. All six completed them for at least two days.

The data extracted from the script were analysed using the fifteen categories of activity shown in appendix two. As all staff were sharing the same base at the time of the data collection, data were analysed by grade only.

Results

Results reflect a high level of activity for all individuals. Apart from the head occupational therapist, it is also evident that levels of activity were compatible across the staff group.

Tables Relating to Analysis of Activity Diaries

Table 7b - Basic Grade

Activity Category	Activity Recorded	Percentage Occurrence
A	14	8.4
TR	25	14.9
AC	8	4.8
PR	13	7.8
PC	2	1.2
E	3	1.8
AP	35	21.0
CR	10	6.0
CP	2	14.9
CC	9	5.4
CD	17	10.2
ED	0	0
TS	5	3.0
T	0	0
O	1	0.6

Table 7c - Basic Grade(i)

Activity Recorded	Percentage Occurrence
4	3.4
6	7.5
8	6.7
4	3.4
0	0
8	6.7
22	18.5
9	7.5
26	21.8
8	6.7
4	3.4
0	0
7	5.9
3	2.5
7	5.9

Table 7d - Senior II

Activity Category	Activity Recorded	Percentage Occurrence
A	11	5.0
TR	23	10.5
AC	9	4.1
PR	17	7.7
PC	1	0.5
E	7	3.2
AP	41	18.6
CR	6	2.7
CP	43	19.5
CC	4	1.8
CD	28	12.7
ED	5	2.3
TS	12	5.5
T	10	4.5
O	3	1.4

Table 7e - Senior II(i)

Activity Recorded	Percentage Occurrence
11	7.1
24	15.4
4	2.6
10	6.4
2	1.3
7	4.5
29	18.6
8	5.1
23	14.7
7	4.5
13	8.3
0	0
8	5.1
7	4.5
3	1.9

Table 7f - Head III

Table 7g - Student

Activity Category	Activity Recorded	Percentage Occurrence	Activity Recorded	Percentage Occurrence
A	0	0	5	3.5
TR	5	4.1	31	21.7
AC	8	6.6	6	4.2
PR	0	0	5	3.5
PC	0	0	4	2.8
E	1	0.8	5	3.5
AP	7	5.7	17	11.9
CR	8	6.6	7	4.9
CP	32	26.2	18	12.6
CC	0	0	0	0
CD	9	7.4	26	18.2
ED	18	14.8	1	0.7
TS	27	22.1	12	8.4
T	6	4.9	6	4.2
O	1	0.8	0	0

Direct treatment activities - ***assessment and treatment in hospital, assessment and treatment in the community***

Apart from the head occupational therapist, treatment undertaken in the hospital setting by staff exceeded time spent in other categories of treatment activity. For the student, this accounted for one fifth of the total recorded time (table 7g). All the occupational therapists had spent some time assessing and treating in a community setting, but this did not exceed 6.7 per cent of total time.

Indirect treatment activities - ***Preparation for patient assessment/ treatment, escorting patients, general patient contact and administration related to patient treatment***

All staff apart from the departmental head spent a large proportion of time undertaking patient related administration. For one of the basic grades (table 7b) and the part-time senior II (table 7e) this was the category of activity which occurred most frequently.

For all occupational therapists, patient contact not involving treatment was either absent or occurred infrequently, the highest proportional incidence being for the student (table 7g). All the staff undertook some preparation for patient treatment during the period of data collection apart from the head occupational therapist. Proportion of time spent escorting patients was variable across the sample. However, it was noted during analysis that some staff recorded this activity where others did not.

Communication activities - ***Communication with other hospital based disciplines, occupational therapy staff, informal carers and professionals working in the community***

All of the subjects spent a small proportion of time talking with carers during the week of data collection. The person who spent the greatest proportion of time communicating with carers was one of the basic grades (table 7b). Communicating with community based professionals did not occur at all for the student or the head of department, all other staff undertaking this activity infrequently. In contrast, communication with other hospital based disciplines was a very frequently occurring category of activity. For three members of staff it was the most frequent type of activity; in the case of the head III taking over a quarter of documented time. All staff communicated with other occupational therapy staff during the period of data collection, the proportion of time spent in this activity being greatest for the student (18.2 per cent).

Education activities - *education, teaching and supervision*

During the two days activity documented, the head III a large amount of her time in education (table 7f). However, education activities were absent or of low occurrence for the other five staff. Table 7g shows that the student only spent 0.7% of her time carrying out these activities. All staff undertook teaching and supervision activities. For the head occupational therapist this can be seen to be the second most frequent category of activity.

Other activity - *non patient related administration and other*

All occupational therapists carried out non patient related administrative activities for a small proportion of time. 'Other' activities occurred very infrequently or were absent for all staff apart from the basic grade who recorded these for 5.9 per cent of her time (table 7c). However, this can readily explained as this member of staff recorded walking to and from wards whereas others did not.

Discussion

The results of analysis of the available data (the equivalent of only two days work for two of the subjects) and the variation in extent of activities documented across the sample can only serve to indicate areas which warrant further investigation. The following questions arise out of analysis of the pilot data:-

- Was the activity of the head III occupational therapist (high involvement in educative activities and low involvement clinically) typical or atypical?
- How worthwhile is it for qualified occupational therapists to spend a large proportion of their time carrying out administrative activities?
- Would the introduction of secretarial support (absent at the time of the pilot) increase time spent in clinical activities?

- Is there any real differentiation in activity between the basic grade and senior II staff?
- Why were all staff apart from the head III spending so little time in educative activities?

Interviews with Staff who Participated in the First Data Collection - Emergent Themes

Clarity of role

There was good agreement between those interviewed about when they would become involved in the treatment of a patient, what their involvement would be during the process of treatment, and when treatment would cease. Due to lack of time and high demand, there was no room for deviation from what appeared to be the core functions of occupational therapists. Although interests in developing other aspects of the work were described by all, the overriding importance of getting through the existing work was paramount.

Training required for the tasks

Although many references were made to the occupational therapy skills of task analysis by all the interviewees, the two junior staff both stated that they learnt most about what was required 'on the job.' The other workers in the department had guided them and taught them. One of the basic grades said that she had been prepared to a certain extent because she had already spent four months in a physical medicine department. The other claimed to have learnt almost everything during her four months in the department, particularly as her college experience had not extended to a hospital placement. The head of department said she had developed the methods of work over a long career.

Ownership of tasks

It was clear that the occupational therapists working in this area believed that they 'owned' the tasks of home visiting and dressing assessment/practice. This is substantiated by the ways in which the other professions involved were said to acknowledge and support the lead role of the occupational therapists rather than challenging it. The occupational therapists perceived themselves as being the only discipline able to arrange a home visit successfully. Furthermore, the notion of another profession conducting tasks like taking the lead role in home visits and undertaking dressing assessment/practice was unacceptable to all those interviewed. Shortage of staffing within the service necessitated priorities being set within the department rather than a sharing of tasks with other disciplines.

Views of the contributions of other members of the multi disciplinary team

All three occupational therapists were unequivocal in the belief that no other profession had the skills that they possessed to carry out certain tasks adequately. References were made to the fact that

both nurses and physiotherapists did not view the patient holistically, whereas occupational therapists did. The role of the physiotherapist was equated with chest problems and mobility, and that of the nurse with physical care within the hospital setting. Little reference was made to the of other contributions hospital based personnel apart from physiotherapists and nurses. Frequent liaison was made with community staff, who attended home visits at the invitation of the occupational therapists.

Involvement of patients and carers

Great efforts were made to engage the patients and their carers in the process assessment and treatment. The interviewees all described discussing different aspects of treatment with patients, and the importance of getting carers involved in home visits. However, it seems that if assessment or treatment were unsuccessful, any subsequent action like counselling the patient was perceived to be the role of the nurse. All three occupational therapists said that their reports were generally accepted and acted upon, whether that entailed a patient returning home or not.

Methods of working

The extent of agreement regarding departmental policies and procedures and their implementation was striking, particularly as two of the three subjects had not worked in the department for four months. Three examples from the many quoted were; the procedure for discharge when on a home visit, the role of unqualified staff in the described processes, and methods of documentation for home visits and dressing assessment.

Expressed job satisfaction

Even though the basic grade staff had moved to other departments, they both described having experienced a high degree of job satisfaction whilst working in this area. Slight inferences were made to difficulties in influencing change, but the positive features of the work were paramount. The two junior staff mentioned clarity of role and positive acknowledgement of their contributions as important features of job satisfaction. The head of department cited a recent injection of money by management as a demonstration of confidence in the work being carried out by occupational therapists. All three respondents expressed certainty over the effectiveness of their work.

The findings from these interviews were used to provide a framework for analysis of the subsequent interviews conducted with staff working in psychiatry of old age (chapter four).

APPENDIX EIGHT

Tables Relating to Charts in Chapter Four

Table 8a - Senior I Base A (DH)

Activity Category	Activity Recorded	Percentage Occurrence
A	1	0.9
TR	16	14.9
AC	0	0
PR	6	5.6
PC	14	13.1
E	9	8.4
AP	0	0
CR	0	0
CP	34	31.8
CC	0	0
CD	18	16.8
ED	0	0
TS	1	0.9
T	8	7.4
O	0	0

Table 8b - Senior I Base A

Activity Recorded	Percentage Occurrence
0	0
23	13.7
18	10.8
12	7.2
1	0.6
16	9.6
12	7.2
0	0
29	17.3
1	0.6
34	20.3
0	0
4	2.4
8	4.8
9	5.4

Table 8c - Head III Base A

Activity Category	Activity Recorded	Percentage Occurrence
A	0	0
TR	14	7.8
AC	4	2.2
PR	7	3.9
PC	3	1.3
E	9	5.0
AP	11	6.1
CR	2	1.1
CP	17	9.5
CC	0	0
CD	39	21.8
ED	5	2.8
TS	25	14.0
T	39	21.8
O	4	2.2

Table 8d -Senior II Base B (DH)

Activity Category	Activity Recorded	Percentage Occurrence
A	3	3.1
TR	11	11.2
AC	0	0
PR	3	3.1
PC	35	35.7
E	4	4.1
AP	6	6.1
CR	0	0
CP	22	22.5
CC	1	1.0
CD	2	2.0
ED	0	0
TS	5	5.1
T	3	3.1
O	3	3.1

Table 8e - Head III Base B

Activity Recorded	Percentage Occurrence
1	0.3
25	8.4
4	1.3
20	6.7
5	1.7
10	3.3
25	8.4
4	1.3
39	13.2
0	0
52	17.6
12	4.0
20	6.7
63	21.3
16	5.4

Table 8f- Basic Base C

Activity Category	Activity Recorded	Percentage Occurrence
A	2	0.7
TR	0	0
AC	25	9.3
PR	18	6.7
PC	0	0
E	13	4.8
AP	59	21.9
CR	22	8.2
CP	32	11.9
CC	10	3.7
CD	28	10.4
ED	5	1.9
TS	36	13.4
T	10	3.7
O	9	3.4

Table 8g - Senior II Base C

Activity Recorded	Percentage Occurrence
20	7.2
3	1.1
51	18.5
15	5.4
3	1.1
10	3.6
29	10.5
10	3.6
31	11.2
14	5.1
28	10.1
11	4.0
16	5.8
20	7.2
15	5.4

Table 8h - Head IV Base C

Activity Category	Activity Recorded	Percentage Occurrence
A	11	4.0
TR	9	3.2
AC	49	17.6
PR	2	0.7
PC	2	0.7
E	13	4.7
AP	46	16.6
CR	13	4.7
CP	27	9.7
CC	4	1.4
CD	33	11.9
ED	16	5.8
TS	23	8.3
T	20	7.2
O	9	3.2

Table 8i - Senior I Base D

Activity Category	Activity Recorded	Percentage Occurrence
A	2	0.7
TR	0	0
AC	80	27.5
PR	26	8.9
PC	0	0
E	34	11.7
AP	31	10.6
CR	20	6.9
CP	31	11.7
CC	6	2.0
CD	3	1.0
ED	0	0
TS	22	7.6
T	28	9.6
O	8	2.8

Proportion of Time Spent in Collapsed Activity Categories

Table 8j -Senior I (DH) Base A

Activity Category	Activity Recorded	Percentage Occurrence
Direct	17	15.9
Indirect	29	27.1
Communication	52	48.6
Education	1	0.9
Other	8	7.5

Table 8k - Senior I Base A

Activity Recorded	Percentage Occurrence
41	24.6
41	24.6
64	38.3
4	2.4
17	10.2

Table 8l - Head III Base A

Activity Category	Activity Recorded	Percentage Occurrence
Direct	18	10.0
Indirect	30	16.8
Communication	58	32.4
Education	30	16.8
Other	43	24.0

Table 8m -Senior II Base B

Activity Category	Activity Recorded	Percentage Occurrence
Direct	14	14.3
Indirect	48	49.0
Communication	25	25.5
Education	5	5.1
Other	6	6.1

Table 8n - Head III Base B

Activity Recorded	Percentage Occurrence
30	10.1
60	20.2
95	32.1
32	10.8
79	26.7

Table 8o - Basic Base C

Activity Category	Activity Recorded	Percentage Occurrence
Direct	27	10.0
Indirect	90	33.5
Communication	92	34.2
Education	41	15.2
Other	19	7.1

Table 8p - Senior II Base C

Activity Recorded	Percentage Occurrence
72	26.8
57	20.7
83	30.0
27	9.8
3	12.7

Table 8q - Head IV Base C

Activity Category	Activity Recorded	Percentage Occurrence
Direct	69	24.9
Indirect	63	22.7
Communication	77	27.8
Education	39	14.1
Other	29	10.5

TABLE 8r - Senior I Base D

Activity Category	Activity Recorded	Percentage Occurrence
Direct	82	28.2
Indirect	91	31.3
Communication	60	20.6
Education	22	7.6
Other	6	12.3

APPENDIX NINE

Occupational therapy services in locations X, Y and Z at the time of research.

Table 9.1a - Occupational Therapy Services: Location X Dec 1993

OT Staff	WTE	Area of Work
Head III	1.0	Management (Mental Health) 2 clinical sessions; day & community
Senior I	1.0	Functionally ill patients In, day, & community
Senior I	0.5	Organically ill patients In, day, & community
Senior II*	1.0	Physically ill patients with cognitive problems
Basic Grade	1.0	Organically ill patients Day & community

* Temporary post due to experimental service

Table 9.2a - Occupational Therapy Services, Location Y: Dec 1993

OT Staff	WTE	Area of Work
Senior I(i)*	0.6	Organically ill in-patients
Senior I	0.4	Functional and Organic patients
Senior II*	1.0	Functionally and organically ill in- and day patients

*for purposes of identification

Table 9.3a - Occupational Therapy Services, Location Z: Dec 1993

OT Staff	WTE	Area of Work
Head III	1.0	Management of service Functionally and organically ill day & in-patients
Head IV	0.33	Referrals from one consultant
Senior II	1.0	Unknown – vacant post
Senior I	1.0	Organically ill patients Day & community
Basic Grade	1.0	Functionally and organically ill day patients

Tables Relating to Charts in Chapter Five

Table 9a: Basic Grade Location X

Activity Category	Activity Recorded	Percentage Occurrence
A	2	1.0
TR	41	20.4
AC	5	2.5
PR	37	18.4
PC	11	5.5
E	9	4.5
AP	48	23.9
CR	4	2.0
CP	27	13.4
CC	7	3.5
CD	4	2.0
ED	0	0
TS	0	0
T	6	3.0
O	0	0

Table 9b :Senior II Location X

Activity Category	Activity Recorded	Percentage Occurrence
A	4	3.1
TR	16	12.4
AC	6	4.7
PR	3	2.3
PC	7	5.4
E	3	2.3
AP	27	20.9
CR	5	3.9
CP	27	20.9
CC	0	0
CD	15	11.6
ED	2	1.6
TS	2	1.0
T	12	9.3
O	2	1.6

Table 9c: Senior I Location X

Activity Category	Activity Recorded	Percentage Occurrence
A	2	1.7
TR	18	15.1
AC	0	0
PR	3	2.5
PC	0	0
E	0	0
AP	18	15.1
CR	1	1.0
CP	20	16.8
CC	2	1.7
CD	5	4.2
ED	34	28.6
TS	0	0
T	13	10.9
O	3	2.5

Table 9d: Senior II Location Y

Activity Category	Activity Recorded	Percentage Occurrence
A	12	8.6
TR	22	15.7
AC	0	0
PR	16	1.4
PC	0	0
E	0	0
AP	43	30.7
CR	3	2.1
CP	14	10.0
CC	2	1.4
CD	14	10.0
ED	0	0
TS	0	0
T	0	0
O	14	10.0

Table 9e: Senior I(i) Location Y

Activity Recorded	Percentage Occurrence
32	16.2
43	21.8
12	6.1
11	5.6
0	0
0	0
21	10.6
11	5.6
24	12.2
4	2.0
15	7.6
2	1.0
2	1.0
11	5.6
9	4.6

Table 9f: Senior I Location Y

Activity Category	Activity Recorded	Percentage Occurrence
A	0	0
TR	4	5.8
AC	8	11.6
PR	2	2.9
PC	0	0
E	0	0
AP	16	23.2
CR	16	23.2
CP	3	4.3
CC	4	5.8
CD	8	11.6
ED	0	0
TS	0	0
T	1	1.4
O	7	10.1

Table 9g: Basic Grade Location Z

Activity Category	Activity Recorded	Percentage Occurrence
A	5	2.0
TR	36	14.0
AC	0	0
PR	14	5.4
PC	9	3.5
E	1	0.4
AP	32	12.6
CR	16	6.3
CP	41	16.1
CC	7	2.7
CD	44	17.2
ED	10	3.9
TS	11	4.3
T	16	6.3
O	6	17.1

Table 9h: Senior I Location Z

Activity Category	Activity Recorded	Percentage Occurrence
A	31	9.2
TR	14	4.1
AC	6	1.8
PR	11	3.3
PC	60	17.8
E	14	4.1
AP	61	18.0
CR	39	11.5
CP	22	6.5
CC	12	3.6
CD	30	8.9
ED	0	0
TS	6	1.8
T	17	5.0
O	15	4.4

Table 9i: Head III Location Z

Activity Category	Activity Recorded	Percentage Occurrence
A	1	0.4
TR	20	7.6
AC	7	2.7
PR	10	3.8
PC	5	1.9
E	3	1.1
AP	31	11.7
CR	23	8.7
CP	56	21.2
CC	5	1.9
CD	40	15.2
ED	3	1.1
TS	14	5.3
T	32	12.0
O	14	5.4

Proportion of Time Spent in Collapsed Activity Categories

Table 9j: Basic Grade Location X

Activity Category	Activity Recorded	Percentage Occurrence
Direct	48	23.9
Indirect	105	52.2
Communication	42	20.9
Education	0	0
Other	6	3.0

Table 9k: Senior II Location X

Activity Category	Activity Recorded	Percentage Occurrence
Direct	26	20.1
Indirect	40	31.0
Communication	47	36.4
Education	2	1.6
Other	14	10.9

Table 9l: Senior I Location X

Activity Category	Activity Recorded	Percentage Occurrence
Direct	20	16.8
Indirect	21	17.6
Communication	28	23.5
Education	34	28.6
Other	16	13.5

Table 9m: Senior II Location Y

Activity Category	Activity Recorded	Percentage Occurrence
Direct	34	24.3
Indirect	59	42.2
Communication	33	23.5
Education	0	0
Other	14	10.0

Table 9n: Senior I(i) Location Y

Activity Category	Activity Recorded	Percentage Occurrence
Direct	87	44.2
Indirect	32	16.2
Communication	54	27.4
Education	4	2.0
Other	20	10.1

Table 10o: Senior I Location Y

Activity Category	Activity Recorded	Percentage Occurrence
Direct	12	17.4
Indirect	18	26.1
Communication	31	44.9
Education	0	0
Other	8	11.6

Table 10p: Basic Grade Location Z

Activity Category	Activity Recorded	Percentage Occurrence
Direct	41	16.0
Indirect	56	21.9
Communication	108	42.2
Education	21	8.2
Other	30	11.7

Table 10q: Senior I Location Z

Activity Category	Activity Recorded	Percentage Occurrence
Direct	51	15.1
Indirect	146	3.2
Communication	103	30.5
Education	6	1.8
Other	32	9.4

Table 10r: Head III Location Z

Activity Category	Activity Recorded	Percentage Occurrence
Direct	28	10.6
Indirect	49	18.6
Communication	124	47.0
Education	17	6.4
Other	46	17.4

APPENDIX TEN

Interview Guides

Topic Guide for Interviews Held with Occupational Therapists

Overall questions the interview will address:-

1. Why is an occupational therapist required to undertake certain activities?
2. What range of skills are used when carrying out the activity?
3. Which activities are considered to be of the most value?

