AN EXPLORATION OF CLIENT-CENTRED PRACTICE IN OCCUPATIONAL THERAPY: PERSPECTIVES AND IMPACT

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ABSTRACT

Client-centred practice underpins Occupational Therapy and is defined as a partnership between the client and therapist that empowers a client to fulfil his/her occupational roles in a variety of environments. Given the importance of this approach, there has been limited exploration of what therapists and clients experience of this approach.

A mixed method design examining the view of the clients and therapists was undertaken using; a systematic review to examine worldwide evidence of a client-centred outcomes measure, a survey of a sample of therapists' experiences and individual client and therapist interviews.

Findings from this programme of work revealed that the clients' perspective of client-centred practice was the value they placed on the attitude and behaviour of the therapist, communicating respect and treating them as equals. Therapists valued partnership but were challenged in establishing a relationship with the client and failed to negotiate goals with them. Using a client-centred outcomes measure (the COPM) reinforced partnership, demonstrated joint goal setting and evaluated client satisfaction.

Implications for practice; training needed in client-centred practice, theoretical models, interviewing, risk assessment, goal negotiation and use of outcome measures. Communication, use of language and documentation should be client-centred and reflect the client's needs.

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CHAPTER 1: INTRODUCTION

Background:

Client- centred practice provides the foundation for occupational therapy in many countries, particularly in Canada and the United Kingdom (UK). It is frequently referred to in core practice frameworks (Fearing & Clark 2000; Restall et al 2003) and more importantly in respective codes of professional conduct (COT 2010a; CAOT 2002). The professional body for occupational therapists in the UK, the College of Occupational Therapists (COT), sets the benchmark for occupational therapy practice in the UK Code of Conduct by stating:

"The College of Occupational Therapists is committed to client-centred practice and the involvement of the service user as a partner in all stages of the therapeutic process" (COT 2010a p.v)

In addition the Code requires;

"a continuing duty to respect and uphold the autonomy of service users, encouraging and enabling choice and partnership-working in the occupational therapy process" (COT 2010a p.9)

and that therapists;

"should work in partnership with the service user and their carer(s), throughout the care process, respecting their choices and wishes and acting in the service user's best interests at all times" (COT 2010a p.16).

In the Code the term 'service user' refers to any individual in direct receipt of any services / interventions provided by a member of occupational therapy personnel.

Knowledge of the theories and concepts of client-centred practice has grown considerably in the last two decades (Sumsion and Law 2006) and they have been explored in the professional literature (Law 1998; Sumsion and Law 2006; Townsend & Polatajko 2007; Fearing & Clark 2000). Despite this wealth of knowledge, my personal experience of managing an occupational therapy service and talking with clients, students and therapists suggested that this approach may not be widely applied in practice. This observation led me to question whether therapists were able to practice in a client-centred manner and whether this could be determined using available clinical outcome measures and most importantly, what did clients understand about this approach and did it make a difference to their treatment? This concern developed into a research question focused on understanding how client-centred practice was evidenced in occupational therapy. In order to address this question a research plan, which incorporated the therapist perspective, the client perspective and the clinical outcome was developed. This involved a three study design which was iterative and interlinked to create a comprehensive programme of work.

The research question

The research question was:

'What are clients' and the therapists' perceptions of client-centred practice in occupational therapy in the UK'?

To understand the importance and influence of client- centred practice within the profession of occupational therapy and its impact on practice, the therapist and the client, the history and background to this way of working requires exploration. This chapter will provide that context by considering the following key components: the history of the profession; the background and development of client centred practice; the relevance of outcome measures; and the part my own professional role had in questioning the relevance of client-centred practice. Arising from this context the research design was developed to address the research question, examine practice issues and explain the factors relevant to professional development, clinical practice and future research.

Defining Occupational Therapy:

The profession of occupational therapy has acquired a multiplicity of definitions during the years since the first training school was opened in the UK in Bristol in 1930. One of the earliest definitions by McNary in 1947 described it as;

"any activity, mental or physical, medically prescribed and professionally guided to aid a patient recover from disease or injury" (Hopkins 1993 p.3).

The World Federation of Occupational Therapy (WFOT) lists 37 definitions which have been developed by national member organisations to reflect their practice

(Duncan 2006). When Duncan (2006) reviewed these definitions he found that there was a consensus regarding the core elements of Occupational Therapy (OT), namely the connection of occupation with the therapeutic perspective. In 2010 the council of WFOT published a 'Statement on Occupational Therapy' (http://www.wfot.org/ResourceCentre.aspx) which affirmed for the member organisations, the scope, practice, education and focus of occupational therapy worldwide (WFOT 2010). The statement opens with;

"Occupational Therapy is a client-centred health profession concerned with promoting health and well being through occupation" (WFOT 2010 p4)

In the UK, the Council of the COT acknowledged that defining occupational therapy was complex (Creek 2003) and adopted a shorter definition in January 2004 which is listed as the current COT UK definition on the World Federation of Occupational Therapists website, it reads:

"Occupational therapy enables people to achieve health, well being and life satisfaction through participation in occupation" (COT 2004 p1)

This definition underpins the framework of this research with a focus on the core skills of enablement through participation with occupation. Core skills are the expert skills shared by occupational therapists irrespective of their field or level of practice (see below). The College of Occupational Therapists (COT) in the UK defined the profession's core skills (Table 1.1) as built around occupation and activity whilst recognising that these complex skills are composed of many component sub skills which include cognition and group leadership (COT 2009a).

Table 1.1

Core Skills of Occupational Therapy

Core Skill	Descriptor
Collaboration with the client	Building a collaborative relationship with the client that will promote reflection, autonomy and engagement in the therapeutic process
Assessment	assessing and observing functional potential, limitations, abilities and needs including the effects of physical and psychosocial environments
Enablement	enabling people to explore, achieve and maintain balance in their activities of daily living in the areas of personal care, domestic, leisure and productive activities
Problem solving	identifying and solving occupational performance problems
Using activity as a therapeutic tool	using activities to promote health, well being and function by analysing, selecting, synthesising, adapting, grading, and applying activities for specific therapeutic purposes
group work	planning, organising and leading activity groups
Environmental adaptation	analysing and adapting environments to increase function and social participation

Creek 2003 p36

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The focus of occupational therapy practice, which appears deceptively simple, is the doing of everyday activities or occupations; its complexity is in understanding the factors that influence and shape these activities by constructing interventions which enable the client to achieve mutually agreed goals. Duncan (2006) explained that the key skill of the occupational therapist is to bring an occupational perspective to the therapeutic context, taking into account a person's ability and identity. Occupational therapists work with clients' strengths and address areas of occupational dysfunction, in other words activities of everyday living with which the client struggles as a result of illness, disease or trauma. Occupational therapists work with all age groups across a variety of settings for example; physical and mental health hospitals and communities, prisons, rehabilitation units, private health and the voluntary sector and deal with a wide range of social, medical and environmental problems. The skill of the occupational therapist lies in the accurate assessment of a person's abilities and deficits and the construction of a planned graduated intervention plan, using activity or occupation to remediate function and increase independence. Key to this approach is the use of occupation or activity and the centrality of the individual within the therapeutic context (Duncan 2006).

Historical roots of Occupational Therapy:

Appreciating the history of occupational therapy adds to an understanding of current approaches and theories which influence how occupational therapy practice has been shaped. The title of the profession links the practice directly to occupation. The historical basis for health through occupation can be traced back to the Old Testament. In 30 B.C. Seneca recommended employment as a treatment for mental agitation and in the classical period of the Ancient Greeks and Romans, the remedial

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and health promotional effects of occupation were noted as essential to human happiness (Haworth & McDonald 1946). Occupation has been central to human existence throughout time and remains pivotal today in terms of health and well being, with lack of health reducing the ability of the individual to engage in occupation (Reed 1993). During the 19th century the issues of health and occupation were explored in many writings in English society, but those which had the greatest influence on occupational therapy were related to the philosophy of humanism and the social values of humanitarianism, which were also the basis of the moral treatment and the arts and crafts movements (Reed 1993).

The moral treatment movement was the vision of the Quaker, William Tuke, (Tuke 1813 cited by Borthwick et al 2001) who founded the York Retreat in England in 1796. This movement set out to treat patients with mental illness using work and occupation rather than confinement. It was a humane revolution that had a huge and lasting influence on the practice of psychiatry as it aimed to provide a compassionate, homely environment for people afflicted by loss of reason (Reed 1993). Based on the Quaker principles of spiritual equality for all human beings and with an emphasis on creating an environment which encouraged the individual to take personal and social responsibility, the moral treatment movement recognised the importance of useful occupation as a form of treatment contributing to the maintenance of health (McDonald et al 1972).This principle is also at the heart of the patient-centred philosophy which is central to occupational therapy today (Duncan 2011).

The arts and crafts movement, spearheaded by John Ruskin the English philosopher and William Morris an artist and architect (Reed 1993), emerged in the latter half of

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the 19th century. This movement, when translated into education and therapy provided two approaches; one approach became known as diversional therapy and the other as occupational training. The former became dominant in occupational therapy practice in psychiatry whilst the latter was prevalent in occupational therapy practice for people with physical disabilities (Reed 1993).

Modern day Occupational Therapy:

Occupational therapy as it is known today was formally recognised in 1917 with the establishment of the National Society for the Promotion of Occupational Therapy in the USA. Prior to that, programmes of occupation are known to have been in existence in the early part of the twentieth century (Haworth & McDonald 1946). A group of professionals from a broad range of backgrounds founded the National Society, an organisation which later became the American Occupational Therapy Association and was influential in the development of the profession (Duncan 2006). However one individual who had a significant impact on the development of occupational therapy was Dr Adolph Meyer (1886 -1950), who was born in Switzerland but spent his professional career in America, eventually becoming the Director of the Johns Hopkins University Medical School. During his career Meyer recognised the importance of instincts, habits, interests and experiences in people's lives. Consequently he developed an interest in the impact occupation had on his patients and employed Eleanor Clark-Slagle (a founder member of the National Society), who had trained in occupational therapy, to work with him. Meyer presented the first organised model of occupational therapy in 1921 in a lecture 'The philosophy of occupational therapy' (Reed 1993 p29). Even at this very early stage in the development of the profession, the core themes of occupation, a sense of doing and

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the relationship with the client were evident. Meyer described human organisation as having a particular rhythm of work, play, rest and sleep which needed balancing (Meyer 1922). He believed the only way of achieving this balance was by 'actual doing and actual practice' (Meyer 1922 p6) recognising the value to the individual of occupation and the satisfaction of achievement and completion of work activities. He also acknowledged the individuality of the therapists, noting that resourcefulness and a respect for the client's capacities and interests contributed to the client's sense of achievement.

The work of Meyer and Slagle influenced others to establish occupational therapy departments and the first in the UK was at the Gartnavel Royal Hospital which opened in Glasgow in 1919. In 1922, the first occupational therapist in the UK was appointed in Glasgow (Duncan 2006). Elizabeth Casson, was the first female medical doctor to graduate from the University of Bristol in 1929 and was influenced by the department in Glasgow. Casson worked with Octavia Hill (1838-1912) founder of the National Trust, as her secretary at the Red Cross Hall. Hill is believed to have had a considerable effect on Casson who became involved with Hill in various housing and social work projects organising a variety of recreational and educational activities for the tenants (Wilcock 2001). Casson developed an interest in occupational therapy which culminated in the opening of the first school of occupational therapy at Dorset House in Bristol in 1930. This was closely followed by other establishments in London, Northampton and Exeter (Morrison 1990). By the early years of the 21st century the provision of occupational therapy education in the UK was extensive with courses available at 31 universities involving a range of study options from first degree to PhD level.

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Occupational Therapy and the NHS:

The National Health Service Act in 1948 re-shaped provision of health care in the UK with care free at the point of use. The act outlined the role of the services in the NHS which included occupational therapy and the allied health professions (McDonald et al 1972). Subsequent legislation changed the face of the NHS and influenced the role of occupational therapy; for example the Chronically Sick and Disabled Persons Act (DH 1970) which provided for individual needs and welfare services; the Patient's Charter (DH 1991), which laid down Patients' rights and standards of care focussing on access to services, personal respect, privacy and dignity, patient choice, and the right to receive information about treatment and other NHS services. The Disability Discrimination Act (DH 1995) which made it unlawful to discriminate against disabled persons in connection with employment, the provision of goods, facilities and services and the Care Standards Act (DH 2000b) established a major regulatory framework to improve the protection of vulnerable people. The Mental Capacity Act (DH 2005a) provided a statutory framework to protect vulnerable people, carers and professionals based on the fundamental principle that a person has capacity and that all practical steps must be taken to help the person make a decision. More recently the NHS Plan (DH 2000a) outlined the vision of a health service designed around the patient; changes for NHS doctors, for nurses, midwives, therapists and other NHS staff, for patients and in the relationship between the NHS, social services and the private sector.

 At the start of the NHS in 1948, occupational therapists already had a formal education and had developed standards of practice. As one of the professions allied to medicine (PAMs), occupational therapy was an intervention prescribed by medical

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colleagues across the NHS and emerging social care environments. It was not until the 1960s that state registration for OT was mandated under the Professions Supplementary to Medicine Act 1960 which linked professional conduct and practice within a process of regulation. Since then the profession has become a recognised allied health profession (AHP) regulated by the Health and Care Professions Council (HCPC). This body applies a rigorous and transparent process to practitioner registration and fitness to practice following its reorganisation in the NHS Reform and Health Care Professions Act (DH 2002). Together with the registration function of the HPC, the professional body the COT, has contributed to the continuing development of the profession and its practice through issuing practice standards and guidelines, encouraging evidence based practice, conducting research, guiding curriculum design and the application of theoretical frameworks.

Client centred practice in the wider clinical context:

Carl Rogers is credited with being the first person to use the term, client-centred in his book, '*The Clinical Treatment of the Problem Child'* in 1939 (Law 1998). He described a practice that was non-directive and focused on concerns as expressed by the client. He believed that people receiving services were capable of playing an active role in defining and solving problems, with the therapist serving as a facilitator to help solve their problems enabling understanding and proposing solutions. At the same time, rehabilitation as a treatment was also emerging, and Law (1998) explored the history of both approaches in relation to occupational therapy. She described rehabilitation, as emanating from a medical model during the post war years, in which

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a diagnosis was made and specific treatment techniques prescribed and carried out by the therapist and patient. Although a team supported this process, the doctor was the leader and the patient was required to comply. It was not until the latter decades of the 20th century when disability rights campaigners challenged discrimination and the conventions of rehabilitation, which together with the emergence of consumers demanding greater influence and control over societal issues, saw people with disabilities demanding more involvement in rehabilitation (Law 1998).

The development of client-centred practice reflected Rogers' key humanitarian principles of self actualisation, personal growth and the importance of the environment which are all closely linked specifically in the philosophical framework of occupational therapy. However client-centred practice is not the exclusive domain of occupational therapy and other professions, such as nursing and medicine, have endorsed the principles of that approach to encourage closer working with service users. The following section explores some examples of how this has been addressed.

Nursing practice:

Nelligan et al (2002) reported on work carried out by nurses in Ontario, Canada who had developed a set of guidelines supporting best practice. Their guidance set out a framework of core values and processes as well as organisational strategies for facilitating client-centred care. They concluded that nurses needed to embrace as fundamental to practice, the values of respect and dignity and the belief that clients are experts regarding their own lives. In addition nurses should advocate for the client's goals within the healthcare team and that client choice should be recognised

as important in the delivery of care. Whilst this guidance document was developed for nursing practice in one region of Canada, it was identified as a means of closing the gap between what nursing should be and the reality of nursing care as taught in educational establishments. The pilot study established to examine this, provided evidence that the guidelines assisted nurses in delivering care that promoted quality of life from a client's perspective. In a later revision of the guidelines, changes were made which recognised that adequate and continual training and resources were paramount in supporting the adoption of client-centred practice (Registered Nurses Association of Ontario 2006).

In the UK, standards of conduct for nurses and midwives described in 'The Code' of the Nursing and Midwifery Council (NMC 2008) state quite clearly that nurses should

"make the care of people your first concern, treating them as individuals and respecting their dignity" and "work with others to protect and promote the health and wellbeing of those in your care" (NMC 2008 p1).

Much of the focus of this document has strong parallels with the principles of client-centred practice in occupational therapy, namely respect for the individual, active listening, sharing information and recognition of the contribution the individual makes to their own care and well being.

Studies in the 1990s (Rodwell 1996; Cahill 1996) explored the concepts of empowerment and patient participation in nursing practice. It was concluded that they involved a partnership valuing self and others and active mutual decision making. Rodwell (1996) concluded that empowerment was an important concept for nursing practice but that nurses needed a management structure and educational process to

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deliver this approach in nursing care. Later, Sahisten et al (2008) concluded that the concept of patient participation lacked clarity and had multiple interpretations, identifying that a shift in power from nurses to patients, shared knowledge and active engagement with the individual were required.

Practice in mental health nursing appears to have embraced the concept of patient participation and empowerment with the development of clear practice-based models of nursing (Fletcher & Stevenson 2001). Both the Tidal Model and the model of Therapeutic Partnership provided nursing with conceptual models based on patient-centred care to empower people with mental health problems (Fletcher & Stevenson 2001). This indicated that delivering a change in practice such as patient or client-centred care required the development of conceptual models to underpin that practice. Much of nursing practice however still remains aligned to the term patient rather than client, retaining the connection with ill health rather than a partnership approach.

Medical Practice:

There is evidence that the medical profession has been changing practice to a more person centred approach. As early as the 1980s in Canada, an alternative model to the more traditional disease–centred method of patient care was suggested. A patient–centred clinical method was described as being designed for gaining an understanding of the patient as well as his/ her disease (Levenstein et al 1986). This model was limited in so far as it was based on the combination of the doctor's receptivity to the behaviour and cues offered by the patient, adding to the doctor's explanation of the illness or disease. The model offered an alternative means of

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communicating with the patient, recognising their expectations and views but failed to demonstrate partnership working or empowerment. In America in the 1980s and 90s much of the debate about the doctor – patient relationship focused on the two extremes of autonomy and paternalism (Emanuel & Emanuel 1992). Whilst it was recognised that this would result in a conflict between the values of the patient and those of the physician, it was argued that the physician's dominance could be balanced by greater patient autonomy. An alternative approach was proposed which challenged the convention of the paternalistic approach to patient care by offering four models for the doctor-patient relationship. Of these approaches; the informative model, the interpretive and the deliberate model all reflect patient involvement, empowerment and are supportive of patient autonomy, whilst the paternalistic model suggest that it is the doctor's role to be the sole guardian of the patient's interests (Emanuel & Emanuel 1992). See table 1.2 below.

Table 1.2:

Four models of the Physician-Patient relationship

Model	Patient values	Physician's obligations	Concept of patient's autonomy	Concept of the physician's role
Paternalistic	Objective and shared by physician and patient	Promoting the patient's well being, independent of the patient's current preferences	Patient assents to physician's objective values & decisions	Guardian
Informative	Defined, fixed and known to the patient	Providing relevant factual information and implementing patient's selected intervention	Choice of and control over medical care	Competent technical expert
Interpretive	Unclear and conflicting, requiring elucidation	Elucidating and interpreting relevant patient values plus informing the patient and implementing patient's selected intervention	Self understanding relevant to medical care	Counsellor or adviser
Deliberate	Open to development and revision through moral discussion	Articulating and persuading the patient of the most commendable values as well as informing the patient and implementing the patient's selected intervention	Moral self development relevant to medical care	Friend or teacher

(Emanuel & Emanuel 1992)

The authors suggested the deliberate model as the preferred option because it

supported patient empowerment, offered information and choice and advocated a

greater partnership approach than was suggested in the other models. In a later work

a different model was proposed in which the individual physician and patient

participated in shared decision making and physicians were held accountable to

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professional colleagues and to patients (Emanuel & Emanuel 1992). However this steered the focus towards accountability rather than a person orientated care approach.

Similarly it was acknowledged in the Canadian medical literature that patient-centred medical care was on the periphery of medicine in the 1980s (Sumsion 2006) and it was not until the 1990s that this approach became integral to undergraduate and graduate medical training. It was found that patients wanted and desired satisfaction with patient-centred care as well as indicating the positive impact this had on patient outcomes and healthcare utilization (Stewart et al 2000). In an attempt to shape a global definition of patient centred care for doctors, Belle Brown ,Weston & Stewart (2003) described the key features as; an integrated understanding of the patients' world (their emotional needs and life issues), the need for information, mutual agreement on management and the enhancement of prevention and health promotion.

Little et al (2001) carried out an observational study of patient centredness with 865 patients at three mixed community general practices in the UK. Participants completed a pre and post consultation questionnaire covering for example, aspects of illness experience, the doctor-patient relationship, reasons for the consultation and the doctor's approach. They concluded that if doctors were positive and definite about the diagnosis it had a positive effect on client satisfaction, enablement and symptom burden. In parallel with some key features of the client- centred components in occupational therapy, Little et al (2001) found that communication and partnership were strongly linked to patient satisfaction. This study concluded that

components of patient perceptions of patient centredness could be measured reliably, citing communication as a key element in this. However the study did not take into account or reflect in the results, any evidence that some patients may have had a long term relationship with their general practitioner which may have influenced their perception of partnership and communication. There has been no follow up study or further evidence produced to demonstrate that the patient centred model of doctor consultation advocated for use in general practice, was widely adopted.

The General Medical Council in the UK included the principles of patient centred care in guidance about good medical practice (GMC 2006). These principles of good practice are described as encouraging patients to take an interest in their health and to take action to improve and maintain it. This may require the doctor to advise patients on the effects of their life choices on their health and well-being and the possible outcomes of their treatment. Partnership with patients is reinforced with good communication needed to address their individual needs. This partnership approach should involve treating patients as an individual and with dignity and respect. The guidance reinforced the need to encourage patients to acquire knowledge about their condition and to use this when making decisions about their care (GMC 2006). Whilst this document provided a sound and explicit range of guidance which reflected several components of client-centred practice within a medical approach to patient-centred care, it is advisory rather than obligatory and fails to link directly to a theoretical model of practice. The emphasis in the medical and nursing professions indicated a shift towards greater involvement of the individual in decision making about treatment and care choices, which resonates with

some of the principles of client-centred practice in occupational therapy emphasising the importance of the individual as the centre of intervention.

The political context:

The wider political agenda also influenced the development of client-centred care and its adoption in occupational therapy practice. In the broader health economy, individual and patients' rights movements had promoted patient involvement in healthcare for many years (Gibson 1991), however it took some time for this philosophy to be incorporated within national directives on health and well- being. The concept of health had already been linked with well being and was described in the preamble to the constitution of the World Health Organisation (WHO) of 1946 which described health as;

"a state of complete physical, mental and social well being and not merely the absence of disease or infirmity" (WHO 1992).

This concept of the health of a person being multi dimensional and including life satisfaction and a sense of well being (Epp 1986) was linked with the holistic view of the individual emphasised by the Canadian Association of Occupational Therapists (CAOT) and the Department of National Health and Welfare (CAOT & DNHW 1983) in the initial version of the Guidelines for the Client-centred practice of Occupational Therapy. The first international conference on Health promotion was held in 1986 and was supported by 38 countries. The outcome was the Ottawa Charter for Health Promotion, the focus of which was to achieve health for all by 2000 (appendix 1.2). The charter discussed health as a positive concept emphasising that health promotion was a process of enabling people to have control over their own health

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and well being. It recognised the changing patterns of life, work and leisure and the impact these have on health. Furthermore it advocated the need to change the attitude and organisation of health services in order to focus on the needs of the individual as a whole person. Whilst it recognised that health pervaded all aspects of a person's life, reinforcing the need to enable the individual to take control, to make informed choices and to have information in order to do so; the Charter was a document of aspiration rather than policy. The outcome was an appeal to the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion to achieve Health For All by the year 2000.

