OCCUPATIONAL THERAPY SKILL MIX STUDY

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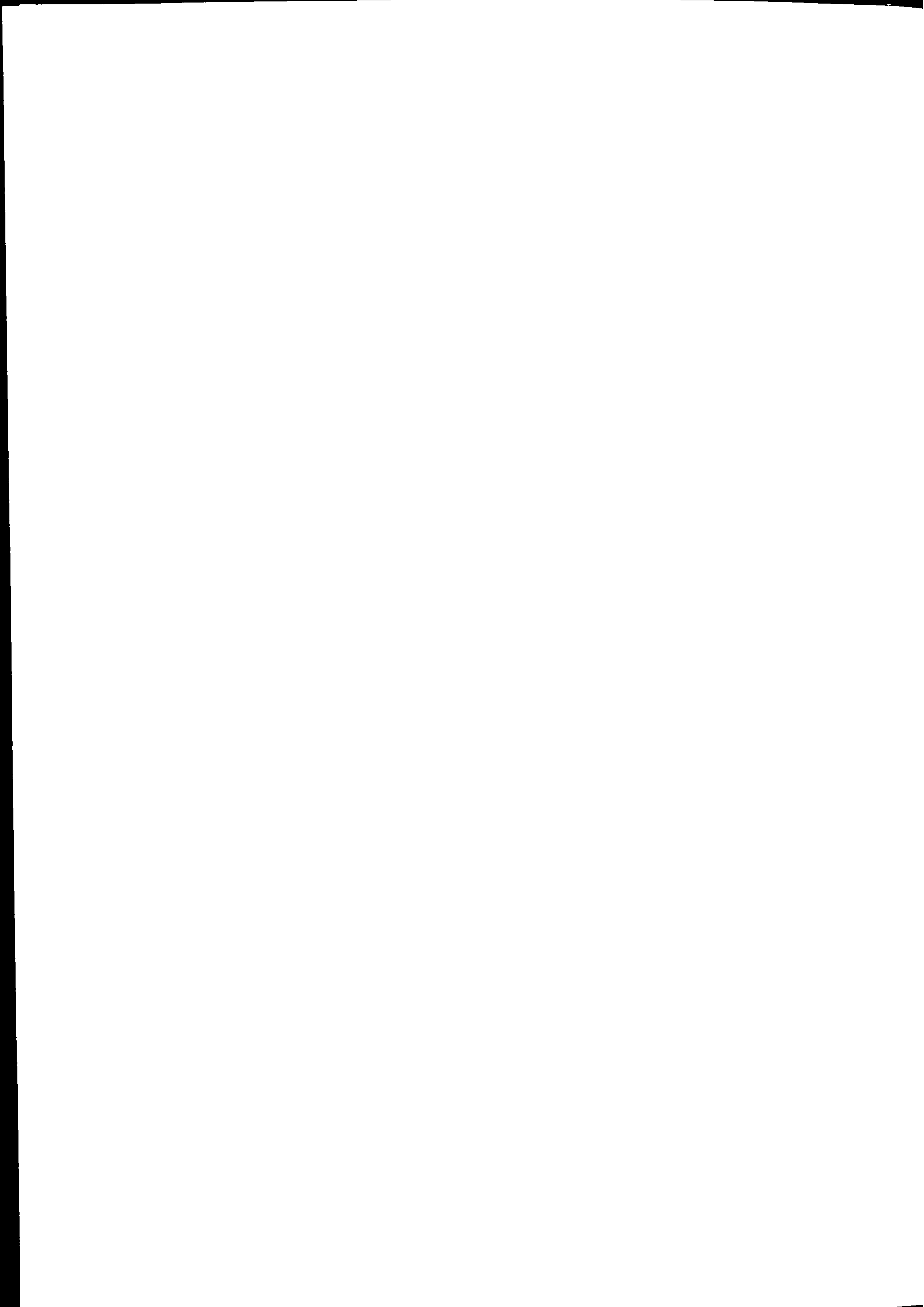

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Conferences and meetings attended by various members of the Project Team

Conferences

September 22, 1988	Conference on occupational therapy skill mix at Department of Health
April 28, 1989	Occupational therapy conference, Exeter
June 29 & 30, 1989	National occupational therapy conference, Glasgow

Meetings

August 26, 1988	King's Fund Centre
September 27, 1988	King's Fund Centre
October 28, 1988	King's Fund Centre
November 2, 1988	Claybury Hospital, Waltham Forest Health Authority
November 4, 1988	Claybury Hospital, Waltham Forest Health Authority
November 29, 1988	King's Fund Centre
December 16, 1988	Claybury Hospital, Waltham Forest Health Authority
February 2, 1989	Claybury Hospital, Waltham Forest Health Authority
March 31, 1989	Claybury Hospital, Waltham Forest Health Authority
April 19, 1989	Claybury Hospital, Waltham Forest Health Authority
July 5, 1989	Claybury Hospital, Waltham Forest Health Authority
August 3, 1989	Claybury Hospital, Waltham Forest Health Authority
August 18, 1989	Claybury Hospital, Waltham Forest Health Authority
August 30, 1989	King's Fund Centre

Members of the research team also met with a wide range of senior members of the occupational therapy profession and other senior policy makers in health at regular intervals throughout the duration of the study.

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EXECUTIVE SUMMARY

INTRODUCTION

The Occupational Therapy Skill Mix study was commissioned by the Department of Health's Manpower Planning Advisory Group to examine the present structure of the Occupational Therapy service and to make recommendations about the most appropriate models for the future. The research team was also charged with studying the various levels of skill needed by Occupational Therapists to perform the range of tasks which are central to the provision of the Occupational Therapy service.

To do this the research team set out to establish what society needs from the Occupational Therapy service and then to consider how this service can best be provided in terms of effectiveness, efficiency and economy. In other words this study took as its starting point the needs of people with disabilities and the kind of care which would be of grestest value to them. It also attempts to describe a method which will help to determine when a person with a disability may need assistance and when that help should be provided by a professional Occupational Therapist or when support staff could be used.

The report is divided into six main chapters. Chapters One and Two are concerned with the conduct of the study, the analysis of the data and presentation of the results. Chapter Three concentrates on the data from locations defined as being the "leading edge" of current Occupational Therapy practice. The series of themes which emerged within the data could provide authorities with models for future development. Policy analysis issues raised by the study and recommendations for future action follow in Chapters Four and Five. Annexe One deals with policy and the associated literature review. This material analyses in detail the process of professionalisation and the concept of skill mix; the structure of the Occupational Therapy profession and its impact on service users are analysed together with the related issues of Occupational Therapy manpower; the epidemiology of disability; the cost effectiveness of Occupational Therapy services; international comparisons and the impact of social change on the future of health care services. Finally, there are comprehensive appendices and references.

The study is an exhaustive piece of research - the first to look at the Occupational Therapy profession in such detail - which all managers in the health service, not only those involved in the provision of Occupational Therapy services, are urged to read in its entirety. However, this summary of the main recommendations and the reasoning behind the research team's conclusions has been produced as an introduction to the report. It should be stressed that this guide is no substitute for reading the report in full.

Health and illness are described in the report as the two poles of a continuum for which a range of interventions have been developed, mainly by doctors and nurses. Medical interventions being concerned with the prevention, diagnosis and treatment of disease while nursing interventions concern the support of the individual through promotion of health and care during illness. Such a description was quite acceptable for the first half of this century but as medical science has become more complex new specialist groups have been formed to cope with the range of skilled interventions required along this continuum. These groups are, undoubtedly, closely linked and frequently it is difficult to distinguish responsibility for particular procedures. For example, physiotherapists were initially concerned with joint massage and mobility while Occupational Therapists have concentrated on the interface between the environment in which individuals with disabling impairments find themselves and how they cope with their handicaps in every day life.

Occupational Therapy began first as a branch of nursing but post World War 2 it became an auxiliary profession to medicine with the focus on rehabilitation through work. The presence of other professions working in that particular area of the therapeutic space entailed some boundary disputes and overlapping. Historically, there have been particular problems in physical medicine, where there has been overlap with physiotherapy, and in psychiatry where the space is shared with nursing. Current trends suggest, however, that physiotherapists are now working in psychiatry and that there are concerns about the overlap of art and other creative arts therapists with Occupational Therapy.

There is growing confusion in the therapeutic space. It is not and never has been neatly marked out; in some areas there are clearer lines than in others, but nowhere can any of the occupational groups within that space claim that every task can be neatly labelled 'doctor', 'nurse', 'physiotherapist' and so on. This is the issue of staff mix which is intimately linked with questions about the goals and purpose of occupations and their legal and statutory obligations.

It is not easy to offer any definition of Occupational Therapy because of the many areas in which Occupational Therapists work. The College of Occupational Therapists defines Occupational Therapy thus:

> "The treatment of physical and psychiatric conditions through selected activities in order to help people reach their maximum level of function and independence in all aspects of daily life."

It has been pointed out by Jay (1981) that:

> "Occupational Therapy is a much misunderstood profession. There are many reasons for this. Probably the main one is that their training equips Occupational Therapists (OTs) to work in so many different areas that the various jobs individual

therapists are doing seem to bear little resemblance to each other."

Because of these factors the research team decided that a better starting point for defining the goals of the Occupational Therapy service would be to consider definitions of health and illness and how and where the Occupational Therapy contribution has developed.

The most recent definition of public health from the Acheson report (DHSS, 1988) is:

"the science and art of preventing disease, prolonging life and promoting health through organised efforts of society."

This is helpful in considering the role of health care professionals in providing service to clients or patients since there is a focus on the collective efforts of societies to resolve the problems of health care. It is noteworthy that many developments in the Occupational Therapy profession have occurred because of clearly defined statutory obligations placed on health and local authorities to provide service to specific client groups.

THE LEADING EDGE

Six major issues dominated the interviews undertaken by the research team in 15 health and local authorities. These authorities were chosen because their services represent centres of excellence.

The staff interviewed included Occupational Therapy staff at all levels from district managers to Occupational Therapy helpers and technical instructors from health, social services and private practice. The specialities of paediatrics, the elderly, the mentally ill, the elderly mentally ill as well as the acute, surgical, rheumatology, community and child psychiatry services were included. A senior Occupational Therapy lecturer in an Occupational Therapy college was also interviewed.

1. Interface and joint planning of Occupational Therapy services was by far the most frequently mentioned issue. It concerns the division of services between Occupational Therapists in the NHS and those employed in local authority social services departments.

   In most cases, joint planning, consultation and the development of integrated services had been determined but comments were made about the movement of staff between the two services and the inconsistancy of structures and grades which made true combining of services apparently impossible.

2. Recruitment, training and retention of Occupational Therapy staff

   Comprehensive schemes which dealt with every aspect of staff recruitment and retention were described. One authority had devised an elaborate post-graduate training programme aimed at enabling newly qualified Occupational Therapists to consolidate their basic diploma education and to continue professional education in a work setting. The same authority had a return to work training course for Occupational Therapists who had had a break from work for a few years.

   The desirability of recruiting mature people as helpers and seconding them on inservice training courses as a way of increasing the stability of the qualified work force was mentioned by some district Occupational Therapists. A social services department Occupational Therapy manager mentioned that overwhelming caseloads lead to bureaucratic processing with not enough time being spent on client problem solving. This it was felt can lead to disillusionment and lack of professional energy in young Occupational Therapists. The answer was to be found in better use of Occupational Therapy assistants: with qualified staff being responsible for prioritising work for other staff to do, and training them to work with clients. Occupational Therapists were then freer to undertake assessment and more complex work with people

with greater degrees of disability and/or greater complexity of problems to be solved.

3. Contracts of Service

Examples of contracts of service negotiated by district Occupational Therapists with their unit general managers were submitted to the research team. These were specific about which treatment would be provided to which patients. These contracts enabled:

- The establishment of a written operational policy.
- Services to be prioritised - and reprioritised, in response to problems of fluctuating staff levels.
- The setting of targets for the development of services.
- The provision of a detailed breakdown of Occupational Therapy services and costing.
- The establishment of agreed standards of Occupational Therapy services.
- The institution of regular reviews.

4. Resource management

The resource management projects instituted by the NHS Management Board were reviewed. Given further work on the specific Occupational Therapy input into these programmes and the outcome for Occupational Therapy services, these projects could prove useful models for developing and shaping services.

5. Models of practice - definition of core skills

A number of centres produce documents which determine the core skills of Occupational Therapists. Such information is important in helping others to understand the role and function of Occupational Therapy and can be used in the production of contracts of service.

6. Role of private Occupational Therapy services

Occupational Therapy in the private sector appears to be developing along the lines of work with clients at home and in private hospitals.

- Care packages for provision of equipment. This was seen to be an important aspect of the work where resources were being used.

- Providing reports in litigation cases.

- Training staff in local authorities, where previously the Occupational Therapy service was too small to encompass a large training element.

POLICY ANALYSIS

At the heart of the report is Chapter 4 which analyses in detail public policy and its effect on the practice of Occupational Therapy and the response the profession will need to consider in the light of changes within society. It is the philosophy which emerges in this section which has influenced the final shape of the recommendations.

1. Legislation

The impact of government legislation on the practice of Occupational Therapy in the areas of professional regulation, employment, housing, education, disablement and health is seen as profoundly important. However, as the report indicates, Occupational Therapy is mentioned in legislation only in the 1960 Act regulating the Professions Supplementary to Medicine.

This Act established the process of registration, but registration is not, in itself, obligatory for Occupational Therapists, rather registration is required by some employers under different regulations, for example, the National Health Service employment regulations.

Occupational Therapy is a profession which is dependent upon other service providers for its ultimate usefulness. However, shifts in the ways in which local and health authorities fulfil their statutory obligations may have great impact on the development of the profession. Although a small number of local authorities still do not employ Occupational Therapists, legislation such as the Chronically Sick and Disabled Persons Act 1970 has led to an enormous growth in the number of Occupational Therapists employed in local authorities. Consequently, shifts in public policy and ensuing legislation may be described as major factors in predicting the employment patterns of Occupational Therapists. It is because of this that the profession needs to be extremely vigilant to ensure that current trends are understood and articulated by its representatives.

2. The public policy debate

Topics on the current agenda with which the research team believes all professions will have to come to terms fall into three main areas: demography, consumer expectations and technological developments.

Technological change and consumer expectations go hand in hand. At the birth of the National Health Service, the typical service user was likely to be a worker in heavy industry involved in mass production, or a dependant of such a person. Work patterns have changed dramatically in the past 15 years and there is now a focus on high technology and service industries. Meanwhile, the changes in the demographic structure of the United Kingdom have

been dramatic with a growing number of elderly people being supported by the State.

The relatively small number of young people are now more likely to work in occupations related to high technology and there seems to be a focus on raising educational standards. It would seem likely that the consumer of services will become increasingly informed, critical and aware from his own experience of employment, of what technological innovations are available and what service systems can be developed to satisfy consumer demand. Consequently, all health care professions and managers must come to terms with the better informed, less deferential and more critical consumer. Out of this climate, a series of policy initiatives have arisen. The Griffiths Report (Griffiths, 1982) which led to the introduction of general management may be seen as an early attempt to provide a more efficiently managed health service which shifted the focus from the pursuit of professional goals to the pursuit of goals established by professional managers. Therefore, health care professions will need to be keenly aware of the underlying reasons for such initiatives.

Two documents are of great importance in the current debate. The Griffiths Report on Community Care (1988) and the White Paper on the NHS both contain policy measures which respond to a changing society. Consequently, it can be seen that the shift from health care professional domination of health to managerial control may subsequently lead to consumer choice. Health care professionals who have as yet been unable to come to terms with the agenda set by general managers, are going to find the consumers' agenda even more challenging.

The evidence is that consumers already have fairly distinct goals and organisations capable of articulating their demands. Currently, they are seeking partnership with Occupational Therapy but would clearly like to control resources. Some are, already, unwilling to accept the meaning of "shortage of Occupational Therapists" offered by some Occupational Therapists within the profession. Seeking larger and larger areas of influence over consumers' lives and even wider areas of clinical practice may lead eventually to a direct clash with consumers and their carers. The control of services is likely to lie increasingly with the users and attempts to expand the professions in ways developed during the past 100 years are unlikely to be successful.

However, some Occupational Therapists seem to be too pessimistic and also to have misjudged the consumers. Realists within the profession will have already entered into partnership with local user groups who will benefit from the information base of the skilled professional. It is important, however, for all health care professionals to recognise the limits of their power.

3. Options for future development
Course Validation -

The College of Occupational Therapists' Validation Committee and the OT Board of the Council for the Professions Supplementary to Medicine both validate the professional content of courses. Where courses are also involved in higher education, they could be validated by the institution itself or by the institution and the Council for National Academic Awards. As Occupational Therapy courses are increasingly within higher education so the validation mechanisms are likely to become more complex. The current system was developed before the expansion of Occupational Therapy into higher education and it may be suggested that changes to meet the developments of the past ten years are due.

The following are some of the options which could be chosen:

- that the professional content of courses should be validated by the Validation Board of the Council of Professions Supplementary to Medicine and that the academic content of courses should be validated by the Higher Education Institution which may also involve the Council for National Academic Awards (CNAA), depending upon the status of the Institution.

- that the College of Occupational Therapists should validate the professional content and that academic content be validated by the Higher Education Institution as above.

- that a new body be established to validate the professional content of courses and to make recommendations to the Council for Professions Supplementary to Medicine.

- that the CNAA develops a capacity to validate professionally as well as academically in view of its increasing involvement in health care professional training.

The aim of simplifying the validation mechanism would be to enable the profession to respond more quickly to social change, therefore in deciding the most competent way to validate courses, the following criterion should be used:

- that the simplest mechanism involving the least number of people compatible with maintaining educational and professional standards be adopted.

Registration

Registration is closely linked with the validation mechanism. The Register of Occupational Therapists does not, in theory, have the effect of protecting the public from rogue practitioners, as registration is not a requirement for practice. It is, however, a condition of employment in the National Health Service and most local authorities. In reality, most private employers probably also check registration status. The current register, however, cannot be used to estimate manpower stocks since it would seem that as many as 5,000 qualified Occupational Therapists are not on the register.

This state of affairs seemed unsatisfactory to the research team, since the register does not, in reality, protect the public and does not provide much information about manpower.

The following options: abolition of the register; retain the status quo; and develop a new type of register were considered by the research team. The first two options were examined but it was the development of a new register which the research team believed would have significant advantages.

If registration became a requirement of employment for all Occupational Therapists, rather than a condition of employment, this would have the effect of making the claim of public protection a reality in both theory and practice. It is also likely that it would assist the profession in fostering greater interest in professional issues. Finally, it would ensure that there would be a better public record of available manpower. A new Register would, therefore, represent a shift in the balance away from an employer's condition to an individual's professional responsibility.

Education and training

The current situation with regard to Occupational Therapy is a profession largely trained through diploma schemes and funded by bursaries from the Department of Health. It is possible that a considerable percentage may not be entering practice. Helpers and technical instructors may have been heavily concentrated in the large institutions for people with mental illness and mental handicaps. However, a national system of training which does not lead to a recognised, assessed qualification, has been long established. It is important to note that the issue of re-deployment and re-training of helpers and technical instructors is likely to become a pressing issue which has, as yet, received scant attention in public forums. An issue of great importance in looking at the future pattern of education is the apparent gap between theory and practice. It is suggested that students are attracted by the prospect of a three year full time diploma providing a wide and varied educational experience funded

by the Department of Health. It is also apparent from some of the publicity to attract students into training that an impression is given that there are ample job openings in all areas to work with all age groups of clients and patients. This does not, in fact, seem always to be the case. There is evidence that many of the applicants for training and those qualifying from the schools wish to work with children - a field where there are, in fact, fewer job prospects than with the elderly. It is possible that, in their enthusiasm for their professional role some of the schools do not, at the stage of selection of candidates, make clear that very large numbers of positions for Occupational Therapists exist in facilities for elderly people. Positions in facilities for the younger age groups will be fewer given what is known about current and future configurations of services. In any case, candidates should be made aware that the demographic structure of our society is such that there are proportionately far more elderly clients than young clients using the health and social services.

Options considered include common core education; degree level education and retaining the status quo.

The common core curriculum so long discussed, could become a reality with little or no input from professional organisations. It is possible that higher education institutes, CNAA and the CPSM Boards could agree a common core curriculum without reference to some of the professional bodies concerned.

Merger of the professions would be of less importance or even relevance then because individuals will be able to opt for extra units in, for example speech therapy if so directed by professional interest and enthusiasm. It should also be noted that with the proposed changes in the funding of higher education, such career developments could be funded out of a loan scheme or by health authorities keen to alter their staff mixes.

There is undoubtedly pressure for higher degree level from many quarters. The move into higher education will probably increase that pressure since the Occupational Therapy students themselves are unlikely to accept diploma level qualifications as other professions such as nursing and physiotherapy are increasingly converting their basic qualifications for professional entry to degree level.

There is, however, a dilemma for all health care professionals in that the level of funding required for lengthy professional courses tends to be high, students require financial support during study and are likely to earn the modest salaries traditional at the lower grades on entry into practice. Student loans may be available, but there will, no doubt, be careers available where loan repayment would be much easier and, therefore, more attractive to all but the most altruistic. Health authorities will have to think seriously about the

implications of student loans, perhaps considering sponsorship schemes and golden hellos.

The issue of pre-registration education would seem to be of great importance. The consensus of the data within the study pointed to the need for a practitioner who was more responsive to the consumer view point and better able to understand social and legislative issues. The escalator model is recommended as a way of drawing in to the profession groups such as mature students and graduates in other disciplines. It should also be noted that many people with disabilities have, themselves, a great interest in Occupational Therapy and would perhaps welcome the opportunity to enter the profession. The social work profession has already devised a scheme whereby people with disabilities are encouraged to enter the profession. Since entrants to Occupational Therapy from its traditional sources may be diminishing, perhaps the scheme established for entry into social work could be reviewed and a similar scheme for entry into Occupational Therapy be devised.

4. Post-basic and post-graduate education

Provision of post-basic and post-graduate education specifically for Occupational Therapists is virtually non-existent.

Multi-disciplinary courses such as a B.Sc. in Remedial Therapy have been developed. At the post-basic rather than academic level even fewer opportunities exist, although there is now a community module for Occupational Therapists which has been developed by the London Boroughs Occupational Therapy Managers Group.

It is unlikely that a large range of post-basic courses for Occupational Therapists would be viable particularly as the courses in remedial therapy at Masters degree level have been developed and which cater for all the remedial professions. Such courses will be of great value in encouraging professions to review the impact of their work and develop intervention strategies.

5. Skill mix

A whole range of different people contribute to the efficient running of an Occupational Therapy service. These include:

- Qualified Occupational Therapists at varying levels (newly qualified - managerial)
- Technical instructors at varying grades
- Occupational Therapy helpers/assistants at different levels of supervisory requirements
- Clerical/administrative workers

- Porters

- Drivers

An effective and efficient Occupational Therapy service ensures that all tasks which are required for the benefit of patients/clients are done by the most appropriately trained staff with most appropriate skills. All tasks do not have to be undertaken by the most qualified person. What is vital is that the assessment of tasks required and skills available are matched. Appropriate supervision of staff is essential.

There should be regular evaluation of service delivery to ensure that the service can respond to changing circumstances in health care at a local level. The skill mix should not be seen as constant while health services may be constantly changing.

Role of helpers in 'hospital and community'

In both hospital and community, helpers are involved in situations where repetition of tasks is important for patients/clients. For example in training and rehabilitation of a person through frequent repetition of tasks such as regular dressing practice or meal preparation. In psychiatric work helpers may use skills which Occupational Therapists do not have, such as skills in crafts of different kinds. It is important to relate the grade of a helper to that person's skills. Some helpers will need to work under greater supervision, others may work single handed with access to a qualified Occupational Therapist. It is also important to define what can and cannot be done without supervision.

From the interview data it is clear that helpers spend a greater proportion of time with patients/clients than qualified staff. In hospital departments helpers are best employed when patients are available for treatment.

Education and training of helpers and technical instructors

There are plans for the current helper's course to be incorporated into the National Council for Vocational Qualification framework. The profession will need to look again, very carefully, at the criteria for the award of accreditation since the four levels of helper they have defined, do not meet the criteria for levels One to Four of the National Vocational Qualification. It is likely that the Helpers' course will meet levels One and Two. The bridging access courses, currently being developed for helpers by Occupational Therapy schools, will be more suited to the National Vocational Qualification level Three.

Another issue which will need to be studied urgently is the redeployment of helpers and technical instructors as

large institutions close. These people represent a stabilising force in Occupational Therapy departments and their loss in terms of skill and expertise could be catastrophic. Access to training should be made available with several options. For example, distance learning courses, so that geography is not a constraint on education.

6. Staffing : recruitment and retention

The shortage of Occupational Therapists is one which has dominated the debate about the staffing of the service. However, there would appear to be a serious discrepancy, between the definition of the Occupational Therapist's professional role and the reality of the functioning of Occupational Therapy in service settings. Further cause for concern is the gap between education and practice. Approximately 30 per cent of those completing training do not enter employment in the National Health Service or Social Services.

Students who are recruited into Occupational Therapy at the age of 18 with no life experience or work experience and who are told that, on qualification, they will be able to work in any health or social service setting with any client group, making any intervention they believe to be appropriate, could find subsequent work experiences a disappointing corollary to training. The wastage rate from training noted from the past ten years, may have been replaced by the refusal to practise on qualification.

The following options could be considered:

- a requirement that all students have some relevant work experience before entering training

- Sponsorship schemes so that health and local authorities offer funding in return for service

- the expansion of training opportunities for helpers.

Recruits to the profession need a very realistic view of the type of work involved before training. Recruitment is linked, crucially, to that of retention. If only 60-70 per cent of those qualifying are entering employment, and if some of that group are dissatisfied with the functions required of them by the organisations for which they work, this is further evidence of the phenomenon of Reality Shock. The approach to service provision, as many interviewed during the course of the study pointed out, has been to offer things professionals like to do. The demand from the service user has far greater control of the service. This could entail the need for radical shifts in the way in which services are provided. Additionally, there are moves for the district health authorities and social service departments of local authorities to become bodies which assess service needs and purchase services from providers rather than providing

all services themselves.

This development could be useful in resolving both the chronic dissatisfaction of Occupational Therapists and the desires of service users to have more control of the services they receive. The issues of recruitment and retention and shortage might be less pressing if Occupational Therapists become service contractors. District health authorities, for example, have to work increasingly to health objectives established by the Department of Health. They may choose to contract with a group of Occupational Therapists to provide specific services for specified groups. This system would ensure that all groups involved were clear as to what the Occupational Therapists were going to provide.

Another major factor in the manpower equation is that of the pay and conditions of Occupational Therapists. There is some evidence of movement between health and local authorities as the balance of pay and conditions shifts. However, the options for salary increases currently depend upon national pay bargaining. It is possible that one pay range could be established for Occupational Therapists. However, it will be necessary for decisions about the numbers of Occupational Therapists required in each district to be made. Local pay bargaining may be a way in which districts can attract staff because each District may provide slightly different types of service requiring different salary structures.

7. Decision making level

As health and local authorities develop into procuring bodies rather than direct service providers, decisions about the staff groups who will fulfil the health objectives established will have to be made. In establishing the nature and size of Occupational Therapy services, health and local authorities should work together. Service users should be involved in the enterprise. This is the only way in which the numbers of Occupational Therapists, and the definition of shortage in terms of inadequate numbers to meet functions required of these, could be established.

8. The future

The "leading edge" data which the research team examined showed that these authorities had a sound Occupational Therapy structure. This included qualified Occupational Therapists at all levels of experience and support staff doing a range of work. They all had a senior manager of each service, NHS and local authority social services, who is an Occupational Therapist. They have already started work on interface issues for patients/clients discharged from hospital with many areas of joint working to maximise resources between the health authority and local authority.

There are a number of reasons for pulling together the Occupational Therapy services between NHS and local authorities.

For example:

1. The move to community care will require greater co-ordination between treatment in hospital and resettlement/management in the community. The Occupational Therapy service is ideally placed to be a major force in the implementation of community care policies because of its work with all the vulnerable client groups - people who are elderly, mentally ill or mentally handicapped. The Occupational Therapist's major contribution has always been with people who have severe and chronic disabilities rather than mild and acute illnesses.

2. Better utilisation of limited specialist Occupational Therapy resources to minimise competition between the NHS and local authorities. There is a need to see the Occupational Therapy service as a pool of resources for patients/clients in hospital and then at home.

3. The development of community Occupational Therapist posts to work with all client groups is becoming a priority because of shorter stays in all forms of hospital, and the need for satisfactory follow-up after discharge.

4. There is a need to facilitate the movement of Occupational Therapists between hospital and community care work, for career development, without losing individual practitioners from the profession. This should be done by ensuring that Occupational Therapists can progress within their local structure according to both career and family needs by flexible employment conditions, flexible hours and job sharing. These can often all be encompassed much more easily in a structure with a greater variety of different services. Various structures from the "leading edge" data were studied. These models showed that a service managed with explicit professional leadership provides the best structure for service as well as addressing recruitment and retention issues. A professionally managed service can provide:

   1. Good supervision models which professional staff would see as attractive.

   2. Someone who can have an overview on planning Occupational Therapy services. The senior Occupational Therapy manager is the most appropriate person to address the skills mix issue.

   3. Someone who can move resources around to ensure that services are prioritised and reprioritised in response to problems of fluctuating staff levels.

4. Someone who can give time to recruitment and retention.

5. Someone who can liaise at a strategic level as well as an operational level.

6. A senior Occupational Therapist in each agency who can facilitate joint planning of services and effective use of limited Occupational Therapy resources.

In the NHS this means district Occupational Therapists leading the Occupational Therapy services. In social services departments this means a principal officer of Occupational Therapy.

Four models are proposed by the research team and the pros and cons of each are examined. No one model is recommended but in view of the Government's response to the report on Community Care (Griffiths 1988), every health and local authority will be jointly responsible for planning services for clients in the community. This is likely to have considerable impact on the Occupational Therapy services. Models C and D as outlined in the report may, therefore, be of particular value in planning for the future.

Finally, in this chapter the users' views are elaborated.

Articulate users are seeking a service over which they have more control. There is some impatience with the attempts by some members of the Occupational Therapy profession to become total life-style managers. There is considerable respect for the practical skills and knowledge of the profession, along with a strong desire for Occupational Therapists to share these skills with service users and for more formal links to be forged between organisations for disabled people and Occupational Therapy. Some options could include:

- representatives from local organisations for people with disabilities on the Boards and Committees of Occupational Therapy Schools and Departments.

- advice on curriculum content from organisations for disabled people

- recruitment of people with disabilities into Schools of Occupational Therapy using the programme developed for social work as a model.

The need to understand and meet the agenda of the service user is pressing. The skills and knowledge base of Occupational Therapy are important, but a failure to understand the aspirations of people with disabilities and their carers would not be helpful for the future development of the profession.

A start has been made to involve service users in decision making about the kind of skill mix needed for Occupational Therapy. It has been established that service users do accept the need for the professional kitemark in a range of situations and that the confidence of service users would be eroded if qualified Occupational Therapists were not available. There is little desire for de-professionalisation and de-skilling, however, there does seem to be a strong desire by people with disabilities to control their own destinies.

RECOMMENDATIONS

The issues raised by this study are many and fall into four major groups which overlap and are closely interlinked: skill mix; education and training; manpower, recruitment and retention; and the relationship of the profession to people with disabilities and their carers. The research team has produced a series of recommendations in these four areas.

Each of the recommendations has arisen directly from the policy review, data collection and policy analysis. Many themes have converged and similar issues have been identified as threads running through all the available sources of information.

Skill mix

Skill mix should be determined in terms of benefit to the service users. It should be seen in terms of the total staffing pattern of the health district and local authority, paying attention to the staff mix within facilities, that is availability of other health care professionals such as speech therapists, district nurses, and specialist social workers.

Defining optimum skill mix should be a tri-partite exercise between service managers and planners, professionals and service users to ensure that public confidence in skill levels is maintained. The decision about the appropriate skill mix should be made after consultation with professions and service users and should include consideration of the importance of ancillary staff such as clerical workers and porters.

Recommendation 1

> **Optimum skill mix should include considerations of the local staff mix and ancillary staff and should hinge on consultation with service-users as well as professionals so that the best service possible within each locality is achieved making the best use of available skills.**

Training

The current helper's course is considered a laudable effort by the profession to meet a supply need. As the National Council for Vocational Qualifications develops its system of credits for vocational training, the Helper's Course should be developed to enable access for all helpers and technical instructors to further training or to entry into training for the professional qualification.

Recommendation 2

> **All helpers and technical instructors should be encouraged and enabled to enter training courses designed for them and receive credit from the National Council for Vocational Qualifications. This**

will require the development of accessible courses and techniques such as open learning should be examined.

Education

In view of the stability of the helper and technical instructor workforce within Occupational Therapy and the very low vacancy factor for these grades, the profession may benefit from the further development of access courses. These may prove expensive initially but it is suggested that a long term cost-benefit analysis would demonstrate considerable advantages. Also, it is suggested that open learning techniques could reduce the costs to the service.

Recommendation 3

Access courses should be developed using techniques such as open learning by all Occupational Therapy schools and departments and all helpers and technical instructors should be offered this opportunity.

Consolidation of helper and technical instructor grades

Changes in the provision of health care and the need to recognise the skills and qualifications of all support staff, means that the distinction between helpers and technical instructors is no longer seen as important, except in terms of salary differential.

Recommendation 4

The helper and technical instructor grade should be consolidated, and the new grade be described as Occupational Therapy support worker. Current staff would retain seniority and pay levels, but new staff would be placed on the new grade pay scale at a point which would recognise previous experience and relevant qualifications.

The position of helpers and technical instructors within large institutions

As large institutions close, the skills, knowledge and experience of helpers and technical instructors could be lost.

Recommendation 5

Health authorities should be reminded of the need to ensure that helpers and technical instructors are given the opportunity to provide service either in community facilities or to be re-oriented to helper and technical instructor posts in other areas of the authorities.

Education and training, validation and reality

The educational base of Occupational Therapy will be

increasingly in higher education and will be greatly affected by credit accumulation and transfer. The report suggests that there was reality shock among newly qualified staff. This was evidenced by their failure to enter the profession after qualification and difficulties in entering practice. A need for wider experiences of clinical practice at the basic level and specialised clinical courses at post-basic level is apparent. Establishing a convincing research base for practice is stressed.

Course validation procedures seem to be unnecessarily complex and to involve too many bodies. Course validation procedures need to be reviewed to ensure that all courses are validated only by one body for professional content and by the procedure within the institute of higher education. It is further suggested that the Occupational Therapy Board of the Council for Professions Supplementary to Medicine be clearly identified as the only body which is responsible for validating professional content.

There was evidence of the need to ensure that students acquire a real appreciation of the work of the Occupational Therapy service before, during, and on qualification and entry into employment. Schools should be more closely involved in the manpower planning process at district and regional health authority levels.

Recommendation 6

Schools should require a period of relevant work experience prior to entry into the profession.

Recommendation 7

All students should have a rotation of clinical placements including community experience.

Recommendation 8

Clinical placements should take place in a wide range of community facilities, some of which may not already have an Occupational Therapy service, but all should be approved for training on the basis of the skills, competencies and philosophies of the people in the service. There should be adequate supervisory arrangements in place, but complex accreditation procedures with contracts of affiliation are not advised.

Recommendation 9

All health and local authorities should develop plans to ensure adequate orientation and support for new entrants.

Recommendation 10

Schools and departments of Occupational Therapy

should include at least one practising Occupational Therapist from health and one from social services in curriculum design work. Senior clinicians wishing to enter teaching should not suffer salary loss.

Higher education

The many positive benefits of moving to higher education institutions were apparent: for example, a less isolated profession; the possibility of developing a research base; the need for all health care professions to be mindful of the impact of credit accumulation and transfer.

Recommendation 11

All Occupational Therapy schools should continue to develop links with higher education and all should eventually become part of an institution of higher education.

Recommendation 12

An escalator model of education should be adopted whereby some entrants may gain access through courses for helpers, and some along with some relevant work experience, through academic qualifications. All would register when enough credit units had been completed, some may leave to work and return to complete credit units for graduation and some would leave at first degree level, whilst some may decide to complete only the credit units for registration.

Recommendation 13

The value of post-basic clinical specialisation should be recognised and courses developed, some perhaps with other disciplines which could be acceptable for academic credit.

Recommendation 14

The extension of research training schemes for Occupational Therapists, particularly to develop techniques to evaluate clinical interventions, is recommended.

Manpower, recruitment and retention

The many shades of meaning given to the phrase "a shortage of Occupational Therapists" were revealed in the study. The need for an agreed definition of the term was apparent.

Recommendation 15

It is recommended that the numbers of Occupational Therapists required should be a local decision depending upon the objectives for health agreed nationally, and that this should be decided based

upon consultation by service managers and planners among Occupational Therapy professionals and local organisations by and for disabled people and their carers. A local contract of service should be drawn up on this basis and staff members should be agreed according to contracted work load.

Overlap

The continuing difficulties of overlap and waste of resources between health and local authorities were noted. However, the Government's response to the report on community care would suggest that the debate about co-operation will have to cease.

Recommendation 16

All health and local authorities, in seeking to implement the new policy on community care should establish integrated Occupational Therapy services, which may be based on a number of models, and which are complementary to locally organised initiatives by people with disabilities and their carers. Models C and D in Chapter Four may prove in the long term the most relevant.

Recruitment and retention

The issue of recruitment and retention will be better resolved when each integrated Occupational Therapy service has a local contract of service. It will then be possible to establish the numbers of Occupational Therapists required in each region.

Recommendation 17

Initial recruitment into the profession should be examined carefully. The bursary system should change to a sponsorship scheme administered through the regional health authorities.

Recommendation 18

Schools should have affiliation contracts with regional health authorities which should include mutually agreed goals for recruitment. The contract should specify the expectations that the regional health authority has of the school, including the requirements that schools should implement active equal opportunities programmes, particularly to develop access to the profession for people with disabilities and people from ethnic minorities. The contracts should be monitored and reviewed on a five yearly basis.

Recommendation 19

Each health district and local authority should examine carefully with senior members of the

profession as to how a more flexible service can be provided. As plans for integrated services are advanced, consideration should be given to evening and weekend working. The 9-5 Monday to Friday service will probably need to change if Occupational Therapists are to be recruited back into the service and to be retained within it. Distance learning packages should be offered to returners.

Recommendation 20

There should be a specific commitment by the profession to abandon the custom and practice of entering the profession via health. As integration of health and social services occurs and community care policies are implemented, such advice will be increasingly unrealistic.

Recommendation 21

Local authorities should be more involved in the selection of students for sponsorship by the integrated service and should be prepared to offer sponsorship finance in an integrated Occupational Therapy service.

People with disabilities and the Occupational Therapy profession

People with disabilities and their carers are, in effect, the service users or consumers of Occupational Therapy services. The efficiency and effectiveness of Occupational Therapy is not improved by the complex, overlapping structure of the rehabilitation services. There is a strong demand for direct contact with fewer professionals and preferably only one. In developing integrated services, case management and key worker systems should be considered. In the current context, the role of Occupational Therapy within the rehabilitation services is unclear, therefore, discontent with the system may be projected into the profession. However, it should be noted that people are seeking more control over their own lives, more choice and fewer professional interventions. There should be a serious effort to lessen the gap between the agendas of the profession and those it serves.

Recommendation 22

The Occupational Therapy profession should take a lead in requesting a review of rehabilitation services. Structures within the profession should be examined to ensure that service needs as articulated by service users, managers and planners are taken into account, for example membership of the Occupational Therapists Board could be widened to include representatives from the employment field and service users groups.

Recommendation 23

Schemes to extend consumer choice such as self-assessment and voucher schemes should be explored by the profession with local organisations. The legal implications of these should be considered.

Recommendations for further research

Recommendation 24

Manpower

In view of the confusion surrounding the issues of entry and re-entry into practice, it is suggested that key areas for manpower research are follow-up studies of students qualifying from Occupational Therapy schools and studies of Occupational Therapists who return to practice.

Recommendation 25

Skill mix

There is a need to study in closer detail the issues which affect decisions about skill mix within the rehabilitation service. The Provisional Tool to measure Skill Level may be a useful means to this end, but needs further development.

Recommendation 26

Evaluation of interventions

It became apparent during this study that little data existed as to the efficacy of the interventions in Occupational Therapy. In view of the investment in the service, it is important that Occupational Therapists are encouraged and provided with the resources to develop evaluative studies of clinical practice.

Guidelines for Local Contracts of Service for Occupational Therapy Services

General Points

1. Each contract should cover a particular unit or type of service. Within health authorities these would normally correspond to the existing units of management and in local authorities correspond with locations or functions.

2. It is suggested that the term of each contract should be for one year which would correspond to each authority's annual review of policy and budgetary cycle.

3. Each contract should be drawn up between the Occupational Therapy manager, the provider, who is responsible for the service and the purchaser who could be the unit manager or the most appropriate social services manager.

4. In the event of non-agreement of the contract, there must be recourse to the most senior manager in each authority, that is the district general manager or director of social services.

Components of the Contract of Service

1. Description of the service covered by the contract including the unit to be served; it's characteristics, bed; catchment area and any other information which defines the unit to be covered by the contract.

2. Management responsibilities and delegation arrangements: including budget holders; actual or delegated responsibilities for recruitment; authorisation of resources; service monitoring; staff training, and so on.

3. Referrals to the service:
   this section should define:

   a) Type of referral system.
   b) Criteria for acceptance of referrals.
   c) Prioritisation of referrals.
   d) Method of dealing with inappropriate referrals; referral forms; details of prioritisation methods; and guidelines for referrers should be established.

4. Definitions of Services:

   The range of services required and offered should be agreed and a clear definition of what each entails and how workloads will be measured, given:

   a) Forecasting demands, taking into account previous activity levels and epidemiological analysis.
   b) Type of service to be provided for example, assessment, treatments, home visits, and so on.
   c) Data on current workloads.

d) How workloads are to be measured including short, medium and long term work (that is intensity).

Caution is recommended in predicting the frequency of treatment of numbers of patients because this will be dependent upon a balance of work between caseloads and the quality of work required.

e) Definition of the standards and quality of service:

The College of Occupational Therapists' Standards of Practice should be used as a basis for establishing a local definition for quality of service.

Purchaser and provider should agree the level of service for the term of the contract and should make statements about any issues which will be addressed to resolve the agreed deficiencies in 5) below.

5. Statement of Deficiencies:
There could be several areas where there might be deficiencies in the service which would result in an inability to deliver. These should be highlighted in the contract if they can be forecast.

For example:

Staff vacancies due to difficulty in recruitment to certain posts.
Deficiencies in other services affecting the Occupational Therapy service such as lack of physical space in which to conduct treatment or, in the community, shortage of surveyor time to complete adaptations to client's homes.

6. Statement of services required from the purchaser to enable the contract to be fulfilled:
This will include details of support services required which are outside the control of Occupational Therapy managers such as portering, clerical, cleaning, transport, and so on.

7. Establish costs:
These will include:

a) Staffing including on costs for agreed level of service.
b) Other costs, equipment, materials, transport.
c) Running costs of buildings where appropriate, such as heating, lighting, telephone, stationery.
d) Recruitment and training costs.

8. Statement of any special problems which may need to be addressed via the planning process.
This will include proposals which are already in the pipeline for additions to the service when the contract is being established.

9. Monitoring arrangements:

Throughout the term of the contract, both purchaser and provider should regularly monitor costs and activity levels. Effective information systems will be essential to ensure that potential variances from the contract are highlighted early to allow corrective action to be taken.

This will also allow for action in the event of major unexpected changes being imposed upon purchaser and/or provider from outside the service during the term of the contract.

Procedure to determine Occupational Therapy manpower within a locality

1. Epidemiological data:

Number of people with disabilities within locality: physical, emotional, sensory deficits.

Specific factors likely to increase numbers of vulnerable people, for example, increase in numbers of people aged 70 years or more.

2. Service Users:

Consult views of users on access to services. Complex, overlapping services may be simplified and will affect required numbers of Occupational Therapists and their effectiveness.

Consultation can be effected through local groups for disabled people and through carers' groups.

3. Resources:

Human
Review human resources within health district and local authority establishing where overlapping is occurring, and noting the current staff mix within the rehabilitation service:

Occupational Therapy
Physiotherapy
Speech Therapy
Nursing: Hospital - Specialist Nurses
Community - District Nurses, Health Visitors, Community Psychiatric Nurses

Financial
Financial review focusing on total cost of rehabilitation services and establishing the proportion of funding spent on staff and the proportion of funding spent on non-staff costs.

For example, in re-provision of services for mentally ill people, a small workshop in the community staffed by two technical instructors receiving clients referred by an Occupational Therapist may be a more effective way of providing a service to users than the employment of three Occupational Therapists offering social skills training.

Consultation with Local Community
Local groups for and by disabled people and their carers could be consulted to elicit views on the shape of services.

4. Establishing a Local Contract of Service

When the locality has established the types of services required and the level of Occupational Therapy manpower required, a local contract of service should be drawn up.

This will state clearly the objectives of the Occupational Therapy service agreed between Occupational Therapy managers and service managers and planners after consideration of in-put from local service users.

5. Skill Mix

Skill mix should be viewed broadly and should include at least:

Occupational Therapists
Occupational Therapy Helpers
Technical Instructors
Clerical Staff
Porters

Items describing the work of the Occupational Therapy service can be submitted to interested groups (such as Occupational Therapists, service users, carers, and other professions involved in rehabilitation services, as well as service managers). These may be taken from the Provisional Tool to Measure Skill Level or from a development of that tool. The data generated will give service planners information about the discrepancies between these groups. The data collected from the service users and carers' groups will demonstrate the level at which public confidence in the service could be eroded if, for example, there were inadequate numbers of Occupational Therapists to carry out tasks seen by service users as highly skilled.

The decision about the optimal skill mix should be taken by service managers, Occupational Therapy managers and service planners who would consult other disciplines as necessary on the basis of the data generated.

OCCUPATIONAL THERAPY
SKILL MIX STUDY

KING'S FUND CONSORTIUM

AUGUST 1989

Preface

The King's Fund Consortium was awarded the contract by the National Health Service Manpower Planning Advisory Group to investigate skill mix, structures and models of service for the future in the Occupational Therapy profession. This challenging and interesting venture has taken place in the context of the publication of the White Paper on the National Health Service and the response of the Government to the Griffiths Report on Community Care. Changes on the education front are also gathering pace: the National Council for Vocational Qualifications and the Credit Accumulation and Transfer scheme are set to alter vocational training and higher education irrevocably.

The swift pace of technological change has already affected the nature of work within our society and professions in general are now being challenged to justify their position in the social order. In health care, this has entailed the need to examine many assumptions: consumers question health care providers and are no longer content with reassuring answers, now perhaps perceived as paternalistic or, worse, arrogant. Professionals are, therefore, under pressure to justify their actions and to dispel their mystique.

Occupational Therapy has, in many ways, been an innovative profession. It was for this reason that the Manpower Planning Advisory group chose Occupational Therapy for the Skill Mix study, since it had developed a nationally organised system of training Helpers and had a long tradition of working with Helpers and Technical Instructors. As the research progressed, it became clear that skill mix could not be studied in isolation from the other two planks of this report: structures and models of service, since the gestalt of all professions is undergoing so much change.

The research team has proceeded from a series of assumptions about the needs of people, the nature of health care and the role of professions within society. Health care professions exist solely to serve those who need assistance in managing their health needs. Professional assistance is definable and can be explained to lay people in terms which can be understood. Service users and their carers must be given clear information about the options available to them by health care professionals. Professional actions are open to scrutiny, especially since the bulk of the funding for training and employment is derived from the public purse. Society must ensure that professions provide value for money and do not hide behind claims of the impossibility of defining and describing esoteric activities. Professions have value in that they provide a body of unique expertise which they place at the disposal of society, the loss of which would damage the health of the population.

CHAPTER ONE

Conduct of the Study

1.1 Method

The purpose of the project was to identify factors which need to be taken into account when making decisions about appropriate skill mixes and manpower requirements for Occupational Therapy in both the National Health Service and Local Authorities and to make recommendations for models of service, supported by pertinent data. The proposals for skill mix should take into account the current position of Occupational Therapy helpers and have regard to the National Vocational Qualification framework being established. The approach to the study was to generate empirical data from a wide range of sources which could begin at an early stage to identify important issues and could be adapted to take account of emerging themes.

Several methods of data collection were used to ensure that any issues which emerged from the data were not unduly affected by the biases inherent in one particular method of data collection. This is known as the technique of triangulation, by which the known weaknesses of each method are counterbalanced by the strengths of the other procedures. Interviews were sought based on a semi-structured schedule (see Appendix F). These elicited responses to questions about:

- the role of Occupational Therapy
- the adequacy of Occupational Therapy services
- issues likely to be of importance to Occupational Therapy in the next five to ten years
- alternatives for the future of Occupational Therapy.

An observational tool to record actual activities and, thereby, to record the work of Occupational Therapy departments was developed based upon earlier work by Ashworth (1980). These two instruments were tested by a preliminary trial in one health authority. It was found that the interview schedule was useful in that the questions elicited much that was interesting and relevant to the field of study. The observation schedule was tried by three members of the data collection team and was found to be a useful means of recording the activities of Occupational Therapy departments. It was proposed, initially, to select Occupational Therapy departments in England, Wales, Scotland and Northern Ireland to reflect a multitude of features and, therefore, to present a picture of Occupational Therapy which could be said to represent the average standard over the four countries. During discussions with the Steering Group, it emerged that professional leaders believed this would represent a bias against understanding the nature of the Occupational Therapy profession. They believed much of the profession's strength emanated from its capacity for local innovative initiatives.

However, in methodological terms, to collect data only from such locations would represent a departure from research orthodoxy; that is to say that research generally is interested in the commonalities of phenomena rather than the unique features of some examples. To ensure that the project benefitted from both approaches, it was decided that data would be collected from a range of locations which could be described as representing normal or "Standard" Occupational Therapy practice, and a range of locations to be nominated by professional leaders which could be described as particularly innovative and, therefore, be said to represent examples of the "Leading Edge" for the future of the profession.

In view of the methodological problems involved, it was decided that these two data sets should be analysed separately and each would be used to inform the study in quite different ways. The standard data would provide quantitative information about current practice, whereas the data from the Leading Edge locations would provide information and ideas about innovations which would enable recommendations to be made about future structures.

1.2 The Field Work

Field work was undertaken in England, Wales, Scotland and Northern Ireland. The field work comprised visits to many locations to collect data for both the "Standard" set and the "Leading Edge" set. The Standard data were collected from a wide variety of health authorities and social service departments to reflect the social, economic and cultural diversity of the United Kingdom. The Leading Edge data were collected from a multiplicity of agencies nominated by senior members of the Occupational Therapy profession as outstanding examples of professional practice.

1.2.1 Standard Data

The Standard data initially consisted of observations of the work of Occupational Therapists, Occupational Therapy helpers and technical instructors in a range of health authority and social service facilities and interviews with three groups: Occupational Therapists, leaders of voluntary organisations for and by the disabled and other professionals who have informed views of Occupational Therapy. These will be referred to respectively as Occupational Therapists, Voluntary Sector (VS), and Other Informed Professionals (OIPs).

1.2.2 Characteristics of the settings in which the Standard data were collected

The settings for the standard data were selected on the basis of a matrix designed to produce 12 settings with widely varying characteristics. These are reported in Table I Appendix G. From this it can be seen that the settings included a wide range of varying features over seven criteria.

The teaching commitments of the health districts varied widely. See Table I Appendix G Section (a). The fact that in

only two of the 12 districts were located schools of Occupational Therapy is probably reflective of the national situation since there are only 16 schools of Occupational Therapy providing full time courses in the UK. The situation as regards medical schools within health districts is also reflective of the national situation, while all 12 health districts contained some type of training for health care professions. This is also a fair reflection of the national picture. The information on the training status of the districts was derived from the 1988 Hospitals and Health Services Year Book (Institute of Health Services Management, 1988).