I would like to ask you some questions about one of the activities you carried out and documented during the data collection...

1. **The referrer**

- Who asked you to do this? (specify activity from diary)
- Did you decide to carry out this activity - if so why?
- Did you suggest it first or did you just go ahead?
- Did you discuss it with anyone else?
- Did an another professional ask you - if so who?
- Did the patient ask you - if so describe the circumstances?
- Did the patient's carers ask you - in what circumstances?

2. **Why was the case referred to occupational therapy?**

- Were you asked because the activity needed the skills of an occupational therapist?
- Were you asked because you were available/ easily accessible?
- Who else could have carried out the activity - Why could they/ why couldn't they?
- If others were capable, why were you asked?
- Are the occupational therapy staff always asked to undertake this activity?
- What would happen if no one was available?
- Are there any circumstances where it would be better if another professional carried out this activity?
- Was it the occupational therapy skills you offer or circumstances which led to you being involved in this way?
- Did you feel adequately trained to undertake the activity?
- Should the activity be carried out by a more senior occupational therapist?
- Could a junior/ untrained member of the occupational therapy staff undertake this activity?

3. **The occupational therapy aims of the activity**

Perhaps we can now move on to looking at what actually occurred ...

- Why was it necessary to....? discuss documented elements of the activity

- What were you wishing to achieve?
- If there was more than one aim, what was the most important aspect and what was the least important aspect?
- What were the implications for the patient/ carers of the activity?
- How much preparation was involved?

4. What occurred during the activity

- If other professionals were with you, what was their contribution?
- Did they understand your contribution?
- Did you consider their contribution to be of lesser, equal or more value?
- What skills did you employ during the activity?
- Were you supervised, if so by who?
- Did anything go wrong - if so why?
- Did the patient/ carers understand what you were trying to achieve?

5. The results of the activity

- What occurred as a result of the activity?
- Did you achieve your aims?
- What documentation did you produce - did you make any recommendations?
- Who did you report back to?
- Where did you report to - formally or informally?
- Did you report back alone or with others who had been present?
- How was your report received by other professionals?
- Were your recommendations adhered to?
- Did you let the patient/ carers know the results of the activity? - explain

6. The value of occupational therapy activity

Finally, I would like to discuss the activity of occupational therapists in this field more generally....

- What do you view as being the most important activity that an occupational therapist carries out in this field? - give reasons
- Do you think that it is cost effective for an occupational therapist to carry out this activity?
- Are you able to carry out this activity - if not why not?
- Are there any activities which are not currently requested which occupational therapists could undertake?
- Can occupational therapy staff only act as a result of a specific request?
- Are staff able to offer suggestions regarding their involvement?
- Do you think that the role of occupational therapy is valued enough in this field - if not, how might things improve?

Additional questions asked of the second group of interviewees:-

7. Decisions regarding content of activity

- Why are you not carrying out certain activities?
- When not carrying out specific groups or individual work, can you explain the value of other activities you were undertaking e.g.....?
- Do you believe that you should be carrying out certain tasks?

8. Philosophy underlying activity

- Occupational therapists often say that they work holistically; what does that mean for you?
- Why are some occupational therapists working in the same field involved in certain areas of work and others are not?

Topic Guide for Interviews with Consultant Psychiatrists

Overall questions the interview will address:-

1. What is the role of the occupational therapist in the treatment team?
2. What are the perceptions of occupational therapy undertaken with elderly people in a hospital setting?
3. What are the perceptions of community occupational therapy with this client group?

1. What is the role of the occupational therapist in your treatment team?

- Do you currently have an occupational therapist in your treatment team?
- If so, what does that person do?
- If not, why not?
- If not, does this cause any identifiable problems?
- Do you directly refer to occupational therapists or is referral via team consensus decision?
- Is any other professional in your team able to provide similar input to occupational therapists?
- If so, describe which aspects of the work which can be undertaken by other professionals?
- How important is the personality of the individual therapists in your team?
- Does personality ever dictate the distribution of work?
- Do you take part in the selection process for occupational therapy staff?
- Do you think that occupational therapists are value for money?

2. What are the perceptions of occupational therapy undertaken with elderly people in a hospital setting?

(Situations identified via the interviews with older people may be used as illustration).

- In what circumstances would you wish to refer a patient to the occupational therapist while they were attending the day hospital?
- What activities would you expect an occupational therapist to undertake with day hospital patients?
- Do you think that occupational therapists should routinely provide input to the day hospital?
- If so, what would be the benefits to patients?
- If no, what level of input is preferred?
- Would you expect to directly refer a day hospital patient to the occupational therapist or would you expect referral to be a team decision?
- How are day hospital patients reviewed?
- In what ways could the current occupational therapy service to the day hospital be improved? (expand beyond staffing levels)

3. What is the value of community occupational therapy with this client group?

(Situations identified via the interviews with older people may be used as illustration).

- Do you have access to a community based occupational therapist?
- Do you expect the hospital based occupational therapist to follow individuals into the community?
- If so, in what circumstances?
- What are the benefits of community occupational therapy input for the patient? (illustrate with interviews)
- Do you think that patients are able to identify any benefits for themselves?
- If so, what is the nature of the identified benefits?
- How are community patients receiving occupational therapy reviewed?
- Can the occupational therapist offer different skills to those of other community based professionals like CPNs, social workers and psychologists?
- Do you rely upon the skills of individual therapists rather than on their professional training?
- In what ways could the current community occupational therapy service be improved? (expand beyond staffing levels)

Topic Guide for Interviews Held with Older People

Overall questions the interview will address:-

1. What could the person recall of the occupational therapy intervention they received?
2. Why did they think they had received occupational therapy?
3. What was the impact of the occupational therapy intervention?

1. What could the respondent recall?

- Which staff here can you remember? - prompt with photographs of staff
- Who has been involved in your care?
- Do you know who the occupational therapist is at - (give name of service)?
- What sort of things did you see that person doing in the hospital (name service)?
- Were you ever asked to do anything by that person? -If so what?
- Where did you do it?
- Did she visit you at your home/ did she come home with you? - If so what did you do there?
- Does anyone else visit you at your home?
- How often did you see her?
- Did she work with anyone else? - If so did they ask you to do anything?
- Did you see or hear of occupational other patients being asked to do things by the occupational therapist or helpers?
- Which member of staff here has given you the most help? why?

2. Why did they think they had received occupational therapy?

- Did everyone have to do the sorts of things you were asked to do?
- What do you think the occupational therapist was trying to find out or do?
- Did she explain the treatment to you?
- Did anyone else explain what was happening?
- Why do you think that you were asked to do them?
- Did she ask you to give information?
- Did she ask for your ideas/ opinions?
- Do you think that someone asked her to see you - if yes who?
- Do you feel that it is right that you were referred to the occupational therapist?

3. What was the impact of the occupational therapy intervention?

- Was what happened of benefit to yourself/ a waste of time?
- Might it be of benefit in the future?
- Was it of benefit to anyone else? - probe carers, other professionals, social services
- Did you feel at ease when you were with the occupational therapist?

- Did you understand what was happening to you?-Did you feel frightened at any time? if so what frightened you?
- Were you able to say if you felt unhappy or unsure about what was happening?
- Did you feel in control over what was happening?
- Were you able to refuse?
- Did you wish to refuse any aspect of the treatment you received?
- Do you think that it has affected your overall hospital treatment in any way?
- Has your life changed in any way as a result of occupational therapy? - probe social care, hospital attendance
- Would you recommend occupational therapy to others?

Follow Up Interviews with Occupational Therapists After Interviews with Each Older Person

For each patient:-

1. Explain treatment
2. What was the criteria for success?
3. Was treatment a success? What measures/ indications were used?
4. What problems were encountered?
5. Who else was involved with client?
6. What liaison was there?
7. What was the importance of occupational therapy in patient's overall treatment?
8. Was the referral appropriate?
9. Was the treatment specifically occupational therapy or could someone else have done it?
10. Could/ should an occupational therapist of higher/ lower seniority have carried out the treatment? What effect would this have had?
11. What would be the ideal treatment plan for this person?

APPENDIX ELEVEN

Pilot Interviews With Service Users: Analysis of the Interview Data

The transcripts produced from the four pilot interviews were first considered individually in order to look at the specific issues and outcomes contained in each. As a result categories for analysis were identified. The text in each transcript was coded by hand and analysed in the same manner as the staff interviews described in chapter five, the initial codes for analysis being derived from the questions in the topic guide and other themes emerging through the analytic process.

Analysis of the four transcripts was undertaken to consider themes which may be pertinent in analysis of future interviews. However, the analysis also assisted in illuminating the research question of how the activity of occupational therapists impacts upon those in receipt of their interventions.

Although all four interviewees had attended day hospital, only three were current attenders at the time of interview. The themes identified from the coding and analysis of the interviews covered three aspects:-

1. The specific circumstances of each individual and reasons for their involvement with the service.
2. Perceptions of their treatment overall.
3. Perceptions and experiences of the occupational therapy service.

Individual Circumstances

Recall of Events

The elderly people we talked to found it difficult to recall events and people involved in their treatment. It was necessary to use prompts to explore the sequence of past events with every person. Difficulty in recall appeared to be compounded by different hospital admissions and resulting interventions by several occupational therapy staff as well as by other professionals. Mr L initially recalled his experience of occupational therapy as an in-patient rather than his more recent experiences as a day patient.

> *I cooked my dinner, yes. I think she came from H R what came before.....a lady from H R* (location A). *She came and I cooked a meal.*

There was also confusion about the different roles of staff. When shown a photograph of one of the occupational therapy helpers, Mrs N could not initially correctly identify her role, despite having had a lot of involvement with that particular staff member.

> *She's a nurse, I think so. I think they help the patients on the ward you see...*

Expressed problems and associated feelings

Limited reference was made to the problems which resulted in a need for hospital treatment.

Problems mentioned included physical disabilities associated with the ageing process like poor eyesight, poor hearing and limited mobility.

Reference was also made to physical manifestations of mental ill health and difficulties in coping.

> *I just didn't want to go out, you see for a long time, I didn't want to go out at all. I'd go across the road for my pension because I knew I had to. I knew I couldn't function without my pension, so I went for that you see.*

> *I mean I'm sick now. I'm sat here and I don't know where to put my foot, it hurts and my eye hurts and my ear hurts. It seems as though I want to be quiet.*

Home circumstances

Only two people talked about their home circumstances. For both of these people their living situations had changed in the recent past; one lady had moved in with her son and the other had been receiving extensive home rehabilitation from the occupational therapist to help her to continue living at home.

Informal care

There was also little said about care received by friends and relatives, possibly due to the emphasis upon professional care in the discussions. Three of the people we interviewed mentioned help received from family. The fourth person relied upon assistance from volunteers arranged by the occupational therapist.

Independence skills

When describing tasks that they carried out themselves, it was apparent that it was sometimes necessary to accept a less than ideal outcome. The reasons given were diminished skills due to poor mobility or eyesight. It is not surprising that if practical help was offered in the form of meals at day care or housework, then necessary activity was adapted in order to reap maximum benefit from this assistance.

> *Well, I tell you why I don't cook at home and then you'll understand. I get my groceries on a Wednesday, 7 o'clock. I start breaking into them on Saturday morning. The simple reason is I come here (day hospital) on Thursday during the day, Friday I go to day centre and Saturday, Sunday, Monday I don't go anywhere so I make sandwiches. Saturday, Sunday, Monday, three days....so I don't need to cook do I?*

Interventions from Health and Social Care Professions other than Occupational Therapy

A range of medical and social care services in addition to occupational therapy were cited. Home care was provided to the three interviewees who were living alone, giving assistance with laundry and cleaning, and in one instance food preparation. As well as home care, one person was receiving

meals on wheels, a daily warden and attending a day centre. Medical and community nursing involvement were also mentioned.

Day hospital attendance

Three of the four respondents were still attending the day hospital when we interviewed them. Most of the comments about the day hospital were favourable.

> *I didn't want to go, but when I went I quite enjoyed it. You see there were a lot of people there and I think that was part of it.*

However, in order to enjoy the day hospital atmosphere a pre-requisite is an interest in mixing with others, a large part of the programme being orientated towards groups.

> *They'll all be having groups and noise.*

Perceptions of Occupational Therapy Intervention

Once prompted by photographs and the sequence of events, the elderly people we talked to could remember aspects of the practical interventions they had received from the qualified occupational therapist based at location D, although the point at which they took over from hospital based therapists remained unclear for the two people who had relatively recent admissions to the institution, location A. It was also apparent that how they had been referred for occupational therapy or who else would receive details of their progress were not processes they were involved in. Interventions they described included assessments. Mrs B described assessment during a home visit;

> *About cooking. A long time ago. At my home.....She watched me make a cup of tea.*

Features of the assessment process involved discussion of problems and treatment suggestions;

> *....well, she asked me like they all do. Asking me what you know and showing me what and having a go at this, having a go at that. She showed me the kettle and I said 'well I've got a kettle', and she showed me all the other things you know.*

> *She was talking to me how to cook. She asked about my health.*

Three of the four people we talked to did offer reasons for their assessment and treatment.

> *That was the whole idea, for her to come down and see if I could make a meal, and to help me with my cooking.*

> *But as I say, the idea was to get you to manage on your own and cook she was very keen, you've to have something in, don't not have any meals - that was against their principles.*

The occupational therapist was viewed as being someone who could get practical issues sorted out. Mrs N had needed a lot of assistance with organising the decorating and refurbishment of her property.

So she did help a lot with the decorating, getting things done reasonably. And we went about for curtains and things like that, she got them a bit cheaper.

Day hospital based interventions viewed as being the remit of the occupational therapist in the day hospital setting included a relaxation therapy group and exercise group.

The occupational therapist was perceived as having a certain amount of authority, particularly in relation to the two helpers.

I only know that she is in charge. I've never seen her do no cooking.

Perceptions of unqualified occupational therapy staff intervention

All our interviewees were certain that the role of the two helper staff centred around the teaching of cookery.

I went to their cookery class. We helped cook a meal and then we ate the meal.

Mr L stated quite clearly;

They teach you how to cook.

The reasons for teaching cookery were not articulated as clearly. It was seen as occurring to "*get you going*" and "*to help you mix in*".

The association between cookery and the role of the helper staff appeared to be in relation to the day hospital schedule. The lady interviewed in her own home was receiving home visits from one of the occupational therapy helpers at the time of the interview, but was less definite about the nature of this intervention than the day hospital cookery which she had participated in previously.

Compliance with occupational therapy treatment

All said that they agreed to participate in occupational therapy even though they had little or no idea why.

I never asked. She seemed to be doing everyone you know.

There was no pressure applied to cooperate with assessment and treatment. It was described as "*optional.*" However they all made measured decisions about the advice and assistance they were willing to accept and what they were not. Decisions about take up of advice was frequently governed by the acceptability of existing routines and available assistance.

Mr L talked animatedly about participating in the cookery sessions at the day hospital, but also said that he was going to continue to eat sandwiches at home.

Mrs W allowed the occupational therapist to show her how to use the washing machine, but admitted that she would not use it due to the assistance she was already receiving with laundry;

I didn't bother because well I thought I get it done every Wednesday.

Another reason for non compliance was a determination to remain independent. As Mrs B stated;

I can do things for myself.

However, this determination was not always helpful.

I wished afterwards...she got some knives and forks and I didn't have them. I said 'No I can manage with a fork'.

Perceived benefits of occupational therapy

All the respondents praised the service they had received, citing interventions from which they had benefited. Benefits included assistance with independence skills and practical tasks within the home. This subject referred to a specially adapted key provided by the occupational therapist;

I've got a key. She helped me have the key made. I wouldn't be without it.

Mrs N said that the occupational therapist had helped her to cope with having her house decorated, assisted her with money management and found a volunteer to transport her to the supermarket.
Reference was also given to the benefits of groups run by the occupational therapy staff in the day hospital. Groups mentioned included relaxation, exercise and cookery.
In some instances the respondents were able to articulate why they had found specific activities beneficial.

Some things are easier for me.

I think it perhaps gives you a bit of confidence.

There was also a recognition that although there was not a current need to undertake certain activities, this might change in the future;

I try because I know that one day I might not get no sandwiches and I'd have to make do with what I've got.

Opinions of the occupational therapy staff

Comments to describe the staff like "*very kind*" and "*very good*" peppered the discussions. It was clearly difficult to criticise the service, possibly because of fear of repercussions. Only one person made a slightly negative comment about one staff member;

I wouldn't say anything against her but she's a bit sharper you see.

APPENDIX TWELVE

Information about the Older People Interviewed from Different Data Sources

Information Extracted from the Case Notes

1. Mrs EC

Diagnosis: Depressive illness

Admitted to W ward, location E on 13.1.93 from a medical ward. Suffers from arterio sclerotic disease, depression appearing to be precipitated by a proposed further arteriogramme. Discharged on 13.3.93. May have attended the day hospital at location E prior to admission (reference to day hospital in notes, 26.10.92). Attended day hospital twice weekly after discharge.