Government policy in the UK during the 1990s began the process of recognising the patient element in healthcare with the publication of the Patient's Charter in 1991. This set out the goals of listening to and acting on people's views and needs and set clear standards of service for meeting those goals (DOH 1991). As a document, it was been described as weak and ineffective by critics (Mold 2010) as it failed to specify real responsibilities and outcomes, however it did highlight patients' rights to health care which up until then had not been made explicit in a single framework document (McNab 1999). It was eventually superseded by the changes to health care implemented in 2000 following the publication of the NHS Plan (DH 2000a) which outlined changes for health and social care and described the relationship between public and private health care. The role and importance of patient involvement was reflected in the emphasis given to patient surveys and forums which were seen as a means of promoting patient focused care. Further initiatives were aimed at effecting cultural change rather than purely organisational or structural

transformation (DH 2004). Patient and Public Involvement in Health (DH 2004) evaluated research evidence about patient and public involvement, concluding that patient involvement improved patient satisfaction and was rewarding for professionals advocating public involvement in planning services. 'Now I feel Tall' (DH 2005b) advocated empowering patients in health care by active listening and responding to individuals' views in order to improve the public experience of healthcare in the UK. Finally the NHS Constitution (DH 2012a) brought together in one place information about what staff, patients and the public can expect from the National Health Service. This Constitution describes the principles and values of the NHS in England as well as the rights and responsibilities of patients, public and staff and pledges which the NHS is committed to achieve. Those rights include involvement in decision making, information, respect and dignity. Interestingly whilst this document reflects the NHS it also covers all private and third sector providers supplying NHS services who are required by law to take account of this Constitution in their decisions and actions. Furthermore the document will be renewed every ten years involving patients, the public and staff in its revision.

Client- centred practice in Occupational Therapy:

Client-centred practice in Occupational Therapy emerged in Canada during the 1980s and was steered by CAOT and DNHW. Their work to develop a clear framework for the unique contribution of occupational therapy to client-centred practice culminated in the publication of the Occupational Therapy Guidelines for Client-Centred Practice; a consolidation of three earlier documents written to establish quality assurance in occupational therapy throughout Canada. There was recognition by authors in the field (Law, Baptiste & Mills 1995) that whilst these

guidelines were widely publicised, there was little discussion about the concepts and issues relating to the practice of this approach, resulting in difficulties for therapists seeking to implement it in practice. The authors set about defining the key concepts of client-centred occupational therapy in order to support practice. Their definition described client-centred practice as;

"an approach to service which embraces a philosophy of respect for and partnership with, people receiving services"(Law, et al 1995 p253).

This became the first formal definition of the term with which to guide and influence practice and remained the de facto working definition until 2000 when Sumsion created a version for the UK which is the one used in this research. The Sumsion definition took more account of context, acknowledging the influence of the current health economy pressures for example and came with a preamble:

"There are many factors that influence the successful implementation of client centred practice, including a clear determination of who the client is and the recognition of the impact of resources.

Client- centred occupational therapy is a partnership between the client and the therapist which empowers the client to engage in functional performance to fulfil his /her occupational roles in a variety of environments. The client participates actively in negotiating goals which are given priority and are at the centre of assessment, intervention and evaluation. Throughout the process the therapist listens to and respects the client's values, adapts the interventions to meet the client's needs and enables the client to make informed decisions" (Sumsion 2000a p308).

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Whilst the original Canadian definition included the key concepts of partnership, respect, choice and involvement, Sumsion widened the scope of the UK definition to include the impact of resources and a clear identification of who the client was (Townsend 1998a; Christiansen 1997; CAOT 1997; Sumsion 2000a).

Despite this approach being implicit in the World Federation of Occupational Therapy (WFOT) code of ethics, with its reinforcement of respect and regard for individual circumstances, there are no internationally agreed guidelines or standards for client-centred practice (WFOT 2005). At a national level delivering client-centred care is part of the strategy for professional and service development endorsed by the UK regulatory body (HCPC). Evidence of this can be found in the standards of proficiency for Occupational Therapists, where the HCPC describes good practice as the need to engage service users and carers in planning and evaluating diagnostics, treatments and interventions to meet their needs and goals (HPC 2007). Also the professional bodies for occupational therapy in Canada and the UK, CAOT and COT, both promote the philosophy of client centred practice as a core principle of occupational therapy education and practice (COT 2003, 2004; CAOT 1983, 1991, 1993). COT promotes client-centred practice in standards of practice and professional practice guidelines, where the focus for therapists is;

"to provide intervention that is appropriate to your service users as individuals, based on their identified occupational needs" (COT 2007 4.4).

Therapists are also required to treat service users with respect and dignity at all times working in partnership with them and their carer(s), putting them at the centre of practice whilst upholding the service users' right to make choices over the care they

receive and the plans they wish to make. In developing these standards, COT acknowledged current government policy in support of best practice, the National Care standards (DH 2010b) for example to promote the profession's occupational perspective of humans and their well-being. They also recognised the role of the Care Quality Commission (CQC) a public body sponsored by the Department of Health, which was set up to promote and drive improvement in the quality of health care and public health in England and Wales.

The COT identifies client-centred practice as one of the core elements in the undergraduate curriculum in its guidance on pre registration education (COT 2009b). However it would appear that the delivery of client-centred practice at undergraduate level on OT courses in UK Universities is typically integrated within the whole curriculum. I enquired of several university occupational therapy departments which my service had links with, to ascertain how client-centred practice was taught to undergraduates. I anticipated that this approach would feature within specific modules or taught elements of the course. The Occupational Therapy departments at Derby, Plymouth, Oxford, Coventry and East Anglia universities were approached and all described the delivery of this philosophy as permeating the whole course from modules in professional development, foundations for practice, and knowledge and skills and concepts underpinning occupational therapy. Of those contacted, two establishments indicated documents which referenced client-centred practice (University of Derby 2009; University of Coventry 2008) see appendix 11. However this assurance of its inclusion in undergraduate education does not guarantee that client-centred practice as a working philosophy is explicitly taught or clarity given as to its application in practice. With greater emphasis placed on the role of the

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individual in treatment and care decisions from both the political arena and the professions themselves, the means of assessing the quality of the care provided stresses the importance of the role which outcome measures have in the client-centred approach.

Outcome measures:

One means of measuring the impact of practice is to use outcomes measures. The need to deliver high quality health care based on the best quality evidence is of prime importance in today's health economy (Jerosch-Herold 2005; Unsworth 2000). In clinical practice, where intervention takes place between a therapist and a client, judgment of its evident success or otherwise is often based on the view of the professional. Outcome measures are commonly designed to capture increased ability, function or change in circumstance reflecting the success and focus of the treatment. From a professional perspective, the College of Occupational Therapists for the UK (COT 2010a) places this responsibility firmly with the occupational therapist, recommending the use of outcome measures to determine clinically relevant change. When considering how quality of care can be assessed Donabedian suggested there was a need to learn accurately how to determine a patient's preferences in order to arrive at 'truly individualised assessments of quality'(Donabedian 1988 p1748).

Outcome measures cover a wide range of domains in disability and health (Jette 1995) and are defined as measuring the actions or consequences of an event (COED 2005). Some are designed for specific client groups which limit their applicability; the Clifton Assessment Procedures for the Elderly for example is

specific for the functional assessment of older people (Pattie and Gilliard 1979).

Others are limited by their scope; such as the Rivermead Perceptual Assessment

Battery which determines perceptual ability only (Whiting et al 1985). Measures

which are clinically specific or defined by their diagnostic range may be less sensitive

to measurement of clinical change from the clients' perspective. Stapleton and

McBrearty (2009) in their study on the use of standardised assessments and

outcome measures found that respondents considered that many were not client-

centred or holistic and that this influenced the use of such measures.

One such client-centred outcomes measure is the Canadian Occupational

Performance Measure (COPM) designed for use by Occupational Therapists to

detect change in a client's self perception of occupational performance over the

course of a programme of Occupational Therapy (Law et al 1991, 1994, 1999, 2005).

Occupational performance can be broadly defined as participation in daily life in

context (Townsend 2005).This measure is unique in its blending of the assessment

of functional ability with measuring satisfaction with that ability. As an outcome

measure the scores from the COPM are used for comparative purposes at

reassessment. Unlike some norm-referenced tests where a client's score is

compared against a population norm, the COPM is an individualized outcomes

measure so the client's scores are compared with their own reassessment scores.

This measure is described as being designed for use in client-centred occupational

therapy practice and noted for the participatory process of involving people in

producing a quantitative score calculated from their self perceived qualitative

experiences of occupational performance (Law et al 2005). As this tool combines the

client-centred element with treatment planning and outcome measurement it has the

potential to provide a valuable means of determining how client-centred occupational therapy is applied in practice.

Developing the research design

The majority of the literature published about client- centred practice in occupational therapy has focused predominantly on definition, interpretation and evaluation of clinical programmes (Sumsion 2000a; Law, et al 1995; McKee & Rivard 2004). There has been limited attention paid to therapists' understanding and application of this approach (Daniels, Winding & Borell 2002; Toth-Cohen 2008; Clemens et al 1994; Cott 2004). Leading authors in the field of client-centred occupational therapy advocated partnership, client involvement and client empowerment as fundamental elements in its successful delivery (Law, et al 1995). However there is evidence that client and professional opinions differ in several fundamental areas, especially goal setting, treatment priorities and judgment of outcomes, creating barriers to client centred care (Corring 1999; Gage & Polatajko 1995; Corring & Cook 1999). These arguments have featured as recurring themes during the last decade (Falardeau & Durand 2002; Lum et al 2004; Maitra & Erway 2006). It could be argued that if both clients and therapists have different goals, intervention is likely to lack focus and the judgement of outcomes of that intervention will have little relevance to the well being of the client. The means of determining the quality of the intervention, particularly from a client's perspective, may be a client-centred approach to care and evaluating that care using a client- centred outcomes measure. Some authors have begun to explore the assumptions made by therapists about the clients' role in determining the care they receive (Corring & Cook 2006; Palmadottir 2006; Hammell 2007b), whilst others have examined clients' perceptions of client-centred practice (Maitra &Erway

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2006; Larrson Lund et al 2001). The case for undertaking the present research study was based on the need to explore how client-centred practice is experienced by both the therapist and the client.

Delivering a client-centred occupational therapy service to clients in an NHS acute hospital department and measuring the impact has been my professional challenge. My occupational therapy career of over 35 years has encompassed NHS and Local Authority social care environments and the clinical specialities of adolescence, adult and elderly mental health, adult acute and long term physical rehabilitation, child physical rehabilitation and acute in-patient care. As a service manager for half of those 35 years I have had responsibility for training and developing staff and undergraduates, setting and maintaining standards of practice and ensuring service delivery meets the requirements of the population my team serves. My responsibility to deliver that practice is influenced by external factors; a government agenda of patient involvement (DH 2004; 2012) and a professional body and regulatory council which reinforce the underpinning principles of practice as client-centred. However in my professional experience there has been limited exploration of what client-centred practice means to therapists and, more importantly, little attention paid to clients / patients / service users' experience of client-centred practice. Given the name of this approach, an investigation of the therapist and client perspectives of client-centred practice and an examination of its value, determined by exploring a client-centred outcomes measure, was necessary to inform future training, development, practice and service delivery.

Methodological approach:

The need to consider the views of clients, therapists, and to examine outcome measures resulted in a multi-method design with different approaches used to address the complexity of client-centred practice as identified earlier. The research was qualitative, involving an iterative approach. The conceptual framework for the research was developed by drawing on a number of research perspectives resulting in a mixed methods design. Details of how this design was developed and applied to the research are discussed in the methodology chapter (3). The overall framework facilitated a progression from an international perspective by examining the literature on the outcome measure, the COPM, to a focus group and survey of therapists for a wider professional view and finally a more local individual perspective which was assessed by interviewing clients and therapists see fig1.1 below.

The thesis is organised as follows (see Fig.1.1. below). First the narrative review in chapter 2 examines a range of evidence related to client-centred practice and sets the context for the whole research. The methodology chapter (3) then explains the approach taken to the research. Each of the individual studies (chapters 4, 5, 6 and 7) are reported separately and related to the overall methodology. The discussion chapter (8) draws together the findings of all the studies, addresses limitations and explores and analyses the results. The conclusion (chapter 9) reflects on the whole research, considers the potential impact of the findings on practice and recommends areas of consideration for further research. An overview of the research is presented here to provide a summary of the structure of the thesis.

Fig: 1.1.Thesis Design:
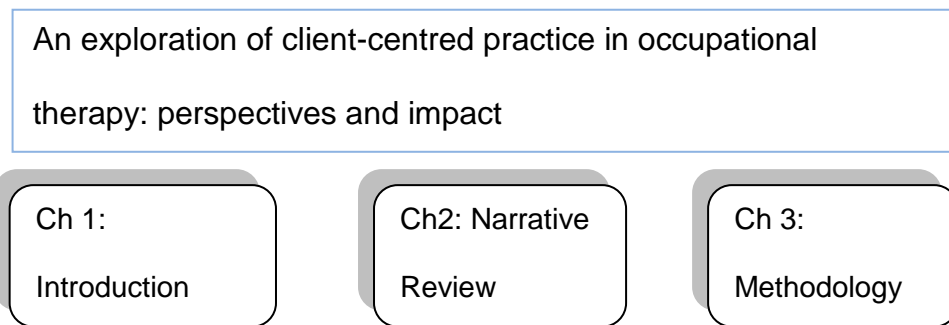
An exploration of client-centred practice in occupational

therapy: perspectives and impact

Ch 1:

Introduction

Ch2: Narrative

Review

Ch 3:

Methodology

International Perspective

CH.4: Study 1

The systematic review of the COPM

Professional Perspective

CH. 5

Study 2:
Focus Group

CH.6

Study 2:
Survey

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Study 3: Interviews

Ch 8: Discussion

Ch 9: Conclusion
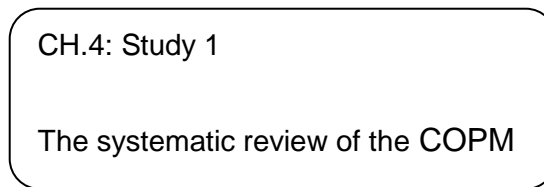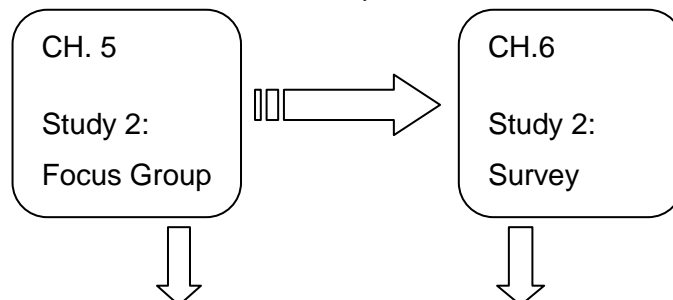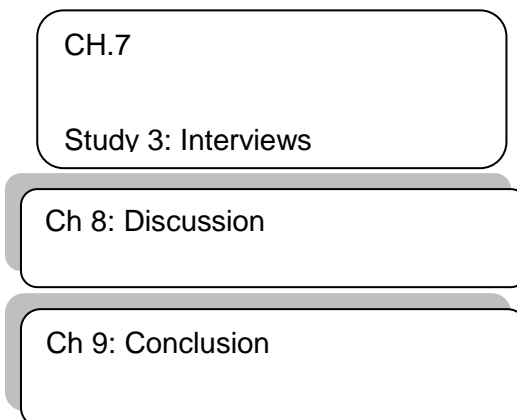
Study 1:

Focusing on an international perspective, study 1 explored the evidence base for the Canadian Occupational Performance Measure (COPM) as an outcomes measure in clinical practice, in the form of a systematic review. The rationale for this was that a systematic review would result in an appraisal of the wide range of published studies on the COPM, and would identify objectively, the advantages and disadvantages of using this outcomes measure as reported by clinicians in practice. Sampling the Occupational Therapy literature related to the COPM indicated that a wide range of research methodologies had been used in studies of the COPM. This included single case studies (Waters 1995) evaluations set within particular clinical settings (Healy and Rigby 1999), studies adopting a quantitative/qualitative mix (Ripat et al 2001), a systematic review (Parker & Sykes 2006) and opinion based articles (Fedden, Green & Hill 1999).

Systematic reviews establish where the effects of healthcare are consistent and where research results can be applied across populations and clinical settings (Alderson et al 2003). The advantages are that bias can be limited, reducing systematic errors and chance effects, generally providing more reliable results upon which conclusions can be based (Antman 1992; Oxman 1994, Clarke and Oxman 2001). The value of systematic reviews in research is their focus on synthesizing and disseminating results (Massy-Westropp and Masters 2003). Tickle-Degnen 2002) suggested that the results of systematic reviews can, amongst other things, change practice, pathways and guidelines and indicate areas for further research.

The approach taken in this review followed the process described by Tickle-Degnen (2000) starting with a clear research question; what is the evidence for using the

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COPM in clinical practice? This was addressed using a comprehensive literature search strategy, followed by a screening process of each study using clear inclusion / exclusion criteria (Bannigan, Droogan & Entwhistle 1997; Brown & Burns 2001) (see chapter 4). The studies were then subject to critical appraisal and synthesis using validated tools such as the Critical Skills Appraisal Programme guidelines (PHRU 2006) and the Cochrane Database of Systematic Reviews (2006) (Dickson and Entwhistle 1996, CDSR 2006) which were used in the methodology. Once the review was complete and results interpreted, conclusions were drawn. These findings informed the design of studies 2 and 3 (Massy-Westropp & Masters 2003).

Study 2:

This study was focused on the professional perspective at a national level and involved an exploration of what occupational therapists understood about client-centred practice in their own clinical domains using two methods of enquiry; a focus group and a survey. It has already been noted that the philosophy of Occupational Therapy practice in the UK is client-centred (COT 2010a), what is less clear is how that philosophy influences the provision of therapy. Sumsion and Law (2006) for example, noted that there was some dissonance between the theory which underpins practice and the role of the therapist in its implementation. Similarly Pollock, McColl and Carswell (2006) reported that therapists experience difficulties in trying to operationalise the basic principles of client-centred practice. This has implications for the delivery of that approach in practice and is particularly relevant given the practice pressures and organisational challenges which can impact on its delivery (Christie and Cross 2003; Rebeiro 2000; Sumsion and Smyth 2000). Sumsion and Law (2006) also highlighted that the complexity of being client-centred meant that further

research was needed to help therapists understand and evaluate whether they were being truly client-centred in their practice.

A self-selected focus group of occupational therapists in the UK was held at a national conference to explore therapists' views and understanding of working with clients in a client-centred manner. The issue of client-centred practice and the challenge of how therapists engaged clients in therapy provided the framework for the semi-structured approach to this part of the research. The importance of explaining how therapists perceive and deliver client-centred care in practice was paramount in meeting the aims of this part of the research. The group session was audio recorded, later transcribed, and the data subject to content analysis to identify themes.

Secondly, a survey was undertaken using a questionnaire which was circulated to a wide purposive sample of occupational therapists which focused on the links between the theory and practice of client-centred practice, and explored the use of the COPM. The design of the questionnaire was influenced by the findings from the focus group and aimed to ascertain respondents' understanding and views about the key concepts of client-centred practice and the use of a client-centred outcome measure. This was sent to a purposive sample of occupational therapists working in the UK and others who were members of the Copmnetwork, an electronic database on the COPM. The data was analysed using SPSS v14 (SPSS 2005).

Study 3:

The final element of the research concerned the local perspective. This study was designed to examine the individual understanding and experience of both practicing

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and experiencing client-centred occupational therapy by exploring the views and perceptions of a sample of therapists and clients. This was a qualitative study using semi-structured interviewing.

Ethical approval was sought and granted for this study from the National Research Ethics Service and from the health organisation managing the study site. Sampling was purposive from a group of clients who met the study inclusion criteria and who consented to take part. The therapists worked in community occupational therapy in the sample location. The interview format was designed to reflect some key themes of client-centred practice from the shared perspective of both client and therapist. For example the themes of communication, respect and listening, were identified in the literature and the findings of study 1. The questions for clients and therapists followed the same structure but with adjustments made to the wording to reflect the client or therapist perspective (see appendix 1.2).

Interviews were undertaken in the client's own home or in the therapist's work base as appropriate. They were recorded and transcribed verbatim. Each transcription was then subject to analysis of content to reveal key themes and patterns. Data from the interviews were combined with field notes on observations taken by the researcher and added to the findings from this study.

In summary it was intended that this research would address a gap in the profession's knowledge about the application of client-centred practice by exploring the therapist and client's perspective. The challenge of placing the client at the centre of practice is considered integral to the provision of client-centred practice (Rebeiro 2000) with Sumsion (2005) suggesting that an effective partnership between the

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client and therapist provides the means of establishing and achieving shared goals and thus effective client-centred practice.

This research was designed to explore client- centred practice in Occupational Therapy on three levels. Internationally to determine the evidence for use of a client-centred outcomes measure (the COPM) in clinical practice; professionally to determine the knowledge and understanding of therapists on applying theory into practice; and locally by examining the perspectives of both clients and therapists of what it means to experience client-centred care. The results of these studies indicate areas for future study in client-centred practice, suggest changes and gaps in our learning which may impact on practice and provide evidence for the successful implementation of client-centred occupational therapy.

CHAPTER 2: LITERATURE REVIEW

Introduction:

This chapter presents a review of the key literature relating to the practice of client-centred occupational therapy and examines the evidence for this approach and explores its impact on the way occupational therapy is practiced in the UK. A narrative review of the literature was carried out to identify the core elements of client-centred practice, to explain its impact on practice and to explore evidence of client or therapist perspectives on this approach (Cronin, Ryan and Coughlan 2008; Green, Johnson and Adams 2006). Throughout the review contradictions or gaps in the evidence base are considered and explained in support of the rationale and justification for undertaking this research.

The reason for carrying out a narrative review rather than a systematic one was because I wanted the review to explore and cover a wide range of issues related to client-centred practice. I did not want to be constrained by examining the efficacy or otherwise of each individual piece of evidence against strict criteria for quality, rather I wanted to explore the extent of the evidence and to establish any emerging themes in the literature on client-centred practice. By taking this approach, the scope of the research question, which included client and therapists' perspectives and the impact of client-centred practice on occupational therapy, was addressed. The narrative review process allowed for greater flexibility of evidence selection and inclusion, as the evidence was not required to comply with rigid selection criteria (Collins & Fauser 2004). In organising the whole thesis, a systematic review had already been planned and was undertaken (see ch.4) to examine the evidence for a client-centred

outcomes measure, the COPM in clinical practice. In those circumstances, a

systematic review was applicable as the COPM was a specific subject and the review

was designed to examine and judge the available evidence related to its clinical

application in occupational therapy. That review demanded a specific question,

inclusion and exclusion criteria and a rigorous process for discerning the quality of

the evidence. Using a systematic review in that situation meant that both the quality

of the available evidence and the reliability and validity of the review were judged.

The purpose of the traditional or narrative review was to summarize the mass of

literature about client-centred practice, critique the evidence and provide a summary

of evidence about it. The aim was to establish the context for understanding current

knowledge about client –centred practice and to highlight any gaps or inconsistencies

in the body of knowledge, which would support the design and purpose of the studies

in the thesis. This narrative review sourced both published and non-published

literature on client-centred practice in relation to occupational therapy.

Rationale:

Whilst the narrative review is not the same as a systemic review, its principles and

structure can be helpful in determining how to approach undertaking a narrative

review (Cronin et al 2008). Newell and Burnard (2006) recommend that relevance

and comprehensiveness are features which should be considered in a narrative

review as well as being as specific as possible about the topic or question being

searched. In this case the reason for carrying out a narrative review was to establish

a broad framework of knowledge about client-centred practice rather than focusing

on one aspect in particular. The time period considered for evidence gathering can

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be flexible in narrative reviews and for this review was selected as any literature post 1995, the date at which Law et al (1995) published the first definition of client-centred practice in occupational therapy.

Regardless of this being a narrative review, a methodical approach was followed to ensure that the process was thorough. The research question had already been framed; namely 'What are clients' and the therapists' perceptions of client-centred practice in occupational therapy in the UK? Therefore the purpose of this narrative review was to scope the evidence in the literature which addressed that question. Selection of what to include can generally be driven by the reviewer, depending on emerging evidence (Cronin et al 2008). Client-centred practice was already a key subject in occupational therapy literature (Law 1998; Sumsion 2000a), however this narrative review sought to address the impact of client-centred practice on both the client and the therapist; and to explore what issues affected its application in practice.