The unemployment rates within health districts were derived from Fothergill and Vincent (1985) and may, therefore, have been a little out of date but would reflect the proportions of low to high unemployment areas since these are unlikely to change greatly over three years. (See Table I Appendix G Section (b)). It may seem that the proportion of areas with rates of unemployment of greater than 16 per cent is rather high at five of the 12 health districts in the sample. However, it is important to note that to get a wide spread sample over Great Britain and Northern Ireland, three Scottish and three Northern Irish health Boards were included in the sample (Table Ig, Appendix G Section (g)). Since these are known unemployment blackspots, this explains the apparent imbalance of this aspect of the sample.

The rates at which non-indigenous people have settled in the health districts was also derived from Fothergill and Vincent, (1985). These data are unavailable for Scotland and Northern Ireland, therefore, the sample reflects the rate of settlement in the health districts of England and Wales and shows maximum variation of the five categories from less than 1 per cent to greater than 4 per cent.

The morbidity rates of the health districts were also derived from Fothergill and Vincent, (1985). These data are also unavailable for Scotland and Northern Ireland but show almost maximum variation over the six districts of England and Wales. (See Table I, Appendix G Section (d)). The information on the political control of the predominant council within the area was similarly derived from Fothergil and Vincent, 1985 and seems to reflect the national picture in 1988 fairly well. (See Table I, Appendix G Section (c)). The populations of the health districts were derived from the 1988 Hospitals and Health Services Year Book (Institute of Health Services Management, 1988). These show a wide range from 960,000 to 101,804 with a median of approximately 300,000.

The health districts to be included in the study were derived from the six criteria listed above and were chosen by dividing the four countries into eight zones. (See Map, Appendix G). In fact, the North West of England and Wales have probably been under-represented in the sample. However, as can be seen from the information reported above, the settings represented a very wide range of characteristics.

1.2.3 The Observational Data

These were collected using the observational instrument attached in Appendix H. This instrument allowed data to be collected over 25 observational points during a two hour period of data collection. The activities of the Occupational Therapist or helper was to be recorded on a separate sheet for each of the 25 observational points. Nine basic categories of activity were recorded.

The Categories of activity observed

4 = Patient related administration
5 = Staff related administration
7 = Individual clinical practice
8 = Group clinical practice
10 = Teaching of patients
13 = Teaching of Occupational Therapy student
14 = Teaching of Occupational Therapy staff
12 = Teaching of other groups
2 = Meal breaks, travelling, waiting and preparation time.

Since the observers had to write details of the patients or clients and the activity on each of the 25 observational sheets for each observational time span, it was possible to derive from these data descriptions of activities occurring within Occupational Therapy departments. These proved useful in developing another technique to examine the matters within the brief of the study.

1.2.4 The characteristics of the observational sample

These are presented in Table II and demonstrate that the proportion of hospital to community based Occupational Therapy is in the ratio of 6.5 : 3.5 and is thus slightly out of line with national trends which would suggest a ratio of 7.5 : 2.5. The ratio of Registered Occupational Therapists to helpers and technical instructors (See Table II, Appendix G Section (a)) is in the ratio of 7.5 : 2.5, which is not quite so reflective of national trends since these are said to show a ratio of Occupational Therapists to helpers and technical instructors of 3 : 2. However, this could be accounted for by the disproportionate use of helpers in some areas such as hospitals for people with a mental handicap. The structure of the hospital sample is reported in Table II. Since it has been suggested that helpers pre-dominate in mental health areas, the sample in the study could be described as reflective of the situation in areas where Occupational Therapy helpers are not used without the adequate supervision recommended by College of Occupational Therapy Guidelines (College of Occupational Therapy, 1984).

1.3 The Interview Data

Interviews were conducted with 60 subjects: 20 Occupational Therapists, 20 members of voluntary organisations by and for disabled people and 20 members of other professional groups who work with Occupational Therapists.

The interviews were conducted using a semi-structured interview schedule which had been tested earlier and which was found to be useful (See Appendix F).

1.4 Developments out of the initial data set

The study was designed so that issues emerging could be taken up and incorporated into the study. In reviewing the interview data from the voluntary sector, it became apparent that there were considerable discrepancies between two major interest groups. It seemed to be important to discover if there were differences between the two groups concerning the levels of skill required for various Occupational Therapy department functions. If there is a degree of rejection of the skilled professional, then it was important to find out in what circumstances professional skills were sought and valued and how much confidence service users would have in non-professionals when given the choice between them and professionals.

1.4.1 The Development of the Provisional Tool to measure Skill Level

The data which were collected during the observational study proved to be a source on which to draw to begin the tasks of measuring skill level and defining areas of legitimate professional intervention. Based on the Celentano framework (Celentano, 1982), at issue are the areas of Occupational Therapy operations that it is important should remain as skilled and professional, not only to professionals themselves, but also to service users. For example, a competent adult paraplegic who wishes to make adaptations to his home, may employ an interior designer or architect at his own expense with whom he will discuss his needs. If, however, he is unable to afford to do this, he will apply for help to his local authority and will have to wait for an assessment, which in most cases will be performed by an Occupational Therapist. The Occupational Therapist will then mediate between the service user and the other professions, yet if the service user had the economic resources, no such mediation would occur. It is unclear, therefore, that Occupational Therapists are needed in this particular case for their professional skills. Rather, it may be suggested that the Occupational Therapist is operating as part of the ad hoc secondary benefit structure which has grown up around the legislation on disability.

By contrast, a severely mentally handicapped adolescent who becomes paralysed and whose parents wish to offer care for him in their home would have quite different requirements. This situation would require a level of professional skill and help in assessing the home situation where the skills of the Occupational Therapist would be used legitimately and could not easily be replaced by an interior designer or an architect. From these two extreme cases, certain features emerge concerning the legitimacy of professional Occupational Therapy intervention. An important issue is that of competency: the competent adult paraplegic wishes to make his

own decisions about his environment in conjunction with a specialist in home design. Competent adults do not always necessarily make good decisions, but they will rarely make decisions which are not in their own perceived interest. The Borrie Report (Office of Fair Trading, 1982) makes this point in relation to the consumer's choice of spectacles (Para 14.12, p.159). The complexity of the situation is also important in involving the professional Occupational Therapist. The second case is clearly complex and the parents would probably be unable to negotiate a satisfactory life situation for their child with a designer alone. A further issue is that of advocacy; a professional Occupational Therapist may need to use her knowledge of bureaucratic structures to ensure that the client and family obtain all available help.

As the Borrie Report (Office of Fair Trading, 1982) demonstrated, professions cannot always be relied upon to recognise and define areas of legitimate intervention. The desire to protect us all from our own folly may be laudable but can also interfere with our rights as competent citizens to make decisions for ourselves. The Provisional Tool to Measure Skill Level was designed to begin the process of looking for consensus about legitimate professional intervention.

A further issue of central importance to this study was that of the role of the non-professional support worker. When areas of legitimate professional intervention are defined, it may be that many activities could be performed by support workers - known in Occupational Therapy as helpers. The College of Occupational Therapists has produced guidelines for helpers' courses (College of Occupational Therapy, 1984) and sample job descriptions. The helper works under the overall supervision of a trained Occupational Therapist and must always have access to one for advice and guidance (p.6, College of Occupational Therapy, 1984).

It is this requirement which has been controversial. Spashett (1981) pointed out that several Occupational Therapy departments were run entirely by helpers. Yet clearly if a situation is defined as requiring intervention beyond the capability of an ordinary competent adult, a degree of professional skill is involved. The College of Occupational Therapists has been in the vanguard of developing support worker courses, but the legal relationship between the support worker and the registered professional remains unclear, since health authorities continue to employ Occupational Therapy helpers without professional Occupational Therapy supervision. The NHSTA strategy document. "The Way Forward" (NHSTA, 1987) addresses this issue in relation to nursing by stating that "the support worker should work at all times under the direction and supervision of registered nurses...." (p.7).

It may be suggested, therefore, that while there is evidence that the competent lay adult should be allowed to make whatever decisions he wishes within the legal framework of his rights and obligations as a citizen, there is a discontinuity

at this point. The support worker should only operate within the framework of professional supervision. Malby (1989) further clarifies this in her application of the support worker concept to a district health authority. She notes the difficulty of eliciting from staff the true nature of the supervision of unskilled staff and the need to incorporate mechanisms to ensure that their input is adequately reported to a professional nurse.

1.4.2 Description of the Provisional Tool to Measure Skill Level (PTMSL) (Appendix J)

This is a 175 item tool. Its validity is based on its derivation from the pertinent universe of content; that is, actual observations of 48 Occupational Therapists, Occupational Therapy helpers and technical instructors in England, Scotland, Wales and Northern Ireland. Since the tool is, as yet, untested there can be no further evidence offered of its validity or reliability.

The tool was distributed to 20 Senior Occupational Therapists and 20 disabled service users. Each subject completing the tool was asked to perform 175 ranking tasks. The ranking is completed by assigning each item to a position on a nine-point scale. Positions 1, 2 and 3 are assigned if the subject believes this task could be completed by a lay person with general life experience. At this point, there is a discontinuity on the scale, because positions 4, 5 and 6 are assigned if the subject believes the task requires skills beyond those of the competent lay person and could be performed by a support worker. The scale does not specify "under the supervision of a professional Occupational Therapist", but it is assumed that the task has now become one amenable to legitimate professional intervention and that the College of Occupational Therapy guidelines (1984) for helpers would be followed. Positions 6, 7, 8 are reserved for activities which should only be performed by a professional Occupational Therapist.

The samples were purposive, volunteer samples. Since the disabled service users could be described as active in disablement pressure groups and the Occupational Therapists could be described as professional leaders, each group could, therefore, be described as embodying high-profile leadership characteristics. If there were significant differences between the two groups, it is likely they would be found and identified through a very small purposive sample such as this. The results of such an exercise should be interpreted with great caution since it is likely that they would provide much greater differences than would be found in the general populations from which the two groups were drawn.

CHAPTER TWO

Analysis of the Standard Data and Presentation of Results

1. Analysis of the standard data

Three types of data were collected during the course of the study on the premise that all methods of data collection are likely to be flawed and to contain biases. It is suggested that several types of data should be collected so that the inherent biases within each method will be slightly different and will have nullilfying effects on each other when the central phenomenon of the study is examined. This is the rationale underlying the notion of the triangulation of data sets. In this study three types of data were collected and analysed:

a. direct, structured, observational data from the activity analysis of Occupational Therapists, helpers and technical instructors in a wide variety of settings.
b. semi-structured interview data from Occupational Therapists, voluntary organisations for and by people with disabilities, and other professional groups such as service managers, doctors and nurses who work with Occupational Therapists.
c. 175 items derived from the observational study were submitted to two groups: senior professional Occupational Therapists and people with disabilities linked with a variety of coalitions for the disabled.

1.1 Activity Analysis of Occupational Therapy (Appendix I)

These data were analysed descriptively. Each observational period of two hours produced 25 observations, therefore, a total of 1,200 observational sheets were generated. These fell into categories. The observations were then displayed in a series of five Pie Charts (see Appendix G) to reveal the following information:

i) Overall pattern of work
ii) The pattern of work of hospital Occupational Therapists
iii) The pattern of work of community Occupational Therapists
iv) The pattern of work of hospital Occupational Therapy helpers and technical instructors
v) The pattern of work of community Occupational Therapy helpers.

1.2 Semi-structured Interview Data

The semi-structured interview data involved the analysis of replies in response to four questions by 60 interviewees. Questions one and two concerned issues which were essentially attempts to consider the range of definitions of Occupational Therapy (question one) and the perceptions of the adequacy of current services (question two) of the three groups interviewed. They were analysed into categories developed as a result of the perusal of the initial data by the research

team. Seven judges from the research team (including the two Occupational Therapy experts) then categorised the data from the 60 interviews. Following the usual procedure for this, a decision was made that five out of seven of the judges should be in agreement before an item could be considered to be valid and placed in a category. The categorisation of the answers to the two questions was then presented as two bar charts.

Questions three and four required a rather different approach to analysis since the interviewees were asked which issues would impact on Occupational Therapy in the future (question three) and what alternatives they would suggest for the future of Occupational Therapy (question four). These led to the generation of a series of lists. A master list of issues and a master of alternatives was assembled. These were then divided into:

- items on the common agenda and, therefore, shared by at least two of the groups
- items on the individual agenda of each group and not shared by the other two groups.

This allowed for the generation of two charts which summarise issues and alternatives proposed by the 60 interviewees.

1.3 The 175 item Provisional Tool to Measure Skill Levels (Appendix J)

As this is a tool in the process of development, the Provisional Tool to Measure Skill Levels (PTMSL) was analysed carefully. Completed and usable replies came from 16 people with disabilities and 18 senior members of the Occupational Therapy profession. A reply was counted as usable where the respondent had made a serious attempt to answer all 175 items. This exercise was performed mainly as a filtering operation rather than an attempt to provide substantive data on the issue. The first step was to eliminate from further analysis items which were ambiguous. Ambiguous items were defined as items which remained unanswered or which were placed in more than one category by at least one respondent in both groups. This entailed that nine items were eliminated since at least one Occupational Therapist and one person with a disability was unable to categorise the item unambiguously. The remaining 166 items were scrutinised and placed into the modal category, provided that category contained a modal percentage of 50 per cent or better. In a few cases there were missing data or dual scoring, in which case the modal percentage was calculated on a lower base. However, there could be objections to this procedure and, if the tool were to be developed further, careful consideration of the effects of this would have to be taken into account. The respondents failure to categorise an item had the effect of lowering the percentage base. There were also a few cases where the modal percent was a little less than 50 but a category above or below would demonstrate the direction of opinion and the item was categorised accordingly. This occurred in 11 items from

the Occupational Therapists' sample and six items from the sample of people with disabilities. In one or two cases opinion was evenly divided and the items could not, therefore, be categorised. This applied to two items from the Occupational Therapists' sample and one item from the sample of people with disabilities. Sixteen items from the Occupational Therapists' sample and 16 items from the sample of people with disabilities were, therefore, categorised according to the weight of opinion within each group. For each item, the respondents were asked their opinions as to the degree of skill required: Lay person (numbered 1-3), support workers (numbered 4-6), or Occupational Therapist (numbered 7-9). These data were treated as categorical rather than ranked data since the respondents were, in essence, being asked to classify the suitability of the item for a particular level of skill.

The items were, therefore, initially cross classified and percentages were calculated. However, it was clear that further analysis could be undertaken by testing for differences in the patterns of categorisation of the two groups.

2. Presentation of results of the analysis of the standard data

The results of the analysis are presented in a series of charts and tables in the appendices. These will be examined separately and then summarised jointly.

2.1 The Activity Analysis (Appendix I)

The Activity Analysis data displayed a picture of work which essentially confirms that of previous studies with regard to the work of Occupational Therapists in hospital settings (Edwards, 1980, DHSS, 1981) since it demonstrates a picture of the hospital based Occupational Therapist as essentially concerned with individual treatment (41%) and patient-related administration (23.6%). Hospital based Occupational Therapy helpers and technical instructors spend far more time on preparation and waiting for patients (24.3%) and little on patient-related administration (2.8%).

The data are particularly interesting in that the community Occupational Therapists' activity pattern can be contrasted with that of their hospital counterparts. It is interesting to note that a similar percentage of observations to that of their hospital counterparts fell into the patient-related administration category (24%) but that all their clinical activities fell into the individual patient category and no group clinical work was recorded. However, 26.15 per cent of the observations fell into the category of travelling, waiting, or preparation. This would suggest that travelling time for Occupational Therapists working in the community is a significant factor and one which must be noted for future reference.

2.2 The Interview Data

2.2.1 Question One: What is the role of the Occupational Therapist? (Appendix K)

Question one concerned views as to the role of the Occupational Therapist. The majority of interviewees (33/60) viewed Occupational Therapists as providing physical, psychological and social assessment; this view of Occupational Therapy was most enthusiastically endorsed by Occupational Therapists themselves of whom 15/20 put forward this definition. The remainder of interviewees sharing this view was divided equally between the other professionals and the voluntary organisations. The view of Occupational Therapy as essentially concerned with activity was endorsed by five Occupational Therapists and seven other professionals. An interesting phenomenon was that of the category of "Occupational Therapist as gatekeeper." This was supported by six interviewees; all of them were from the voluntary organisations and four were themselves people with disabilities. This group perceived Occupational Therapy as a mediating structure between people with disabilities and resource provision. There were some expressions of irritation at the control which Occupational Therapists were perceived as having over their lives. This phenomenon had not been expected nor sought by the research team but it demonstrated the importance of building up a picture of Occupational Therapy from many points of view. The people with disabilities holding this view of Occupational Therapy were convinced that the historical development of services for people with disabilities had not necessarily served their interests. For example, one of them said:

> "Occupational Therapists are an intermediary structure between the physical needs of the disabled and the resource givers/providers to pay for appliances we feel we need. That's their ONLY function as far as I'm concerned."

She added later:

> "The bureaucratic structure of Occupational Therapy is not needed."

The views of this group of interviewees on the role of Occupational Therapy seemed to be quite cohesive and to form a distinct agenda which would be revealed throughout the interviews.

Their approach contrasted greatly with that, in particular, of the Occupational Therapists' views of their own role. Those supporting the view of themselves as physical, psychological and social assessors might be described holding the holistic view of Occupational Therapy. This view was encapsulated in this comment by an Occupational Therapist:

> "By virtue of training Occupational Therapists have the skills to assess, understand and implement requirements for an individual's dysfunction. Occupational Therapists have a holistic view and I

feel that I look at problems with the family/carers and negotiate solutions within clients and professionals expectations."

This strongly supported view among Occupational Therapists clearly implies differences with the views of the disabled people within the sample. The other professionals within the sample and some of the interviewees from the voluntary organisations had a less messianic view of Occupational Therapy than did the Occupational Therapists themselves, but a more instrumental, pragmatic and utilitarian view of their function than the people with disabilities. Their view might be expressed in this reply from a consultant neurosurgeon:

"They deal with people who have got disabilities which prevent them functioning normally in their own environment. People who have difficulty dealing with things in their everyday life. I hope Occupational Therapists do the following for my patients:

(i) tell me what their problems are;
(ii) work out how they have arisen;
(iii) work out means of minimising problems via therapy and adaptations or other means."

Another subset of opinion came from groups in the voluntary sector concerned with mental health who supported the instrumental and utilitarian view of Occupational Therapy and were particularly concerned the Occupational Therapists should not abandon their traditional skills in assessing and providing activities:

"Occupational Therapy has got a lot of different roles. The traditional arts and crafts are getting less emphasis. Their most important role is in occupation and employment especially vocational training where clients benefit from Occupational Therapists' social skill background.

"The managers of some community projects are Occupational Therapists and I've been impressed by them. There's a bit of danger in the shift away from practical skills. New entrants to the profession look down on crafts. It leaves a gap as clients need help with basic daily living rather than exciting therapies. Vocational training and assessment to maximise skills are very important for continuing mental health. Everybody wants to be a therapist these days. People need a lot of help with basic practical skills - Activities of Daily Living. They need help and training. Long stay patients need help to look after themselves from day to day.

"There are opportunities in multi-disciplinary teams who can learn from Occupational Therapists about practical skills. Occupational Therapists can give practical skills to multi-disciplinary teams rather than therapies."

The overall impression of the data was that Occupational Therapists, in general, had a view of their role somewhat at odds with the views of service users and other professionals with whom they worked. Occupational Therapists seemed to be valued for practical, down to earth skills but many seemed to view themselves as total life-style managers who could use their position in people's lives to gain insights and offer help with all kinds of dysfunction, whether this was on the original remit for referral or not.

This approach to their role by Occupational Therapists was one with which the people with disabilities within the voluntary sector group were particularly at odds and a theme to which they returned again and again throughout their interviews. It might be described at this stage as the issue of who controls the agenda when a person with a disability is assessed by an Occupational Therapist.

2.2.2 Question Two: What is your view of the adequacy of the Occupational Therapy Service? (Appendix K)

The answers to question two similarly revealed some of the themes and issues which were to re-surface through the interviews. Many Occupational Therapists pointed to the difficulties caused by the overlap between health and social service Occupational Therapy services and the poor utilisation of manpower inherent in the situation as a major reason for inadequacies in Occupational Therapy services. One head Occupational Therapist in a health authority said:

> "There are artificial boundaries between hospital based and social services based Occupational Therapists."

Very few interviewees provided "knee jerk" responses by saying there were not enough Occupational Therapists and more needed to be employed. Even when shortage of Occupational Therapists was given as the major reason for inadequate services (17/60 respondents), there were many thoughtful replies. For example, a basic grade Occupational Therapist in the health service said:

> "Not enough Occupational Therapists are employed. What are we employed for? We need to educate other professions because they tend to stereotype our role."

The interview data began to point up the issue of defining what a "shortage" of Occupational Therapy meant. To the Occupational Therapists quoted so far shortage was related not just to actual numbers but to service structures and role definition. Other respondents suggested other facets of the situation which highlighted the meaning of shortage. An interviewee from a housing association pointed to the problems of a female profession:

> "The turnover seems to be very high. So many Occupational Therapists seem to be setting up home

and family. The structure of the profession and the perception is of a woman in her late 20s. You feel, will she be here in a year's time? Any profession must have a mix of people and ages, we don't want to build up a service with people who disappear."

Clearly, "shortage" could also mean a shortage of long standing members of the profession with whom voluntary sector organisations could liaise.

The people with disabilities who had such a cohesive view on the role of Occupational Therapists seemed to hold more disparate views around this issue. One of this group, however, suggested ways in which the shortage could be alleviated: improving the skill mix with clerical support and technicians, better co-operation between health and social services and also he suggested:

> "It should be easier for disabled people to be employed as Occupational Therapists and to train as Occupational Therapists."

However, another person with a disability in the voluntary sector interviews suggested that services were inadequate because of the inadequacy of Occupational Therapists in their assessments of the needs of individuals:

> "Professionals tend to by-pass disabled people's direct experiences of need and to impose inflexible professional prescriptions and, therefore, to fall short of really meeting needs."

She went on to suggest:

> "There are alternative aids people are talked into having that can't be used because they're not exactly right. The WASTE - it would be interesting to monitor the WASTE - it must be incalculable."

She also suggested that "shortage" of Occupational Therapists was a phenomenon related to the way Occupational Therapists are trained and that training should be directed at people with disabilities and that waste of resources on inappropriate aids could then be overcome.

Clearly, people with disabilities felt keenly the lack of professional interest in their expertise in helping to resolve the problems of the inadequacy of the service and the shortage of Occupational Therapists.

An interesting personal view on the issue of shortage was put forward by an interviewee working in an academic research unit in rehabilitation:

> "Classically, there are said to be not enough Occupational Therapists. There's an urgent need to look at current provision in the light of real needs instead of the traditional view. We might find there

are enough. Until we look more closely at the extent to which services meet needs we can't say anything about provision.

"I won't agree to say that we are too short of Occupational Therapists or that we have too many - we just don't know.

"It would be a waste to increase resources in the present state of knowledge. We need to put more money into evaluation - we need to develop client/patient centred services. Professionals tend to see needs in terms of things they want to offer, not in terms of client need."

The researcher's comments highlight the themes within the adequacy and shortage phenomena. Indeed, the enthusiasm of some Occupational Therapists for providing services they are trained to do was summarised in this comment from an Occupational Therapist employed in a social services department:

"We don't have enough Occupational Therapists to do the job we would want to do as a profession. In the service, we don't get the opportunity to do what we are qualified to do.

"Our training prepares us to offer services to all types of clients, including the mentally ill and handicapped but we can't do all that we are trained to do... Yet, we are a well staffed County, they are very supportive of us and recognise our value."

Clearly, for this interviewee there was a shortage of opportunities to fulfil herself professionally in the ways in which she had been promised she would be allowed to do in the course of her professional training.

The inadequacy of Occupational Therapy services was rarely a straightforward numbers issue. "Shortage" of Occupational Therapists is a complex area with many meanings according to the perspective of the interviewee. The interviewees were then asked what issues would impact on Occupational Therapy in the future and what alternative structures they would suggest should be developed.

2.2.3 Question Three: What issues do you believe will affect the Occupational Therapy Service in the next five to ten years? (Appendix L)

At this point the interviewees began to put forward several types of agenda - professional agendas in which their professional socialisation had clearly played a considerable part, personal agendas emerging out of life experiences, agendas relating to the client groups with whom they worked or to which they belonged. The data are displayed in such a way that while it is hoped they are comprehensible to the reader, the many individual contributions are displayed. Four lists

were generated:

- one list consisted of items on the common agenda which were mentioned in the interviews with at least two groups.
- the other three lists were made up of items on the agendas of the three groups interviewed which were not shared with other groups.

The items on the common agenda will be considered first. The item of most concern to the whole group was that of demography - both the rise in the numbers of elderly people and the decrease in the younger age groups. It is placed first on the list because it was also mentioned by 11 out of 20 of the other informed professionals. It was of particular concern to general managers, who, no doubt, see themselves as responsible for planning services. Similarly, the voluntary organisations were responsible for the position, as second on the list, of the 1986 disability legislation, for which many of them had been involved in lobbying activity. The community care policy was also of great concern to the other informed professionals. In reviewing this table, it is interesting to note that the common agenda was set largely by the voluntary organisations and the other informed professionals except in the case of two items (no 6 and 7), the National Health Service review and technological change which were placed there because of the Occupational Therapists. However, it should be noted that many of the interviews with the other two groups were completed before the publication of the review. Indeed, it may be suggested that voluntary organisations and the other informed professionals shared their agendas to a far greater extent than either shared with the Occupational Therapists.

The Occupational Therapists and the members of voluntary organisations differed significantly on three issues: disabled people's activism and the Griffiths review of community care and technological change. Interestingly, the first two differences occurred because the Occupational Therapists had not mentioned these items in large enough numbers. Similarly, the Occupational Therapists seemed to be some distance away from the other informed professionals where there was one significant difference.

In reviewing the items solely on the agenda of the Occupational Therapists, it is interesting to note, first of all, that the Occupational Therapists seemed to be concerned about a more disparate and wider range of issues than the other two groups, since they mentioned 14 items, as compared with seven mentioned by other informed professionals and 12 by respondents from the voluntary sector. The only item which could be described as part of an Occupational Therapy agenda is item one "Education about Occupational Therapy for other professionals", which was mentioned in three interviews as an issue which Occupational Therapy must address in the future. Placing this issue on the agenda gave two Occupational Therapists a chance to express their fears about the future thus:

"I fear the new White Paper, but until supporting

papers are released it is really wrong to comment. I fear the references to local medics and G.P.s getting more control, and I fear where decisions will be made on what is cost effective. Occupational Therapy will be dropped, so there is a lot of convincing to do; compared with physiotherapy where people understand what they do, we need to educate people and we're bad at that. People don't know what we do, especially medics who are only aware of what they see."

It also gave another Occupational Therapist the opportunity to return to the theme of "Shortage" of Occupational Therapists in terms of the limitations placed on their role by other professions. This head Occupational Therapist had already defined inadequacy in her service in terms of shortage of posts and had also described the training for the profession as a "limited baseline." However, she went on to say:

> "A hospice is being set up. The Occupational Therapy service they are demanding is for occupational crafts, but that's not how I see it. The creative therapy and psychotherapy should be Occupational Therapy input."

She went on to provide her definition of Occupational Therapy:

> "Occupational Therapy should be improving the quality of life of all patients."

This expansionist agenda was counterbalanced by that of a community Occupational Therapist:

> "We have to look realistically at what we can do and not try to be all things to all people...."

By contrast to the Occupational Therapists, the interviewees from the voluntary sector showed greater agreement around the items on their agenda. A minor issue for them was that of the questioning of the current role of Occupational Therapists, particularly from representatives of organisations who were themselves disabled people and who might loosely be described as supporters of the activist disabled person's agenda.

One such respondent mentioned the possibility of merger between Occupational Therapy and physiotherapy as a chance to re-define professional boundaries for the benefit of people with disabilities:

> "It's got to be looked at from the point of view of disabled people. Sometimes distinctions between professional groups can make services very complicated for consumers. Hard and fast distinctions between professions sometimes do more harm than good."

Another person in this group pointed out:

> "We resent Occupational Therapists being fully in

control of our lives. If you question whether an aid is suitable or not, it's not permissable. We want to work with Occupational Therapists to gain understanding and we want them to gain understanding."

Besides the desire to influence Occupational Therapists to change, there was a considerable respect for the practical help Occupational Therapists could provide. A representative of a voluntary organisation, not herself a disabled person, said:

"There's high praise for Occupational Therapists from care workers in mental handicap homes. They give sensible advice."

This appreciation of the practical advice available from Occupational Therapists was a focus for five of the interviewees from the voluntary organisations. A respondent working for a mental health charity said:

"If people with long term needs are given priority, then practical skills will be recognised that Occupational Therapists can give and they should make a difference."

She added:

"Occupational Therapy should be amongst the more popular professions by providing more of the sort of things consumers want. They should be reasonably liked by consumers - they want someone to listen and help with practical things that are some of the traditional skills of Occupational Therapy. Therapies are tolerated rather than looked for. The client is looking for relevant occupation and the Occupational Therapists traditional skills are in assessment and occupation."

The third item on the voluntary sector agenda - disabled people as co-ordinators of the rehabilitation team, related to both the first and second items. Partnership and sharing of practical skills imply a shift in the power base towards people with disabilities. This was described succinctly in this comment:

"The disabled person should be the co-ordinator and each profession should make its role very clear. The agenda for assessment - the topics covered should be agreed with the disabled person for example, a disabled person asked for a ramp and the assessment said that he was capable of sexual intercourse."

Clearly, disabled people want help on their own terms and are not happy with the idea that Occupational Therapists should concern themselves with total life-style management.

The other informed professionals were more concerned with

items on the common agenda; indeed many of those items appeared mainly because of their support. Their separate agenda contained only one item, mentioned by three people, around the issue of the extent to which there would be public recognition of Occupational Therapy skills. A consultant neurosurgeon said:

> "There is an increasing realisation by disabled people that things can be done for them, the hospital service has failed them in the past and they are under-achieving."

He pointed out that as Occupational Therapists' skills became known to this group, consumer demand could increase.

This question had revealed some gaps in the agenda between people with disabilities, Occupational Therapists and other informed professionals. It could be said that the other informed professionals were concerned with very pragmatic issues occurring as a result of policy initiatives. The voluntary sector interviews again revealed a fairly cohesive block of supporters for the ideals of the disabled activist movement while the Occupational Therapists seemed pre-occupied with a wide range of items inspired by recent personal experiences. It is suggested that those Occupational Therapists with realistic, pragmatic approaches to their work are closer to the agenda of the voluntary sector and more in tune with consumer opinion. It may be important for Occupational Therapists to overcome the fears of abolition and extinction which were expressed. This might also be described as a dilemma of professional ideals versus functional demands, as expressed by a voluntary sector interviewee:

> "This means a note of caution re: the word profession. Occupational Therapists are essentially carrying out functions to the health authorities and social service departments. It is up to them how Occupational Therapy should function. Occupational Therapy should not be driven by professional interest e.g. sexuality - professionals are very interested in sexuality and its demands and sometimes fail to recognise other demands. It's an important issue for <u>managers</u> of the service."

The dilemma of professional ideals versus functional demands was to surface in the answers to the next question.

2.2.4 <u>Question Four: What alternatives would you suggest for the future of Occupational Therapy Services?</u> (Appendix <u>M</u>)

In reviewing the items on the agendas offered in reply to this question, a similar pattern to that revealed in question three was seen. The common agenda was again dominated by items placed there by the other informed professionals. There were fewer and less statistically significant differences between the two groups. The number of items on the individual groups' agendas was again of interest. The Occupational Therapists'

individual agenda was again distinguished from that of the other two groups by its length - 20 items - and by the large number of items supported by one person (13 items). The other professionals' individual agenda was again the shortest (eight items).

At the top of the common agenda was the suggestion of improved skill and staff mix. This was specifically mentioned by half the other informed professionals, none of the voluntary sector interviewees and four Occupational Therapists. Item number two was also placed on the common agenda at that position by the weight of suggestions from the Other Informed Professions, who were clearly concerned about the implications of the demographic issues raised earlier. A general manager had this to say:

> "The problem is that in the 60s, 70s, 80s, it was the lack of finance: In the 90s it is going to be the lack of people."

Planning for the future of the profession is taking place without the service; that is, in training colleges. Therefore, there must be an advantage in examining the role of Occupational Therapy especially in hospitals and broadening and developing the role, but not as an all qualified Occupational Therapy workforce; but to release time for qualified Occupational Therapists to make better use of their skills."

He added later:

> "There is a danger of the Occupational Therapy profession seeing itself as an end in itself, so that the purpose of training is to produce qualified Occupational Therapists; not to benefit people. Very little cognisance is given to proper management of training."

Training issues were of great importance to all groups. Item three was suggested by Occupational Therapists and the voluntary organisations and was a call for educational reform. The other informed professionals, however, were more likely to suggest common core training or the merging of professions. A researcher from a rehabilitation unit had this to say:

> "Merging the professions is a good idea. The Canadian experience and the Cardiff experience didn't work. But they didn't work because if you scratch most therapists, you find they are full of prejudices. If the therapists would stop arguing it would all work out. The merging of the professions would be easier now because the professions are going into higher education. They could have experimental schools with the care together and then specialise. In 1975, there was less overlap between the professions than there is now. The Occupational Therapists then did no electrical treatments and the Physiotherapists did no psychology. Now that has

> changed and there are few differences. Physiotherapists now include behavioural sciences and there is an emphasis on the person which is given lip service by the Physiotherapists. Occupational Therapists do emphasise the person. All sides say a merger wouldn't work because people who have experienced the Canadian approach say students choose one side or the other, but that is specialisation. The experiment has not been done with an open mind."

However, despite the level of support for some moves toward a common core for health care professionals, some interviewees cautioned against the production of a "generic" professional. For example an interviewee from a mental health organisation in the voluntary sector noted:

> "In the community and multi-disciplinary team, there's a tendency for some to think that all professions should become generic mental health workers. Although there are areas of care that are shared, all need a unique area."

A general manager was particularly opposed to the idea of loss of specialised areas:

> "An obvious one is the amalgamation of Occupational Therapy and physiotherapy; that ought to improve the limited manpower/womanpower problems."

However, he added later:

> "I can't conceive of a generic therapy profession. I can't see it as an option. Look what happened to social workers."

A slightly different focus on the theme of core plus specialisation, which seemed to be the major suggestion, given that only one person wanted to see a totally generic profession, was put forward by interviewees in the voluntary sector and particularly by the two consultants in the other informed professionals group. The re-organisation of the profession into separate entry levels and the development of post-basic specialisation was suggested. A technician level therapist, it was suggested would allow the less academic person to enter the profession, while specialisation could save Occupational Therapy time. A consultant neurosurgeon suggested:

> "Services needs could be met more easily by clear sub-specialisation within Occupational Therapy.... This would have the effect of purifying skills for a group of patients and prevent a lot of unnecessary things going on. So preventing a waste of Occupational Therapy time, as the Occupational Therapist will know what will work and what won't."

The internal re-organisation in the ways suggested was not put forward by the Occupational Therapists. They focussed more on

educational reform, although one community Occupational Therapist combined her support of educational reform with a range of options which seemed to embody the reformist approach to Occupational Therapy:

> "Why not have 'Access Officers' in planning departments in County Offices re new buildings? They would need to be experts in ergonomics, and to have special knowledge of the handicapping effects of the environment, not just a knowledge of how to cope with a disability. However, this kind of job is very limited and, therefore, not attractive. People are not attracted to it, but as an Occupational Therapy role it could be a thing of the future, considering the diversity of the role. An Occupational Therapist would look at the wider world issues. At Occupational Therapy School the world is your oyster, which is down to the training and expectations given to people. In training, for example, we should not be too precious about holding on to anatomy and physiology, but should concentrate more on what we need to know about the environment. Otherwise Occupational Therapy will become a minority profession and will disappear."

There was also some support on the common agenda for better deployment of Occupational Therapists and better use of them by educating others about their skills. Some support was also given to ideas such as the "key worker" concept, improved, broader based recruitment strategies, role change to advisor and mediator, the development of research and better planning of services. An interesting phenomenon was the support given to the de-professionalisation and abolition of the profession; particularly that of an Occupational Therapist. However, in her case it was less an expression of support for the concept, more a question of facing a rather unpleasant reality:

> "Do we need Occupational Therapists? Not the way things are now where service may be provided one day and not another, eg in hospitals at weekends, therefore if we can manage without them then do we really need Occupational Therapists?"

The real challenge to the profession was laid out by a planning officer in a social services department:

> "My personal view - the de-professionalisation of Occupational Therapy. The question I ask as a lay man is "If I can go into someone's home and be told by that person that they need a lift to get upstairs, then does the job have to be done by an Occupational Therapists?" O.K., I'd have to find out about the types of lifts, and what would be most suitable, but even so. The problem is the over-protective professionalism of Occupational Therapists, don't get me wrong, I think they have special skills, but do they need them at the level they work at most of them?

> If Occupational Therapists were less protectionist, through puts and service provision could be better."

The planner's view, though expressed badly, reflected the notion apparent in several of the suggestions on the common agenda. Shortage of Occupational Therapists could also be seen in terms of a shortage of therapists who recognised the limits of expansionist professionalism. It was, however, interesting to note that only two interviewees in the voluntary sector supported total abolition of the profession, although several wished to see considerable changes in the training and structures of the profession.

The items solely on the agenda of the Occupational Therapists were largely idiosyncratic and personal but numbers one and two were put forward by groups of Occupational Therapists. Item one was the selling of Occupational Therapy to other agencies. This suggestion was articulated in this remark by a community Occupational Therapist:

> "Occupational Therapists will have to be much more vocal and assertive and make it clear to agencies and other bodies why they need us. The whole marketing end is something we have to come to terms with, we've got to learn to sell Occupational Therapy as a profession."

There was also a strong suggestion that Occupational Therapy Departments failed to provide positive experiences for new entrants to the profession (item 2). A senior Occupational Therapist in the National Health Service noted:

> "In order to retain staff, more attention needs to be paid to early experiences of new staff."

This suggestion was related back to entry into training by a head Occupational Therapist in the National Health Service:

> "Training schools and more places are not necessarily the answer because where will teachers come from? Good selection processes are important to ensure that the right people stay with the profesion."

The other informed professionals had an agenda which was less than half the length of the Occupational Therapists. Their list was headed by the suggestion of improved hospital community liaison, more flexible working hours and greatly increased levels of clerical support. This last item was interesting in that it related the shortage of Occupational Therapists to a shortage of back-up personnel to assist in service administration rather than service provision. A general manager in the Health Service said:

> "There should be clerical support; if Occupational Therapists are spending all their time writing up records etc. then they aren't with patients or clients."

A salutary reminder of the need for all health and social service professionals to look carefully at such issues was offered by a physiotherapist working in the community:

> "We all need to get our act together; Social Services and Health Service and develop a Community Resource Team philosophy."

The voluntary sector interviewees seemed to share a fairly clear and coherent agenda. Their suggestions centred around the need for services to meet their requirements. A strong case was made for co-ordination of all types of agencies for all kinds of disabilities. A person with a disability working in a voluntary organisation said:

> "The training for rehabilitation in an ideal world would be that of rehabilitation nurse, physiotherapist and Occupational Therapist combined into one. I think that would be supported by most disabled people. I would like to see an end to professional boundaries. They're all too protective of their professions. It builds in fear for professionals and limits their ability to work with others across those boundaries."

A very realistic view of the future was provided by another voluntary sector interviewee:

> "There has to be co-ordination between social services and health authorities as to respective roles of their Occupational Therapists."

Similarly, the demand for individual assessment was articulated by an interviewee from a mental health charity:

> "We need a range of services, individually assessed, with long term funding, commitment and skilled staff. It should involve users and their relatives and should have flexible hours."

The voluntary sector interviews were also looking for control of services by consumer groups and thereby through their organisations they could become service providers and employers of professions. This was clearly articulated by a person with a disability working in a voluntary organisation:

> "The growth of confidence among disabled people to become more knowledgeable about what they want; Greater self-confidence in demonstrating as individuals that they have rights; and building this up in the disability movement, which will affect what Occupational Therapy and other professions will be able/expected to do.
>
> "There will be changes in demand for Occupational Therapy and other services which will be different from what they have been trained to do. As a result they will either respond to these changing demands or

> they will become redundant. Disabled people will control the service.
>
> "As regards Occupational Therapy, nothing more or less than a radical change of their training and occupation is required. There must be changes in the knowledge and skill bases of the profession and a reorientation of their process of working with rather than for disabled people."

There was, however, still a desire to work with the professions and to use their expertise, but that should be put at the disposal of the service users rather than imposed upon them.

Another interesting theme was the focus on practical skills and the rejection of counselling. This was articulated by an interviewee from a mental health organisation:

> "If Occupational Therapists focus on social skills and counselling, these are not unique and they will lose their uniqueness. Uniqueness lies in work assessment. They should explore the link with employment schemes. The Employment Initiative has no Occupational Therapists."

The relative clarity and cohesiveness of the agendas of the other informed professionals and, particularly, that of the voluntary sector organisations would suggest that these groups are far more confident in articulating their demands for the future. The strong consumer demand for clarity of structures ease of access and control of services seemed to be important and it was, therefore, decided that people with disabilities would have an important contribution to make in the third aspect of the data collection : that of assessing skill levels required to perform observed tasks.

2.3 The data from the initial trial of the Provisional Tool to Measure Skill Levels

These data were obtained from senior members of the Occupational Therapy profession and from members of a variety of coalitions for disabled people throughout England as purposive samples. Since this was a trial of a methodological approach to the issue of skill mix, no further data were collected about the two samples. The goal of this part of the study was to examine the possibility of developing a process to measure skill levels with both professional and consumer in-put. The results of this exercise were interesting and shed further light on issues which may eventually be seen as areas of agreement between professionals and service users.

Some of the Occupational Therapists who were involved in the exercise made vigorous comments about the inadequacy of the items. However, since no data were gathered about the nature of the sample, it is not possible to comment on the characteristics of that group. Many Occupational Therapists, however, commented on the ambiguities in specific items but

completed the vast majority of the items by assigning them unambiguously to a particular skill level. The respondents from the coalitions for disabled people seemed to experience far less difficulty in completing the exercise and offered no comments or criticisms of the method. Since the nine items which proved to be ambiguous for respondents in both groups were eliminated from the analysis, this was a first step to improving the measurement technique.

A cross classification table was constructed to provide a preliminary overview of areas where differences between the two groups may eventually be found. At this stage there can be no generalisation to the population at large since the sample was purposive for convenience and, therefore, likely to provide quite exaggerated differences between the two groups. If differences did not exist between two groups which contained at least some of the most extreme opinions within the Occupational Therapy profession and the coalitions for disabled people, there would be very little point in pursuing this line of research. Relative agreement on skill levels between these two groups would suggest that only one needs to be consulted in future to represent both groups, whereas relative disagreement would suggest that, in deciding skill levels of tasks, differing views may be obtained from each group. In the second case, further research in this area would be indicated.

The cross classification table reveals a picture in which some differences between the two groups can be seen. For example, the Occupational Therapists placed almost twice as many items in the category of "Professional" as did the people with disabilities. However, the Occupational Therapists placed almost half as many items as the people with disabilities in the category of lay person. The groups were a little nearer in the number of items they considered suitable for support workers where the people with disabilities placed approximately 10 per cent more of the items than the Occupational Therapists. It is interesting to note that the two groups agreed that 26 of the items should be placed in the category as suitable for lay persons, 31 of the items as suitable for support workers and 42 items as suitable for professional Occupational Therapists. these items have been extracted and can be found in Appendix I. Reviewing the items it is interesting to note that the items in the lay persons category are short and describe unskilled activities. The items in the Support Worker category are longer and many are concerned with providing routine treatment after assessment. However, the items in the category for professionals are complex and involve clients and patients with difficult problems. Clearly, this bears out the notions that the complexity of a situation and the level of competence of the actors are important criteria in the judgement process. It would also suggest that people with disabilities in this sample, in general, acted in accordance with the principles outlined in the Borrie Report (OFT, 1982), that is, that consumers would not generally behave in ways likely to jeopardise their own interest.

A further statistical procedure was performed to see if the apparent differences between these two groups could have occurred by chance. A chi-squared CX2 test was, therefore, performed to test the following hypothesis:

> H, That there are differences in the use of the three categories: Lay Person, Support Worker and Professional between a group of professional Occupational Therapists and a group of people with disabilities who are members of coalitions for disabled people, when they are asked to classify a series of items describing Occupational Therapy services.

<u>Result</u>

X2 = 22.948 06
with 2 degrees of freedom
Exact Probability = < . 00007
Therefore, this is significant at p = .001

The chi-squared analysis demonstrated that the differences in perspective of these two particular groups could be demonstrated statistically as not occurring by chance. It is, therefore, suggested that the provisional tool to measure skill level be viewed as a contribution to developing a process involving service users in establishing appropriate skill mixes in provision for people with disabilities. This tool is in no way to be considered final, nor should the results of the analysis be generalised.

The emphasis of the results of the use of this tool should be on the way in which a technique has been developed with the potential for involving many interested parties in decisions about levels of skill within health care provision. Skill mix can clearly be seen to be an issue in which many groups as well as professions themselves have vital interests. The results of the application of this technique demonstrate the need for some changes, for example, greater attention to detail in writing individual items. However, the basis of the technique; the submission of behavioural vignettes extracted from in vivo observational schedules to a variety of groups for judgement would seem to be an important and useful development, which could be exploited to advantage in the future.

CHAPTER THREE

The Leading Edge Data

1. Introduction

The data from the locations defined as being at the Leading Edge of current Occupational Therapy practice were not analysed quantitatively, rather they were carefully scrutinised by the Occupational Therapy members of the research team involved in the policy analysis. They have a series of themes within the data and described models for the future development of services which may prove valuable in assisting health and local authorities by offering examples of, for example, co-operation between the two types of authority in providing integrated services.

2. Overview of the Leading Edge Data

Some 15 NHS and local authority Occupational Therapy services were selected for the research team to gain information about departments at the forefront of the profession. They were described as having good practice and well defined, forward looking services.

Separate interviews were recorded with a range of staff. There were four non-occupational therapy staff; a director of physical disability in a specialist centre; a unit general manager; an assistant director of social services and the director of an employment agency.

Occupational therapy staff at all levels from district manager to occupational therapy helpers and technical instructors were interviewed from health, social services and private practice, in the specialities of paediatrics, the elderly, mentally ill, elderly mentally ill people, acute, surgical, rheumatology, community and child psychiatry services. There was also a senior Occupational Therapy lecturer in an occupational therapy college.

These services were selected by members of the Occupational Therapy profession and were termed "leading edge" although it is acknowledged that many other Occupational Therapy services not selected are dealing routinely with the task of providing effective Occupational Therapy services to meet the real needs of patients in hospital and people with disabilities at home. These examples of good practice showed clearly where Occupational Therapy services are placing an emphasis on the issues of greatest relevance to the provision of effective services today.

Six major issues dominated in the material given to the project team:

1. Interface issues between hospital and community services.

2. Recruitment, training and retention of Occupational

Therapy staff.

3. Contracts of service.

4. Resources management.

5. Models of practice and definition of core skills.

6. Role of private Occupational Therapy services.

2.1 Interface and Joint Planning of Occupational Therapy Services

This was by far the most frequently mentioned issue. It concerns the division of services between Occupational Therapists in the NHS and those employed in the local authority social services departments. All the client groups are mentioned but in particular elderly people and people with mental illness and mental handicap. Occupational Therapy services were charged with providing effectively for people being discharged from hospital, either after a short interval, such as contact with Accident and Emergency department or long term, for example, upon closure of long stay hospitals, and all points in between. References were made to the priorities of patients at this interface and to the importance of a smooth hand over to local authority Occupational Therapists, who were in control of practical resources in the community.

In most cases, joint planning, consultation and the development of integrated services had been determined but comments were made about the movement of staff between the two services and the inconsistancy of structures and grades which made true combining of services apparently impossible. Authorities had experimented with community posts, employed to work at the interface with patients in the first few weeks after their discharge. The effectiveness of Occupational Therapy intervention in keeping people functioning independently at home after a period of hospitalisation would seem to be a very fruitful area for further research. At one authority which was planning for a jointly funded service, a social services senior manager commented on the value of continuity of Occupational Therapy services from their involvement in early discharge plans to their specific role in community care.

2.2 Recruitment, training and retention of Occupational Therapy staff

Comprehensive schemes which dealt with every aspect of staff recruitment and retention were described. One authority had devised an elaborate post-graduate training programme aimed at enabling newly qualified Occupational Therapists to consolidate their basic diploma education and to continue professional education in a work setting. Other aspects of the course were designed to teach basic management skills and develop research skills. The training programme also includes such essential areas as time and stress management and the use of supervision.

Many Occupational Therapy services recognise the importance of orientating newly qualified Occupational Therapists to the real world of work. A good basic experience will help retain people in their profession and assist their career development. The same authority had concentrated on a return to work training course for Occupational Therapists who had had a break from work for a few years.

Some district Occupational Therapists commented on the desirability of recruiting more mature people as helpers and seconding them on inservice training courses. This is a way of increasing the stability of the qualified work force and this appears to be an important trend within the profession. Comment was made from a social services department Occupational Therapy manager that overwhelming caseloads lead to bureaucratic processing with not enough time being spent on client problem solving. This it was felt can lead to disillusionment and lack of professional energy in young Occupational Therapists. The answer was to be found in better use of Occupational Therapy assistants; and qualified staff being responsible for prioritising work for other staff to do, and training them to work with clients. Occupational Therapists were then freer to undertake assessment and more complex work with people with greater degrees of disability and/or greater complexity of problems to be solved.

2.3 Contracts of Service

Examples of contracts of service negotiated by District Occupational Therapists with their unit general managers were submitted to the research team. These were specific about which treatment would be provided to which patients. These contracts enable:

a) the establishment of a written operational policy.

b) Services to be prioritised - and reprioritised, in response to problems of fluctuating staff levels.

c) the setting of targets for the development of services.

d) the provision of a detailed breakdown of Occupational Therapy services and costing.

e) the establishment of agreed standards of Occupational Therapy services.

f) the institution of regular reviews.

2.4 Resource Management

Details of the Resource Management projects instituted by the NHS Management Board were reviewed. Given further work on the specific Occupational Therapy input into these projects and the outcome for Occupational Therapy services, these projects could prove useful models for the Occupational Therapy profession to consider.

2.5 Description of models of practice - definition of core skills

Documents concerning the determination of core skills of Occupational Therapists were produced from a number of centres. This type of documentation will be helpful for people to understand the role and function of Occupational Therapy and can be used in the production of contracts of service.

2.6 Role of Private Occupational Therapy Services

From contact with the private sector of Occupational Therapy it was clear that a range of work is developing:

a) private work with clients at home and in private hospitals.
b) care packages for provision of equipment. This was seen to be an important aspect of the work where private resources were being used.
c) providing reports in litigation cases.
d) training staff in local authorities, where previously the Occupational Therapy service was too small to encompass a large training element. Main areas of training were lifting and handling people with disabilities in day and residential care.

The increase of private hospitals and private residential homes for elderly people, means that there will be a growing need for private Occupational Therapy services.

2.7 Centres for Integrated Living

The Centre visited was proposed by a Coalition of Disabled People on the premise that services for disabled people should themselves be integrated to achieve full participation and equality. The philosophy is, therefore, one of integrated living. The Centre is a registered charity and is jointly managed by disabled and non disabled people (there must be at least 50 per cent of the members disabled), working together in partnership.

The Centre offers help and advice on information, housing, transport, environmental access, counselling, personal assistance, technical aids, and has an employment agency and local community facilities. In the counselling service, the philosophy is for the service to be provided for disabled people or carers by disabled people or carers.

Occupational Therapists are not employed by the Centre, but are involved by the advisors at the Centre ensuring that disabled people are put in contact with the local Occupational Therapist if this is felt to be appropriate. This particularly concerns the area of technical aids and equipment. Occupational Therapists also use the Centre for gaining information.

This can be seen to be a model which provides services for

people with a disability with whom Occupational Therapists work alongside and in partnership. Occupational Therapists were not the key workers, but were used as a resource when appropriate.

3. Summary

Within the Leading Edge data, there was evidence of much innovative thinking. The attempts to resolve the issues of the definition of the role and responsibilities of the Occupational Therapy service and to change the interface between health and local authorities were particularly helpful and provided important frameworks for the policy analysis.