Community psychiatric nurse involved. Occupational therapy intervention commenced while the patient was on the ward. Occupational therapy home visit conducted on 9.3.93 while patient was on leave from the ward. Support identified at the time of the visit included a nephew who managed her finances and a niece who does some shopping. A neighbour visits frequently. Mrs EC is a church attender and was very involved in voluntary work in the past. Problems identified by the occupational therapist were lack of motivation, interest and reported panic attacks. Further intervention by the community occupational therapist was recommended, alongside liaison with the day hospital and multi disciplinary team.

Discharge letter from occupational therapist to locum consultant dated 25.8.93. Treated problems were loss of confidence using public transport and loss of leisure role.

Currently involved:-

Consultant psychiatrist, GP, CPN, Physicians

Home care twice a week

Informal care from family, neighbour and church

Previously involved:-

W ward, Day hospital, occupational therapist

2. Mrs DB

Diagnosis: Anxiety disorder, panic attacks, depression, emphysema

Lives with husband who finds it difficult to cope. Married for 42 years; two daughters live locally. Limited physical activity due to medical condition. Has a chair lift in house to access bathroom and toilet on first floor. No practical help from social services. Husband does most of the housework etc.

Referred to clinical psychology together with husband by consultant psychiatrist on 19.1.93. Referral was for anxiety management. Also referred to the day hospital for treatment of depression, anxiety and panic attacks.

Admitted to S ward, location E on 23.1.93 with a panic attack; subsequently transferred to W ward. Discharged from W ward 3.2.93 but readmitted urgently on 21.3.93 with a panic attack. Referred

by psychiatric team to physician on 11.2.93 for review of chest condition; response from physician was that her condition was irreversible.

Discharged from clinical psychology on 8.3.93; no further input necessary. Discharged to primary care on 27.4.93. Documented follow up included physiotherapist to visit at home and out-patient attendance. Summary letter from the junior doctor to the GP states that the patient is "*receiving physiotherapy input at home from which benefit is being derived.*" This was probably erroneous in that appears to refer to the occupational therapy input.

Currently involved:-

Consultant psychiatrist, GP, ?Occupational therapy

?Informal care from husband and daughters

Previously involved:-

Day hospital, W ward, Clinical psychologist

3. Mrs LF

Diagnosis: Manic depressive psychosis; depressed type

Lives with common law husband. Had a previous admission to location C under adult psychiatry services. Two medical admissions in 1991 with anaemia. Attended day hospital in the past.

Referred to consultant psychiatrist following home visit by GP on 14.5.92.

In-patient on W ward, location E 14.8.92 - 13.10.92 with a diagnosis of chronic anxiety with panic attacks. Admission arranged by clinical psychologist. Treatment on the ward included a behavioural programme by nurses under the guidance of the psychologist. Upon discharge follow up provided by a community psychiatric nurse for counselling and psychologist to cope with hypochondriacal symptoms.

Admitted to W ward again from a medical ward on 16.1.93. Received ECT and discharged in February. Psychology input completed during April 1993. Referred to psychiatric social worker for social support.

Occupational therapy follow up arranged in discharge letter after second admission. No mention of the nature of occupational therapy intervention in the notes. Letter from psychiatrist to GP on 27.8.93 discharging patient back into his care.

Currently involved:-

GP, informal care from partner

Previously involved:-

W ward, Day hospital, CPN, Psychiatric social worker, Occupational therapist, Clinical psychologist

4. Mrs MR

Diagnosis: Alcoholism, epilepsy, overdose

Next of kin documented as daughter but care giving not mentioned. In-patient on ward 39, location C July 1992. Home visit report from occupational therapist 20.7.92 while patient still on ward. Aims of the visit were to assess ability to function in the home environment and assess attitude to

discharge. The report recommended follow up for socialisation and confidence boosting; through exploration of community facilities, use of public transport and involvement in voluntary work.

Has a two year history of attendance at Leeds Addiction Unit. Occupational therapy is the main source of psychiatric follow up in the community.

In-patient admissions arranged by the occupational therapist on 9.12.92 and 19.5.93. Admitted to acute care on for three days on 9.3.93. Referral made to Tuke House (therapeutic community) for psychotherapy. Application made to move accommodation. Further admission to location E; 2.6.93-28.6.93. Follow up maintained by occupational therapist.

Currently involved:-

Consultant psychiatrist, GP, ?Physicians

Housing project workers, Psychiatric social worker, Occupational therapist

?Informal care from daughter

Previously involved:-

W ward, Ward 39, Leeds addiction unit

5. Mrs KA

Diagnosis: Manic depressive psychosis; depressed type

Lives in warden controlled accommodation with son. Three other children live nearby. Poor physical health. First admitted to W ward, location E December 1992 and subsequently admitted to the day hospital. Discharged to out-patient and community services 12.3.93. Other admissions to medical wards, location C due to physical problems.

Initially discharged from the day hospital into the care of the clinical psychologist. Discharged from psychology 18.5.93. Occupational therapy is currently the key mental health professional in the community. Documented role of the occupational therapist is to introduce practical measures to increase daily activities and to help the patient combat her agoraphobia.

Currently involved:-

Consultant psychiatrist, Occupational therapist, GP

Warden (housing), social services day centre, home care once a week

Previously involved:-

Day hospital, clinical psychologist, W ward, district nurse

Psychiatric social worker (after admission to reinstate day centre attendance)

6. Mrs HW

Diagnosis: Depressive illness

Preoccupied with living alone. Husband dead; no children. Tends to stay in due to arthritis and bronchitis. However, also a reference in notes to meeting sister in town once a week. Reviewed at home by community psychiatric nurse 22.12.92. Admitted to day hospital 7.1.93. Discharged to community and out-patient care following discharge from the day hospital. Occupational therapy discharge report 6.7.93. Originally referred to occupational therapy to explore ways of increasing

activity at home within the patient's physical limitations. The stated aims of occupational therapy were to assess areas of need, explore use of time and introduce hobby activities.

Letter from psychiatric registrar to GP on 10.9.93 reported failure to attend out-patient clinic following discharge from day hospital. Transport subsequently arranged to next out-patient appointment. Psychiatric social worker involved in her care has recently left the service.

Currently involved:-

Consultant psychiatrist, GP

?Day Centre, home care once a week

Previously involved:-

Day hospital, psychiatric social worker, occupational therapist, CPN

7. Mrs DW

Diagnosis: Chronic anxiety, agoraphobia, fear of dentists

Visited at home by community psychiatric nurse and psychologist on 13.5.92 who decided that psychotherapeutic intervention was required. Admitted to the day hospital 12.11.92 by the community psychiatric nurse for relaxation to cope with panic attacks. Other specified aims of attendance were involvement in group work, medication review and to provide a reason for leaving the house.

Daughter shops and collects pension. Neighbour downstairs is supportive.

Referred to occupational therapist 19.2.93 for anxiety management and participation in the leisure group. A behavioural programme was introduced to help the patient to go out.

Admitted to medical ward, location C, 14.4.93 with a panic attack and subsequently transferred to W ward. Attended the day hospital and occupational therapy while still an in-patient. Admitted to ward 39, location C from home on 10.8.93. Discharged to the day hospital and occupational therapy.

Currently involved:-

Consultant psychiatrist, GP, CPN, ?occupational therapist, clinical psychologist, Orthodontist - dental hospital, ?day hospital

Home care for heavy housework, informal care from daughter and neighbour

Previously involved:-

W ward, Ward 39

Meals on wheels

8. Mrs BP

Diagnosis: Manic depressive psychosis; depressed type

Admitted to W ward, location E on 9.3.93 from medical ward where she was admitted with stomach pains. Discharged 27.5.93. Has attended for out-patient appointments since then. Home visit report by occupational therapist on 19.5.93. Recommended overnight stay at home from the ward. There is no further reference to this so it might have not occurred. Following discharge, referred to

social services for meals on wheels and home care. Also referred to occupational therapy to monitor and encourage living skills.

Currently involved:-

Consultant psychiatrist, GP, ?occupational therapist

Home care twice a week, meals on wheels, informal care from son and church, warden (housing)

Previously involved:-

W ward, psychiatric social worker (for referral to sheltered housing), occupational therapist (while on ward)

9. Mrs SF

Admitted to ward 39, location C on 16.1.92 under section 3 of the Mental Health Act and treated with ECT. Discharged 20.9.92. Previous compulsory admission in 1990.

Has two daughters who she sees frequently. At the time of discharge she was managing to shop but avoiding public transport. Attendance at the day hospital was arranged but this worried the patient and she phoned the GP. Referred to occupational therapy and clinical psychology. Occupational therapy sessions on a weekly basis since 24.9.92; progress report dated 1.11.92 in the notes. The documented treatment plan was to explore the structure of days and plan purposeful activity through re-establishment of social contacts using a goal setting approach and providing information on community contacts. Attendance at the occupational therapy leisure group was suggested. Further details of progress in occupational therapy treatment stated that the patient was intending to contact Age Concern for social activities (art, chess and woodwork). Cookery sessions at home were planned with the patient inviting family and friends for meals, with the therapist visiting afterwards. A further undated occupational therapy report in the notes discharged Mrs SF. It stated that she had rekindled social contacts and joined a Jewish day centre.

Patient briefly admitted to location C with dizziness in August.

Clinical psychology requested a psychiatric review at home on 9.9.93. Medication changed by locum consultant at out-patient clinic on 20.9.93.

Currently involved:-

Consultant psychiatrist, GP, clinical psychologist

Jewish day centre, home care, informal care from daughters

Previously involved:-

Ward 39

Occupational therapist

Interviews with Occupational Therapists about their Treatment of the Older People Interviewed

Interview With the Senior I Occupational Therapist

1. Mrs EC

Treatment also involved an occupational therapy helper.

Problems perceived to be experienced by the patient

They were mostly down to her mental state and the fact that obviously she's still quite up and down in her moods.

Aims of treatment

Firstly assisting with the use of public transport, particularly getting on and off buses. The results of assessment in the community showed that this was not as problematic as had been suggested by the referral and the patient was able to use taxis if she wished to.

Secondly, helping to develop a leisure role. Mrs EC had lost confidence and contact with people. The occupational therapy staff assisted in getting her back to church.

Treatment was described as being "*quite straightforward really.*"

Frequency of treatment

This was weekly at first, then fortnightly and then once a month. At the time of interview with the occupational therapist, Mrs EC had been discharged. (The occupational therapist was also imminently due to leave the service).

Success of treatment plan

The responsible therapist was not sure that Mrs EC's improved level of function was directly due to the occupational therapy intervention.

Well that she was able to go on a bus by herself and could get out more.

However, the point was made that the patient had achieved her own goals and therefore treatment had been a success for her.

The respondent thought that it was likely that Mrs EC would relapse at some time but felt that nothing more could be achieved by continuing treatment.

Other involved professionals

The day hospital - the occupational therapist said that she liaised with the day hospital sister but that it had been "*one-way.*"

Appropriateness of the referral

I think a good nurse could have done it, yes I think other disciplines could have done it but I think this is seen as our role in this area.

It was also stated that the treatment could have been carried out by a less experienced senior II occupational therapist but that this particular person did require a certain degree of skilled management because;

...she does tend to go off the point, so you have to be quite directive.

Interview With the Senior II Occupational Therapist

1. Mrs DB

As the occupational therapist had been seeing Mrs DB over a long period of time she found it difficult to summarise treatment.

Problems perceived to be experienced by the patient

Mrs DB was referred to occupational therapy after an in-patient admission because of anxiety, depression and panic attacks. She was described as being *extremely anxious.* Identified problems were that she lacked support in the community and anxiety was reducing her ability to cope with daily living. A very specific area of difficulty was that she was unable to go into her bedroom and as a consequence was sleeping on the settee.

Aims of treatment

The aims of treatment were stated to be:

> *...continuing support for anxiety management.*

In addition treatment was focused upon increasing her supportive network.

The treatment plan involved relaxation and education regarding anxiety and coping strategies, involving her husband in treatment and using goal setting techniques to enable her to go into the bedroom.

Frequency of treatment

Occupational therapy treatment commenced in the patient's home after discharge from the ward. Treatment was on a weekly basis.

Success of treatment plan

Criteria for success was for Mrs DB to feel supported and be able to deal with her anxiety to some extent and for her to be able to go into the bedroom.

The respondent said that Mrs DB was now able to go into her bedroom so that aspect of treatment had been a success. The patient was also more involved in the running of the house, gradual improvement occurring over a three month period. A lot of time had been spent practising relaxation which also involved Mrs DB's husband. Various treatment techniques were described embracing both physical and psychological effects of anxiety; some of which were described as being successful and others were not.

> *Her ability to cope with anxiety has improved greatly in that she does not experience full blown panic attacks now.*

As treatment took place over an extended period of time, the occupational therapist was able to adjust the treatment plan according to the patient's needs. Therefore, when progress with the initial plan ceased, it was decided to look at the emotional problems associated with panic attacks through a fixed number of counselling sessions.

The occupational therapist saw herself as being very important to the patient and viewed overall treatment as being successful.

> *Obviously any treatment plan can be more ideal but I think this was a reasonable one.*

Other involved professionals

Some anxiety management had been carried out by ward staff with the patient and her husband prior to discharge. After discharge the occupational therapist said that she was the only involved professional.

Appropriateness of referral

It was felt that this referral could have been made to any member of the multi disciplinary team.

> *...dealing with anxiety is quite a blurred area.*

She happened to be the one to pick it up and saw her involvement as being appropriate.

> *It could have been another discipline that took it on, perhaps a CPN. Having said that it isn't inappropriate for an OT to take on counselling, anxiety management, relaxation. I was happy to do it.*

However, the importance of involvement from someone with experience in anxiety management and counselling was emphasised.

2. Mrs LF

Problems perceived to be experienced by the patient

Mrs LF was referred to occupational therapy due to chronic anxiety with panic attacks and hypochondriasis. The patient was anxious and this affected her ability to engage in activities.

Aims of treatment

> *..firstly to increase independence and secondly to assist in the development of coping strategies to deal with anxiety. The first is specifically OT. The second could have been any discipline.*

Treatment subsequently concentrated upon increasing ability to cope with anxiety and engage in activities. The occupational therapy helper was involved in assisting Mrs LF in taking up activities. This embraced a grade programme of going out.

Success of treatment plan

The programme of going out was not successful as Mrs LF's anxiety prevented her from being able to do this.

> *She became preoccupied with physical symptoms and her level of activity went down.*

This lack of success was followed by new symptoms including dizziness and a feeling of not being able to swallow food due to pains in her throat. The treatment plan was adjusted accordingly so that they looked at the anxiety associated with these symptoms.

> *She took that on board to a degree but I think that she is always going to have that preoccupation and never quite fully grasp that anxiety can cause that kind of symptom.*

Mrs LF's partner was not involved in treatment. The occupational therapist tried to involve him in the anxiety management but he was reportedly unable to cope.

Other involved professionals

> *She's had lots of people involved...the ward, day hospital, day centre, numerous people from social services.*

Occupational therapy was not seen as being particularly important to this patient.

> *I just formed a small part of the jigsaw...so I was just one of the many and my importance in overall treatment was quite small.*

Appropriateness of referral

The occupational therapist was not convinced of the relevance of her continued involvement.

> *I think she'll need long term low key involvement. I question whether that is appropriate from an OT.*

Professionals viewed as being more suitable for this kind of involvement were social workers or community psychiatric nurses.

Another rationale for disengagement was that the respondent was no longer working in the same locality.

> *I'm really weaning her off.*

3. Mrs MR

Problems perceived to be experienced by the patient

> *She's 'query' depressive illness, previous alcohol and medication abuse - not a very clear diagnosis really.*

The occupational therapist went on to describe problems Mrs MR was having socialising in the hostel where she lived and occupying her time generally.

> *When I first saw her problem areas were lack of structure to her days and being isolated in the community.*

One of the factors which contributed to Mrs MR's current difficulties was the frequency with which she changed accommodation to try and escape from her problems.

As the occupational therapist was acting as the key worker for Mrs MR she had to arrange admission twice when her condition deteriorated.

> *She was very anxious, and I felt that she was a risk to herself in that I felt she was suicidal...*

Whilst on the ward she developed foot drop due to alcohol abuse.

Frequency of treatment

Mrs MR was referred to the leisure group run by occupational therapy staff and she attended three times. She also attended a pottery group in the occupational therapy department twice. She then stopped attending as she started drinking and moved accommodation. A considerable amount of time was spent trying to track down Mrs MR, monitoring her mental state and arranging admission to the ward. During her admission occupational therapy treatment was put on hold but contact was maintained.

Aims of treatment

Occupational therapy focused upon trying to help Mrs MR get some structure into her days.

> *The things I've looked at have been to look at using alcohol as a coping strategy and to look at developing other coping strategies, to re-engage her in normal daily living activities and to encourage her to take responsibility for her own actions.*

However the course of treatment was not simple.

> *But whatever treatment plan we've had has been quite quickly changed. She's up and down very quickly.*

Success of treatment plan

> *It has been quite a woolly treatment programme because I've been spending most of my time chasing her. She had a home assessment while she was on the ward as well.*

The occupational therapist viewed her role as being *supportive and crisis intervention,* success of treatment being limited by the patient's lack of insight and reluctance to take responsibility for her actions. Mrs MR's husband was not involved in her occupational therapy treatment. (Mrs MR did not live with her husband for the majority of the time).

Other involved professionals

Liaison occurred with the key workers at Mrs MR's hostel accommodation and with the ward, consultant and the team.

> *Since she moved last time we've had quite a lot of regular care planning meetings to review her care plan.*

Appropriateness of referral

Once again there was reference to the difficulties of maintaining patients from a different catchment area having changed working location.

> *Again, I'm not part of the team for M but I am the key worker for this person, so this causes problems. It's because I've changed teams.*

The role of the occupational therapist was viewed as being of great importance but only due to the fact that she was the key worker for this patient.

> *I think it's still a valid role. I think it's one any team member could have taken on, but it just happened to be me.*

Treatment was still ongoing at the time of interview.

4. Mrs KA

Problems perceived to be experienced by the patient

> *Initial problems identified were firstly withdrawal from activity at home, secondly that she was agoraphobic and didn't go out of her flat alone and thirdly that she lacked a social and supportive network in the community.*

Frequency of treatment

Referral was made while Mrs KA was still an in-patient and the respondent originally saw her on the ward.

Treatment was carried out on a weekly basis on average by either the occupational therapist or the occupational therapy helper. For a three month period Mrs KA was only visited by the helper who was closely supervised by the qualified member of staff.

Aims of treatment

Aims of treatment were to build up activity levels at home and help her to be able to go out of her flat alone.

> *We ended up doing a graded programme of going out using public transport, walking out alone...*

After a crisis at home new problems of lack of self esteem emerged. It was recognised that Mrs KA had problems which required more intensive treatment than had been originally apparent.