Search Strategy:

The process of the literature search strategy commenced with the keyword search to identify the range of available literature. Much of the literature about client-centred occupational therapy had originated in Canada so one criteria had to be that the papers were written in English not French (which is the second language in Canada) unless direct translations were available. The selection of the keywords was straightforward and restricted to;

Client-centred practice, and / or Client-centred occupational therapy;

Client focus, and /or Client- centred care

Client perspective and/ or understanding

Therapist perspective and /or understanding

Patient focused care for example was not included as this had a specific definition within the context of the NHS it being an organisational process rather than a philosophical approach to involvement in care.

Accessing search databases was done through an NHS Trust library using on line facilities, plus hand searching journals and conference proceedings and seeking grey material through contacts with professional colleagues and personal contacts with subject authors.

Sources:

Cumulative Index to Nursing and Allied Health (Cinahl) = English language journals and literature from 1983 onwards in nursing and allied health

Medlars (Medical Literature Analysis and Retrieval System) onLine (Medline) – database for medical and allied health researchers accessing computer sub systems

Pubmed –accesses biomedical literature from Medline, life sciences and online books. Allied and Complementary Medicine (AMED) – bibliographic database from 1985 produced by the Health Care Information Service of the British Library

The keyword search aimed to locate primary source data as well as conceptual or theoretical accounts and anecdotal studies – the latter contributing opinion pieces or reports from clinical areas which could be valuable in understanding the individual perspective. Once the papers were identified, they were read through and critically

evaluated for the contribution they made to the research question. This was an ongoing process with ideas developing throughout. As the literature on client-centred practice is very broad and covers both theoretical and practical applications, the intention here was not to present an overview of current evidence on client-centred practice per se, rather to organise and select from the mass of information available, to support the key themes of this thesis and to address the research question (Depoy and Gitlin 2005). In total 149 articles were located and considered for their relevance in supporting the research. Finally fifty were selected which, having reviewed their abstracts indicated their contribution to a review of the evidence for client-centred practice in occupational therapy. These are included in a literature review chart (see appendix 2.1) as a summary to support the review.

As already noted the sources of literature for this review included both published and unpublished material. Those unpublished documents which were accessed, provided a source of useful background material which informed my thinking about the areas of clinical investigation being undertaken by therapists in areas related to client-centred practice. This material was subject to the same scrutiny as the published articles and most were discounted in the critical review process. A Doctoral thesis by Kjeken (2006) examining the COPM with a specific client group was included in the final review as it contributed towards the evidence for client involvement in therapy. The evidence was grouped together in three main categories; firstly a review of current knowledge and evidence about the core elements of client-centred practice, secondly its impact on practice and finally an exploration of the perspectives of clients and therapists. Throughout the review, inconsistencies and gaps in the evidence were noted which were of relevance to the focus of the thesis in particular

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where these indicated areas for future research, impact on learning or change in practice.

Core elements of client-centred practice:

Development:

The historical context of client-centred practice was heavily influenced by the work of Carl Rogers, an influential American psychologist and one of the architects of the humanistic approach to psychology, who developed and articulated the person-centred approach to therapy. During the 1950s, Rogers identified some of the key constructs of client-centred practice, which emphasised the importance of cultural values, the dynamic nature of the client / therapist interaction, the need for a client to have an active role in approaching problems and the need for honesty and openness in the clinical relationship (Law et al 1995). He referred to this approach as emanating from the client's perspective. Rogers stressed the importance of empathy, respect, active listening and an understanding of the person's self-actualisation and goal directed behaviour, both in relation to the development of the individual and as part of the client-therapist relationship. When this approach was articulated in relation to occupational therapy, Law et al (1995) concurred that one of the most important points Rogers made about client-centred practice, was the skill of listening and an exploration of the quality of the therapist- client interaction.

Client-centred practice in occupational therapy emerged in Canada in the 1980s with the development of practice guidelines produced by the Canadian Association of Occupational Therapy in collaboration with the Department of National Health and Welfare (CAOT and DNHW 1983). These guidelines addressed the challenge of how

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to facilitate the involvement of clients in therapy intervention and concluded that client-centred practice was a collaborative approach to working with people (CAOT and DNHW 1991; CAOT 1993), where the emphasis for practice should be on an acknowledgement of the worth of, and the holistic approach to, the individual. The UK professional body for Occupational Therapy, COT also declared its support for client-centred practice at that time, by including a statement to that effect in the Code of Ethics and Professional Conduct (COT 1995). Some authors had also begun to explore its application in practice, for example Polatajko's focus was on enablement with a clear recognition of the autonomy of the individual (Polatajko 1992); Townsend (1993) reinforced respect for and partnership with people engaging in occupational therapy, and linked these to empowerment, whilst Sumsion (1993) reinforced the benefits which came from client – therapist collaboration; notably use of clinical reasoning skills, engagement with the client and informed decision making by the client.

The CAOT guidelines were described as practice guidelines however they lacked any definition of client-centred practice. This omission was criticised by Law, et al (1995) who argued this exclusion created difficulties for therapists who tried to implement the guidelines in practice. Recognising the lack of debate and definition with which to guide practice, they explored the underpinning concepts of client-centred practice and developed a definition for client-centred Occupational Therapy which they described as;

"'an approach to providing occupational therapy which embraces a philosophy of respect for and partnership with people receiving services. Client-centred practice recognises the autonomy of individuals, the need for client choice in making

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decisions about occupational needs, the strengths clients bring to a therapy encounter, the benefits of client-therapist partnership and the need to ensure that services are accessible and fit the context in which a client lives" (Law, et al 1995 p253).

This definition was developed from their discussions about the concepts which underpinned client-centred practice, these included; autonomy and choice; partnership and responsibility; enablement; contextual congruence, accessibility and flexibility and respect for diversity (Law, et al 1995). In addition, they argued that there were several features of the definition, and those concepts which underpinned client-centred practice which could be used to guide the structure and process of occupational therapy. The authors suggested that the following were important; recognition of the uniqueness of each client, using partnership as the optimal way of working and providing information to clients to enable them to make choices about needs and outcomes, Whilst this definition was designed to assist therapists, there was no evidence that clients had been involved in the process to help shape it. Neither was the client considered as a potential source of data for developing this approach despite further research being recommended in areas of practice.

The literature included evidence of some consistency in the core elements of client-centred practice. Following the work discussing the key concepts of client-centred practice for occupational therapy (Law et al 1995; Law 1998b) examined other areas in the health care system for similar concepts of care. She identified several frameworks of which the following are examples, across a range of services to determine if there were any similarities (Law 1998). The Picker-Commonwealth programme developed seven dimensions of patient-centred care based on research

with 6000 patients and 2000 family members and emphasised respect for individual values (Gerties et al 1993). Planetree developed a model for hospital-based care in its units which emphasised participation in decision making and access to information (Blank, Horowitz & Matza 1995). The Canadian Association of Occupational Therapy guidance reinforced listening to and facilitating clients to identify their needs and participate in therapy (CAOT 1997). Whilst she concluded that there were differences in emphasis across the frameworks examined, several key concepts were common to all; these included respect, client responsibility for decision making, provision of information and communication, participation in individualised service delivery, enablement of clients and a focus on the person – environment – occupation relationship (Law 1998). This consistency of core elements common to other frameworks reinforced that whilst a client-centred approach was not unique to occupational therapy it provided a basis for practice.

Core elements in practice:

In terms of seeking evidence of where the core elements of a client-centred approach feature within occupational therapy, there are examples in the literature of where authors have identified that these core elements have applications in practice.

In terms of **respect** for clients and their families and the choices they make about managing the challenges of everyday living, Falardeau & Durand (2002) suggested that respect of the individual should take into account their opinions, choices and values as well as their limitations and capabilities. In their paper which attempted to define the concepts of respect and power in the therapist – client relationship, they suggested that negotiation instead of partnership offered more applications for practice with the potential to achieve a more balanced approach to client-centred

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practice. Individual abilities and understanding may set limits on client interaction however being able to show respect for an individual, to listen and to demonstrate empathy provides the basis for a trusting relationship with a client.

Law et al (1997) argued that enabling **clients to take responsibility** for decision making and making choices about their care did not remove the responsibility of the therapist to alert them to potential dangers or risks in pursuing a particular course of action. Hebert et al (2000) introduced a new assessment tool for evaluating the quality of service provision incorporating the values and beliefs of client-centred practice. They suggested that the client's experience and self knowledge about their own needs should be valued and used to assist them making choices about which occupational performance issues they need help with. To ensure this was achieved, they developed a questionnaire based on client-centred principles and suggested that evaluating services using this tool would ensure that outcomes were integrated into clinical settings and service improvements made based on clients' views. A study to explore whether occupational therapists involved clients in a goal setting process was carried out by Northern et al (1995) who found that this may present a challenge to therapists. A sample of 30 occupational therapists took part in the study to identify patients' participation in goal setting by evaluating assessment sessions. They recognised that the most consistent methods used by therapists to involve patients were explanation of procedures, giving information, collaboration with patients and inclusion of patients' goals in treatment planning. They concluded in their study that whilst therapists did include clients in goal setting, less than 50% of the goal setting criteria agreed, were used during the therapy sessions.

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Law concluded that clients needed **information** provided in a way that supported their understanding and decision making (Law 1998). Sharing information using a common language which is understandable to both was recognised as showing respect but also affirmed the relationship between therapist and client (Lum et al 2004). However the nature and level of communication between therapist and client was identified as needing more attention as it raised important questions for the future, in particular those challenges around language and culture.

Townsend & Wilcock 2004) contributing to an international debate about occupational justice and client-centred practice concluded that joint goal setting and collaboration with clients was key to promoting social inclusion for people disadvantaged by disability or ill health. They advocated the benefit of **client participation** in the planning and delivery of individual treatment programmes. In a study exploring a client-centred approach to the provision of splinting (orthotic intervention) McKee & Rivard (2004) concluded that client input into the design and construction of orthoses was important in making a difference to their lives and enabling them to carry out valued occupations.

Enablement was seen as a process that involves clients as active participants in occupational therapy (Townsend et al 1997). Its key elements are listening, facilitating, and encouraging people to shape their own lives (Law et al 1997). Law et al (1997) clarified that the translation of the client- centred approach into practice was through the process of enablement but concede that at that time, it was a term used widely, but not well defined. They presented a definition of enablement comparing it to treatment; treatment describes something being done to or for a person as opposed to enablement which is about doing something with a person. Although

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Law, Baum and Dunn (2001) went on to develop the concept of enablement, they recognised that differences would occur in understanding its meaning, however they reaffirmed that client-centred practice was all about sharing, listening, and recognizing the strengths and resources which a client brings to the therapeutic encounter.

The contextual congruence of client- centred practice was the term which described the context of the client's life; the situation within which a client lives, and the individual nature and circumstances of each person, their roles, interests, culture and environments (Law and Mills 1998). Put simply it concerns appreciating people as individuals, rather than them being labelled with a medical diagnosis, for example referring to a person with an amputated leg rather than someone as an amputee. By applying this context into practice, means using individualised assessment and intervention tools together with individualised outcome measures, to evaluate that practice. Part of the unique concept of client-centred practice is the acknowledgment that clients are not separate from the environments in which they live, work and play. Strong et al (1999) and Reed and Sanderson (1999) identified that environments can either facilitate or constrain a person's ability to fulfil their roles and occupations and emphasised the development of interventions to change environmental factors to support enablement. Sumsion (2006) commented that it was important to remember that people are dynamically linked to a range of different environments all of which can present both challenges and potential solutions to those challenges faced by clients when undertaking activities of daily living. Sumsion also noted the emergence of increased attention on the impact of the environment on the realisation of the client's goals. Several theoretical models designed to support practice include the

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environment within their frameworks ensuring the congruence of the client with their surroundings is assessed. For example Kielhofner (2002) describes in the Model of Human Occupation (MOHO) the environment influencing behaviour and impacting on occupational choice and the Canadian Model of Occupational Performance (CMOP) (CAOT 2002) presents the client integrated within and influenced by their environment (Figure 2.1).

Client- Centred Practice re-defined:

Throughout the 1990s concerns were expressed that more distinctive parameters and clearer communication were needed to guide the practice of client-centred occupational therapy. Mew and Fossey (1996) for example, argued for a clearer definition to promote consistency in practice and Corring and Cook (1999) exposed the omission of the client perspective in the development and description of this approach whilst arguing that each individual should be seen as a valuable human being. Gage and Polatajko (1995) questioned the usefulness of the term because the descriptions used by clinicians to describe client-centred practice were diverse and ranged from 'considering the client's needs when making treatment decisions to having the client direct the care planning process' (Gage and Polatajko1995 p116). They pointed out that whilst client-centred practice implied that professional attention was centred on the needs of the client, the term did not address the role of the client in the care process.

Sumsion recognised the need for a British definition concluding that if occupational therapists were committed to being more client-centred then clients deserved the assurance of a common approach based on a clear definition (Sumsion 1999).

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Therefore, she set about creating a British definition of client-centred practice using a Reactive Delphi Technique where subjects responded to a list of items generated from the literature to create a draft definition (Sumsion 1999). The subjects (UK occupational therapists) were required to complete a series of questionnaires in order to consider, eliminate, prioritise and then rank those components which they felt should be included in the definition. Those remaining items were then used to create the draft definition which was examined further by a series of focus groups where content and the ranking of the components of client-centred practice were discussed and suggestions made for changes. The analysis of all this data resulted in a revised definition accepted and validated by the Council of the College of Occupational Therapists for the UK and published in 2000 (Sumsion 2000a). Sumsion identified early in her study that clients should be included in this work as this was a core component reflecting genuine client-centred practice and one which she personally valued. Voicing her concerns in an opinion piece in an Occupational therapy journal, it was noted that client involvement was logged as an exclusion and rejected in the early stages with no reason given. Sumsion concluded that excluding the client in the creation of this definition, begged the question of how can a profession be client – centred if clients are not included? (Sumsion 2000b). Recent contact with the author confirmed that this remained a concern in her development of the definition and whilst she had wanted to include clients in this research, she had been advised against it by research supervisors, but that she did obtain clients views of the definition later in Canada (Parker 2012a).

Sumsion's definition of client-centred practice (Sumsion 2000a) has been adopted as the benchmark in this research as it was written against a background of UK

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occupational therapy practice and has a 10year history of underpinning practice. Whilst Law et al recognised that occupational therapists supported the philosophy of client-centred practice, they voiced concerns about the importance of knowing whether this approach made a difference to practice, process and outcomes recommending further research to develop the meaning and application of client-centred practice (Law et al1995). Sumsion updated the work of Law et al (1995), and highlighted the complexity of creating such a definition within a profession as diverse as occupational therapy. Her revised Occupational Therapy definition of client centred practice also included a preamble which was an integral part of the definition;

Preamble: *"There are many factors that influence the successful implementation of client-centred practice, including a clear determination of who the client is and the recognition of the impact of resources".*

Definition: "*Client-centred occupational therapy is a partnership between the client and the therapist that empowers the client to engage in functional performance and fulfil his or her occupational roles in a variety of environments. The client participates actively in negotiating goals which are given priority and are at the centre of assessment, intervention and evaluation. Throughout the process the therapist listens to and respects the client's values, adapts the interventions to meet the client's needs and enables the client to make informed decisions"* Sumsion 2000a p308.

This definition brought together and reinforced many of the core elements of client-centred occupational therapy including the concepts of respect, client involvement in decision making, partnership and the environment (Law et al 1995; CAOT1997). The

need for collaboration was considered in the work of Townsend (1998a) and Christiansen (1997) about the importance of engaging clients in occupational performance by means of determining negotiated goals. Sumsion accentuated a shift away from therapist-led goal setting and treatment planning by placing greater importance on the centrality of the client's expressed goals by clearly stating that they should be the priority in assessment, intervention and evaluation, providing practical application of the philosophy. When examining each definition, the words used themselves are of interest. There was a clear emphasis in the Sumsion definition on practice, the words used were verbs and were directive; empowers, engage, participates, respects, adapts, enables. Whereas Law et al's (1995) approach reflected a more philosophical perspective employing description and use of nouns to provide context; respect, partnership, autonomy, choice, needs, strengths, benefits. Their definition was described as:

> 'an approach to providing occupational therapy which embraces a philosophy of respect for and partnership with people receiving services. It recognises the autonomy of individuals, the need for client choice in making decisions about occupational needs, the strength clients bring to an occupational therapy encounter and the benefits of the client- therapist partnership and the need to ensure that services are accessible and fit the context in which the client lives'. (Law et al 1995 p253)

This difference in language may have reflected the research methodology used to determine the definition. Sumsion's use of the Delphi method involved therapists directly in identifying the words used, whereas Law et al developed their definition based on a conceptual analysis of the literature. Alternatively it may be suggestive of

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a transition from a philosophical framework to a practice approach as knowledge developed over time. By taking a practitioner's perspective, the UK definition places greater emphasis on clinical application, in particular understanding who the client was and the impact of resources, both factors which influenced the successful implementation of client-centred practice. This reference to resource issues was new, with Sumsion acknowledging that both health and social care services were resource limited and that this impacted on the delivery of client- centred practice; in essence grounding the definition in healthcare reality. There was greater emphasis on partnership with Sumsion identifying it as a means of empowering the client to engage in functional performance in the fulfilment of occupational roles in a variety of environments (Sumsion 2000a) which in turn reinforced the need to engage the client in the process so that they understood the limitations of service delivery and was able to make informed choices.

Impact on practice:

Theoretical frameworks:

Evidence of where the client-centred approach has influenced occupational therapy practice by linking theoretical frameworks to practical application can be seen in the development of practice tools. The growth of formalised theory came relatively late in the history of occupational therapy with the emergence of conceptual models of practice and frames of reference which provide the organisational structures for delivering occupational therapy practice (Duncan 2011). Models are occupation-focused theoretical constructs developed specifically to explain the process and practice of occupational therapy, whilst frames of reference are theoretical ideas

developed outside the profession but which are applicable to practice. Both models and frames of reference provide the theoretical framework for planning assessment and interventions in order to meet a client's goals and assist the therapist in structured clinical decision making. The evidence for a client-centred focus within these constructs should provide evidence of theory linking with practice. It is usual for the therapist to select one conceptual model of practice which best supports their practice, although use of a model does not negate the need for applying professional judgement when it comes to practice (Duncan 2006). Based on clinical experience, the decision about which model to be adopted is usually taken at a service leadership level. The basis for that selection is usually discussed within teams and a suitable model selected which will support practice and which reflects the approach taken by clinicians. Clinical experience indicates that departments working with people with physical disabilities are more likely to select the CMOP as an applicable model, whereas those working with clients with mental health difficulties may select MOHO as suitable for their service needs. Adoption of any model of practice is made more relevant by applying their constructs into assessment and intervention tools and outcome measures.

Models of practice

There are a range of models of practice available with evidence that some demonstrate explicit client-centred features whilst others, which may have a different focus, reflect some elements of this approach. A summary of some of the key models used in practice and their links with client-centred practice are featured below (see Table 2.1).

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Table 2.1 Features of models of practice in Occupational Therapy

Model	Core construct	Key features	Client-Centred element	Linked tools
Canadian Model of Occupational Performance CMOP (CAOT 2002)	Human occupation occurs as a result of the dynamic interaction between the person, occupation and the environment	Performance & engagement The essence of the person(spirituality) The interaction that results in occupational performance.	The person is at the centre of the model Client is integrated within their environment, occupations & culture Philosophically aligned to client-centred principles	COPM – outcome measure
Model of Human Occupation MOHO (Kielhofner 2002)	The person, environment and occupational participation	Volition –motivation & choice Habituation – routines of doing Performance capacity – personal abilities Occupation focused	Client is seen as a unique individual What the client feels, does and thinks are central to the mechanism of change Client- therapist relationship supports & respects client values	OSA Occupational Self Assessment
Kawa (River) Model (Iwama 2006)	Individuals or collectives (families) are presented as 'rivers'	Life flow – life energy Occupation is the expression of life Challenges the notion that the therapist knows best	Each person's meaning & experience of life is unique Diversity of the client's lived experience & occupational narrative recognised	

The Canadian Model of Occupational Performance (CAOT 2002) seen in figure 2.1 below for example, places the client at the centre of intervention and planning and integrates the client within their environment.

N.B. This figure has been reproduced with permission from CAOT (appendix 2.2), however as it was taken from an original text, it retains its original text label as Figure 1 but for the purpose of this thesis it is labelled Figure 2.1.

Figure 2.1 The Canadian Model of Occupational Performance

Figure 1: Canadian Model of Occupational Performance

Sumsion and Blank (2006) considered this model as interactive and client-centred with its foundation on the relationship between the person, the environment and occupation. The diagrammatic representation of the model (Figure 2.1) shows the spirituality of the person at the centre, with the performance components of affective (feeling), physical (doing) and cognitive (thinking) encompassing the individual (CAOT 1997; 2002). The occupations of self care, productivity and leisure reflect the individual's functions which in turn are influenced by environmental factors such as cultural, social, physical and institutional features. The current expanded representation of the CMOP, the Canadian Model of Occupational Performance and Engagement, the CMOP-E (Townsend and Polatajko 2007) advances a vision of health, well being and justice through occupation, not limited to occupational performance. It provides a graphic representation of the Canadian perspective on occupation as the core domain of interest and reducing the professions concerns about the person and environment, by suggesting that aspects of the person and environment not related to occupation are beyond the scope of occupational therapy. Both CMOP and CMOP-E are described as client-centred, on account of the person being at the centre and integrated within their environment and abilities (see fig.2.1). Given that this model was developed from the work by Law et al (1995) on client-centred practice to provide a theoretical framework, it clearly reflects the core elements of this approach within a theoretical construct. The model provides the therapist with a simple visual framework with which to organise intervention and focus on the individual throughout the occupational therapy process (Sumsion, Tischler-Draper and Heinicke 2011).

Other theoretical frameworks which reflect a client-centred approach include the Model of Human Occupation (MOHO) described as being client-centred and which addresses issues of occupational performance with its main focus on the influence of the environment on occupations (Forsyth and Kielhofner 2011). Its key theory base is not framed explicitly within client-centred practice rather its prime focus is to address the complexity of the human occupation, recognising the personal components of volition, motivation and values. The Kawa (River) model confirms other aspects of client-centred practice by recognising the uniqueness of the person's experience which is central to understanding their occupational world (Lim and Iwama 2011). Whilst this is a complex model which uses eastern cultural metaphors to provide context and suggests a different approach to occupation, the strength of partnership between therapist and client in the determination of goals and treatment planning is emphasised. The core concept of client-centred practice is that the client is the most important component of any intervention. Models which focus on a specific intervention or treatment approach do not reflect the core elements of client-centred practice as they fail to provide a holistic view of the individual within the context of their environment. One example is the Allen's Functional Information processing Model, the purpose of which is to clarify the capacity of a disabled brain. Whilst this model defines cognitive functioning in relation to a person's engagement with occupational performance, its association with craft-oriented assessment tools defines it as an abilities focussed model rather than a client-centred one (Pool 2006).

Frames of reference

There is limited evidence however, for the integration of a client-centred approach in the range of frames of reference which are available for the therapist. These are tools

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which support models of practice with specific areas of knowledge and which the therapist selects prior to assessment and goal setting in order to meet the client's needs (Duncan 2011). Only one, the Client-Centred frame of reference (Parker 2011) clearly endorses the philosophy, core elements and process of practicing in a client-centred manner. This frame provides the therapist with practical examples throughout the occupational therapy process, of demonstrating how to apply a client-centred approach. When asked by the editor of a proposed OT textbook (Duncan) to develop this frame of reference, I was surprised to discover that such a tool was not already in existence to support such a fundamental aspect of occupational therapy. Duncan (2011) suggested that developing this frame of reference would, like others, support conceptual models of practice, (the CMOP and MOHO for example), and bring additional knowledge and tools which therapists could apply to practice. It is usual practice for therapists to select a frame of reference prior to commencing the assessment and goal setting process so that the frame will shape and influence the information gathered and the selection of the interventions used to meet a client's goals. The rationale for developing the client-centred frame of reference was to create a tool which linked the theoretical model, the CMOP, with the practical skills of delivering client-centred occupational therapy. This frame was therefore based on the professional paradigm of client-centred practice, the shared belief that the client is at the centre of intervention (Law et al 1995; Maitra and Erway 2006), it was structured to reflect the core elements of client-centred practice emphasising partnership and goal negotiation, whilst providing the therapist with practical examples of application based on the occupational therapy process (Foster 2002).