CHAPTER FOUR

Policy Analysis

1. Legislation and its impact on Occupational Therapy

The practice of Occupational Therapy is directly affected by legislation in many areas: professional regulation, employment, housing, education, disablement and health. Occupational Therapy is, however, mentioned in legislation only in the 1960 Act regulating the Professions Supplementary to Medicine. This Act established the process of registration, but registration is not, itself, obligatory for Occupational Therapists, rather registration is required by some employers under different regulations, for example, the National Health Service employment regulations.

Occupational Therapists are one group who may assist health and local authorities to carry out a range of functions required of them by legislation. For example, the Housing Act 1978, does not mention Occupational Therapists but the accompanying circular notes the potential role for Occupational Therapists in housing adaptations. It could, therefore, be said that Occupational Therapy practice cannot be codified directly from legislation but that Occupational Therapists are the means by which local authorities and health authorities fulfil their legal obligations to provide services.

It may be, therefore, that shifts in public opinion, leading to shifts in public policy in areas such as health and housing, will have an impact on Occupational Therapy which is different, for example, than that of the impact on professions such as social work. There are many examples of legislation where social workers are specifically named as the agents through which health authorities and local authorities must act and it is quite clear that the individual professional is bound by a specific statutory duty. For example, the Mental Health Act 1983 names three professional groups as having specific duties under the Act: these are Medicine, Social Work and Nursing. Shifts in opinion about the operation of this Act cannot change the statutory obligations of these three professional groups until legislative change occurs. However, Occupational Therapists, while they may be recognised as important in housing adaptations have no statutory obligations themselves. Their obligations arise because they are the agents chosen by the local authority to fulfil its statutory obligation. Occupational Therapy seems, therefore, as a profession to be dependent upon its utilisation to service providers. Shifts in ways in which local authorities and health authorities decide to fulfil those obligations may have great impact on the development of the profession. Although a small number of local authorities still do not employ Occupational Therapists, legislation such as the Chronically Sick and Disabled Persons Act 1970 has led to an enormous growth in the numbers of Occupational Therapists employed in local authorities. Consequently, shifts in public policy and ensuing legislation may be described as major

factors in predicting the employment patterns of Occupational Therapists. It is because of this that the profession needs to be extremely vigilant to ensure that current trends are understood and articulated by its representatives.

2. Current topics in the public policy debate which may impact on Occupational Therapy

The agenda of current topics in public policy revealed through this study was very large. The issues may be divided into general areas of interest such as demography, consumer expectations and technological developments. These are issues with which all professions will have to come to terms. Technological change and consumer expectations go hand in hand. At the birth of the National Health Service the typical service user was likely to be a worker in a heavy industry involved in mass production, or a dependent of such a person. Work patterns have changed dramatically in the past 15 years. There is now a focus on high technology and service industries. Meanwhile, the changes in the demographic structure of the post-industrial countries such as the United Kingdom have been dramatic with large numbers of elderly people, many of whom have retired or been made redundant from heavy industries. The relatively small number of young people are now more likely to work in occupations related to high technology with the focus on raising educational standards. It would seem likely that the consumer of services will become increasingly informed, critical and aware from their own experience of employment, of what technological innovations are available and what service systems can be developed to satisfy consumer demand. In other words, the manager of a Macdonalds or a 7-11 store who has a personal computer to check his stock will also keep his branch meticulously clean and ensure his customers are not kept waiting for service. He is unlikely to accept a health service which cannot achieve similar standards. Consequently, all health care professions and managers must come to terms with the better informed, less deferential and more critical consumer. Out of this climate, a series of policy initiatives have arisen. The Griffiths Report (Griffiths, 1982) which led to the introduction of general management may be seen as an early attempt to provide a more efficiently managed health service which shifted the focus from the pursuit of professional goals to the pursuit of goals established by professional managers.

Further policy initiatives which seem to point to increasing pluralism in health care are currently being debated. These initiatives are a party political way of responding to consumer demands fuelled by social and technological change. It is, therefore, important for the health care professions to understand that these are expressions of underlying forces for change and that, no matter which political party was in government, initiatives to meet new demands would occur. Therefore, the health care professions need to be keenly aware of the underlying reasons for party political initiatives. Two documents are of great importance in the current debate. The Griffiths Report on Community Care (1988) and the White Paper on the National Health Service (1989). Both contain

policy measures which respond to the changes in a society previously organised for mass production. For example, the Report on Community Care became necessary because of the general demise of large institutions such as the Victorian asylums. Routine, institutionalised care is no longer seen as a desirable way of maintaining many care groups. For example, people with physical disabilities and people with a mental handicap as has recently been revealed in the Wagner Report (NISW, 1988). Similarly, one of the issues underlying the recent White Paper on the National Health Service is the unwillingness of consumers to accept the rationing of health care. A part of the proposed solution entails the separation of health care provision from health care procurement, so that district health authorities will become responsible for the maintenance of standards and the achievement of health objectives rather than, necessarily, direct providers of that service.

The proposals of the Griffiths Report, with negotiated packages of care and the NHS White Paper with GPs as budget holders negotiating the best deal for their patients, reflects a growing movement towards services being tailored for individuals, perhaps best expressed through the concept of "Service Brokerage", which has been operationalised in Canada for people with a mental handicap. In this system each person is allowed a sum of money and with the help of a service broker, buys a package of services specifically designed to help the individual maintain his or her chosen lifestyle. Consequently, it can be seen that the shift from professional domination of health to managerial control may subsequently lead to consumer choice. Health care professionals who have as yet been unable to come to terms with the agenda set by general managers are, perhaps, going to find the consumers' agenda even more challenging.

The evidence in the study is that consumers already have fairly distinct goals and organisations capable of articulating their demands. Currently, they are seeking partnership with Occupational Therapy but would clearly like to control resources. Some are, already, unwilling to accept the meaning of "Shortage of Occupational Therapists" offered by some Occupational Therapists within the profession. Seeking larger and larger areas of influence over consumers lives and even wider areas of clinical practice may lead eventually to a direct clash with consumers and their carers. The control of services is likely to lie increasingly with the users and attempts to expand professions in ways developed during the past 100 years are unlikely to be successful.

However, some Occupational Therapists seem to be too pessimistic and also to have misjudged the consumers. Realists within the profession will have already entered into partnership with local user groups who will benefit from the information base of the skilled professional. It is important, however, for all health care professionals to recognise the limits of their power. The absolutist, monarchical model where professionals pursue what they believe to be in the best interests of the client may have produced a

benevelent despotism but that is unlikely to satisfy current demands. The call from service users seems to be for a constitutional monarchy model where professionals advise, encourage and warn, remembering that, even if the life adjustment made by their client is not one they would have chosen for him or her, this is the client's choice.

Health care professionals will have to come to terms with developments such as service brokerage and to understand their role in relationship to the rights of the citizen more clearly. Some Occupational Therapists are already in the forefront of health care developments in their partnership with disabled people, particularly in their community. This should be developed in the future.

3. Public policy options for Occupational Therapy to meet current and future developments

Just as governments respond to trends and developments with initiatives such as the White Paper on the National Health Service (1989), so professions must analyse underlying trends and examine ways in which they can come to terms with the effects of social and technological change. The rise and fall of many occupations within industry and commerce has already occurred. Similarly, health care professions have had to change their practices and training systems as technology has developed. The goal of this section is to set out some of the ways in which the Occupational Therapy profession could respond to the changes within society.

3.1 Professional Structures

3.1.1 Course Validation

The validation mechanisms for courses are currently quite complex and variable. The College of Occupational Therapists' Validation Committee and the Occupational Therapist Board of The Council for the Professions Supplementary to Medicine both validate the professional content of courses. Where courses are also involved in higher education, they could be validated by the institution itself or by the institution and the Council for National Academic Awards. As Occupational Therapy courses are increasingly within higher education so the validation mechanisms are likely to become more complex. The current system was developed before the expansion of Occupational Therapy into higher education and it is suggested that changes to meet the developments of the past ten years are due.

The following are some of the options which could be chosen:

- that the professional content of courses should be validated by the Validation Board of the Council of Professions Supplementary to Medicine and that the academic content of courses should be validated by the higher education institution which may also involve the Council for National Academic Awards, depending upon the status of the institution.

- that the College of Occupational Therapists should validate the professional content and that academic content be validated by the higher education institution as above.
- that a new body be established to validate the professional content of courses and to make recommendations to the Council for Professions Supplementary to Medicine.
- that the CNAA develops a capacity to validate professionally as well as academically in view of its increasing involvement in health care professional education.

The aim of simplifying the validation mechanism would be to enable the profession to respond more quickly to social change, therefore in deciding the most competent way to validate courses, the following criteria should be used:

> That the simplest mechanism involving the least number of people compatible with maintaining educational and professional standards be adopted.

This was the basis adopted by the research team for its recommendation (see below).

In view of the importance for professions of fulfilling their obligations to society, it may be argued that both service users and employers have a legitimate interest in the validation of courses and should be involved in the process.

3.1.2 Registration

Registration is closely linked with the validation mechanism. The maintenance of professional registers has its origin in the need to protect the public from rogue practitioners and to ensure that professionals who fell below expected standards of practice were judged by informed peers. It has clearly acquired a secondary value over the years as a status symbol for groups which wish to be considered professions. Another function for a professional register is the maintenance of an up to date list of qualified people who are available to practice.

The Register of Occupational Therapists does not, in theory, have the effect of protecting the public from rogue practitioners, as registration is not a requirement for practice. It is a condition of employment in the National Health Service and most local authorities. In reality, most private employers probably also check registration status. The current register, however, cannot be used to estimate manpower stocks since it would seem that as many as 5,000 qualified Occupational Therapists are not on the register.

This state of affairs seemed unsatisfactory to the research team, since the register does not, in theory, protect the public and does not provide much information about manpower.

The following options are available:

- abolition of the register
- retain the status quo
- develop a new type of register

These will be considered and their advantages and disadvantages will be presented.

3.1.3 Abolition of the Register

If the register were abolished, there would be impact in three areas:

- the protection of the public
- the self-esteem of the profession
- the lack of a record of current practitioners.

There are alternative ways in which the public could be protected against rogue practitioners. Since registers were originally developed before the state had centralised employment records, their original function of alerting the public to the dangerous practitioner has long since been overtaken. Since every working person has a National Insurance number, which is kept for life, the Department of Employment could become the body which alerted employers to rogue practitioners. The use of Social Security numbers for this purpose is already current in the USA. The need for justice in terminating employment for malpractice could be served through current legal structures such as the Employment Tribunals and the need to protect the public could be served by suits against individual practitioners. Investigations by the Health Service Commissioner could be conducted in cases where legal action was inappropriate.

The original function of registers as the sole means of protecting the public may now be redundant. However, their function in promoting professional pride, interest in professional standards and, therefore, higher self-esteem should not be discounted, even though the downside of this may be viewed as a conspiracy against the public interest.

A further argument against the abolition is the need for some viable system of measuring manpower stocks. A register would seem to be an acceptable way of providing public information about the availability of people with particular skills and as such is of value to members of professions, central and local government, politicians, interest groups and the public at large.

3.1.4 The Status Quo

The current register would seem to be unacceptable for the reasons given above. It does not necessarily protect the public and it does not provide an accurate record of the number of available practitioners. It should be emphasised that the present register complies precisely with the current legal requirements and the critique offered is of those requirements not the Council for Professions Supplementary to Medicine or its employees. It is suggested, that the status

quo is a poor option, but that abolition of the register is equally unacceptable, therefore, a third option of a new register will be considered.

3.1.5 A New Register

A new register would have significant advantages. If it became a requirement of employment for all Occupational Therapists, rather than a condition of employment, this would have the effect of making the claim of public protection a reality in both theory and practice. It is also likely that it would assist the profession in fostering greater interest in professional issues. Finally, it would ensure that there would be a better public record of available manpower.

A new register would, therefore, represent a shift in the balance away from an employer's condition to an individual's professional responsibility. The new register would protect the title of Occupational Therapist from misuse, much as current legislation protects the title of registered nurse, but would not imply that there are activities solely reserved for Occupational Therapists.

3.2 Education and Training

The changes in education and training which are occurring as a result of the high technology, information age, into which post-industrial society is now moving, are likely to be profound. The governmental policy initiatives to meet these changes include the development of the Credit Accumulation and Transfer Scheme and the National Council for Vocational Qualifications. Additionally, there are proposed changes in the funding of education and training with student loans, the freedom of institutions to set course fee levels and the funding of training through the Employment Training Agency.

The current situation with regard to Occupational Therapy is a profession largely trained through diploma schemes and funded by bursaries from the Department of Health. It is possible that a considerable percentage may not be entering practice. Helpers and technical instructors have been heavily concentrated in the large institutions for people with mental illness and mental handicaps. A national system of training (which does not, however, lead to a recognised, assessed qualification) has been long established. It is important to note that the issue of the re-deployment and re-training of helpers and technical instructors is likely to become a pressing issue which has, as yet, received scant attention in public forums.

The options for each of these two groups will be considered taking into account the current developments in education and training.

3.2.1 The education and training of Occupational Therapists Education for entry into practice: pre-registration

Occupational Therapy developed as a new group of people

entered the labour market - the middle and upper-class woman who had previously stayed at home. As with many other "female" professions developing around that time, there seems to have been a considerable amount of sexual stereotyping. The Occupational Therapists extended the lady-like pursuits with which they filled their days at home into the hospital to benefit the patients. Just as nursing was equated with motherhood and nurturing, so Occupational Therapy may have been equated with the provision of useful hobbies. Each profession was considered suitable for nice girls - the future nurse should have a practical and motherly bent, while the future Occupational Therapist should have an artistic bent. Each would provide a service for patients under the supervision of male doctors and this would provide an interlude of suitable occupation between marriage and motherhood. Since career opportunities in other fields were limited and discrimination against women in employment could not be challenged until 1975, the cosy assumption that an endless supply of young women would be available to fill these temporary positions was the basis for such workforce planning as was attempted - about 100 years for nursing, and 50 years for Occupational Therapy. These professions grew in the era of mass-production; as society has moved into the information age, all occupations have gone through a process of change or demise. That the female professions are also going through this process is only to be expected. However, a factor which may complicate their particular situation is the much higher value the information society is likely to place on the intellectual ability of all its citizens. Women have entered into professions from which they had previously been discouraged such as Law and Medicine. The development of new professions which value intellectual ability, in particular, such as computing and the ability of women, thereby, to earn much higher salaries may all contribute to the decline in the numbers of able young women willing to enter "female" professions.

Since the Occupational Therapy profession has been found to be a useful means by which health and local authorities can fulfil their statutory obligations, the situation is not analogous with male occupations developed in the era of mass production. The redundant welder from the shipyard has to look for a new occupation, whereas, as health care changes, the health professionals providing the service remain, but their specific skills may have to be updated.

The issue for the "female" professions becomes one of attracting the redundant welder into their profession so that professions become androgynous and are not identified with a particular gender role. Attempts to attract the redundant male manual workers into the formerly "female" professions occurred in the Depression years, when many Welsh coalminers became psychiatric nurses. However, this time the change is not related to a temporary downturn in industrial production but to permanent changes in the economic infra-structure. The challenge for the "female" professions is to attract, train and provide a living for the available labour supply.

In the information age, the labour supply must be capable of responding quickly to technological change, consequently professions such as Occupational Therapy will require a knowledge base rather than a specific skill base. The recognition of the need to have a more flexible system of higher education has led to the development of the Credit Accumulation and Transfer Scheme. This will have a very great impact on health care professionals since each element of the curriculum will have to be evaluated for its portability under Credit Accumulation and Transfer.

A further issue of some importance in considering options for the future pattern of education of Occupational Therapists is that of the apparent gap between theory and practice which was noted in the interview data. Students are attracted by the prospect of a three year full time diploma providing a wide and varied educational experience funded by the Department of Health. It is also apparent from some of the publicity to attract students into training that an impression is given that there are ample job openings in all areas to work with all age groups. This does not, in fact, seems always to be the case. There is evidence that many of the applicants wishing to train and those qualifying from the schools want to work with children - a field where there are, in fact, fewer job prospects than with the elderly. It is possible, in their enthusiasm for their professional role, that some of the schools do not, at the stage of selection of candidates, make clear that very large numbers of positions for Occupational Therapists exist in facilities for elderly people, but that positions in facilities for the younger age groups will be fewer given what is known about current and future configurations of services. In any case, candidates should be made aware that the demographic structure of our society is such that there are proportionately far more elderly clients than young clients using the health and social services.

The options for the future include:

- Common Core Education
- Degree Level Education
- The Status Quo

3.2.2 Common Core Education

The topic of a common core or merger of education for all therapy professions has been on the public agenda for many years. However, the objections raised previously include issues such as the depth of detail and direction of study of particular academic subjects, the location of schools, the lack of resources to fund curriculum development, and policy drift, by which was meant that no one body seemed to be responsible for initiating such developments. It is interesting, therefore, to note that the national system of Credit Accumulation and Transfer seems to have provided a catalyst for the development of a system which may eventually rationalise course provision.

Similarly, the move to higher education will act along with

the above scheme to encourage shared learning. Course units taken during one degree or diploma course will transfer, so that these need not be repeated in other courses. The Credit Accumulation and Transfer Scheme now being established for post-registered degrees in remedial therapy, for which specific funding was provided, could point the way for the development of a similar scheme for degrees and diplomas at the pre-registration level. It may be suggested that the effects of Credit Accumulation and Transfer will be two fold:

- hastening the development of pre-registration level degrees
- fostering the growth of common core curricula for all health care professionals.

Professional bodies should note these developments, since it is likely that the common core curriculum so long discussed, could become a reality with little or no input from professional organisations. There is no statutory requirement for COT involvement in curriculum development and validation; it is entirely possible that higher education institutes, CNAA and the CPSM Boards could agree a common care curriculum without reference to some of the professional bodies concerned.

Merger of the professions is a less important or even relevant issue as individuals will be able to opt for extra units in, for example, speech therapy if so directed by professional interest and enthusiasm. It should also be noted that with the proposed changes in the funding of higher education, such career developments could be funded out of a loan scheme or by health authorities keen to alter their staff mixes.

3.2.3 Degree Level Education

There is undoubtedly pressure for degree level from many quarters. The move into higher education will probably increase this pressure. Occupational Therapy students themselves are unlikely to accept diploma level qualifications since other professions such as nursing and physiotherapy are increasingly converting their basic qualifications for professional entry to degree level.

There is, however, a dilemma for all health care professionals. The level of funding required for lengthy professional courses tends to be high, students require financial support during study and are likely to earn the modest salaries traditional at the lower grades on entry into practice. Student loans may be available, but there will, no doubt, be careers available where loan repayment would be much easier and, therefore, more attractive to all but the most altrumistic. Health authorities will have to think seriously about the implications of student loans, perhaps considering sponsorship schemes and golden hellos.

Although many degree level courses in health science subjects are currently four years in length, and in view of the complexity and curricular crowding of such courses this may be

desirable, the current policy of the University Funding Council is believed to seek the reduction of "professional" degree courses from four years to three years.

However, in view of the apparent problems of retaining students on qualification and the apparent approximate 30 per cent loss of students between qualifying and entry into practice, it may be that an escalator model of professional and academic education should be adopted. In this way, all students who had completed the relevant course units would then be given the opportunity to register; some may terminate at that point and may return later, while others would continue and complete the degree course. The system would, undoubtedly, be less tidy and more complex but would allow for the feed in of National Vocational Qualifications and students who decided to take Occupational Therapy credits after completing a degree in another discipline.

This model would allow for both personal development and education.

3.2.4 The Status Quo

This cannot be considered as an option since the changes within our society demand that all health care professionals should be capable of understanding and coping with the technological re-structuring of our society.

3.2.5 Summary

The issue of pre-registration education would seem to be of great importance. The consensus of the data within the study pointed to the need for a practitioner who was more responsive to the consumer view point and better able to understand social and legislative issues. The escalator model is recommended as a way of drawing in to the profession groups such as mature students and graduates in other disciplines. It should also be noted that many people with disabilities have, themselves, a great interest in Occupational Therapy and would perhaps welcome the opportunity to enter the profession. The social work profession has already devised a scheme whereby people with disabilities are encouraged to enter the profession. Since entrants to Occupational Therapy from its traditional sources may be diminishing, the scheme established for entry into social work could be reviewed and a similar scheme for entry into Occupational Therapy be devised.

4. Post-Basic and Post-Graduate Education

Very little exists in the way of post-basic or post-graduate educational provision specifically for Occupational Therapists. Multi-disciplinary courses such as a B.Sc. in Remedial Therapy have been developed. At the post-basic rather than academic level even fewer opportunities exist, although there is now a community module for Occupational Therapists which has been developed by the London Boroughs Occupational Therapy Managers Group.

In the future, as provision for people is increasingly within the community, and since the basic training of the Occupational Therapist does not necessarily guarantee that the student will receive a community placement, it would seem important to consider the extent to which Occupational Therapists from, for example, large psychiatric hospitals will have the skills and knowledge of community work to fill their new roles satisfactorily. By comparison, the nursing profession has received funding to develop courses in community psychiatric nursing and psychiatric nurses are seconded by health authorities to these courses. It may be suggested that Occupational Therapists could share such courses, and specific units to develop their skills in areas such as work assessment, for which there seemed to be strong demand in the voluntary sector. It is unlikely that a large range of post-basic courses for Occupational Therapists would be viable.

Similarly, it is apparent that courses in remedial therapy at Masters degree level have been developed and which cater for all the remedial professions. Such courses will be of great value in encouraging professions to review the impact of their work and develop intervention strategies.

Post-basic and post-graduate education are of great importance if Occupational Therapy is to provide a service which meets society's requirements. Currently, the basic three year course seems to be viewed as a basis for practice in any area. It could, indeed in itself be viewed as a qualification for a generic remedial therapist. The sharper focus given to specialities through post-basic and post-graduate courses may encourage a clearer definition of the competencies expected of a basic practitioner.

5. Skill Mix

When considering the efficiency of an Occupational Therapy service there is a need to acknowledge that a whole range of different people contribute. These could be:

- Qualified Occupational Therapists at varying levels (newly qualified - managerial)
- Technical instructors at varying grades
- Occupational Therapy helpers/assistants at different levels of supervisory requirements
- Clerical/administration workers
- Porters
- Drivers

An effective and efficient Occupational Therapy service ensures that all tasks which are required for the benefit of patients/clients are done by the most appropriately trained staff with most appropriate skills. All tasks do not have to be undertaken by the most qualified person. What is vital is that the assessment of tasks required and skills available are matched. Appropriate supervision of staff is essential.

There should be regular evaluation of service delivery to

ensure that the service can respond to changing circumstances in health care at a local level. The skill mix should not be seen as constant while health services may be constantly changing. For example, 10 years ago the requirements for portering in an Occupational Therapy Department with four Occupational Therapists in a hospital of 700 beds, with an average length of stay of 14, days and a throughput of 200 patients a month, was one porter who could porter 12 patients a day. Today there are 12 Occupational Therapists still for 700 beds, an average length of stay of nine days and a throughput of 700 patients a month through the Occupational Department - still is only allocated one porter a day (still 12 patients a day). A skill mix evaluation has obviously not taken place and an inappropriate use of other staff is being used to fulfil the Occupational Therapy service requirements.

5.1 Role of Occupational Therapy Helpers in Hospital and Community

In the community the difference between what a helper does and what an Occupational Therapist does is a matter of degree. The information on the degree of a client's disability will indicate whether the case should be allocated to an Occupational Therapist or Occupational Therapy helper for a first assessment visit. The greater the level of disability, the more disabling the conditions, the more severely ill or critically ill a client appears to be, the more likely a qualified Occupational Therapist will make the first assessment visit.

Occupational Therapy helpers undertake assessments of clients with more stable conditions, milder levels of disability, less acute or critical illnesses. They will always be supervised by an Occupational Therapist so that if they visit and find that there is a greater level of disability or complexity of problems than indicated by the initial referral information, then they can seek advice or even a joint visit with their supervisor. The degree of complexity of a case will dictate who should visit the client. Complexity is indicated by a multiplicity of factors, psycho-social, physical, emotional, at-risk; the greater number of factors indicates the need for a qualified worker. The greater the number and complexity of problems which a client expresses and the greater the range of possible solutions to those problems will also indicate whether a helper or Occupational Therapist should assess the client. In the community the cost of the solutions proposed will also have a bearing on this allocation. A complex major adaptation to a client's home will only be undertaken by a qualified Occupational Therapist whereas provision of simple handrails can be undertaken by a helper. All of the above questions of degree add up to the accumulated skills required in the assessment process.

In hospital departments, helpers can be more closely supervised or conversely work single-handed while still having regular access to qualified staff. In both hospital and community, helpers are involved in situations where repetition of tasks is important for patients/clients as in training and

rehabilitation of a person through frequent repetition of tasks such as regular dressing practice or meal preparation practice. In psychiatric work helpers may use skills which they possess which Occupational Therapists do not have such as skills in crafts of different kinds. It is important to relate the grade of a helper to that person's skills. Some Helpers will need to work under greater supervision, others may work single handed with access to a qualified Occupational Therapist. It is also important to define what can and cannot be done without supervision.

From the interview data it is clear that helpers spend a greater proportion of time with patients/clients than qualified staff. In hospital departments helpers are best employed when patients are available for treatment and not expected to wait around at times when Occupational Therapists are in meetings or involved in administration work.

5.2 The Education and Training of Helpers and Technical Instructors

There is a demand for a nationally assessed course for helpers and there are already plans for the current helper's course to be incorporated into the National Council for Vocational Qualification framework. However, the profession may need to look again, very carefully, at the criteria for the award of accreditation since the four levels of helper they have defined, do not meet the criteria for levels one to four of the National Vocational Qualification. It is likely that the helper's course will meet levels one and two and then the bridging access courses currently being developed for helpers by Occupational Therapy schools, will be more suited to the National Vocational Qualification level three.

The issue of the re-deployment of helpers and technical instructors as the large institutions close is quite urgent. The helpers and technical instructors who may have worked in industrial therapy for many years may need retraining and reorienting to community based facilities. The decline in the numbers of unqualified staff working in Occupational Therapy over the past ten years may also entail the loss of skilled, experienced people from the workforce. The helpers and technical instructors represent a stabilising force in Occupational Therapy departments. The development of courses offering them access to training could be a way in which the whole workforce could be stabilised. There should, perhaps, be several options available, for example, distance learning courses, so that geography is not a constraint on education.

6. Staffing: Recruitment and Retention

The issue of the shortage of Occupational Therapists is one which has dominated the debate about the staffing of the service. In fact, the definition of shortage of Occupational Therapists is unclear and it may be argued that the multiple meanings of shortage have led to a confused situation. For some people with disabilities, shortage is viewed in terms of a shortage of people to provide assessments for much needed

aids and adaptations. The need for such assessments is often questioned by them, and so the Occupational Therapist is seen as an unnecessary bureaucratic irritation. Shortage may also be seen by other professional groups, particularly doctors, as a shortage of Occupational Therapists with specialised competencies who can quickly assess patients and organise interventions. It can also be argued that since Occupational Therapy interventions have rarely been evaluated for their effectiveness, it is impossible to say that Occupational Therapy makes a significant difference. A more difficult definition of shortage concerns the lack of job satisfaction clearly felt by some Occupational Therapists. The definition of the profession offered to them in training and their belief that their skills were not being adequately utilised was at odds with their perception of being already under pressure. It may be suggested that while Occupational Therapists find that there is a great deal of routine work to do in their busy departments, even when these are well staffed, they remain discontented and believe there is a shortage.

This definition of shortage could suggest a serious discrepancy between the definition of the Occupational Therapist's professional role and the reality of the functioning of Occupational Therapy in service settings. Further cause for concern regarding the gap between education and practice is the previously noted possibility that approximately 30 per cent of those completing training do not enter employment in the National Health Service or social services. the multiple definitions of "shortage" impact upon the issues of recuitment and retention. If students are recruited into Occupational Therapy at the age of 18, with no life experience or work experience and are told that, on qualification, they will be able to work in any health or social service setting with any client group, making any intervention they believe to be appropriate, it may be assumed that subsequent work experiences would be a disappointing corollary to training. The declining wastage rate from training noted in the past ten years may have been replaced by a disinclination to practise on qualification and a desire for alternative employment.

The following options could be considered:

- a requirement that all students have some relevant work experience before entering training.
- Sponsorship Schemes so that health and local authorities offer funding in return for service.
- the expansion of training opportunities for helpers.

It would seem that recruits to the profession need a very realistic view of the type of work involved before acceptance for training.

The issue of recruitment is linked, crucially, to that of retention. If only 60-70 per cent of those qualifying are entering employment, and if some of that group are dissatisfied with the functions required of them by the organisations for which they work, this is further evidence of

the phenomenon of Reality Shock. The approach to service provision, as many interviewed during the course of the study pointed out, has been to offer things professionals like to do. The demand from the service user is for greater control of the service. This could entail the need for radical shifts in the way in which services are provided. Additionally, there are moves for the district health authorities and social service departments of local authorities to become bodies which assess service needs and purchase services from providers rather than providing all services themselves. This development could be useful in resolving both the chronic dissatisfaction of Occupational Therapists and the desires of service users to have more control of the services they receive. The issues of recruitment and retention and shortage may be less pressing if Occupational Therapists become service contractors. District health authorities, for example, have to work increasingly to health objectives established by the Department of Health. They may choose to contract with a group of Occupational Therapists to provide specific services for specified groups. This system would ensure that all groups involved were clear as to what the Occupational Therapists were going to provide.

Another major factor in the manpower equation is that of the pay and conditions of Occupational Therapists. There is some evidence of movement between health and local authorities as the balance of pay and conditions shifts. However, the options for salary increases currently depend upon national pay bargaining. It is possible that one pay range could be established for Occupational Therapists through mechanisms to be discussed later. However, it is also necessary that decisions about the numbers of Occupational Therapists needed in each district are made. Local pay bargaining may be a way in which districts can attract staff because each district may provide slightly different types of service requiring different salary structures.

7. Location of Decisions about Numbers of Occupational Therapists

As health and local authorities develop into procuring bodies rather than direct service providers, decisions about the staff groups who will fulfil the health objectives established will have to be made. In view of the strength of the service users' views and their clearly articulated agenda, it would seem necessary to ensure that these decisions are taken in consultation by many groups in each locality.

It is also important to note that in some areas there may be more staff available in some groups than in others to fulfil the health objectives. Consequently, just as has occurred in countries such as Canada and the USA, some district health authorities may, in consultation with user groups and the profession, believe that, since there are Occupational Therapists available locally, particular services should be provided by Occupational Therapy. This may not be the case in other health districts. The location of decision making about such matters is increasingly at the level of the regional

health authority and the district health authority. It is suggested that across the board national increases in the numbers of Occupational Therapists are misleading. The health district's definition of need will vary depending upon many factors. It is suggested that in establishing the nature and size of Occupational Therapy services, health and local authorities should work together and that service users should be involved in the enterprise. This is the only way in which the numbers of Occupational Therapists and the definition of shortage in terms of inadequate numbers to meet functions required of them could be established.

8. Models of Occupational Therapy Service for the Future

The services from the 'Leading Edge' data which appear to achieve the most in terms of recruitment of qualified staff, achieving a good skill mix, and provision of a comprehensive service have certain elements in common. They all have a sound Occupational Therapy structure which includes qualified Occupational Therapists at all levels of their experience and support staff doing a range of work. They all have a senior manager of each service, NHS and local authority social services, who is an Occupational Therapist. They have started to work on interface issues for patients/clients discharged from hospital. They have already put forward many areas of joint working to maximise resources between the health authority and local authority.

8.1 Reasons for pulling together the Occupational Therapy Services between NHS and Local Authorities

1. The move to community care will require greater co-ordination between treatment in hospital and resettlement/management in the community. The Occupational Therapy service is ideally placed to be a major force in the implementation of community care policies because of its work with all the vulnerable client groups - people who are elderly or who are mentally ill or mentally handicapped - and the practical basis of Occupational Therapy in promoting peoples' competencies in daily living. The Occupational Therapist's major contribution has always been with people who have severe and chronic disabilities rather than mild and acute illness.

2. In order to promote effective utilisation of limited specialist Occupational Therapy resources and minimise competition between the NHS and local authorities for the resources, local services should become more united. There is a need to see the Occupational Therapy service as a pool of resources for patients/clients in hospital and then at home.

3. The development of community Occupational Therapy posts to work with all client groups is becoming a priority because of shorter stays in all forms of hospital, and the need for satisfactory follow-up after discharge.

4. There is a need to facilitate the movement of Occupational Therapists between hospital and community care work, for career development purposes, without losing individual practitioners from the profession. This should be done by ensuring that Occupational Therapists can progress within their local structure according to both career and family needs and by flexible employment conditions that is, flexible hours, job sharing and so on. These can often all be encompassed much more easily in a structure with a greater variety of different services.

When these current developments are considered, it is possible to put forward a number of models which could be used as effective and efficient service structures for the future.

8.2 Individual Structures from the Leading Edge Locations

Examples are given from both health and social services departments which indicate that a service managed with explicit professional leadership provides the best structure for service as well as addressing recruitment and retention issues. The reasons seem to be that a professionally managed service can provide:

1. Good supervision models which professional staff would see as attractive.
2. Someone who can have an overview on planning Occupational Therapy services. The Senior Occupational Therapy Manager is the most appropriate person to address the skills mix issue.
3. Someone who can move resources around to ensure that services are prioritised and reprioritised in response to problems of fluctuating staffing levels.
4. Someone who can give time to recruitment and retention.
5. Someone who can liaise at a strategic level as well as an operational level.
6. A senior Occupational Therapist in each agency who can facilitate joint planning of services and effective use of limited Occupational Therapy resources.

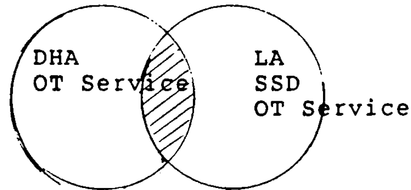
In the NHS this means District Occupational Therapists leading the Health Occupational Therapy services. In SSD this means a Principal Officer of Occupational Therapy.

8.3 Four models of service outlined

There appear to be some areas where a dispersed model is in evidence, which indicates that there are only very informal links between NHS and Local Authority Services. By and large these services work independently and without communication with one another. This is obviously a weak model from the consumer's point of view and one which would not appear to fulfil the necessary requirements of community care.

The following models are recommended for consideration and may be already in use in different parts of the country.

8.3.1 Model A



The shaded area represents the interface between the two services which in this model are:

1. Informal Links - meetings between two senior managers
   - meetings between Occupational Therapists
   - meetings between Helpers and Technical
   - Instructors

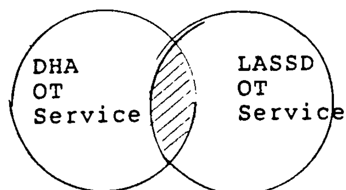
   These meetings consider strategic issues such as planning for future services and operational issues such as day to day service delivery. Staff at all levels share information about their ways of working and make proposals for improvements which can be carried out within the remit of their senior managers.

2. Formal Links such as:

   - Shared induction packages
   - Shared training and development
   - Joint planning of Occupational Therapy Services
   - Shared Occupational Therapy Student training
   - Ordering and issue of equipment at the point of the patient's discharge.

   All these are within the control and realm of responsibilities of the two senior Occupational Therapy managers of the respective Authorities Services

8.3.2 Model B



The shaded area is a larger interface in this model and represents whole areas of work where there can be negotiation involving the two agencies and some budgetary flexibility namely

1. Rotational posts between health and social services.

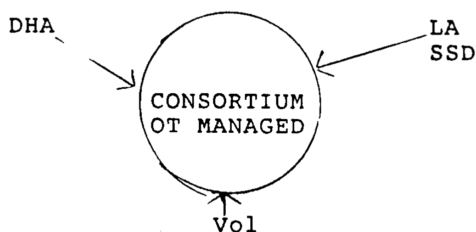
2. Secondment of staff from one authority to the other for a given period.
3. Use of joint funding to provide specific posts to work at the interface (or in other special venues). This could be for any grade of staff.
4. Use of joint finance monies for specific projects.

<u>This would be jointly planned by the two senior managers but would include agreements with District Health Authority and Social Services Committee</u>

8.3.3 <u>Model C</u>

In this model one of the authorities takes responsibility for the management of the whole service provided to the NHS and the LASSD. From a service point of view this appears to be a very effective model but relies entirely on co-terminosity and the issues of pay and conditions of service of staff being resolved, that is either the NHS or the LASSD conditions applying to all staff. Work in one authority's environment when not employed by it can pose problems which will need to be identified and resolved.

8.3.4 <u>Model D</u>



This is a model independent of both authorities, managed by a consortium with representation from each authority which wishes to 'buy in' Occupational Therapy services. It can operate without co-terminosity and provide Occupational Therapy services to any NHS or local authority within a given area. There would be representation of each authority on the consortium management with Occupational Therapy managers in the position of the general managers responsible for agreeing contracts of service with each authority. Organisations of disabled people would also have a role to give expert advice on needs of people with disabilities within the geographical area.

The advantages of the consortium model are, it:

1. Gives a fully integrated Occupational Therapy service which can function in spite of the political, financial, co-terminosity and structural/organisational differences between the authorities.

2. Can provide a comprehensive service across boundaries and can utilise limited staff resources in the most effective and efficient manner, avoiding duplication of effort.

3. Can provide good career development offering staff a variety of experience in a wide range of settings without changing their jobs. It can eliminate competition locally around pay and conditions, and work opportunities.

4. Can respond quickly and flexibly to changing health care needs; including developments in community care and consumer involvement.

Disadvantages

1. If a consortium is independent it can make individual Occupational Therapists more vulnerable if agencies choose not to have an Occupational Therapy service. This would either mean massive redevelopment of staff, or redundancy. If, however, the consortium sought to "sell" its Occupational Therapy services elsewhere, existing staff would need to be prepared to travel further afield to work, or leave the consortium's employment.

2. Locally negotiated pay and conditions including pensions may be attractive but could leave Occupational Therapy staffing vulnerable.

There would have to be certain safeguards such as:

1. Establishing with the agencies that Occupational Therapy is an essential service.

2. Pay and conditions would have to be at a level recognised by other authorities and comparable in the economic market.

9. The Service Users' Voice

It has become apparent that changes and developments in Occupational Therapy are desired by service users. Articulate service users are seeking a service over which they have more control. There is some impatience with the attempts by some members of the Occupational Therapy profession to become total life-style managers. However, there is considerable respect for the practical skills and knowledge of the profession, along with a strong desire for Occupational Therapists to share these with service users.

It is important for the profession to come to terms with these developments. There is considerable scope for the development of more formal links between organisations for disabled people

and Occupational Therapy. Some options could include:

- representatives from local organisations for people with disabilities on the Boards and Committees of Occupational Therapy Schools and Departments
- advice on curriculum content from organisations for disabled people
- recruitment of people with disabilities into Schools of Occupational Therapy using the programme developed for social work as a model.

The need to understand and meet the agenda of the service user is pressing. The skills and knowledge base of Occupational Therapy are important, but a failure to understand the aspirations of people with disabilities and their carers would not be helpful for the future development of the profession.

Models already exist of services for people with disabilities which provide for the management and development of services by service users. The funding for such groups comes from a variety of sources. It is salutary for all health care professionals to note that at least one of these groups provides counselling by people with disabilities or carers for people with disabilities. Occupational Therapists give advice on technical matters. This would suggest that such professionals begin to re-define the holistic approach. Many service users themselves have very clear ideas about which areas of their lives they would wish to receive advice from professionals. If health care professionals continue to believe that "holism" means the right to assess all areas of their clients' lives, there is the potential for conflict. It is important to note that the wishes and concerns of six million people are likely to be taken seriously by policy makers. Furthermore, it is urgent that Occupational Therapists and other health care professionals come to terms with this change in the balance of power and recognise that people with disabilities and their carers will increasingly dictate the terms on which they ply their trades.

A start has been made in this study in involving service users in the decision about the kind of skill mix needed for Occupational Therapy. It has been established that service users do accept the need for the profesional kitemark in a range of situations and that the confidence of service users would be eroded if qualified Occupational Therapists were not available. There is little desire for de-professionalisation and de-skilling, but there seems to be a strong desire by people with disabilities to control their own destinies.

CHAPTER FIVE

1. Issues raised by the study and recommendations for future action

The issues raised by this study were many and fell into four major groups which overlap and are closely interlinked: Skill mix; Education and Training; Manpower, Recruitment and Retention; the relationship of the profession with people with disabilities and their carers. The research team have produced a series of recommendations in these four areas.

Each of the recommendations has arisen directly from the policy review, data collection and policy analysis. Many themes have converged and similar issues have been identified as threads running through all the available sources of information. It is hoped that the recommendations will be viewed as positive and helpful contributions to a professional group which has both much to offer to the community and much to gain from recognising the future roles available to health care professionals.

2. Skill Mix

Skill mix should be determined in terms of benefit to the service users. It should be seen in terms of the total staffing pattern of the health district and local authority, paying attention to the staff mix within facilities, that is, availability of other health care professionals such as speech therapists, district nurses, and specialist social workers.

Defining optimum skill mix should be a tri-partite exercise between service managers and planners, professionals and service users to ensure that public confidence in skill levels is maintained. The decision about the appropriate skill mix should be made after consultation with professions and service users and should include consideration of the importance of ancillary staff such as clerical workers and porters.

Recommendation 1:

Optimum skill mix should include considerations of the local staff mix and ancillary staff and should hinge on consultation with service-users as well as professionals so that the best service possible within each locality, making the best use of available skills is achieved.

2.1. The Development of Training and Education for Helpers and Technical Instructors

2.1.1 Training

The current helper's course is a laudable effort by the profession to meet a need. As the National Council for Vocational Qualifications develops its system of Credits for Vocational training, the helper's course should be developed to enable access for all helpers and technical instructors to

further training or to entry into training for the profession at qualification.

Recommendation 2:

All helpers and technical instructors should be encouraged and enabled to enter training courses designed for them and receive credit and SCOTVEC from the National Council for Vocational Qualifications. This will require the development of accessible courses and techniques such as open learning should be examined. these developments are already occurring and should be encouraged.

2.1.2 Education

In view of the stability of the helper and technical instructor workforce within Occupational Therapy and the very low vacancy factor for these grades, the profession may benefit from the further development of access courses. These may prove expensive initially but it is suggested that a long term cost-benefit analysis would demonstrate considerable advantages. Also, it is suggested that open learning techniques could reduce the costs to the service.

Recommendation 3:

Access courses should be further developed using techniques such as open learning by all Occupational Therapy schools and departments and all helpers and technical instructors should be offered this opportunity.

2.2 Consolidation of Helper and Technical Instructor Grades

In view of changes in the provision of health care and the need to recognise the skills and qualifications of all support staff, the distinction between helpers and technical instructors no longer seems to be of great utility and is of declining importance, except in terms of salary differential. Some consolidation of the helper and technical instructor grades has already occurred.

Recommendation 4:

The helper and technical instructor should be consolidated, and the new grade be described as Occupational Therapy support worker. Current staff would retain seniority and pay levels, but new staff would be placed on the new grade pay scale at a point which would recognise previous experience and relevant qualifications.

2.3 The position of Helpers and Technical Instructors within large institutions

As large institutions are closed, the skills, knowledge and experience of the helpers and technical instructors could be lost.

Recommendation 5:

Health Authorities should be reminded of the need to ensure that helpers and technical instructors are given the opportunity to provide service either in community facilities or to be re-oriented to helpers and technical instructors posts in other areas of the authorities.

3. Education and Training

The educational base of Occupational Therapy will be increlasingly in higher education and will be greatly affected by Credit Accumulation and Transfer. There seemed to be some evidence of Reality Shock among newly qualified staff, evidenced by their failure to enter the profession after qualification or difficulties in entering practice. There seems to be a need for wider experiences of clinical practice at the basic level and specialised clinical courses at post-basic level. The need to establish a convincing research base for practice was established.

3.1 Validation

Course validation procedures seem to be unnecessarily complex and to involve too many bodies. Course validation procedures need to be reviewed to ensure that all courses are validated only by one body for professional content and by the procedure within the institution of higher education. It is further suggested that the Occupational Therapy Board of the Council for Professions Supplementary to Medicine be clearly identified as the only body which is responsible for validating professional content.

3.2 Preparation for Reality

There was evidence of the need to ensure that students acquire a real appreciation of the work of the Occupational Therapy service before, during, and on qualification and entry into employment, and that schools should be more closely involved in the manpower planning process at district and regional health authority levels.

Recommendations 6:

Schools should require a period of relevant work experience prior to entry into the profession.

Recommendation 7:

All students should have a rotation of clinical placements including community experiences.

Recommendation 8:

Clinical placements should take place in a wide range of community facilities, some of which may not already have an Occupational Therapy service, but all should be approved for training on the basis of the skills, competencies and philosophies of the people in the service. There should be adequate supervisory arrangements in place, but complex

accreditation procedures with contracts of affiliation are not advised.

Recommendation 9:

All Health and Local Authorities should develop plans to ensure adequate orientation and support for new entrants.

Recommendation 10:

Schools and Departments of Occupational Therapy should include at least one practising Occupational Therapist from health and one from social services in curriculum design work.

3.3 Higher Education

The many positive benefits of moving to Higher Education institutions were apparent. This does not imply that there should be any change in the funding of courses and Occupational Therapy students would continue to be eligible for Department of Health bursaries rather than Mandatory Awards:

- a less isolated profession
- the possibility of developing a research base
- the need for all health care professions to be mindful of the impact of Credit Accumulation and Transfer.

Recommendation 11:

All Occupational Therapy schools should continue to develop links with higher education and all should eventually become part of an institution of Higher Education.

Recommendation 12:

An escalator model of education should be adopted universally whereby some entrants may gain access through courses for Helpers, and some along with some relevant work experience, through academic qualifications. All would register when enough credit units had been completed, some may leave to work and return to complete credit units for graduation and some would leave at first degree level, whilst some may decide to complete only the credit units for registration.

Recommendation 13:

The value of post-basic clinical specialisation should be recognised and courses developed, some perhaps with other disciplines which would be acceptable for academic credit.

Recommendation 14:

The extension of research training schemes for Occupational Therapists, particularly to develop techniques to evaluate clinical interventions is recommended.

4. Manpower, Recruitment and Retention

4.1 Shortage

The many shades of meaning given to the phrase "a shortage of Occupational Therapists" were revealed. The need for an agreed definition of the term was apparent.

Recommendation 15:

It is recommended that the numbers of Occupational Therapists required should be a local decision depending upon the objectives for health agreed nationally, and that this should be decided based upon consultation by service managers and planners amongst Occupational Therapy professionals and local organisations by and for disabled people and their carers. A local contract of service should be drawn up on this basis and staff numbers should be agreed according to contracted work load.

4.2 Overlap

The continuing difficulties of overlap and waste of resources between health and local authorities were noted. However, the government's response to the report on Community Care would suggest that the debate about co-operation will have to cease. Models C and D in Chapter 5 may prove in the long term the most robust.

Recommendation 16:

All health and local authorities, in seeking to implement the new policy on Community Care should establish integrated Occupational Therapy Services, which may be based on a number of models, for example models C or D, described in Chapter Four, and which are complementary to locally organised initiatives by people with disabilities and their carers. Models C and D in Chapter Four may prove in the long term the most relevant.

4.3 Recruitment and Retention

The issues of recruitment and retention will be better resolved when each integrated Occupational Therapy service has a local contract of service. It will then be possible to estblish the numbers of Occupational Therapists required in each region and to construct a national manpower picture.

Recommendation 17:

Initial recruitment into the profession should be examined carefully. The bursary system should change to a sponsorship scheme administered through the Regional Health Authorities, but should not change to a system of mandatory award.

Recommendation 18:

Schools should have affiliation contracts with Regional Health

Authorities which should include mutually agreed goals for recruitment. The contract should specify the expectations that the Regional Health Authority has of the school, including the requirements that schools should implement active equal opportunities programmes, particularly to develop access to the profession for people with disabilities and people from ethnic minorities. The contracts should be monitored and reviewed on a five-yearly basis. Regional health authorities may have affiliation contracts with more than one school. There is no requirement for a school in each regional health authority, since students may be sponsored by regional health authorities where they intend to work and attend a school in a different region of the country.

Recommendation 19:

Each health district and local authority should examine carefully with senior members of the profession as to how a more flexible service can be provided. As plans for integrated services are advanced, consideration should be given to evening and weekend working. The 9-5 Monday to Friday service will probably need to change if Occupational Therapists are to be recruited back into the service and to be retained within it. Distance learning packages should be offered to returners and other methods of preparation for re-entry should be investigated.

Recommendation 20:

There should be a specific commitment by the profession to abandon the custom and practice of entering the profession via health. As integration of health and social services occurs and community care policies are implemented, such advice will be increasingly unrealistic.

Recommendation 21:

Local authorities should be more involved in the selection of students for sponsorship by the integrated service and should be prepared to offer sponsorship finance in an integrated Occupational Therapy Service.

5. People with disabilities and the Occupational Therapy Profession

People with disabilities and their carers are, in effect, the service users or consumers of Occupational Therapy services. The efficiency and effectiveness of Occupational Therapy is not improved by the complex, overlapping structure of the rehabilitation services. There is a strong demand for direct contact with fewer professionals and preferably only one. In developing integrated services, case management and key worker systems should be considered. The complexity of rehabilitation services and the confusion of clients seeking access were commented upon unfavourably by service users. In the current context, the role of Occupational Therapy within the rehabilitation services is unclear, therefore, discontent with the system may be projected onto the profession. The

structure of the rehabilitation services seems to be in need of review. Such a review would have implications for the provision of Occupational Therapy services. It should also be noted that people are seeking more control over their own lives, more choice and fewer professional interventions. The Occupational Therapy profession cannot initiate a major service review, neither should it be held responsible for the perceived negative effects of the current system. However, it could take a lead in making a serious effort to lessen the gap between its own agenda and that of service users.

Recommendations 22:

The Occupational Therapy profession should take a lead in requesting a review of rehabilitation services.

Structures within the profession should be examined to ensure that service needs as articulated by service users, managers and planners are taken into account, for example membership of the Occupational Therapists Board could be widened to include representatives from the employment field and service users groups.

Recommendation 23:

Schemes to extend consumer choice such as self-assessment and voucher schemes should be explored by the profession with local organisations and the legal implications of these should be considered and their impact on Occupational Therapy manpower should be reviewed.