Success of treatment plan

It was not possible to involve Mrs KA in any activity at home due to her low mood and preoccupation with physical problems.

> *She seemed to need to talk more really.*

The occupational therapy helper was subsequently involved in helping Mrs KA to get up and dressed with the aim of going into the community. Mrs KA made good progress with the graded programme of going out supported by the helper.

> *She did excellently, became relatively independent.*

Attendance at a day centre was also commenced, organised by the psychologist.

Unfortunately, Mrs KA then became depressed again and she stopped going out.

The occupational therapist carried out an emergency home visit following a crisis telephone call from Mrs KA and she was visited by the consultant psychiatrist and GP.

AD thought that she should have remained more involved at the time as the psychologist treating Mrs KA had just left the service but due to staff shortages this was not possible.

Other involved professionals

The occupational therapist referred Mrs KA to community workers to look at developing a supportive network in the community.

Psychology was involved to look at "*adjustment reaction to her physical problems.*" The CPN withdrew from the treatment process. The respondent talked about liaising closely with the psychologist. Mrs KA also attended the day hospital, where her difficulties were minimised by the nursing staff.

> *She presented well at the day hospital so she only had a short attendance there.*

During the time she attended day hospital, occupational therapy and psychology reduced their input which was increased after discharge.

No contact was made with Mrs KA's son who lived with her. The interviewee said that she had left her card and asked Mrs KA about her son.

> *...I get the impression that it's convenient for him to live there, but he's not terribly involved.*

Appropriateness of referral

The numbers of staff involved with Mrs KA was large.

> *At the time it seemed a bit of a mistake really because she already had quite a lot of community involvement from other staff, but by the time this was sorted out I was already involved and did seem appropriate.*

However, after consideration it was felt that some of the areas of need were quite specific to occupational therapy.

AD thought that figures that Mrs KA could identify with were more important than professions. Having said that she saw the occupational therapy role as being important alongside the ability to be able to cope with other problems she presented. Correct supervision of the occupational therapy helper was also seen to be important.

Interview with the Head IV Occupational Therapist

1. Mrs HW

As well as having individual occupational therapy treatment Mrs HW was also attending the day hospital where she had contact with the occupational therapy helper.

Problems perceived to be experienced by the patient

> *This was a lady with longstanding physical problems but her only way of understanding and expressing her emotional self was through emotional problems, and so what the problem was not what she could manage but what she believed she could manage...*

An example of this was given in that Mrs HW believed that she had a limited social network whereas it transpired that she had quite a lot of social contact. She also said that she could not cope with any physical exertion but was able to go to town using public transport every week.

> *So her motivation and her functioning weren't corresponding with what she said she could and couldn't do.*

Frequency of treatment

The occupational therapist visited Mrs HW at home three times, on the third occasion accompanied by the occupational therapy helper. By the time of interview, Mrs HW had been discharged.

Aims of treatment

Referral was to look at ways of increasing activity at home and structure her day taking physical limitations caused by obstructive airways disease and arthritis into account. Mrs HW was not able to identify how occupational therapy might help her. It was suggested that they try and find alternative hobbies as she was not able to crochet any more because of her arthritis. This is where the occupational therapy helper became involved.

That was really where our treatment ended because H didn't want anything more from us.

Success of treatment plan

Assessing this patient was said to be very difficult. There were problems in getting accurate information, the patient preferring to discuss her physical illnesses. When asked about criteria for success the respondent just laughed and said "*pass.*"

Other involved professionals

The day hospital were also involved but at the time of our discussion Mrs HW had also been discharged from there to a day centre and no one else was still involved apart from home care.

Appropriateness of referral

The referral was perceived as being appropriate.

..I don't think that anybody else would have looked at it from the same angle as us, and it was practically based and it was activity based....I don't think we could have done anything else.

2. Mrs BP

Problems perceived to be experienced by the patient

The referral stated that she was depressed and anxious due to loneliness and isolation at home. She described herself to the occupational therapist as being *a very private person.* Recently a close friend had moved out of the area and she had subsequently lost confidence.

Frequency of treatment

The majority of occupational therapy contact was while Mrs BP was an in-patient. One home visit was carried out by the occupational therapist upon discharge.

Aims of treatment

An assessment was used employing a form devised by another occupational therapist in the service.

Aims of treatment (read from treatment plan) were:-

Use of easily achievable activities to improve and consolidate previous skills....explore the need for relaxation skills, anxiety management....promote constructive use of leisure time at home and reintroduce to previous social activities....to establish present level of functional ability.

A range of activities were described to meet this plan including gardening and cooking, discussion of use of leisure time. A domestic assessment was also carried out in the hospital followed by a home visit.

Success of treatment plan

It was put to the occupational therapist that the patient had thought that she was trying to persuade her to return to hospital. This was denied but the information was said to be unsurprising.

I think she thought it was a test situation and she had to say she was alright otherwise she'd end up in hospital.

The home visit was carried out with the home care team leader who did not feel that Mrs BP was well enough to be at home. There was a conflict of opinion between the community staff and the

ward staff regarding whether she should stay at home and the occupational therapist had to report this to the ward.

> *But all I could do was pass on the information to the ward because she was discharged on leave.*

Mrs BP was subsequently discharged from occupational therapy.

> *And she didn't want any input from me so there wasn't really anything I could do about that.*

Other involved professionals

Part of the occupational therapy treatment plan was to liaise with nursing and physiotherapy staff. The views of the nursing staff and occupational therapy staff regarding this patient were quite different in that the nursing staff felt she was improvising whereas the occupational therapist viewed her as being anxious and depressed.

Home care were involved after discharge. Although community physiotherapy was thought to be appropriate by the hospital physiotherapist, the occupational therapist did not know whether Mrs BP was referred as the nursing staff were not in agreement.

Appropriateness of referral

The assessment process was seen as being important with this patient, but this was not followed by occupational therapy treatment as she did not wish it.

> *...she knows she was being assessed and she knows that she had to perform to be able to go home again. But it was important that it was done.*

Several examples were provided to illustrate how Mrs BP could have benefitted from occupational therapy. The referral was viewed as being appropriate.

3. Mrs DW

Both the senior II and head IV occupational therapists had been involved in the treatment of Mrs DW. The senior member of staff had run a baking group in the day hospital that she had attended. The head IV member of staff was the occupational therapist most involved.

Problems perceived to be experienced by the patient

Whilst an in-patient, Mrs DW wanted to have some activity but she was also seen to be withdrawing from social contact and self care.

Frequency of treatment

The occupational therapist was first aware of Mrs DW while she was an in-patient but at that time she was too distressed to participate in activities. It was stated that the occupational therapy helper visited her a few times while she was on the ward to try and interest her in activities but this was not successful. The occupational therapist visited her twice after was discharged home.

Aims of treatment

Mrs DW was referred to "*explore leisure activities at home.*"

An initial assessment was carried out to look at daily living routine, supportive network and interests. However, the subsequent visits home seemed to have a different focus.

Visits were carried out because there was a lot of concern regarding whether Mrs DW would look after herself adequately. A second visit was undertaken after the patient had an operation to take all her teeth out. On both occasions Mrs DW was reported to be functioning well.

Success of treatment plan

Really I haven't had any involvement apart from monitoring.

Other involved professionals

The community psychiatric nurse was involved, in addition to staff at the day hospital.

Appropriateness of referral

Referral was seen as being appropriate initially and did demand the skills of an occupational therapist, although it was thought that a more junior therapist could have treated this patient.

I mean you can never predict how somebody's going to behave - so my intervention wasn't actually necessary but it was an appropriate referral.

4. Mrs SF

We spoke with the occupational therapist about this lady before we interviewed Mrs SF. This may account for the discrepancy between how Mrs SF presented in interview and how she was described by the occupational therapist.

Problems perceived to be experienced by the patient

Mrs SF has a history of manic depressive psychosis, and was admitted to hospital with severe depression. She was also affected by the death of her husband two years previously.

The respondent recognised that Mrs SF needed confidence as one of the features of her depression was that she thought she looked strange and everyone was staring at her.

Frequency of treatment

Mrs SF was admitted in January and the first occupational therapy contact was in September.

It is difficult to ascertain the frequency of treatment, but it is clear that Mrs SF was seen on a regular basis over a period of time. The psychologist kept the occupational therapist informed of Mrs SF's progress.

I haven't seen her for ages actually.

Aims of treatment

Mrs SF was referred to occupational therapy whilst an in-patient with regard to discharge planning.

...I saw her on the ward and interviewed her and she was actually quite keen to have my input. She was very worried about going home.

The initial treatment plan was to visit her at home after discharge to plan cookery sessions to build confidence, to explore the structure of her week and help her to plan purposeful activities. She also talked involving Mrs SF's daughters in the treatment plan in that they would shop for the food for Mrs SF to cook herself.

Efforts were also made to resocialise Mrs SF.

> *The other thing we did.. was setting goals like every week making some social contact with somebody...and then build up to going back to her leisure groups.*

Mrs SF was quite involved in her treatment plan and was able to ask for help for example she asked for help to find hobby activities in the house.

> *From this we worked out a programme of using the bus - going to town because she hadn't been for ages and she wanted to.*

The last planned intervention was for her to get the bus alone and be met in town by the occupational therapist but *she wasn't very keen on this.* She was waiting for Mrs SF to call her with a date, but the trip did not take place.

Success of treatment plan

Treatment was successful up to the point where Mrs SF was asked to travel to town independently.

> *Anyway eventually she did phone me up and I said I'd arrange to go and see her but when I did a friend had just died....*

It was felt that this had been the onset of another depressive episode. She then talked about handing her treatment over to the senior occupational therapist, who it was thought could carry out some relaxation training with her.

> *I do believe that if she can be supported through this bad patch she's going through at the moment she can get back to being independent again.*

Other involved professionals

The psychologist was involved in a joint treatment plan with occupational therapy which looked at building up Mrs SF's confidence at home.

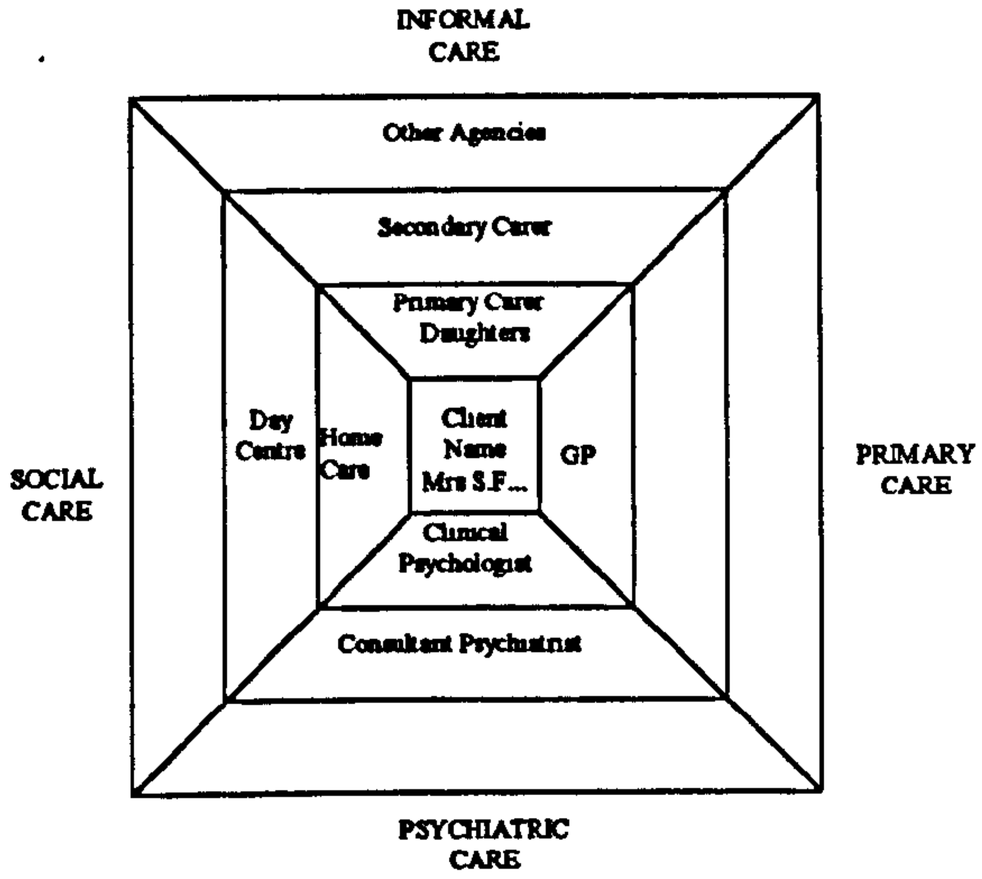
> *Well, I was looking at it from a practical point of view and the psychologist was looking at it more dealing with S's emotions.*

Appropriateness of referral

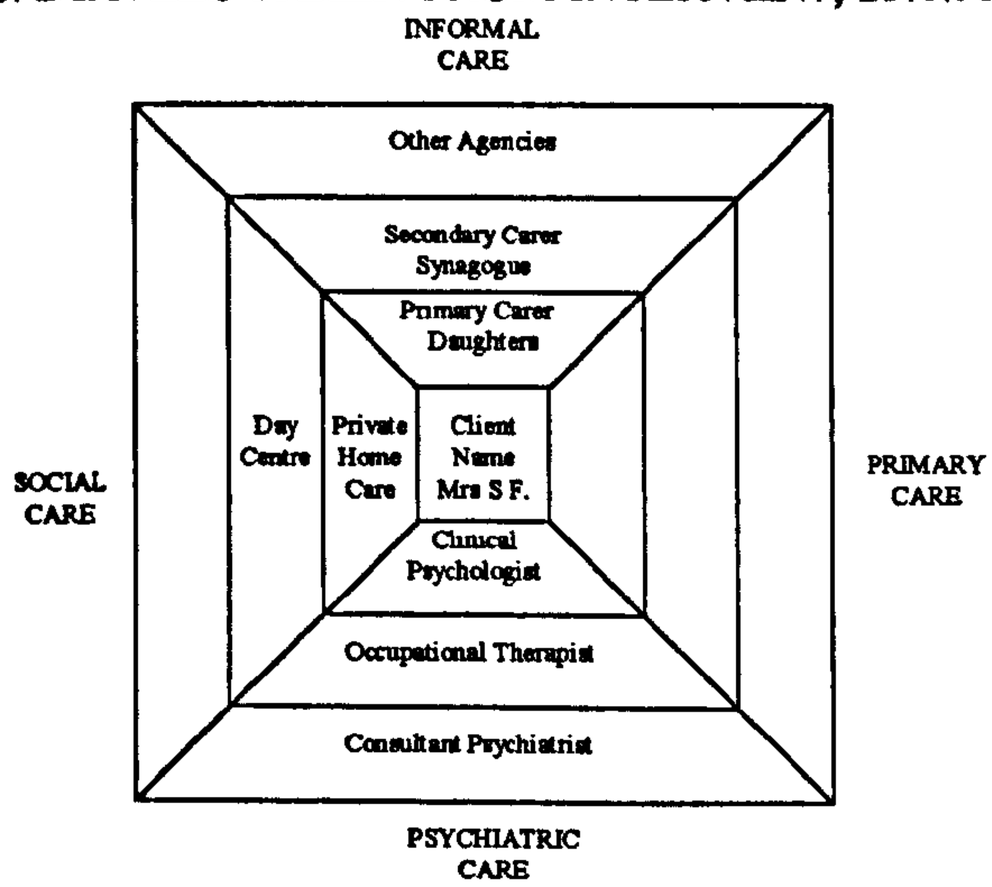
It was thought that occupational therapy had been very important for Mrs SF, particularly a practical approach as she finds it difficult to show her emotions.

Figures 6.4a-c
Patient Mrs S.F.

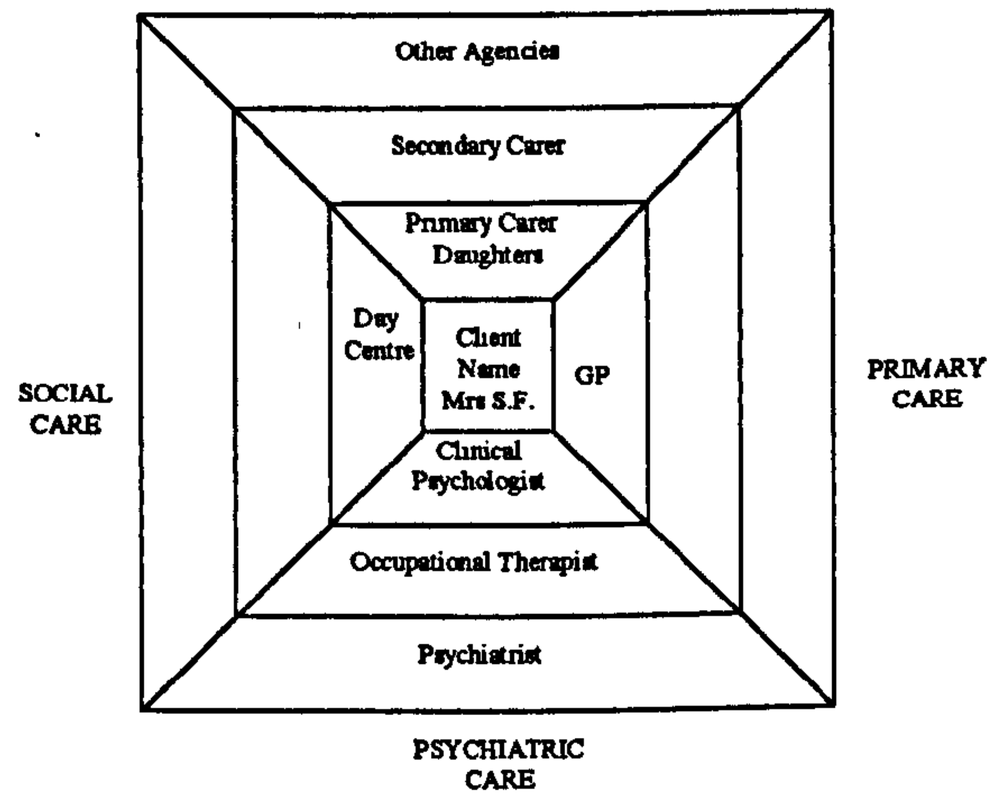
a. DETAILS OF CARE TAKEN FROM CASE NOTES, 1.10.93