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Many of the other frames of reference available for use relate to specific functions and any reference to aspects of the client-centred approach are tenuous ; for example, the biomechanical frame (McMillan 2011) deals specifically with a person's problems in relation to their capacity for movement in occupations although it alludes to engagement of the person in the process. The focus of the psychodynamic frame of reference (Daniel and Blair 2011) is on the dynamic factors in human relations and the value of group work , although the authors also explored how this frame could contribute towards the health and well being of the client.

Professional Practice:

At a strategic level, there is evidence of the core elements of client-centred practice informing how occupational therapy should be practiced. In the UK for example the Occupational Therapy statement of ethics and professional conduct for practice in the UK (COT 2010a) highlights partnership and involvement with the client as key elements in practice delivery. This is a statement of intent and a driver for practice and sets down a benchmark against which standards and guidelines are developed in the profession.

The Client-centred Strategies Framework incorporating the key concepts of client-centred practice was designed as a tool to assist therapists in the evaluation of their practice, using feedback from clients and considering alternate strategies for improvement (Restall et al 2003). The authors suggested that it could facilitate learning and understanding of client-centred practice by means of personal reflection, consideration of client-centred processes and settings, and the advocacy of this approach in the wider community. They shared Sumsion's focus on the importance of

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client-led goal setting and the use of client language to determine intervention, but challenged therapists to remain true to the client-centred approach. Despite the usefulness of this framework in stimulating the debate about client-centred practice, Restall and Ripat (2008) concluded in a review of its applicability, that therapists experienced challenges in implementing it. In their review, based on a sequential mixed-methods study, the authors surveyed 230 occupational therapists and conducted telephone focus groups to explore the application of the strategies and the utility of the framework in implementing client-centred approaches. The strategies framework incorporated guidance on personal reflection, client-centred processes, practice settings, community organisation, coalition, advocacy and political action. They concluded that therapists identified multiple factors that influenced the implementation of the strategies and ways of incorporating them into practice. The authors identified the need for strong leadership to support client-centred practice and that therapists should develop the necessary skills and knowledge with which to promote the active participation of clients in their own healthcare. The challenges to implementation were identified at three levels; micro, meso and macro environments. At the micro level personal reflection and client-centred processes influenced the relationship between therapist and client. At the meso level -practice settings strategies influenced the environment in which the occupational therapist practiced; whilst the external community and political macro environment influenced the structure, organisation and delivery of occupational therapy services as a whole. The results suggested that occupational therapists felt confident about implementing client-centred practice at a micro or individual level but were less well prepared to action it at an organisational level (Restall and Ripat 2008). As a framework it

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provided strategic direction for service and operational change but perhaps due to its rather complex design it failed to provide a ready and easy tool with which clinicians can readily apply in their field of practice and deliver that change. The intention was for this framework to enhance the leadership of occupational therapists in client-centred practice but despite it providing a valuable tool for learning, the authors concluded that it had not been widely implemented within practice settings. Whilst this exploratory study was limited demographically to Canadian therapists, it indicated areas of further research which are applicable to any occupational therapy body adhering to client-centred practice, including a recommendation to explore further the link between client-centred practice and client satisfaction.

Clinical Practice:

A key focus of the practice of a client-centred approach is jointly agreed goal setting between the therapist and client which structures intervention. This includes client involvement in judging expected outcomes and determining satisfaction, with partnership being the conduit for success (Sumsion 2006). Achievement of these goals may come about as a result of changing roles or environment, skills or occupations rather than pure remediation. Determining what a client's needs and goals are is integral to how the occupational therapy process is delivered and intervention planned (Dressler & MacRae 1998; Sumsion 2006; Parker 2006). In America, studies examining the degree to which occupational therapists incorporated client priorities and concerns into assessments and treatment planning identified substantial gaps between self reported actions and observed actions (Neistadt 1995; Northen et al 1995). Maitra & Erway (2006) considered client-centred practice as being a process in which occupational therapy revolves around the client as the focal

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point of intervention. This meant that the active involvement of clients in discussion about occupations that they identified to be meaningful and purposeful resulted in more engaged participation in the goal-setting and treatment-planning processes (Maitra & Erway 2006; Tickle-Degnen, 2002). Cott (2004) however challenged this view suggesting that client-centred care was more than joint goal setting and decision making between client and therapist, it was about developing a more fundamental approach to delivering services which really reflected the needs of clients.

Further evidence of the influence of client-centred practice can be seen where it has been applied in clinical studies and reported in the literature. These are some of the examples of studies reflecting its adoption within a range of clinical areas and service organisations demonstrating how this approach has been incorporated into clinical practice. Particular note has been made where studies identify any of the core elements of client-centred practice which are relevant to practice.

The Client-Centred approach in practice:

Encouraging clients to use their own expert knowledge in enabling them to develop improved coping strategies was identified as an important learning point in a study examining the participation in occupations of people with Parkinson's disease (Benharoch & Wiseman 2004). Whilst the study was limited in size, further research was recommended to consider this approach and its impact on well being. Promoting quality of life and enabling client engagement in life roles was achieved through applying client-centred practice in an RCT investigating client-centred practice with individuals with spinal cord injury (Cohen & Schemm 2007). Thirty

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participants 6 months post-spinal cord injury (SCI) were randomly assigned to 2 groups, one group receiving client-centred occupational therapy and the other group having social visits, with 21 participants completing the study. Four measures of assessment were used pre and post intervention with data analysis concluding that occupational therapy promotes quality of life as perceived by individuals with SCI. Participation and using client-centred goals empowered clients to engage in meaningful occupations and promoted a sense of empowerment. This study was small and had potential for bias in the selection of a convenience sample, however as a pilot study it provided evidence of the value of a client-centred approach for people with spinal cord injury and larger trials were recommended to confirm conclusions. Hobson (2006a) suggested that therapists should adopt strategies such as enhanced assessment, as one means of preventing clients with cognitive impairment from being vulnerable to having their capacity to participate in client-centred practice questioned. Whilst she acknowledged that this was a challenging approach to adopt it was not impossible and demanded that the therapist acquire extensive knowledge of the client in order for their needs to be understood. Similarly when working with older adults, Hobson recommended that therapists respect and value the client's wishes in establishing their needs, modify their communication strategies and cultivate trust and rapport with the client (Hobson 2006b). Building a firm relationship with the client, listening to their needs, valuing them as a whole person and creating mutual trust were identified by Gage (2006) as the key elements of a client-centred relationship with people with physical disabilities. She recommended that this process ensured that clients' needs are integrated with the skills of the therapist to achieve desired outcomes supported by using a client-

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centred outcome measure (such as the COPM) to assess performance and satisfaction.

Barriers to client-centred practice:

Despite the evidence of client-centred practice being applied in clinical situations, other studies report the barriers that prevent the therapist implementing this approach. Some which considered the therapist perspective, focused on direct patient care and indicated that clients and therapists may have differing views of occupational therapy intervention (Corring 2004a; Corring & Cook 1999; Sullivan & Yudelowitz 1996) with particular concerns that OTs and clients have different goals when it comes to planning treatment (Wressle et al 2002; Rebeiro 2000; Sumsion 2005; Maitra & Erway 2006). Sumsion and Smyth (2000) explored frequently noted barriers to client-centred practice and considered the most effective means of resolving them. Using evidence gained from the literature they created a questionnaire which was circulated to a sample of 60 practicing therapists in the UK. The results indicated that the most frequently reported barrier was the therapist and client having different goals. They also found that the impact of the values and attitudes held by therapists, and their employment culture also made it difficult and uncomfortable to practice in a client-centred manner. This had been reported in earlier studies (Law et al 1995) and was explained as the therapist being unable to separate professional and personal attitudes. The influence of the medical model on being client-centred was discussed in relation to power, where traditionally in the medical model the health professionals have knowledge and authority (Sumsion 1997). Sumsion and Smyth (2000) suggested that such an imbalance of power prevents partnership with the client and recommended that therapists share power

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with clients to enable them to influence and shape the intervention. Whilst the results from this study provide some insight into the barriers to implementing client-centred practice as perceived by therapists, generalisation of the results can only be considered with caution as the research was based on a small sample size.

This echoed a previous study by Law et al (1994) which suggested that professionals often assume that the clients' goals and their own are the same, when in fact this may not be the true. Solutions to resolve therapist barriers which emerged from the Sumsion and Smyth study were identified as increased education, use of case examples and peer support to demonstrate client- centred practice (Sumsion & Smyth 2000). Wressle and Samuelsson (2004) repeated this study in Sweden and found that the highest ranked barrier identified by therapists was a lack of knowledge about client-centred practice, followed by the therapists and client having different goals. This study involved therapists attending a course on client-centred occupational therapy. Repeating Sumsion and Smyth's methodology, they aimed to identify barriers and solutions in Sweden by requiring participants to complete a questionnaire based on statements about client-centred practice and possible methods to resolve barriers. Whilst the participants were given free text space to write their own comments, there is the concern that bias was introduced by the authors who asked specifically about barriers which may have influenced how participants considered and rated their responses. The authors concluded that management and peer support provided the best solution to overcoming these barriers (Wressle and Samuelsson 2004).

Other authors however have suggested different barriers to implementing this approach, indicating that time pressures (Fuller et al 2004) and organisational

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challenges have a negative impact on the collaborative approach required in client-centred practice creating tensions in service delivery (Christie and Cross 2003; Rebeiro 2000; Sumsion and Smyth 2000;Townsend, Langille and Ripley 2003). Further accounts of the difficulties that occur when implementing this approach into practice, were reported by Brown & Bowen (1998), Law & Mills (1998), Neistadt (1995) and Sumsion (1993) who all identified issues of managing the transition from theory into practice. Law and Mills (1998) noted that client-centred occupational therapy took time and required the therapist to understand their own beliefs and values as well as developing new skills in areas such as negotiation. Sumsion's earlier paper exploring the impact of client-centred practice, questioned whether therapists understood about the implications of this approach to practice (Sumsion 1993). Neistadt (1995) in her survey of 269 occupational therapy directors in adult physical rehabilitation centres in North America, examined how client priorities were incorporated into client – centred goal setting. She concluded that therapists failed to discern clear client goals and failed to demonstrate the successful transition of theory into client-centred practice. Whilst it could be argued that many of these comments relate to studies conducted in the 1990s and may therefore be outdated, there continues to be evidence that client-centred practice remains a challenge for therapists in particular relating theory into practice (Sumsion & Smyth 2000; Sumsion 2006; Gage 2006; Parker 2006; Parker 2011).

Therapists' perspective:

Although there is evidence that client- centred practice has influenced professional guidance, conceptual models and frameworks and clinical practice (Palmadottir 2003; Conneeley 2004; Falardeau & Durand 2002; Stern et al 2000), there has been

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little exploration of the therapist's perspective of practicing in a client-centred manner. Rebeiro (2000), in an opinion piece on reconciling philosophy with daily practice, challenged the premise of client-centred practice by conceding that it may be a philosophy to which therapists aspire rather than it being a reality in practice. Her argument was that statements in professional documents did not provide the practical support needed to implement client-centred practice within systems which were evaluated by outcomes based on symptom reduction rather than promoting independence. Providing case examples to demonstrate where difficulties occur in implementing this approach, she advocated development of pragmatic guidelines translatable into practice as a solution to this problem.

Understanding terminology had been noted as an issue. For some clinicians client-centred practice meant refocusing of their practice on the needs of their client, while for others it had simply changed the way they 'named' the practice, without them actually changing it (Gage & Polatajko 1995). In Sumsion and Smyth's study (2000) the barriers identified by therapists reflected the challenges of the practical application of this approach rather than the lack of knowledge about the approach (Sumsion and Smyth 2000). In a study exploring the challenges of implementing client-centred practice (Wilkins et al 2001), therapists were interviewed about their knowledge and understanding of this approach. Three studies were carried out in separate clinical locations. One group wrote a metaphor of their practice which they explored later at interview. A second group was asked specific questions about the use of the COPM and the impact of using a client-centred measure in practice. The third group comprised service providers and their perspective of family-centred services was sought. This group did not contribute any evidence about

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understanding the therapist perspectives. It was not possible to discern from the paper exactly what questions were asked, and as different methods were used it made it difficult to generalise the findings. However results from the two therapist groups indicated that there were problems for some therapists with defining and understanding what client-centred practice was, although some reported that awareness was improved when a client-centred outcome measure, the COPM, was used. Conclusions drawn from this study were that the use of reflection can support therapists in understanding client-centred practice; clients need information to become empowered and participate in a partnership with the therapist; and the therapist needs to acknowledge that power differentials exist in the relationship with a client which can be addressed by becoming more skilled in negotiation and collaboration (Wilkins et al 2001). Stern et al (2000), acknowledging the enormity of this approach, also suggested the use of reflection and discussion with colleagues as the most powerful tools in delivering client-centred practice. Developing a framework for engaging in this reflection, the authors categorised the challenges of client-centred practice into three distinct areas: personal attributes of the therapist; the nature of the relationship with the client; and the qualities of the environment in which the therapeutic process takes place.

A phenomenological study explored the experiences of client-centred practice with a group of therapists working in mental health with the aim of understanding the meaning of this approach from the therapists' experience (Sumsion and Lencucha 2007). Twelve therapists with a range of clinical experience were interviewed. The data was analysed in a multi-phase process using open coding (Strauss and Corbin 1998), a concept map (Clifford, Carnwell & Harkin 1997) and themed analysis.

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Several themes emerged which endorsed core elements of the client-centred definitions (Law et al 1995; Sumsion 2000a) namely the importance of partnership, treating the client with respect, listening and enabling choice. Therapists identified several factors which impacted on their ability to understand how to practice effectively in a client-centred manner, these included; a client's lack of insight, client safety and risk management; communication using client-centred language and the need to establish rapport with each client. The authors concluded that this approach demanded working in partnership with the client and advised that issues of power for client and therapist need addressing in order to achieve a balance. The limitation of this study was that it was carried out with therapists in one mental health facility and this may have influenced their views of the challenges of being client-centred, also whilst the authors acknowledged the constraints on this approach by the community no consideration was given to any organisational pressures which may have influenced therapists' experiences.

The Client perspective:

Considering that this practice is called client-centred one might assume that during the course of intervention, the client is the priority. However given the small number of papers exploring their view of this approach the literature suggests that the client's perspective of client-centred practice is poorly represented. However despite this paucity, there is a view adopted across health professions that client-centred care is the optimum way of delivering health care as clients' perspectives are regarded as important indicators of quality in health care (Gan et al 2008; Little et al 2001; Goulet et al 2007). This is particularly relevant given the increased emphasis on client

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involvement and engagement in the management of personal health and their contribution to determining service priorities (Parsons et al 2010).

Whilst it may be said that there has been an historical concept of respect for the client, articulated by Meyer in the 1920s, the notion of engagement with the client is a new and emerging model. In traditional models of healthcare delivery, the patient or client adopts a passive role, being the recipient of medical intervention, expertise and service (Ellins & Coulter 2005). This is changing, with an emerging consensus that clients can and should be an active partner in healthcare and be more involved in decisions about their own care, a view supported in the client centred approach when applying the COPM. In relation to doctors, Stewart et al (2003) concluded that there are four key evidenced based guidelines for achieving that connection with clients; namely clear information given to the client, mutually agreed goals, an active role for the client and positive empathy, affect and support from the physician, all of which resonate with occupational therapy.

Coulter (2002) found there was evidence which demonstrated that client engagement in treatment decisions and in managing their own healthcare improved the appropriateness and outcomes of that care. Additionally she found that patient involvement improved patient satisfaction with and experience of NHS services in the UK. This co-relation between a more active engagement of the individual in what happens to them in healthcare services and the links with satisfaction and outcome may focus attention on the use of the COPM which as an outcomes measure is client- centred and connects function with satisfaction as well as enabling engagement to take place.

Considering that client-centred practice is described as a partnership that empowers the client to engage in occupational therapy and therefore could provide a powerful tool in achieving improved outcomes and quality of care, it is both puzzling and a gap in the evidence base, that the client's view has not been explored more fully. Some authors however have explored their views and their studies indicate the value of that enquiry. Corring and Cook (1999) carried out a qualitative study with a sample of seventeen service users, using a focus group to explore their views on the delivery of mental health services. The participants were split into three groups to discuss the meaning of a client- centred approach to practice from the clients' perspectives. Whilst this study is somewhat dated, the findings suggested that the most important factor for clients was them being viewed with respect and seen as valuable human beings by service providers. Bibyk et al (1999), contributing to an online discussion forum on the Canadian occupational therapy website on client-centred practice, challenged colleagues to view client-centred practice from the perspective of the client. Using a focus group methodology with users of mental health services, they asked what a client-centred therapist looked, acted and felt like to a client. Unfortunately the emphasis in their study was on the client- therapist relationship rather than the overall experience of client-centred practice; however it provided valuable insights from clients on their perception of this approach. They felt that therapists should fine tune their skills in becoming client-centred, that they should acknowledge the extensive and complex knowledge that clients have and that therapists should actively listen to the client. They also concluded that clients perceive a client-centred therapist to be one who accepts them for who, what and where they are. Falardeau & Durand (2002) expanded on this by suggesting that

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respect for the individual goes beyond their opinions, choices and values, it includes their limitations and capabilities. Individual abilities and understanding may set limits on client interaction but understanding disability from a disabled person's perspective is recommended by McCormack and Collins (2010) as fundamental to client-centred practice.

In a cross sectional survey study by McKinnon (2000) examining client values and satisfaction with occupational therapy a purposive sample of clients was asked to rate a set of statements about the service received. This concluded that applying the principles of client-centred practice made a difference to client satisfaction and reinforced some core elements of client-centred practice. Clients valued having their views respected, sharing open and clear communication and intervention which met their needs for information, advice or assistance. The limitation of this study was that the findings may have been context specific as all clients were from the same geographical area, although further research was recommended with clients from different occupational therapy experiences.

Larsson Lund et al (2001) acknowledged that whilst the client-centred approach had philosophical support it remained a complex issue for therapists which was best addressed by shared decision making by client and therapist. They carried out a descriptive study using semi-structured interviews with a sample of 57 clients and 50 staff to explore the perceptions of clients in planning rehabilitation. The views of occupational therapists and nurses of the strategies they used to encourage client participation were collected and compared. Following content analysis of the data, it was concluded that clients could be categorised as 'relinquishers', 'occasional participants' and 'participants', with the latter group the only ones considering

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themselves as participating in rehabilitation planning, the other two handed responsibility for decision making to the therapist. The participant group valued being in control of their rehabilitation and sharing decision making with the therapist. This study only considered the client involvement in rehabilitation planning and did not address the client's perception of what it felt like to experience client-centred practice. The environment may also have been a factor in this study as the setting was ward based and included nurses and therapists. There was no surety that the approach adopted on those wards was client-centred or whether a medical model approach may have influenced client behaviour which may account for two of the groups in the sample relinquishing decision making to therapists.

One study which specifically explored the perception of client-centred practice in therapists and their clients was undertaken by Maitra and Erway (2006). Semi structured interviews were carried out with a sample of 11 therapists and 30 clients in adult health care facilities to determine their perceptions of client-centred practice, in particular goal setting. They concluded that whilst the occupational therapist sample considered that they applied the principles of client-centred practice in their daily contact with clients, this was not the perception held by the clients who were unaware of this approach. The main conclusion drawn from this study was the difference in perception between the client and the therapist samples in their understanding of client-centred practice. For example therapists asserted that they involved their clients in discussions about goal setting and treatment planning however only those clients in the younger age group appeared to be actively engaged in the process. Similarly whilst all therapists explained what occupational therapy was, only half of the client sample confirmed that they were informed about

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occupational therapy and what it could do for them. This perceptual gap between therapists and clients may be attributed to communication skills and lack of understanding of each other's roles. The authors suggested that in order to reduce this perceived gap, therapists should use a client-centred interview and assessment process as well as a client –centred outcomes measure (the COPM) to determine and evaluate practical collaborative goals with clients. This study provided some valuable insights into the perceptions of clients about client-centred practice in relation to goal setting, although the focus was specific and did not gather general feelings and perceptions of clients of the broader nature of client-centred practice.

Conclusion:

Concerns have been noted in the literature as articulated by Sumsion and Law (2006) and Hammell (2007b) that misconceptions remain about the key elements of client- centred practice, in particular the role of the therapist in its implementation, the perception of the client and the delivery in practice of client -centred care. Many studies reinforce the need for clients and therapists to work together at defining, clarifying and achieving goals (Peloquin 1997; Rebeiro 2000). Negotiation can only start once a relationship has been forged with the client and when listening and communicating with each other is comfortable. Law et al (1997) describe active engagement in problem identification and planning as a fundamental part of working in a client-centred way. Mew and Fossey (1996) identify the need for therapists to use their clinical reasoning skills to evaluate performance and match client skills with potential to achieve goals. Negotiation about how to achieve established goals, the risks involved and an agreed time frame, demand constant attention and much sharing of information between therapist and client.

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Of greater concern is the apparent difficulty for therapists of acquiring knowledge about client-centred practice, in particular an understanding of the theory and translating this into delivering client-centred practice (Healy & Rigby 1999). Wressle et al (2002) and Maitra and Erway (2006) concluded that having a structured model, assessment tools and outcome measures based on client-centred principles was valuable in clinical work and reinforced the client-centred approach. Training in the underpinning theory of practicing client-centred care and using a related outcomes measure such as the COPM, was noted in studies across a broad range of practice (mental health, physical disability, community, clinical reasoning and interviewing) (Mew & Fossey 1996; Hebert et al 2000; Ward et al 1996; McColl et al 2000; Chesworth et al 2002; Richardson et al 2000; Kjeken et al 2004). Other authors emphasised the importance of knowledge, practice and confidence when translating theory into client -centred therapy (Wressle et al 2002; Warren 2002; Heaton & Bamford 2001; Cup, Scholte- op-Reimer et al 2003) with Parker (2011) suggesting solutions to this in the form of team education, reflection, supervision and practical learning opportunities. From the client perspective there was little evidence that their perceptions had been explored to find an understanding of their experience of this approach. What evidence there was indicated a perceptual gap in understanding and lack of engagement in goal setting with clients valuing being respected and listened to and having knowledge of their own conditions and circumstances.

Rationale for the research question:

Knowledge and familiarity with the concept of client-centred practice has grown considerably in the last two decades (Sumsion & Law 2006), however there is limited published evidence which examines how well this is **translated into practice** (Law

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1998; Sumsion 2006; Townsend & Polatajko 2007; Fearing & Clark 2000). There is a gap between the knowledge and application of client-centred practice. (Hammell, 2006). The majority of the literature about client- centred practice in occupational therapy has focused predominantly on definition and interpretation (Sumsion 2000; Law et al 1995; McKee & Rivard 2004). There has been limited attention paid to **what therapists understand** by and how they apply this approach (Daniels, Winding and Borell 2002; Toth-Cohen 2008; Clemens et al 1994; Cott 2004). Nor has there been research into understanding the impact this may have on clients and their care **from a client's perspective** (Corring 1999; Corring and Cook 1999). This is despite leading authors in the field of client- centred occupational therapy advocating partnership, client involvement and client empowerment as fundamental elements in its successful delivery (Law et al 1995).