Recommendations for further research

Recommendation 24: Manpower

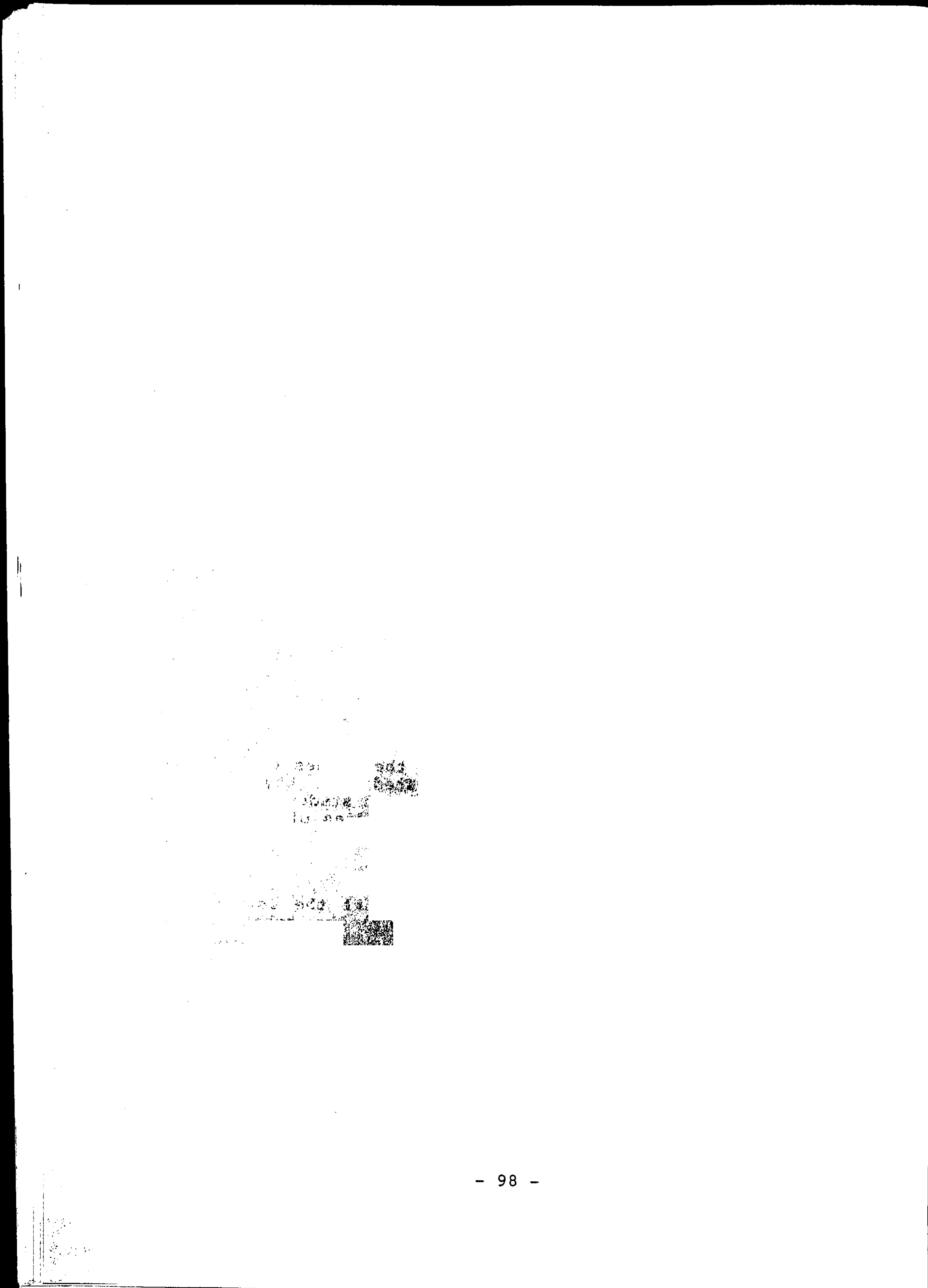
In view of the confusion surrounding the issues of entry and re-entry into practice, it is suggested that key areas for manpower research are follow-up studies of students qualifying from Occupational Therapy schools and studies of Occupational Therapists who return to practice.

Recommendation 25: Skill Mix

There is a need to study in closer detail the issues which affect decisions about skill mix within the rehabilitation service. The provisional tool to measure skill level may be a useful means to this end, but needs further development.

Recommendation 26: Evaluation of Interventions

It became apparent during this study that little data existed as to the efficacy of interventions in Occupational Therapy. In view of the investment in the service, it would seem to be important that Occupational Therapists be encouraged and provided with the resources to develop evaluative studies of clinical practice.



Annexe 1

Policy and Associated Literature Review

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Annexe 1

Policy and Associated Literature Review

Health and illness are frequently described as poles of a continuum. Health care occupations such as medicine and nursing are long established and have developed a range of interventions along this continuum. Medical interventions may be described as concerned with the prevention, diagnosis and treatment of disease while nursing interventions concern the support of the individual through promotion of health and care during illness. These are, undoubtedly, closely linked, and it is frequently difficult to distinguish responsibility for the performance of tasks. During this century, as medicine has become more complex, providing the range of skilled interventions required has become more difficult. This has led to the formation of new specialist groups. Physiotherapists were initially concerned with massage and then mobility. The Occupational Therapists were concerned initially with the provision of occupation and later, more generally, with the human environmental interface and the ways in which individuals with disabling impairment˜s of all types are handicapped in their dealings with everyday life. Occupational Therapists and physiotherapists, therefore, also share the therapeutic space along the health/illness continuum. This space is not, and never has been, neatly marked out; in some areas there are clearer lines than in others, but nowhere can any of the occupational groups within that space claim that every task can be neatly labelled "Doctor", "Nurse", "Clinical Psychologist" or "Physiotherapist". This is the issue of staff mix which is intimately linked with questions about the goals and purposes of occupations and their legal liabilities and statutory obligations.

Epidemiological data concerning the prevalence of disability in the population can help to establish the level of need for assistance (OPCS, 1988). This study will attempt to describe a method which helps to determine when a person with a disability may need assistance and when that help should be provided by a professional Occupational Therapist or when other professions and other types of workers could be used to provide a service meeting the criteria of effectiveness, efficiency and economy. To this end the review of the literature will examine the process of professionalisation, the concept of skill mix and the structure of the Occupational Therapy profession in terms of their impact on service users. The initial part of the literature review will analyse these issues and will be presented in seven sections. The related issues of Occupational Therapy manpower, the epidemiology of disability, the cost-effectiveness of Occupational Therapy services, international comparisons and the impact of social change on the future of health care services will be reviewed separately and presented in Section 9 of this review.

Hall (1987) makes it clear that Occupational Therapy began as a branch of nursing; but after World War Two became a medical auxiliary profession with a focus on rehabilitation through

work. The presence of other professionals working in that area of the therapeutic space has entailed some boundary disputes, overlapping and perhaps, therefore, a failure to meet the criteria of efficiency, effectiveness and economy. There have, historically, been particular problems in physical medicine, where there has been overlap with physiotherapy, and in psychiatry, where the space is shared with nursing. Current trends suggest, however, that physiotherapists are now working in psychiatry (Hare 1986), and that there are concerns about the overlap of art and other creative arts therapists with Occupational Therapy. It is possible that the confusion in the therapeutic space is growing.

It is not easy to offer any definition of Occupational Therapy because of the many areas in which Occupational Therapists work. It may be more fruitful to view Occupational Therapy from the point of view of the users of the service and to examine the impact of current Occupational Therapy provision on them. This perspective has been reinforced by the accumulation of evidence during data collection. It has also become increasingly clear that an identity of interest between the service users and the service providers should not be assumed. Indeed, it is apparent that people with disabilities, who are service users, have a quite different interest in the rehabilitation services than those who provide them. Beardshaw (1988) and Fielder (1988) both point out that service users have little input into the design and development of rehabilitation services and that the perspectives of professionals on disability differ markedly from people with disabilities and their relatives. Furthermore, the current structure of the remedial professions - physiotherapy, occupational therapy and speech therapy - may not be conducive to the delivery of coherent rehabilitation services.

Interviews with people with disabilities in the course of the study have reaffirmed that the current structure of the remedial professions should be examined carefully from the perspective of the service users. Skill mix in Occupational Therapy cannot be considered in isolation from the interests and concerns of people with disabilities. For the purposes of this study, the definition of disability is that offered by the 1988 OPCS Survey:

> "....a restriction or lack of ability to perform normal activities, which has resulted from the impairment of a structure or function of the body or mind." (pxi).

This study takes as its starting point, the need to provide people with disabilities with the kind of help which is of greatest value to them.

The Occupational Therapy Skill Mix study was commissioned by the Manpower Planning Advisory Group to examine the number of staff and describe the work that needs to be done and the range of tasks that might appropriately be undertaken by members of staff of an Occupational Therapy service. This

brief entailed that a thorough study be made of the appropriateness of the levels of skill needed to perform the tasks required of the Occupational Therapy service. It is important, therefore, to examine what society needs from the Occupational Therapy Service and to proceed, then, to consider the issue of how best this service can be provided in terms of effectiveness, efficiency and economy. An effective service may be defined as one in which the best outcomes for clients are obtained. An efficient service may be described in terms of the competency with which the service is managed, for example, by ensuring that skills are not wasted. An economical service is one in which effectiveness and efficiency are balanced so that clients are assured of satisfactory outcomes in an efficiently managed service which makes the best possible use of available resources. Occupational Therapy is one of many occupational groups which contribute to the health of the citizen and it has become apparent during the course of the study that it is often difficult to single out any one profession as being directly responsible for any particular outcome. This is especially difficult in Occupational Therapy, since there are many ways in which the standard definition of Occupational Therapy can be operationalised. The College of Occupational Therapists (COT 1984) offers this as a public definition:

> "Occupational Therapy is the treatment of physical and psychiatric conditions through selected activities in order to help people reach their maximum level of function and independence in all aspects of daily life."

Jay (1981) however, points out that:

> "Occupational Therapy is a much misunderstood profession. There are many reasons for this. Probably the main one is that their training equips Occupational Therapists to work in so many different areas that the various jobs individual Therapists are doing seem to bear little resemblance to each other." (P.163).

It is, therefore, necessary to look at some other ways in which the important task of defining the goals of the Occupational Therapy service can be accomplished. It is suggested that a better starting point would be to consider definitions of health and illness and how and where the Occupational Therapy contribution has developed. The Acheson Report (DHSS 1988) provides a definition of public health:

> "the science and art of preventing disease, prolonging life and promoting health through organised efforts of society." (p.1.)

which is helpful in considering the role of health care professionals in providing services to clients or patients, since there is a focus on the collective efforts of societies to resolve the problems of health care. It is noteworthy that many developments in the Occupational Therapy profession have

occurred because of clearly defined statutory obligations placed on health and local authorities to provide services to specific client groups.

Section One

The processes of professionalisation and concepts of skill mix in professions.

1.1 Introduction

The development of professions has long been studied by groups such as historians and sociologists. Skill mix, however, has been less extensively studied and there are, therefore, fewer studies of the phenomenon. Nonetheless, it is clear from studies of the development of professions that most professions involve a degree of skill mix. Abel-Smith and Stevens (1965) in their classic study of the legal profession did not just interview barristers and solicitors but included the views of barristers' clerks and legal executives in their study.

There is a classic division of professions into "true" or "ideal" professions proposed by Weber (1964) and "semi-professions", described by the Etzioni School (1969); the one largely male, autonomous and powerful, the other largely female, working within bureaucracies and lacking much power. However, it would be correct to say that even the legal profession, frequently given as an example of a "true" profession as opposed to a semi-profession such as teaching or nursing (Friedson and Goode in Etzioni, 1969), is dependent upon a large number of auxiliary personnel to conduct its business. Indeed, it may be noted that the semi-professions are far more concerned about the issue of skill mix than the "true" or "ideal" professions. For example, the nursing profession has been long concerned about the supervision and training of the large numbers of non-professionals who are involved in providing nursing care, but the Wright-Warren report (DHSS, 1986) found that there was "a dearth of literature" on the subject. However, McGuire (DHSS, 1986) in the same document describes the issue as a:

> "battle line drawn up between the profession......and the employing authority" (P.83).

Spashett (1981) reflects a similar point of view within the Occupational Therapy profession since she suggests that "Occupational Therapy" departments without qualified Occupational Therapists in supervisory positions, should be re-named. The lack of control over their working environment and fears of substitution of qualified semi-professionals by the lesser qualified or even unqualified workers may explain these reactions. However, there are many themes within the literature on professionalisation and skill mix which relate to all professions and which may provide useful analogies to and increased understanding of the situation within the Occupational Therapy profession.

1.2 Developments within Professions

Although the process of professionalisation as reported in the medical profession would seem an obvious choice of model,

given the medical connections of Occupational Therapy, in fact, the development of the remedial professions may be studied in a more illuminating way by examining three other areas: the legal profession, the optical profession and the development of the certified respiratory therapist.

The legal profession is said to be a "true" profession because it fulfils the criteria against which all professions are measured:

- a long training
- a client relationship
- a code of ethics
- an orientation to public service
- self government

(Weber, 1964)

Yet the legal profession in England is not a unified profession for it is divided into two major branches: solicitors and barristers. This divide has occurred as a result of historical forces and has continued until the present day. Abel-Smith and Stevens (1965) note the persistent attempts to achieve reform:

> "Again and again the same attempts are made and defeated by much the same forces and for much the same reasons. In this field history repeats itself - ad nauseam. But we thought it right to tell the story in full, in order to expose the whole grave yard of rejected reforms." (P. viii - ix).

This is a particularly telling and important point. At the present moment, (HMSO, 1989) a further attempt is being made to reform the legal profession. Yet once again there are ferocious arguments about the "fusion" of the roles of solicitor and barrister and it remains to be seen whether barristers will maintain their monopoly over advocacy in the senior courts, as they have thus far managed to do. (Cocks, 1983 p.1.). The parallels between the legal and remedial professions' reactions to reform will become increasingly obvious as the attempts to reform the remedial professions are documented in Section three.

A further interesting parallel with the remedial professions is provided by the study of the provision of optical services. These have been traditionally provided by one profession with two branches - the ophthalmic opticians concerned with consultation and advice and the dispensing opticians, concerned with selling and commerce (Jack and Alpine, 1980). Into this scenario entered the Office of Fair Trading with the Borrie report (OFT, 1982) which was concerned that the opticians had a monopoly not only of sight testing but also on dispensing and supply of equipment. Since simple magnifying spectacles are on sale in many areas of the world and provide adequate correction for many people, it was considered that this monopoly was not in the interests of the consumer and it was, therefore, abolished. The parallel here with the position of the occupational therapist in the supply of aids and

equipment to the person with a physical disability will be explored later in this report.

A final parallel which demonstrates a further development in the professionalisation process may be found in the rise of the certified respiratory therapist in the USA. The certified respiratory therapist seems to have developed in response to the need for technical assistance in the intensive care unit. Although the tasks they perform might at one time have been performed by nurses or physiotherapists, since these two groups have professionalised, there was obviously a niche for a narrowly, intensively trained technician who would be unable to use his skills in any other area of the labour market. Just as nursing has professionalised in the USA, creating a wider, more extensively educated profession, so the number of nurses willing to work in hospital settings has declined (RN, 1988). It is arguable that a highly flexible professional education will supply flexible manpower capable of working in many areas but it will also create manpower which chooses situations it sees as desirable at the expense of the less desirable where it is needed. Hence the development of narrowly trained technicians for specific tasks such as the certified respiratory therapist has occurred. A more stable workforce may, in fact, be created by the employment of less flexible manpower.

Farrell (1986) points out that most respiratory care therapists are still trained in a very limited range of techniques, such as maintenance of bronchial hygiene and airway, but, in their attempts to contain health care costs, hospitals are now looking for respiratory therapists with competence in many more techniques. Thus, the gaps left by the professionalised groups within the US health care system may be increasing.

There seem to be some parallels with the Occupational Therapy profession in this country. Occupational Therapists are a highly flexible source of health care manpower which can be used in many different situations, while there is a manpower deficit filled with Occupational Therapy helpers and technical instructors. Other groups with more directly definable and less flexible skills such as arts therapists (art, music and drama therapists) may also be filling the niches vacated by the Occupational Therapy profession. Finally, it is worth considering two other aspects of professionalisation. Cipollia (1973) comments on the rise of the legal profession in Italy:

> "The advocates of the restrictions and controls always claimed that they were needed to maintain a high standard of competence and ethics in the profession. I mentioned above that they were inspired by the selfish interest to restrict competition. In fact both motives were at play and reinforced one another....."

and this is a telling comment on the lack of identity of interest between professions and those whom they were

established to serve. Nowadays, service users are becoming less passive and Grunow (1984) notes that doctors in West Germany have begun to complain that they are treated like servants by their patients. He suggests that, in the future, service users should expect less dominance and arrogance from professionals, but that professions should be maintained as a means of ensuring citizens rights vis a vis bureaucratic systems.

1.3 Skill mix

This is an issue which has been debated frequently in the field of health and personal care. Professionally trained staff are expensive to recruit and employ and managers are reluctant to have them spend time on tasks which could be performed by less skilled non-professional workers. Yet there are surprisingly little data available to provide guidance for the optimal skill mix in any profession. Indeed, it is difficult to find any definition of the concept. Bessell (1976) in commenting on the Department of Health and Social Security working party on manpower planning in the social services, notes that the history of social work training:

> "is littered with attempts to set up a body of para-professionals who would undertake tasks which did not require the full range of social work skills thereby freeing the social worker for tasks only he could perform."

Bessell (1976) in considering one of these many attempts notes that:

> "the result was that what were originally thought of as second grade staff, those trained on the new CSW courses, quickly showed themselves to be quite as able as social workers from the more traditional university based courses,....."

He concludes that:

> "Social work practice simply does not permit such divisions, however much easier it would make the task of administration."

Attempts to introduce lower levels of qualification into social work have led inevitably to staff trained at these levels performing the full range of social work tasks. The nursing profession in the UK has had a similar experience with the enrolled nurse, while in the USA, the two year trained associate degree nurse is used interchangeably with the Bachelor of Science in Nursing graduate who has four years of education. Indeed, it seems likely that in no other human service field has the ideal of optimal skill mix been more vigorously pursued than in nursing. Yet the results have been very disappointing. The Wright-Warren Report (DHSS 1986) makes it clear that there is a long history of failure to define skill mix. Ultimately the decision about skill mix is an arbitrary one. It may be influenced by patient dependency

measures as Goldstone and Collier (1982) have suggested, but ultimately, after deciding on the number of nursing personnel, Goldstone and Collier (1982) leave the issue of skill mix to "professional judgement." Similarly, the Wessex Regional Health Authority, Report on Nursing Manpower for the Elderly (Wessex RHA, 1984) has built norms for skill mix into its proposals, but provides no rationale for those norms.

One of the few attempts to define skill mix is offered by Celentano (1982) in the context of the development of the allied health professional (AHP) in the USA. AHPs may be nurse practitioners or physician's assistants and assist the medical profession by taking over many of their functions. Celentano (1982) suggests that the phenomenom can be analysed through the related concepts of "Optimum Utilisation" and "Appropriate Responsibilities". Celentano (1982) poses a series of questions. He suggests that the issue of optimum utilisation should be examined from three perspectives: the patients, the health care providers and the health care planners. If optimum utilisation is a problem for patients seeking services then there may be inadequate numbers of appropriately qualified personnel to provide the type of service sought. Health care providers are concerned with maximising time and effort, therefore, the productivity of health care personnel is important. The health care provider needs to ensure that the most highly qualified and, therefore, the most expensive personnel perform the most skilled tasks and that tasks requiring less skill are performed by less highly qualified and, therefore, less expensive personnel. A further question related to optimum utilisation is that of providing equitable distribution of goods and services in the health care system. A top heavy system in which the best health care is offered to the least sick, and possibly most wealthy, members of society may be partially balanced by the provision of health care to the less wealthy through the services of the nurse practitioner or physician's assistant, as occurs in the USA.

"Appropriate Responsibilities" within the health care system are explored by Celentano (1982) in a global context. He suggests that there are different needs in different types of health care systems and that the stage of technological development and cultural context of society should also be considered.

Applying these ideas to one particular health care system produces interesting insights. Celentano's (1982) questions could be adapted thus:

- What are the different needs in different areas of the health care system?
- What is the technological context of practice?
- What is the cultural context of practice?

It may be that the issue of skill mix cannot be defined by reference to a whole profession but only to the groups for whom service is provided. This would help to account for the lack of success which professions such as nursing and social

work have had in their attempts to define and develop optimal skill mix by creating sub-professionals. This applies also to Occupational Therapy where Spashett (1981) points out that some Occupational Therapy departments exist, for the most part, in mental illness and mental handicap hospitals, which are staffed entirely by Occupational Therapy helpers and technical instructors. It may be that the concept of skill mix has so far been too narrowly defined within professions. Bessell (1976) suggested that social work should abandon its attempt to create sub-professionals and should instead co-operate with other groups, in particular the home help service, which could take on a whole range of work with social workers. Challis and Darton (1988) report on the work of one such project establishing a multi-purpose care worker for the elderly in the community. They report that:

> "The home care assistant is also used as an auxiliary by nurses or therapists working in the community and is instructed to carry through a treatment programme such as wound dressings or physiotherapy exercises under the supervision of the appropriate professional."

Not only does this avoid the problem of overlapping roles, which is so frequent in the health and personal services, but also it ensures that no one professional "owns" the care worker. Therefore, the difficulties of the extension of sub-professions into roles for which they have not been trained seems is largely avoided. As the National Vocational Qualification Scheme develops, it would seem possible that care workers with common core training and specialised training units, which would allow them to assist in areas such as Occupational Therapy, could be equally useful in hospital or the community.

The issue of professionalisation, the desire to define a professional territory, and skill mix, the concomitant need to ensure that only professionals provide certain services and that non-professionals always work under professional supervision are inextricably mixed. These two themes will be explored with particular reference to Occupational Therapy in the subsequent sections of this review.

Section Two

The current structure of the Occupational Therapy profession in the United Kingdom.

2.1 Registration and Regulation and Representation

2.1.1 Introduction

State registration should be:

> "seen as the hallmark of full professional status" (CPSM, 1988).

Occupational Therapists in the United Kingdom were initially regulated as medical auxiliaries. However, since 1960, they have been regulated under the Professions Supplementary to Medicine Act. A Council for the Professions Supplementary to Medicine (CPSM) was established over which the Privy Council has a surveillance role and default powers. Each of the professions named in the Act: chiropodists, dieticians, medical laboratory scientists, orthoptists, Occupational Therapists, radiographers and physiotherapists, has a Board which is required to scrutinise and approve training courses and training establishments, approve qualifications, define standards of behaviour and practice, with disciplinary powers in the event of default, and to publish an annual register of those approved to practise. Additionally each profession must have Investigating and Disciplinary committees. These are the statutory bodies responsible for the regulation of the profession (HMSO, 1988 p. 1377 and BAOT, 1988 p.13).

In practice the Occupational Therapy Board and Committees work in tandem with the College of Occupational Therapists and there is a liaison committee to ensure adequate collaboration. (BAOT, 1988 p.13).

2.1.2 Approval of Training Courses

The Occupational Therapy Board works with the Validation Board of the College of Occupational Therapists. The Validation Board of the College of Occupational Therapists:

> "has the delegated resonsibility of recommending to the Privy Council through the CPSM, the approval of the Occupational Therapy Training Schools syllabi submissions for validated courses which lead to the Diploma of the College of Occupational Therapists." (BAOT, 1988 p.10).

The system is currently under review by the Validation Board Review Group which is a joint body set up by the College of Occupational Therapists and the Occupational Therapy Board of the Council for Professions Supplementary to Medicine (CPSM). It is now necessary for all new courses to be the subject of recommendation:

> "from the Validation Board to the Occupational

Therapists Board and hence, via the Council (CPSM), to the Privy Council." (CPSM, 1988, p.11).

The Diploma of the College of Occupational Therapists is only one way in which Occupational Therapists may register with the CPSM. The Occupational Therapy course at the University of Kent leads to a Diploma in Occupational Therapy and is acceptable for registration by the CPSM.

The validation procedure of most courses may be summarised in this way:

Step one:

A course submitted for approval to the Validation Board of the College of Occupational Therapists. The course is recommended for approval.

Step two:

The Occupational Therapy Board of the CPSM reviews the decision and also recommends the course to the CPSM.

Step three:

The CPSM recommends the course to the Privy Council and approval is granted.

2.1.3 Registration

Requirements for registration with the CPSM are governed by National Health Service and local authority social service regulations. The CPSM, itself, does not require Occupational Therapists to register with it. It is possible to work in the private sector, in local authorities in Scotland without registering with the CPSM.

There were 9,915 Occupational Therapists registered with the CPSM on June 1, 1988 (CPSM, 1988). This is not necessarily an accurate figure of the number of Occupational Therapists in the country, since the CPSM is not required to maintain such a record. There is no record of retirement from the register, neither are there records of all Occupational Therapists in local authority social services. For example, in Scotland this is not required and in the other three countries of the UK, the job title may not include the term Occupational Therapy. Therefore, the Occupational Therapist may not need to register with the CPSM. There is no penalty for returning to the register if, for example, an Occupational Therapist decides to return to the NHS. The register is, therefore, not a very accurate reflection of the workforce nor of the availability of qualified Occupational Therapists in the labour market.

The CPSM is financed entirely by its fee income and the sale of registers. (CPSM, 1988).

2.1.4 Representation

It is interesting to note that the BAOT and the COT are still financed by membership fees. Occupational Therapists, therefore, pay not only for the CPSM Occupational Therapy Board but also for the Validation Board of the COT.

The British Association of Occupational Therapists represents Occupational Therapists and provides the usual range of services expected of a trade union body. There are about 7,820 members and associate members (BAOT, 1988 p.9). BAOT reports that 528 Occupational Therapists work in charities and other non-statutory agencies, 950 work in local authorities and 6,342 in the NHS. To represent its NHS members, BAOT is a member of the Whitley Professional and Technical "A" Council (PTA Council) on which it has two of the 22 seats.

Local authority Occupational Therapists have joint membership with the Managerial, Administrative, Technical and Supervisory Association (MATSA) (BAOT, 1988, p.9) and many of them choose to be represented by other unions such as the National Association of Local Government Officers (NALGO).

2.2 Education and training of Occupational Therapists and Occupational Therapy Helpers

2.2.1 Occupational Therapists (Diploma and First Degree Level)

There are currently 16 Schools of Occupational Therapy, 10 of which are now situated in higher education institutions of which three are now degree level courses (BAOT, 1988, p.6). There are five four-year in-service training courses for Occupational Therapists. The curriculum is prescribed in general terms by COT (1987); before 1981, the curriculum was laid down in detail by COT, but individual schools are now allowed to produce innovatory courses for approval within the general guidelines laid down by the COT.

For example, the University of Ulster has replaced the three year Diploma with a four year degree, B.Sc. with Honours in Occupational Therapy. Curricular content, in general terms, will be compared and contrasted with those of other health care professions in the course of this review.

2.2.2 Post-Graduate Education

Apart from a small number of Occupational Therapists who have conducted independent research for higher degrees for example Edwards (1980), Masters degrees have, so far, been undertaken in generic remedial or rehabilitation departments, for example at Kings College, London University and the University of Southampton. There were nine Remedial Research Fellows listed in the DHSS Handbook of Research and Development (DHSS, 1987). There is apparently no differentiation between Occupational Therapy and other remedial professions at this educational level.

2.2.3 The Training of Occupational Therapy Helpers and Technical Instructors

There is little information currently available about the training of Occupational Therapy helpers and technical instructors although both groups are permitted to become members of the BAOT and there is a helpers committee elected by the BAOT Council. The Education and Research Board is now responsible for helpers and technical instructors' educational development. The College of Occupational Therapists has produced guidelines for helpers courses (COT, 1984) and maintains a list of those it has approved (COT, 1989). There are 16 helpers courses as at March 1989. Fifteen of these are in England, one is in Scotland. There is none in Wales or Northern Ireland. The four Thames regions have one each and there is an additional course designed by the London Borough Occupational Therapy Managers Group which offers a London-wide Occupational Therapy assistants course through the London Boroughs Training Committee. Five of the courses are located in colleges of further or higher education.

The Helpers and Technical Staff Handbook (COT, 1984) defines the course as being:

> "designed to increase the level of interest and knowledge of Occupational Therapy Helpers and Technical Staff." (P.1).

A Certificate of Attendance is issued and only those already working in a helper or technical instructor's position for at least six months before the start of the course are eligible. The course covers most of a year with not less than six hours of instruction over 36 weeks, and the total hours of instruction amount to 216. The Handbook (COT, 1984) emphasises that the Occupational Therapy helper must always be under the supervision of a trained Occupational Therapist and have access to one for advice and direction (P.6).

The College of Occupational Therapists has agreed four levels of competence for Occupational Therapy support staff (COT, 1989) which it believes will provide the competencies required for Occupational Therapy helpers to receive National Vocational Qualifications from the National Council for Vocational Qualifications (NCVQ). However, there is some confusion around this issue since the NCVQ seems to have interpreted the levels of qualification rather differently than the COT. The NCVQ provisional accreditation to Technician Engineers:

> "with successful attainment of a BTEC Higher National Certificate/Diploma in an appropriate subject area" (NCVQ, 1989)

has been given at level IV. The COT is proposing that the Occupational Therapy helper at level IV should have a helper's certificate with some extra short courses to upgrade technical and medical knowledge. (COT, 1989).

The NCVQ, Criteria and Procedures (NCVQ 1989) describe Level IV as:

> "Level IV: competence in the performance of complex, technical, specialised and professional work activities, including those involving design, planning and problem-solving, with a significant degree of personal accountability. In many areas competence in supervision and management will be a requirement at this level" (P.10).

It is difficult to see how the Occupational Therapy helpers' course plus some extra short courses, along with the requirement of Occupational Therapy supervision will lead to the achievement of a Level IV NVQ on the NCVQ criteria. Moreover, it is by no means NCVQ policy that, merely because there are four levels of qualification, there need to be four qualifications in any given occupational area. The qualification structure should reflect employment - related requirements and should not dictate them.

2.3 The Management Structure of Occupational Therapy

2.3.1 The National Health Service

The National Health Service is the largest single employer of Occupational Therapists. This can be seen from the Health and Personal Social Services Statistics for England (Department of Health, 1988) where the number of Occupational Therapists working in the Health Services in September 1986 is shown as 4,334. At this time the CPSM (1988) had 8,559 Occupational Therapists registered in the UK, so approximately half of all registered Occupational Therapists work in the NHS in England.

There are seven clinical and managerial grades of Occupational Therapy ranging from Basic to Head I as follows:

- Basic
- Senior II
- Senior I
- Head IV
- Head III
- Head II
- Head I

However, there is lack of clarity about the role of Occupational Therapists in the upper management structure of health authorities. Before the introduction of general management (Griffiths 1983) into the NHS, Occupational Therapy had just developed a management structure. This had been recommended by the Macmillan report back in 1973. (DHSS, 1973). District Occupational Therapists were being appointed as from April 1st 1980 (Haylock, 1987 p.10). District general managers then became responsible for recommending whether or not District Occupational Therapist posts would continue. Haylock (1987)(p.11) suggests that many health authorities have decided to retain these positions. However, there have been press reports of problems. For example, the College of Occupational Therapists is reported to have been instrumental in persuading North Tees Health Authority to abandon a plan to merge the management of the occupational and physiotherapy

services led by a remedial therapist manager (TW, 1, 1986). The abolition of the district occupational therapist and district physiotherapist posts in Worcester Health Authority was hotly contested, and the College of Occupational Therapists policy to oppose such changes was restated (TW, 2, 1987).

The current situation within the NHS seems to be that, although there is a very clear grading structure up to and including Head I level, beyond that the situation is entirely dependent upon local conditions. The research team elicited evidence that some Occupational Therapy services are currently being led and managed by remedial therapists from other professions in some health authorities.

2.3.2 Social Services Departments

The social services departments of local authorities are the next largest employer of Occupational Therapists. On September 30 1985, there were 1118 qualified Occupational Therapists employed by Social Services Departments (ADSS, 1988). There is, however, no neat hierarchical grading structure for Occupational Therapists within these Departments. Mendez (1986) makes the point that:

> "....titles, functions, pay scales and accountability are nearly as varied as the number of departments where Occupational Therapists are employed."

Crosbie (1985) has reported that the work of Occupational Therapists within social services departments tends to be focussed on the provision of aids and adaptations.

There is evidence that the numbers of occupational therapists working within social services departments is increasing rapidly. For example; Leeds Social Services increased its Occupational Therapy establishment from one in 1984 to nine in 1986, with a projected increase to 15 with ten Occupational Therapy assistant posts in addition. The service is co-ordinated by a disability officer who is also a trained Occupational Therapist (TW, 3, 1986). There is also evidence that Occupational Therapists are being appointed to general management posts within social services departments (Davidson, 1986) and that efforts are being made to integrate health authority and social service Occupational Therapists, for example, in Devon (White 1987).

However, there is no clear national picture as to the roles and functions of Occupational Therapists within local authorities, although much detailed work in defining the Occupational Therapy function seems to have occurred at local level. For example, the London Boroughs Occupational Therapy Managers Group has been active in many areas to promote debate about local authority and health authority co-operation (LBOTMG, 1985) as shown by the document "Future Needs and Numbers for Community Occupational Therapy" (COT 1984).

2.3.3 Private Sector and Voluntary Sector

Clearly there are considerable numbers of Occupational Therapists who are registered with the CPSM, but work neither in the NHS nor in social service departments. There are probably about 2,500 Occupational Therapists who are either not working or are working for employers in the private or the voluntary sectors. There are no official statistics which can identify their numbers or places of employment. Anecdotal evidence, however, would suggest that Occupational Therapists are active in many areas. The BAOT evidence is that 528 are active in the non-statutory sector (BAOT, 1988).

Some Occupational Therapists are undoubtedly being attracted into private sector medicine. For example, the Priory Hospital advertised for a Deputy Head Occupational Therapist (TW, 4, 1987). Two Occupational Therapists have started a tranquiliser withdrawal clinic at a private health centre in Liverpool (TW, 5, 1986). The research team was also told of Occupational Therapists who work in aids and equipment companies. One such company, which wished to remain anonymous, described its Occupational Therapist as an "assessor" and said that Occupational Therapists, physiotherapists and speech therapists were employed interchangeably as "assessors". The voluntary sector, too, employs Occupational Therapists. Manthorpe (1986) reports that an Occupational Therapist is working as a part-time employee for the charity "Invalids at Home", having formerly worked for the Disabled Living Foundation.

A final area in the private sector which would seem to be developing is the Occupational Therapist as an independent practitioner. The research team was told of an Occupational Therapist who works as an independent practitioner in civil compensation suits, where her professional assessment of the on-going needs for and cost of occupational therapy for accident victims is submitted as expert evidence. There is now an Association of Private Occupational Therapists and the BAOT have issued guidelines to private practitioners (BAOT, 1984). A further area in which Occupational Therapists may be involved, when the current local government Housing Bill becomes law, may be to assist charities (or to take the lead themselves) in the preparation of tenders for local authority adapted housing provision.

The role of the Occupational Therapist in the private and voluntary sectory and as an independent practitioner is wide and varied and has great potential.

2.3.4 Helpers and Technical Instructors

Occupational Therapy services are maintained in some areas mainly by Occupational Therapy helpers and technical instructors (Mendez, 1986). As noted in Section I Spashett (1981) suggested that in areas where the Occupational Therapy service was being provided entirely by non-professional staff that the title of Occupational Therapist Department should be withdrawn. Clearly, the use of helpers and technical instructors is an emotive issue within Occupational Therapy yet helpers and technical instructors can become associate

members of the BAOT and have their own committee. This is in contrast with the position of nursing auxiliaries who are not currently allowed to become members of the RCN. The helper and technical instructor grades are obviously influential within Occupational Therapy, not least by weight of numbers, since the helper/technical instructor grades accounted for 44.2 per cent of the staff in NHS occupational therapy departments and Wallis (1987) suggested that the ratio of helpers to therapists in some large hospitals may be as great as 40:1. Technical instructors (TIs) usually have a background as tradesmen and are paid as such. They are involved in the provision of workshop experiences and liaise with services outside hospitals such as that provided by a Disablement Resettlement Officer. (Profession Allied to Medicine, 1987, p.4). There are three grades of TI, the lowest level being Grade III and the highest Grade I. Each Grade has several salary points. Occupational Therapy helpers are paid on a seven point salary scale and are directly supervised by Occupational Therapists. There is an emphasis on caring skills and therapeutic relationships with patients (Professions Allied to Medicine, 1987, p.5).

2.4 Journals and Availability of British Occupational Therapy Materials in Academic Data Bases

The Occupational Therapy profession's major journal is the *British Journal of Occupational Therapy* which began in 1937. In recent years there has been a shift in emphasis from anecdotal material to well referenced literature reviews and research projects. Trevan Hawke (1986) points out that the average number of references per article increased from 2.5 in 1975-6 to 6.5 in 1983-4. A further important source of information about the profession is *Therapy Weekly*, a newspaper for all the remedial professions. Other publications which are cited frequently are the *American Journal of Occupational Therapy*, which is indexed *in Index Medicus*, whereas the BJOT is not, and the *Canadian Journal of Occupational Therapy* which has only *recently been indexed in Index Medicus*. Clearly, the *American Journal of Occupational Therapy* has established its *dominance within academic data bases*.

The *British Journal of Occupational Therapy* entered the data base *of the Cumulative Index to Nursing* and Allied Health Literature in 1987 as an ancillary journal, and was fully indexed in 1988 (CINAHL, 1987 and 1988). The British Library has recently issued an Occupational Therapy Index. This is in the Current Awareness Topics Service (for example, Occupational Therapy Index, 1989) and provides a large number of papers published in many journals which would be of value to Occupational Therapists in practice, as well as listing the more standard Occupational Therapy material.

Section Three

3.1 Origins of Occupational Therapy

The history of Occupational Therapy in the United Kingdom is short, relatively recent and reasonably well documented. Occupational Therapy text books for example (Macdonald, 1977, Chapter One) are at pains to point out the long history of therapeutic occupation used from ancient times in the treatment of a variety of disorders. However, there can be no doubt that Occupational Therapy as a profession in the modern world developed in North America between 1914 and 1924 to fill the gap between medicine and nursing and provide purposeful activity for people recuperating from serious illnesses (Court, 1988). A central influence in the United Kingdom was Dr Elizabeth Casson who visited the USA and was impressed by the idea of using therapeutic activity in rehabilitation. She founded the first school of Occupational Therapy in the UK in 1929. With the advent of the large number of injured servicemen after World War Two, there was a great need for extra personnel to assist in rehabilitation. It is quite clear that the medical profession at that time envisaged that Occupational Therapy should be a form of treatment to be prescribed only by them and implemented by Occupational Therapists (see Dunton and Licht 1950 (p.vi)). Furthermore, there is an emphasis on the anglophone roots of Occupational Therapy:

> "In almost every country where English is the official or the second language, there are schools of occupational therapy, in operation or soon to be opened: Australia, Canada, Denmark, England, India, Israel, Norway, Scotland, Sweden and the United States including Puerto Rico." (Dunton and Licht, 1950 (p.vii)).

thus bringing into sharp focus one of the major issues in the development of Occupational Therapy. Did Occupational Therapy develop because of some universal gap in service provision, or was it the product of a small group of medical doctors in the USA who believed in the healing power of work as a result of their acceptance of an American (or Anglo-Saxon) core value: the protestant work ethic? Might not there be other ways of providing remedial therapy and rehabilitation other than through the provision of activity? These are themes which underly much of the past and current discussion about Occupational Therapy and which recur in much of the literature on professionalisation. Over the past 20 years, there have been numerous analyses both from within the profession and from outside the profession which study Occupational Therapy in terms of the sociological framework of professionalisation. This body of literature may be divided into three categories: Occupational Therapy as an ideal profession meeting Weber's criteria (see section I); Occupational Therapy as a semi-profession, meeting Etzioni's criteria and Occupational Therapy as a flexible aspiring profession, taking over areas of practice and establishing its presence. These three themes will be examined with reference to the available evidence.

3.2 Occupational Therapy as an ideal profession

The issue of Occupational Therapy as an ideal or true profession has been of great interest to members of the profession and others, such as sociologists, for many years. Alazewski (1977), Atkinson (1980), Tigges (1980), Edwards (1980), Bristow (1984), Wallis (1987 a,b) and Hall (1987) have all been prominent in the debate about professionalisation. However, the works of Hall (1987) and Wallis (1987 a,b) are particularly important in the discussion of Occupational Therapy as an ideal profession because of the support they give to the notion that Occupational Therapy is becoming such a profession. Hall (1987) puts forward a detailed argument to suggest that while Occupational Therapy is not yet an ideal profession, it is closer to achieving it than many professions with which it is often compared, such as nursing. It is likely to achieve that status in the future. Since Hall's (1987) argument is cogent and persuasive, it is worthwhile looking at it in some detail. Hall (1987 p.77) notes that Occupational Therapy has taken many steps towards becoming a profession having full time practitioners, a national professional association, legal protection, public examinations and a code of ethics. She also suggests that self-management has been largely achieved in the NHS and to some degree in local authority social services departments.

The evidence is that self-management has been less secure in the NHS since the introduction of general management and the picture in social services departments is extremely unclear (see Section II). Hall (1987 p.77) also makes the point that Occupational Therapists do not have full clinical autonomy because medicine controls the gateway to patients as a consequence of the legal requirement for some kind of medical referral. This is an important point in the current climate. The Resource Management Initiative (Resource Management, DHSS, 1987) could lead to a re-affirmation and expansion of the role of Occupational Therapy in some areas of practice where Occupational Therapists have been found particularly useful, or to the demise of Occupational Therapy in other areas; these events could occur precisely because Occupational Therapy is dependent on medical referral and has no independent existence. The lack of secured provision for senior management at district level, much lamented by the remedial professions, could have important implications for the remedial provisions if resource management is widely adopted. Hall (1987) goes on (p.79) to suggest that Occupational Therapists have many of the characteristics of semi-professionals in that they are employees within bureaucratic hierarchies and the majority are female. She questions this in view of the moves towards equality for women, embodied in legislation and the widespread acceptance of working mothers. She notes (p.81) that all the recent developments in Occupational Therapy, such as self-management, indicate that the profession is more aware and ambitious and suggests that the increasing clinical autonomy of the Occupational Therapist and the physiotherapist is evidence of this. It is unfortunate, therefore, that these two key pieces of evidence seem to be examples of ill-founded optimism as

long as the Occupational Therapy profession has no clear role in health authority management.

It seems more likely that Ovretveit (1985) is perspicacious in his suggestion that there is no evidence for a significant decline in medical dominance because doctors often willingly handed over work they did not want and control they did not need. Although Ovretveit (1985) does not say this, it is possible that they could reassert this control if they so wished in the right conditions. Hall's (1987) view of Occupational Therapy as a profession inexorably becoming an ideal or true profession looks over optimistic in view of evidence now available.

3.3 Occupational Therapy as a semi-profession

Edwards (1980) writing some seven years before Hall (1987) places Occupational Therapy firmly within the category of a semi-profession, largely because of the amount of conflict and ensuing guilt which Occupational Therapists have vis a vis their clinical role and the demands of the bureaucratic hierarchies in which they work. This entails that a good deal of direct clinical work is performed by helpers or technical instructors. This, however, is not in itself any reason to place Occupational Therapy in the semi-profession category. As reported previously, Cocks (1983) notes that barristers have always been surrounded by a plethora of helpers of various types, for example, clerks and law - writers (p.3). Wallis (1987a) is surely correct in pointing out that strong, influential professions tend to encourage and even sponsor aspiring groups and implies (Wallis (1987b)) that Occupational Therapy helpers and technicians are being sponsored in this way by the Occupational Therapy profession. Wallis (1987b) is convinced that Occupational Therapy is an aspiring profession which will probably become complementary to medicine rather than supplementary. This again looks optimistic in view of the developments already discussed. In terms of professionalisation, Occupational Therapy within the NHS and social service departments looks set to remain a semi-profession. It appears unlikely, in those settings, that it will achieve the level of clinical autonomy and control of its own budgetary resources which would be needed. Wallis (1987b), however, goes on to suggest that the recent increases in private medical care, a sphere in which Occupational Therapy, as noted, has already become active, will provide alternative opportunities for employment. It should also be remembered that the Local Government (Housing) Bill 1989, currently before Parliament, could have interesting implications for Occupational Therapists who could turn away from their salaried, employee status and become independent contractors for the provision of adapted housing to the disabled in social service departments, thus avoiding bureaucratic control and becoming directly accountable to social service committees. Wallis (1987b) suggests, furthermore, that Occupational Therapy is a youthful and ambitious profession:

"which should take advantage of opportunities offered

to increase its own sphere of influence to benefit its members as well as its clients."

This leads to the next theme in the professionalisation process of Occupational Therapy. For it may be suggested, as Wallis (1987a) has, that Occupational Therapists are an extremely diverse group:

"Occupational Therapists follow their own interests and needs to develop their own skills, which they may choose to share with colleagues by organising local or national courses."

This diversity and flexibility provides Occupational Therapy with both its major strengths and its major weaknesses and, because of these factors, it might be described as a flexible profession which extends into many areas.

3.4 Occupational Therapy as a flexible aspiring profession

As already noted Wallis (1987b) perceives Occupational Therapy as a flexible profession which permits professional development to be "diverse and personal." This undoubtedly springs from the Occupational Therapists' holistic rather than technique oriented approach. Alaszewski, (1977) demonstrates how Occupational Therapy has managed to gain control and monopolise one area of practice, geriatrics, in an English town, and to use this as a base from which to expand into other areas. Alaszewski (1977) suggests that Occupational Therapy is most successful in establishing bases in areas where its "holistic" approach is appreciated and where its interest in patients rather than techniques is of importance. He states:

"By stressing the unity of the patient and the dominance of patient orientation over technique orientation, Occupational Therapy can claim to be the dominant remedial therapy and can claim to encompass technique - orientated professions. Furthermore, they can extend into new areas, e.g. mental handicap, by stressing their interest in patients rather than adherence to any particular technique."

However, he sounds a warning note. The focus on person rather than technique has made integration with other remedial professions at national level difficult if not impossible; although it may be relatively easy for Occupational Therapy to extend into areas in chronic medicine, Occupational Therapy may have difficulty especially in the acute sector in competition with technique-based specialities. Bristow (1984) suggests that this argument is circular since Occupational Therapy started in chronic areas and remains there. (p.24)

However, the ability to extend into new areas is one of the interesting professional characteristics of Occupational Therapists. There have been press reports of Occupational Therapy involvement in the following areas:

- Community Drug Abuse Team (TW, 6, 1987).
- Running Stress Management Courses for businessmen and school children sitting exams (TW, 7, 1987)
- Setting up a tranquiliser withdrawal clinic (TW, 5, 1986)

Yet this very characteristic may be a source of difficulty. Ellis (1987) suggests that the ability of Occupational Therapists to adapt to changing demands has not worked in the profession's favour. Hall (1987) suggests that it is evidence of a profession in a panic (p.203) while Atkinson (1980) and Tigges (1980) point to other aspects of this debate: first, the turning away from the tradition of remedial occupation (Atkinson, 1980) and second, the lack of any unifying theoretical base or skill base which would differentiate Occupational Therapists from other health professionals. Tigges (1980) succinctly summarises these dilemmas:

> "What is it that we provide that no other relatively intelligent health professionals could not do without a bit of training?"
>
> ".....Technical instructors and craft teachers are far more skilful in the use of "certain" equipment, tools and materials. If these statements are true, then we must look at the other side as well. Physiotherapists, psychologists, nurses and social workers are not only more knowledgeable in the physical, biological and social sciences than we are, but also can succinctly articulate their definition, goals, objectives and need, whereas we cannot."

Tigges goes on to suggest that Occupational Therapy needs to work from a clearly defined paradigm and names direct services such as observation and assessment of dysfunction within the context of occupational role performance. Thus, the remedy according to Tigges (1980) and Atkinson (1980) is a return to the starting point of Occupational Therapy by using occupational activities in the rehabilitation process. Tigges, (1980), furthermore, notes the paradox of a profession 98 per cent of whose members have jobs before graduation constantly having to justify its existence. There is also evidence that the Occupational Therapy profession in vacating its traditional areas is leaving niches, filled in the USA by activity therapists. In the UK, these niches may be filled by creative arts therapists such as art, drama and music therapists. This may be an inevitable corollary of professionalisation, just as certified respiratory therapists in the USA seem to have filled gaps left by the professionalising physiotherapists and nurses. However, in leaving these areas, the Occupational Therapy profession is then dependent upon its unique approach rather than offering easily definable and measurable skills and activities. Thus the very flexible nature of Occupational Therapy does, as Alaszewski (1977) predicted, make it very difficult for the profession to hold its own not just against technique based professions, but, as Alszewski (1977) could not have known at the time, when all professions are asked to account for their activities, as is now required within the NHS as a result of

the Korner initiative (DHSS, 1983). This seeks to develop a data base of the activities of, among others, the paramedical services. Occupational Therapy can still seek to extend into areas outside the NHS, and is doing so successfully, in view of the anecdotal evidence presented above.

3.5 True professional status - a worthwhile goal?

The debate in Occupational Therapy has thus far centred in the main around demonstrating that Occupational Therapy has the characteristics of a profession and how to achieve the elusive goal of true professional status. Hall (1987) notes (p.74) however, that many recent commentators have suggested that medicine and other health care professions are:

> "taking more and more aspects of life into the field of health and illness in order to treat them as medical problems."

Hall (1987) echoes the theme touched on in Section One, by questioning whether the interests of professionals and the interests of service users are convergent or divergent? Wallis (1987b) seems to be in little doubt that there is an identity of interest between the two groups:

> "successful professions as dynamic power groups should strive to advance their expertise for the benefit of clients <u>and</u> the professions themselves."

Yet Grunow (1984) echoes the doubts recorded by Hall (1987):

> "The discussion of the professional role in the welfare system coincides with a re-discovery and re-evaluation of lay experience and self help. Especially in the health sector, this is already a mature social movement. Even more than bureaucratization, this leads to a new role definition of professionals."

It may be that because of external events over which Occupational Therapists have no control such as the rise of the disabled activist movements, the rules of the professionalisation game have changed and Occupational Therapists will need to consider the impact of this. Undoubtedly, disabled people, themselves, are becoming more organised and demanding a much greater say in service provision. Beardshaw (1988) notes the chronic dissatisfaction of disabled people and their families in their communications with professionals. True professional status may no longer be an attainable goal for any of the emerging health care professions and even for those who have already achieved this status, great adjustments may have to be made.

The issue of the importance of professional guidance was discussed in detail in the Borrie Report (Office of Fair Trading, 1982), which finally came down on the side of allowing the consumer to choose, in this case unprescribed magnifying spectacles, since it was argued that:

> "Although the self selected spectacles may not be the best that could be obtained, they are unlikely to be very wrong. If they were, the customer would notice it...". "We are not convinced that this difference would be more than marginal." (para 14.12)

The report was careful to note that the optical professions had overstepped their competency by insisting on laying down guide lines as to where eye testing could occur.

> "They largely relate to the levels of privacy preferred by patients where the patient is quite able to make up his own mind." (para 14:37).

The extent to which professions are able to regulate for the consumer is clearly going to be challenged and changed.

3.6 Skill Mix in Occupational Therapy

Occupational Therapy has a long tradition of deploying lesser skilled workers, particularly in the less appealing areas of practice, for example, mental handicap and mental illness. Grove (1979) argued that the Occupational Therapy profession must confront reality and that if it were impossible for there to be a large expansion in the numbers of Occupational Therapists, the role of the Occupational Therapist should be that of training and monitoring those who were to perform the tasks. The College of Occupational Therapists' Handbook for Helpers and Technical Instructors (COT 1984) presents one route to training the support worker in Occupational Therapy.

Another approach to helpers courses was adopted by Mead, Crawford and Wells (1985) who organised a multi-disciplinary course for Occupational Therapy helpers, physiotherapy helpers and foot care assistants. Although the Occupational Therapy profession currently is the only paramedical profession with a recognised course for helpers, the course organisers believe that all paramedical professions could benefit from organised courses for helpers and that all would benefit from the multidisciplinary approach. This course was not recognised by the COT and has now been abandoned despite its popularity with the course participants. However, the College of Occupational Therapists Handbook does note that the most basic module of the helpers' course may be shared with other disciplines.

It is interesting to note, also, that the Occupational Therapy profession is not alone in training support workers to assist those with disabilities. The Occupational Therapy profession has not, traditionally, concerned itself with providing services to people with sensory impairments. However, there are courses for those who work with people with visual and hearing impairments. The Royal National Institute for the Blind has developed a one-year course for rehabilitation workers with the visually impaired. (Course in Rehabilitation Work with Visually Impaired People, undated). The overall aim of the course is:

> "To enable the student to develop the necessary

competence in the rehabilitation of people with a visual impairment" (p.4).

The British Society of Audiology (BSA, 1983) describes a course leading to the qualification of Hearing Therapist. it describes the job as being:

> "To assess the rehabilitative needs of those suffering with acquired deafness and to provide help with communication using hearing aids, environmental aids and the skills of speech-reading and auditory training." (p.8).

The physiotherapy profession has also recently updated its position as regards physiotherapy helpers, and the relationship between physiotherapists and community and other general support workers (CSP 1989). The physiotherapy profession is now committed to delegating routine tasks to helpers and to participating in training community care support workers.

The National Health Service Training Authority is engaged in an extensive project to develop support workers in the health service. Reviewing the work actually done by support workers in all departments has led to the establishment of competencies in many areas. Malby (1989) suggested that there were some difficulties in eliciting from nursing staff the true nature of their supervision of unskilled staff members and that there would be a need to incorporate mechanisms to ensure that their input is adequately reported to the professional nurse.

These developments demonstrate the demand for assistance by people with all types of disabilities. As was noted above, skill mix does not necessarily mean loss of professional status. However, as Grove (1979) noted, the professional's role may need to change. Celentano's (1982) framework is helpful here in that it focusses attention on the important issues of skill mix. "Optimum Utilisation" and "Appropriate Responsibilities" are the key concepts he puts forward.