b. DETAILS TAKEN FROM INTERVIEW, 23.8.93

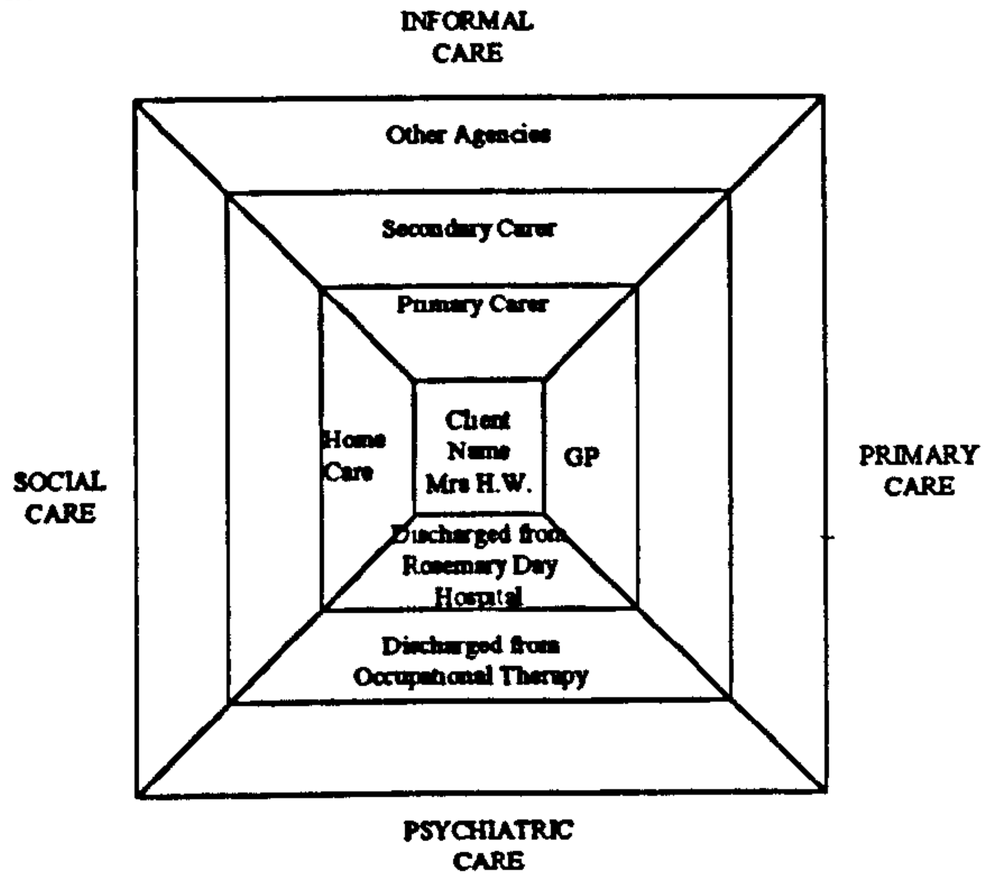


c. DETAILS OF CARE TAKEN FROM INTERVIEW WITH OCCUPATIONAL THERAPIST, 13.8.93

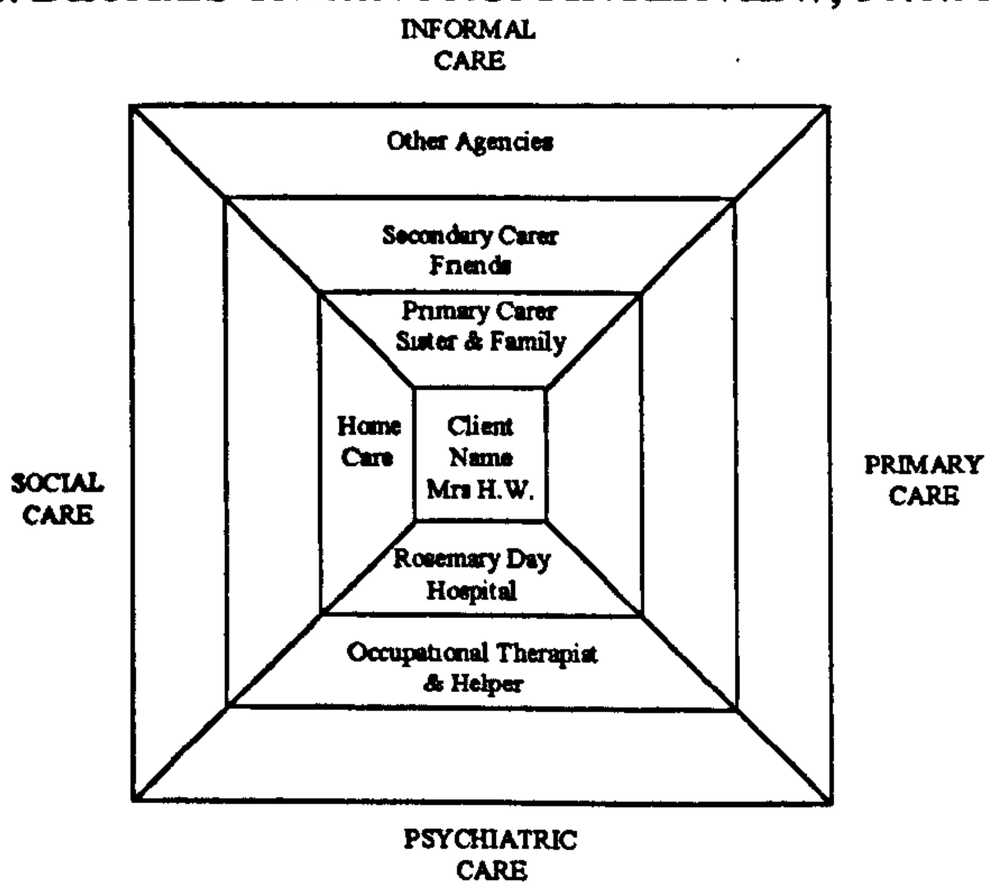


Figures 6.5a-c
Patient Mrs H.W.

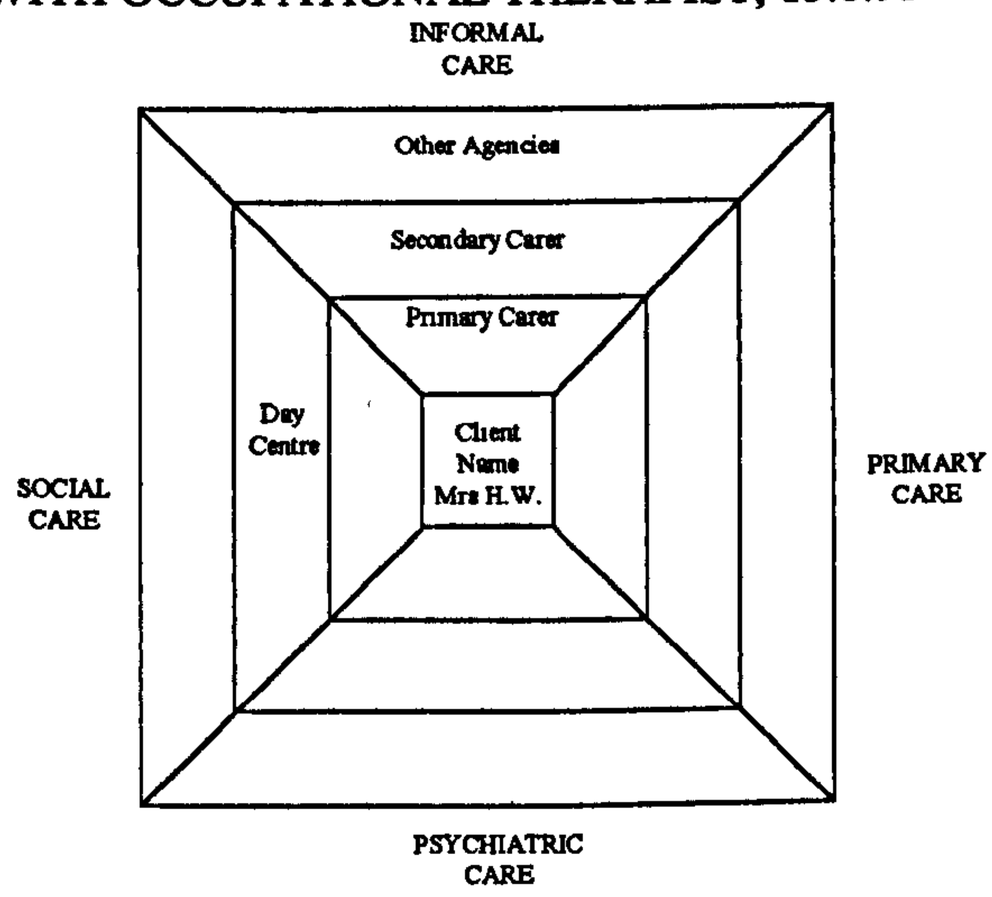
a. DETAILS OF CARE TAKEN FROM CASE NOTES, 1.10.93



b. DETAILS TAKEN FROM INTERVIEW, 30.6.93

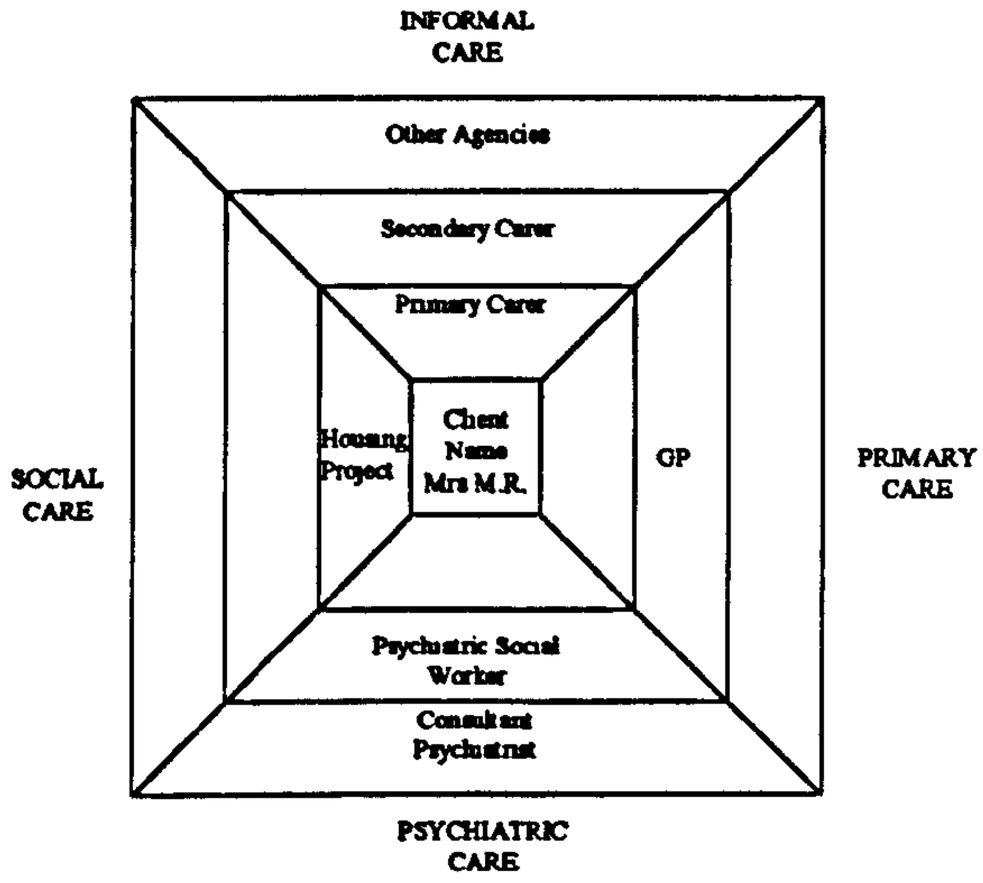


c. DETAILS OF CARE TAKEN FROM INTERVIEW WITH OCCUPATIONAL THERAPIST, 13.8.93

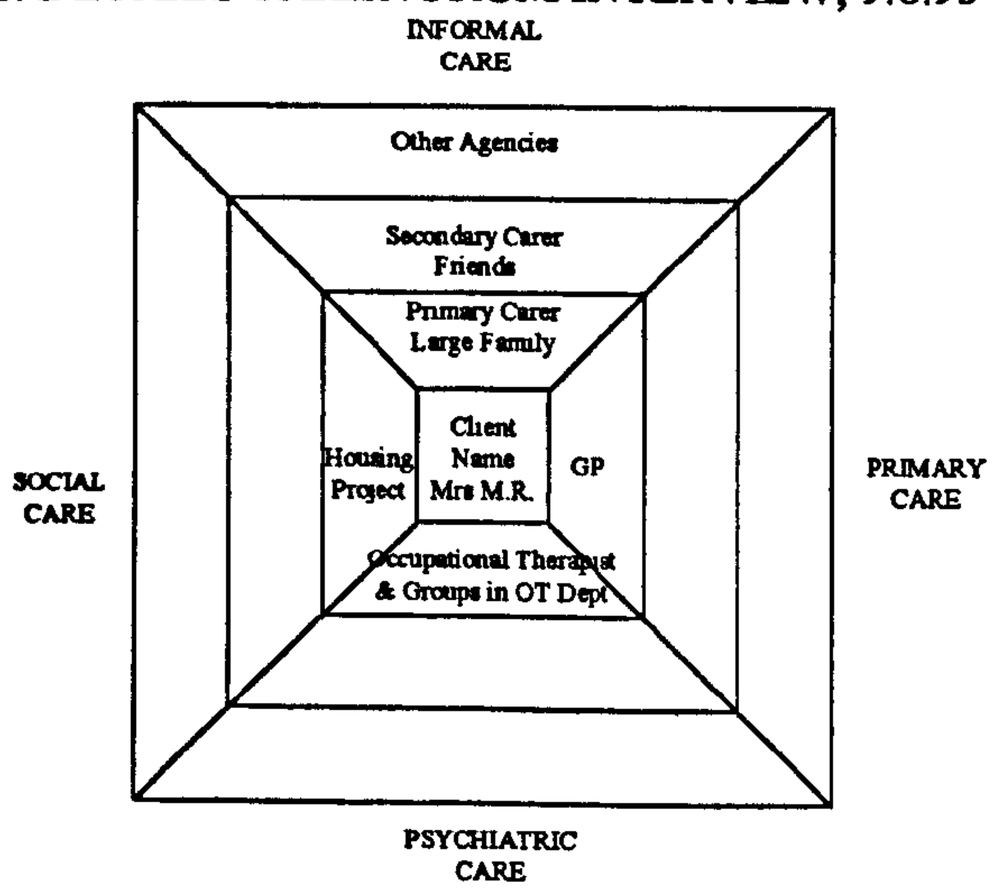


Figures 6.6a-c
Patient Mrs M.R.

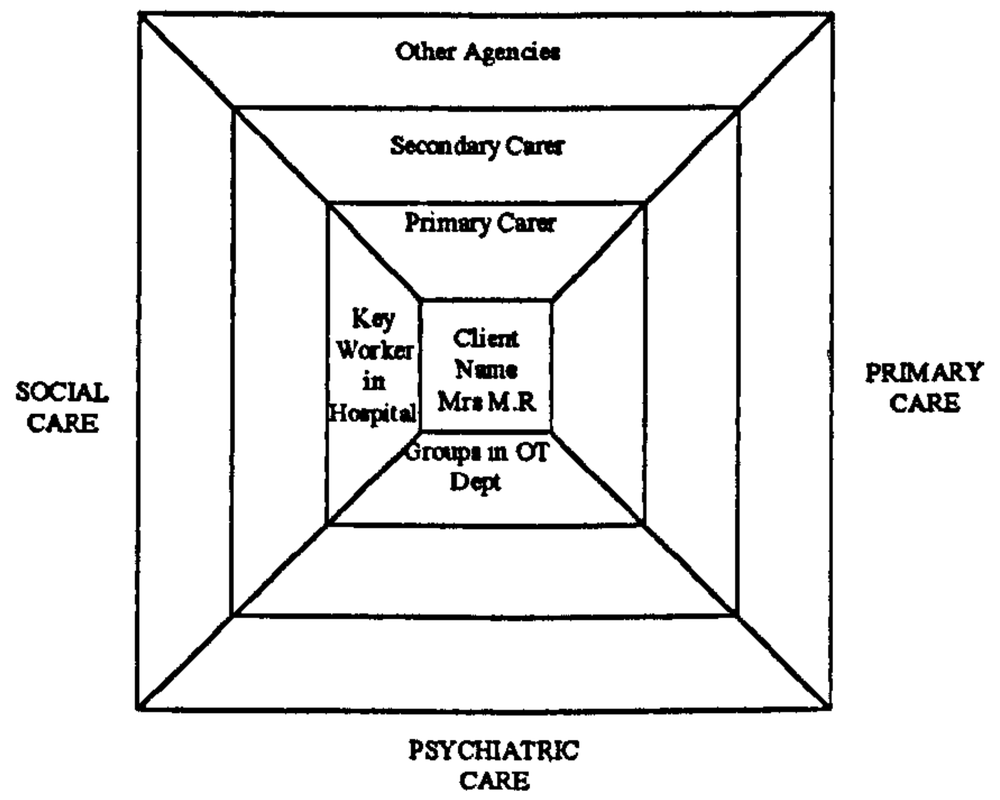
a. DETAILS OF CARE TAKEN FROM CASE NOTES, 20.8.93