The issue of **partnership** was curious because even though it was evident within the Law definition, there was little to qualify its meaning in practice. Although Sumsion points the therapist towards an understanding of how to achieve this relationship, there is little to guide the therapist in practice. The lack of literature would suggest that further research is needed to explore the disparity in goal setting as a key barrier to client- centred practice, the relationship between therapist and client (partnership) and the impact of the environment on delivering client- centred care. Intervention based on the clients' expressed goals and values, demonstrates respect for the diversity of the values held and by working together in partnership links the key components of delivering client centred intervention. Essentially the foundation of client- centred practice is the capacity of the therapist to view the world through the client's eyes (Jamieson et al 2006).

It could be argued that if both clients and therapists have **different goals**, intervention is likely to lack focus and the judgement of outcomes of that intervention will have little relevance to the well being of the client, reinforcing Donabedian's view that quality of care can only be truly achieved if balanced with individualised assessment of need (Donabedian 1988). The suggestion posed by this research is that to truly determine quality of intervention, the individual perspective of the client and the therapist needs to be explored and that client-centred practice should be adopted and evaluated using a client- centred outcomes measure.

Pollock et al (2006) concluded that using a **client- centred outcomes** measure, the Canadian Occupational Performance Measure (COPM), allowed the beliefs and assumptions of client centred practice to be operationalised. This argument strengthens the link between theory and practice in the delivery of health care and recognises that therapists who are more comfortable practicing from a client centred approach are also at ease using the COPM (Pollock et al 2006). This provided the context for the design of the research methodologies aimed to address the research question. Evidence from the literature combined with themes emerging from clinical practice provided the framework for addressing the emerging questions. Exploring the therapists' knowledge base and application of client- centred care into practice would be explored by means of interviews and a survey (questionnaire and focus group), addressing the issues of the application of theory, client- centred practice and use of a client- centred outcomes measure and goal setting. The systematic review of the COPM would examine evidence from the literature of applying a client centred outcomes measure to determine the success or otherwise of intervention. The client perspective would be explored by undertaking in depth semi structured interviews to

understand their perspective of being treated in a client centred manner. This study therefore aimed to explore the impact of engaging people in occupational therapy to determine the influence of a client centred approach on the outcomes of occupational therapy.

CHAPTER 3:

METHODOLOGY

Introduction:

The purpose of this research was to explore the nature of client- centred practice, what it is and how it is experienced by occupational therapists and clients by examining their perspectives, in order to determine its impact on the outcomes of occupational therapy. The research question: 'what are clients' and the therapists' perceptions of client-centred practice in occupational therapy in the UK? came from clinical experience, where the client-centred approach underpins practice and clinical outcomes measure the success or otherwise of the intervention undertaken between the therapist and client. In order to address the subject of this research, it was necessary to define the questions which needed to be asked and then to determine the approach taken to answer them. The structure of the research comprised an examination of the philosophy and practice of client- centred practice and its meaning to both client and therapist, together with an evaluation of a client-centred outcomes measure. The study was grounded in an inductive process using discrete studies with appropriate methodologies in a mixed methods qualitative enquiry. This chapter covers the research aims and approach, the ideological background of occupational therapy which underpins the research and the rationale for a mixed methods study. This chapter will include only an overview of the research methodologies related to each individual study as the detail is contained within each relevant chapter.

Research Aim:

The research aim was to explore client-centred practice in occupational therapy by investigating the clients and the therapists' perspective in order to determine the impact of this approach on practice.

Research Objectives:

➢ to explore the nature of client-centred practice

➢ to explore the therapists' understanding of client -centred practice

➢ to explore the clients' perspective of client- centred practice

➢ to examine the use and impact of a client- centred outcomes measure

➢ to determine how findings will impact on practice and the client /therapist relationship

Philosophical framework:

In carrying out research, scholars suggest that the researcher should choose whichever approach most suits the nature of the problem or phenomenon to be studied. The choice of method can be dictated by a number of issues namely, the nature of the phenomenon under study, the constraints of the setting and the perspective of the researcher (Morse & Field 1996). The choice of method is also influenced by a combination of the philosophical stance of the researcher vis-à-vis the research objectives, the nature of the problem to be explored, its novelty in research terms, and the time and resources available to carry out the work.

The phenomenon under study here was client- centred practice; what it is and what it meant to those practicing it and to those experiencing it in therapeutic encounters. When deciding how these questions might be answered, I was reminded of the

reason for asking the questions in the first place; namely how did we know that occupational therapists were client-centred in clinical practice and did that influence the outcomes of intervention?. The enquiry I wished to undertake meant exploring attitudes, understanding of practice, experiences and the perception of individuals within the context of client-centred occupational therapy. The nature of this enquiry, based in occupational therapy, together with my own philosophical considerations meant that a qualitative study was the basis on which the research would be designed in order to address the questions identified.

Qualitative research, which encompasses a range of methodologies from a variety of fields (anthropology, psychology, philosophy and sociology), is widely used in health research (Luborsky and Lysack 2006). Researchers in occupational therapy have used these methodologies to investigate practice issues and view them as congruent with the profession's philosophical orientation (Hammell 2002). Duncan (2011) noted that occupational therapy has been shaped by a wide variety of philosophies throughout its history and that this richness has created the foundation for the profession's current theoretical traditions as well as forming a profession reflecting diverse backgrounds and approaches.

The core theme which underpinned the research and which linked client, therapist and outcomes was client- centred practice. The key question about client-centred practice related to the human experience of this phenomenon and the meanings attached to it, by the client and the therapist. The approach meant exploring these in detail to develop an understanding of that meaning and to gain insight into the phenomenon.

Authors such as Polit and Beck (2012) and Morse and Field (1996) advise that there are several characteristics of qualitative research which are common across all approaches in this genre and worthy of note here. Firstly that it often involves a multi method approach to data collection strategies; secondly that it is flexible and responsive to new information arising from data collection, and finally that it requires the researcher to be very involved in the process, developing strategies iteratively as the data collection process commences. This flexibility of approach suited this project as each component of the research informed and influenced each subsequent study. It also reflected the eclectic nature of the background and development of occupational therapy which is more suitable to a multi method approach to the research question. This gave flexibility in the design and reinforced the context of the qualitative stance occurring in a naturalistic setting; in the clinical domain of the researcher. Qualitative methods, which are philosophically compatible with a client-centred ethic, enable researchers to identify ways in which therapy interventions and modes of service delivery can meet the needs and priorities of clients and may therefore be the most appropriate strategy in developing client-centred, evidence-based practice in occupational therapy (Hammell 2001). Qualitative methods also provide occupational therapy researchers with the tools to explore their clients' beliefs and value systems and the meanings with which they make sense of their lives and experiences (Hammell and Carpenter 2000).

Whilst a qualitative approach was the one selected, the theoretical tradition underpinning the research needed to be determined. The roots of qualitative methods can be found primarily in the disciplines of anthropology, psychology and sociology with each tending to focus on one or two broad domains of exploration.

When planning this research, shaping the studies and formulating the emerging

aims, it became clear that none of these disciplines specifically provided a perfect fit

with which to address the range of research questions in this study. Rather than seek

to adopt several strands from different philosophical approaches, the decision taken

here was to locate the research firmly within the foundation of occupational therapy,

of which occupation is the core assumption.

Much of the work to define the core assumptions of occupational therapy, which are

statements of belief that are accepted as true and are necessary to underpin

theoretical and practice models, such as the CMOP (CAOT 2002), was carried out by

Reed and Sanderson (1999). Occupation as the core domain, identified as unique to

occupational therapy, was explained by them as the use of direct purposeful

occupations to promote well-being, enabling a person to take responsibility for

meeting their own needs, increasing activity and improving behaviour and

encouragement to develop skills in self care, productivity and leisure. Polatajko et al

(2007) later traced the development of the concept of occupation concluding that its

path traversed the provision of diversional activity, though the use of therapeutic

activity to enablement through meaningful occupation.

Occupation:

Occupational Therapy as a professional discipline is based on the assumption of

using purposeful occupation or activities to influence a person's sense of health and

well being (COT 2009a). The meaning of occupation within the profession has

changed over time from its early beginnings when the founders used occupation to

define the profession, through its use as a term to describe occupying one's time, to

latterly becoming synonymous with purposeful activity (Hinojosa 2003). Occupations

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themselves have also had various meanings and have been described as ordinary things that people do every day, familiar activities engaged in to fulfil time and give life meaning (Christiansen et al 1995). These may include activities which a person undertakes, enjoys and values and if an individual is unable to do what is important to them, their health and wellbeing can suffer. Occupations reflect the unique characteristics of the person and are often the means by which people define themselves and the roles they adopt. The range of occupations undertaken may change over time depending on the circumstances in a person's life and include a wide variety of tasks (Law 1998).

For clarity and consistency, the COT adopted the consensus definition by ENOTHE (2004) where occupation is described as a group of activities that has personal and socio-cultural meaning, is named within a culture and supports participation in society. Occupations can be categorised as self-care, productivity and/or leisure and can be addressed by occupational therapists by enabling individuals to find ways to do those activities despite the barriers they may face. Occupational therapists view people as occupational beings who are intrinsically active and creative, needing to engage in a balanced range of activities in order to maintain health and wellbeing. People shape, and are shaped by, their experiences and interactions with their environments.

> 'The purpose of occupational therapy is to enable people to fulfil, or to work towards fulfilling, their potential as occupational beings. Occupational therapists promote function, quality of life and the realisation of potential in people who are experiencing occupational deprivation, imbalance or alienation. They believe that activity can be an effective medium for

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remediating dysfunction, facilitating adaptation and recreating identity.'

(College of Occupational Therapists 2009a, page 1)

The occupational therapist uses purposeful activities (goal directed behaviours or tasks) to encourage a person to assume responsibility for meeting his or her needs. Therapeutically this is achieved by means of evaluating, facilitating and maintaining an individual's ability to increase their occupational performance levels and improve adaptive behaviour (Reed & Sanderson 1999). Occupation remains at the core of occupational therapy as the philosophical basis of the profession, with the profession's philosophical statement (as above) describing what the profession values and believes to be important. This professional philosophy of enabling people through the use of purposeful activity to achieve fulfilment in their lives is supported by the commitment of the profession to client-centred practice as the means of delivering occupational therapy. The structure in place for delivering that practice is the application of specific interventions, models of practice and frames of reference, which provide the theoretical framework for practice within the philosophy of occupation.

Conceptual Models of practice:

As already noted in chapter 2, the emergence of formalised theory to support practice, came fairly late in the development of occupational therapy with the first use of the terms 'frame of reference' and 'models' attributed to a Miss McLean. She was an American occupational therapist working as a lecturer in England in the 1970s (Wilcock 2001). Her rationale for the development of a structured theory to underpin practice was driven by the need to demonstrate the value of occupational therapy practice to hospital management in response to financial pressures. She suggested

that theory development would enable the evaluation of practice to be carried out and for professional research to be undertaken, thus demonstrating the effectiveness of practice not only to management but to the therapist and the client as well. The rationale for the development of structured theories began to make sense of the function and impact of occupational therapy by helping to explain why a person was experiencing certain difficulties, what solutions could be applied and why a particular intervention might work. Structured theories did not prevent a therapist from using their own skills and clinical judgement in treatment planning as it is their decision to select which conceptual model provides the best evidence for practice and fits with the clinical environment in which they work.

The development of occupational therapy theory was a rapid process from the mid 1980s onwards resulting in a plethora of definitions and meanings for several terms, for example models, frames and approaches, becoming interchangeable. This undoubtedly led to some confusion for clinical staff in their attempt to understand and apply different conceptual models of practice. Latterly the rapid development and understanding of theory and terminology has subsided and a focus has been created by theoretical leaders in this field. Creek (2003 p55) for example defines a model as 'a simplified representation of the structure and content of a phenomenon or system that describes or explains certain data or relationships and integrates elements of theory and practice'. Whilst Forsyth and Kielhofner (2005 p.91) explained their model (MOHO) was defined to focus on the multiple dimensions of a client's unique experiences creating a level of understanding about life's issues for the client. For consistency however Duncan's definition (2011 p45) , will be applied here, as it is more concise and takes a more pragmatic approach by describing conceptual

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models of practice as 'occupation- focused theoretical constructs and propositions that have been developed specifically to explain the process and practice of occupational therapy' in other words the way we think and carry out our practice. Duncan describes frames of reference as ideas that have been developed outside the profession but which can be applied within occupational therapy practice and which are essentially applied knowledge tools. These are normally selected prior to the assessment and goal setting process commencing as they support conceptual models of practice by bringing additional knowledge to the assessment process. They help to shape and inform the information which is gathered during assessment and influence the planning of treatment interventions which are used in order to meet the client's needs. For example treating patients in a mental health facility, the occupational therapist is likely to use a psychodynamic frame of reference with which to structure their intervention (Daniel & Blair 2011) rather than a biomechanical frame. Therapists are not restricted to using only one frame of reference in treatment planning and can adopt several to help shape intervention over time. Parker (2011) suggests that those who adopt an individualised approach to therapy could consider using the client-centred frame of reference alongside others to enhance their client-centred practice.

Conceptual models of practice provide the theoretical construct by which practice can reflect the core assumptions and philosophy of the profession. As well as providing the theoretical basis for practice, Kielhofner (2009) suggests that models should also support the continued development of assessment tools and measures ensuring that theory and practice are integrated, and that clinical decision making is supported and linked back to the philosophy of the profession. The details of specific conceptual

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models of practice are discussed in chapter 2, however this is evident in the model which supports this research, the Canadian Model of Occupational Performance (CMOP) (CAOT 1997). This model (appendix 2.2) is the basis for client-centred practice, placing the client at the centre of intervention and clearly encompassing the key components of occupation; self care productivity and leisure. In turn it also provides the theoretical framework for the client-centred outcomes measure, the COPM which is the subject of review in chapter 4.

Research design:

The plan of this research project comprised three studies each undertaken to inform and influence the others in order to address the overall aim of understanding the impact of client- centred practice on the outcomes of occupational therapy. The methodology was predominantly qualitative employing different approaches in each study aim in a mixed methods design.

As a synopsis (see Fig 3.1.) Study 1 examined the worldwide view by way of a systematic review of a client- centred outcomes measure, the Canadian Occupational Performance Measure. Study 2 explored the perspective of a sample of therapists in the UK as a professional snapshot, by means of a focus group, and an exploratory questionnaire to explore their understanding of the philosophy and practice of client centred practice. Study 3 was undertaken at a service level and focused on the clients' and therapists' perspective using semi structured interviews to explore the individual's understanding and experience of client- centred practice.

Fig 3.1: Research Overview

Study 1

Study 2

Study 3
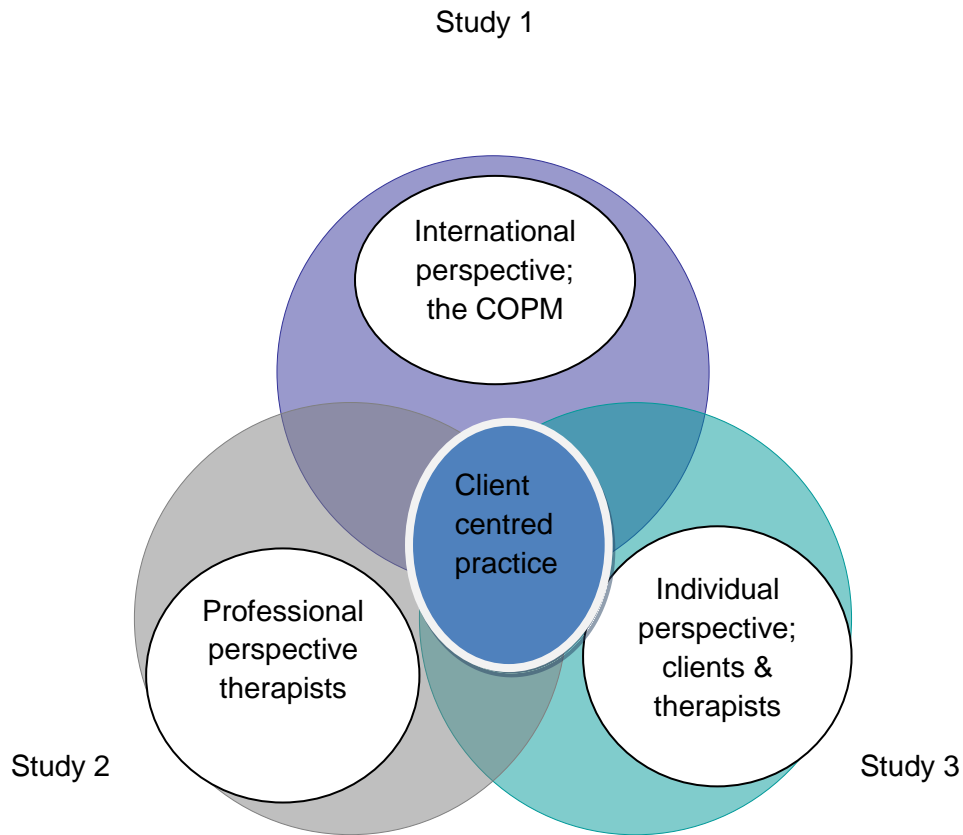
Mixed methods Design:

The reason for carrying out a mixed methods design was in order to use the most

suitable methodologies to explore the range of issues emanating from the initial

query about client-centred practice. The original question: how did I know that client-

centred practice was practised and did that make a difference to the outcomes of

intervention?, triggered additional questions which in turn culminated in the decision

to develop a three study research design. Asking what was known about the COPM and its impact in clinical practice suggested a review of the literature. Enquiring about what therapists know and understand about this approach lent itself to a broader investigation using a survey approach and finally to understand the individual perspective meant asking questions in an interview format.

Research is not limited to one methodology (Stein & Cutler 2000) and in practice can be carried out by combining qualitative and quantitative methods in mixed method designs. According to Robson (2002) there are no specific rules which dictate that one method must be used in an investigation and indeed, using more than one has distinct advantages by combining methods which produce quantitative data with results from qualitative studies. Qualitative and quantitative research methods can be effectively combined in mixed-methods designs to generate understanding of complex issues and cross-verify information. Combining these methods can maximise the strengths of each method and compensate for any limitations as long as only one theoretical reasoning process is used, in this case an inductive approach was used.

Mixed methods, according to Depoy & Gitlin (2005) are an efficient way of addressing the limitations of other approaches and are based on a foundation of pragmatism. Employing a flexible approach means using whatever philosophical or methodological approach best suits the needs of the research problem and was applicable to the eclectic traditions of occupational therapy. Researchers adopting this approach are advised to take note of the principles of the relevant research traditions as each has their own language, set of rules and strategies which need consideration in the development of a mixed method design. Mixed methods are

seen as an attempt to mix experimental and naturalistic types of studies within a specific context incorporating the language and thinking from each of these traditions. One criticism of this approach is that due to lack of consistency of design and potential difficulties in synthesis of the results, mixed methods can lead to an indistinct picture of the outcome (Clarke 1995). However this represented a view from some years ago and current opinion regarding this approach appear to support its development as a third and pragmatic tradition in research methodology (Depoy & Gitlin 2005).

Corcoran (2006) described how mixed methods became a legitimate design approach following work by Denzin in 1978 who introduced the concept of triangulation. This refers to the method of gathering data from various sources for the purpose of detaching the method of measurement from the phenomenon being measured, for example if evidence is observed in one data source and then emerges in another, the finding may be more relevant because two different data sources independently confirmed it. The concept of triangulation fits with pragmatism as that approach asserts that qualitative and quantitative traditions can be combined in the same design. Corcoran (2006) pointed out that methodologists supported the development of mixed methods as a third tradition as it was considered as more than a combination of qualitative and quantitative approaches. However she noted Tashakkori and Teddlie's caution (2003) that as these traditions came from two different epistemologies they should only be combined as inter-dependent but separate procedures during data collection, with the researcher selecting one of these traditions as their core method. The assumption then is that the core method will take precedent in the design and be reflected in the purpose of the study and the

overall analysis. The researcher needs to take care in planning the study by understanding both traditions to ensure that the core method dictates the scope of the data analysis whilst data from the secondary method is integrated to form the whole.

The main reasoning process in this research was an inductive one with the qualitative approach identified as the core philosophy. This meant that the integrity of the qualitative approach had to be respected by appreciating the assumptions and foundation of this tradition. Qualitative research enquires and examines the meaning of individual experiences within the context of their environments with the data collected being qualitative in nature. The meanings here relate to the subjective experiences, perceptions and explanations of the individuals, which in this case are those of the therapist and client. The context is their perspective of client-centred practice. In this approach the researcher is also close to the phenomenon and the participants in the research. Using different data collection methods within an overall qualitative approach ensured that triangulation could be achieved; this meant checking one source or type of data (for example the focus group data) against another (therapist interviews) to determine accuracy and to develop greater understanding of the phenomenon (client-centred practice). Triangulation is a means of finding out where information occurs in multiple places and Hammell (2001) advocates that triangulation is based on the premise that the convergence of different perspectives will confirm the data obtained and ensure a thorough investigation. It also enables the researcher to validate a particular finding with other sources of data by either verifying or discounting the emerging information (Depoy & Gitlin 2005). The process of evaluating the data from the systematic review with the survey data

(focus group and the questionnaire) and the in-depth interviews achieved triangulation in this study. Field notes were also used to note primary observations following the focus group and interview studies and contributed to the triangulation of the data. Gray (2005) suggests that comprehensive field notes incorporating observations and reflections are an essential component of fieldwork and assist in the development of ideas and insights into the subject of study. The data generated by these methods was analysed using thematic analysis for the focus group and interviews, plus inferential statistical analysis of the data emerging from the questionnaire. Data analysis of the focus group involved the systematic process of observation; watching, listening and recording (Depoy & Gitlin 2005 p168). Respecting the integrity of the methodology in practical terms is recommended as a means of continuously linking the research question back to the philosophical foundation of the research (Corcoran 2006). In this research the question and design of the studies both reflected and linked back constantly to the philosophy of client-centred practice and the core assumption of occupation which underpins occupational therapy practice. Using a mixed methods approach meant that the different questions raised about client-centred practice could be explored in each study combining the results to understand the impact on practice and indicate any areas for future research.

The Studies:

Study 1: A Systematic review of the Canadian Occupational Performance Measure

The incorporation of a valid outcomes measurement process is an essential part of evidenced based occupational therapy demonstrating clinically effective quality of care (Law & McColl 2010). To determine the value of using a client- centred outcomes measure with clients as evidence of delivering client- centred practice, a systematic review of the Canadian Occupational Performance Measure was carried out, this study is presented in Chapter 4.

Study 2:

Study 2 (chapter 5 and 6) was designed to capture the therapists perspective at a wider professional level by examining what occupational therapists understood about client- centred practice in the real world practice of their own clinical domain. There has been limited attention paid to what therapists understand about the meaning and practice of this approach (Daniels, Winding and Borell 2002; Toth-Cohen 2008; Clemens et al 1994; Cott 2004). This is particularly relevant given the practice pressures and organisational challenges which impact on service delivery (Christie and Cross 2003; Rebeiro 2000; Sumsion and Smyth 2000).

Evidence in the literature supported by the findings from the systematic review in Study 1 (See chapter 4) indicate that the concerns about the differences between theory and practice remain, with some authors identifying the importance of knowledge, practice and confidence when translating theory into client centred therapy (Wressle et al 2002; Warren 2002; Heaton & Bamford 2001; Cup, Scholte op

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Reimer et al 2003). Others emphasise the importance of learning how to deliver client- centred practice (Healy & Rigby 1999; Wressle et al 2002; Dedding et al 2004) with an emphasis on training in the underpinning theory and use of a client centred outcomes measure (Mew & Fossey 1996; Ward et al 1996; McColl et al 2000; Chesworth et al 2002; Richardson et al 2000; Kjeken et al 2004).

The methodology in study 2 comprised two elements: a focus group and an exploratory questionnaire designed to address the practical knowledge of clinicians. Both methods provided means to examine the knowledge and understanding of practicing occupational therapists as a professional snapshot, of the relationship between the theory and practice of client centred practice with the results of the focus group informing the design of the themes in the questionnaire.