Optimum Utilisation

These questions concern the notion of "For whom is optimum utilisation an issue?" Celentano (1982) suggests that optimum utilisation may be an issue for three groups:

- patients seeking services, who are looking for the best value and greatest advantage for themselves.
- providers of services who need to maximise the time and effort of personnel in their facilities.
- planners of services who have to ensure equitable, well distributed services.

Appropriate Responsibilities

These questions centre around the context of health care:

- how needs are met in different types of health care systems.
- the stage of technological development of the system and the facilities within it.
- the cultural context in which responsibility for service provision occurs.

When this framework is applied to Occupational Therapy in the hospital and the community settings, it becomes apparent that a key issue concerns the first group for whom optimum utilisation is an issue that is, the patient or client group seeking services.

The evidence is that patients in hospital are sometimes confused about which profession provides which service. Patients tend not to differentiate clearly between Occupational Therapists and physiotherapists. Patients in hospital are generally also highly appreciative of the care and services they receive. For example, a survey by East Dorset Community Health Council (East Dorset Community Health Council, 1988) found that 79.9 per cent of patients were happy with their Occupational Therapy activities (p.12) and that several patients confused physiotherapy functions with Occupational Therapy functions (p.13). It seems unlikely that patients will be concerned about the presence of Occupational Therapy helpers provided levels of service are maintained at acceptable standards. Managers are also concerned as providers of health care services to maximise the time and effort of the more highly trained, increasingly scarce and expensive professional, perhaps through the supervision of non-professional support workers. Health service planners are concerned to ensure that levels of service are equitable, for example that one geographical area or care group does not contain all support workers without professional supervision.

Moving on to the notion of appropriate responsibilities, this involves ensuring that needs are met satisfactorily in the area of operation. For example:

- are there different training needs within the context of each hospital?
- what should be the level of involvement with technological developments: are certain technologies to be reserved for professionals only, for example use of computers?
- What is the cultural context of assessment of the helper's responsibility? Are there different levels in different types of hospital, for example, is care of patients following a stroke more "responsible" than mental handicap or less?

Ilson (1989) reports on a conference concerning Occupational Therapy manpower in which a district general manager laid out a framework by which managers will assess the need for Occupational Therapy. It is an interesting parallel to the Celentano framework:

"a) Clarity of purpose
- why do we need you?

- what do you do?
- give facts and figures about provision (currently is a sea of half truths and anecdotes)

b) Pattern of work?
c) Can we afford it?
d) What happens if we cannot get it?" (Ilson, 1989)

Clearly skill mix is an issue of great interest to general managers who are charged with the responsibilities of ensuring that effectiveness, efficiency and economy are maintained in delivering health services.

In the community setting there may be different considerations, since the Occupational Therapy helper there is currently much involved in the assessment of clients for aids and adaptations (London Boroughs Training Committee, Community Occupational Therapist Assistants course, 1988). Yet the professional Occupational Therapist may have the final say about the supply of equipment, so it is possible that clients may be more aware of the status of the assessor. The current role description of the Occupational Therapy helper will probably vary considerably according to the setting, as well as the level of responsibility offered.

Helpers have been the subject of some sociological investigations. For example, Alazewski, Meltzer and Hainsworth (1978) identified unqualified workers as members of a secondary labour market which could be drawn on when there were inadequate numbers of skilled workers at times of full production and could be shed when production was slack; unlike the qualified workforce which could not be dispensed with even in quiet times since its reduction would damage future production (p.118). They went on to suggest that Occupational Therapy has a particularly relaxed qualified to unqualified staff relationship compared with physiotherapy because Occupational Therapy has more unqualified than qualified workers (p.181). It may be argued that this relaxed relationship is reflected in the status of associate member offered to helpers and technical instructors by the BAOT. Green (1989) is currently engaged in a study of the Occupational Therapy helper in which she notes the Occupational Therapy profession as developing a conventional power structure (p.8) where helpers are subordinates. Stewart (1988) suggests that the curriculum guidelines for the helper's course:

> "reads as though it is a potted occupational therapy course."

Stewart (1988) emphasises the importance of helpers to Occupational Therapy since they tend to contribute many more years of service than qualified Occupational Therapists. She is reluctant to suggest a second level qualification bearing in mind the experiences of British nursing and Occupational Therapy in the USA where second level qualifications have led to tension and difficulties in the work situation. However, she is keen to see the helper's course as a first step on the ladder to professional registration.

A further interesting issue is that helpers and technical instructors seem to be actually declining as a proportion of staff in the NHS in England. In 1976, for example, helpers and technical instructors accounted for 56 per cent of the workforce, but in 1986, they accounted for only 46 per cent of the workforce (DHSS, 1988). It is interesting to speculate as to how much of this change may be due to the professionalisation of Occupational Therapy and how much may be due to the closure of the large mental illness and mental handicap hospitals where there was heavy reliance on helpers and technical instructors. It is also interesting to speculate on how this change will affect the traditionally relaxed relationships between British Occupational Therapists and the support workers in Occupational Therapy departments. Smith (1986), however, found that the proportion of helpers and technical instructors in the Southampton and South West Hampshire Health Authority remained unchanged during this period of time. She also found that helpers and technical instructors spent more time on treatment than qualified grades of staff and that the treatment activities in which they were involved were not necessarily restricted to the routine and practical. Smith (1989) shows concern that support staff may have been undertaking work beyond their level of skill without adequate supervision and that this issue should be further investigated.

In considering Celentano's framework (1982) it may be asked for whom is it important that qualified Occupational Therapists supervise helpers and technical instructors and what kind of research could be designed to test the hypothesis that helpers and technical instructors should only work under the supervision of a qualified Occupational Therapist? The extent of dangers to patients and lack of benefit would need to be quantified carefully. These are the issues of interest to general managers in considering the optimal skill mix in health districts. The general manager quoted by Ilson (1989), has already made clear that he needs to know the consequences of not employing qualified Occupational Therapists and the potential for damage if other staff are substituted.

Section Four

Barriers to Professionalisation

4.1 Defining Occupational Therapy

In view of the difficulty in defining Occupational Therapy experienced by many leading Occupational Therapists (for example, Jay 1981, Stewart, 1988) and the sensitivity of many members of the Occupational Therapy profession towards the definitions offered by others (Jay, 1981), it is difficult to attempt to define the skill base of Occupational Therapy. However necessary the exercise, it is clear that, in the opinion of some groups of Occupational Therapists, that definition will be insufficient. A frequently cited, but de-contextualised, definition of Occupational Therapy which ensures that no definition of the skill base of Occupational Therapy can ever be adequate, is that of Edwards (1980):

> "The uniqueness of Occupational Therapy does not lie in the individual parts of its theory, but in the particular combination of knowledge, skill and experience the therapist brings to her work."

This definition neatly avoids specifying whether Occupational Therapy is about activities or techniques, or both, as the BAOT working party "The Way Ahead" recommended it should be (BAOT, 1981 para 7.3, pp. 49-50).

Edwards' (1980) de-contextualised definition has the advantage of being, like psychoanalytic theory, incapable of falsification, the usual criterion by which scientific validity is established. Manning (in Hinshelwood and Manning, 1979) suggests that evaluating a therapeutic community is a task of a similar nature and enters some special pleading by noting that "the overwhelming weight of opinion" would reject normal scientific inquiry. However, the opinion in question was entirely drawn from the world of the therapeutic community. This kind of special pleading is in any case unnecessary in the case of Occupational Therapy. When definitions are adopted which are open to scientific inquiry, Occupational Therapy has already demonstrated that an adequate research base can be developed in many areas of practice. The Way Ahead (BAOT, 1981) suggested that:

> "A specific identify and functions are prerequisites to survival" (para 7.3.3, p.50).

It recommended that activities should remain the identifying the feature of Occupational Therapy and that the role of the Occupational Therapist lay in the analysis of activities, the selection of those appropriate activities and their co-ordination with other staff. A slightly wider dimension to Occupational Therapy is given by the London School of Occupational Therapy Diploma Course Submission (West London Institute of Higher Education, 1984) where there is a focus on the interface of people with their environments. Both these definitions allow for measurement and, therefore, are open to

falsification: the prerequisite for scientific advance.

A further definition of Occupational Therapy is to be found in the Outline Syllabus for the Diploma in Occupational Therapy:

> "Occupational Therapy is the treatment of physical and psychiatric conditions through specific selected activities in order to help people reach their maximum level of function and independence in all aspects of daily life." (College of Occupational Therapists, 1984, p.1).

This may, in fact, be a rather limiting definition in that Occupational Therapists working in the community focus on achieving maximum function and independence rather than treatment through activity. Nonetheless, it, too, provides a definition which could be subjected to scrutiny by scientific method.

4.2 What is Occupational Therapy - the definitional crisis

Like many aspiring professions, Occupational Therapy has been greatly concerned with defining itself and establishing its historical roots. It could be argued that this is one level at which the twin influences of the US health care and education systems are apparent. It is common in USA for professional education to take place in higher education. Therefore professional degree curricula are validated by a variety of organisations such as the accreditation body of the college or university and the professional body. Hospitals must be certified to receive reimbursement under the State medical schemes for the elderly and the indigent; respectively Medicare and Medicard, and to do so they generally apply for accreditation with the Joint Commission on the Accreditation of Hospitals (JCAH). Since both educational and clinical accreditation involve extensive explanation of the discipline, most professions in the USA have learned to define themselves in terms of explanatory models of practice. Ostrow (1983) lists the Quality Assurance requirements of JCAH for Occupational Therapy. Evans (1987) suggests that:

> "Occupation, as the core of the profession, defines the boundaries of the profession's domain....".

Therefore, Occupational Therapists in America have been required to justify their practice and their cost to the health care system. Shalik (1987) even conducted a cost-benefit analysis of Occupational Therapy students field work placements and concluded that field work sites gained approximately $400 per week by accepting students for placement. Such detailed analyses of Occupational Therapy unit costs have yet to be produced in this country, although SCC in the BJOT editorial (SCC, BJOT, 1985) noted that District Occupational Therapists would become involved through the process of management budgeting in selling Occupational Therapy services to the clinical or management budget holder.

Westland (1986) in reviewing an Occupational Therapy book from

USA noted that:

> "Having read it, I found myself feeling glad not to be working in the USA for the impression is given that, at times, economic accountability lead to the development of treatment approaches (most medical and behavioural) which may not be in the patients' best interests......Perhaps the book's main function may be to serve as a warning to those of us working in Great Britain."

It is interesting to note the effects on the provision of remedial therapy services in USA of the restrictions provided by:

- the need to justify treatment in economic terms,
- the need to practice within the scientific framework provided by a model.

Tigges (1980) and Atkinson (1980) deplore the development in USA of numerous "Activity therapists" as a result of the need to focus on standardised techniques rather than crafts and traditional activities, since these cannot be justified in scientific ways. Ellis (1987) on the other hand, while noting that the American approach to professional Occupational Therapy education may lead to less patients receiving treatment, applauds the fact that that which is received, is given on a more rigorous scientific basis.

Langwell, Wilson, and Deane (1981) note that the distribution of Occupational Therapy services in the USA is strongly influenced by the presence of hospitals with Occupational Therapy departments and strongly and positively associated with higher than average per capita income of the population, suggesting that there is a less than even spread of Occupational Therapy through the pluralistic and complex US health care system. This would clearly be anathema to many British Occupational Therapists such as Westland (1986) already cited. Yet as an editorial in the British Journal of Occupational Therapy noted (SCC, BJOT, 1985), there are undoubtedly pressures within in the NHS to ensure that all health professionals become more financially aware.

It is more difficult to assess which situation provides the greatest barrier to professionalisation: the relative clinical freedom of the NHS or the relative economic restrictions inherent in the American health care system, since in each country there is a belief that the Occupational Therapy profession is in crisis (USA) or in a state of panic (UK). The US crisis sounds very similar to the British panic. Yerxa and Sharrot (1986) analyse the nature of the US crisis as lack of:

- a consensus regarding theory base,
- technical tools,
- contribution to society,
- ethical status and
- relation to medicine;

These are shown by the curricular diversity in US colleges. Their prescription for this condition is a return to a liberal arts educational base.

Wallis (1987) lays the blame for the "panic" described by Hall (1987 p.203) in British Occupational Therapy at the door of exclusion from higher education and the restrictions on development caused by World War II. Hall's (1987) analysis of the professionalisation issue is particularly interesting, since she suggests (p.135) that World War II "gave the workforce the opportunity to establish its worth" and suggests that the current "panic" in Occupational Therapy may be the result of improved medical technology which rendered redundant the Mechanical Model. The Mechanical Model, Hall (1987) suggests (p.136) focussed on man as machine and treatment as the fixing of malfunctioning "parts". Hall (1987) also suggests that:

> "the development of diverse patterns of work can be seen as a frantic search by the therapists to find new areas to be classified as occupational therapy." (p.203).

Thus the nature of the crisis or panic in Occupational Therapy does not depend upon the economics of the health care delivery system, nor on the place of professional education, since each of these is quite different in the USA and in Great Britain. It seems that the crisis lies in the definition of Occupational Therapy itself as Tigges (1980) noted after experience in both countries:

> "If we are an essential service, why is it that we are continually in the position of defending and justifying ourselves?"

Thus, one of the barriers to professionalisation may be the very definition of professional activity within Occupational Therapy, which must change as western society moves into the post-industrial, information - rich, high technology age. "Occupation" has changed its meaning. No longer will the Occupational Therapist deal with the results of injuries in heavy manual occupations. New technology would seem to demand a new definition of Occupational Therapy, so that this first barrier to professionalisation can be overcome.

4.3 <u>Establishing the role of Occupational Therapy vis a vis other professionals - the differentiation crisis</u>

Although the specific details of relations with other professions will be dealt with later in Section VI, it is worth noting here that as a part of the definition crisis of Occupational Therapy, comes the differentiation crisis expressed by Tigges (1980) thus:

> "What is it that we provide that no other relatively intelligent health professionals could not do with a bit of training."

Spashett (1981) analysed the situation carefully by noting that "no definitive statement" describes the role of Occupational Therapy adequately but that Occupational Therapy was concerned with ability and function - their attainment and achievement, their restoration and rehabilitation and their maintenance. Additionally, they should try to improve the quality of life. Spashett (1981) offers an interesting view of the definitional "crisis", influenced by her obvious belief in a "Golden Age" of Occupational Therapy. She suggests that nurses are now involved in Occupational Therapy programmes, especially in psychiatry, since they have been relieved of non-nursing duties. Their new involvement in this is due to the shortage of Occupational Therapists. This is surely a flawed analysis. Occupational Therapy developed out of nursing, as Hall (1987) makes clear. Indeed, the first Occupational Therapists were trained on a six month course at the Maudsley Hospital (Hall, 1987, p.114) specifically because of their psychiatric nursing experience. As the Macmillan Report makes clear (DHSS, 1973), in many areas particularly in mental handicap hospitals, nurses had always managed much of the occupational activity in Industrial Therapy Units. Spashett (1981), however, is unremitting in her analysis of Occupational Therapists' inability to adopt a coherent core role definition and suggests that Occupational Therapists need to acquire "specific skills' in defined areas. The differentiation crisis is also touched on by Hall (1987) who points out the need by Occupational Therapists to break with nursing:

> "However, by 1939 it seems that Occupational Therapists had firmly decided that the link with nursing was disadvantageous. It noted that nurses worked a forty-eight hour week and was said that as Occupational Therapists are more like teachers than nurses they should work shorter hours." (p.115).

Thus, the differentiation issue could scarcely be described as a crisis. Occupational Therapists have always made attempts to differentiate themselves from surrounding professions, but probably because of their definitional crisis, it is now more difficult, but not necessarily because other professions are encroaching upon their work, for in some areas Occupational Therapy may never have been a part of the gestalt.

4.4 The impact of general management - the management crisis

The management structure of the remedial professions has undoubtedly been affected by the advent of the Griffiths general management initiative (Griffiths, 1983). Although a BJOT editorial (SCC, BJOT, 1985) pointed to this as an issue of importance for Occupational Therapy, subsequent reports have failed to note its importance. For example, in its report the "Management Training Needs of Occupational Therapists (COT, 1986) while immediately acknowledging the need for management training for Occupational Therapists and differentiating this from the needs of other professions:

> ".....Occupational Therapists differ from other

> remedial professions in their fundamental approach to treatment. Occupational Therapists consider it essential to gain patients' active participation in achieving their maximum physical/psychological independence,"

They note only that this entails a need for a "unique style of management training" and that management skills have for many years been taught in basic training. However, they pay no regard as to how their service can and should fit into the overall pattern of health service management. Craik (1986) in reviewing options for management training, similarly omits this area. However, in Therapy Weekly there have been some reports of difficulties, and it records (TW, 8, 1987) that Joyce Williams, a district physiotherapist has assisted in setting up a five week management training course which will specifically provide therapists with a "clearer picture of how their service fits into other services."

Frazer (1988) notes the degree of exclusion imposed on the remedial professions in hospitals in the health authority where he works:

> "NHS management is concentrated between doctors, nurses and administrators - with no other professional able to get a look in."

In his health authority, the remedial professions have to make their points in writing to the hospital management board. A news item in (TW, 8, 1987) notes the opening of an integrated Physiotherapy and Occupational Therapy unit at Homerton Hospital, East London. It is possible that such units will increase the input of remedial therapy at District Management level.

Thus "general management" may be seen in terms of a unifying force between the remedial professions, or as a major barrier to further professional development because of the large number of small groups involved in the remedial professions and their lack of representation at the highest management levels. This realisation may have prompted the College of Occupational Therapists to recommend further discussions with the Chartered Society of Physiotherapy (CSP). The Council of the College of Occupational Therapists adopted broad proposals for working together and developing good practice in the clinical field (TW, 9, 1988). There is evidence that some Occupational Therapists are moving into general management and more may follow this path.

4.5 The Tradition of Skill Mix within Occupational Therapy - the dilution crisis

Although Occupational Therapy has always, from its very beginnings, involved others, such as craft instructors and technical instructors, in its activities, this involvement has always been a difficult issue for the profession. Perhaps it is the classic conflict and feelings of guilt of the semi-profession as regards hierarchical and bureaucratic

demands versus clinical demands as Edwards (1980) has noted. However, since Occupational Therapy has a long tradition of skill mix and seems to have developed successful helper's courses, the nature of the "dilution crisis" needs to be examined.

Spashett (1981) defines the dilution crisis as a source of blurring in the role definition of the Occupational Therapist. She notes that the role of helper has been abused particularly in the fields of mental illness and mental handicap where there are Occupational Therapy Departments staffed entirely by unqualified staff. She contrasts this with the nursing profession where she says unqualified staff would never be allowed to run wards. This is not an entirely apposite comparison since "dilution" by the unqualified has been a long and persistent fear of trained nurses, and it is likely that many of the mental illness and mental handicap hospitals, where there is a dearth of qualified Occupational Therapists, suffer similarly from a lack of trained nurses - indeed, during the recent grading dispute a key issue was that of the meaning of supervision (Nursing Times, News Item 1988). If this is the nature of the dilution crisis, it could equally well be described in terms of the unpopularity among all health care professionals of mental illness and mental handicap hospitals.

The concept of "skill mix" and the guilt and conflict of the semi-professions about their failure to give direct client services are put into sharper focus when compared with an ideal profession such as law, where it is clear that non-professionals, such as barristers' and solicitors' clerks, have always held positions of great influence and importance and worked with very little supervision. Cocks (1983) notes:

> "Solicitors and attornies also had clerks who were often of great experience; without them many offices would simply have gone out of business" (p.3).

There is also evidence that within institutions, Occupational Therapists have been quite successful in making good use of helpers. Creek and Wells (1988), respectively a former Head Occupational Therapist and a former helper in a mental handicap hospital, describe ways in which an Occupational Therapy department can be organised so that helpers are used in administrative support roles (for example ordering stock) much as lawyers use their clerks.

It may, indeed, be argued that the dilution crisis, far from being a barrier to professionalisation for Occupational Therapists is, in fact, evidence in favour of Hall's (1987) hypothesis that Occupational Therapy is an aspiring profession, since it is probably one of the more advanced of the health care professions in its training and deployment of support staff. Further evidence of this is offered by the serious interest demonstrated by helpers themselves, in their work. Jay (1989) has found that helpers are very keen to obtain further training.

Section Five

Perceptions of Occupational Therapy

5.1 Self perception

Occupational Therapists as a group show much concern about their professional standing. The crisis of definition is felt in very personal ways by many Occupational Therapists who express their deeply felt concerns through such media as the letters pages of the journals. The fear of extinction seems to grip some Occupational Therapists. Aina (1981) for example asks: "But how long can we survive? Till year 2001?" There is an apocalyptic tone to his question. Spashett (1981) continues the theme:

> "Worse still, is there going to be a role at all for Occupational Therapy in the future in this modern world of ever increasing high technology.....?"

Added to this is the belief that Occupational Therapists are misunderstood. The College of Occupational Therapists was invited to explain its work in a journal interview. The journal's sub-editor has added a brief summary of the content of the article:

> "Occupational Therapists are probably the least understood of all the health care professionals." (COT, Contact 1985).

The impression is created of a very defensive profession, despite Wallis' (1987) description of Occupational Therapy as "self confident" enough to sponsor other emerging professional groups. Ellis (1987) describes the qualified Occupational Therapist as a "beacon" who will ensure quality of service through her influence despite the shortages of Occupational Therapists. This optimistic and encouraging imagery is further emphasised by Khan (1985) who writes expansively of the role of Occupational Therapists in many areas. This in fact, is precisely the problem about Occupational Therapy for Spashett (1981) who accuses Occupational Therapists of being "dabblers." The profession's presentation of itself to the world is, therefore, as complex as its many definitions. Occupational Therapists feelings about their profession seem to vary from the blackest despair to utter euphoria.

A further issue of concern to Occupational Therapists seems to be the strongly held perception of Occupational Therapy as the exclusive preserve of white, middle and upper-middle class females. Hall (1987) suggests that the origins of the profession lay in the release on to the labour market of middle and upper-middle class women:

> "These snippets of information suggest a middle or upper middle-class background for these early therapists. It seems likely the increasing independence of women in society achieved through the sufragette movement and enfranchisement, facilitated

the emergence of the new female occupation." (p.117).

Hall's (1987) perception tends to be confirmed by Celentano (1982) who suggests that the physician's assistant (PA) in the USA grew not from:

> "ideals of promoting accessible and available health services for the needy"

but rather from the need to accommodate a labour resource in the discharged medical corpsmen who needed an acceptable place in the US health care system. If allied health professions do indeed develop on this basis, then it may be argued that Hall's (1987) perception of the origins of Occupational Therapy is extremely important in analysing the view of Occupational Therapy as white, female, and upper-middle class. One group of Occupational Therapists which Hall (1987) says have formed a part of Occupational Therapy since World War II, which seems to have become particularly annoyed by that perception, is the small but vocal group of male Occupational Therapists. According to Hall, far from increasing in numbers in Occupational Therapy they are, in fact, actually in decline as a group (p.48).

Harrison (in Collins, 1987) presents an interesting insight:

> "I have a private smile I reserve to myself for those occasions when I am the subject of some kind of eulogy about how brave I was, how difficult it must have been for me, an elderly male Occupational Therapy student at the finishing school for doctors' daughters. The truth of the matter is, it was three years of total self indulgence, of intense pleasure equalled only, perhaps, by the similar period I spent later at Dorset House as a tutor." (p.63).

Struthers (1980) is more critical of the integration of male students into Occupational Therapy schools and in an analysis of the appeal (or lack of it) of Occupational Therapy for males, he notes:

> "It may help if some colleges tried to make their courses somewhat more attractive to males. Whilst not disputing the relevance of subjects such as needlework, dress making and adapted clothing, they do not readily appeal to many males."

He further notes that the College of Occupational Therapists omission of males from a recruitment film in 1976 was the subject of complaint from both male and female Occupational Therapists, but despite this the film continued to be used. He also suggests an ambitious agenda for a career plan; Occupational Therapists should become:

- Directors and Assistant Directors of Social Work
- Directors of Rehabilitation
- Department of Employment Senior Officers.

He notes that female Occupational Therapists have an average working life of two and half years, so obviously his career plan is not designed for women. There was a furious protest about his article in the letters page of the BJOT. Whiting, Harries, and Jarret (1980), three female Occupational Therapy students, made several important points:

- on what evidence did Struthers (1980) base his statement that the average working life of the female Occupational Therapist was two and half years compared with 40 years for a male?
- why did he say that the senior posts, which should be held by Occupational Therapists should be held by male Occupational Therapists?
- that Struthers (1980) was seeking to create a hierarchy in Occupational Therapy where men got the highest positions and women stay at the bottom of the ladder.

Thus three students from the London School of Occupational Therapy were alone in challenging, in print, Struther's assertion about the correct place of men in a "female" profession, as its leaders. That this has happened in other "female" professions is a matter of record. Hardie (1987) noted the relentless rise of male nurses to the most senior positions in administration and education despite often far inferior basic education.

Rider and Brashear (1988) in a survey of 1,000 male Occupational Therapists in the USA found that men were attracted into Occupational Therapy because it offered:

- an opportunity to work with people
- job security
- job availability
- and an opportunity to achieve leadership positions.

Thus, it is clear that the researchers assumed that part of male motivation to enter Occupational Therapy would be, at least in some cases, to achieve leadership positions. Yet the domination of Occupational Therapy by male leaders does not seem to have occurred and this is an interesting issue in view of the phenomenom of male domination of the other, largely female, semi-profession of nursing.

It may be suggested that Occupational Therapy developed in a era of surplus female labour when respectable jobs for middle class women were needed until marriage. It has remained a largely female profession, led by women. The fact that Occupational Therapists certainly now provide a valued service for clients (although this may be a long way from making Occupational Therapy into a profession, as Aina (1981) has pointed out) has allowed them to escape from their own particular dread of the "craft lady" perception. Khan (1985) puts together this rejected picture of the Occupational Therapist:

> "For a long time Occupational Therapists were stuck with the 'fluffy bunny' image of keeping people

occupied in hospital. More recently they have acquired the reputation for being 'nice ladies' who give out bath aids."

She then goes on to present preferred self image of Occupational Therapy:

> "Occupational Therapy concentrates on promoting or maintaining independence in an individual whose ability to cope has been affected or limited by impaired function as a result of developmental deficiencies, the ageing process, physical illness or injury and psychological, emotional and social disability. The three core elements of the Occupational Therapists approach are assessment, function and the therapeutic application of activities as the medium for treatment."

This is a unifying statement of the profession's goals because underlying this image is a deep controversy. Robertson (1987) reveals its nature:

> "Do crafts have some unique contribution to make to treatment or can they be superseded by aspects such as activities of daily living, social skills or remedial games? While such controversy is apparent in the profession, crafts are still taught in Occupational Therapy Schools."

The self image and self-perception of Occupational Therapists are, therefore being undermined by the crisis of definition within the profession and this is expressed via the "crafts controversy", with protagonists such as Kielhofner, whose model of human occupation (Kielhofner, 1982) has done much to re-kindle interest in rehabilitation through the performance of specific tasks. Atkinson (1980) is a British protagonist of this movement who describes herself as:

> "saddened by the students..... who undertook perception tests unsure of what they were looking for"

and contrasts this with the enthusiasm of students who participated in craft activities. Thus it is suggested that the image problem of Occupational Therapy can be resolved by a "return to origins" and a focus on meaningful therapeutic occupation. Clearly, the Occupational Therapy profession has experienced great change and upheaval, with multiple social changes such as the mass unemployment which swept industrialised countries in the 1980s and had such a strong impact on populations treated by Occupational Therapists; it may be difficult to reconcile the origins of the profession in activity with current social trends. Other Occupational Therapists however, such as Ellis (1987) seem, while not attacking the "back to basics" movement, to be much more interested in presenting Occupational Therapy as a profession of the future and focus on the need for degree level education.

However, as noted above in Section Four degree level education has not placed US Occupational Therapists in any better position to cope with the forces of change and Kielhofner, one of the leading protagonists in the "return to basics" movement, is himself an academic in a US college.

The self-perception of Occupational Therapy is intimately linked to the definitional crisis in Occupational Therapy. There can be no doubt that the pessimists among Occupational Therapists would feel better about themselves, if they could have some assurances about their continued existence. This ontological angst is odd in the context of the huge number of disabled people in the United Kingdom (OPCS, 1988). It is their perception of the Occupational Therapy profession which is of great importance for the future of Occupational Therapy, since as Grunow (1984) noted, the consumer is now a very important player in the health care arena. In addition to the growing consumer voice, disabled people and Occupational Therapists seem to mix mainly as clients and providers. There is little evidence that disabled people become Occupational Therapists or that Occupational Therapists have led from the front by ensuring that at least 3 per cent of the Occupational Therapy profession are disabled themselves or that employers of Occupational Therapists have fulfilled the provisions of the 1944 and 1958 Disabled Persons (Employment) Act. In fact, the self image of Occupational Therapists as able-bodied seems to have been a powerful one. An Occupational Therapy school prospectus notes that:

> "The exercise of the profession of Occupational Therapy calls for certain special qualities of character and temperament and makes persistent demands upon the physical and mental resources of the practitioner."

Another notes that:

> "Good health and stamina are essential."

Several schools make a point of encouraging mature applicants in their prospectuses but none mentions the possibility that a disabled person would be welcomed as an applicant. French (1988) has found this to be a common phenomenon in health care professions. There is evidence of much change in the area of Equal Opportunities, however. The London Borough Occupational Therapy Managers Group (1987) in its evidence to the Association of Local Authorities, notes the absence of an equal opportunities policy in the BAOT. Such a policy is currently being debated by the BAOT (OT News, 1989). Schools of Occupational Therapy report that their prospectuses are perhaps rather outdated now. The West London Institute of Higher Education School of Occupational Therapy has recently changed its admission requirements to enable people with disabilities to become students more easily (Personal communication, B. Waters, May 1989).

Clearly, the Occupational Therapy profession is moving into an era when equal opportunities will be more carefully

articulated by professional institutions. In this they would be following social work which has been developing programmes to ensure that people with disabilities enter the profession. (Bookey, 1989).

5.2 Consumers' Perceptions of Occupational Therapy

Mr David Sinclair Kyles, severely handicapped physically and volunteer helper of the disabled, is perhaps an outstanding example of a service recipient whose experiences of Occupational Therapy (Kyles, 1981) have been extremely positive and have enabled him, despite severe handicap, to become part of the local skill mix. He has been involved in establishing a telephone information system for the disabled on the suggestion of his Occupational Therapist. That Occupational Therapists have rarely been so imaginative on a national level as Mr Kyles' Occupational Therapist, in viewing the client as a resource, is noted by an editorial in (TW, 10, 1986):

> "The idea of seeking patients' views is so obvious one wonders why it rarely happened before."

The same editorial notes that the McColl Report on artificial limb and wheelchair services (with its findings that the majority of equipment lies unused) "placed great weight on evidence from the services' customers." They go on to say, however, that "whingers and axe-grinders" may dominate the debate. In view of the kind and appreciative comments about Occupational Therapy made by so many consumers such as Mr Kyles, that has scarcely been the case so far. Indeed Occupational Therapy is not mentioned in the 1988 Report of the Health Service Commissioner (GB Parliament 1988) where complaints against NHS personnel are investigated.

A more sophisticated approach to tapping the consumer's perspective on Occupational Therapy services comes from Maslin (1985) who asked patients to compare Occupational Therapy with other types of remedial therapy. The results were interesting in that patients who had received direct benefit from Occupational Therapy activities tended to see Occupational Therapy as beneficial. It should be noted here that this study was confined to hospital-based Occupational Therapy. As cited previously, Celentano (1982) suggested that services should be seen in terms of optimum utilisation and that the questions to be asked should be whether or not utilisation is a problem for patients seeking services. As noted earlier, it is unlikely that patients would perceive utilisation as a problem within the hospital setting where so many categories of personnel are available to supply services. However, as observed already, it is likely that consumer perceptions change considerably as the disabled patient becomes a disabled client within the community, where so much depends upon the Occupational Therapy assessment for those who lack the financial resources to acquire needed aids and appliances. Davidson (1988) elicited the information from a senior DoH official that the 1986 Disabled Persons Act (G.B. Parliament, 1986) will, as a result of Section 10 of the Act, encourage

the involvement of disabled people in the planning of services. Gilmore (1988) suggests that, in her work in community services for the mentally handicapped, she is now functioning as a trainer of "mediators", acting as a resource for those who will actually provide the care for the client. Thus, the "skill mix" for people with a mental handicap in the community already in some cases includes the clients' relatives, care workers and so on. In view of this development, Gilmore (1988) argues that the traditional role of the Occupational Therapist is being brought into question.

Both the effects of the growing focus on the consumer and changing role of the Occupational Therapist in the community with the switch to resource person and trainer of mediators suggests that a change in perspective for remedial therapy in the community is occurring. Philbrook (1989), Chairman of the Chartered Society of Physiotherapy Council, suggests that:

> "There are extensive moves towards de-professionalisation. It is said that we are not responding to patient/client needs, that we are inflexible and anxious to protect our territory."

Philbrook's (1989) comments appear to have been inspired by Beardshaw's (1988) report "Last on the List" which is seen as accusing professionals of failing to support independent living. Perhaps she is referring to the comments Beardshaw (1988) makes on "problem-solving and Partnership" (p.44) where she notes:

> "By definition, an approach of this kind would involve adjusting the traditionally unequal relationship between professional and client to something more akin to partnership."

Although there is evidence that, at the institutional level Occupational Therapy has perpetuated the inequality between the able bodied and the disabled by its failure to lead from the front in encouraging disabled people into the profession, the anecdotal evidence cited above would suggest that individual Occupational Therapists are already re-negotiating their relationships with their clients. In an anonymous account of his dealings with local authorities (Personal Experiences, Somebody Cares, 1987), a carer notes carefully that the only person to emerge with any credit in a dreadful story of bureaucratic confusion, was the Area Occupational Therapist. This could add weight to Grunow's (1984) view that the true professional of the future will act as an advocate for the client in his dealings with bureaucracy. The Camden Survey of People with Disabilities (Heiser, Ruane and Cotien, 1988) notes that 2,200 out of 19,000 disabled people in Camden had been seen by Occupational Therapists and that 3,200 people who had never been seen by an Occupational Therapist wanted an Occupational Therapy visit, although only 200 had requested such a visit. The consumer interest in an Occupational Therapy visit is obvious since about three quarters of people seen by Occupational Therapists subsequently received:

"some item or items of special furniture or aids as a result of the visit" (p.107).

A further interest which disabled people may have in Occupational Therapy assessment is in assisting them towards independent living. Philip, for example, in recording his story of his move towards independent living (HCIL Papers, 1981) notes that:

"I remember an Occupational Therapist advising me that I had the potential to live alone. It was a vague suggestion, made in terms of my being physically able to "learn" to do everything for myself. I realised it was more of an occupational therapy target than a reality." (p.1).

Later when he decided to try independent living he ran into difficulties with the costing of his care proposal, the Occupational Therapist then became his ally in his dispute with the community physician about his need for skilled nursing. (p.7).

On the level of anecdote and through the small amount of research available, Occupational Therapists, in the eyes of the consumer, are certainly valued for their ability to offer assistance of a practical nature. Maslin (1985) notes that patients favour services that give quick results in terms of getting better, while all the anecdotal evidence cited suggests that Occupational Therapists offer help in fighting bureaucracy and obtaining practical aids to living for those without the resources to buy their own. The Occupational Therapy profession is clearly moving on an individual and local basis to a more equal partnership with the disabled.

5.3 The Occupational Therapy Profession in relation to Public Policy

Although Occupational Therapy is obviously having more success in becoming a true profession outside the public services, professional education is largely financed out of the public purse and about 75 per cent of registered Occupational Therapists work within the public services. It is legitimate, therefore, to examine the initiatives that have occurred in the public policy domain in relation to the development of the Occupational Therapy profession.

The remedial professions have been the subject of many reports over the years by a variety of committees of inquiry appointed by government departments or statutory bodies. The earliest of these being the Cope Report (1951). In the 1970s there were 7 major reports which examined Occupational Therapy from a variety of perspectives. For the purposes of this review, to summarise the recommendations presented in those reports, a matrix has been constructed [see Appendix A]. As will be noted, all seven enquiries agreed on the need to proceed to a common basis for training for all the remedial professions, a suggestion initially made by the Cope Report (1951). It is interesting, therefore, to note that a news item in (TW, 11,

1986) announced that:

> "Radical changes in education for professions allied to medicine are proposed in an unpublished discussion paper...."

The "radical changes" proposed by a group of NHS managers, echo precisely the recommendations of the many official reports over the past 40 years. These are: a shift to core content training, shared training schools and accommodation and lessening of the isolation of small schools. The members of the Oddie Committee (CPSM, 1970) would have agreed. It is possible that the remedial professions may also find change as difficult as many other professions.

Abel-Smith and Stevens (1965) suggested that the legal professions were intractable to change:

> "Again and again the same attempts are made and defeated by much the same forces and for much the same reasons." (p.ix).

Yet now there are specific detailed proposals for change which are codified in a specific policy document (HMSO, 1989, Government Green Papers on the Reform of the Legal Profession). Despite professional protests, there is now a commitment to change at the highest level of policy making. It remains to be seen whether or not the judgement of Abel-Smith and Stevens (1965) holds good. Similarly, with the change in culture of the NHS, it is possible that the interest of NHS managers may lead to a fresh field of forces around the remedial professions. Therefore, it may be instructive first to study the reform matrix and then to compare and contrast two major attempts at reform: the Report of the Macmillan Committee (HMSO 1973) and the report of the Higher and Further Education Working Party: "The Next Decade" (CPSM 1979). The reform matrix [Appendix A] is essentially a comparison of the main findings of the Oddie Report (CPSM, 1970) with all subsequent reports on the remedial professions until 1979.

Throughout the 1970s the demands on the remedial professions made by these committees were essentially the same: every one agreed that the remedial professions must accept some kind of common core training. The CPSM (1979) report has a lucid and important account, taking into consideration the complexity of the issue which concluded that:

> "The problem is insufficiently explored. Such piecemeal negative evidence which we have heard is suggestive of nothing more than the frustrations of initial experiments." (p.50, para 6-12).

They also noted that professional boundaries "are now defended for subjective rather than technical reasons." (p.48, para 6-6). It is, therefore, instructive to compare the effects of two of the most detailed and far-reaching of these reports, since it is now 1989 and there has been, so far, little movement in many of these areas.

5.3.1 The Macmillan Report (DHSS, 1973)

Recommendations were made in eight areas each of which will be discussed below:

5.3.1.1 Inter-professional Relationships

The recommendations that the professions of physiotherapy and remedial gymnastics be amalgamated has been effected since 1986, but the second recommendation, that all three professions that is, including Occupational Therapy should evolve to form one comprehensive profession and all developments in training and services should have this ultimate goal in mind, seems to have acted as a lightening rod for discontent between the Occupational Therapy and physiotherapy professions. A detailed analysis of the complex relationship between the Occupational Therapy and the physiotherapy professions will be presented in Section Six but it should be noted here that the reaction of the Occupational Therapy profession to this proposal was not favourable, indeed Sym (1980) describes clearly the process by which this proposal was defeated. The proposals of the governmental and quasi-governmental reports of the 1970s are described thus:

> "Sounding like a nosegay of flowers they cajoled, threatened and enticed. From them emerged a major threat to the profession. In a previous government report the term Remedial Professions was coined. It covered Occupational Therapy, Physiotherapy and Remedial Gymnastics, and talks took place to see if such a group would fit into the paramedical structure proposed in the report. The talks came to nothing."

Sym (1980) then reveals how this threat was defused. The Occupational Therapists sought the help of the medical group of which their initial sponsor and protagonist was a member: the psychiatrists, and makes it clear that, although she recognises that there are indeed obvious overlaps in the physical field, psychiatry saved the day:

> "Areas of overlap were obvious and not hard to find in physical hospitals. In my view, the profession would have suffered serious damage if it had not been for the solid work established in psychiatric hospitals and already mentioned. The Royal College of Psychiatry strongly supported the retention of Occupational Therapy as a separate profession and though the move towards close co-operation rightly remains, the idea of a "Remedial Therapist" has faded."

A staffing survey (BAOT, 1976) found that 31 per cent of Occupational Therapists worked in psychiatric departments. This figure can be interpreted in a variety of ways, since there is no explanation of the number of helpers and technical instructors which each registered Occupational Therapist may have been supervising at that point. Nonetheless, it is instructive to note that the Occupational Therapy profession

resisted this change with the help of their original sponsors in the medical profession; the psychiatrists.

5.3.1.2 Relationship with the Medical Profession

The DHSS was instructed to initiate a review of the guidance given in DHSS HN (62)18 to allow greater freedom and responsibility. This resulted in a change from a "prescription" for Occupational Therapy, to a referral for Occupational Therapy. Thus Occupational Therapists were allowed the clinical autonomy to decide the content of treatment (DHSS, HN(77)33). Although as Ovretveit, (1982) notes, in relation to physiotherapy, some doctors continue to prescribe treatments in detail. The second recommendation in this section essentially lays out the terms of the medical-remedial professions relationship later adopted in DHSS, HN(77)33. The third recommendation that:

> "Members of the remedial professions should co-ordinate, organise and administer their own services" (para 66[c])

had some important effects in the development of management training for Occupational Therapy. DHSS HN(77)89 gives notice of a "Pilot management training course for Head Occupational Therapists." This laid the foundation for the development of management positions within the NHS, but as has been noted above, the development of general management since 1983 has apparently curtailed this development in some Health Districts.

5.3.1.3 Relationship with the Nursing Profession

The Macmillan Report noted the need to discuss overlap between the two professions and the need for involvement of nurses in the training of the remedial professions and vice versa. From this developed the standard advice to nurses and members of the remedial professions embodied in DHSS HC(77) 124. This defined overlap as intrinsic, where certain skills are shared by one profession, and circumstantial, where members of one profession undertake interventions which are normally part of the role of another profession in abnormal circumstances.

5.3.1.4 Relationship with Social Workers

The report recommended that there should be close liaison between Occupational Therapy and social work in areas of overlap; that junior therapists should have access to professional advice from other senior therapists, not social workers; that therapists should be represented at senior management level in social service departments and that Occupational Therapists should be employed as assessors and advisers rather than as craft instructors in local authorities.

The Occupational Therapy qualification was recognised by social service departments in 1980 for the purposes of promotion, but the management picture, as noted, remains

unclear and variable. However, the Wagner Report (NISW 1988) poses a new problem for Occupational Therapists, since it insists that all staff in residential homes should eventually have a recognised qualification in social work. If an Occupational Therapist owned and managed a private residential home, this would entail employing a qualified social worker to manage the home as the Occupational Therapist would no longer be able to do so. The majority of private homes are owned by nurses and this group, too, would be affected by this.

5.3.1.5 Relationship with other staff concerned with Remedial Therapy

This group of recommendations was concerned with industrial therapy, technical instructors and link therapists. It noted that, since industrial therapy managers were frequently nurses, the issue of responsibility should be decided locally, but that the link therapists in art, music and so on should be responsible to the consultant or other leader of the rehabilitation team. Only where neither existed should they be responsible to a remedial therapist. Technical instructors were, however, placed under remedial therapy. This confusing picture seems to have continued, as will be noted in Section Six.

5.3.1.6 Career Structure

Numerous recommendations were made in this section. Several were of special relevance to this discussion. The committee seems to have envisaged a management structure in which each profession in the district would have a head of department and all three professions would be managed by a district remedial therapist. The use of aides should be encouraged and extended. All the aides should be common to all three professions. These management recommendations may now in fact be occuring in some districts, while the recommended training of aides has been pioneered very successfully by the Occupational Therapy profession. The NCVQ will now, undoubtedly, influence the development of support worker training. The final recommendation of interest is that the remedial professions should be represented at the Department of Health. This has now been implemented.

5.3.1.7 Training

The recommendations on training are very interesting in that the Committee clearly believed that integrated training was an imminent prospect, largely due to the investigation being conducted into the development of an integrated syllabus. However when, Patterson and Johnson (1976) reported their research, they noted, that since it was a first piece of research for each of them, they had found it very difficult to conduct. Also the methods used seem rather odd in view of the remit the Macmillan Committee believed it had. The research turned into a large survey of thousands of Occupational Therapists and physiotherapists. Little or nothing could, therefore, be derived from the study which spoke to the issue of an integrated training. As will be noted in the discussion

of "the next decade" (CPSM, 1979) the few experiments in shared teaching have been unhappy experiences.

The re-appraisal by the professions of the training of their teachers and by the department of health and social security of financing have been followed by documents recording action. DHSS HN(77)90 encouraged members of the remedial therapy professions to take relatively short teacher training courses at colleges offering the Certificate in Education (Technical) with an offer by the DHSS to pay course fees of student teachers "at least until the courses become established." The CPSM issued a landmark document in this area by Stewart (1980), its first Educational Development Officer.

Stewart's (1980) research noted the high level of conformity expected of students in Occupational Therapy schools and the need for problem solving approaches to education. This sort of approach was embodied in the Diploma 81 curricular guidelines issued by the College of Occupational Therapists (COT 1987).

Although the DHSS showed some evidence of being influenced by the Macmillan Report in its issuing of circulars and its employment of Officers to advise, and the Occupational Therapy profession was vigorous in developing its helper programme, the development of common core training seems to have foundered. As in the case of the legal profession, highly specific policies may be needed if significant professional change is to be achieved. Additionally, it should be noted that the remedial professions are quite small and training schools are scattered. If significant changes to the current pattern were to occur, resources to achieve this would be required.

5.3.1.8 Research

The final section of the report concerned academic developments. In the "Training" section investigation of "end-on" degrees was suggested and an integrated entry level degree in remedial therapy. This was clearly to prepare the profession for the expansion in research training. The DHSS currently has 9 (nine) remedial Research Fellows listed and there are now "end-on" degrees and some evidence of curricular integration where the remedial therapy professions are established in higher education for example, as at Salford College of Technology.

5.3.1.9 Summary

The Occupational Therapy profession and other remedial professions gained considerably from this report which laid the foundation for management training, expansion of teacher training courses, liberalisation of the medical referral system and research training for remedial therapists. The remedial professions, on the other hand, seem to have moved fairly slowly in the direction of the objectives desired of them. This could be seen as a corollary to lack of resources, policy drift and the natural reluctance of professions to

contemplate drastic change.

5.3.2 The Next Decade (CPSM 1979)

5.3.2.1 Introduction

This report made recommendations in the familiar areas of the training of teachers, clinical research development, educational research into common-core courses and teaching, degrees at entry level and "end-on" degrees, as well as some recommendations which reflect their special interest in education and training. These included:

- the "tiering" of the remedial professions, involving the creation of professional and technical levels of entry
- joint validation, examination and course provision within higher education
- improvements in clinical training, in particular the provision of trained clinical supervisors
- focus on adult education learning for students
- Health care schools based on medical, nursing and paramedical schools
- transfer of PSMs/education from DHSS to Department of Education and Science.
- forecasts of manpower demand and supply by the DHSS and the need to "stockpile" the present abundant recruits against shortages of the late 1980s.

Many other recommendations were made which related to the above issues. However, the disposition of those listed will now be examined.

5.3.2.2 Recommendations

Clinical supervisors are now a requirement for Occupational Therapy students during placement and they are closely involved in training (see for example, Curriculum, West London Institute of Higher Education, 1984), although schools do not choose supervisors in clinical facilities. The choice of who supervises students is made by the facility and the small financial reward for this is in its gift, although this only occurs under Whitley Council terms and conditions in the NHS, and not in social service departments where there is no provision for financial reward for Occupational Therapy student supervision. A recent development is that of a degree in Occupational Therapy for post-registered students.

Clinical research developments have occurred through the provision of remedial Research Fellowships offered by the DHSS. Educational research into common core teaching and courses seems not to have occurred. This may be because there has been little commitment by the professions or because there has been little investment in research to do this. Salford College of Technology is currently developing shared learning between its Occupational Therapy department and other remedial professions. (Personal communication April 1989 M. Wilson).

Degrees, both entry level and "end-on" are being established.

The University of Ulster has entry level degrees in physiotherapy and Occupational Therapy. "End-on" degrees, however, seem to be being established as remedial therapy degrees, for example, the degree at Coventry Polytechnic and Salford College of Technology (reported in TW, 12, 1986). Occupational Therapists have had little success in their pleas for a wide expansion of degree level training. (TW, 13, 1986) reports the then Junior Health Minister as writing that:

> "The message we are receiving from the NHS management is that priority should be given to increasing the supply of Occupational Therapists trained, as at present, to diploma standard, and helpers, rather than to enhancing pre-registration training to degree level." (p.2).

He made it clear that there was no opposition to the concept of degrees in Occupational Therapy, rather that there was little evidence that the investment involved would add greatly to improved training and standards of care. The Occupational Therapy profession's argument, however, seems to have been that degree courses were essential for British Occupational Therapy to maintain its world standing and that a degree qualification would encourage recruits into the profession. The complexity of the supply and demand issue, mentioned later in the list of recommendations in "The Next Decade" demonstrates the wisdom of that report's recommendation about the need for forecasts of manpower demand and supply. As yet, there is no really satisfactory analysis of the supply and demand issue. This is discussed in detail in Section Eight.

The tiering of the entry levels to the PSM has not occurred, although Occupational Therapy has developed its helpers courses. Joint validation, examination and course provision must have occurred when colleges such as Coventry Polytechnic and Salford College of Technology developed "end-on" B.Sc, courses for remedial therapists. The focus on the adult education approach to learning, with the report's implicit criticism of the current techniques, was probably effected in Occupational Therapy by the "Syllabus and Validation Scheme (COT 1987), which encouraged Occupational Therapy schools to develop educationally.

Health care schools based on medical, nursing and paramedical schools, seem to have developed mainly in polytechnics for example, Coventry. PSM education is still divided between education and health and there are no really adequate forecasts of demand and supply, since forecasts almost all focus on the supply side of the equation rather than the demand side. Nothing has been done about "tiering" the professions.

5.3.2.3 Summary

In 1989, the comments of this report dated November 1979 still look relevant, especially in the area of common core courses. Recommendations in this area were particularly sensitive. It may be that common core courses, brought about by the

mechanism of the National Credit Accumulation and Transfer Scheme, will come into being very quickly and with little regard to the sensitivities of the professions due to their expansion into higher education and the need of higher education to find economies of scale in course provision.

5.4 Occupational Therapy as it is represented in the public policy forum

The perceptions of Occupational Therapy presented are complemented by the study of Occupational Therapy as a player in the public policy forum. There are so many documents in the public domain which are of concern to the Occupational Therapy profession to a greater or lesser degree, that it is possible only to consider some major "landmarks". However, if a public document concerning the health services or social services is a well known and frequently cited source of authority, then it is of interest to note the impact of the Occupational Therapy profession on the public policy forum. There are two ways in which professions may be judged as to their visibility in public documents; one is by giving evidence to committees of inquiry while the other is to be mentioned in the body of the report. Matrix B, which has been constructed examining Occupational Therapy in the light of these criteria, appears as an appendix.

As can be seen from this the Occupational Therapy profession tends not to be highly visible in public documents, but it is important to note that as a small profession it may be difficult for Occupational Therapy to offer evidence to all the bodies reporting on the many different areas of Occupational Therapy involvement at any one time. Grove (1979) urged Occupational Therapists to be realistic about what the profession could provide.

Obviously, the Occupational Therapy profession is much affected by legislation. The Disabled Persons legislation and the Special Education legislation have led to a demand for Occupational Therapists in social service departments and in Education authorities which has opened up new areas of practice for Occupational Therapy. Similarly, the Disabled Persons (Services, Representation and Consultation G.B. Parliament, 1986) may open up the way for Occupational Therapy to greater involvement in the community care of people with mental illnesses when Section 7 requiring assessment for those discharged from psychiatric care is implemented. It is for the Occupational Therapy profession to decide how best to accomplish the difficult task of ensuring that it is represented in all the areas in which the profession might be said to have a vital interest. One example of how the profession has gone about this can be seen from the matrix, Occupational Therapy has been most recently involved in offering evidence to the Short Report (G.B. Parliament, 1985). This was published by Ridler and Yates (1984) in the British Journal of Occupational Therapy. Here they presented the argument that Occupational Therapy, currently little involved in community teams, can make a significant difference to people with mental illnesses and handicaps in the community

and that Occupational Therapy manpower needs to be increased. Occupational Therapy clearly presents itself as having very special skills which can make a significant difference to standards of service. However, this was presented in the evidence without any research to back up the argument. Since Occupational Therapy may have to compete with the larger and better established professions in this area, it would have been more impressive if evidence of the superior skills and benefits could have been adduced in its argument to the committee.