b. DETAILS TAKEN FROM INTERVIEW, 9.8.93

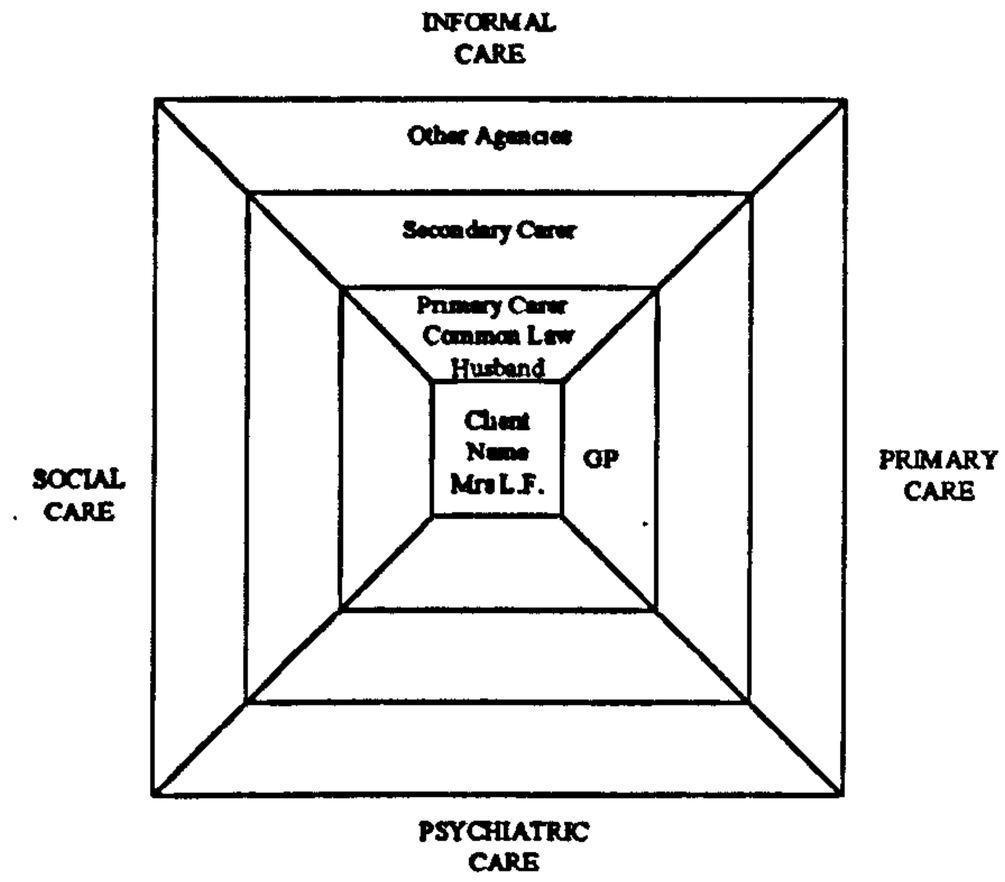


c. DETAILS OF CARE TAKEN FROM INTERVIEW WITH OCCUPATIONAL THERAPIST, 29.9.93

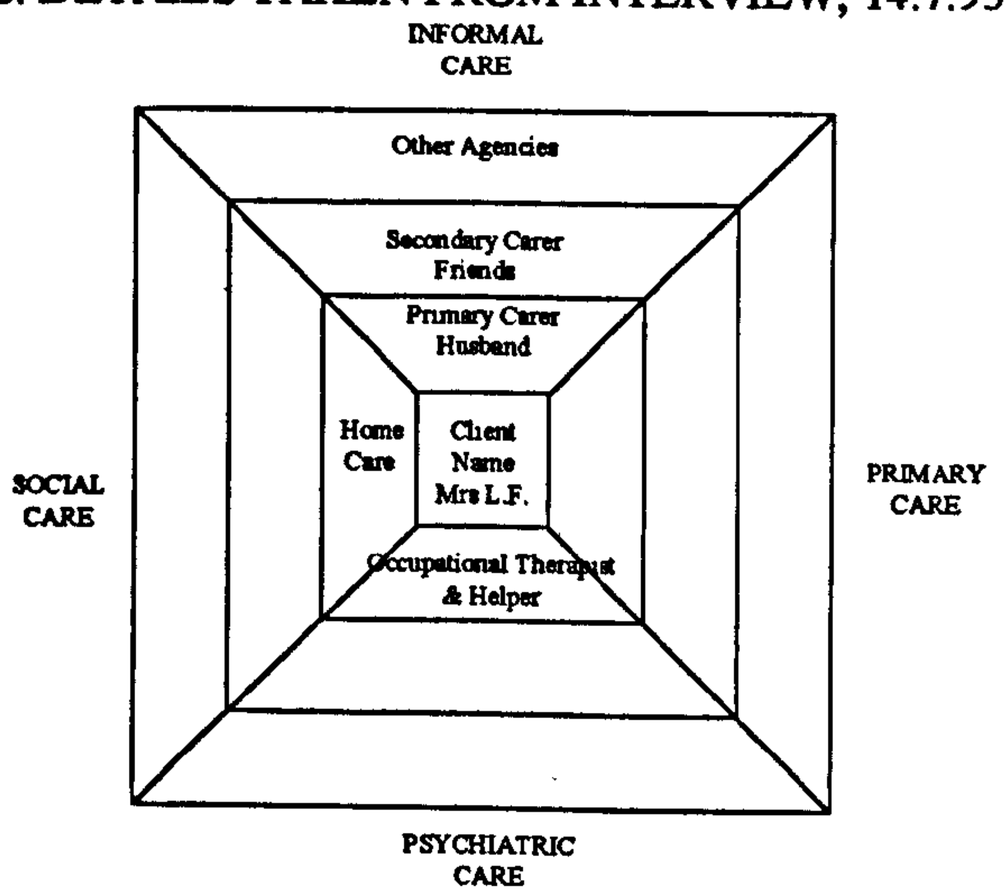


Figures 6.7a-c
Patient Mrs L.F.

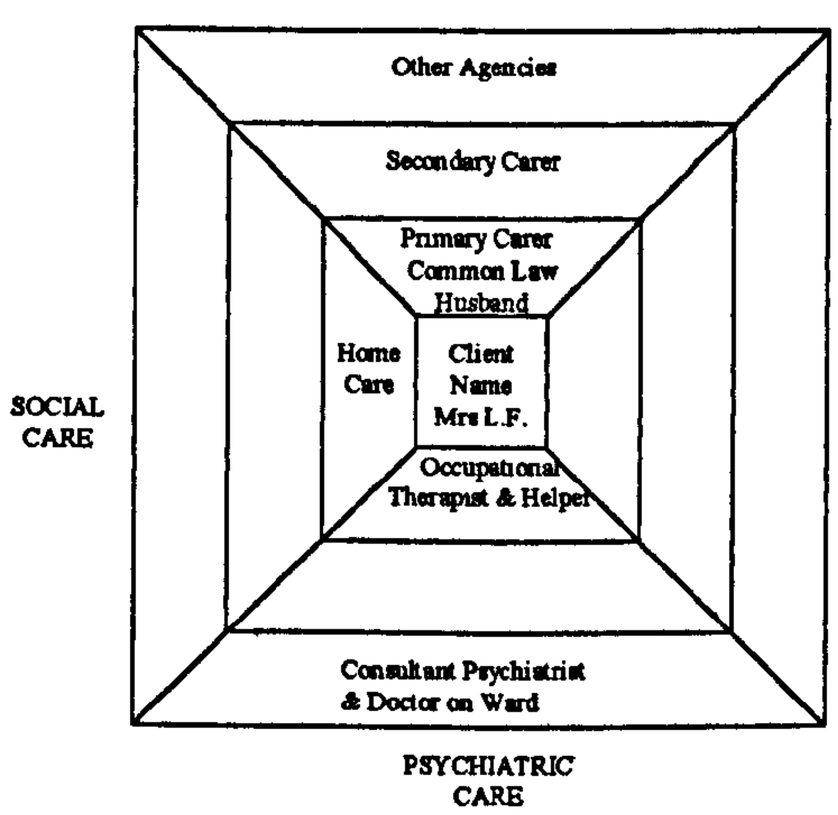
a. DETAILS OF CARE TAKEN FROM CASE NOTES, 20.8.93



b. DETAILS TAKEN FROM INTERVIEW, 14.7.93

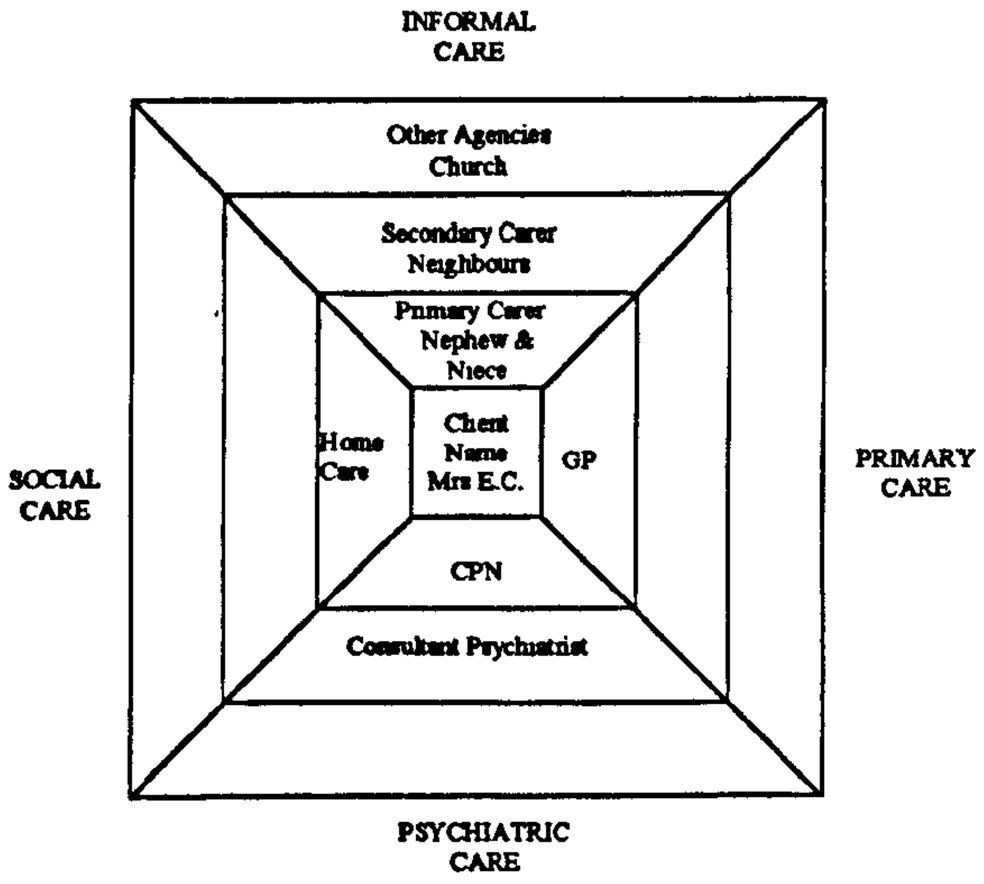


c. DETAILS OF CARE TAKEN FROM INTERVIEW WITH OCCUPATIONAL THERAPIST, 29.9.93

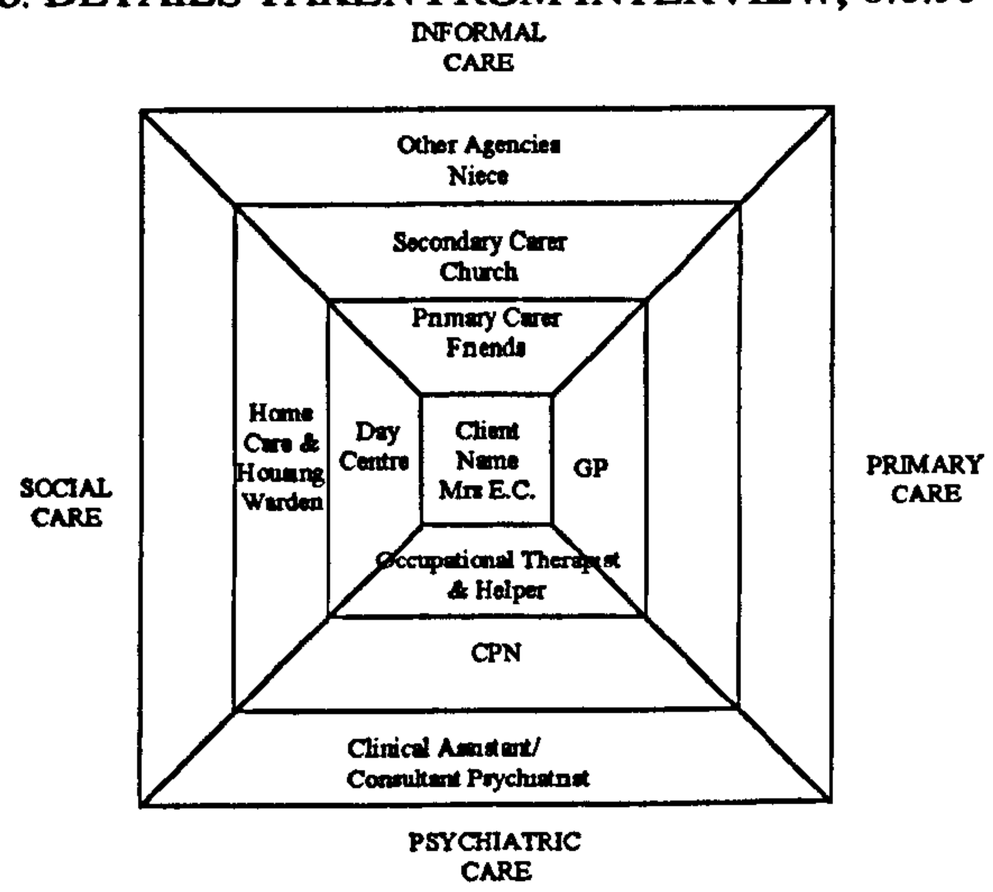


Figures 6.8a-c
Patient Mrs E.C.

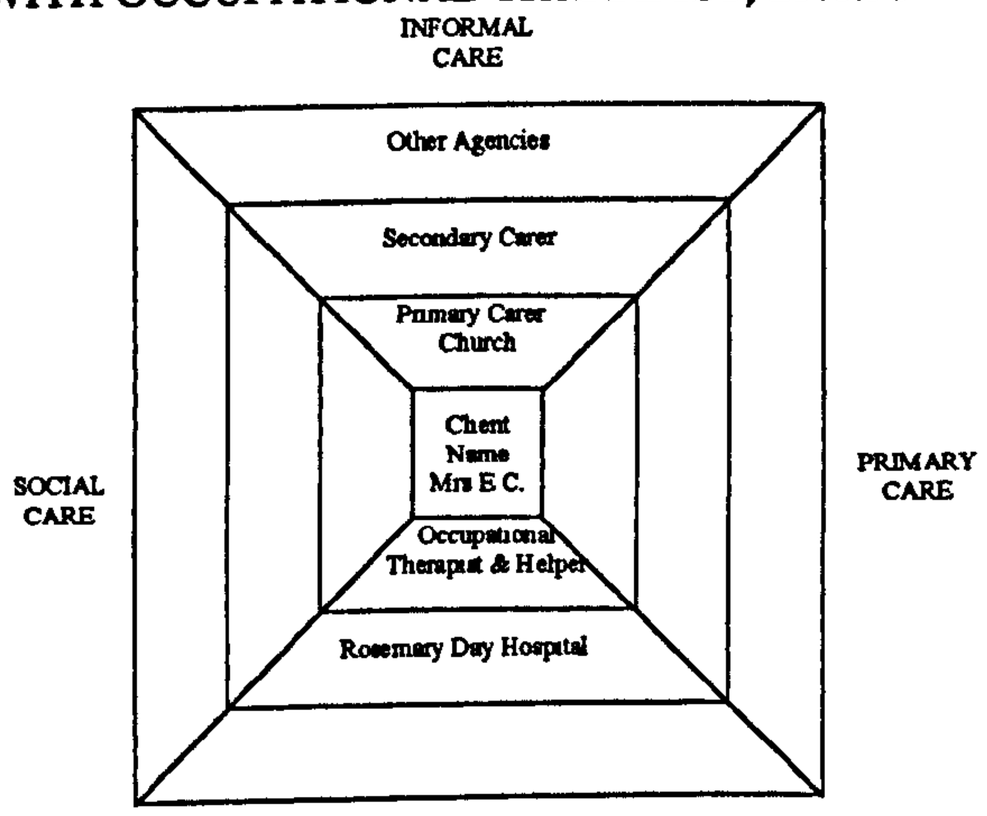
a. DETAILS OF CARE TAKEN FROM CASE NOTES, 1.10.93



b. DETAILS TAKEN FROM INTERVIEW, 6.8.93

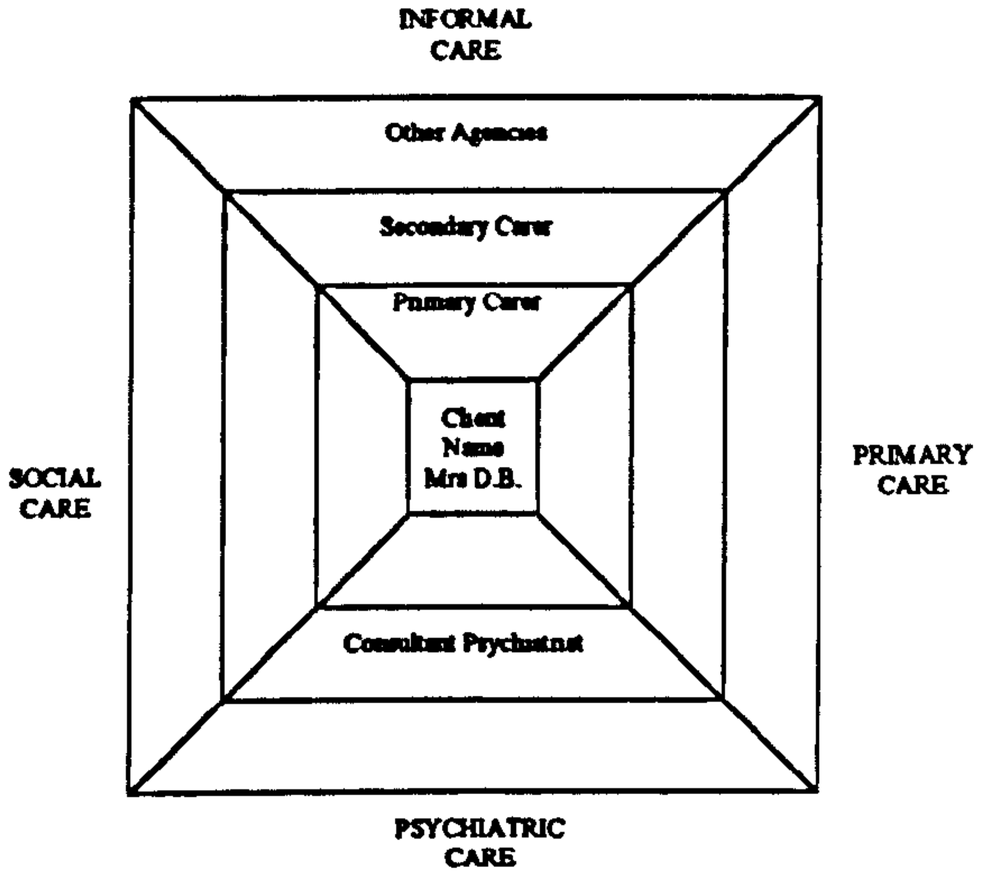


c. DETAILS OF CARE TAKEN FROM INTERVIEW WITH OCCUPATIONAL THERAPIST, 23.8.93

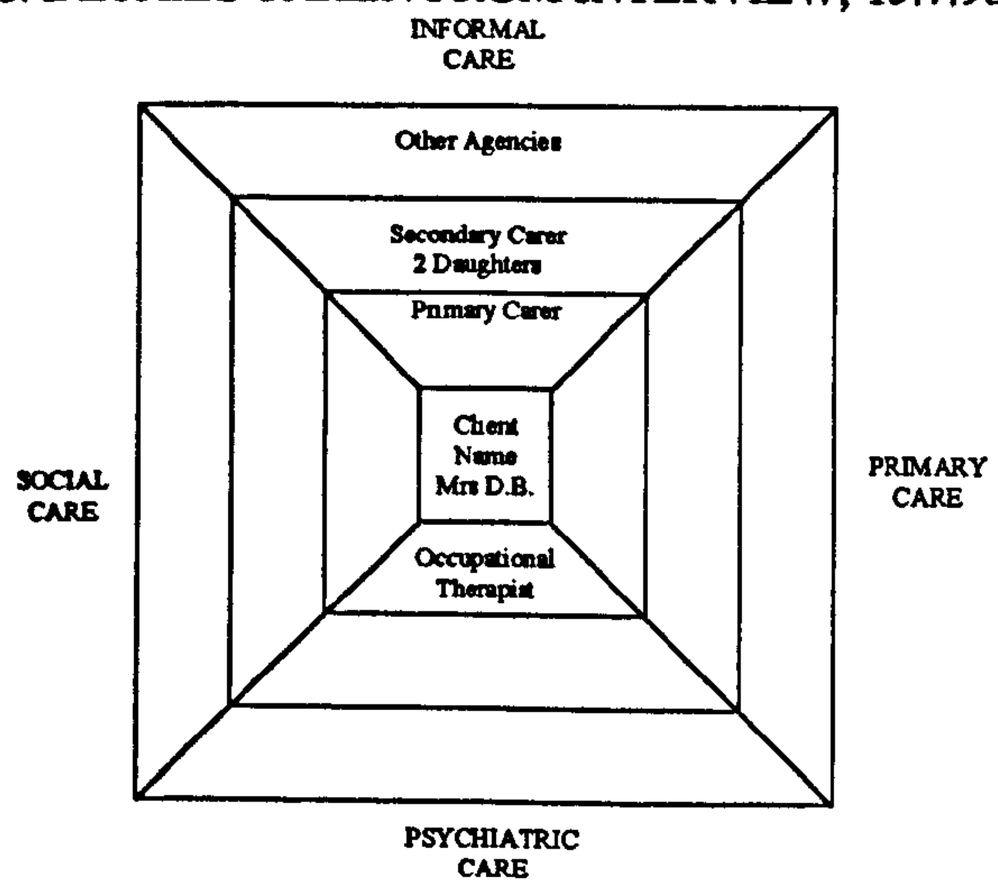


Figures 6.9a-c
Patient Mrs D.B.