The Focus Group

Using qualitative methodology, a focus group was undertaken using a small self selected sample of occupational therapists from the UK, with the aim of examining therapists' understanding and application of client centred practice. This small scale study examined the therapists understanding of partnership working using the question 'whose goals direct occupational therapy? This question had been developed from evidence in the literature about how occupational therapy intervention is shaped (Rebeiro 2000). The style of enquiry was naturalistic within the setting of a professional conference. The information gathering process was iterative and stemmed from the opening question to the focus group about patient engagement.

The Questionnaire

The purpose of the questionnaire was to explore the respondents' knowledge and understanding of the theory and practice of client- centred practice including the use of a client centred outcomes measure. The questions were designed to reflect current evidence in the literature (see appendix 6.1 for cross reference on emerging themes) and were informed by the analysis of the data from the focus group. The survey was designed to incorporate closed questions (for ranked responses) multiple choice (for self reported experience) and Likert scales (recording self reported knowledge of attitudes to client centred practice). The design of the questionnaire was essentially correlational rather than experimental as it set out to examine the relationships between variables (use of theoretical models with delivery of client centred practice for example) and to determine similarities for example, being client centred with using a client centred outcomes measure (Hicks 2004). The questions concentrated on the use and influence of theoretical frameworks on practice, the respondents' knowledge of client centred practice and its impact on delivery of care, and finally, the application and impact of using a client centred outcomes measure on practice.

Study 3 The individual perspective

Introduction:

The final study explored the individual perspective (see chapter 7) by means of undertaking semi-structured interviews with therapists and clients. Whilst much of the evidence for client-centred practice is focused on the therapists' perspective (Moats 2007; Sumsion & Law 2006), the role of the client is becoming increasingly important.

Several authors are beginning to question the limited role which clients have in determining the care they receive (Corring & Cook 2006; Palmadottir 2006; Hammell 2007b) emphasising that their views have value, whilst others have examined clients' perceptions of client- centred practice (Maitra & Erway 2006; Larrson Lund et al 2001). However what matters to both clients and therapists about their experience of client- centred practice has yet to be fully explored and was the focus for this research study. There is evidence of particular concern that occupational therapists and clients have different goals when it comes to planning treatment (Rebeiro 2000; Sumsion & Smyth 2000; Sumsion 2005; Maitra & Erway 2006; Wressle et al 2002). The aim of this study was to explore the experiences of people who practice and receive client- centred occupational therapy in order to understand their experiences of this approach and how it impacted on them. The design was qualitative, involving in-depth semi structured interviews with a sample of clients and therapists within a client- centred occupational therapy service. Using semi structured interviews enabled the researcher to focus on the naturally occurring language of the clients and therapists, reflecting their viewpoints and values, in the natural setting of their own environments. An interview schedule (see appendix 7.1 & 7.2) was devised to reflect key themes from the literature on client- centred practice which explored the participants' perspective on respect, partnership, being valued, being listened to, making choices, negotiating goals and being engaged in the process. The interview schedule was pilot tested in a local service by asking some therapists and patients to comment on the words used and the question format with changes made prior to use with the study sample.

Ethical Issues:

Conducting research requires the researcher to develop knowledge of ethical principles in order to carry out the research task beyond a common-sense understanding of moral issues (Workman & Kielhofner 2006). All research should be carried out both ethically and with integrity. In this study the researcher had to ensure compliance with the regulatory requirements of the National Research Ethics Service (NRES), the supporting academic institution as well as the statutory professional registration body. From a professional perspective, occupational therapists are required to contribute to the development of the profession by participation in research activity (COT 2010a). Enshrined in the code of ethics and professional conduct is the requirement to address the ethical implications of research activity and adhere to research governance processes. The ethical issues and process are described in relation to each study.

Ethical approval for study 1 was initially sought from the Central Office for Research Ethics Committees (COREC) with submission of an application. In addition the study proposal was sent to the Research and Development Group of the College of Occupational Therapy, the researcher's professional body. At that time COREC did not consider that this study required full ethical approval due to its design, and together with COT approved the study going ahead. Study 2, involving the therapists using a questionnaire and focus group approach, was outside the scope for ethical approval at that time and classed as a service evaluation , however ethical approval was sought and gained from the research ethics committee of the University Of Birmingham School of Health Sciences (appendix 3.1).

At the time the research involving NHS staff was carried out in 2011 the guidance confirmed that National Research Ethics Service (NRES) approval was not required. However it was required for all research undertaken with the general public so an application was made to NRES (12/SW/0061). Full submission by Proportionate review was sought and granted for the client part of the study. The completion of the IRAS form paid particular attention to the consent procedures, information to clients, inclusion criteria and information to the GP. A favourable ethical opinion was given by the review committee for the study to proceed. Alongside the NRES application, permission to access and carry out the research in the sample location was sought and received from the professional line manager of the occupational therapy team. In addition a formal request was submitted to the Audit, Research and Clinical Effectiveness manager in the host Trust. The ethical submission and research proposal, plus supporting documentation, was subject to peer review and subsequently approval was granted for the study. There was no conflict of interest for the researcher or participants as the study locations and samples were independent of the work base of the researcher. No actual names and addresses were used in any of the studies; these have been replaced with fictitious names and contacts. In planning all aspects of the study, the following ethical considerations and anticipated risks were addressed by the researcher:

Information to participants

The invitation to participate in the focus group workshop was advertised nationally as part of a conference programme and attendees were given an explanatory letter prior to attending (appendix 5.1).

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Circulation of the questionnaire was by invitation to participate rather than obligation. Members of the COPMNetwork (a web based database) who had indicated a willingness to be contacted for research purposes (as stated in the user terms of joining the network) were sent an electronic letter of introduction, a paper version of this was sent to the wider sample in the sample region. This explained the purpose of the research, noted confidentiality and non attribution (all returned questionnaires were identified by number only).

The **principle of beneficence** was applied so that risk was minimised to the greatest extent possible and the benefits incurred by both participants and researcher were maximised (Workman & Kielhofner 2006). The greatest risk to the individual in the focus group was that of self disclosure, however as that was in their control, they retained responsibility to share or not with others, thus minimising that risk. Potential benefit of participating in the focus group, questionnaire and therapist interviews would come about by increasing the body of knowledge in relation to client- centred practice.

Confidentiality and anonymity were confirmed in the letters circulated to potential and final applicants to the conference at which the focus group was held. It was made quite clear at the start of the group that all information shared within it was confidential to that setting alone. Also that the data gathered would only be used for research purposes. Anonymity was reinforced by the use of numbered cards which participants raised whenever they spoke as a way of identifying an individual response, rather than identifying participants by name. Confidentiality was also confirmed in the letters of introduction circulated to the sample responding to the questionnaire. Likewise participants taking part in the interviews were informed about
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confidentiality in their letters of introduction which was reaffirmed at the time of the interview.

Consent was addressed in the letters to applicants and attendees of the focus group. It was also explicit as attendance at this workshop was by choice. Other workshops were on offer at the conference and attendees had to sign up to join this session. Consent to take part in the survey was confirmed by return of the questionnaire. Participant consent to take part in the interviews was obtained by means of a letter and information sheet followed up by face to face confirmation at the time of the interview. Clients completed a consent form confirming their willingness to take part in the research in accordance with research ethics guidance. Clients also gave consent for their GPs to be informed of their involvement who were notified of their client's involvement by letter.

Data management of the audio recording of the focus group required that it was secure in a locked safe. Once transcribed, the paper document was similarly retained in a secure location. All individuals were only identified by a number in the transcription. All questionnaires were identified by number only and once the data was entered onto the SPSS database, the originals were destroyed. All consent forms relating to the interviews were also stored in a locked safe until archived in secure medical records storage as specified in NHS policy on medical records management. All of the data related to this research will remain in secure storage (locked safe) until completion of the research, following which it will be retained in safe archive storage for a minimum of 5 years until destroyed in accordance with NHS guidance on records management (DH 2006).

Researcher well being and safety

The risk identified in the focus group was that of threat to the researcher should the group dynamics create adverse communication between participants, however this was considered a low risk. The conference was a one off event and participants were unlikely to know each other or have established relationships or known conflicts with each other prior to this. The researcher had experience in managing varied groups; psychiatric in-patients, undergraduate students, staff teams for example, and was cognisant of the techniques of handling diverse groups of people in a group setting. In addition the assistant was on hand should any need arise. The ethical issues involved in the interviews were considered to be low risk. The research involved a one off semi structured interview undertaken in the client's own home and the therapists' work base. The principal practical risk identified was in relation to the researcher, which was Lone Working. This was managed by application of the exclusion criteria, (any clients assessed by the team lead as requiring a two staff visit were noted as risks and therefore excluded) and adherence to the Lone Working guidance used in the researcher's workplace. The main burden in all studies was that of time for the client and therapist but in the interviews and focus group this was limited to one hour, with the burden of completing the questionnaire directed by the diligence of the respondent and the time they took.

Benefit:

There was no direct benefit to the client in the interviews, apart from providing them with an opportunity to share how they felt about and experienced occupational therapy. The main benefit from all the studies for the therapists was the analysis of

the data, which when aggregated would contribute to and benefit the occupational therapy service and clients of the future.

Conclusion:

This chapter has set out the background, the rationale and the process by which the design of the research was planned and executed. The research question which originated from clinical practice generated subsequent enquiries and resulted in the development of a three study project. Each study, although distinctive, was part of an inductive process where the findings of one study informed and influenced the shape and nature of the ensuing project. All the studies together however comprised a predominantly qualitative approach using a mixed method design, capitalising on the strength of a mixed approach to seek and find the best solutions to the questions generated. Evidence from this mixed approach; a systematic review exploring worldwide literature on a client-centred outcomes measure, a survey of therapists providing a professional view by focus group and questionnaire and finally individual interviews with clients and therapists for a personal perspective, provide data to inform and enhance the knowledge of client-centred practice in occupational therapy. Undertaking the research using this approach reflects Hammell's (2001) suggestion that if client-centredness is the philosophy adopted for occupational therapy, the research base that informs client-centred practice should also reflect a client-centred orientation.

CHAPTER 4:

A SYSTEMATIC REVIEW OF THE CANADIAN OCCUPATIONAL

PERFORMANCE MEASURE:

Introduction:

Occupational Therapy has embraced the development and use of evidence-based practice to ensure the delivery of quality care to clients which has been demonstrated by its integration into practice standards by the professional bodies and its underpinning the design of educational programmes (Law & McColl 2010). Evidence-based practice has been described as the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individuals (Sackett et al 1996). The application of evidence-based practice involves using research knowledge together with clinical reasoning and an understanding of the client's values, in order to inform clinical decision making to deliver targeted intervention. Evaluating the effectiveness of that intervention is achieved through outcome measurement which is considered as one of the cornerstones of evidence-based practice (Pollock, McColl & Carswell 2006).

In occupational therapy, outcome measures can be used to determine the effectiveness and impact of occupational therapy interventions on a client's occupational performance skills in areas of self care, productivity and leisure (see appendix 2.2). Law et al (2001) advise that outcome measures should be consistent with the philosophy of practice and that they should measure the elements which are targeted for change. In a client-centred occupational therapy service measures

should be client-centred and focus on change in occupational performance. In rehabilitation there are three classifications of functional outcome measures: generic, condition-specific and client-specific (individualised). In client-centred practice, the recommendation is that an individualised measure be used as this reinforces the client's position at the centre of assessment (Pollock et al 2006). In Occupational Therapy combining the assessment of quality with understanding the client's perspective can be achieved by using a client- centred outcomes measure, such as the Canadian Occupational Performance Measure (COPM).

Description of the measure:

The COPM is an individualized outcomes measure designed for use by occupational therapists to detect change in a client's self perception of occupational performance over the course of a programme of occupational therapy (Law et al 1991, 1994, 1999). The COPM is a standardised instrument with specific instructions on administration and scoring. It was designed to be administered using a semi structured interview format. In collaboration with the therapist, the client identifies a range of occupational performance problems in the categories of self care, productivity and leisure (https://www.caot.ca/**copm**). The client gives an importance score to each activity they want to be able to carry out and the five problems of highest importance to the client are selected to form the basis of the treatment plan. Each of these problems is then rated by the client to reflect their current performance (ability to carry out the activity) and satisfaction with that performance. All scores are rated between 1 – 10 for each of the parameters of importance, satisfaction and performance. For the importance scale the range is; 10 indicating 'extremely important' down to 1 which indicates 'not important at all'. On the satisfaction scale, a

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score of 10 indicates 'extremely satisfied' with a score of 1 denoting 'not satisfied at all'. Similarly the range of scores on the performance scale designates 10 as 'able to do it extremely well' down to 1 'not able to do it at all'. Following a period of intervention the client then re assesses their own performance and satisfaction for each of those occupational performance problems. The change scores are the outcome. If the change score is 2 or more points, research by Law et al (2005) confirms that this change is clinically significant as it indicates change as a result of occupational therapy intervention (Law et al 1991; Law et al 1994; Law et al 1998).

Since its initial publication in 1991 the COPM has been revised three times in 1994, 1998, and 2005 and is widely accepted by the occupational therapy profession internationally (Law et al 2005). A number of studies investigating the COPM, ranging from those examining its psychometric properties (Chen et al 2002) to its role in research (Donnelly et al 2004) and programme evaluation (Case-Smith 2003) have been conducted. Although a comprehensive systematic review of the COPM was conducted by Carswell et al (2004) this focused on the application of the COPM in research and its role as a research tool. There has not been a comprehensive published review of the application of the COPM in clinical practice, apart from the Parker & Sykes study of 2006 which reported on the preparatory work for this thesis (appendix 4.4). In order to examine the extent to which client-centred therapy is grounded in evidence, a systematic review of the literature on the COPM was undertaken to determine the quality of available evidence within the scope of its application to and impact on clinical practice.

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Rationale:

A critical part of the research process involves a search of the literature to locate relevant studies which reveal the historical perspective of the subject as well as a current overview of knowledge (Stein & Cutler 2000). The literature review is a synthesis of the available knowledge and involves a critical appraisal of individual publications to identify emerging trends and patterns, current debates about the topic and gaps in the knowledge base. Selecting the type of literature review will depend on the purpose of the review within the context of the research.

The traditional narrative review is the more common approach when undertaking an evaluation of the literature about a subject and provides the reader with a comprehensive overview of content, rather than a critique of quality (Davies & Crombie 2001) (see chapter 2). Dickson & Entwistle (1996) suggested that narrative reviews can be limited because the literature sources are too narrow and focused on those sources most familiar to the author or those which are readily available. Polgar & Thomas (2008) advise that the professional background of the reviewer can also influence the outcome of the narrative review process arising from bias in the selection process, as publications selected for review may be those based on their own theoretical perspective, excluding others from a different approach. In addition 'grey' literature (conference proceedings or unpublished documents, theses etc) may be neglected in pursuit of broader questions which can lack focus. However a traditional narrative review can provide the researcher with greater flexibility as they can manage the scope and range of literature under consideration when developing the focus of the review. Whilst it is acknowledged that these reviews rarely specify how studies are selected, assessed and integrated, narrative reviews provide the

means to establish a wide-ranging review of the literature in the topic of study. Chapter 2 reports on the narrative review which was conducted to establish the context of this research.

Systematic reviews on the other hand provide a method to examine and critically appraise a specific topic and, as suggested by Hemingway & Brereton (2009), are most needed whenever there is a substantive question which requires critical evaluation. They comprise more than a detailed literature search; they are valid examples of research in their own right. Systematic reviews aim to identify, evaluate and summarise the findings of all relevant individual studies, thereby making the available evidence more accessible to practitioners. Combining the results of several studies can give a more reliable and precise estimate of an intervention's effectiveness than one study alone. The process involves finding, appraising and synthesizing evidence from scientific studies to obtain a reliable overview of research in a specific area (Bannigan et al 1997). By careful preparation and planning, they can help to overcome the difficulties posed by the quantity and quality of available research to provide objective evidence about the effectiveness of health care. By adhering to explicit methodological principles, systematic reviews establish where the effects of healthcare are consistent and where research results can be applied across populations and clinical settings (Cochrane Database for Systematic Reviews 2006). The researcher remains distant from and not directly involved in the research they are reviewing, this limits potential reviewer bias, and reduces systematic errors providing more reliable results from which conclusions can be drawn to inform any decisions made (Antman et al 1992). Oxman1994).

In practical terms, systematic reviews can provide a benchmark against which practitioners can compare their interventions with reviewed evidence and develop good practice. In addition there is recognition that when different types of data such as qualitative data and quantitative data are available to inform a review topic undertaking a mixed methods review is particularly useful when assessing clinical effectiveness (Hemingway & Brereton 2009). Their key role in research is in synthesizing results, disseminating outcomes and offering a reliable source of information about the effectiveness of healthcare (Chalmers & Altman 1995.Droogan & Cullum (1998 p16) describe them as 'the most reliable and valid means of summarising the available research findings on a given topic and are therefore the foundation stones of evidence- based healthcare'. This methodology also has its critics who argue that the main limitations of this type of review are the time and resources it takes to complete one and that ideally they should be carried out by more than one reviewer (Jesson, Matheson & Lacey 2011). However they are widely accepted as offering a reliable source of information about the effectiveness of healthcare (Chalmers & Altman 1995).

Study framework:

Objective:

The systematic review addressed the following question;

What is the impact of using a client-centred outcomes measure, the COPM, on clinical practice in occupational therapy?

The context for this is the premise that occupational therapy practice in the UK is predicated on a philosophy of client-centred practice. This, when combined with the

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requirement to deliver evidenced-based health care, demands that an examination of the applicability of the COPM as an outcomes measure across a range of clinical fields and client groups is needed to help build an understanding of how therapists use it with clients and whether the outcomes of the measure are used to inform practice.

Criteria rationale for the selection of studies:

In accordance with recognised systematic review research methodology, inclusion and exclusion criteria were defined prior to commencing the search and selection of the studies (Bannigan et al 1997; Carnwell & Daly 2001.

The inclusion criteria were:

Timeframe:

All articles should have been published between 1990 and 2010. This time frame related to the first publication of the COPM in 1991, and allowed for early evidence to be included. The end date of 2010 was appropriate as adopting time 'windows' helps to limit the volume of literature whilst retaining a timeframe of sufficient duration to capture a wide range of relevant literature (Dickson 1999; Forward 2002)

Language:

All articles should be written in English. It was acknowledged that some publications may have been written in other languages originally in which case they would only be included if a direct English translation was available.

Description:

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Articles which reported the use of the COPM as an assessment tool in clinical practice. This was to ensure that the question of the application of the COPM could be addressed as evidence of its part in the assessment and goal setting process and the affect of its impact on practice.

Articles should reference the use of the COPM as an outcomes measure. The COPM was developed to support occupational therapy practice and to provide a means of evaluating practice by measuring outcomes. The aim of the review was to assess the impact on practice of using the COPM (either positive or negative). Therefore studies were only included where it was the primary outcome measure in order to determine the impact of the COPM.

Clear reference should be made in the article to the COPM in the clinical field. As the purpose of the review was to investigate the application of the COPM in clinical practice and evidence of any resulting change initiatives, studies were only included if the clinical field was identified.

The exclusion criteria were:

Time frame:

Articles written before 1990 or after 2010 – see inclusion criteria above

Language:

Articles were not included for which there was no direct translation into English available.

Description:

Studies which referenced the COPM but where it was not the primary outcome measure. The reason for this was to limit confusion. If articles included multiple measures then it may not have been possible to attribute findings directly to the COPM thus the value of its contribution to the evidence base may be unclear. Studies described as opinion pieces or personal perspectives with no reference to research or evaluation, whilst providing some valuable insights into the use or otherwise of the measure, would not stand up to the scrutiny of analysis nor provide a tangible evidence-base for clinical practice.

Method:

The systematic review was designed to evaluate worldwide studies on the application of the COPM in clinical practice and to determine the impact of its use as an outcomes measure in Occupational Therapy. Kielhofner (2006) explains that outcomes research is concerned with the results of occupational therapy, so examining the use of this tool as an outcomes measure in clinical settings would inform practice and add to the evidence base.

A search strategy was formulated (Bannigan et al 1997; Brown & Burns 2001) and was conducted primarily in Occupational Therapy publications spanning the period 1990 to 2010 (see table 4.1 below). A hand search of British Occupational Therapy Journals and other sources including conference summaries and reference lists from located articles was also carried out. Hand searches are particularly relevant where researchers have a close working knowledge of their field and are familiar with the key authors in the subject, enabling more lateral lines of enquiry to be followed up (Richards 2008). Grey literature, which can also be a valuable source in systematic

reviews (Greenhalgh 1997), was identified through personal contact with the authors of the COPM who indicated possible unpublished material. Other material, unpublished theses for example were sourced using university and professional body libraries. An initial search of the literature had been carried out to scope potential studies and assess their application of the COPM to practice. This initial review informed the development of the systematic review, in particular the structure of the assessment format and was reported in a peer reviewed journal (Parker & Sykes 2006).

The method of selection to identify which articles would be reviewed was planned on a step by step basis. This was to ensure that those articles finally selected as meeting the inclusion criteria would address the review question of examining the impact of the COPM in clinical practice. The primary search focused on articles where the key search terms were evident in the title and / or abstract and this resulted in 246 articles which were then considered for assessment against the inclusion and exclusion criteria. As already noted in the narrative review (Ch.2) access to unpublished literature gave me the opportunity to examine where the COPM had been used in professional research and informed my thinking about the potential impact of the tool on practice. As before both the published and unpublished literature was reviewed using the same level of scrutiny, each being subject to the methodological process of the search strategy and critical review analysis (Table 4.1 below). Some material was excluded because of failure to meet the inclusion criteria such as Sykes (1998 unpublished MSc thesis) which failed to be matched against the PICO's framework.

Of the 246 articles located, the quality was wide and the detail of the studies variable, for example some were just commentaries or opinion pieces and others did not include information about the clinical area of study. A further level of scrutiny was applied in order to ensure that studies made reference to the COPM as the primary outcome measure and that the clinical area was clearly defined, this resulted in 149 studies being discounted. Of the 97 articles remaining, 78 were matched against the inclusion criteria, with 19 excluded. The methodological process required the appraisal of all (78) studies (Dickson & Entwhistle 1996, Centre for Reviews and Dissemination 1996; Cochrane Database of Systematic Reviews 2006). They were assessed for study content and matched against the inclusion criteria (which included impact on practice, positive and negative aspects, and change initiatives). To provide further structure for this stage of the review process, and to ensure that the sources were subjected to an objective assessment of content and quality, a data extraction tool was designed. This was based on the Participants Interventions Comparators Outcomes (PICOs) framework (CRD 2009) and was applied to the 78 articles meeting the inclusion criteria (see appendix 4.1). The data extraction tool was designed to include the following:

Participants: Studies included a specified sample population of either adults or children in any clinical field, the number of clients needs to be included (exclusions noted) and where clients' experiences or opinions or evidence of consumer views were noted. This indicated the number and range of clients included in COPM studies.

Interventions: Any intervention delivered by an occupational therapist working with clients in any clinical environment. This included any positive or

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negative results as a consequence of using the COPM. Emerging evidence in the literature (Bowman 2006; Bowman & Llewellyn 2002) and clinical experience from my own environment suggests that OTs are reluctant to use outcome measures to support their practice and it is important to understand why.

Comparators: No specific comparators will be included unless referenced in the studies where the COPM is considered against other standardised assessments.

Outcomes**:**   Studies were included where COPM was noted in relation to its impact on practice. This was a key aspect of the review question, and where change initiatives occurred as a consequence of using the COPM as this would also indicate an influence on practice.