The importance for the Occupational Therapy profession of producing evidence of superior performance and benefits for service users is apparent and, as its research base increases, it will perhaps be in a better position to produce arguments which will influence the public policy debate. It is also noteworthy that the professional body has produced no guidance on the position of Occupational Therapists during the re-provision of psychiatric hospitals. It may, therefore, be assumed that as a profession, despite enthusiastic individual efforts, no coherent view of the future of Occupational Therapy in community psychiatry has been formulated.

Section Six

Relations with other Professions

6.1 Some of the issues

Occupational Therapy is a small profession operating in many different areas of the health and social services and as such it has to work with many different disciplines. It is not surprising, therefore, that the Occupational Therapist occasionally sounds as though she is surrounded by enemies. Spashett (1981) reviews the "incursions" into the role of the Occupational Therapist by a long list of disciplines:

- Nursing
- Remedial Gymnasts and Physiotherapists
- Art Therapists
- Drama Therapists
- Music Therapists
- Social Therapists

This list is interesting because it draws attention to the disciplines viewed as "smudging" the role of Occupational Therapy of whom Spashett (1981) says:

> "If all these trends continue at their present rate there will soon be little left of the role of Occupational Therapy for the Occupational Therapist."

Hall (1987) also identifies overlap with other professions as a major problem facing Occupational Therapy but suggests that, far from the Occupational Therapist being faced with sudden new incursions into her field by other professions,

> ".....the development of Occupational Therapy can be seen as a continuous process of struggle, negotiation and conflict as the profession has sought to establish certain areas of work as its own." (p.206).

She describes the successive incursions Occupational Therapy has made into the fields of other professions:

- The hi-tech
- The moral
- The human - potential
- The ergonomic (Chapter 4, p.138 following).

The hi-tech model overlaps with physiotherapy in its provision of sophisticated technique-based high technology treatment. The moral model overlaps with psychology and nursing in its teaching of social skills and activities of daily living to the chronically mentally ill. The human - potential model involves Occupational Therapy in overlaps with virtually all other health care professions in adopting the approach to mental illness and handicap of the encouragement of self-achievement and self fulfilment. Hall (1987) suggests:

> "It is only in the performance of the Ergonomic Model

that Occupational Therapists appear to have established a clear monopoly over an area of work. Even so, it is largely performed within the territory of social work and in some instances the service is managed by social work." (p.210).

Hall (1987), therefore, does not seek to "blame" other professionals for their incursions, rather, with considerable historical authority, she analyses the impact of social and technological change on Occupational Therapy. It is clear that Hall (1987) sees a major area of importance in the utilisation of Occupational Therapy services by the consumer as lying in the community, where the Occupational Therapist is seen as offering a unique service.

Both Hall (1987) and Spashett (1981) have provided thought-provoking and interesting analyses, and it is on the basis of their suggestions that the relations of Occupational Therapy with other professions will be examined.

6.2 Occupational Therapy as compared with related Occupational Groups

The difficulty in finding any definition of Occupational Therapy with which everyone in the profession agrees and which presents the major elements of the work of the Occupational Therapist succinctly and fairly has been noted earlier. It is important to recognise that this is a difficulty facing many professions. A careful perusal of the literature reveals that many other groups, working in the same therapeutic space as Occupational Therapists are similarly engulfed in definitional difficulties. For the purposes of this study, six professions, alongside whom Occupational Therapists work, have been compared and contrasted with Occupational Therapy.

In searching for definitions of physiotherapy, speech therapy, nursing, social work, art therapy and clinical psychology, similar difficulties to those in Occupational Therapy were noted. Particularly in social work there has been much discussion about the nature of the profession and, indeed, the need for social workers. Goddard and Carew (1989) note that there has been a long debate about the purpose, roles and tasks of social work and that there is continuing division in the profession as to whether social workers should be trained or educated. They also suggest that the nature of social work is seriously misunderstood:

> "Social Workers need to start explaining the intellectual complexities and challenges inherent in their roles in order to create a more sympathetic view of their practice, and a more accurate perception of a profession at the cutting edge of intellectual activity."

It could be argued that all professions are facing challenges as to their nature and purpose and are being forced to offer definitions of themselves to ensure that their services to society are fully appreciated. Economic changes in Western society wrought by the oil price hikes have entailed a far

more rigorous approach to the spending of public money. The value for money approach to the National Health Service is embodied in the White Paper "Working for Patients" Working Paper no. 6 (DoH, 1989).

> "...there is a need to develop a comprehensive set of measures of ourcome of much of the work of individual services and doctors." (p.5).

Clearly, all professions are to be involved in the process of rigorous audit to ensure that services are effective, efficient and economic.

In comparing the definitions of the various professions, (see Matrix C] it is clear that each group believes it has a special set of skills which mark it out uniquely. Some professions are much more narrowly based than others. Nursing covers an enormous amount of ground, as does social work. These are huge umbrella-type groupings, containing within their ranks members working in disparate areas. Art therapy and clinical psychology are post-graduate professions, and while art therapy has a clearly defined and delineated role, the definition of clinical psychology is large and could embrace many areas of work. Physiotherapy and speech therapy also seem to have, clear, easily understood definitions. Alazewski et al, (1980) would describe these clearly defined professions as "technique based". Alazewski et al (1980) have produced one of the few studies which has examined the relationship between the paramedical professions. They concluded that the relationship between Occupational Therapy and physiotherapy would always be difficult because of occupational therapy claims that approach and style of work were more important than techniques, the basis of physiotherapy. However, in view of the policy directives regarding clinical audit, it is likely that all professions will have to establish tools to measure the outcomes of their interventions. Thus the professions defined in terms of technique (see Matrix C), that is physiotherapy, speech therapy, and art therapy, will probably find it easier to fulfil this policy requirement. Nurses, social workers and clinical psychologists will probably find that the measurement of outcomes will vary according to their varied areas of work. Occupational Therapy will be able to define outcome if it follows the College of Occupational Therapy 1987 definition, but this will entail a focus on evaluating the impact of activity and will entail the view of Occupational Therapy documented in the "Way Ahead" working party report (BAOT, 1981):

> "While recognising the reasons for the development of techniques, the use of activities should remain as an identifying feature of occupational therapy." (para 7.3.3 p.50).

In thus defining itself Occupational Therapy will have to come to terms with its similarities with physiotherapy and its focus on treatment by movement. Occupational Therapy has traditionally had poor relationships with physiotherapy and

with nursing. The Way Ahead (BAOT, 1981), in noting changes in professional roles, remarked that:

> "Occupational Therapy should be sufficiently mature as a profession not to respond to these changes with defensiveness or hostility."

Grove (1988) also encouraged Occupational Therapists to view the future as necessitating co-operation between professions. Much activity has already taken place in establishing ways in which this can best be accomplished, and meetings between the Royal College of Nursing, the Chartered Society of Physiotherapy and the College of Occupational Therapists have been taking place to explore good practice and overlaps.

Despite much goodwill from senior Occupational Therapists and strenuous efforts to avoid the development of a defensive culture, there have been some difficulties. These will be considered first in relation to the nursing profession, then in relation to the physiotherapy profession.

6.3 Occupational Therapy and Nursing

As can be seen from Matrix C, nursing is an umbrella profession involving people from a wide range of ability levels, from the unqualified school leaver entrant to the doctorally prepared researcher. It encompasses approximately half a million people working in the Health Service in England. (DoH, 1988). Occupational Therapists were traditionally drawn from a fairly narrow band of post A level school leavers, although this may now represent an inaccurate picture of entrants into the profession. However, the profession has, so far, been offered few opportunities for academic development. There are approximately nine and a half thousand registered Occupational Therapists (CPSM, 1988). To compare nursing with Occupational Therapy is most misleading since nursing would count as a super-ordinate group encompassing many subordinate groups which, in themselves, would be comparable with Occupational Therapy. For example, within nursing, there exists an approach versus technique split between the district nurses, involved in technical care in the community, and health visitors, who offer skills in monitoring community health. This is comparable with the physiotherapy and Occupational Therapy division in remedial therapy. Persistent attempts to compare the remedial professions with nursing in rather simplistic ways lead to comments such as those made in the Staff Side evidence to the Pay Review Body:

> "In fact the higher standards of PAM education and consequent differences in clinical autonomy and accountability puts the practice of PAMs into a higher class than that of nurses."

Unfortunately, the report does not specify which groups of nurses are identified as having lower educational qualifications and less autonomy and accountability than professions allied to medicine. Since there are now many

nurses with baccalaureate, masters and doctoral level qualifications and many clinical specialist posts, the comparison is not helpful. Dunkin and Goble (1982) similarly compare the lowest levels of entry into nurse training with Occupational Therapy.

There is evidence of the more constructive approach of Grove (1988) and "The Way Ahead" (BAOT, 1981), being adopted at local level. For example, Jackson (1987) reports on the difficulties of establishing good working relationships between Occupational Therapists and nurses on a forensic psychiatric unit. She describes the progress made when both professions adopt tolerant attitudes and endeavour to see each others' points of view.

6.4 Occupational Therapy and Physiotherapy

The Occupational Therapy-physiotherapy relationship is of a different nature than that between Occupational Therapy and nursing. Physiotherapy is a much smaller profession than nursing, but still has approximately twice as many members as Occupational Therapy (CPSM, 1988). The long history of difficulties between the professions in terms of sharing learning and developing joint endeavours was documented earlier. A recent attempt to encourage debate at local level between the two professions by the Chartered Society of Physiotherapists (CSP, 1989) was reported. (TW, 14, 1986) noted a debate held in Nottingham between the two professions with regards to the suggestions of the CSP about the many routes to merger. Although senior managers from the two professions could see the need for some sharing, the majority favoured clarifying boundaries and defining themselves more tightly. A senior Occupational Therapy manager pointed out that:

> "Various seasoned professionals pointed to the success of their multi-disciplinary teams, without apparently being able to conceptualise a common profession with its own specialisations."

However, at the institutional level there is much evidence of co-operation. For example, the Chartered Society of Physiotherapists and the College of Occupational Therapists have set up joint groups to examine areas of development.

6.5 Relationships with the wider field of caring

Occupational Therapists seem to have good working relationships with clinical psychologists with whom they have collaborated on many projects. There is no recorded evidence of any difficulties between speech therapists and Occupational Therapists. It is possible that social workers and Occupational Therapists may have more boundary difficulties but there are no reports of this. Art therapists are appreciative of Occupational Therapists' efforts in developing the profession (Personal Communication, G. Hicks BAAT, April 1989) but have been recognised as a separate profession by the DHSS since June 1980 (BAAT, 1989). They are now involved in

negotiations with the DoH to develop a separate management structure from Occupational Therapy. (Personal Communication D. Waller BAAT, April (1989)).

6.6 Comparisons of the Deployment of Support Workers

Art therapy and clinical psychology are both post-graduate professions comprising small numbers of highly trained people and, as such, do not use support workers. Social work and nursing are both moving away from two entry gates to their professions. As can be seen from Matrix C, Occupational Therapy has a well-developed system of helpers courses. Physiotherapy has recently produced guidelines as regards physiotherapy helper training (CSP, 1989). Speech therapy has, as yet, published no central guidelines as regards helpers.

"The Way Ahead" (BAOT, 1981) strongly supported the idea of a continuum of education so that helpers could become Occupational Therapists. This is in line with the NCVQ philosophy embodied in the White Paper "Working Together - Education and Training" (DES, 1986). The Department of Health is exploring the possibility of access courses for helpers to conventional Occupational Therapy Schools (Personal Communication B. Waters, May 1989). This would enable helpers to enter conventional Occupational Therapy courses after suitable preparation where locally sponsored four year in-service courses may be available.

6.7 Curricular Comparisons

In constructing the matrix to compare Occupational Therapy with the six other professions, it became clear that all professions share, to some extent, the same knowledge bases. Since art therapy and clinical psychology are for post-graduates only, the real comparisons are with physiotherapy, speech therapy, nursing and social work. The profession which has the least in common with Occupational Therapy is clearly social work (Matrix D) since it does not share the biological and clinical sciences bases with the other professions. The health care professions share most with each other, but all professions share a focus on human growth and development.

It is interesting to note that, despite the lack of funding for the development of shared learning, curricular changes are already occurring. For example, Salford College of Technology is in the process of examining its Occupational Therapy curriculum with other professions allied to medicine. Common assumptions about shared learning are being over-turned. Willson (Personal communication, April 1989) reported that although College authorities had assumed shared learning would occur in areas such as the biological sciences, in fact much shared learning could occur in areas such as the administrative sciences. As can be seen from Matrix D, it is indeed the case that all the professions listed place some emphasis on this area.

6.8 Comparison by field of operation

All professions work in a surprisingly large range of settings in hospitals and in the community. Social workers, speech therapists and Occupational Therapists work from both health authority and local authority bases, although it is frequently stated that only Occupational Therapists span the two (Smith, 1988).

6.9 The relationship of the Medical Profession with Occupational Therapy

> "When I first qualified as a doctor I decided that, from my hospital experience, I would take up psychological medicine, and went to one of the best mental hospitals as a clinical assistant. I had been used enough to busy people when I was house-property managing under Octavia Hill, and to ill people in bed when I was a medical student, but I found it very difficult to get used to the atmosphere of bored idleness in the day rooms of the hospital. Then, one Monday morning, when I arrived at the women's wards, I found the atmosphere had completely changed and realised that preparations for Christmas decorations had begun. The ward sisters had produced coloured tissue paper and bare branches, and all the patients were working happily in groups making flowers and leaves and using all their artistic talents with real interest and pleasure. I knew from that moment that such occupation was an integral part of treatment and must be provided." (p.1)(Casson written in 1950, reprinted in Collins, 1987).

This was one of the sources of inspiration for the development of the Occupational Therapy profession - an idea in the mind of a remarkable female psychiatrist - Elizabeth Casson. It is, therefore, interesting to note that, as Hall (1987) has pointed out, initially Occupational Therapists were managed by nurses and that only after 1948 and the development of the NHS did Occupational Therapists free themselves from nursing control. It was then that they allied themselves to medicine, where, until 1960 they were designated medical auxiliaries. Their title was changed by the 1960 Professions Supplementary to Medicine Act. At this time, Occupational Therapy was still seen as a form of treatment much like chemotherapy, to be prescribed by doctors. It is clear from Dunton and Licht (1950) that all the original text books on Occupational Therapy were, if not entirely written by doctors of medicine, then largely dominated by their writings. Indeed, Dunton and Licht (1950) in the preface to their textbook (p.i) make it clear that Occupational Therapy was then viewed as a branch of therapeutics. Clearly, Occupational Therapists were seen in terms of pharmacists - prescriptions by doctors of medicine to be filled by Occupational Therapists. This somewhat mechanistic approach to the doctor - Occupational Therapist relationship prevailed until the 1970s. The remedial professions began to chafe under the restrictive and mechanistic guidance from the DHSS (HN(62)18). Although the

Tunbridge Report (DHSS and WO, 1972) suggested that the above circular was "still appropriate" (para 152), they noted that remedial staff should be given greater discretion in terms of patients' treatment but "within limits set by the appropriate consultant" (para 150). They then went on to recommend specifically (XV, p.47) that:

> "The delegation of responsibility for day to day treatment of patients should be permitted to members of the remedial professions, provided that they are always under the supervision of the appropriate consultant."

Clearly the mechanistic prescription model was crumbling in favour of a more equal referral model. This was picked up by the Macmillan Report (DHSS, 1973) which specifically cited the prescription analogy of HN(62)18 as inappropriate to then current practice (para 20). It went on to recommend a review to the more relaxed referral system. Although an element of accountability to the medical profession (para 22a) was retained it suggested that other professions such as nursing or social work could also make referrals to expedite treatment. However, a report should be made by the therapist at "the earliest appropriate opportunity." (para 22d).

These proposals were encapsulated in a new note of guidance (HN(77)33), so that the situation, which had clearly come about in practice, was legitimised in policy terms. Despite the chafing of the Occupational Therapy profession at medical dominance, their old allies the psychiatrists were very helpful as noted above when one of the familiar "fusion" crises flared up after the publication of the Macmillan Report (DHSS 1973). Sym (1980), cited above, specifically names the Royal College of Psychiatrists as having "strongly supported the retention of Occupational Therapy as a separate profession." Since this report undoubtedly presented the most serious challenge to the legitimacy of Occupational Therapy as a separate profession, it was, therefore, fortunate that Occupational Therapists could rely on their traditional medical allies and their initial professional sponsors.

Their relationship with the medical profession is, nonetheless, fraught. On the one hand, some of their leading protagonists are doctors, while on the other hand some doctors are sceptical of the benefits of Occupational Therapy or indeed any kind of remedial therapy. Felstein (1980), a geriatrician, and a keen supporter of Occupational Therapy, shows little real understanding of the work of Occupational Therapy as compared with nursing and his remarks seem to be likely to increase antagonism between the two groups:

> "The therapist may recognise the patient's personal aims and the depression and frustration in achieving functional recovery, where the nurse may view the patient as slow, a poor trier, a complainer or else view the therapist as over-firm in approach...."

Felstein's (1980) support and promotion of Occupational

Therapy is understandable from his background as a geriatrician where Alaszewski (1976) predicted that Occupational Therapists "holistic" approach would be a successful professional strategy. It is interesting to note, however, that Smith (1986), who is herself an Occupational Therapist, in a very small study of the views of other professions towards Occupational Therapy, found that the ward sister was the only member of the multi-disciplinary team who could provide an accurate description of the Occupational Therapist's role and that consultants in many cases left it to ward sisters to refer patients to Occupational Therapists. Smith (1986) also uncovered, in the course of this study, the indifference of some doctors towards Occupational Therapy She notes that:

> "One of these consultants admitted that he did not use the Occupational Therapist as much as he should, but did not elaborate."

By contrast, some doctors seem to have attitudes towards Occupational Therapists which demonstrate hostility. An editorial in (TW, 15, 1986) records that an Occupational Therapy forum:

> "gave a slow handclap to a doctor - a member of the state registration board, no less - who, having spoken dismissively of psychiatric Occupational Therapy, went on to remark in a jocular sort of tone that he was a physical medicine man anyway."

The editorial, furthermore, suggests that:

> "there are still many doctors around who take an avuncular view of the professions. They think of therapists as "my girls."

It may be suggested that this group, while not hostile to Occupational Therapy, may have attitudes to women, in general, somewhat out of tune with current thinking on the place of women in society.

The importance to the remedial professions of the spectrum of medical views about and knowledge of their work is very great in view of the resource management initiative. Frazer (1986) a physiotherapist, cited above, is already chafing under the management of a hospital board composed of medicine, nursing and general management. The remedial professions, as a group, do not seem to be securing the kind of place at the "top table" which would enable them to influence events and, since many doctors seem to be either indifferent, patronising, ignorant or working from an emotive agenda with regard to Occupational Therapists, perhaps there will be few lucid exponents of their case. There have been attempts to improve doctors' knowledge of Occupational Therapy, for example, a booklet from the Royal College of Physicians, Edinburgh (reprinted in the British Journal of Occupational Therapy, 1977). One doctor who has an informed and non-emotive approach to the Occupational Therapy profession is Professor

Cairns Aitken who gave a prescient address in 1976 as the Casson Memorial Lecturer for that year (Aitkens, 1976). He noted the focus of Occupational Therapy on defining its differences from physiotherapy; the lack of interest in looking at commonality and the ways in which other professions have managed to combine multiple different groupings under one umbrella. He noted the necessity for all health care professionals to focus on their common interest in their relationships with patients and then made the following observations:

> "It would seem inefficient for a dietician just to prescribe a diet and then expect an occupational therapist to teach the patient how to cook it. Instead of debating your aspirations for a profession of 5,000, it could be one of 50,000 ... a number comparable to those in medicine, nursing or social work. If you were to have a common career structure in some kind of confederation, then one of you too could have a salary of £16,000 per annum, which is that of Strathclyde Region's Director of Social Work."

Section Seven

Current actual skills of Occupational Therapists as validated by research and potential uses of Occupational Therapy.

7.1 For the purposes of this study, the Occupational Therapy service will be viewed from the perspective of the difference it would make to patients or clients if there were no such service. The literature has been searched for examples of Occupational Therapy practice in all areas which have been validated as being of benefit to the client. In view of the cultural specificity of Occupational Therapy, and the extent to which the role of the Occupational Therapist is influenced by public policy and legislation, the validation of the role of the Occupational Therapist has been limited to the British literature. Clearly, as a small profession with little access to research funding, Occupational Therapy is unlikely to have developed a large research base. This review is concerned with the trends and developments in Occupational Therapy research so that areas where Occupational Therapy has a clearly defined and potentially valid scientific base for practice can be identified.

In examining the many areas of health care to which Occupational Therapists contribute, it is difficult to find a satisfactory framework. However, the Golden Jubilee Edition of the British Journal of Occupational Therapy (BJOT, 1987) provides a structure for analysis. This divides Occupational Therapy into services for:

- People with physical dysfunction
- Mental handicapped people
- Elderly people
- Psychiatry
- Children
- Community

This provides a framework which is based on pathology, development stage and area of function, but, since this is the framework chosen by the professional journal of Occupational Therapy, it may be of use in the current task. Each of these aspects of Occupational Therapy will be examined with some examples of current practice, documented within the past five years and evidence of evaluation through research will also be presented. The focus will be on material presented by British Occupational Therapists, or by British Occupational Therapists in conjunction with other professional groups. The five year cut off has been chosen because this may be said to represent the state of the art of Occupational Therapy practice; references before that time may be useful as historic or classic material but will not represent the current situation.

7.1.1 People with physical dysfunction

Occupational Therapy has been involved in many areas of medicine and surgery. One prominent area of involvement has been with patient rehabilitation following a cerebral vascular accident (CVA) or stroke. Turton and Fraser (1988) report on

the development of a battery of tests to assess recovery following a stroke. Crofts and Crofts (1988) describe the use of biofeedback with orthopaedic patients to maintain and develop muscle movements. King and Nixon (1988) describe the development of a cardiac rehabilitation programme. Giles and Allen (1986) describe the role of the Occupational Therapist in the treatment of chronic pain. Stevens, Simms, Jones and Rees (1985) report a study of the views of schools of Occupational Therapy and patients on the use of adapted printing, which they found to be used most frequently in relation to upper limb conditions. Marsh and Smith (1986) report on the use of timed functional tests to evaluate sensory recovery in sutured nerves. Rickards (1984) has developed a method to measure finger joint motion.

These examples of the work of Occupational Therapists in the field of physical disability demonstrate its wide range from the assessment and rehabilitation of the stroke patient to the rehabilitation of hand injuries. The current focus is clearly on developing tools which will then be sensitive to the measurement of change after intervention. Turton and Frazer (1988) provide a model which could be used to validate much Occupational Therapy practice since they assessed stroke patients in nine areas and evaluated the usefulness of the tests used. Maslin (1985) approached the issue differently by asking patients their views about the benefits of Occupational Therapy compared with other types of remedial therapy for example, physiotherapy. This approach may be equally important in validating the benefits of Occupational Therapy since Maslin (1985) notes that patients tend to favour services that help them improve quickly and which work on obvious problem areas. Bumphrey (1987) notes that the earlier focus of Occupational Therapy in the physical field was on the actual provision of activity. Current practice, however, would suggest that the measurement of treatment effect and the patients' perspective on treatment are becoming important areas of research for Occupational Therapists in the field of physical disability.

7.1.2 Mentally Handicapped People

Trevan-Hawke (1986), in a study of authorship patterns in the BJOT, observed that "less than 10 per cent of papers could be categorised under "intellectual handicap." It seems that this remains the case and it was certainly more difficult to find material in this category. Armstrong and Rennie (1986) describe a programme in which microcomputers are used to assist residents who are mentally handicapped to increase concentration and assist in decision making. Several other papers focus on the role of the Occupational Therapist in the Community Mental Handicap Team. Blundy and Prevezer (1986), Curry (1988) and Newman and Donoghue (1988) all focus on the role descriptions of the Occupational Therapist in the community mental handicap team. Curry (1988) offers a straightforward activity analysis and finds that client contact time was over 50 per cent in the two studies he conducted. Blundy and Prevezer (1986) offer a more personal and anecdotal approach which demonstrates concern for role

overlap and role blurring with other professions. One of them notes that:

> "The Occupational Therapist does tend to take on an all-encompassing role; she is able to justify her involvement in such a variety of situations and yet often feels very dispensable - the jack of all trades syndrome. Because of this, I have always felt it important to hold onto some skills that are definitely occupational therapy and do not overlap with other professions, such as aids and adaptations."

By contrast, Newman , Donoghue and Rees (1988) studied community mental handicap teams containing Occupational Therapists and found that in individual work 35 per cent of their time was spent on social skills training and in group work, 38 per cent of their time was spent in life skills training. In summarising the work of Occupational Therapists with people with mental handicap over the past 50 years, Bracegirdle (1987) notes that hospitals for people with mental handicaps have, by and large, functioned without much Occupational Therapy involvement and that role blurring is an important issue for some Occupational Therapists in this area. She suggests that the focus for the future will be in equipping residents for life in the community.

However, Newman, Donoghue and Rees (1988) noted that not all community mental handicap teams employ Occupational Therapists. This naturalistic variation may provide a way in which the work of the Occupational Therapist in this area can be validated, since the outcomes of treatment by teams with and without Occupational Therapists could be compared. Considering the small number of Occupational Therapists who work in this field, there is a very interesting research base developing which could demonstrate the difference Occupational Therapy skills can make when applied in this area.

7.1.3 Elderly People

This is another area where, although the Occupational Therapist has been involved for many years and has clearly been a leader in innovative thinking (Howard, 1987) there is a relatively small amount of literature which could be said to validate the interventions which have often been pioneered by Occupational Therapists. Trevan-Hawke (1986) found that less than 10 per cent of papers fell into this category.

There is a detailed review of the literature concerning memory function and aging (Robertson, 1987) which is an area of importance for Occupational Therapists and could provide the foundation for measuring memory functioning before, during and after Occupational Therapy intervention. Long, Taylor and Hanley, (1988) report on the development of a scale to assess activity developed for elderly people attending a day hospital to enable Occupational Therapists to assign them to the correct activity level. Benson (1985) describes a self-medication survey of patients who are elderly which aimed

at identifying the practical handling difficulties that such people experience with their drugs on discharge from hospital. Corless, Ellis, Dawson, Fraser, Evans, Perry, Silver, Reisner, Beer, Boucher and Cohen, (1987) report a study in which activities of daily living were used as the dependent variable to measure the effectiveness of vitamin D supplements in elderly patients who were long stay. Although vitamin D levels rose in the treated group, there were no significant differences in behaviour as measured by the activities of daily living scores. It is interesting to note that the research reported in this area is so closely linked with pharmacology, since Dunkin and Goble (1982) note that this is an area in which Occupational Therapists do not receive in-depth education. Long, Taylor and Hanley (1988) report on a rating scale to assess elderly patients functioning in a variety of areas performing everyday tasks. Conroy, Findham, and Agard-Evans (1988) report an interesting analysis of the functioning of elderly people suffering from dementia in terms of their engagement in activities. Dawson, Reason and Chick, (1984) attempt to extend the methodology of dependency measurement through formal assessment by Occupational Therapists.

There is a good base for assessment in this field of Occupational Therapy. From the material reviewed, it is fair to conclude that it may be possible to extend this to include more evaluative studies as the assessment tools are developed.

7.1.4 Psychiatry

Trevan-Hawke (1986) notes that psychiatry is the second most popular area for papers in the BJOT. This possibly reflects the historical development of Occupational Therapy from psychiatric nursing (Casson, in Collins 1987). In examining Occupational Therapy intervention in psychiatry, the problem of validating all forms of treatment by all disciplines is raised. It is interesting to note that so much of the research based material is jointly authored by Occupational Therapists and other disciplines. The approaches noted in the physical section are apparent in the psychiatric literature. Johnson and Spratt (1987) report on the results of a study of the planning abilities of patients with schizophrenia using a sorting task and a planning task, compared with patients suffering from other psychiatric disorders and non-patients. This, again, provides some useful tool development which could be used to assess interventions. Stockwell, Powell, Bhat, and Evans (1987) attempt to assess the impact of Occupational Therapy activities through the use of a questionnaire to patients. There are many papers which focus on describing the activities of Occupational Therapists within specialised settings. For example, Occupational Therapists as part of a treatment team using behaviour modification with disturbed adolescents (Schell and Giles, 1985). They found that the Occupational Therapy retained the professional concern of function and rehabilitation while working within a multi-disciplinary team. Miller and Matthews (1988) report on their nine-month long group, run while both were in post as a clinical psychologist and an Occupational Therapist

respectively. The Occupational Therapist and a psychiatric nurse were co-therapists for the group and the clinical psychologist supervised them. There is no evaluation of the impact of the group on this acute admission unit, however, the Occupational Therapist's comments are of interest. She notes the debate within Occupational Therapy as to the importance of Occupational Therapy involvement in psychotherapy and suggests that Occupational Therapists should be involved in both action techniques and verbal psychotherapy. One of the most interesting suggestions to provide validation for Occupational Therapy practice in this area comes from a clinical psychologist (Chamove, 1986), who proposes that activity is an important treatment in long-term mental illness and he demonstrates that Occupational Therapy and work therapy have important short-term benefits. This framework could provide important information to validate Occupational Therapy interventions in the care of people who are defined as long term mentally ill.

Of some importance in the current situation is the disposition of Occupational Therapists in the community as the large hospitals for mentally ill people are run down. There seem to be considerably fewer papers devoted to this area. Voisey (1988) records her experiences preparing a group of people who are defined as long-term mentally ill for life in a group home. Westland (1985) describes the setting up of a relaxation group in a health centre for patients who were attending for GP treatment and receiving tranquilizers. There is, however, no evaluation of this. One of the most interesting studies in this area is that by Vaughan and Prechner (1985). They point out the historic role of Occupational Therapists in developing psychiatric day hospitals over the past 40 years. Their study, however, does not actually investigate the impact of Occupational Therapy in psychiatric day care, rather they analyse the patients' perceptions of what seemed to have helped. Patients found arts and crafts as beneficial as group psychotherapy and valued all staff for their personal qualities rather than professional backgrounds. There seem to be, as yet, no research based studies specifically to evaluate the intervention of the Occupational Therapist in community mental health. There is one study known to the research team currently being conducted by Emck (Personal Communication, S. Emck April 1989) to evaluate the efficacy of a roving day care team organised by an Occupational Therapist containing personnel with a variety of skills in areas such as music and art, providing day-time activities for the mentally ill in the community. This seems to be a promising and important line of research.

7.1.5 Children

Trevan-Hawke (1986) notes this as another area where there are few publications. It is also interesting to review the Diploma syllabus of Occupational Therapy (COT, 1987). Occupational Therapy students study the human life cycle but do not have specific required placements in paediatric units. Rockey (1987) records the development of Occupational

Therapists involvement in paediatrics after World War II. She notes that current practice has been much influenced by the Education Act of 1981 and the mainstreaming of children with disabilities into local schools.

However, there is, as yet, little evidence of validation of current Occupational Therapy practice in this area. Three recent papers focus on the role of the Occupational Therapist in child psychiatry. Copley, Forryan and O'Neill (1987) record case work done by an Occupational Therapist under the supervision of child psychotherapists. Davis (1985) records her work with a child who had been sexually abused, while Irving, Carr, Grawlinski, and McDonnell (1988) describe an assessment programme for families with physically abused children and highlight the role of the Occupational Therapist in assessment. On the physical side Kelly (1987) reports the use of sensory integration as a treatment technique for speech and language disordered children.

Chia Swee Hong (1984), Roberts, Marlow and Cooke (1989) and Fairgrieve (1989), focus on physical problems which may lead to perceptual motor difficulties in children. There is an emphasis on developing means of assessment. It may be that, as Occupational Therapists become more involved in this area of work as a result of legislation, the profession will have to re-consider its curriculum.

7.1.6 Community

Trevan-Hawke (1986) again records this as an area which is not yet well reported. Occupational Therapy in the community seems to have developed at the end of the 1950s and to have expanded greatly during the 1970s as a result of the Chronically Sick and Disabled Persons Act 1970. Much of the work of the community Occupational Therapist has developed because of the provisions of this act and much of it has had a physical focus. Since the issue of the Occupational Therapist in relation to the mentally ill in the community has been dealt with, this section will focus on the development of research-based practice for the physically disabled in the community.

A clear theme in the research emerging from Occupational Therapy practice in the community is that of classifying decisions about assessments for aids, adaptations and housing. Phillips and Stewart (1985) present a coding system for the housing needs of people with disabilities, developed to provide a less haphazard system for re-housing based on clients' functional abilities rather than emotional or political responses. Abraham, Boyle, Clamp and Robson (1987) developed a framework to provide a structured system within which reasons for Occupational Therapy recommendations could be presented.

A very interesting development, in view of the strictures of the Borrie Report (OFT, 1982) as regards the monopoly that dispensing opticians had established over the supply of spectacles, is that of Garbutt (1989) who reports on the

development of self-assessment forms for clients in the community. This would seem to be a valuable beginning in involving the service user more actively in the assessment process.

A further area in which research is just beginning is that of the liaison between hospital and community services. This is particularly important for elderly people as has been noted by Carter (1989) in her evaluation of her role as a community Occupational Therapist.

The development of jointly funded posts by health authorities and social services departments of local authorities could have significant impact on the pattern of admission and re-admission to hospital of vulnerable people. This line of research will probably become of great interest as patterns of community care are evaluated.

7.1.7 Summary

There is already a good amount of research material in most areas of Occupational Therapy practice. The range of work of Occupational Therapy is presented in the large amount of anecdotal material which is useful but it does not address the issue of the effectiveness of Occupational Therapy interventions as research based material does. Current research in most areas of Occupational Therapy focusses on the assessment of patients and clients and a base for the validation of Occupational Therapy interventions is being established. As research develops, it is possible that the definition of important variables, a *sine qua non* for the development of good empirical studies, will continue. Occupational Therapists seem to have been focusing on the development of tools for assessment in most areas of practice, and will be able to assess the effectiveness of intervention as a result of these instruments.

7.2 Potential uses of Occupational Therapy

Occupational Therapists have been encouraged to work in many areas by many different people. Given the generic educational basis and its practical orientation, it is not surprising that Occupational Therapists are seen as a very flexible, all-purpose source of professional skills in the health and social service arena.

Age Concern is recorded (*TW*, 16, 1986) as suggesting that Occupational Therapists, along with physiotherapists, and dieticians, should work with GPs in the primary health care team. As noted previously, Occupational Therapists have already expanded into areas such as opening a tranquilizer withdrawal clinic (*TW*, 5, 1986). Occupational Therapists are now being urged to work with AIDs victims (*TW*, 17, 1987). It has also been suggested that Occupational Therapists are the ideal group to work with the victims of child abuse (News item, *BJOT*, 1988). Other areas in which Occupational Therapists can be found are those of chronic pain (Giles and Allen, 1986) and as technical sales representatives in

companies selling equipment to the disabled (Hemsworth, 1982). Spashett (1981) described the profession as "dabblers." Ellis (1987) has suggested that Occupational Therapists' flexibility and willingness to work in different areas has not been to the profession's advantage. Nonetheless, the generic training base of the Occupational Therapist seems to inspire remarkable self-confidence and an entrepreneurial spirit. In considering the potential users of the Occupational Therapy profession, it is clearly of importance to look at the potential for Occupational Therapy which is implied already in current legislation. One of the most important pieces of legislation which is at present being put into practice is the Disabled Persons (Services, Consultation and Representation) Act 1986. Since the OPCS Survey (1988) estimates that there are 6,000,000 people in the UK with some degree of disability, then the key provisions of this Act, such as the duty of local authorities to consider the needs of disabled people, represents an enormous challenge to the qualities of entrepreneurship, self-confidence and flexibility which seem to be characteristic of Occupational Therapy professionals. Clearly if current Occupational Therapy practice continues, it would be impossible to provide adequate numbers of Occupational Therapists to fulfil the obligations placed on local authorities by the act. The issue of manpower demand and the nature of that demand will be dealt with in the subsequent section of this review. However, it is important to note some of the potential for change to traditional local authority practice which could be initiated by Occupational Therapists.

Bristow (1984) in her interesting study of the role of the Occupational Therapist in social services departments, makes some very interesting observations. First, the volume of referrals that social service Occupational Therapists receive is "a source of considerab concern" (p.135). Further, she notes the general picture of referrals can be summarised as large numbers of elderly clients who need relatively simple aids and equipment, and a smaller group of younger and middle aged clients who frequently have more severe handicapping conditions. Although Occupational Therapists in social services departments derive much satisfaction from their jobs, it must be noted that Bristow (1984) records the following as areas of irritation to some Occupational Therapists:

"1. Volume of referrals - particularly for minor aids and minor problems.
2. Routine clerical procedures.
3. Delays/time wasters......
4. Lack of Resources - refers to insufficient time, finance for provision, staff or facilities." (p.245).

Bristow (1984) also lists six other sources of irritation. However, the first four listed (above) are particularly germane to this review since it is in these areas that Occupational Therapists could make considerable changes in their work practices.

As has already been noted, skill mix as a concept is very ill

defined and the framework suggested by Celentano (1982) has been used to illuminate this issue. From that, it has been noted earlier that disabled people in the community are likely to have far stronger motivation for Occupational Therapy assessment because of the inherent economic implications. Furthermore, as has already been noted, the position of Occupational Therapists working in local authorities with regard to the provision of aids and equipment is analogous, but not identical, with the dispensing optician. Occupational Therapists supply aids and equipment such as is permitted through local authority finance departments.

Local authorities have a duty under the 1970 Chronically Sick and Disabled Persons Act, reinforced by the Disabled Persons (Services, Consultation and Representation) Act 1986, to decide:

> "whether the needs of the disabled person call for the provision by the authority of any services in accordance with section 2(1) of the 1970 Act (provision of Welfare Services).

Organisations of disabled people are themselves becoming increasingly active in ensuring that they use the provisions of the 1970 and 1986 Acts. Saunders (1987) notes that assessments under the Act are open to problems:

> "If his questions are limited to filling in the squares on his form, and you do not volunteer the right information the assessment may go wrong.
>
> "Another unfair aspect of assessments arises where the assessor and the provider are the same person. If the community Occupational Therapists have a fixed budget for aids and there is insufficient money to buy the stair lift would the Occupational Therapy say: 'yes, you need it but we cannot give it to you?'"

A further aspect of that issue has been referred to earlier: since assessor and provider are the same person, it may be asked to what extent are Occupational Therapists assisting local authorities in creating a monopoly on supplies of items of equipment? What sort of choice are disabled people offered when they have to get an assessment because their economic circumstances are such that this is the only way to get an important aid to daily living?

Saunders (1987), himself a wheelchair tetraplegic, notes the role which disabled people themselves can have under Sections 1 and 2 of the 1986 Act which allow the disabled person to choose an advocate:

> "Often another disabled person with a similar handicap will make a good representative."

By broadening the concept of skill mix in Occupational Therapy to include people with disabilities and by encouraging disabled people into the profession, as registered members or

as helpers, perhaps Occupational Therapists could tap into the group with the most obvious interest in developing the Occupational Therapy profession, an important use of the concept of the active citizen. Occupational Therapists also could use the potential of information technology, currently being developed at St Loye's School, Exeter, so that instead of filling in a form on behalf of the client, clients could be asked to provide a computerised (or manual) self assessment form. This would be an extension of work already being developed by Garbutt (1989). The professional skills of the Occupational Therapist would lie in the devising of valid and reliable assessment tools and working with people with more complex problems rather than making multiple home visits for relatively simple aids and adaptations.

A further way in which the potential of the professional expertise of the profession could be tapped would be by the development of expert systems. Expert systems have already been developed in other professions such as law and medicine. The expertise of Occupational Therapists, particularly within the ergonomic model, in which the Occupational Therapists uses her expertise to resolve human/environment interface problems, could well be adapted into an expert system to allow disabled people and their carers or their advocates to make assessments of very complex needs. In this way Ellis' (1987) concept of the Occupational Therapist as a "beacon of light" could be used for the benefit of the service user.

A further potential use of Occupational Therapy arising from legislation currently before parliament (Local Government Bill) may be suggested. Local authorities will in the future, if the legislation passes into law, be allowed "to provide services of any description for owners or occupiers of houses in arranging or carrying out works of maintenance, repair or improvement" (pIX, p.110 Local Government and Housing Bill). Local authorities may give financial assistance in any form to housing associations, charities or anybody approved by the Secretary of State (p.110). The potential for Occupational Therapists to bid for the provision of home adaptations for the disabled would seem to be there. This would allow Occupational Therapists to become independent of local government bureaucracy and external, non-Occupational Therapy management and would provide them with the incentive to pursue self assessment forms and expert systems. The issue of the creation of a monopoly in the supply of aids and equipment to those in economic need would have to be resolved. However, Occupational Therapists who took advantage of this opportunity would be enabled to work as "ideal" or true professionals since they would form firms, much as the legal profession now does, working on a contract basis.

The issue of the role of the Occupational Therapist with the mentally ill and mentally handicapped in the community will, no doubt, be affected by the Griffiths Report on Communicy Care and also the way in which local authorities choose to fulfil their obligations under Section 7 of the 1986 Disabled Persons Act. It would seem from the research evidence that Occupational Therapists have long experience in the area of

Day Hospitals and would have much to offer local authorities implementing Section 7 of the Act.

Much of the potential for the Occupational Therapy profession seems to arise from legislative changes and developments in the public policy arena as regards services to the groups which could benefit from the interventions of Occupational Therapists. This issue is one which is considered in some detail in the Policy Analysis Chapter.

Section Eight

Supply and demand

8.1 Introduction

The demand for Occupational Therapists has never matched the supply. Dunton noted this in Dunton and Licht (1951) and suggested that it was a feature which made Occupational Therapy an attractive profession (p.vi). The concept of "shortage" in Occupational Therapy has, therefore, been an ever present part of its history. It would seem that there have never been "enough" Occupational Therapists. Yet the shortage phenomenon is never straightforward. There are many different types of shortage in the labour market. It may be that there is a shortage of entrants to the profession because it is an unattractive option. (TW, 18, 1986) published a news report based on the Management Side's evidence to the Professions Allied to Medicine Pay Review Body. The report notes that:

> "In Occupational Therapy the limited number of training places is a far more important factor in staff shortages than pay levels, the management side says, and it proposes some modest expansion, probably four schools in England."

A report published later in the year (June 1986) notes that when asked about the shortage of Occupational Therapists and the need for degree level education, a junior government minister is reported as saying:

> "Although demand for Occupational Therapists exceeds supply, I do not accept that present shortfalls are related to standards of training.
>
> There is no shortage of students applying for entry to Schools of Occupational Therapy and over the last eight years numbers of qualified Occupational Therapists employed in the NHS have increased on average by about six per cent a year." (TW, 19, 1986).

Consequently it may be assumed that Occupational Therapy, despite the falling number of eighteen year olds, is likely to be seen as an attractive option by many school leavers.

This is an important issue because, if Occupational Therapy is a particularly attractive health care profession, then it may help in maintaining entry to the health and social services of newly qualified professionals at a time when all health care professionals are likely to be in short supply as the number of 18 year olds in the population drops. The shortage of Occupational Therapists does not, therefore, lie in the profession's lack of attraction to applicants. The suggestion, at the level of public policy, is that there is a shortage of Occupational Therapists because of a lack of training places. This takes the argument back to where it

began, the mismatch between supply and demand. Yet there are many questions which must be asked about this issue. These include:

- When would there be "enough" Occupational Therapists?
- How would we define "enough" Occupational Therapists?
- Who should define "enough" Occupational Therapists?

There have been few attempts until recently to ask such searching questions of any health care profession. However, a body of policy documents and research into the issues of health manpower is now being developed. The National Audit Office report (NAO, 1986) on "Control over Professional and Technical Manpower" suggests that three areas are of importance:

> "demand forecasting based on service requirements and available cash; supply forecasting made in the light of service developments and available cash, current staff numbers and intakes to training schools; and finally the matching of supply and demand." (p.14, para 3.2).

They are not alone in noting that demand forecasting seems to be highly inexact and little attempted, for Long and Mercer (1985) make a similar point:

> "Estimates of the demand for AHPs have rarely extended beyond staffing norms" and "But although demographic and epidomiological factors affect the demand for AHPs, there have been few attempts to trace through this relationship."

The NAO (1986) report examines carefully the often cited and much misunderstood claim that workforce projections which forecast a required increase in the NHS of 73.4 per cent of Occupational Therapists from 1984 to 1994. This has been translated into:

> "There is a shortage of about 1700 Occupational Therapists in the NHS and Social Services at a time when an expansion of services requiring a 79 per cent increase in Occupational Therapy staff is required...." (TW, 20, 1989).

In fact, this "required increase" seems to be an aggregation of demand for Occupational Therapists from the 14 regional health authorities all of whom seem to plan personnel provision in entirely different ways. The NAO (1986) notes that:

> "Planned provision of Occupational Therapists per 100,000 population, ranged from 7.6 to 19.98." (p.15, para 3.8).

It is noted further that these wide variations led the Manpower Planning Advisory Group, which collected the data, to question the reliability and basis of long term demand

forecasts for Occupational Therapists and to conclude that simple aggregation of current regional projections was not a reliable indicator of demand. However, it seems likely that the regional aggregations of demand were themselves aggregations of the district health authorities demands. If the definition of "enough Occupational Therapists" were to be based on the regional health authorities with the largest forecasts then the manpower implications would be quite different than if they were based on the regions with the lowest forecast demand.

A further analysis is that by Gray, Normand and Currie (undated). The significance of the turnover rate among Occupational Therapists may have been overlooked previously since Gray, Normand and Currie note that while nurses account for 48 per cent of all leavers in their sample of 37 DHAs, their turnover rate is lower than other groups, while the professional and technical group which includes Occupational Therapy has a higher turnover rate but accounts for less than 10 per cent of all leavers (para 4.13, Pp24-25). Gray, Normand and Currie note the importance to the NHS of turnover and suggest that very little is known about this phenomenon partly because of lack of data and partly because of lack of thought as to the kinds of costs it may involve (para 6.1, p.39). They suggest that turnover may cost the NHS up to £50million per annum in England.

The importance of a rigorous analysis using clear definitions of terms is apparent. Such an analysis may be developed using the framework devised by Long and Mercer (1985) on the basis of extensive research into the processes of health manpower planning. In their "Evaluative checklist of the Health Manpower Process" (Long and Mercer, 1985, p.228), they suggest that there are four areas which should be explored:

- Planning
- Production
- Management
- Integration of planning, production and management.

These may be defined briefly as:

Planning has as its objective the specification of numbers and composition of health teams to achieve the agreed health goals of society. Clinical questions about current and future roles of professions, skill mixes and the impact of the health team would help to provide a systematic assessment of manpower requirements. There should also be a searching assessment of existing and future stocks of manpower and flows of manpower. The match between manpower supply and requirements of the system to meet agreed health objectives is crucial.

Production concerns the number and type of manpower required. Long and Mercer (1985) point out that it is critical to ask how far and in what ways education and training organisations are responsive to and orientated towards service needs. There has to be careful study of the ways in which curricula are

linked to expected and desired manpower roles.

Management has as its objective the need to deploy manpower effectively, use the optimal skill mix and ensure that health goals are reached. The recruitment, motivation and optimal deployment of skills within the workforce are of great importance.

Integration of the three above areas should occur to ensure that planning, production and management are considered. Integration involves examining plans, their implementation, their costs in human and monetary terms and their monitoring.

In applying this checklist to the manpower issues in Occupational Therapy, many interesting insights emerge.

8.2 An evaluation of Occupational Therapy manpower using the "Evaluative Checklist of the Health Manpower Process."

8.2.1 Planning

The objective of planning is said by Long and Mercer (1985) to be the specification of

> "the number of teams and their composition needed to improve the level of health up to a proposed level."

To achieve this, they suggest, there should be a systematic assessment of manpower requirements, supply of manpower and the match between the two.

8.2.2 Manpower Requirements

This should be based on an exploration of current and future roles, skill mixes and staff mixes in the multidisciplinary team. Currently Occupational Therapists are employed in the NHS, local authorities, the private sector and the voluntary sector. The outstanding feature of Occupational Therapy manpower is its extreme flexibility. Current roles vary widely as was noted earlier. However, major developments in the Occupational Therapy role often seem to have developed as a result of legislation and this is likely to be the case in estimating requirements for Occupational Therapy in the future. Skill mix and staff mix are issues which are only now beginning to be defined and explored. The current study of skill mix in Occupational Therapy may lead to the development of a method to estimate the proportion of work in Occupational Therapy departments which needs to be performed by professional Occupational Therapists. Staff mix is an even more nebulous concept, touched on in Long and Mercer (1985) who strongly recommend that manpower planning should be based on an examination of skills available within teams to meet health objectives. The National Audit Office (NAO) "Report on Community Care" (1986) also looks at this issue. It seems to accept the conventional wisdom that there is a shortage of Occupational Therapists largely because of inadequate numbers of training places (although, as will be seen later, this is not necessarily the only interpretation of the Occupational

Therapy manpower data base) (paras 139-141). However, it points out the:

> "risks and difficulties inherent in a manpower planning approach which involves predicting the numbers required in each separate professional group and then attempting to deliver just the right mix. The skills described above for Occupational Therapists are too important and too fundamental to the new community care service to be restricted to a small specialist cadre that cannot hope to meet demand in the forseeable future." (para 142).

It is also important to note that this report adopts a very clear definition of Occupational Therapy as based on practical skills:

> "....Occupational Therapists are currently responsible for the specification of activities for people to help them reach their maximum level of function and independence in all aspects of daily life, the assessment of handicap, and the selection of aids and design of adaptations to buildings."

The report is, therefore, predicated on the assumption that these are the core skills of Occupational Therapists and that since the Occupational Therapy profession is unlikely to be able to fulfil the requirements for these in the near future, professional Occupational Therapists should be reserved for situations where very specialised skill is required (para 142). They go on to emphasise the need for skill sharing and shared learning.

It may be deduced from the above that the following are requirements for assessing Occupational Therapy manpower, given that Occupational Therapy is as defined in the NAO report on Community Care,

- current and future legislation concerning the provision of services to vulnerable groups who would benefit from Occupational Therapy
- the proportion of work which should be performed directly by Occupational Therapists; work which should be performed by Occupational Therapy Helpers and work which could be performed by other occupational groups such as home helps either after training by Occupational Therapists or under Occupational Therapy supervision.
- the groups for whom there is demonstrable benefit in having Occupational Therapy as part of the staff mix.

The Occupational Therapy profession itself has been active in attempting to fulfil some of these requirements since it has produced staff norms for hospital Occupational Therapy and a report on future needs and numbers in community Occupational Therapy The College of Occupational Therapists' document "Recommended minimum standards for Occupational Therapy staff patient ratios." (College of Occupational Therapy, 1980) puts forward a formula by which numbers of Occupational Therapists

may be calculated. This notes that:

> "The recommendations are based on experience of Occupational Therapists in various parts of the country in a wide range of health districts."

Long and Mercer (1985) found in their study of ways in which Health Authorities plan manpower needs, that professional judgement is still a dominant factor in planning but is no longer seen as sufficient. There is a move to workload based approaches (p.140). This is embodied in the Occupational Therapy profession in the later document produced by the College of Occupational Therapists "Community O.T: Future needs and numbers" (College of Occupational Therapy, 1984). In a wide ranging review of community Occupational Therapy, estimation of manpower requirements is made based on epidemiological data concerning the prevalence of disability, current work loads and working practices of Occupational Therapists, clerical and technical support and the presence of Occupational Therapy helpers on the team. This is probably the most rigorous plan for Occupational Therapy manpower and the nearest to the model for health manpower planning proposed by Long and Mercer (1985). The complexity of the issue is not shirked and it is noted that more work is needed on the method, but these guidelines

> "represent a reasonable basis for examining the current level of provision and assessing the extent to which change is needed." (P.54).