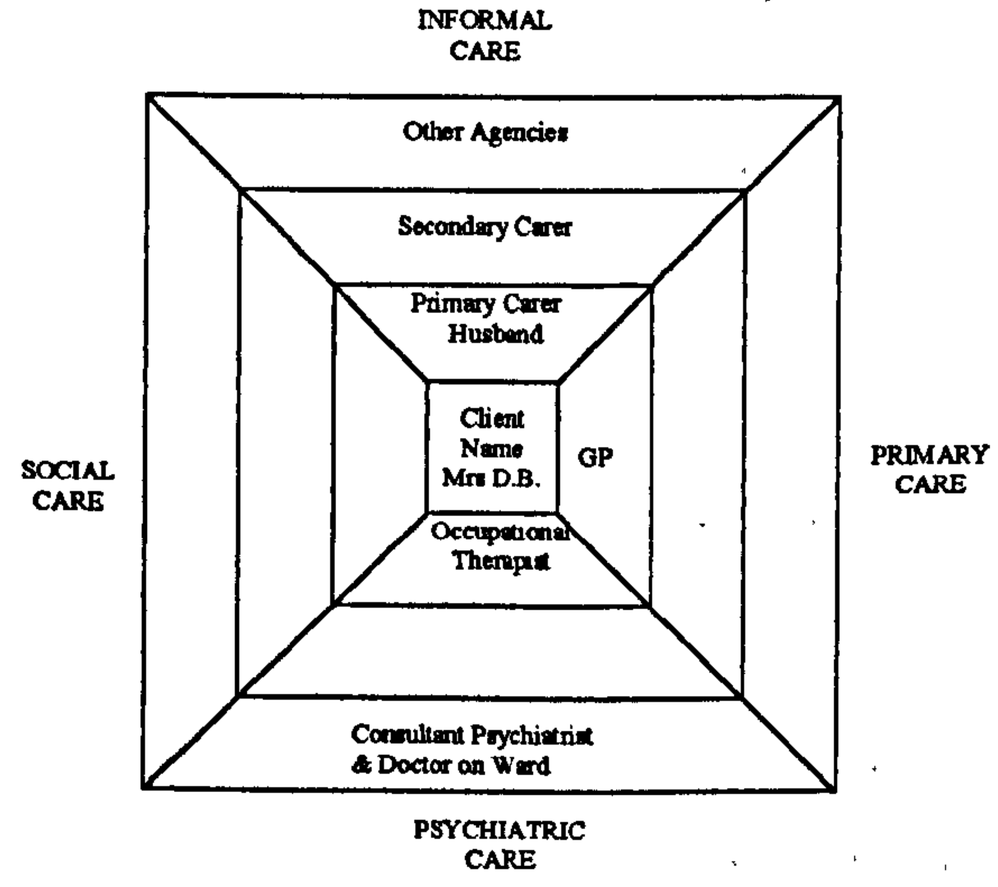
a. DETAILS OF CARE TAKEN FROM CASE NOTES, 1.10.93



b. DETAILS TAKEN FROM INTERVIEW, 15.7.93



c. DETAILS OF CARE TAKEN FROM INTERVIEW WITH OCCUPATIONAL THERAPIST, 29.9.93



APPENDIX THIRTEEN

Interviews held with Representatives from other Professions working with Older People with Mental Health Problems

Views of Occupational Therapy from Home Care Managers

There was one home care manager for each of the five social services offices situated in the areas in where the older people interviewed were living. At the time it was only possible to make contact with four of the five, who were all quite willing to be interviewed by telephone.

The information obtained from all four interviews was collated under a number of pertinent headings.

Remit of home care managers

The home care managers were responsible for the activity of a number of home care team leaders and home care staff. One of the people we spoke with commented that the variation in management arrangements allowed them to follow their own interests. Another person viewed their role in a very different way, stating that as home care does not operate within specific criteria it has had to take over from other groups of staff whose role had changed.

Contact with occupational therapists

The greatest amount of contact with occupational therapists was with community staff employed by social services, particularly as two of the people we spoke to were located in the same building as the therapists. When referring to 'community occupational therapists' the respondents were talking about staff employed by social services.

Familiarity with occupational therapy staff working for the health service was generally poor. One of those interviewed was able to spontaneously name occupational therapists working in mental health of the elderly and physical disability. A second could not recall any hospital based staff until prompted. However, she did eventually remember two of the staff participating in the case study. Another person could not recall any occupational therapy staff but was able to name one of the community psychiatric nurses based at location E. It was therefore inevitable that interviews were concerned with the totality of occupational therapy services they came into contact with rather than those specifically concerned with hospital based mental health services for older people.

Apart from daily contact due to shared accommodation, most of the contact with occupational therapists was by telephone. Telephone conversations were generally concerned with sharing information about clients common to both or to discuss hospital discharges.

It was usually the home care managers who worked with the occupational therapists rather than the team leaders. One person commented home care has had to take over cases for washing criteria now applied by nursing. This has resulted in them needing more assistance from occupational therapists.

Referrals from occupational therapists

Two of the four people we spoke to talked about receiving referrals from occupational therapists. One person said that the most common method of referral from hospital occupational therapist was an invitation to a home visit. Written referrals by occupational therapists to home care were infrequent. Another individual referred to requirements resulting from implementation of community care policy in that there was a need for a written referral including a core assessment.

Referrals by home care to occupational therapy

One of the home care managers frequently referred to occupational therapists for advice on lifting and handling of dependent clients, asking them to show other home care staff how to use the correct techniques. Another person referred to community occupational therapists for aids and adaptations following home visits as this was a quicker method of getting necessary work done than waiting for a referral to be passed from hospital occupational therapists to those in the community. A third commented that it would be rare for her to refer to occupational therapists and the advent of GP fundholding has stopped her from making any direct requests for health services as everything had to be channelled through the GPs.

Joint assessments and home visits

The terms 'home assessment' and 'home visit' appeared to have interchangeable connotations. Home care managers carry out initial assessments of need, and the team leaders undertook ongoing monitoring and dealt with straight forward problems.

All four respondents discussed home assessments/visits with occupational therapists and there was general agreement that this was very useful; enabling care to be planned jointly and be appropriate to client needs. Examples were given to illustrate these points. One home care manager said that she carried out more home visits with district nurses than with occupational therapists. The short notice of home visits given sometimes by occupational therapists was mentioned as being problematic by one interviewee.

General amount of information about clients expected/ received

There was a dichotomy of opinion across the four interviewees regarding the acceptability of the volume and quality of information they received. Two home care managers were satisfied; one commenting that she appreciated the problems of passing on confidential information across different agencies and that people being discharged from hospital were usually known to her anyway. The other two were far more questioning of the system. The effects upon practice of implementation of community care policy was referred to; and the expectation that occupational therapists should provide them with a core assessment of a client's abilities. They both thought that they should be given more information.

Information about mental health problems of clients

Information about mental health problems of clients was not generally available to the home care managers. One person said that she could deduce who had mental health problems from the source of referral. Once again there was a range of experience across the interviewees; one person said that she was going to attend a community meeting at the day hospital at location E that week whereas another said that she rarely had referrals for people with mental health problems and was doubtful about her involvement in this area.

Cooperation with other professionals

Contact with other professionals was through both formal and informal routes.

Referrals frequently come direct to home care from the wards as part of the discharge process. This referral route was said to be unsatisfactory at times due to lack of information. There was some confusion regarding who was responsible for informing home care when a patient was discharged. Examples of bad practice were cited by two people; one example being that of relatives having to contact home care themselves after discharge and the other being that of people sent home despite assessment demonstrating that they would have difficulty in coping.

Main sources of information were social workers and occupational therapists. Community psychiatric nurses were mentioned in two cases. Two of the respondents talked about attending case conferences, one in mental health services and the other in elderly medicine, and a third mentioned attending ward rounds. One person complained about a lack of case conferences resulting in discharge decisions being taken purely on the occupational therapy report.

Views of Occupational Therapy from the Multi Disciplinary Team

1. Clinical assistant

A face to face taped interview was conducted, which was then transcribed and summarised. The focus of the interview was that of in patients being followed up into the community. Dr R confirmed that he did not have any direct involvement with day hospital patients but he might become involved with people who had been discharged from day hospital care.

Contact with occupational therapists

His personal contact with occupational therapists was stated as being 'very limited.'

Referral to occupational therapists

Referrals were through the multi disciplinary team. It was implied that the team made the referrals; usually for home assessments.

> *One thing is to assess their functional ability at home, and the other thing is the safety aspect.*

The importance of multi disciplinary working was stressed

> *It's a multi disciplinary approach, so its not just giving tablets, everyone has to play a part in it.*

The referrals were directed to the occupational therapists attached to the relevant teams, although he thought that they were sometimes distributed amongst available staff. The profession who had been most involved with the patient while they were hospitalised were approached first when deciding upon who would carry out the community follow up. He could recall situations where the team occupational therapist had subsequently referred a patient on to the community occupational therapy service, but could not remember the reasons for this.

Perceptions of occupational therapy role

The skills of the occupational therapist in following up patients at home were mentioned. Dr R said that physiotherapists sometimes went to patients' homes but he did not consider this to be their job. He viewed assessment and treatment as integral concepts so that even when patients were being assessed on the ward they were also receiving *'training.'*

Involvement with out patients was described as being mainly short term but with situations where it can get prolonged; for example attendance at the leisure group run by occupational therapy staff. This out-patient group was said to be of great value. However, it's short term nature (eight to 12 weeks) caused problems as patients could become depressed again after it had finished.

> *Sometimes when the group is finished, there's nothing for them to do, nothing for them to look forward to, especially people who live on their own.*

While agreeing that occupational therapy with out patients could offer more than the leisure group, no other examples were forthcoming.

Periodic reports of occupational therapy treatment were not expected; it was left up to the therapist's discretion. Discharge was also up to the occupational therapist.

> *When the OT feels that they have done enough and there's nothing else to offer, then yes they come back to us.*

He was of the view that each specialty has their own skills to offer and they cannot replace each other.

Benefits of occupational therapy

In explaining the benefits of occupational therapy, the success of occupational therapy interventions with one of the older people interviewed (Mrs MR) was described. He felt that occupational therapists were definitely value for money in enabling people to;

> *....go back and function in a much better way.*

Recruitment and retention

The need for more occupational therapy staff was stated. Sometimes patients had to be discharged from in patient care without occupational therapy intervention because the staff could not cope with the number of referrals.

2. Social workers

As the senior social worker for elderly psychiatry based at location E had recently left, a letter was sent to the principal social worker based at location C to request assistance in identifying the most appropriate person to interview.

After some difficulty, contact was made with a new member of staff based at location C. She was the team leader responsible for three other members of staff. She made contact about the research, consulted with her staff team and phoned back with the views of the group.

Contact with occupational therapists

In general the social workers felt that there was good interface between the two professions. Both disciplines are an integral part of the multi disciplinary approach. However, team working is less than satisfactory due to vacant occupational therapy posts.

Joint working

Joint home visits frequently took place. The person interviewed cited an example of what might happen during a visit to a person with dementia. The occupational therapist would look at issues like safety and mobility while the social worker assessed how the illness affected the individual's familiarity with their home surroundings.

She saw the role of the occupational therapist as advising the social worker on how situations might develop; for example whether mobility will be an increasing problem.

However, how adequately a home situation can be assessed in a one hour visit; and whether several visits are optimum was questioned.

Referrals to/ from occupational therapy

It was said that there are referrals sent between both professions. However, the subsequent discussion only concerned referrals from social work to occupational therapy. She said that she might refer people with a functional mental illness so that the occupational therapist could assess what skills the patient had lost while in hospital and how well they were coping in their home situation.

Perceptions of role

Type of referral was often dependent upon the skills of the individual occupational therapists, for example if an occupational therapist had a known interest in bereavement counselling she would refer for this. Referrals for interventions that could carried out by a number of different professionals was dependent upon team members being aware of each other's skills and interests. Although it was appreciated that an occupational therapist could remain involved with a patient as the key worker, it was thought to be unlikely as most referrals were made to obtain practical information.

Social workers felt that occupational therapists made a very valuable contribution.

3. Community psychiatric nurses

The team leader for the community psychiatric nurses based at location E gave her view of the service.

Contact with occupational therapists

The person interviewed felt that forming a relationship with the occupational therapy staff was problematic as they were based at location C rather than location E. In addition some of the consultant teams did not have an occupational therapist because of staff vacancies, making it difficult to know who to relate to. She mentioned one member of staff who had worked in a specific geographical patch and as a result had more established contact with the community psychiatric nurses in that area. However, commitments elsewhere still resulted in restricted involvement.

She said that the occupational therapy manager was aware of the difficulties and there were plans to locate four occupational therapists at location E. This would include a service to the day hospital and to the wards. She said that she felt that she had a good relationship with the service manager and had been able to contribute to decisions about the future of the occupational therapy service.

Referrals to/ from occupational therapists

Referrals to occupational therapists could be through the nursing team or direct, depending upon how the multi disciplinary team operated. There was a preference for potential referrals to be discussed at a nursing meeting first to try and ensure that they were appropriate.

She said that when assessments are required, referrals were sent by the team to the occupational therapy service, and despite shortage of staff they did get done. It was the ongoing work that suffered. She would have been interested in referring people with long term or recurring mental health problems and thought that occupational therapists had a specific role to play in rehabilitation in terms of skill deficiency.

Joint working

At the time of the discussion, there were no joint assessments because the occupational therapists were not available. The person we spoke to did not know if joint assessments had occurred in the past.

Perceptions of role

The work of the community psychiatric nurse tended to vary across the different consultant teams. She said that she found it difficult to draw a line between the role of the two professions. Assessments specific to each discipline are different but some aspects overlapped. It was considered appropriate for occupational therapists to look at human occupation in terms of mental health; for example assessing lifestyle changes in retirement. Community psychiatric nurses could have this involvement but have to prioritise nursing tasks. Also, occupational therapists are better qualified for this type of work. Other expressed benefits of occupational therapy were home assessments for people with dementia to determine coping abilities. This provided useful information for both professionals and carers.

There had been a lot of problems due to the different operational bases of the professions. As community psychiatric nurses tend to be the most stable members of the team they have to cope with the problems. However, tasks are shared around.

4. Psychologists

Two psychologists were contacted to share their perceptions of the occupational therapy service. One was consultant grade with both clinical and managerial responsibilities (Mr P). The other worked half time clinically and half time as an academic (Ms M).

The comments from both interviews are summarised under each heading.

Contact with occupational therapists

The consultant psychologist said that he had contact with occupational therapy managers during management meetings. The contact at clinical level was within teams. He felt that the relationship between the professions was generally good but he would like more skill sharing through professional forums and supervision networks.

The other psychologist said that she no longer had access to an occupational therapist within her team. Even though the position of occupational therapy was not well established in the team due to a lot of staff movement, lack of staff was a disadvantage. In the past she had quite a lot of contact,

mainly over shared patients but this had tended not to happen in her present team. In addition, as she was part-time, it was difficult to get together with other professions.

Referral to/ from occupational therapy

The sort of patients Ms M said she might refer would be dependent upon the interests of the individual occupational therapists; she has found that they had very different interests. A reason for referral to an occupational therapist would be to work together on rehabilitation techniques to compensate for problems. Mr P spoke in the past tense, implying that referral to occupational therapists was no longer a possibility. He would refer people with memory deficit for investigation of their domestic skills.

Joint working

Both psychologists talked about joint working with occupational therapists. One of them discussed how they would work together on the practical and psychological reasons for an individual not utilising their full capabilities. Working together might include seeing the patient at the same time for assessment.

Ms M commented that she would be happy to see families with other professionals but this did not happen due to lack of time. Mr P suggested the possibilities of joint assessments with stroke patients, but also added that this did not occur to his knowledge.

Perceptions of role

Ms M felt that many professionals, particularly occupational therapists were becoming more interested in the psychological aspects of treatment. She was happy for occupational therapists to carry out behavioural work like counselling and relaxation. Whilst working with occupational therapists involved with other client groups she had observed the use of techniques like drama and art therapy and could see no reason why these should not be used with the elderly. She said that much of the work which was normally carried out by occupational therapists like checking that people are managing at home was being undertaken by community psychiatric nurses. The consultant grade psychologist presented a slightly different perspective. He said that he saw the service as being both therapeutic and assessment, but he thought that psychologists and occupational therapists work at a different level, with occupational therapy skills being more fundamental and technique based. He felt that they should be carrying out a higher level of work like training and passing down skills to other health care workers and undertaking more psychotherapeutic work.

Benefits of occupational therapy

Both interviewees were asked if they thought that occupational therapists represented value for money. One felt that the most important issue was getting a good 'fit' between the needs of the particular post and the individual therapist. The other referred to the need for occupational therapists to involve themselves at a higher skill level.

One person referred to the difficulties which occur due to poor recruitment, and that the service could be improved by staff remaining in their posts for a greater length of time.

Views of Occupational Therapy by the Day Hospital Team

1. Day hospital sister

This interview was face to face, taped and transcribed.