Table: 4.1 Search Strategy - summary

Action	**Process**	**Rationale**
1: Data Search: Search terms identified: Canadian Occupational Performance Measure; Client- centred outcome measure and / or occupational performance; occupational therapy and outcome.	Terminology used in Occupational Therapy literature and key words known to link to the subject of the review	Terms reflected the key words in the review question
Sources used: Ovid, Medline, CINAHL- (Cumulative Index to Nursing and Allied Health Literature), AMED (Allied and Complementary Medicine Database), the Cochrane	NHS medical library search facilities used	Ease of access to library facilities which were able to access wide range of publications and sources

Database, (Cochrane 1997). Hand searches of British and Canadian OT journals		Familiarity with OT journals meant ease of access to other sources of material e.g. conference reports
2: Data Selection: Step 1 All titles and/or abstracts generated by the searches were screened by two reviewers for potentially relevant studies. Step 2 – The full-length articles of the selected titles and/or abstracts were assessed for eligibility against the inclusion / exclusion criteria	246 articles were identified and matched for inclusion of the COPM in clinical practice 97 articles selected 78 – inclusions 19 - exclusions	Studies for matching against the inclusion criteria had to reflect relevance of COPM to clinical practice
Step 3: A data extraction tool based on PICOs was created and checked prior to use. Those 78 articles meeting the inclusion criteria were mapped on the PICOS tool	PICOs framework	Assessment of studies against a framework to provide rigorous match with inclusion criteria
Step 4: Articles on the PICOS tool reviewed for final assessment of quality. Terms restricted to COPM in clinical practice	Hierarchy of evidence determined by use data quality tool 16 studies assessed	Assessment of the quality of studies related directly to clinical practice was required

Study design:

The type of study needed to be specified for example; Qualitative studies including case reviews, case series and case studies, evaluations and observational studies or Quantitative studies including randomised controlled trials (RCT) and experimental studies. The data analysis process needed to be clear and include details of any tests used.

Once the data extraction tool was designed, it was piloted for ease of use and relevance using a small number of articles to test its applicability. Each of the 78 articles was then read through by the reviewer. Evidence was systematically sought and noted against the parameters identified on the data extraction tool. Once all the articles were assessed and checked, the outcome was reviewed. During the review process a random selection of studies had been simultaneously reviewed by two reviewers to ensure consistency with the research methodology, application of the inclusion and exclusion criteria, reduction of bias and to determine greater reliability of the process. Whilst this was applied in the initial stages, the final part of the critical appraisal was carried out by a single reviewer. At that stage it was recognised that there was a risk of bias as I was the sole reviewer. Therefore in order to arrive at an objective outcome of content quality and an answer to the review question, I explored how to manage the next stage of the review with a supervisor. Whilst the high number of studies was acknowledged, volume was not the reason for applying further re-examination of the studies; this was to meet the prime objective of determining the evidence for the use of the COPM in clinical practice and its impact on practice. Therefore the studies which had been scrutinised for evidence of the search terms in the title, met the inclusion criteria and provided evidence of use of

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the COPM as an outcomes measure in clinical practice were included in the final review. This level of scrutiny resulted in a total of 16 studies which were subject to analysis of their strength of methodology, the relationship of the findings to the research question (namely impact on practice), and consideration of study conclusions that may be reproducible and add to the evidence base for the COPM in practice (Massy-Westropp & Masters 2003). The merits of each study in this group were analysed by strength of design (generalisability), internal validity (rigour of method) and outcome (Appendix 4.2). Adopting this approach meant that by applying a robust systematic process of assessing study quality, the findings from the final articles reviewed would provide evidence of the use of this client-centred outcomes measure and would identify the impact its use has on clinical practice.

It was recognised that studies of the COPM were likely to comprise a mixed range of design methods. One of the outputs of a systematic review is that it provides a synthesis of the research evidence resulting in identification of themes from the literature (Polgar & Thomas 2008). Due to the nature of the mixed designs in studies on the COPM it was not be possible to conduct an overall synthesis of results, therefore to achieve a robust objective process for study appraisal, I created a framework for the different studies based on guidance from the Centre for Reviews and Dissemination (CRD 2009) and the Critical Skills Appraisal Programme (CASP) (PHRU 2006) and applied a quality rating threshold for each study included in the final stage of the review (Ciliska et al 2001).The criteria for judging the quality of quantitative research are well documented and are presented as a hierarchy of research designs which is based on the best evidence for treatment decisions(Oxman 1995; Guyatt & Rennie 2001). However it should not be assumed

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that all studies of the same basic design (e.g. RCT) are equally well-conducted. The quality of the studies should be formally assessed as this will impact on the reliability of the results and therefore on the conclusions drawn (CRD 2009).

Polit & Beck (2010) point out that the main design characteristics in quantitative studies are that they are accurate, unbiased and provide replicable evidence, whereas qualitative studies are shaped by different principles, typified by a flexible holistic design which strives to reflect the whole with ongoing data analysis to formulate future strategies. Khan et al (2003) suggest that the quality of a study depends on the degree to which its design, conduct and analysis minimise bias. Research quality for quantitative designs was assessed using the hierarchy of evidence described by CRD (2009 p.11) which ranged from Randomised Control Trials (RCTs) as the best quality evidence, through Quasi- experimental studies to Observational studies. Daly et al (2007) concluded that ways of incorporating evidence from qualitative research should also be included into systematic reviews using the CASP appraisal tool (Critical Skills Appraisal Programme PHRU 2006). They proposed a hierarchical ranking of evidence for qualitative studies which comprised four levels ranging from studies least likely to produce good evidence for practice (Level 4) single case studies; descriptive studies (Level 3) which focus on a sample from a specific group but lack detailed analysis; conceptual studies (Level 2) based on a conceptual framework where all data is analysed but lacks diversity; to those of the highest quality evidence Generalisable studies (Level 1). These studies comprise findings which are defined within a clear literature base across diverse samples, are applicable across other settings or groups and provide clear indications

for practice with indicated directions for change. Each study was then assessed and

a simple code was applied to each study to denote level (see table 4.2 & 4.3).

Table 4.2: Hierarchy of evidence: Quantitative Studies

Study Code	Description	Types of studies	Definition
QT1	Level1 Randomised controlled trials where eligible participants are randomised to two or more groups, treated according to assignment and the outcomes compared	1.Cross over trials 2. Cluster randomised trials	1. Where all participants receive all the interventions. It is the sequence of interventions that is randomised. 2. A cluster randomised trial is a trial where clusters of people rather than single individuals are randomised to different interventions.
QT2	Level 2 Quasi – experimental studies – these do not use random assignment to create comparison groups	1.Non randomised controlled studies 2. Before and after studies 3. Interrupted time series.	1. Individuals are allocated to a concurrent comparison group, using methods other than randomisation. The lack of concealed randomised allocation increases the risk of selection bias. 2. Comparison of outcomes in study participants before and after the introduction of an intervention. 3. Interrupted time series designs are multiple observations over time that are 'interrupted', usually by an intervention or treatment.

QT3	Level 3 Observational studies where natural variations in interventions are investigated to explore their effect on outcomes	1.Cohort studies	1. A defined group of participants is followed over time and comparison is made between those who did and did not receive an intervention.
		2. Case control study	2. Groups from the same population with (cases) and without (controls) a specific outcome of interest, are compared to evaluate the association between exposure to an intervention and the outcome.
		3. Case series	3. Description of a number of cases of an intervention and the outcome (without comparison with a control group). These are not comparative studies

Centre for Reviews & Dissemination (2009 p.11)

Table 4.3 Hierarchy of evidence: Qualitative Studies

Study Code	Description	Type of Study	Definition
QL1	Level1 Generalizable studies	Sampling is focussed by theory and the literature. Located in the literature to assess relevance to other settings	Clear indications for practice or policy, may offer support for current practice or critique with indicated directions for change.
QL2	Level2 Conceptual studies	Theoretical concepts guide the sample selection, based on analysis of the literature	Weaker designs identify the need for further research on other groups or urge caution in practice. Well-developed studies can provide good evidence if residual uncertainties are clearly identified.
QL3	Level3 Descriptive studies	Sample selected to illustrate practical rather than theoretical issues	Demonstrate that a phenomenon exists in a defined group. Identify practice issues for further consideration
QL4	Level4 Single case studies	Provides rich data on views or experiences of one person. Can provide insights in unexplored contexts	Alerts practitioners to the existence of an unusual phenomenon

Daley et al (2007p.46)

Results:

Types of studies

Of the 16 studies reviewed, eight were quantitative studies (Cup et al 2003; Jenkinson, Ownsworth & Shum 2007; Roberts et al 2008; Carpenter, Baker & Tyldesley 2001; Bodiam 1999; Rochman et al 2008; Sewell & Singh 2001; Gilbertson & Langhorne 2000), five were of a qualitative design (Richard & Knis-Matthews 2010;Wressle, Marcusson & Henriksson 2002; Wressle et al 2003; Verkerk et al 2006; Chesworth et al 2002) and the remainder (Edwards et al 2007; Parker 1995; McNulty & Beplat 2008) were mixed method studies. The research was carried out in North America, UK, Australia, Netherlands, Sweden and Canada across a range of clinical areas including hospital, community, rehabilitation and outpatient facilities.

For a summary of the findings and evaluation see Appendix 4.2

For a summary of the clinical profile and research location of each study see Appendix 4.3.

Study quality:

As a general comment the quality of the studies was variable with lack of methodological strength characterising studies published in the 1990s. In order to present the findings from this review in a logical format, judgement on study quality will be approached by grouping the studies into their qualitative and quantitative design.

Internal validity:

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Of those studies based on a qualitative design, one study (Wressle, et al 2002) was a Level 1 generalisable study – comprehensive and clear with sampling focused on both theory and literature. This study demonstrated quality by being well written providing good evidence of rigour applied to the research method and data collection processes. These were explained and justified in a well structured manner; the findings were credible and highly relevant to all aspects of clinical practice.

The other studies in this group (6) were in the Level 3 category – Descriptive studies - illustrating more practical issues and based in a particular clinical setting. Of these, Parker (1995), Wressle et al (2003) and Richard & Knis-Matthews (2010) were well written studies, representing good evidence of rigour by justification of their design methods, clearly stated ethical considerations and clear sampling processes. Whilst the presentation of data in Parker's (1995) study could have shown greater sophistication and detail, all three studies demonstrated credibility in their findings and examined their results in relation to their original research question.

The remaining studies in this group lacked clarity and justification for their research design. Verkerk et al (2006) examined the reproducibility and validity of the COPM using an interview approach, but they were not explicit about data collection processes or study design, resulting in findings which lacked qualitative depth. Two studies lacked evidence of some key research design components, in particular ethical issues, sampling design, selection and methodological rigour (Chesworth et al 2002; Bodiam 1999).

Edwards et al (2007) produced a credible study using the COPM with individuals with hip fractures detailing a clear sampling process and data analysis. Despite the sound

methodical approach the overall study design was inferred rather than explicitly described which created uncertainty when it came to assessing its strength.

Chesworth et al (2002) explored clinical effectiveness in mental health services using a retrospective case evaluation. This study presented credible findings discussed in the context of other studies with a clear data analysis process. However the research design, sampling and data collection processes were unclear which impacted on reproducibility. Also the findings could have been improved by more detail and sophistication in the data presentation.

Studies in the quantitative group were spread across three categories of the hierarchy as described by CRD (2009). Two studies, Cup et al (2003) a cluster randomised trial and Gilbertson & Langhorne (2000), a single site blind randomised controlled trial (RCT), were judged at Level 1. The Gilbertson & Langhorne (2000) study was a fairly well constructed design showing good methodological rigour with bias minimised by computer generated randomisation. Whilst the sampling process and data collection methods were well described and justified, the literature review lacked scope and could have been improved by inclusion of patient satisfaction material.

Cup et al (2003) addressed test–retest reliability and discriminant validity of the COPM in their study with stroke patients. It was a well designed study with a clear hypothesis and method with data analysis reflecting the research question. The authors did not include a specific literature review section, electing to illustrate the study with references in the text, had they done so it would have provided a stronger conceptual framework for the study.

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Level 2 studies are described as quasi -experimental studies (CRD2009). In this group, unlike RCTs, the assignment of subjects used to create comparison groups is not randomised. Other methods are used instead which may increase selection bias. Included in this group are before and after studies which seek to compare outcomes in study participants before and after an intervention. Comparisons may be made with the same sample or across different ones.

Of the six studies in this group, rigour of design was variable. Roberts et al (2008), Rochman et al (2008) and Sewell & Singh (2001) demonstrated good methodological strength in their study designs. Internal validity was evident with clear research aims, breadth of literature review and results applicable to practice. Roberts et al (2008) carried out a repeat measure design in a natural setting measuring occupational performance with clients in the community. The study was well constructed and written using a reasonable sized sample of 62 subjects. Rochman et al (2008) carried out an examination of the concurrent criterion validity of the COPM by comparing it to other measures used in oro-facial pain. The study was well constructed with literature based on primary resources and findings linked to practice, the only lack of clarity related to poor definition of the intervention. Despite the small study sample used by Sewell & Singh (2001), planned as a preliminary study for an RCT in pulmonary rehabilitation, the methodology was clearly written and the authors gave excellent consideration to the limitations of their study.

Of the remainder, Bodiam (1999) produced a clinical facing study but with limitations in methodological strength related to lack of ethical considerations, no sampling design and minimal use of data display. Despite a well sourced literature review and sound context, the findings in the study by Jenkinson et al (2007) were less clear and

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difficult to discern which had potential to impair the application of its findings. Despite a reasonably well set out study resulting in endorsement of the validity of the COPM, Carpenter et al (2001) failed to describe sample design, risk of bias or ethical considerations in the study.

Sample sizes in the quantitative studies ranged from 138 (Gilbertson & Langhorne 2000) to 15 (Sewell & Singh 2001). The majority of studies had clear sampling designs and explicit processes to minimise sampling bias (Roberts et al 2008; Jenkinson et al 2004; Cup et al 2003; Rochman et al 2008). Bodiam's study (1999) however was less explicit and failed to describe sample selection, increasing the risk of bias, whilst Carpenter et al (2001) based their sample on participant motivation rather than any specific sampling criteria.

McNulty & Beplat (2008) addressed the validity of the COPM with older adults in a retrospective comparative study (Level 3). This was an observational study where variations in interventions were investigated to explore their impact on outcomes (CRD 2009). The sampling design was explicit with clear selection criteria. Researcher bias was minimised with an external researcher involved in the methodological design and data collection. Whilst the small sample reduced the strength of the findings and generalisability of results, the authors identified the limitations of the study.

Study Findings:

The purpose of this systematic review was to examine the literature for evidence of the impact of using a client-centred outcome measure, the COPM, on clinical practice. In particular, to examine the evidence for its effectiveness as an outcomes

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measure when carrying out occupational therapy and to ascertain the external validity of this client-centred measure by consideration of its application and use in practice. Due to the mixed designs used in the studies and assessed in this review it was not possible to synthesise the results in the classic style of systematic reviews where statistical analysis is produced, however synthesis of the findings was carried out. However despite this, the review identified several themes which have emerged from the findings and which indicate impact on practice. In addition there is robust evidence of the value of the COPM provided by one high quality RCT (Gilbertson & Langhorne 2000) and two high quality clinical trials (Roberts et al 2008; Richard & Knis-Matthews 2010).

Gilbertson and Langhorne (2000) conducted a single site RCT involving 138 patients who were randomly allocated to either a conventional out-patient follow up (control group) or a conventional service plus home based occupational therapy (intervention group. The study aimed to evaluate a short post-discharge occupational therapy service for stroke patients. The COPM was used as an assessment tool before discharge and on 2 occasions post discharge to determine patient satisfaction with occupational performance and occupational therapy service provision. The authors concluded that the COPM was a meaningful outcomes measure for patients because it was client-centred and was more sensitive to change over time. Data analysis of the COPM scores involved deducting the baseline scores from the reassessment scores. The intervention group reported significantly greater change in performance scores ($p=0.0006$) and satisfaction scores ($p=0.0001$) between discharge and 7 week follow up. The change in satisfaction scores was significant at a 5% level using the Mann-Whitney U test. Although their study had limitations in its literature review by a

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somewhat narrow reference to other related studies which could have been improved with a more detailed contextual discussion of the findings, it demonstrated good methodological rigour and indicated issues for practice. Using the COPM in this study provided the authors with the evidence that a 6 week home-based occupational therapy service can improve patients' perceptions of their occupational performance and satisfaction with services, suggesting that stroke services should consider organising specialist community based occupational therapy services for stroke patients after they are discharged home.

The primary aim of the study by Roberts et al (2008) was to examine changes in clients' occupational performance and satisfaction with that performance within a community setting, using the COPM to measure those changes. Fourteen occupational therapists completed assessments using the COPM with 62 adult clients in a quantitative repeated measure design in a natural setting, where client performance and satisfaction were rated at the start of assessment and then again once intervention had been completed. The COPM scores were analysed using inferential statistics and the results found that there was an increase in means between the initial and final COPM scores for both performance and satisfaction. The differences were examined using the t-test and both were found to be statistically significant at $P<0.01$. The study was well written with a clear methodology and relevant literature to provide context, furthermore it sought to determine findings which would guide service planning and approaches to occupational therapy intervention. The study found that clients improved their performance in their chosen occupational activities and increased their satisfaction with that performance following occupational therapy intervention. The study demonstrated the

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effectiveness of occupational therapy by the improvement in the clients' perceived performance and satisfaction with that performance, it provided empirical rather than anecdotal evidence of the value of occupational therapy in helping clients to fulfil their occupational performance goals and highlighted the value of using the COPM as an outcomes measure.

Richard & Knis-Matthews (2010) addressed the lack of convergence between therapist and client goal setting in their study designed to explore concerns identified in the literature about gaps in therapists knowledge of client –centred practice and its integration into practice (Sumsion & Smyth 2006; Wilkins et al 2001). Despite the small sample size (seven clients), use of a single therapist and a single study site, they examined the consistency of goals identified by the therapist with those identified by the clients in a residential programme for people with mental health problems. Interviews were conducted with clients and to explore goal setting and to complete the COPM. Further interviews were carried out with the therapist to determine what goals she thought the clients had identified. The results were analysed following data transcription and use of analytic memos (Ely et al 1997) and then formulated into categories of intervention goals. These were then compared across the participants and then compared with the therapist's perception of their goals. The implications for practice were clearly identified and the results supported previous findings regarding the potential for a disconnection between the goals identified by the therapist and the client. The difficulties of being client-centred were demonstrated by lack of empowerment of the clients and a failure to recognise the contextual environment of the client being wider than the work context of the therapist. The authors concluded that the COPM provided therapists with a tool that

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can be used to develop intervention goal statements from a client's perspective. Those goal statements can create the opportunity for mutual understanding and negotiation and greater convergence between client and therapist to support client-centred practice. They reinforced that a commitment to client-centred practice needed to be reflected in all aspects of practice supported by training and development to improve competencies.

Impact on practice:

Training

Several studies (Wressle, Marcusson & Henriksson 2002; Parker 1995; Wressle et al 2003; Verkerk et al 2006; Richard & Knis-Matthews 2010; Gilbertson and Langhorne 2000) identified the need for knowledge and training before using the COPM. Firstly, knowledge of the theoretical underpinning of the COPM, especially the key components of client-centred practice and occupational performance were identified as essential. Richard & Knis-Matthews (2010), Parker (1995) and Wressle et al (2003) also recognised that support was needed during the period of introduction and implementation of the COPM, endorsing that this should be a process rather than a one off event, recommending staff development and training to improve competence in client centred practice.

Secondly the need for practical training on the application of the measure, especially with regard to interviewing skills was endorsed by other studies (Wressle, Marcusson & Henriksson 2002; Parker 1995; Sewell & Singh 2001; McNulty & Beplat 2008). Sewell & Singh (2001) considered that the interview process placed emphasis on the OT's interviewing skills which may present difficulties when using the COPM, with

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Cup et al (2003) recommending further study to understand the impact of interview styles on COPM results.

Occupational Performance

The influence of occupational performance on the use of the COPM emerged clearly across the range of studies. Roberts et al (2008) found that the COPM demonstrated an improvement in clients' perceptions of occupational performance and satisfaction. Their results provided clear evidence of the value of occupational therapy in helping clients fulfil their occupational performance goals. Similarly, Wressle et al (2003) and Rochman et al (2008) confirmed the importance of the COPM in generating unique information about occupational performance and satisfaction with treatment. Carpenter et al (2001) concluded that the COPM provided an excellent medium for discussion of occupational performance issues with McNulty & Beplat (2008) supporting the clinical utility of the COPM in providing client centred intervention that focused on self perceived occupational performance. Jenkinson, Ownsworth & Shum (2007) was the only study to indicate that the relationship between therapist and client during the COPM interview may influence the number and nature of the occupational performance problems identified. Whilst there was an acknowledgement of the association between the COPM and occupational performance, few studies addressed the relationship of the measure to its theoretical foundation. Wressle et al (2003), Richard & Knis-Matthews (2010) and Wressle, Marcusson & Henriksson (2002) recognised the role of the Canadian Model of Occupational Performance (CMOP) underpinning the COPM but only Parker (1995) noted that therapists needed to understand the theoretical basis of the model in order to apply it in practice.

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Goal Setting

The association of the COPM with developing client-centred goal statements was a key finding in several good quality studies. Richard & Knis-Matthews (2010) concluded that using the COPM created the opportunity for mutual understanding and negotiation between the OT and the client, creating a convergence of views, which in turn supported client-centred treatment planning. Parker (1995), Wressle, Marcusson & Henriksson (2002) and Wressle et al (2003) advocated delivering the OT Process using the COPM, reinforced goal setting and added value to planning treatment interventions. The professional role of the OT was considered by Wressle, Marcusson & Henriksson (2002) to be strengthened by using the COPM in delivering client focused goal setting. Goals centred on occupational performance issues rather than function, were broader and more distinctive, which enhanced communication and helped establish a partnership approach to goal setting. Although weaker methodologically, Chesworth et al (2002) also reinforced this in their clinically relevant retrospective evaluation. Verkerk et al (2006) concluded that the COPM was a valuable tool for defining intervention goals for children from a parent's perspective. When comparing the COPM with other standardised instruments, the Paediatric Evaluation of Disability Inventory (PEDI) for example, they found that the COPM provided the best means of identifying child specific occupational performance goals.

Client-centred practice

Evidence that client-centred practice underpinned the COPM was clear throughout this review. Several of the studies assessed as high quality (Richards & Knis-Matthews 2010; Parker 1995; Wressle, Marcusson & Henriksson 2002; Roberts et al

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2008) found that success in using the COPM was only assured if balanced with the commitment to client-centred practice. These studies were clear that client-centred practice should be reflected in all aspects of occupational therapy and reinforced with training.   Roberts et al (2008) and Wressle, Marcusson & Henriksson 2002) also concluded that the COPM can demonstrate improvements in client perception of occupational performance and provide clients with feedback about their own performance. Despite having design weaknesses, Bodiam's study (1999) also found that as the COPM was client-centred and individualised, it was more meaningful to clients and more sensitive to change over time. Gilbertson & Langhorne (2000) and Cup et al (2003) corroborated that the COPM ensured assessments and outcomes reflected clients' views and could support more appropriate referrals to OT. Cup et al (2003) and Verkerk et al (2006) concluded that because the COPM focused on unique client issues which were not evaluated when other standardised measures were applied, it reinforced the client-centred focus of the tool. Their argument was that other measures addressed a fixed range of questions (Barthel Index, Frenchay Activities Index, and PEDI) and did not enable the client to express their own needs or promote goal setting based on unique client identified priorities.

The value of the COPM in establishing a relationship with clients facilitated by effective communication skills, such as negotiation, sharing of information and cooperation was addressed by only a few studies (Carpenter et al 2001; Verkerk et al 2006; McNulty & Beplat 2008) and not identified in others.

Outcome measure evidence:

As the COPM measures occupational performance, which is the core element of occupational therapy, it is a valuable tool for evaluating the outcomes of occupational therapy (Gilbertson & Langhorne (2000; Carpenter et al 2001). Sewell & Singh (2001) undertook analysis using mean differences, and confirmed 95% confidence levels and correlation coefficients concluding that the COPM has test-retest reliability in men and women with COPD, thus providing evidence that the COPM is a reliable tool when used with this client group. Wressle et al (2003) concluded that the COPM, when used as a team based outcomes measure, increased client participation. This occurred when clients were given the opportunity to identify their own problems and to agree goals using the COPM.

In some studies with smaller sample sizes the impact of the findings should be treated with caution. Bodiam (1999) found significant clinical change in COPM scores in a study in neuro-rehabilitation and Jenkinson, Ownsworth & Shum (2007) established that their findings could not be generalised to all those with Acute Brain Injury as the sample size limited the statistical power of the study.