8.2.3 Production

As noted earlier, Long and Mercer (1985) suggest that education and training should be examined for their responsiveness and orientation to service needs and the ways in which curricula are linked to expected and desired manpower roles.

In this area Occupational Therapy, along with several other Professions Allied to Medicine, is described by Long and Mercer (1985) as second only to the medical profession in terms of control by bodies external to the National Health Service which may pursue their own goals for curriculum development and patterns of training. (p.38). They list the many bodies which may have interests in the production of Professions Supplementary to Medicine: health departments, regional health authorities, NHS and Private Schools, CPSM, Boards of the CPSM, professional organisations, DES, LEAs and DES, LEAs and educational institutions and regional advisory councils (p.39). They also point out that the Professions Supplementary to Medicine are distinguished from other occupational groups within the NHS because of the duality of their professional associations which act simultaneously as trade unions and as validation bodies for courses. They suggest that this gives these groups influence over:

> "the numbers in which manpower is produced, the roles

> for which they train and subsequently adopt, and in some cases the workload which they are expected to undertake." (p.38).

Another factor, in general terms, in production is the influence of central policy on NHS manpower targets since it is the Department of Health which

> "limits the number of people by category of manpower to be employed by each Region..." (p.49).

They suggest also that it is the availability of manpower which dictates the sort of services to be provided (p.49).

In reviewing Occupational Therapy in the light of these factors, it is interesting to examine developments within the Occupational Therapy profession. The difficulty in establishing a specific role definition within Occupational Therapy, not just in this country but also in the country where Occupational Therapy originated, the USA, (Jay 1981, Yerxa and Sharrot, 1986) has been noted previously. Consequently, it is difficult to assess orientation to service needs and the link between curriculum and the outcome of expected and desired manpower roles. It may be suggested that Occupational Therapy, as a highly flexible health care profession, is also highly responsive to immediate local needs (Ellis, 1988) but this has also led to an aura of dilettantism which has led to accusations of dabbling (Spashett, 1981). It is certainly the case that many, but not all, Local Authorities have found Occupational Therapists to be a convenient group to assist them in carrying out their statutory obligations because of their didactic and enabling skills in assisting people with disabilities (Smith, 1987). However, there is also evidence that some of the profession's initial sponsors, the medical profession, have little interest in Occupational Therapy and question its value (Smith, 1986).

The organisation of education, validation of courses and training support is quite complex. There are private Occupational Therapy schools, NHS schools and schools within the higher education system. It would be possible, currently for courses to go through as many as four validating bodies: the Validation Board of the College of Occupational Therapists, the Occupational Therapy Board of the CPSM, the internal validation procedure of a college, polytechnic or university and the CNAA (if the course were to be approved for degree or academic diploma status). Anecdotal reports to the research team have suggested that the validation process has been very complex and has resulted in delay in the establishment of courses, but no written evidence within the public domain has been found to support these reports. Funding of student bursaries, course fees, and capital expenditure is provided mainly by the Department of Health for English and Welsh students, the Scottish Education Department and the Department of Education and Science in Northern Ireland. Apart from these national bodies, the only other significant source of funding for Occupational Therapy training comes from health authorities. This amounted to 13 per cent of all

funding for students from England and Wales in 1987 (source: Council of Heads of Occupational Therapy Schools, Annual Return of Student numbers, Paterson, 1988). Furthermore, it is interesting to note that although approximately 1,000 Occupational Therapists work for English local authorities (DHSS, 1987) as opposed to approximately 4,500 working in the NHS in England (DHSS, 1988) giving a ratio of Local Authority to NHS Occupational Therapists in England of approximately 1:4, English Local Authorities funded only 1.8 per cent of Occupational Therapy students.

Although there is no evidence that the Occupational Therapy professional body has ever attempted to use its potential for control to limit numbers entering the Occupational Therapy profession, as Long and Mercer (1985) suggest may have occurred in radiography, the professional body has been very active in examining the issue of shortage in Occupational Therapy. It seems to be received wisdom that the shortage of Occupational Therapists springs from the lack of training places and that the problem of shortage can be resolved by expanding training places and opening new Occupational Therapy schools. This ignores the possibility that the shortage of qualified Occupational Therapists may have arisen from other sources for example, a failure of qualifying students to enter the profession or a high wastage rate during training. In an Appendix to a letter from the Chief Executive of the NHS Management Board, (Peach, 1987) it is noted that the Board concurs with the view of the Committee of Public Accounts that:

> "the number of training places for Occupational Therapists should be increased."

The National Audit Office Report on Community Care (1986), however, notes the limitations of this approach and suggests that it is unlikely that training places can be expanded sufficiently to fill the requirements for Occupational Therapy skills in the community. The report argues that a manpower planning approach based on predicting the precise numbers required in each profession and hoping to deliver the right mix is fundamentally flawed and that the important skills of Occupational Therapy should be made more widely available possibly through a core skills curriculum for all those involved in the delivery of community care, leaving a "small specialist cadre" of Occupational Therapists to provide services in the most complex cases (p.63). The British Association of Occupational Therapists(1984) pointed out that the shortage of Occupational Therapists in the NHS was strongly linked to salary levels and that the drain of staff from NHS to local authorities was, at that time, a result of the disparity between remuneration levels. Indeed, it was noted that the policy of increasing training places in physiotherapy to increase the supply of qualified practitioners was like throwing "a bucket of water onto sand" (CSP, 1988). As was noted earlier, there seems to have been, so far, little difficulty in recruiting students for Occupational Therapy courses. Paterson (1988) notes imprts in the numbers of students qualifying:

"The percentage of students successfully completing the course has slowly increased from 78% for the 1975 intake, to 85.7% for the 1983 intake and the indications are that this success rate will at least be maintained for the students currently on courses. This rate is now in line with rates in Higher Education."

To summarise, the production of Occupational Therapists may be viewed, therefore, as increasingly efficient, although the NAO report (1986) hints at a need for skill re-alignment to the requirements of community care and the professional association's contribution would suggest that economic factors may weigh heavily rather than production factors in maintaining the Occupational Therapy workforce. A further issue which is linked to the third area of evaluation, that of management, may be the extent to which the Occupational Therapy curricula truly prepare students for the real world of Occupational Therapy work. Because turnover issues have so rarely been investigated amonge the Professions Supplementary to Medicine, the factors which influence this can only be mere speculation. Only one small study has been found which would suggest that Occupational Therapy students may have distinct preferences about future positions. Bentley (1985) found that around one third of students leaving the Exeter school would consider post with the elderly of mentally handicapped and about 45 per cent would consider posts with the mentally ill. There was, however, no exploration as to the factors which had influenced them in these preferences, although most of the students seemed to be willing to work with the physically ill.

8.2.4 Management

The management of Occupational Therapy was analysed carefully by Long and Mercer (1985, p.108). They commented that literature pertaining to the management of all the professions supplementary to medicine was "extremely sparse," but such material as is available examines the disputes about the merits of administrative self-management versus general management (p.106). The role of the District Occupational Therapy seems, in general, to be advisory where it exists rather than strictly executive. Establishing resonsibility for the manpower issues related to management is, therefore, quite difficult. Long and Mercer (1985, p.228) pose four questions concerning management. They ask:

- the extent to which people with desirable characteristics are recruited
- the extent to which manpower is utilised optimally
- the extent to which manpower is sufficiently motivated
- the extent to which the quality of services is maximised?

District Occupational Therapists will generally be responsible for recruitment of adequately qualified personnel and for their disposition within the Occupational Therapy service. However, this may not be the case within local authorities where it has been noted that Occupational Therapists may be evaluated on recruitment by other professionals, usually

social workers and managed by them (Bristow, 1984). The motivation of manpower and the extent to which quality of services is maximised, are likely to be functions of the District Occupational Therapist in the NHS in conjunction with the general managers. In view of the high turnover rates of the professions supplementary to medicine compared with similar professions, motivation is a factor which, it may be suggested should be investigated. As noted above, motivation may be affected by economic rewards or by role expectations but lack of evidence as to the motivation of Occupational Therapists to remain within the NHS or within the profession means that these suggestions are entirely speculative. The issue of optimal utilisation of Occupational Therapy personnel as a factor in the evaluation of manpower management provides an interesting link with the earlier definition of skill mix offered by Celentano (1982).

Long and Mercer (1985) suggest that this may have been affected by economic factors such as the need to make efficiency savings in the NHS:

> "Changes in resource availability have easily overridden other indicators of need." (p.99).

It would be interesting, therefore, to apply the first of Celentano's (1982) tests of optimal utilisation - for whom is this an issue? - to the recent past to establish the impact of economic factors on skill mix and the concomitant impact on services to consumers.

8.2.5 Integration

Long and Mercer (1985) propose that the final area in which the health manpower process should be evaluated, is that of the integration of the planning, production and management dimensions to achieve health objectives. This kind of integration is in fact the goal of the Manpower Planning Advisory Group, which has established this present study of Occupational Therapy so that such evaluation can occur on the basis of accurate information.

8.3 Issues arising from the Evaluative Checklist

Issues of supply and demand in Occupational Therapy seem to be affected by many factors including

- the definition of Occupational Therapy itself
- the education of a specialised cadre versus the dissemination of skills
- the underlying motivations for relatively high turnover levels
- the economics of the NHS
- the deployment of Occupational Therapists in local authorities
- the difficulty of devising a method to calculate the need for Occupational Therapists.

Above all, there would seem to be a very weak relationship

between the production of Occupational Therapists and their deployment within the service. It may be suggested that these many factors will be of importance in resolving the issues of supply and demand in the rehabilitation service.

Section Nine

Sources of manpower information and the costs of Occupational Therapy services.

9.1 Registration

The register of Occupational Therapists is one source of information about the stocks of Occupational Therapists. However, there are limitations on the information which can be extracted from this. Registration is required for the following:

- Occupational Therapists working in the NHS throughout the UK.
- Occupational Therapists working in local authorities in England, Wales and Northern Ireland but not in Scotland.

The Council for the Professions Supplementary to Medicine (CPSM, 1988, p.30) makes the point that these restrictions are not imposed by the CPSM itself but by the regulations of the NHS and local authorities.

Occupational Therapists working in the private sector or in local authorities in Scotland may not necessarily be registered, although, in practice, many of them will be. Occupational Therapists working in local authorities and the NHS must be registered and renew that registration annually. Those not in employment may allow registration:

> "to lapse and to restart it again when required on payment of a small re-instatement fee (currently 1.70)," (CPSM, 1988, p.30).

Given the above, it is interesting to note that as at June 1, 1988 there were 9,915 Occupational Therapists on the register, as compared with 7,890 Occupational Therapists as at June, 1985. This represents an increase of 25 per cent in 3 years. It is also interesting to note that in 1986, approximately 4,500 NHS Occupational Therapists, 1,000 local authority Occupational Therapists and 500 voluntary sector Occupational Therapists were in the workforce, leaving approximately 2,000 Occupational Therapists on the register who cannot be accounted for. As well there was the group of Occupational Therapists in employment in Scottish local authorities and in the voluntary and private sectors who may not have been registered. The register, however, does not have as its goal the provision of information about stocks of manpower, rather it is to ensure that the public is protected from incompetent practitioners. Information about active versus inactive status, retirement or change of profession cannot be gleaned from this source. However, cases of misconduct and removal from the register are recorded. Very few cases of misconduct and removal from the register have ever been brought. For example, in the CPSM Annual Report, 1987-8 (CPSM, 1988), the Disciplinary Committee of the Occupational Therapy Board considered only one case which was an application for restoration to the register. It is apparent that removal from

the register is not, therefore, a significant source of loss of available manpower from the Occupational Therapy profession.

9.2 Information about the numbers of Occupational Therapists in the population

There are several sources of information about the numbers of Occupational Therapists but much of the existing information is conflicting and confusing. Information may be divided into:

- the numbers of qualified Occupational Therapists in the population
- the numbers of Occupational Therapy students qualifying each year in Great Britain
- the numbers of qualified Occupational Therapists and helpers employed in England, Scotland, Wales and Northern Ireland
- the numbers of qualified Occupational Therapists and helpers employed in psychiatric hospitals in England.

9.2.1 The numbers of qualified Occupational Therapists in the population

Since it has already been seen that the Register of Occupational Therapists does not provide an adequate basis for estimating the numbers of Occupational Therapists potentially available, other sources have been consulted. Thompson (1988) performed a manpower analysis of stocks and flows within the North East Thames Regional Health Authority. She studied the situation from the point of view of manpower flow and argued that when there are steady flows of manpower within a system and there are staff shortages, shortage is caused by too few people entering the system. Thompson (1988) found no evidence that there were significant losses of staff from the system and suggested that those leaving tend to return. However, she collected data only from Occupational Therapists who entered and remained within the registration system and she pointed out that there could have been people who were not on the Register who were excluded. Thompson (1988) concludes that the only way to resolve high vacancy factor rates is to increase the number of training places since there is no evidence of significant losses when people enter the system.

Wheeler (1989), however, set about the task of assessing the numbers of qualified Occupational Therapists in the population. He contacted the Schools of Occupational Therapy for the numbers qualifying. This led to an estimate of 25,000 Occupational Therapists, which may be affected by phenomena such as migration and mortality. This would mean that as many as 15,000 qualified Occupational Therapists were not on the Register. It seems likely that Wheeler's figures are rather an over-estimate and that since very few Occupational Therapists were produced in the 1950s and 1960s it is possible that the true figure is likely to be lower. Clearly, Thompson (1988) could be correct in stating that there are no significant losses from within the system. However, her

conclusion that the numbers of Occupational Therapists can be boosted only by increasing the number of training places would seem to be unjustified; if substantial numbers of Occupational Therapists are not working in the profession, there may be scope for increasing the number of returners instead.

9.2.2 The numbers of Occupational Therapists qualifying each year

The major source of information for these data is the Annual Return of student numbers compiled by Paterson (1988). This demonstrates that the numbers starting training have increased from 577 in 1975 to 834 in 1985. The numbers starting training in the United Kingdom alone are available from 1986. In 1986, 787 started training and in 1987, 887 started training. The numbers withdrawing and the numbers qualifying have changed considerably. In 1975, 22 per cent withdrew from training and 78 per cent (448) qualified. In 1985, only 11 per cent had withdrawn from training after two years and 742 were due to qualify. As will become apparent, read in conjunction with data to be discussed below, it is uncertain as to the destination of the students on qualification, and, in view of the continuing high vacancy factor, despite the fast increasing numbers from schools and Thompson's (1988) evidence of a free-flowing manpower system, there would seem to be significant losses of manpower occurring on qualification.

9.2.3 The numbers of qualified Occupational Therapists and Helpers employed in the National Health Service and Social Service Departments in the United Kingdom

Data concerning these statistics are available from a variety of sources. The following have been consulted for this study:

1. Health and Personal Social Services Statistics for England.
   (Dept. of Health, 1988)

2. Local Authority Social Services Statistics, England.
   (DHSS, 1987)

3. The facilities and services of mental illness and mental handicap hospitals in England.
   (DHSS, 1987)

4. The NHS Workforce in England.
   (Dept. of Health, 1989)

5. Occupational Therapists in Scotland (NHS)
   (Scottish Office, 1988)

6. Occupational Therapists in Northern Ireland Area Boards (Health and Social Services)(Northern Irish Office, 1989)

7. Occupational Therapists in Wales.
   (Welsh Office, 1989)

These seven sources may be described as the major official sources of information. Alongside these further sources may be cited:

8. Professions Allied to Medicine and Related Grades of Staff (PT"A") Council - Staff Side Evidence
   Paper 1, Demand, shortages, recruitment and retention of staff.

9. Manpower Survey, Independent Commission of Inquiry (COT, 1989).

10. Occupational Therapy Service in Social Service Departments. (ADSS, 1988).

Establishing the numbers of Occupational Therapists and Occupational Therapy helpers actually working in the National Health Service and social services departments is a complex task. The numbers of people in positions has to be differentiated from the Whole Time Equivalent numbers. Similarly, the numbers of positions may be divided into posts which are funded and filled; posts which are funded but unfilled and posts which may have once been included in a notional establishment but which have never been funded or filled. Some posts may also have been funded and filled but are surplus to requirements. They may remain part of the establishment even though they are redundant due to re-organisation or may no longer be filled for reasons of productivity or economy.

For the purpose of this project, it seemed to be important to examine the data in terms of the numbers of people actually in positions as Whole Time Equivalents; the numbers of vacancies reported and the numbers of newly qualified recruits entering posts in the National Health Service and Social Services Departments.

9.2.3.1 <u>The numbers of people actually in positions</u>

In view of the multiple sources of data, it was decided to construct a matrix of the numbers of Occupational Therapists and helpers actually in positions as Whole Time Equivalents, wherever possible. (Appendix E)

It is interesting to note, in reviewing the Appendix that there are quite considerable differences between the material collected by the various sources. For example, the Survey conducted for the Independent Commission of Inquiry, even allowing for differences in time, would suggest that there are approximately 1,000 more Occupational Therapy Whole Time Equivalents (WTEs) in post than the other sources. Similarly, either the number of Occupational Therapy WTEs in local authorities has almost doubled in three years, or there is a discrepancy in the numbers. It may be that these are false comparisons in that it is unclear as to whether these are positions which are filled or not.

9.2.3.2 <u>The numbers of vacancies reported</u>

Two sources reporting the number of vacancies were examined. The Staff Side Evidence (PAM, 1987) reports these as a percentage of funded establishment. For Occupational Therapy there was a 20 per cent vacancy factor of funded establishment in the NHS in 1987. The material from the Independent Commission of Inquiry is more difficult to understand since the definitions on which the figures are based are unclear. However, a table headed "% Funded vacancies by grade", shows that in 1987 the pattern of vacancies was as follows:

Grade	% Vacant
District	4.1
Head	9.6
Senior	14.1
Basic	25.4
Helper T.I	2.3
Helper	2.8
T.I	2.5

In considering these two sources, the high vacancy factor reported in the first source (PAM, 1988) is apparently mainly accounted for by the vacancies for the more junior posts at Basic and Senior levels reported by the second source. There would seem to be little difficulty in filling the helper and technical instructor grades. In view of this absence of personnel in the junior qualified grades, a further perusal of the sources was made to identify the proportion of newly qualified Occupational Therapists entering the National Health Service or social services departments of local authorities.

9.2.3.3 <u>The numbers of newly qualified recruits entering posts in the Health and Local Authorities</u>

Three sources report the number of vacancies. Paterson (1988) provides data on the numbers of Occupational Therapists qualifying. Around 650-700 students could be expected to have qualified in 1986 in the U.K and Eire, of whom approximately 85% (612) would be from English schools.

The third source of evidence is that of the Pay Review Body which conducts an annual survey of vacancies. In their 1989 report (Pay Review Body, 1989), vacancies for qualified Occupational Therapy staff lasting over three months were given as 14.1 per cent. Of the total vacancies thus defined, 22.5 per cent were in the basic grade, 13.9 per cent in the Senior II grade and 12 per cent in Senior I. In considering these three sources, the high vacancy factor in the first source is apparently mainly accounted for by the vacancies for the more junior posts at Basic and Senior Levels, reported by the other two sources.

These data have been derived principally from one source: that of the National Professional Manpower Initiative which has just produced its provisional data set. These demonstrate that out of 680 Occupational Therapists qualifying in 1988, in Great Britain (excluding Northern Ireland for which data were unavailable), so far 491 have been employed in the National

Health Service. The regional employment information is as follows:

Region	Number of newly qualified Occupational Therapists (WTE)
Northern	20
Yorkshire	38.73
Trent	55
East Anglian	25
N.W. Thames	22
N.E. Thames	29
S.E. Thames	22.50
S.W. Thames	27
Wessex	22
Oxford	25.25
South Western	33
West Midlands	34
Mersey	25
North Western	31
Special Health Authorities	8
Wales	18
Scotland	61
Total	491.58

(Based upon returns from 212 districts).

These data would suggest that each health district recruited 2.3 WTE newly qualified Occupational Therapists. There were in theory, three newly qualified Occupational Therapists per health district. This would suggest that approximately 26% of the qualifying Occupational Therapists did not enter the National Health Service. The information from the Independent Commission of Inquiry in Occupational Therapy (COT, 1989) would tend to confirm these data. Table 9 shows that from 1/4/87 to 31/3/88, 395 newly qualified Occupational Therapists joined the National Health Service in the United Kingdom and a further 23 joined local authority social service departments.

9.3 Manpower issues in Scotland, Northern Ireland and Wales

Each of these countries has a different system of health care administration which perhaps has some bearing on manpower issues. Wales is the most similar to England and, although statistics tend to be collected for England and Wales, Occupational Therapy manpower statistics are available only through the Welsh Office. Northern Ireland has a quite different system of administration and has developed a structure of health boards which combine both health and social service functions. The number of Occupational Therapists per head of population is the lowest in the United Kingdom (COT, 1989) but there are very few unqualified staff and they have, therefore, the highest proportion of qualified to unqualified staff in the United Kingdom. It would seem that the effect of a high percentage qualified workforce could be examined. Also a study of the effects on Occupational Therapy service provision of the integration of services would be a useful contribution.

Scotland's health services are organised around health boards working in conjunction with local authorities, as in England. Scotland has a very active health policy review body, the Scottish Health Service Planning Council, which has recently published a report by a working party on health priorities in the eighties and nineties (SHHD, 1988). In this document, it is noted that employment in the Professions Supplementary to Medicine increased in part-time working, however, there are localised recruitment problems despite:

> "the large pool of qualified staff that in theory exists in professions dominated by women." (SHHD 1988 p. 139-140).

Studies of recruitment patterns in Scotland would be of value. It has already been noted that the Scottish experience is of localised recruitment problems. It may be that the characteristics of positions, in terms of location and job content, help to explain the recruitment difficulties.

9.4 Korner Data

Information about the activities of staff within the NHS was reviewed by the Korner Committee and as a result of this, the Health Service Management Performance Indicators were defined based upon information already available. In relation to Occupational Therapy, these focussed on three aspects:

(See Manpower Screen 26, document accompanying DHSS HC(85 23)).

- M66 Staff Cost/Resident Occupational Therapy
- M67 Qualified WTE/100,000 population Occupational Therapy
- M68 Qualified:Unqualified Staff Occupational Therapy

The PIs became Health Service Indicators (HSIs) (Health Service Indicators Group, 1988). The Health Service Indicators for Occupational Therapy are contained within the section on "Professions Allied to Medicine" (p.75). These record the following information:

- Total staff per total contact by staff groups: Occupational Therapy
- Total staff per first contact by staff groups.
- The percentage who are qualified of the total staff by staff groups.
- Qualified staff per resident population by staff groups.

Each health district must collect Korner data but can design its own data collection instrument, thus allowing for extra information to be gathered as required for local needs.

In addition to the Health Service Indicators, health districts are required also to provide details of Occupational Therapy activity. The Korner report on Professions Allied to Medicine (DHSS 1983) requires that Occupational Therapy work is to be measured in terms of

developments in public policy has become apparent. The following roles for Occupational Therapists have been noted:

- surgical dressings of hands in a burns unit in the USA
- assessment of cognitive functioning after cerebro vascular accidents in Sweden
- Occupational health services in Australia (verbal report to research manager)

It is tempting, perhaps, to suggest that because Occupational Therapists are found performing these tasks in other countries, this demonstrates that they are a legitimate area of practice and that all countries should, therefore, follow these examples. In fact, the three examples given above only demonstrate the nature of the division of tasks within each country. The importance of understanding the limits of transcultural comparisons in health care may be seen in particular through the study of patterns of deployment of Occupational Therapists.

The World Federation of Occupational Therapists has 31 members, of whom nine are also members of the European Community. This would suggest that even within the prosperous continent of Europe, Occupational Therapy is not a community wide profession. The European Community has issued two directives providing for the harmonisation of qualifications and the free movement of labour. Their effect on the supply of Occupational Therapy manpower is, as yet unpredictable, since the supply of and demand for Occupational Therapists in the European Community would seem to be variable.

The situation developing in Europe may, in fact, be of a pattern similar to the USA and Canada, where Occupational Therapy originated and where it is considered the profession is very well established. The manpower situation in Canada and the USA would suggest a very patchy and less than universal service. MacKinnon (1985) reports that some rural health care facilities in British Columbia have no Occupational Therapy service. Far from being well established everywhere, the profession seems to be in the process of trying to convince some facilities of the need for a service. The situation would seem to be highly variable from State to State in the USA and from Province to Province in Canada. It is noteworthy that one of the effects of the closure of large psychiatric hospitals in North America seems to have been diminution in the number of Occupational Therapists employed in psychiatry, a phenomenon noted by Mackinnon (1985) and an American survey of Occupational Therapists (Dataline, 1984). The American study showed that there has been a 7.6 per cent decline in Occupational Therapists working in psychiatry between 1973 and 1982. It would also seem that the greater competition among health care facilities common in North America is likely to lead to a less even distribution of Occupational Therapists. Langwell, Wilson, and Deane (1981) found that factors such as geographical location and the wealth of a community had a strong influence on the provision of Occupational Therapy Services. Wealthier communities were more likely to have access to Occupational Therapy services.

It would seem that the most important factors which influence the supply of Occupational Therapy may be social and economic.

9.8 Summary

The issue of the supply of, and demand for, manpower is extremely complex. In this section, a number of concepts have been used to explore the problem. In the field of Occupational Therapy, it seems possible to identify a number of factors which affect it:

- the relationship of production with planning and management is currently rather tenuous and may underlie some difficulties in recruitment and retention
- there is a rather inadequate record of the stocks of Occupational Therapists
- the international evidence would suggest that Occupational Therapy is a profession which is useful in many countries, but may develop in different ways
- the distribution of Occupational Therapists within countries is affected by systems of health care delivery
- models exist in the United Kingdom which could increase our understanding of localised recruitment problems.

These factors emerged strongly throughout the policy review. They also surfaced in the Policy Analysis.

APPENDIX A

MATRIX A

The Reform Matrix

	Oddie CPSM 1970	DHSS (Tunbridge) CHS, 1972	DHSS 1972 (Committee on Remedial Professions)	DHSS 1973 (Macmillan)	DHSS 1975 (Halsbury)	CPSM 1979 (The Next Decade)	G.B. Parliament 1979 (The Royal Commission on the NHS)
Joint courses for helpers able to work with all Remedial Professions	X						
Common Training or a common course in basic subjects	X	X	X	X	X	X	X
Sharing of common accommodation, facilities and lectures during course to registration	X	X	X	X		X	
Attending common post-registration courses	X	X					
Higher qualification and a degree course common to all Remedial Professions	X	X	X				

APPENDIX B

MATRIX B

O.T. in the public policy forum

Report and Date	References to O.T.	Significance for O.T.	Evidence from O.T.s
The Warnock Report. (G.B. Parliament, D.E.S. "Special Educational Needs" (1987))	Two references to O.T.	O.T. noted as a continuing need for the disabled child during schooling and into adulthood. O.T. is particularly mentioned as being concerned with aids and adaptation for daily living.	BAOT gave evidence
The Merrison Report (GB Parliament Command No. 7615 The Royal Commission on the National Health Service (1979)	OT mentioned several times	Focus on need to rationalise training of all paramedical professions working in rehabilitation. Encouraged examination of a common training for OTs and Physios.	BAOT gave evidence
The Barclay Report (NISW " Social Workers: their role and tasks" 1982)	No mention of OT	Concern about clients critical of social work services. Physically handicapped were one of four critical groups. They placed emphasis on material help for their handicap above psychological support.	No evidence from OT organisations
The Attenborough Report (Carnegie UK Trust "Arts and Disabled people" 1985)	No mention of OTs - focus on arts therapists	Noted the isolation of therapists who provide specific arts therapies and of their lengthy and intensive training courses in highly specialised areas.	College of OTs was consulted
The Short Report (GB Parliament (1985) House of Commons Second Report from the Social Services Committee Session 1984/85 "Community Care with special reference to adult mentally ill and mentally handicapped people."	No mention of OT	Recommended that the DHSS, Department of Employment, employers and trade unions explore possibilities for expanding the narrow base of sheltered employment.	Evidence published in OT journal and received by committee but not cited as such in report
The Wagner Report (NISW "Residential Care: a positive choice" (1988))	One mention of OT to provide services to clients in residential care	All senior posts in residential care should be filled with staff having SOCIAL WORK qualifications. Aim to introduce this by 1993.	No evidence from OT organisations

APPENDIX C

Entry to, definitions of and position of support workers in O.T. and other related professions.

Profession	Definition	Entry Level	Position of Support Worker
O.T.	Occupational Therapy is the treatment of physical and psychiatric conditions through specific selected activities in order to help people reach their maximum level of function and independence in all aspects of daily life. (C.O.T. 1987).	Post "A" level entry. Mainly 3 year Diplomas No consensus on all-graduate. 3/4 year degree programmes currently in operation.	Central list of 16 courses approved by C.O.T. Helpers and Technical Instructors can become associate members of C.O.T.
Physiotherapy	A systematic method of assessing musculo skeletal and neurological disorders of function including pain and those of psychosomatic origin and of dealing with or preventing those problems by manual therapy and physical agencies. (C.S.P, 1987).	Post A-level entry. 3 or 4 year Diploma or Degree Courses. Aim for all-graduate profession.	No central organisation of Helpers' courses as yet. Courses organised locally. C.S.P. has defined role.
Speech Therapy	"Students will be taught general theories and issues in speech therapy, including how to decide when intervention is not appropriate or should be withdrawn, and the various forms of indirect intervention. They should also be aware of the importance of identifying the different needs of ethnic minority groups. They will observe a variety of clinical disorders, management techniques and therapy techniques." (C.S.T. undated)	Post A level entry. All 3 or 4 year Degree programmes. All-graduate profession.	No central organisation of Helpers' courses. Very little use of helpers.
Nursing	A professional nurse is some one who is recognised by the United Kingdom Central Council and abides by the professional code of conduct of nursing. She/he possesses a body of knowledge based on biological and social sciences. This body of knowledge is the tool for the professional nurse. The nurse must apply the principles of care and promote the optimum quality of life for the individual, his/her family, and the community within the politico, socio-economic environment in which she/he works. (Waltham Forest School of Nursing, 1987).	Very variable umbrella profession. Many different types of courses for a very wide range of ability level. There will only be one level of qualification.	State Enrolment is being phased out. Support Worker training is being organised on a local basis, but work proceeding on national training and qualification structure. Most existing nursing nursing auxiliaries receive little or no training.
Social Work	Newly qualified social workers will be expected to acquire: - "core" values, knowledge and skills to achieve the required competence in social work; - competence in assessing, planning, interviewing, evaluating outcomes; - competence in working with groups over a sustained period in a particular area of practice within the relevant Legal and organisational frameworks. (C.C.E.T. S.W. 1989).	Very variable profession. Many different routes to qualification.	The profession is phasing out the two levels of qualification.
Art Therapy	Qualified Art Therapists have a considerable understanding of art processes, are proficient in the area of non-verbal communication and are able to provide a trusting and facilitating environment in which patients feel safe to express strong emotions (BAAT 1989).	Entry at post-graduate level for graduates in Art or Design or approved subjects.	No second level therapists and no support workers.
Clinical Psychology	Clinical psychology is the application of psychology to behavioural and emotional problems. Such problems may be associated with physical or mental illnesses or learning difficulties or they may reflect difficulties or adjustment to the stresses of life (B.P.S. undated).	Entry at post-graduate Level.	No central system of support workers. Psychology graduates may be employed as Technicians prior to training.

APPENDIX D

EDUCATIONAL PREPARATION AND FIELDS OF OPERATION OF THE O.T. PROFESSION COMPARED WITH SEVERAL RELATED PROFESSIONS** — MATRIX D

	Behavioural Sciences	Biological Sciences	Administrative Sciences	Clinical Sciences Sciences	Specific Occupational Teaching	Major Fields of Operation
1. Occupational Therapy	Psychology Sociology (Psychology includes Growth and Development)	Anatomy and Physiology	Management Skills	Medicine Surgery Psychiatry	Assessment of Patients Practical Skills	NHS, Local Authorities,
2. Physiotherapy	Sociology Growth and Development	Anatomy and Physiology	Organisation and Administra tion of Health care	17 Clinical areas from acute Trauma to Mental Handicap	Physiotherapy Studies Biomechanis movement Thermal, ultra-sonic electrical treatments	NHS (Hospital and Community)
3. Speech Therapy	Psychology (includes Growth and Development) Sociology Education	Human Structure and function	Service Organisation and management	Neurology Paediatrics Otorhinology Psychiatry Geriatrics	Acquisition and use of language, audiology,	NHS (Hospitals and Community) Education Authorities
4. General Nursing	Psychology (includes Growth and Development) Sociology	Integrated Body Systems	Social Policy Law Management	Integrated Clinical: Medicine, Surgery, Trauma Elderly, Specialities, Paediatrics, Obstetrics, Mental Health	Theories of	NHS (Hospital and Community) G.P.s
5. Art Therapy	Developmental Studies		Institutions	Psychiatry, Psychotherapy	Art Therapy: Theory and Practice	NHS, Social and Community Services
6.* Clinical Psychology	Growth and Development	Genetics	Professional Issues	Abnormal Psychology	Clinical Applications	NHS (Hospital and Community)
7.* Social Work	Growth and Development		Social Policy Law		Social Work: Theory and Practice	NHS, Local Authorities

* Post-graduate courses
** Derived from curricular guidelines for the professions validating bodies or their equivalents.

APPENDIX E

APPENDIX E

Sources of Information about Occupational Therapy Manpower

Grade	Source (1) NHS OTs in England	Source (2) Soc. Serv OTs England	Source (4) NHS Workforce in England	Source (5) NHS OTs in Scotland	Source (6) OTs OTs in Northern Ireland	Source (7) NHS OTs in Wales	Source (9) NHS OTs (Survey for COT inquiry)	Source (10) UK Soc. Serv OTs
Occupational Therapists	4,334 WTE 1986 Table 3.18	973.7 WTE 1985 Table 4	4,600 WTE 1987 p.4	534 WTE 1988	255 (in post not WTE) 1989	229 (WTE) 1989	6,439 WTE 1988	1,669.2 WTEs 1988
Helpers and Technical Instructors	3,662 WTE 1986 Table 3.18	Unavailable	3,210 WTE 1987 p.4	Unavailable	68 in post (not WTE) 1989	Unavailable	4,729 WTE 1988	

APPENDIX F

Semi-Structured Interview Schedule

1. What do you understand to be the role of the Occupational Therapist?

2. What is your view of the provision of Occupational Therapy services in...........?

3. What changes do you expect will affect the demand for Occupational Therapy services in the next 5-10 years?

4. What do you consider are the most appropriate alternatives for meeting these demands?

TABLE I APPENDIX G

CHARACTERISTICS OF THE SETTINGS (N=12)

(a) Teaching commitments within Health Districts

(i)	School of Occupational Therapy		2
	No. School of Occupational Therapy		10
		Total	12
(ii)	Medical School		4
	No. Medical School		12
(iii)	Other type of health care school		12
	No. other type of health care school		0
		Total	12

(b) Unemployment rates within Health Districts (as at

7% to 9.9%		2
10% to 12.9%		3
13% to 15.9%		2
Greater than 16%		5
	Total	12

(c) Non-indigenous resident rates within Health Districts

Less than 1%		1
1% to 1.9%		1
2% to 2.9%		2
3% to 3.9%		1
Greater than 4%		1
Unavailable		6
	Total	12

(d) Morbidity rates of residents within Health Districts (This is measured on a scale from 1 to 6, 1 being the lowest and 6 being the highest rate).

Morbility level	1	1
	2	2
	3	0
	4	1
	5	1
	6	1
	Unavailable	6
	Total	12

(e) Political control of predominant local council within health district (as at 1985)

Conservative	4
Labour	3
Independent	1
No overall control	1
Not applicable	3
Total	12

(f) Population of Health Districts
Range of population = 960,000 Highest
to 101,804 Lowest
Median population = Approx 300,000

(g) Number of health districts and boards from each country of the United Kingdom (N=12)

England	5
Wales	1
Scotland	3
Northern Ireland	3

TABLE II

CHARACTERISTICS OF THE OBSERVATIONAL SAMPLE (N=48)

(a) Qualifications	Number
Registered Occupational Therapists	36
Helpers and Technical Instructors	12
	Total = 48

(b) Functional Area	Number
Hospital	31
Community	17

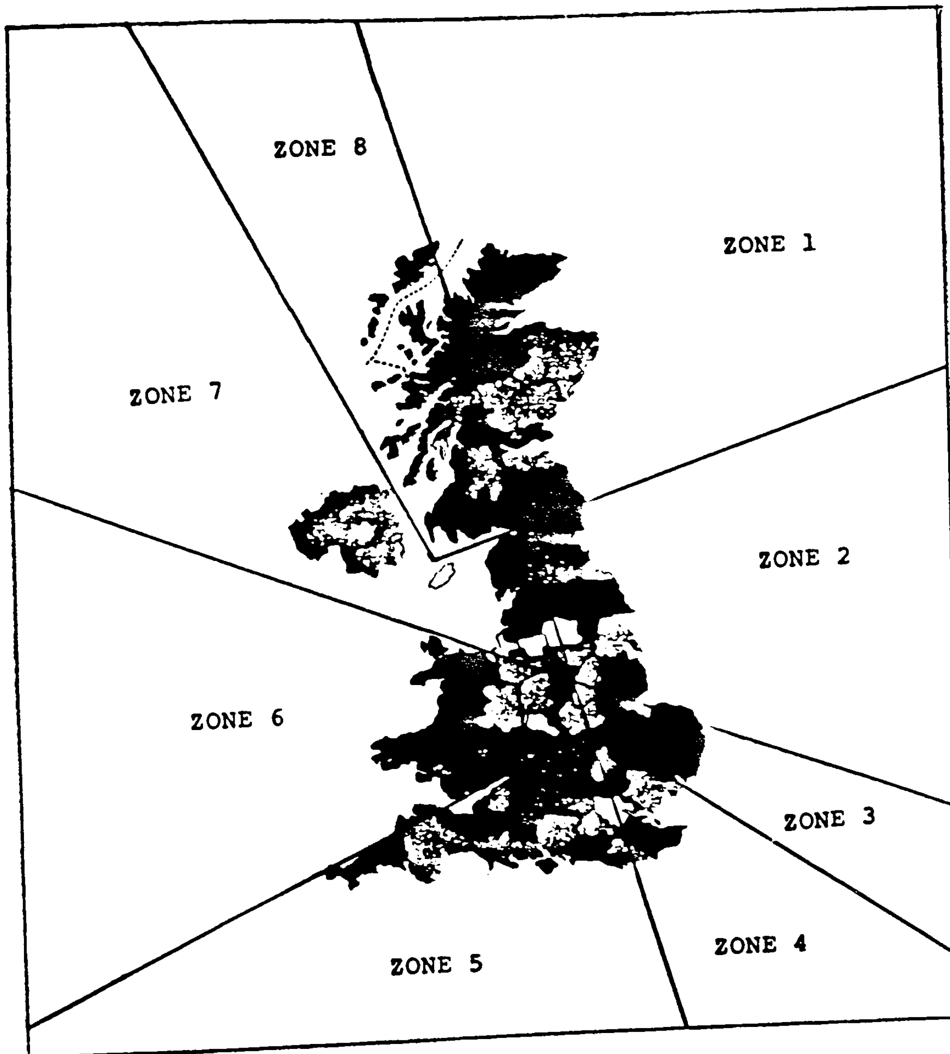
(c) Facilities by type	Number
Social Service Departments	Sub total = 12
Hospitals:	
Types: Acute General	7
Mental Illness	2
Mental Handicap	3
Long stay and Geriatric	3
	Sub total = 12
	Total = 27

TABLE III

CHARACTERISTICS OF THE INTERVIEW SAMPLE (N=60)

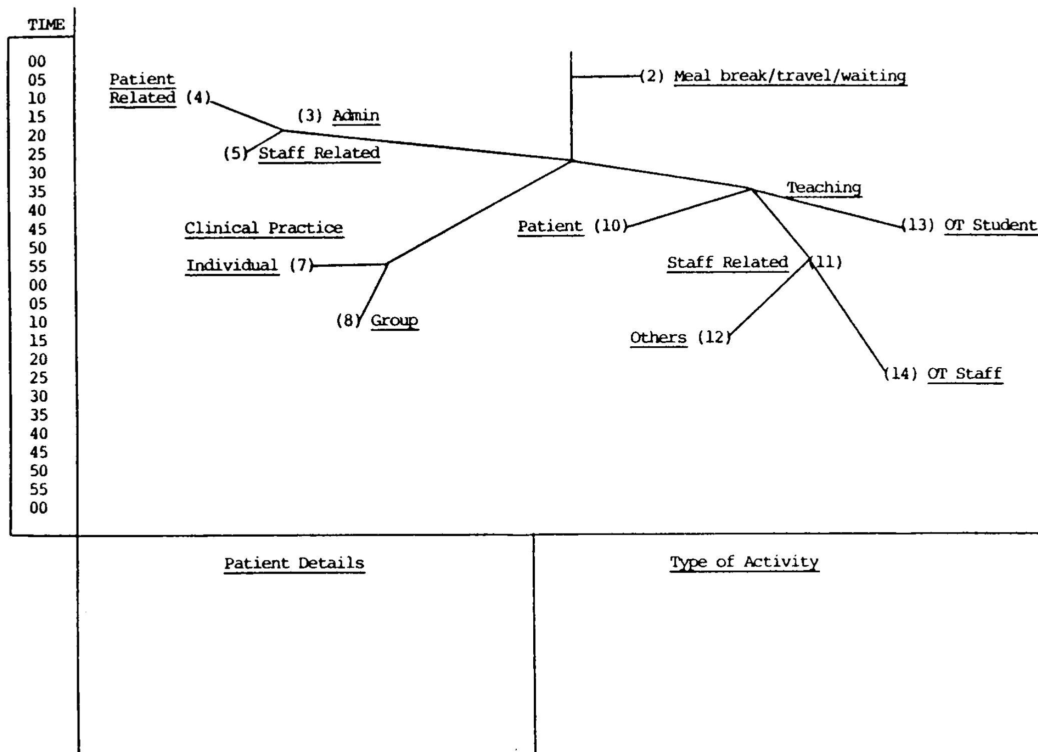
Qualified Occupational Therapists	= 20
Voluntary organisations for and by the disabled	= 20
Other informed professionals	= 20
	Total = 60

The Eight Fieldwork Zones of the United Kingdom



Observation Schedule

APPENDIX H



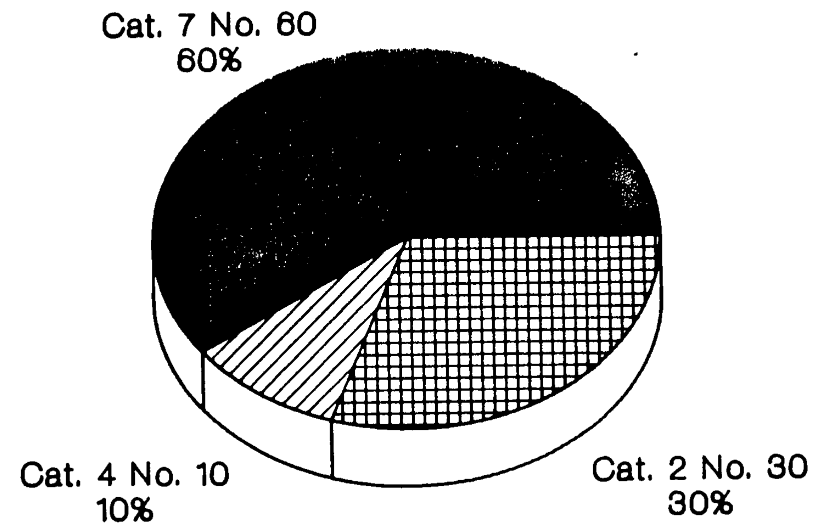
Appendix I

Activity Analysis: Pie Charts

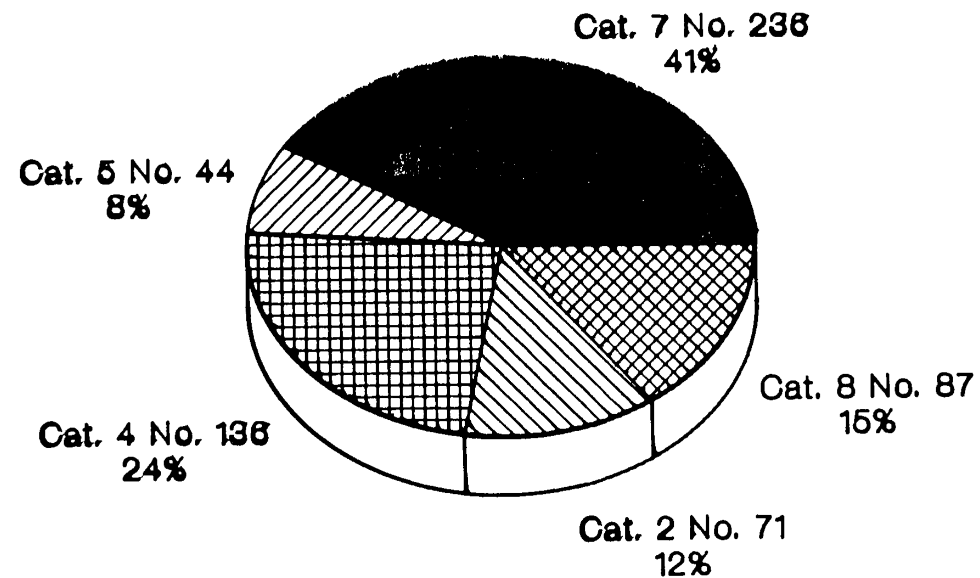
Key to Categories

4. Patient Related Administration
5. Staff Related Administration
7. Clinical Prtactice - individual
8. Clinical Practice - group
10. Patient related teaching
12. Other staff teaching
13. Occupational Therapy student teaching
14. Occupational Therapy staff teaching
2. Preparation, Breaks, Waiting, Travelling

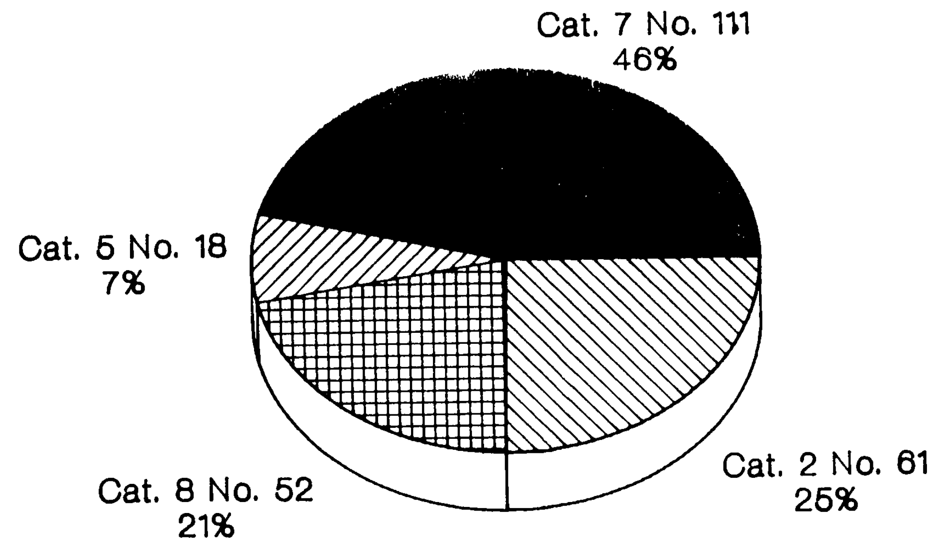
ACTIVITY ANALYSIS
COMMUNITY OT HELPERS



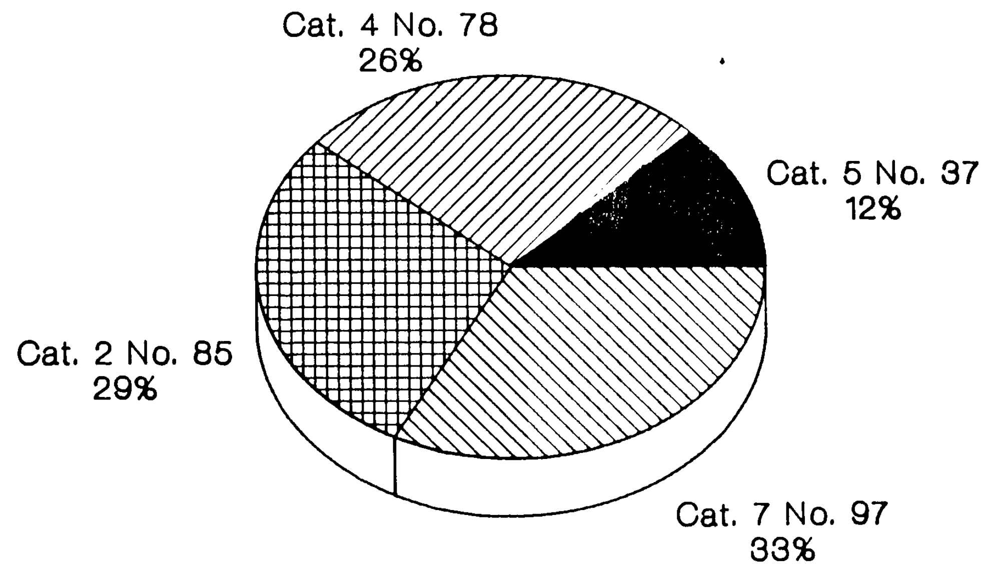
ACTIVITY ANALYSIS
HOSPITAL OCCUPATIONAL THERAPISTS



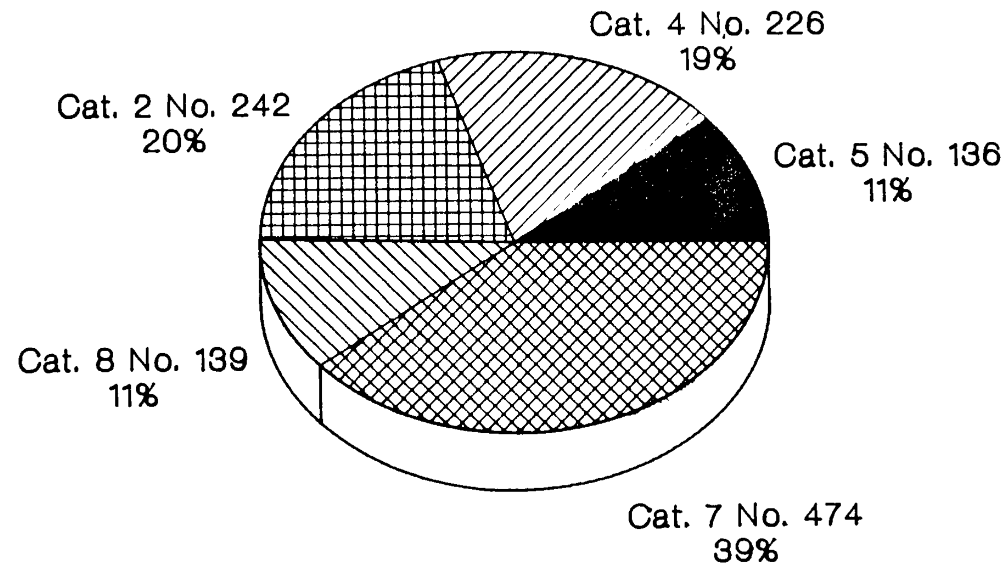
ACTIVITY ANALYSIS
HELPERS AND TECHNICAL INSTRUCTORS
HOSPITALS



ACTIVITY ANALYSIS
COMMUNITY OCCUPATIONAL THERAPISTS



ACTIVITY ANALYSIS
ALL GROUPS



Appendix J

Analysis of data from the Provisional Tool to Measure Skill Levels

Cross-classification of responses of people with Disabilities (n=16) and Occupational Therapists (n=18).

	Lay Person		Support Worker		Occupational Therapist	
	No.	%	No.	%	No.	%
People with disabilities (based on replies to 165 items)	52	31	70	42	43	26
Occupational Therapists (based on replies to 163 items)	27	16.6	53	32.5	83	51

(Percentages do not add to 100 exactly due to rounding).