Professions involved in the running of the day hospital

The only other profession apart from nurses and occupational therapists involved in the day to day activity of the day hospital was physiotherapy.

Contact with occupational therapists

As there had been a lot of changes, the sister said that she was not sure who was still involved. The names of the occupational therapy manager and one other member of staff who took part in the case study were mentioned. She also knew the names of the occupational therapy helpers who worked sessionally in the day hospital.

Day Hospital contact with the service was problematic due to the distance between the occupational therapy base at location C and the day hospital at location E. Working as a team and making phone contact was difficult and frustrating. Some attempts had been made in the past by herself and the head occupational therapist to improve the links between the two professions and promote a multi disciplinary approach. However, this had not been successful.

> *The way things have worked for us in the past has been via the phone for specific things and the impression I get is that is the way that OTs prefer.*

Referral to occupational therapy

Written referrals were sent to the occupational therapy department at location C and discussed over the phone as well, or a referral would be made in person at the consultant's ward round. The sister stressed that a referral would always be made if it was considered to be necessary and that the interests or personality of the actual member of staff were irrelevant. However at a later stage in the interview she did say that one of the consultants referred to occupational therapy frequently but the day hospital nurses would tend not to. The key worker for the patient (a nurse) would make the decision about referral, or a consensus opinion would be reached in a nursing meeting or ward round.

Joint working

There was little reference made to joint working during the discussion. Joint home visits with the occupational therapy and physiotherapy staff were mentioned fleetingly. One example was given where the sister had worked together with the occupational therapist, but this had occurred due to a inadvertent duplicate referral to both members of staff rather than as a prearranged decision.

Interventions carried out by occupational therapy staff

A skills based group run by the two occupational therapy helpers was discussed. There was a complicated mechanism associated with the implementation of this group in that it was being supervised by the senior II occupational therapist, planned jointly with the nursing staff and run by the two helpers. Other groups which had taken place in the past had been organised along similar lines. The rationale given for nursing involvement was the lack of knowledge of the patients by the occupational therapy staff.

> *We would look at it because the OTs don't have enough knowledge of the patients here so its not appropriate, unless of course they have somebody that they've been seeing that they felt would benefit from joining.*

Communication about patient treatment

It was made quite clear that the occupational therapy staff were marginal in decisions made about patient treatment and discharge. The system in operation to review patients consisted of a discussion first thing each morning and a ward round; neither of which were attended by occupational therapy staff. The one mechanism for feedback about occupational therapy interventions to the day hospital nurses was through formal written reports. The point was made that any notes made by the occupational therapy staff were not kept in the patient's notes, the day hospital staff just receiving typed reports.

Perceptions of day hospital role

That occupational therapists were not based within the day hospital limited their involvement, as they could not be key workers. Some doubts were expressed about the uniqueness of some of the skills of occupational therapy but the point was also made that some tasks like domestic assessments and home visits were "*owned*" by the occupational therapy staff and therefore nurses would not undertake those tasks.

> *Yes, it's always been owned by them. I mean anybody - you don't even have to be a nurse do you - could observe somebody and their safety in the kitchen...but the quality of the assessment is going to be different isn't it? So we wouldn't set out to do a domestic assessment ourselves.*

There was a stated need for someone with creative skills to work in the day hospital. However, the person we spoke to did not think that this role should always be fulfilled by an occupational therapist.

> *But that's not what I think OTs are all about, but what they're about either.*

Benefits of occupational therapy

The day hospital sister was not prepared to say whether she thought that occupational therapists were value for money or not. Complaints rather than benefits of the service dominated. Value in seeing the patients needs from different perspectives was mentioned, but the problems stemming from lack of sustained involvement dominated.

Optimum working arrangements

The most appropriate staffing arrangements were rather vague.

> *It would be nice if they did have a higher profile within the running of the day hospital in so far as they felt able to be part of the team and join in the planning of activities.*

However, it was made clear that a prerequisite to being accepted would be to conform to the regime of a six weekly group programme instigated by the nursing staff.

2. Other day hospital nursing staff

Postal questionnaires were sent to all other nursing staff working in the day hospital at the time that the sister in charge was interviewed. Only one was returned completed; the respondent being an E grade RMN/RGN.

The information from the one completed questionnaire is summarised below.

Contact with occupational therapists

The respondent referred to occupational therapy one a month on average for:-

-recreational and social activities

-support regarding loss of work role

-support with creative groups in the day hospital

-advice on what's available

-home assessment and information regarding aids and equipment

The referral procedure

Four different referral routes were described:-

1.Through discussion of the patient at the multi disciplinary team meeting

2.Informally via a discussion with the day hospital doctor who will then complete the referral with reasons

3. The respondent fills out the referral with reasons herself

4. Phone call by the respondent to the occupational therapist with the paperwork being completed later

Expected feedback

-date and time of home assessment so that the key worker can make a joint visit

-reports of occupational therapy assessments

-verbal feedback and discussion of occupational therapy perceptions of client

-information regarding arrangements made for group

Other routine contact

-contact in the multi disciplinary meetings when there is an occupational therapist in post

The respondent stated that there was no other form of contact unless the nurses specifically request help, resources or facilitation of a group

Benefits of occupational therapy

Stated to be 'masses' - creative, recreational, anxiety management, structure and directed activity for a purpose.

Outside contact with staff other than familiar nursing staff'.

Can nurses provide a similar service?

Yes, but not with the same degree of expertise. The nurses role is generic whereas occupational therapists are able to 'focus more.'

Are other professionals able to offer a similar service?

'Not within the NHS.'

Should OTs provide routine input to the day hospital?

'Absolutely.' The response then described different forms of groups once again and 'possibly one to one work.'

How can the service to the day hospital be improved?

Improved availability of staff. There is a need for consistent and continuous occupational therapy input.

Additional Comments

The respondent questioned the attractiveness of elderly psychiatry for occupational therapists, suggesting that other specialties held more cuedos.

This nurse gave a very favourable opinion of the place of occupational therapy in the day hospital setting. It is unfortunate that the opinions of the rest of the nursing staff were not obtained, as it is easy to surmise that their views were less positive in light of non response to the questionnaire.

3. Clinical assistant (day hospital)

The clinical assistant was a permanent medical practitioner whose sole responsibilities were that of the day hospital.

Much of the conversation centred around the lack of staff and the adverse affect this was having upon the day hospital.

Contact with occupational therapists

All the time Dr S had worked in the day hospital there had never been regular occupational therapy input. At one stage there was someone with a part-time commitment but the situation had worsened so that there did not seem to be anyone at all.

Referral to/ from occupational therapy

Recently it had been necessary to prioritise patients for referral, there was little informal communication and there had been a tremendous delay in getting reports so that sometimes the patient had been discharged by the time reports had been received.

Home visits/ assessments

When input was slightly better the person interviewed recounted that patients would be initially seen in the day hospital by the occupational therapist to get an idea of their abilities and this would be followed up by a home visit. After the visit there would be an informal discussion with staff regarding the results and then a written report. She felt than no one else was able to carry out a quality assessment like occupational therapists. Without the assessments they had to rely upon the information provided by the patient's family.

Perceptions of role in the day hospital

The main need was the assessment of people with early dementia within their home surroundings. Dr S said that there was nobody else available to carry out the assessments. Community occupational therapists were *"like gold dust."*

Her perceptions of what occupational therapists should be doing and what they did the day hospital were completely different. She thought that the day hospital did not receive enough input because there were not enough people. However, there was no need for any of occupational therapy staff; qualified or unqualified to be carrying out diversional activities in the day hospital as it was a waste of their skills.

Benefits of occupational therapy

The person interviewed said that occupational therapy was of great value in the day hospital setting, and had more to offer than physiotherapy. Occupational therapists definitely represented value for money due to their contribution to the multi disciplinary team, her complaints being not of the quality of the service, but of its quantity.

Optimum working arrangements

Part-time input was accepted, but the need for this input to be consistent every week was stated. Ideally she would have preferred an occupational therapist to be available to carry out home assessments as required. She did not see the need for occupational therapists to have ongoing contact with the patients; the best use of time being the provision of initial advice and then a limited number of follow up visits to see how things were going. In her opinion they then have to let go and become involved again if the patient is re-admitted. The need for improved administrative support to the occupational therapy staff so that reports are produced faster was also mentioned.

Involvement in decisions regarding the occupational therapy service

Dr S said that she was aware of plans for an occupational therapist to work in the day hospital in the future, but she had not been involved in any decisions. The lack of influence of doctors in decision making was alluded to.

4. The day hospital registrar

The day hospital registrar was a junior member of the medical staff on a six month placement in the day hospital as part of a training programme.

Contact with occupational therapists

At the time of interview there was no qualified occupational therapist attached to the day hospital so referrals were sent to team based occupational therapy staff. Dr P was aware of the helper staff who did *"baking and things like planting out bulbs."*

Referrals to/ from occupational therapists

It was said that nurses did the actual referring so in the absence of a permanent member of staff she was not aware of who the referrals were being sent to. However, decision to refer would be taken at the daily nurses meeting or the weekly consultant's referral meeting.

The sort of patients who might be referred were those requiring assessment at home or follow up treatment. These would be the minority rather than majority of day hospital clients. She did not know whether this was due to need or scarcity of resource, as they may have more readily requested a home assessment when there was an identifiable member of staff. The types of referral being made to the community occupational therapists were for assessment for aids and adaptations in the home.

Perceptions of role in the day hospital

Dr P said that the role of occupational therapists was so broad that lots of people might be potential beneficiaries. There was a lot of role overlap with other professions. She mentioned the involvement of the physiotherapist in home assessments and role overlap with social work and community psychiatric nursing. As they had no occupational therapist, other professions were having to compensate. However, the relevance of occupational therapy intervention with both functionally ill and cognitively impaired patients was discussed. For the functionally ill, occupational therapy interventions could improve self confidence and maintain independence.

Benefits of occupational therapy

Value was expressed in terms of the different insights into problems, resulting from different training and skills in assessing people's abilities to cope at home. The occupational therapist's understanding of mental health problems was also cited. Our interviewee felt that value for money might result from not providing inappropriate services due to the assessment procedure. She had difficulty in expressing what the benefits of occupational therapy might be from the patient's perspective, viewing the results of interventions primarily as a source of information for other staff.

It is of great advantage for us to know just what people can manage in their own homes.

Optimum working arrangements

Having an occupational therapist based at the day hospital was not a top priority, but it was said that if there was a member of staff they would be found plenty to do.

The problems of working in multi disciplinary teams for both medical and occupational therapy staff was discussed, as both groups tend to move round so much. It takes time for people to get to know each other and work as a team.

Involvement in decisions regarding the occupational therapy service

Dr P was not aware of any plans for the future of the occupational therapy service, but assumed that the consultants were involved and aware of the problems in the day hospital. She felt that there should be medical input into these plans, but it did not have to be her personally.

The Consultant Psychiatrists

Three consultant medical staff were interviewed, the interviews being taped and transcribed. At the time of interview, they were all working from the same base at location E Hospital. Each had responsibility for a number of patients attending the day hospital.

The multi disciplinary team

For two of the three interviewees, the team was of central importance. The third person we spoke to referred to it less and in terms of a structure rather than in the context of a method of working in the way suggested by her colleagues. Role establishment on the basis of permanence in the team was suggested by Dr B, the example being given of occupational therapists not getting long term work in the same way as junior doctors do not get involved long term due to staff turnover. In contrast, Dr A stated that the contribution of each person joining the team rather than discipline was a strong determinant of role within it.

Occupational therapy staffing

When interviewed, only Dr B had an occupational therapist dedicated to his community team, this member of staff having recently transferred from one of the other consultant teams, that of Dr A. The other two consultants were without a member of staff. The community teams consisted of medical staff, community psychiatric nurses, social workers, psychologists and occupational therapists. Apart from occupational therapy staff shortages, other vacancies were in psychology and physiotherapy. Dr C explained that the social worker on her team was also expected to cover her day hospital patients.

Referral to occupational therapy

For the two consultants without an occupational therapist in their team, referrals were made to the service by staff other than themselves.

I don't know if somebody else has to write it but I don't have to.

These referrals resulted in the work being undertaken by ward based occupational therapists, and it was acknowledged that for urgent cases this was acceptable, Dr C saying that she was satisfied given the numbers of staff. However, the problems with this method of working was that the consultants could not identify specific staff to have a working relationship with. Dr A was strongly of the opinion that written referrals were unsatisfactory as he likes referrals to be by word of mouth, followed up by the necessary paperwork.

The consultant with a member of staff in his team, Dr B, made all the referrals himself, both through the multi disciplinary meeting and directly. He considered appropriate referrals to be those where the home situation was complex with a lot of differing opinions.

The personality of the occupational therapist was a strong influencing factor in determining work load for staff working for two of the three consultants we interviewed. The occupational therapists were expected to behave fairly assertively.

> *...people can pick up as many or as few referrals as they want in that meeting.*

> *Who gets referred depends a little bit on what we know about the skills of the individual and what they know as well as their background.*

> *We need people who have a very secure sense of themselves and their profession and can put up with criticism.*

All three consultants were aware of the existence of community occupational therapists, but only Dr A had referred patients to them through GPs.

> *I'm more and more now, if people need OT service, I'm passing them on to the community OT service which I think is very unsatisfactory because I think our patients really need an OT with psychiatry knowledge.*

Staffing problems

All three consultants felt that there were problems with their occupational therapy staffing arrangements. For the two consultants without an identified member of staff, problems centred around the lack of team based staff. The prime reasons given for this were the way the service was organised and the quick staff turnover.

> *Well people come and go with OT, and it's been reorganised and they change the way that they do it and sometimes they are attached to a team and sometimes to a ward.*

> *....they like to be organised so that they're based on wards or in day hospitals and things.*

Dr B was also dissatisfied with the focus of occupational therapy involvement which he perceived as being with the in patients rather than in the community. He saw occupational therapy input with in patients as a waste of time as interventions just confirm what is already known about a patient's abilities; the effectiveness of occupational therapy being undermined as a result of such short term involvement.

> *...I think that necessarily pulls down what everybody thinks of the efficacy of OT....too many short term involvements, too many one off assessments and too many chopping and changing of OT personnel.*

Dr C and Dr B both acknowledged that there just were not enough staff to go around. Dr A appeared to believe that several resources originally designated to his service had been re-allocated elsewhere.

Optimum staffing arrangements

Not surprisingly the preferred arrangement for the two consultants without a designated member of staff was to have an occupational therapist within their team.

Dr C reiterated the point made by Dr B in that staff working within a community orientated team are more useful as they are able to follow patients through different services rather than handing them on to someone else. This method of working improves communication as the patient is not passed around as much and there is direct feedback to the team and consultant.

The person who had a team based occupational therapist admitted to being in a "*bit of a fog*" regarding her role, and said that he would like to have more dialogue with her about this. It was again suggested that the occupational therapist needed to be more assertive about what they could offer, if necessary overriding other members of the multi disciplinary team. The requirement for the occupational therapist to be team based for continuity of service and clear about their skill base was reiterated by Dr A; the optimum method of allocating work in his opinion being by team consensus. He felt quite strongly that he needed an occupational therapist to attend his team meetings and that staff numbers limits specialisation so that they cannot be attached to day hospitals or wards.

Occupational therapy role in the day hospital

All three consultants appeared to be quite remote from the day to day activity in the day hospital, relating to it theoretically rather than practically.

They were unclear about the nature of the existing occupational therapy contribution, leaving any referrals to the nursing staff or medical staff designated to the area.

> *So I don't know what the OT position is in the day hospital.*

The point was again made that although there was a role for occupational therapists in the day hospital, they should concentrate their efforts upon work arising from the community team, taking one off referrals from the day hospital. Dr A could see no great problems with the day hospital staff having to relate to more than one occupational therapist.

> *There are obvious disadvantages from the day hospital's point of view in having to relate to say three OTs, but they very quickly learn which community nurses to call or which psychologist to call.*

Dr B could appreciate that it might be difficult for an occupational therapist to work within the existing day hospital regime.

> *It's quite a stable set up here...so it would have to be a fairly ebullient sort of person, I think that could carve out a tremendous role for themselves in that type of environment.*

He also thought that the rapid turnover of patients also mitigated against appropriate occupational therapy interventions, but acknowledged that there was a gap between day hospital attendance and the patient's home.

If occupational therapists were to work in the day hospital setting, it was agreed that this should be for assessment and treatment purposes rather than for provision of diversional activities.

Perceived role of occupational therapists

Even though each of the consultants appeared to conduct their work quite differently there was a general consensus of opinion about the role of occupational therapists. This incorporated looking at lifestyle, assessing safety issues in the home, recommending aids and adaptations, liaising with social services and providing a care network in the community. However Dr B saw patients with dementia as main patient group with whom occupational therapists would work whereas Dr A thought that the main group to benefit would be those with depression.

Apart from these core activities, two of the interviewees mentioned role in the context of a member of the multi disciplinary team, but in different contexts. Dr B specifically talked about the potential role of occupational therapists to act as keyworkers whereas Dr A saw felt that team involvement would "*broaden and strengthen the team.*"

There was also agreement that the personality and interests of the occupational therapy staff themselves was a big factor in determining their workload.

> *I think how the OT takes in the team is 80 per cent directed by their personality...*
>
> *... I've found that they work - like everybody they're very much individuals aren't they?*

However, the two consultants without a member of staff saw some aspects of the role of the occupational therapist as being unique whereas the consultant with a designated member of staff was not sure. He said that either there were no special skills or "*we aren't hitting the target.*"

> *...they don't appear to offer any unique skills....it could be truly that the role of OTs in psychiatric work with old people is peripheral...*

Benefits of occupational therapy

The patient perception of benefits of occupational therapy had not been considered by any of the consultants.

> *I think its a very nebulous concept.*
>
> *....patients tend not to bother too much about the disciplines of the person helping them - you're either a doctor or a nurse usually...*
>
> *I don't know. I honestly haven't a clue.*

The question regarding value for money caused some difficulties. Dr C had doubts but was unwilling to voice them clearly, mentioning the skill mix of nurses and value of occupational therapy helpers. Dr A did not answer the question. Only Dr B was willing to give a clear opinion.

> *I think they don't do anything that the other team members couldn't do.*

Involvement in decisions regarding the occupational therapy service

As the most senior and established consultant, Dr A placed his influence upon decision making in an historical context, implying that things used to be better in the past and that posts had disappeared for no reason.

When asked about taking part in the selection of occupational therapy staff, two of the three respondents felt that they should be involved, but their experiences were different

> *I'd love to if there was a chance but all the professional defensiveness has reasserted itself and I'm not involved in the appointment of anybody now.*

In contrast Dr C said that there was to be a new appointment and that she had been approached by the occupational therapy manager to be on the interview panel which she was keen to do. However, this seemed to be the limit of her involvement. When asked about who would take decisions regarding team or ward involvement she said "*It's not me!*", but also admitted that she had not tried to become more involved.