Results of X2 test performed on frequences

X2 = 22.94806 with 2d.f
p = .00007

Therefore the research hypothesis cannot be rejected since the probability is less than .001.

Provisional Tool to Measure Skill Level (PTMSL)

(NOTE: this tool is at an early stage of development and its use in this form was solely for the purposes of testing)

Here are a large number of items which we would like you to assess for us. Please read each item (do not spend too long on this) and then tick the part of the scale beneath the item which you believe would provide the most suitable person to be involved in this situation.

You have a choice of three types of person:-

Lay person - no training or experience except general life experience. Scale points 1-3.

Support Worker - a care worker such as an O.T. helper who has specific training or experience or both in this area. Scale points 4-6.

Professional - a professional Occupational Therapist who has followed a 3 year course of training and is registered as an Occupational Therapist. Scale points 7-9.

Remember: the higher the number you assign, the greater the skill you think is involved.

Here is an example:

The O.T. assesses an elderly lady who has had a CVA (Stroke) and has a left hemi-plegia (left-sided paralysis), whilst she is preparing a cup of tea.

1	2	3	4	5	6	7	8	9
	Lay person			Support Worker			OT	

In this example, we have ticked point 8 on the scale, because we believe this is a highly skilled task which needs specialised professional training.

Here is another example:

The O.T. delivers a walking frame to the home of an elderly lady and shows her how to use it.

1	2	3	4	5	6	7	8	9
	Lay person			Support Worker			OT	

In this example, we have ticked point 5 on the scale. This task we believe, is one which most people with some experience and training could perform on a routine basis and it does not seem to us to require extensive professional training.

Please try to tick all items.

1. Organising and conducting a reminiscence group for ten elderly people using slides of places of interest.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

2. Telephoning a new client with Parkinson's disease to discuss her problems and arrange a visit, then complete a referral form.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

3. Telephoning ALAC (Artificial Limb and Appliance Centre) about a wheelchair for a client which needed an extension to the back rest of the chair.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

4. Travelling to see a client for an initial assessment interview to establish problems. Client is a 48 year old male, married with cerebellar ataxia (difficulty in walking). Discussion includes outdoor mobility, bathroom transfers, driving, examination of plans of the bungalow for a garage or covered car port. Performing a physical assessment of client getting into and out of the shower.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

5. Discussing activities of daily living with a patient and her relatives. The patient has had rheumatoid arthritis for 40 years. The discussion centres on aids and equipment in the home eg. highchair, toilet seats and shower and use of feeding utensils. The hospital O.T. says she will discuss this with the community O.T. and Social Workers, but to remember that this is the end of the financial year. She refers the patient to physiotherapy for maintenance exercises.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

6. A new patient is referred. She is 50 years old with hypertension (high blood pressure) having had a left sided CVA 10 years ago from which she has some residual weakness. The patient also has rheumatoid arthritis. The O.T. takes a history of joint function, pain and stiffness. She discusses the disease and its management with the patient. She performs joint assessment for range of motion, and grip, especially of the upper limbs and she discusses performance of activities of daily living. She then observes the patient making a cup of tea and discusses aids for the kitchen with her.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

7. Being involved in a staff meeting, discussing the rotation of O.T. staff in the district between the mental illness and mental handicap units. Writing notes of the meeting.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

8. Ordering stores for the O.T. department.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

9. Testing an 80 year old lady after a stroke who is dysphasic (difficulty in speaking) and apractic (unable to initiate movement). Tests include shape recognition, maze tasks, mirroring of movement, knee tapping and picture/action associations. Progress is discussed with the patient. Hand exercises are then performed.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

10. An elderly female patient is admitted for a two week assessment after falling twice. The O.T. had previously assessed the patient's ability to perform activities of daily living. She talks to the patient about how she has managed that morning as the patient is eating breakfast.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

11. Organising a group crossword activity with 2 O.T. Helpers in a Day Unit for the elderly. Starting the activity, and then leaving the group with the Helpers, to attend a ward meeting with the Ward Sister, Consultant, Physiotherapist and Social Workers.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

12. Checking the availability of equipment in a store cupboard.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

13. Receiving returned keys and equipment borrowed by physio-therapists.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

14. Going up to the ward and searching for a patient to give treatment.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

15. Talking with nursing staff about a patient's progress.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

16. Discussing transfer methods with a 56 year old female patient suffering from a sub-arachnoid haemorrhage (stroke). The stroke transfer method is tried with a nurse. The patient is transferred from chair to commode using a pivot transfer. The patient is positioned in the chair and stimulated verbally. The patient keeps on closing her eyes so she is approached from the other side. The patient responded a little to a left hand squeeze. The patient is moved upright by folding a blanket and further stimulation is tried. The next day's programme is discussed with the nurses.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

17. Helping a 46 year old female patient with an acoustic neuroma (tumour on the nerve for hearing) and non-communicating hydrocephalus (water on the brain) into the O.T. department. The O.T. asks questions to establish level of disturbance and prompts the patient to establish the answers. Patient is asked to write name and address. O.T. assists with writing. O.T. then explains the hand function test to the patient. She times the patient with a stop watch, observing and recording twice with slow explanations in between. The O.T. then explained her findings to the patient and what she would concentrate on. She discussed problems with the patient and the future plan, walked patient to her wheelchair, said good bye and returned equipment to the cupboard.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

18. O.T. collects equipment, a patient's referral card and goes to look for a patient up to the ward.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

19. The O.T. provides stimulation to a comatose patient, a 28 year old man suffering from T.B. meningitis (inflammation of the brain). She speaks to him and touches him. She stretches his right hand and wrist and provides stimulating sensations by rubbing his arm.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

20. The O.T. provides coma treatment to a 64 year old male patient after surgery for a pituitary tumour (tumour of a gland on the brain). She washed his hands and settled him in a lower position. She stimulated the patient by talking and releasing her finger grip. She stimulated him by brushing him with different textures. She then talked with his wife.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

21. The O.T. makes a telephone call to discuss a new wheelchair for a client with severe extensor spasm (muscular spasm).

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

22. The O.T. goes to visit the home of a 79 year old client with osteo-arthritis of the spine who needs a wheelchair to get about in the shopping precinct. Her right leg keeps giving way. The O.T. arrives to make an initial assessment but finds on arrival that the G.P. had already contacted the Disablement Services Authority and they had already approved a wheelchair and were sending it.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

23. The O.T. discusses case management with an O.T. helper and plans a group activity with her.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

24. The O.T. discusses the process of an assertiveness training group with her colleagues.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

25. The O.T. checks the medication regimes of a group of residents in a villa for the mentally handicapped in a hospital. She also reads the Nursing notes to assess the clients' suitability for a residential home.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

26. The O.T. helper goes to visit a female client with rheumatoid arthritis to assess for a grab rail in the bathroom. This is the second visit and the client is out.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

27. The O.T. helper goes to visit a female client aged 75 years with vertigo. She assesses the client for a bath aid, a rail at the front of her bungalow and a walking frame.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

28. The O.T. helper goes to visit a female client aged 63 years with severe rheumatoid arthritis. Her hands are increasingly crippled so crutches are difficult to use but she gets about at home. She only uses a wheelchair when she is taken out. The O.T. Helper assesses the door access of her home and for a ramp as the client goes to a Day Centre one day per week. The helper refers this to the O.T. as it is a complex situation.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

29. The O.T. helper assesses a 60 year old female client who has had a total hip replacement for a bathing seat.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

30. The O.T. helper assesses an elderly infirm but independent female client for a toilet frame. She can manage well without and a frame is not required. The O.T. helper will discuss this with the Home Help Organiser, who referred her for the assessment.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

31. The O.T. goes to visit a male client who is recovering at home from surgery for ankylosing spondilitis (rheumatic condition). He also has an ileostomy. This is the O.T.s third visit. She has assessed him for a shaver which has been approved and she has returned to discuss details of this. Since his wife is out, she will return in the morning.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

32. The O.T. calls to visit a 78 year old female client who is recovering at home from a left femoral popliteal by-pass (surgery to the left leg to improve circulation). An O.T. assistant had called previously. The client is requesting help with a move to be nearer her daughter.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

33. The O.T. goes to visit an 82 year old female client who has

bilateral amputation of her lower limbs. She is having difficulty transferring onto a new toilet seat. The O.T. does a full assessment and advises her on the transfer trouble with her new seat. (The G.P. had referred the patient to both hospital and community O.T. services and both were involved at this time).

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

34. The O.T. goes to visit a 75 year old female client with rheumatoid arthritis after surgery for bilateral hip replacement. The O.T. assessed her for a stair lift. The hospital had already provided her with bath aids.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

35. The O.T. assesses a male patient, aged 68, with ankylosing spondilitis (a rheumatic condition) ten days after surgery for hip replacement. This is an initial assessment. The patient is for discharge the following day. The O.T. assesses the details of patient's family and progress of disease. She performs a physical assessment of back, neck, and arms for functional ability. She assesses him for dressing practice, bathroom, toileting and tea making. The O.T. has liaised with the community O.T. to ensure that aids and adaptations eg. toilet will be supplied.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

36. The O.T. sets up equipment - a draughts board.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

37. The O.T. goes to collect a patient in a wheelchair from the ward.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

38. The O.T. plays draughts with a 72 year old female patient who had a CVA (stroke) four months ago. The patient has a left sided hemi-plegia (paralysis). The O.T. has the patient sitting without support to practice balance. The draughts game is used to encourage the patient to straighten her left hand fingers and to use both hands. It is also used to measure concentration, short term memory and understanding.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

39. The O.T. discussion the completion of car tax forms with a male patient who has had a spinal tumour removed.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

40. The O.T. assists a patient with a right hemi-plegia (paralysis) to dress and takes the patient for a walk to the O.T. department and back to the ward. The O.T. then tests the patient for dysphasia (difficulty in speaking) and dyspraxia (difficulty in movement). She then has a brief discussion with the patient about these.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

41. The O.T. supervises a female patient, aged 87, who has a left hemiplegia (paralysis) following a CVA (stroke). The patient is asked to stand at a table to help her balance and to do simple jigsaw puzzles for her perceptual problems. The O.T. then asks the patient to participate in discussing social sequencing cards of a woman catching a train. The patient is then transferred to the ward.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

42. The O.T. supervises 2 male patients; one with a right hemiplegia (paralysis) after a CVA (stroke) and a previous accident who has poor sensation and proprioception (sense of position), the second has had a right sided paralysis for a year and also lacks proprioceptive sense, he was referred from the physiotherapist because he could move his arm but he could not feel anything. The first patient is given peg solitaire by the O.T. to develop his fine movement, she then gives him silicone putty exercises

for his fingers, followed by writing practice and sanding down of wood for sensory stimulation. The second patient makes holes in a board using a drill, and eventually goes to play a computer game.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

43. The community O.T. supervises an O.T. regarding the referral of a client for shower facilities. The client had a total hip replacement and there was no evidence that she was unable to use a bath therefore the client did not fit the criteria.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

44. The O.T. supervises an O.T. regarding a client's request for central heating. The client has given a vague account of medical problems: sciatica, and gall bladder problems. The client does not fit the criteria.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

45. The O.T. supervises an O.T. assistant about an application for a stair lift for a client.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

46. The O.T. reads application forms for orange badge disabled car stickers. All applications for badges come through the O.T. section. The Senior O.T. sees if applicants fit the criteria, approves them or not and signs the forms.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

47. The O.T. logs in a new referral for her own case load.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

48. The O.T. deals with an orange badge claim which has been refused and an appeal has been lodged with the ombudsman. The O.T. reads the report and drafts a reply.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

49. The O.T. deals with a request from the matron of a residential home who wants equipment for a resident.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

50. The O.T. assesses the monthly budget statements which she monitors.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

51. The O.T. makes a telephone call to a residential home to see if equipment ordered has been received.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

52. The O.T. sorts out proposals for new posts to help implement the 1986 Disabled Persons Act.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

53. The O.T. writes a memo to one of the team managers regarding orange badge applications in relation to 3 clients and a G.P. and checks with the secretary on any other clients who are awaiting replies from G.P.s regarding orange badge applications.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

54. The O.T. meets with a 20 year old client suffering from multiple sclerosis and in a wheelchair to discuss aids and problems with his bungalow.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

55. The O.T. collects a patient in a wheelchair from the ward.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

56. The O.T. discusses home management with a patient using crutches after surgery to his toe who has rheumatoid arthritis. The patient then practises making a cup of coffee.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

57. The O.T. provides printing equipment for two patients post hand injury, setting up the printer and allowing the patients to work on the equipment while she performs other tasks.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

58. The O.T. returns a wheelchair bound patient to the ward and assists the staff with the transfer of another patient from bed to chair.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

59. The O.T. liaises with the community O.T. regarding equipment for a patient.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

60. The O.T. assists a patient, who has had surgery for a Dupuytrens contracture (contraction of the skin on the hand) to his hand, to work on a tray border; she then transfers him to printing equipment.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

61. The O.T. gives a demonstration of O.T. department equipment to a Red Cross worker who will work as part of the Red Cross team which supervises most of the craft work.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

62. The O.T. attends a meeting of O.T.s, helpers, Art therapist, Music therapist and voluntary services, all connected with working with the elderly mentally ill where the patients programmes are discussed. The group also discusses problems in co-operation with nursing staff and reviews progress of a tea dance group. The O.T. acts as group secretary, recording the minutes.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

63. The O.T. prepares for a session with patients. She gets a ball and parachute game together and collects other activities to take to a ward for the elderly mentally ill.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

64. The O.T. moves furniture to prepare for her session with the elderly mentally ill and organises patients to get them from the ward to the Activity room.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

65. The O.T. escorts a male patient who has a right hemiplegia (paralysis of the right side) to the toilet.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

66. The O.T. conducts a group session with four elderly patients suffering from mental illnesses. She gets the patients to introduce themselves to each other and finds out if they can remember their names. She orients them to the group. They have to throw and catch a beach ball and they are asked to say the name of the person they are about to throw the ball to. The O.T. talks to hem throughout to encourage communication. The O.T. then asks them to guess the object (a parachute) and she talks about its manufacture. The group then holds onto the parachute in a circle and they throw a bean bag each which they have been asked to choose by naming a colour. The activity is to provide physical exercise, orientation, colour perception and to encourage communication.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

67. The O.T. escorts a group of elderly patients back to the ward after an activity and, on the way, escorts one of them to the toilet.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

68. The community O.T. telephones a company about failure to deliver a commode.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

69. The O.T. teaches a new member of staff how to issue orange badges to allow the disabled to park.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

70. The community O.T. prepares an order for equipment from catalogues, then telephones to the company to place the equipment order.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

71. The O.T. instructs a new O.T. about a home visit where a lift is required.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

72. The O.T. completes several order forms for equipment.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

73. The O.T. sorts invoices received from companies for equipment orders and distributes forms around the department for action.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

74. The O.T. prepares to hand over work to a new O.T. and discussion the management of the social services department where O.T.s are no longer attached to area teams and its impact on services.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

75. The O.T. helper plays table tennis with a patient who has tunnel vision, speech impediment and a left sided paralysis. She then settles him in front of the computer and supervises him whilst playing "Hangman".

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

76. The O.T. helper makes coffee for the O.T. staff and discusses her work with the next patient with them.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

77. The O.T. helper goes to the Catering Store and collects food which she then unpacks in the O.T. kitchen whilst clearing up the coffee cups.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

78. The O.T. helper escorts a young female patient to the kitchen. The patient has brain damage following a road traffic accident and is chairbound. She cannot talk and writes to communicate. The patient is supervised by the helper as she collects ingredients to make scrambled eggs on toast. She cleans and clears up. The helper assists the patient in making a list of food she enjoys. The O.T. joins them twice for a few minutes each time. After the session, the helper reports to the O.T.s on the patient's progress and then writes up notes on the session.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

79. The O.T. helper in the Day Hospital plays board games with dice with a group of 6 elderly female patients. The purpose of the activity is to stimulate memory and encourage participation.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

80. The O.T. helper assists 2 elderly patients to pack forceps with another helper, whilst talking to the patients.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

81. The O.T. helper takes a patient to the toilet and escorts her back to the ward.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

82. The O.T. helper prepares equipment by setting up a printing block.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

83. The O.T. helper works at a table with four female patients packing forceps for CSSD. She makes social conversation with them.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

84. The O.T. helper assists a patient to the toilet.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

85. The O.T. helper tidies up the equipment used in activities.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

86. The O.T. helper escorts a patient back to the ward.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

87. The O.T. helper sets up and prepares for use a printing block.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

88. The O.T. organises the morning's work and checks details of patients to attend O.T.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

89. The O.T. works with a female patient who has been suffering from

anxiety and depression after a CVA (stroke). The patient is given support and supervision as she bakes scones in the kitchen. The O.T. assesses her capacity for activities of daily living and discusses her mood and sleep pattern.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

90. The O.T. works with a female patient who has a spastic paralysis. She prepares the patient for fitting into a standing frame with the assistance of another O.T. and helper and after a brief standing session, she helps the patient back into a chair.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

91. The O.T. helps a patient into a standing frame. The patient is 69 years old and lives in a nursing home after bilateral CVAs (strokes). The frame will help him to become upright. He is then taken to a keyboard which he is being trained to use. The O.T. discusses his progress in Physiotherapy and they practice chair to chair transfers.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

92. The O.T. goes to the ward to collect an 88 year old female patient recovering from a fractured femur. She is taken to the O.T. kitchen where she is assessed for her competence in activities of daily living (ADLs) as she makes a cup of tea.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

93. The O.T. discusses a client's problem with a colleague. An elderly patient is in need of a hoist.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

94. The O.T. receives and makes telephone calls about ordering equipment for the O.T. office.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

95. The O.T. receives a telephone call from the Housing Executive about a grant for home improvement.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

96. The O.T. discusses several matters with her Social Work colleagues including referral of clients and a client problem regarding safety in the home with bathing.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

97. The O.T. visits a residential unit which provides respite care for the mentally handicapped to discuss equipment orders - types of equipment and their suitability for residents.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

98. The O.T. makes a telephone call to arrange an appointment to visit a child at home and to discuss suitability of equipment.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

99. The O.T. goes to the Store to find a walking frame required by a colleague's client.

1 2 3 4 5 6 7 8 9
Lay person — Support Worker — OT

100. The O.T. goes to a Day Centre to visit a mentally handicapped resident of a home who is working there. She takes a walking frame and walks with the client to try out the frame.

1 2 3 4 5 6 7 8 9

and combs her own hair, and takes her medication. The O.T. then leaves.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

107. The O.T. greets an 18 year old female patient who has a severe head injury with visual impairment. The patient has developed behavioural problems and is reluctant to do anything. She is dysphasic (has difficulty in speaking) and has perceptual problems (difficulty in seeing). The patient has the Speech Therapist with her and the O.T. discusses progress with them. When the Speech Therapist has gone, the O.T. supervises and instructs the patient in preparing for a morning wash. She asks the patient to identify objects. The washing session is unsuccessful, so the O.T. proceeds to dressing practice and supervises and assists the patient who is very reluctant. The O.T. then returns to the Therapy Department to discuss this with the Speech Therapist.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

108. The O.T. conducts a life skills group with 5 clients, 2 male and 3 female. 4 of them have been diagnosed as suffering from anxiety and depression and one from schizophrenia (a severe mental illness). The O.T. acts as a facilitator to encourage the group to identify skills and to discuss how they can improve their performance.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

109. The O.T. attends a ward round with doctors, social workers, and nurses. The purpose of the meeting is to discuss social needs. The O.T. contributes to the discussion by presenting her assessments of the patients capacities in activities of daily living (ADLs).

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

110. The O.T. discusses clinical work for O.T. students in the O.T. department with the deputy head O.T.

Lay person Support Worker OT

101. The O.T. performs a variety of administrative tasks such as filing, completing her diary sheet and photocopying correspondence.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

102. The O.T. telephones to book a visit to a client.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

103. The O.T. prepares notes and equipment for a home visit.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

104. The O.T. visits a female client of 86 years with Rheumatoid Arthritis to re assess her for the "Orange Badge" Disabled Parking Permit. She has had the badge for several years and is now re-assessed for it and for other aids and equipment.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

105. The O.T. visits a female client who had been in hospital for lower back pain. She has now fully recovered and doesn't need help so the O.T. leaves.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

106. The O.T. assists a 73 year old female patient who has a flaccid right hemiplegia (paralysed right side). She helps the patient to sit on the edge of her bed and to wash while supporting the patient's right side. She guides and instructs the patient through the activity. She then assists the patient to put on her nightdress, and to stand up while the nurse washes the patient's buttocks. The patient is then assisted into a chair

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

111. The O.T. collects a patient from the ward in a wheelchair whom she is going to observe at work in the kitchen.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

112. The O.T. discusses possible location for a patient on discharge with a Sister and a Health Visitor.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

113. The O.T. collects a wheelchair to transfer a patient to the O.T. Department from the ward.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

114. The O.T. transfers a patient from the ward to the O.T. department in a wheelchair.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

115. The O.T. discusses the use of a trolley and a frame with an elderly female patient. She supervises the patient whilst tea-making and discusses with the patient what her home help does. The O.T. assists the patient to move from her stool to her wheelchair with her tea on the trolley. The O.T. discusses this activity with the patient. She then discusses aids which the patient could use at home and finally returns the patient to the ward.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

116. The O.T. is working with a 34 year old male patient after a road traffic accident. The patient is transferring a ball from right to left in a mobility game. She then transfers him to the computer room where she sets up the computer for the patient and searches for a programme which she talks through with the patient. The next game is a jigsaw game and the patient works on hand eye co-ordination and conceptualisation. The O.T. observes and assists as necessary. A third game is a memory game. At the end of this the O.T. packs up the computer equipment, talks with the patient then returns to her office to write up records.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

117. The O.T. discusses with an O.T. student plans for her day with her patients and teaches the student about the use of and variations on perceptual tests. She then refers an additional patient to the student.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

118. The O.T. talks with a more senior colleague about patient load, new referrals and plans patients' programmes for the coming week with her.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

119. The O.T. goes to collect a 26 year old patient suffering who has had a road traffic accident. The patient is unable to speak and writes down all her responses. She has difficulty in movement and has spastic (stiff) paralysis. The O.T. takes her to her bed to discuss her home visit with her. She tells her that her second wheelchair will not be supplied and she has to work out with the patient how she will get about. She takes the patient to the W.C. to practice transfers with her - on and off the W.C. They talk about home conversion and return to bed to draw up plans. They then try a "Glide about" but it is too unstable for use in W.C. and return to use of wheelchair. The O.T. talks to the patient and then returns to the O.T. Department.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

120. The O.T. discusses the patient in item 119 above with a senior colleague regarding the home situation. They decide to refer

the case to the Social Services Department O.T. They telephone her and discuss the provision of ramps and the need to talk to the patients parents about her dependency and isolation if she is left upstairs. They discuss equipment alterations and possible alternatives.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

121. The community O.T. sorts and files cards, and checks her diary to plan visits.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

122. The community O.T. telephones the CPN (Community Psychiatric Nurse) to arrange for a Health Visitor to visit a client.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

123. The community O.T. makes diary entries, writes letters, and patients' cards.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

124. The community O.T. telephones a client but there is no answer so she decides not to visit.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

125. The community O.T. telephones a client to talk about equipment, how she's getting along and how the home help is working out. She arranges to visit to collect equipment and talks about reading and sight problems. She talks with the client about self-management and poor eye sight and suggests a magnifying glass. She encourages client with her medication regime.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

126. The community O.T. goes to visit clients. They are a couple. The wife is 92 years old with mild dementia and the husband is 88 years old with arthritis. She delivers equipment and talks with them. He has fallen and he is now sleeping downstairs on 2 chairs. The bed is upstairs. The O.T. discovers the home help is not coming but they are receiving meals on wheels and are visited by a nephew. The O.T. then leaves.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

127. The community O.T. goes on a supportive home visit where she will perform a mobility assessment on an elderly lady of 86 who is suffering from dementia and has had surgery to pin a fracture of her left hip. They talk about her well-being, her home help and the bed is checked. The O.T. leaves.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

128. The community O.T. writes reports on her visits.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

129. The community O.T. takes telephone messages for her colleagues.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

130. The Technical instructor takes a mentally handicapped client into the workshop.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

131. The Technical instructor prepares equipment to make concrete.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

132. The Technical instructor works with a group of adult mentally handicapped clients on making and mixing concrete.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

133. The community O.T. goes to the Stores to collect equipment for home visits.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

134. The community O.T. goes to visit an elderly couple. The husband has Alzheimer's Disease (dementia) and the wife has injured her knee. The O.T. discusses bath aids for the wife with her. They then discuss the husband's problems and their management.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

135. The O.T. technician collects patients from the ward for activities in the O.T. Department.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

136. The O.T. technician supervises two patients. One is a male patient who has had a CVA (stroke). The other is a male patient who has been involved in a road traffic accident. He sets up a chess game and instructs regarding the activity. They have previously been assessed by a qualified O.T.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

137. The O.T. technician makes tea for the patients.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

138. The O.T. technician prepares material for French polishing.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

139. The O.T. technician takes a wheelchair to the ward to pick up a patient.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

140. The O.T. technician discusses a walking frame with the patient whilst delivering a wheelchair to him.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

141. The O.T. technician goes to the ward to visit a young male patient who was severely disabled whilst playing football. He goes to assess the progress of the patient.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

142. The O.T. technician sorts out equipment and checks an order from the store.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

143. The O.T. goes to the ward to collect two patients.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

144. The O.T. treats two patients. Both are elderly ladies, one has had a CVA (stroke) and the other is suffering from a fractured neck of femur. The first patient has a left sided weakness so she plays Solitaire to exercise her left arm and shoulder then practises getting into bed from a wheelchair. The second patient practises activities of daily living in the O.T. bathroom and kitchen.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

145. The O.T. walks back to the ward with two patients and collects another patient while she is there.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

146. The O.T. treats an elderly male patient who has had a CVA (stroke). The patient is shown how to dress himself after his stroke.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

147. The O.T. prepares a "recognition" activity for an elderly male patient who has had a CVA (stroke). She copies shapes and lines onto paper using a large marker pen.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

148. The O.T. instructs a middle-aged male patient who has had a head injury in sorting through letters for a printing machine.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

149. The O.T. prepares equipment whilst waiting for a patient.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

150. The O.T. treats two male patients one of whom has had a stroke and the other a head injury. The first patient blows up a bag to treat his right, paralysed, arm and then he performs balancing exercises. The second patient organises a carpentry activity for himself. The O.T. later discusses progress with his work and problems he encountered.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

151. The community O.T. checks with the OT. helper her programme of work for the coming week.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

152. The community O.T. goes to visit a middle aged female client who has rheumatoid arthritis and is almost chair bound. An architect accompanies the O.T. so that arrangements can be made to adapt her home to accommodate a wheelchair.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

153. The community O.T. makes a telephone call to a company which supplies equipment about an order for a client.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

154. The community O.T. telephones the Housing Executive about criteria for client selection to various types of housing.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

155. The community O.T. telephones the Housing Executive's Maintenance Officer to discuss access to a client's house.

1 2 3 4 5 6 7 8 9
Lay person Support Worker OT

156. The community O.T. receives a telephone call from a company which supplies the Social Services department about equipment for a client.

1 2 3 4 5 6 7 8 9

ITEMS AGREED TO BE SUITABLE FOR A LAY PERSON

3. Telephoning ALAC (Artificial Limb and Appliance Centre) about a wheelchair for a client which needed an extension to the back rest of the chair.

12. Checking the availability of equipment in a store cupboard.

13. Receiving returned keys and equipment borrowed by physio- therapists.

36. The O.T. sets up equipment - a draughts board.

37. The O.T. goes to collect a patient in a wheelchair from the ward.

51. The O.T. makes a telephone call to a residential home to see if equipment ordered has been received.

55. The O.T. collects a patient in a wheelchair from the ward.

68. The community O.T. telephones a company about failure to deliver a commode.

72. The O.T. completes several order forms for equipment.

73. The O.T. sorts invoices received from companies for equipment orders and distributes forms around the department for action.

77. The O.T. helper goes to the Catering Store and collects food which she then unpacks in the O.T. kitchen whilst clearing up the coffee cups.

80. The O.T. helper assists 2 elderly patients to pack forceps with another helper, whilst talking to the patients.

85. The O.T. helper tidies up the equipment used in activities.

86. The O.T. helper escorts a patient back to the ward.

87. The O.T. helper sets up and prepares for use a printing block.

101. The O.T. performs a variety of administrative tasks such as filing, completing her diary sheet and photocopying correspondence.

102. The O.T. telephones to book a visit to a client.

113. The O.T. collects a wheelchair to transfer a patient to the O.T. Department from the ward.

114. The O.T. transfers a patient from the ward to the O.T. department in a wheelchair.

129. The community O.T. takes telephone messages for her colleagues.

135. The O.T. technician collects patients from the ward for activities in the O.T. Department.

137. The O.T. technician makes tea for the patients.

139. The O.T. technician takes a wheelchair to the ward to pick up a patient.

143. The O.T. goes to the ward to collect two patients.

145. The O.T. walks back to the ward with two patients and collects another patient while she is there.

149. The O.T. prepares equipment whilst waiting for a patient.

ITEMS AGREED TO BE SUITABLE FOR A SUPPORT WORKER

8. Ordering stores for the O.T. department.

10. An elderly female patient is admitted for a two week assessment after falling twice. The O.T. had previously assessed the patient's ability to perform activities of daily living. She talks to the patient about how she has managed that morning as the patient is eating breakfast.

26. The O.T. helper goes to visit a female client with rheumatoid arthritis to assess for a grab rail in the bathroom. This is the second visit and the client is out.

27. The O.T. helper goes to visit a female client aged 75 years with vertigo. She assesses the client for a bath aid, a rail at the front of her bungalow and a walking frame.

29. The O.T. helper assesses a 60 year old female client who has had a total hip replacement for a bathing seat.

30. The O.T. helper assesses an elderly infirm but independent female client for a toilet frame. She can manage well without and a frame is not required. The O.T. helper will discuss this with the Home Help Organiser, who referred her for the assessment.

31. The O.T. goes to visit a male client who is recovering at home from surgery for ankylosing spondilitis (rheumatic condition). He also has an ileostomy. This is the O.T.s third visit. She has assessed him for a shaver which has been approved and she has returned to discuss details of this. Since his wife is out, she will return in the morning.

38. The O.T. plays draughts with a 72 year old female patient who had a CVA (stroke) four months ago. The patient has a left sided hemi-plegia (paralysis). The O.T. has the patient sitting without support to practice balance. The draughts game is used to encourage the patient to straighten her left hand fingers and to use both hands. It is also used to measure concentration, short term memory and understanding.

56. The O.T. discusses home management with a patient using crutches after surgery to his toe who has rheumatoid arthritis. The patient then practises making a cup of coffee.

57. The O.T. provides printing equipment for two patients post hand injury, setting up the printer and allowing the patients to work on the equipment while she performs other tasks.

60. The O.T. assists a patient, who has had surgery for a Dupuytrens contracture (contraction of the skin on the hand) to his hand, to work on a tray border; she then transfers him to printing equipment.

65. The O.T. escorts a male patient who has a right hemiplegia (paralysis of the right side) to the toilet.

66. The O.T. conducts a group session with four elderly patients suffering from mental illnesses. She gets the patients to introduce themselves to each other and finds out if they can remember their names. She orients them to the group. They have to throw and catch a beach ball and they are asked to say the name of the person they are about to throw the ball to. The O.T. talks to them throughout to encourage communication. The O.T. then asks them to guess the object (a parachute) and she talks about its manufacture. The group then holds onto the parachute in a circle and they throw a bean bag each which they have been asked to choose by naming a colour. The activity is to provide physical exercise, orientation, colour perception and to encourage communication.

78. The O.T. helper escorts a young female patient to the kitchen. The patient has brain damage following a road traffic accident and is chairbound. She cannot talk and writes to communicate. The patient is supervised by the helper as she collects ingredients to make scrambled eggs on toast. She cleans and clears up. The helper assists the patient in making a list of food she enjoys. The O.T. joins them twice for a few minutes each time. After the session, the helper reports to the O.T.s on the patient's progress and then writes up notes on the session.

100. The O.T. goes to a Day Centre to visit a mentally handicapped resident of a home who is working there. She takes a walking frame and walks with the client to try out the frame.

104. The O.T. visits a female client of 86 years with Rheumatoid Arthritis to re assess her for the "Orange Badge" Disabled Parking Permit. She has had the badge for several years and is now re-assessed for it and for other aids and equipment.

105. The O.T. visits a female client who had been in hospital for lower back pain. She has now fully recovered and doesn't need help so the O.T. leaves.

106. The O.T. assists a 73 year old female patient who has a flaccid right hemiplegia (paralysed right side). She helps the patient to sit on the edge of her bed and to wash while supporting the patient's right side. She guides and instructs the patient through the activity. She then assists the patient to put on her nightdress, and to stand up while the nurse washes the patient's

buttocks. The patient is then assisted into a chair and combs her own hair, and takes her medication. The O.T. then leaves.

124. The community O.T. telephones a client but there is no answer so she decides not to visit.

132. The Technical instructor works with a group of adult mentally handicapped clients on making and mixing concrete.

136. The O.T. technician supervises two patients. One is a male patient who has had a CVA (stroke). The other is a male patient who has been involved in a road traffic accident. He sets up a chess game and instructs regarding the activity. They have previously been assessed by a qualified O.T.

140. The O.T. technician discusses a walking frame with the patient whilst delivering a wheelchair to him.

147. The O.T. prepares a "recognition" activity for an elderly male patient who has had a CVA (stroke). She copies shapes and lines onto paper using a large marker pen.

148. The O.T. instructs a middle-aged male patient who has had a head injury in sorting through letters for a printing machine.

153. The community O.T. makes a telephone call to a company which supplies equipment about an order for a client.

160. The O.T. conducts a group for stroke patients. Exercises to loosen joints are interspersed with conversation, ball passing and throwing bean bags.

165. The O.T. conducts a social skills activity group with 4 adolescents, 2 male, and 2 female. She explains the activity and they then name themselves and each other. The O.T. prompts them as necessary and praises their achievements. The group continues with an observation game, then a game of "Simon Says".

169. The Technical instructor shows a patient how to do a carpentry project. The patient is a young male with a mental illness.

171. The Technical instructor works with a male out-patient who suffers from a mental illness. He is advising the patient on a woodwork project. He is teaching the patient how to use a power jigsaw.

172. The Technical instructor shows a male patient with a mental illness how to use a plane for a woodwork project.

174. The O.T. technician in the community goes to visit a 47

year old female client suffering from Multiple Sclerosis. She has poor co-ordination and difficulty in walking. The technician goes to check on the installation of grab rails to ensure that they are correctly positioned for her use.

ITEMS AGREED TO BE SUITABLE FOR AN OCCUPATIONAL THERAPIST

4. Travelling to see a client for an initial assessment interview to establish problems. Client is a 48 year old male, married with cerebellar ataxia (difficulty in Walking). Discussion includes outdoor mobility, bathroom transfers, driving, examination of plans of the bungalow for a garage or covered car port. Performing a physical assessment of client getting into and out of the shower.

6. A new patient is referred. She is 50 years old with hypertension (high blood pressure) having had a left sided CVA 10 years ago from which she has some residual weakness. The patient also has rheumatoid arthritis. The O.T. takes a history of joint function, pain and stiffness. She discusses the disease and its management with the patient. She performs joint assessment for range of motion, and grip, especially of the upper limbs and she discusses performance of activities of daily living. She then observes the patient making a cup of tea and discusses aids for the kitchen with her.

11. Organising a group crossword activity with 2 O.T. Helpers in a Day Unit for the elderly. Starting the activity, and then leaving the group with the Helpers, to attend a ward meeting with the Ward Sister, Consultant, Physiotherapist and Social Workers.

16. Discussing transfer methods with a 56 year old female patient suffering from a sub-arachnoid haemorrhage (stroke). The stroke transfer method is tried with a nurse. The patient is transferred from chair to commode using a pivot transfer. The patient is positioned in the chair and stimulated verbally. The patient keeps on closing her eyes so she is approached from the other side. The patient responded a little to a left hand squeeze. The patient is moved upright by folding a blanket and further stimulation is tried. The next day's programme is discussed with the nurses.

17. Helping a 46 year old female patient with an acoustic neuroma (tumour on the nerve for hearing) and non-communicating hydrocephalus (water on the brain) into the O.T. department. The O.T. asks questions to establish level of disturbance and prompts the patient to establish the answers. Patient is asked to write name and address. O.T. assists with writing. O.T. then explains the hand function test to the patient. She times the patient with a stop watch, observing and recording twice with slow explanations in between. The O.T. then explained her findings to the patient and what she would concentrate on. She discussed problems with the patient and the future plan, walked patient to her wheelchair, said good bye and returned equipment to the cupboard.

25. The O.T. checks the medication regimes of a group of residents in a villa for the mentally handicapped in a hospital. She also reads the Nursing notes to assess the clients' suitability for a residential home.

28. The O.T. helper goes to visit a female client aged 63 years with severe rheumatoid arthritis. Her hands are increasingly crippled so crutches are difficult to use but she gets about at home. She only uses a wheelchair when she is taken out. The O.T. Helper assesses the door access of her home and for a ramp as the client goes to a Day Centre one day per week. The helper refers this to the O.T. as it is a complex situation.

33. The O.T. goes to visit an 82 year old female client who has bilateral amputation of her lower limbs. She is having difficulty transferring onto a new toilet seat. The O.T. does a full assessment and advises her on the transfer trouble with her new seat. (The G.P. had referred the patient to both hospital and community O.T. services and both were involved at this time).

35. The O.T. assesses a male patient, aged 68, with ankylosing spondilitis (a rheumatic condition) ten days after surgery for hip replacement. This is an initial assessment. The patient is for discharge the following day. The O.T. assesses the details of patient's family and progress of disease. She performs a physical assessment of back, neck, and arms for functional ability. She assesses him for dressing practice, bathroom, toileting and tea making. The O.T. has liaised with the community O.T. to ensure that aids and adaptations eg. toilet will be supplied.

48. The O.T. deals with an orange badge claim which has been refused and an appeal has been lodged with the ombudsman. The O.T. reads the report and drafts a reply.

52. The O.T. sorts out proposals for new posts to help implement the 1986 Disabled Persons Act.

54. The O.T. meets with a 20 year old client suffering from multiple sclerosis and in a wheelchair to discuss aids and problems with his bungalow.

62. The O.T. attends a meeting of O.T.s, helpers, Art therapist, Music therapist and voluntary services, all connected with working with the elderly mentally ill where the patients programmes are discussed. The group also discusses problems in co-operation with nursing staff and reviews progress of a tea dance group. The O.T. acts as group secretary, recording the minutes.

71. The O.T. instructs a new O.T. about a home visit where a lift is required.

74. The O.T. prepares to hand over work to a new O.T. and

discussion the management of the social services department where O.T.s are no longer attached to area teams and its impact on services.

89. The O.T. works with a female patient who has been suffering from anxiety and depression after a CVA (stroke). The patient is given support and supervision as she bakes scones in the kitchen. The O.T. assesses her capacity for activities of daily living and discusses her mood and sleep pattern.

90. The O.T. works with a female patient who has a spastic paralysis. She prepares the patient for fitting into a standing frame with the assistance of another O.T. and helper and after a brief standing session, she helps the patient back into a chair.

96. The O.T. discusses several matters with her Social Work colleagues including referral of clients and a client problem regarding safety in the home with bathing.

97. The O.T. visits a residential unit which provides respite care for the mentally handicapped to discuss equipment orders - types of equipment and their suitability for residents.

107. The O.T. greets an 18 year old female patient who has a severe head injury with visual impairment. The patient has developed behavioural problems and is reluctant to do anything. She is dysphasic (has difficulty in speaking) and has perceptual problems (difficulty in seeing). The patient has the Speech Therapist with her and the O.T. discusses progress with them. When the Speech Therapist has gone, the O.T. supervises and instructs the patient in preparing for a morning wash. She asks the patient to identify objects. The washing session is unsuccessful, so the O.T. proceeds to dressing practice and supervises and assists the patient who is very reluctant. The O.T. then returns to the Therapy Department to discuss this with the Speech Therapist.

108. The O.T. conducts a life skills group with 5 clients, 2 male and 3 female. 4 of them have been diagnosed as suffering from anxiety and depression and one from schizophrenia (a severe mental illness). The O.T. acts as a facilitator to encourage the group to identify skills and to discuss how they can improve their performance.

109. The O.T. attends a ward round with doctors, social workers, and nurses. The purpose of the meeting is to discuss social needs. The O.T. contributes to the discussion by presenting her assessments of the patients capacities in activities of daily living (ADLs).

110. The O.T. discusses clinical work for O.T. students in the O.T. department with the deputy head O.T.

117. The O.T. discusses with an O.T. student plans for her day with her patients and teaches the student about the use of and variations on perceptual tests. She then refers an additional patient to the student.

118. The O.T. talks with a more senior colleague about patient load, new referrals and plans patients' programmes for the coming week with her.

119. The O.T. goes to collect a 26 year old patient suffering who has had a road traffic accident. The patient is unable to speak and writes down all her responses. She has difficulty in movement and has spastic (stiff) paralysis. The O.T. takes to her bed to discuss her home visit with her. She tells her that her second wheelchair will not be supplied and she has to work out with the patient how she will get about. She takes the patient to the W.C. to practice transfers with her - on and off the W.C. They talk about home conversion and return to bed to draw up plans. They then try a "Glide about" but it is too unstable for use in W.C. and return to use of wheelchair. The O.T. talks to the patient and then returns to the O.T. Department.

120. The O.T. discusses the patient in item 119 above with a senior colleague regarding the home situation. They decide to refer the case to the Social Services Department O.T. They telephone her and discuss the provision of ramps and the need to talk to the patients parents about her dependency and isolation if she is left upstairs. They discuss equipment alterations and possible alternatives.

126. The community O.T. goes to visit clients. They are a couple. The wife is 92 years old with mild dementia and the husband is 88 years old with arthritis. She delivers equipment and talks with them. He has fallen and he is now sleeping downstairs on 2 chairs. The bed is upstairs. The O.T. discovers the home help is not coming but they are receiving meals on wheels and are visited by a nephew. The O.T. then leaves.

127. The community O.T. goes on a supportive home visit where she will perform a mobility assessment on an elderly lady of 86 who is suffering from dementia and has had surgery to pin a fracture of her left hip. They talk about her well-being, her home help and the bed is checked. The O.T. leaves.

134. The community O.T. goes to visit an elderly couple. The husband has Alzheimer's Disease (dementia) and the wife has injured her knee. The O.T. discusses bath aids for the wife with her. They then discuss the husband's problems and their management.

150. The O.T. treats two male patients one of whom has had a stroke and the other a head injury. The first patient blows up a bag to treat his right, paralysed, arm and

then he performs balancing exercises. The second patient organises a carpentry activity for himself. The O.T. later discusses progress with his work and problems he encountered.

152. The community O.T. goes to visit a middle aged female client who has rheumatoid arthritis and is almost chair bound. An architect accompanies the O.T. so that arrangements can be made to adapt her home to accommodate a wheelchair.

157. The community O.T. goes to visit an elderly female patient who has rheumatoid arthritis, heart trouble and poor eye sight. She fell three years ago on her steps going into the garden. The community O.T. discusses her re-housing problems with her.

158. The O.T. treats an elderly female who has had a Colles fracture (broken wrist) with a series of exercises to encourage movement in her right hand. The O.T. also assesses the patient's progress.

159. The O.T. makes a splint for a female patient who has a fracture of the left thumb. She makes an outline of the thumb and completes the splint.

161. The community O.T. helper meets with the District Nurses to liaise with them.

162. The community O.T. helper goes to visit an elderly female client with severe rheumatoid arthritis. They discuss special beds for the client and the helper makes suggestions about their suitability.

163. The O.T. discusses an independence regime with a 14 year old female patient who has had a head injury. The patient is going home for half term and the O.T. is explaining the independence regime.

164. The O.T. discusses a group activity plan with a junior colleague deciding which games to play to develop social skills and offering advice to her on how to do this.

166. The O.T. receives a visit from the REMAP representative (REMP - Rehabilitation Engineering Movement Advisory Panels). The engineer talks with the O.T. and the client (an adolescent boy) and assesses the client for a wheelchair table using equipment he has brought. The O.T. discusses details of the equipment design with the REMAP engineer eg. size, neet to fit on computer and typewriter.

167. The community O.T. goes on a home visit to a female client of 72 years who is suffering from non-Hodgkins Lymphona (tumours of the lymph glands). The O.T. is going to meet a representative of a company which manufactures automatic door openers at the client's home. The O.T. discusses its position with the client

and the company representative. The O.T. also assesses the client's home situation. The O.T. finalises details of the equipment with the representative.

168. The community O.T. visits a female client to check her stair lift. The O.T. discusses her general health and mobility and tries a stocking aid which is not useful and a gas fire lighter which is very useful. The client keeps the gas fire lighter. The O.T. discusses the stair lift guarantee and the maintenance contract for it which the Social Services Department has with the company and she takes the serial number of the stair lift. The O.T. tries the stair lift to ensure it is working smoothly and checks on other equipment the client may require eg. a trolley.

APPENDIX K

Classification of interview data

The role of Occupational Therapy (Question 1)

Views on current provision of Occupational Therapy (Question 2)

APPENDIX L

ISSUES WITH IMPACT FOR THE FUTURE OF O.T.

ITEMS ON THE COMMON AGENDA	OTs	VOs	OIPs	Total
1 Demography	1/20	6/20	11/20	18/60
2 1986 Act	3/20	7/20	2/20	12/60
3 Community Care Policy	1/20	1/20	8/20	10/60
4 Disabled people's activism	1/20	6/20	2/20	9/60
5 Griffiths	0/20	6/20	2/20	8/60
6 NHS Review	6/20	2/20	0/20	8/60
7 Technological change	4/20	0/20	3/20	7/60
8 Recruitment	1/20	4/20	2/20	7/60
9 Shorter admissions	3/20	0/20	2/20	5/60
10 Health education	2/20	0/20	1/20	3/60
11 Validating OT effectiveness	1/20	0/20	2/20	3/60
12 Generic therapist	0/20	1/20	1/20	2/60

ITEMS SOLELY ON THE OT AGENDA

Item	Support
1 Education about OT for other professionals	3/20
2 Developing assessment methods	2/20
3 Buying in of OT services by professionals	2/20
4 Greater client awareness	2/20
5 AIDS	2/20
6 OT involvement in new areas	1/20
7 Facing reality of staffing	1/20
8 Working with voluntary organisations	1/20
9 Increase in head injuries and strokes	1/20
10 Increase in numbers of patients leaving hospital	1/20
11 Closure of Training Centres	1/20
12 Relationship of OT with general management	1/20
13 Defining unique role of OT	1/20
14 Change in family structure	1/20

ITEMS SOLELY ON THE VOLUNTARY SECTOR

Item	Support
1 Questioning of current role definition of OT	6/20
2 Focus on practical needs of consumer	5/20
3 Disabled people as rehab team co-ordinators	4/20
4 Campaigns by vol. organisations	4/20
5 Local Govt (Housing) Bill	2/20
6 Pressure on voluntary organisations to fill in the gaps in provision	2/20
7 Vouchers or cash grants to buy services or equipment	2/20
8 Independent Living movement	1/20
9 Ethnic minorities	1/20
10 Effects on dispersal on staff time	1/20
11 The Family Fund	1/20
12 Need to promote OT	1/20

ITEMS SOLELY ON THE AGENDA OF OTHER INFORMED PROFESSIONALS

Item	Support
1 Public recognition of OT skills and extent to which this occurs	3/20
2 RTAs	2/20
3 Measuring effectiveness of OT services	2/20
4 Assessment for aids	1/20
5 Move from heavy to light industry	1/20
6 Better employment opportunities for people with disabilities	1/20
7 O.T. degree courses	1/20

Key
O.T. Occupational Therapy
V.O. Voluntary Organisation
O.I.P. Other Informed Professional

APPENDIX M

ALTERNATIVES FOR THE FUTURE OF O.T. SERVICES

ITEMS SOLELY ON THE OT AGENDA

Item	Support
1 Selling OT to other agencies	4/20
2 More focus on early experiences of new staff	3/20
3 Increasing staffing levels	2/20
4 More money for OT services	2/20
5 Publicise OT through College of OTs	2/20
6 Job sharing/creche facilities/ part-time posts	2/20
7 Move OT base to community	1/20
8 Move OT involvement in general management	1/20
9 Working with people towards self-determination	1/20
10 Working through companies which supply equipment	1/20
11 OT as specialist in ergonomics	1/20
12 OT in F.E. Colleges to advise	1/20
13 No helpers	1/20
14 Retainer schemes	1/20
15 Place OT in health authorities	1/20
16 Workers co-ops	1/20
17 Joint funded posts	1/20
18 Increase in Part III housing for AIDS	1/20
19 Increase in community care for AIDS	1/20
20 Craft instructors for housebound under OT supervision	1/20

ITEMS ON THE COMMON AGENDA

ITEMS ON THE COMMON AGENDA	OTs	VOs	OIPs	Total
1 Use of helpers/better skill and staff mix	4/20	0/20	10/20	14/60
2 Generic therapist/common core	0/20	2/20	5/20	7/60
3 Educational reform	3/20	4/20	0/20	7/60
4 Subspecialisation/different entry levels	0/20	3/20	3/20	6/60
5 Use of volunteers/involvement of voluntary organisations	1/20	3/20	1/20	5/60
6 Educating others to deploy OTs better	2/20	0/20	3/20	5/60
7 Key workers	0/20	2/20	2/60	3/60
8 Equal opportunities/broader based recruitment	1/20	2/20	2/20	3/60
9 Better recruitment systems	2/20	1/20	0/20	3/60
10 De professionalisation/ Abolition	1/20	0/20	2/20	3/60
11 Planning services with general managers	1/20	0/20	2/20	3/60
12 Clinical audit/research/P.I.s	0/20	1/20	1/20	2/60
13 OT as consultant/adviser/ enabler	1/20	1/20	0/20	2/60

ITEMS SOLELY ON THE VOLUNTARY SECTOR

Item	Support
1 Co-ordination between all agencies providing services and equipment to people with all types of disability	5/20
2 Individual assessment for a range of services by level of client need	4/20
3 Control of services by consumer groups through Independent Living Centres, vouchers, cash grants, client centred decisions	4/20
4 Consultation with organisations by and for disabled people	3/20
5 Rejection of counselling and focus on practical support	3/20
6 Vocational assessment and re-training for employment schemes	3/20
7 Recognition of carers needs	2/20
8 Monitoring of waste	2/20
9 Better training for O.T.s	2/20
10 Disabled people to work with professions (eg architects) directly	1/20
11 Development of technology for disabled people by O.T.s	1/20
12 Flexible social security regulations for severely mentally ill	1/20
13 Common system for supply of aids	1/20
14 Open records policy	1/20
15 OT to provide help with bureaucracy	1/20

ITEMS SOLELY ON THE AGENDA OF OTHER INFORMED PROFESSIONALS

Item	Support
1 Hospital community liaison	3/20
2 More flexible working hours	2/20
3 Clerical support	2/20
4 Better pay and conditions for OT	1/20
5 Better training for OT assistants	1/20
6 Staff substitution	1/20
7 OT training for practice, not an end in itself	1/20
3 Measuring effectiveness of OT services	2/20

Key
O.T. Occupational Therapy
V.O. Voluntary Organisation
O.I.P. Other Informed Professional

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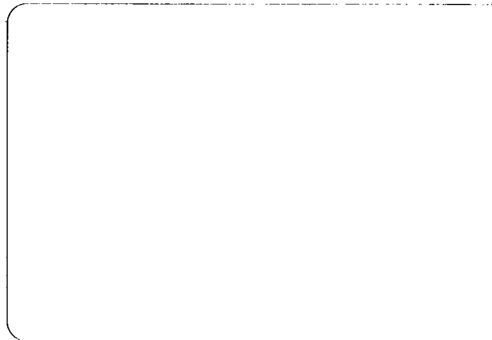

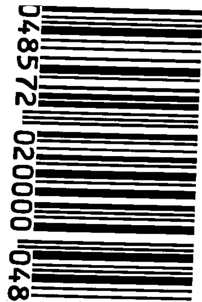

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