McNulty & Beplat (2008) concurred that the use of the COPM with older adults with depressive symptoms, where a decline in occupational performance was linked to depressive symptoms, was valid. Carpenter et al (2001) found that concurrent criterion validity of the COPM was clearly demonstrated in pain management with significant correlations between the COPM and other tests of psychological functioning, such as the Beck depression inventory (Beck et al 1961). Cup et al

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(2003) concluded that test-retest reliability of performance and satisfaction scores was good.

Wressle, Marcusson & Henriksson (2002) acknowledged the clinical utility of the Swedish COPM. Roberts et al (2008) and Wressle et al (2003) both affirmed the importance of being able to measure and report outcomes using the COPM. Gilbertson & Langhorne (2000) and Wressle et al (2003) confirmed that the COPM was sensitive to change over time making it a more meaningful outcomes measure. Additionally Roberts et al (2008) reported the value of using the COPM as an outcome measure to both support client choice and provide evidence for external organisations, such as health commissioners, of the value of occupational therapy.

Some studies identified problems using the COPM, for example with clients who are unable to identify occupational performance issues (though this gave therapists useful information about client knowledge) or where English was a second language (Parker 1995; Wressle, Marcusson & Henriksson 2002; Gilbertson and Langhorne 2000). Similarly for those with cognitive difficulties, Bodiam (1999) found that they rated themselves as less dissatisfied with their performance. Cup et al (2003) suggested the reliability of the COPM item pool was doubtful, and whilst this was not a problem in clinical practice it may cause issues if the COPM is used in clinical trials. Parker (1995) found that pressures in acute care can constrain the use of the COPM.

External validity:

Despite there being variation in the sample sizes and quality of study designs in the review, there was widespread confirmation of the value of the COPM as a clinically applicable measure able to detect changes in performance and satisfaction with

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occupational performance in a range of clinical settings. These included specific clinical areas such as mental health (Chesworth et al; McNulty & Beplat 2008; Richard & Knis-Matthews 2010); trauma orthopaedic rehabilitation, (Edwards et al 2007); chronic obstructive pulmonary disease (Sewell & Singh 2001) pain management (Rochman et al 2008; Carpenter et al 2001). Rehabilitation settings for brain injury and stroke (Bodiam 1999; Jenkinson, Ownsworth & Shum 2007; Gilbertson & Langhorne 2000; Cup et al 2003; Carpenter et al 2000), in the community (Roberts et al 2008; Wressle et al 2003), and in wider practice areas including acute physical (Parker 1995; Wressle, Marcusson & Henriksson 2002) and with parents of children with disability (Verkerk et al 2006).

Some studies indicated the need for further research in particular clinical areas. For example, Sewell & Singh (2001) found that the COPM was a reliable tool with COPD clients but recommended further study to enhance the evidence for its use in this clinical area. Rochman et al (2008) concluded that the COPM gave unique information about the impact of pain on occupational performance and client satisfaction with treatment and showed promise as an outcome measure in orofacial pain, however as the sample size was small further study was needed to determine the usefulness of the COPM as an outcome measure in orofacial pain. Jenkinson et al (2007) had concerns about the impact of cognitive impairment on COPM self ratings and recommended further research to explore the influence of the alliance between the therapist and the client on the problem of outcome assessment.

Conclusion:

This study set out to examine the impact of using a client-centred outcomes measure, the COPM, on clinical practice. This was addressed by carrying out a systematic review of the literature on the COPM using a robust methodology within a planned time frame. The search and review process identified sixteen studies of different designs, with a range of clients in a variety of settings being assessed for quality and content. The systematic review concluded that there is robust evidence provided by consistent, statistically significant findings in at least one high quality RCT (Gilbertson & Langhorne 2000) and two high quality clinical trials (Roberts et al 2008; Richard & Knis-Matthews 2010) of the value of the COPM as a client-centred outcomes measure valued for use by occupational therapists to detect change in client's occupational performance.

There were four key themes which emerged as outcomes of this review which have a critical impact on the use of the COPM in clinical practice and which informed the progress of the next studies in this research.

Firstly **knowledge of and training** in **client-centred practice**, **occupational performance** and **effective interviewing skills** are required to use the COPM successfully. On-going support during implementation of this training is recommended.

Secondly the COPM was identified as being a conduit for establishing a relationship with a client by enabling and reinforcing **goal setting** within a **partnership** approach.

Thirdly, knowledge and application of the **model of occupational performance** which provides the theoretical foundation for the COPM, is crucial to determine
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occupational performance rather than functional based goals. For the COPM to be used effectively as an outcomes measure to influence and impact on the relationship with a client, then occupational therapy must be client- centred.

Finally there was evidence that the COPM was a **clinically relevant outcomes** measure applicable across a wide range of client groups and environments whose use can impact on practice.

Law et al (2001) concluded that outcome measures should be consistent with the client-centred philosophy of practice for occupational therapy. The COPM provides us with an outcomes measure which is both client-centred and focuses on change in occupational performance. This review has highlighted that there are several key questions which need further investigation in order to understand more clearly the nature of client-centred practice in occupational therapy. The focus of client-centred practice is the client working with the therapist in partnership to achieve prioritised goals. If there is to be a clearer understanding of a practice involving client and therapist then their perspectives should be explored and considered. The main focus of the next two studies was on understanding the client and the therapist experience of client-centred practice in occupational therapy. This was addressed by exploring the knowledge and understanding of therapists about client-centred practice and occupational performance, understanding the skills they need to practice this approach, exploring the nature of the client / therapist relationship to determine where partnership evolves and exploring what it means to the client to experience this approach.

CHAPTER 5:

THE THERAPISTS PERSPECTIVE OF CLIENT–CENTRED PRACTICE: A PROFESSIONAL VIEW

The Focus Group Study

Introduction:

The College of Occupational Therapists in the UK (COT) states its commitment to client-centred practice and the involvement of the service user as a partner in all stages of the therapeutic process in guidance contained in the Code of Professional Conduct (2010). It is made clear that occupational therapists should;

"work in partnership with the service user and their carer(s), throughout the care process, respecting their choices and wishes and acting in the service user's best interests at all times" (COT 2010a. p 16.3.3.2).

This guidance reflects evidence in the literature reporting how client-centred practice influences the relationship therapists have with their clients. Early descriptions of client-centred practice advocated partnership, client involvement and client empowerment as fundamental elements in its successful delivery (Law, et al 1995). In a later review of evidence, Sumsion & Law (2000) confirmed the importance of an effective partnership between therapist and client, the use of communication using appropriate language and listening, to deal with issues of power and client choice in interventions linked to the provision of information. In the 1990s, there was evidence that client and professional opinions differed in relation to understanding the terminology of client-centred practice, particularly with regard to defining and setting

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goals, agreeing treatment priorities, and the judgement of outcomes, which created

barriers to client centred care (Corring 1999; Gage & Polatajko 1995; Corring & Cook

1999).

In America, studies examining the degree to which occupational therapists

incorporated the clients' priorities and concerns into assessments and treatment

planning identified inconsistencies in self reports of actions and observed actions

(Neistadt 1995; Northern et al 1995). Neistadt (1995) concluded that occupational

therapists had not successfully translated their values about client – therapist

collaboration into procedures for practice.

More recent evidence suggests that this is still the case and continues to challenge

how client-centred care is delivered (Falardeau & Durand 2002; Lum et al 2004;

Maitra & Erway 2006). In addressing this challenge Pollock et al (2006) suggested

that therapists who are comfortable practicing in a client-centred way tend to be more

at ease using a client-centred outcome measure such as the Canadian Occupational

Performance Measure (COPM), which allows the beliefs and assumptions of client-

centred practice to be operationalised. They suggested this was a means of

strengthening the link between the theory and practice of client -practice. Gage

(2006) also considered the challenges of client-centred practice and suggested that a

key element in overcoming these difficulties of implementation was to create a

synergistic relationship with the client. She described this as being a relationship

which combined the efforts of all participants in seeking solutions to problems, whose

resolution was structured by joint goal setting. Key to this relationship was the

common vision of the therapist and the client articulated through goal setting which

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has been found to be the most effective means of attaining a suitable outcome (Locke & Latham 1990).

Evidence from the systematic review (Ch.4) indicated that goal setting within a client-centred relationship was reinforced by using a client-centred outcomes measure, such as the COPM. In order to develop a clearer understanding of how the relationship between a therapist and a client works in relation to goal setting and achieving outcomes of intervention, a focus group was convened to examine the therapist's experience and perspective of the challenges of the therapeutic relationship by exploring whose goals shape the intervention.

The setting:

The setting for the focus group was a national conference for occupational therapists held in the UK organised by the Gloucestershire Occupational Therapy service. The aim of the conference was, to explore and showcase the use of client-centred practice and models in occupational therapy services. As a one off event it attracted occupational therapists interested in client-centred approaches from across the UK. Whilst there was no certainty that the audience would all be in favour of this approach to practice, it could be argued that those who were not interested in the subject would not have paid to attend a conference where the keynote speaker was one of the leading advocates and authors of client-centred practice in the profession, Thelma Sumsion. Those who attended the conference included occupational therapists, undergraduate, qualified and support staff, from a wide variety of clinical and organisational backgrounds. The focus group provided an opportunity to explore

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the views of occupational therapists who were interested in the client-centred approach.

Rationale for the Focus Group:

After the systematic review had been completed, I planned the second study to explore the views and knowledge of occupational therapists about client-centred practice. When considering the possible ways of doing this, my first thought was that I needed to talk to OTs, to find out from them what it meant to practice using this approach. I had decided that the scope of this study was to be at a broader professional level in the UK as this was the professional practice base Sumsion's definition was developed from in 2000. Having established what I wanted to ask and who I wished to approach, my sampling strategy had to address how this could be achieved. As I wanted to access a broad spectrum of opinions from OTs in the UK, research methods involving one on one interaction were discounted, as they were more appropriate for exploring individual experiences (see Ch.7), so for this stage of the research observational studies and interviews were disregarded. To target a wider sample population, I decided that a focus group would enable me to explore the knowledge of, ideas about and attitudes to client-centred practice within a professional setting (Kitzinger 1995). The outcome of the focus group would then inform the development of questions in a survey designed to explore the knowledge and opinions of a wider population of therapists of client-centred practice (see Chapter 6). Evidence in the literature indicated that focus group methodology can be used to complement quantitative sample surveys (Thomas et al 1992) and Robinson (1999) consider the flexibility of qualitative methods to either stand alone or be used alongside quantitative methods is particularly useful in health care research.

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Conducting a focus group was realistic both in terms of organisation and as an appropriate forum for investigating knowledge, opinions and ideas about client-centred practice with an appropriate sample (Thomas et al 1992).

Focus group methodology

A focus group is described as an in-depth discussion amongst a group of people led by a group moderator or facilitator who introduces the topic and facilitates the debate (Holloway & Wheeler 2002). The session is recorded, transcribed and subject to subsequent analysis. Several authors acknowledge that Merton (1956) was the originator of focus group interviews in his work which examined people's reactions to wartime propaganda (Thomas et al 1992; Kitzinger 1995; Robinson 1999), although prior to that it was used as a market research technique in the 1920s. In healthcare, with NHS reforms (DH 2005; 2012) demanding greater understanding of people's attitudes to issues such as quality and outcomes the use of focus groups has increased (Robinson 1999). The principles of focus group methodology have been described and revised by Kitzinger (1996),Patton (1990) and Stewart and Shamdasani (1990). The method involves a group interview with participants who form either an homogenous (common backgrounds) or heterogeneous (different backgrounds) group who are asked to reflect on and consider a specific topic. The discussion is guided by the researcher (referred to as the moderator or facilitator) with the session lasting between one and two hours (Robson 2002). Opinion on optimum group size varies with twelve generally considered suitable, however smaller or larger groups can be acceptable (Stewart and Shamdasani 1990; Lysack, Luborsky & Dillaway 2006; Morse & Field 1998). The role of the moderator is to manage the group session and to facilitate the discussion. Skills and experience in

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group dynamics are considered to be essential in order to achieve the right balance between an active and passive role (Robson 2002). Whilst it is common for focus group studies to involve several group meetings for discussion of a specific topic single meetings are also suitable as data gathering events (Kitzinger 1995).

Focus groups take advantage of the communication between participants as it is this interaction which is the basis for the development and exploration of the topic in question, however this relies on the skills of the moderator to encourage group members to talk to each other in order to develop ideas. Focus groups provide a means to gather data more quickly and economically than individual interviews with contributions noted in the words of the participants. As with any interview, they involve direct contact with the participants and because they are not designed around fixed questions, respondents can react to and develop their ideas in response to comments made by other members of the group. This can cause conflict, however it can be a creative part of the process and add to the data for analysis, as the value lies in exploring underlying attitudes and assumptions (Robinson 1999). Another advantage of this interview format is that it can be used in most settings and with a range of people and, unlike questionnaires, does not discriminate against those who are illiterate.

Some of the disadvantages of focus groups noted by Stewart and Shamdasani (1990) concerned the discussion which can be biased or influenced by a dominant member. This is the responsibility of the moderator to manage by encouraging all members to contribute. This was monitored closely and the findings confirm that all members contributed to the discussion. Also some participants may find the group setting intimidating which may reduce their contribution; the role of the assistant in

this focus group involved noting non-verbal communication from participants as a means of recording their involvement in the group.

Time and resources were also a consideration (Robson 2002) and the feasibility of maximising resources and using the most appropriate approach was important in the research design. The decision to conduct a single focus group comprising 25 participants was undertaken as part of the data gathering process and acted as a precursor to exploring the wider view by other methods.

The opportunity to run a focus group came about through involvement in planning a conference with the Gloucestershire occupational therapy service on client-centred ways of working. This was a national event, advertised in the occupational therapy professional journals (BJOT and OT News) which are circulated to the OT membership and available in NHS libraries nationwide.

The purpose of the focus group was to examine the understanding of the participants of partnership working by asking the question; whose goals direct occupational therapy, which was a theme previously identified in the literature and as an issue in the systematic review. The style of enquiry was naturalistic using an iterative information gathering process initiated by posing the question noted above.

Focus group session

An outline plan of the focus group workshop was submitted to the conference steering group for approval and inclusion in the conference programme. The advertisement for the conference included the programme listing the choices of workshops for self selection, the information relating to the workshop on "Patient engagement – whose goal is it anyway?" alerted potential delegates that participation
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would involve being part of a research study (appendix 5.1). The group was led by me as the moderator and an assistant. The session was limited to one hour.

During the planning stage potential problems with the environment or equipment which could impact on the flow of the focus group were considered in detail by the researcher. These involved attending to the room layout. Too large a space would have made communication and recording difficult, too small a room would also impact on communication. A high ceilinged room would have created an echo effect on the recording, in addition location of electrical sockets may affect the flexibility of managing the environment and placement of the recorder. They were reviewed again with the assistant at a pre-workshop briefing, this ensured familiarity with the environment and the plan for the group session

Arrangements for managing the workshop had already been confirmed with the conference organisers before the session commenced. These included a room with space for participants to sit and see each other, provision for the researcher and assistant to sit centrally with adjacent power supply for the recorder and access to the room prior to the event to view and set up equipment. The start and finish times were confirmed together with the arrangements for the delegates to sign in(ensuring they arrived on time with no latecomers).

 I had previously been trained and gained experience in group therapy and was responsible for handling the questions, keeping participants focused and for managing group dynamics. The setting was a meeting room. The layout was organised with chairs in a horseshoe shape enabling all the participants to see each other. The assistant and I placed ourselves at the base of the horseshoe so we could

see and be seen by everyone in the group. The recording equipment was located centrally and the recorder was tested beforehand to ensure that contributions from all points of the room would be recorded. A numbered card was placed on each chair for participants to show when speaking. A flip chart was available in view of all participants for use as a visual prompt.

Planning for the focus group entailed careful consideration of how the session would be structured in order to maximise the time available. The session comprised an introduction to set the scene for the participants, followed by an opening question to stimulate reflection and discussion. Supporting prompt questions were used to encourage communication and focus on the key topic (see below).

The session was planned by myself and discussed with the assistant in to ensure the purpose and format of the focus group was clear. The opening question was formed from evidence in the literature where goal setting was indicated as a means of delivering client-centred practice. The wording of this and how it would be introduced were discussed and drafted using feedback from the assistant.

Confirmation of attendance included explanatory letters regarding the purpose of the research; maintenance of confidentiality; the data recording process and the opportunity to withdraw from the focus group workshop, by selecting an alternative. On the day of the conference, final focus group attendees were given an additional explanatory letter (appendix 5.1) reiterating the research process, plus information on how the data would be used. It also acknowledged that by attending, their consent to participate was assumed (there was a choice of other sessions available on the programme).

The session was opened with a brief clarification of its purpose as part of a research project. This was followed by a brief introduction to the group about patient engagement, with participants asked to consider how therapists engage and connect with patients in their clinical practice; what they felt succeeded; what did not succeed. This then led into the key question of 'whose goals direct therapy?' which opened the discussion and the debate was allowed to flow with limited direction and prompting from the researcher. It was important that the group was not led in its exploration of the subject but enabled to explore the topic with the researcher monitoring and maintaining the focus of the group. A flip chart was used to note key words and act as a prompt during the session. When each respondent spoke, the assistant noted down in the session log, the number displayed on their card and managed the tape replacement and audio recorder. This use of a numbered card by each respondent facilitated data analysis as it meant that comments repeated by the same participant would not be mistaken for the opinion of another member of the group, these were recorded on a paper record by the assistant and noted in the transcription. Similarly if there was a different opinion held by one person, this was not incorrectly identified as a group view. This will be evident later in the findings section of this chapter.

The pre-planned prompt questions were used to explore how key themes in the delivery of client-centred practice were regarded by practitioners (Parker 2006; Sumsion & Smyth 2000; Law 1998). For example; how confident are you in delivering client centred practice? What concerns you about client centred practice? What influences you in making decisions in patient care when being client centred? What is your view on partnership and what does partnership mean? The use of open ended

questions was important as this supported the purposes of the session which were to enquire and explore (Depoy & Gitlin 2005).

The Sample:

A total of 80 people attended the conference and 25 opted to attend the focus group. Demographic information about participants was not part of the conference booking process and had not been separately requested or noted prior to attendance at the focus group session. However as part of the introduction, participants were encouraged to state their clinical field and working background when they first spoke. This worked well as during the session the assistant noted in the session log that the participants came from a range of backgrounds in health, social care and education. The group was essentially homogeneous, sharing a background in occupational therapy but with a variety of experiences, knowledge and working backgrounds which I had anticipated would be diverse and which would enrich the discussion (Robson 2002). Similarly age data had not been requested as this was not required information for conference attendance; however it could be assumed that the age span was between 18 and 60 yrs reflecting the minimum age at which undergraduate education in OT commences (18) and the expected retirement age (60) of occupational therapists. It was unlikely that retired OTs would attend or if so that they would do so in great numbers. The gender profile of the group was 3 male and 22 female participants.

Although Bowling (2002) recommends balance when organising focus groups, in relation to age, gender and ethnicity it was not appropriate in this instance to request pre attendance information related to personal profiles in order to achieve such

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balance in the group. Also for the purposes of this study it was not required. The participants reflected the professional profile, which is predominantly female with a range of clinical backgrounds (Parker 2010). Considering that the conference was advertised nationally within occupational therapy journals, it was assumed that those attending the conference and subsequently selecting the focus group workshop would come from a range of Occupational Therapy practice areas. In other words the focus of the conference was not specific to a clinical domain or services for a disability group. At the time the focus group was held, there were just over 29,000 OTs registered to practice on the Health Professions Council (HPC) register, and according to the HPC, the gender mix for occupational therapy is 92% female and 8% male (Parker 2010). In planning the focus group, the potential for low attendance was considered, bearing in mind possible reluctance to join a group which was being audio taped, however this was not the case. Each workshop in the conference was limited by the organisers to a maximum attendance of 25, the maximum for the rooms allocated and the focus group had maximum attendance.

Data management process

The data collected comprised the transcript of the session, notes from the session log and the researcher's reflections written as field notes. Field notes were made which captured the detail of impressions, feelings and reflections on the focus group. This is a valuable element of the data gathering process because if reflections are noted as soon as possible after completion of the session (Gray 2004) it removes the need for the researcher to rely on memory alone to capture the detail. The use of field notes as a method of expanding data collection is recommended as a useful tool in data collection (Polgar &Thomas 2008 Depoy & Gitlin 2005), however Stein &

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Cutler (2000) argue it requires the researcher to systematically document observations ensuring that good field notes are descriptive, concrete and detailed. To provide further detail the assistant kept a session log of key comments matched with the participants' numbers.

Data analysis was qualitative and was completed by the researcher after the focus group session. Robson (2002) advises familiarity with the detail of the data as this achieves a more skilled interpretation. Listening repeatedly to the recording, reviewing the transcript and reflecting on the themes emerging from the data ensured familiarity was achieved. Analysis of the qualitative data was thematic analysis and involved data display, data reduction, and data interpretation (Miles and Huberman 1994). A theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set (Braun & Clarke 2006). Analysis of themes can be achieved using various tools; such as thematic networks which break up the text creating a system or organisation such that the themes are classified according to the underlying story they are telling into basic, organising and global themes (Attride-Stirling 2001). Another tool is a taxonomy which is a system by which themes are organised into categories and relationships which create taxonomies or mind-maps (Depoy & Gitlin 2005). Taxonomies involve two processes, firstly grouping similar or related themes or categories into larger groups and secondly identifying any differences between the sets of categories and overarching themes. Taxonomies can provide a useful means of visualising the mass of data into patterns such that themes can be identified and categorised. Whilst these methods of analysis were considered, thematic analysis was applied because it was part of the inductive approach used in this research.

The process of data analysis employed here began with data display. The verbatim transcription of the audio-tape recording included the notation of the number of the respondent against the comment made and was cross referenced against the session log kept by the assistant. It was re- checked for accuracy against the tape recording and read through several times to ensure familiarity with the data. Data reduction involved reviewing the data by systematically working through the written transcript, highlighting key words to create a level one map of emerging themes. A coding system was not adopted at this stage, which in hindsight may have enhanced the data analysis. Instead I proceeded to manually review the data to undertake a more detailed examination of these themes which resulted in the creation of second level themes as related words and concepts were identified and grouped together on the basis of similarity (see example table 5.1 below). The process of data interpretation involved an examination of the second level themes for differences, links, inferential meanings or conflicts (Depoy and Gitlin 2005) (see appendix 5.2).

This process was carried out systematically incorporating a degree of intuition, perhaps due to familiarity with the data and the subject matter. During the analysis, there was continual reference to the transcript to check for comparisons, similarities and differences between emerging themes.

Table 5.1 Example of data analysis

Transcript data 1st level	Sub themes 2nd level	Key Category	Inferential meanings /links	Conflicts / comparisons
Client – Person related				
Who, Individual, Know client, Person's story, Person, Themselves Client choice, Limitations, Empowered Client centred Client Skills, Learning Process Client's Perception, Insight, Difficulties Acceptance Adjusting to client-centred practice Therapeutic relationships Boundaries Being valued, Respect Understand/ being understood	Client centred practice Who is the client? Client skills boundaries	Client	Link = knowing the client, individual, person's story Knowing (client skills/ limitations/ story) >learning process> insight> client-centred practice	Boundaries - both Acceptance of change –both Adjusting to client centred practice – both
Connected, equal, Co-operation, Participation, involvement, engagement, Relationship, Client centred, Cooperation Partnership	Relationships Engagement connections	Relationship	Link = connection Relationship> participation> involvement> engagement	Motivation – both Insight – client Desire –both Understanding -both

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Findings:

The focus group was homogenous as all participants were linked by being a part of the occupational therapy profession in the UK (both qualified OTs and students are all share membership of the profession). Details of participants' work backgrounds were volunteered spontaneously and were recorded. Respondents' practice environments included adult physical community, community intermediate care, acute physical hospitals, occupational therapy university course educator and student, community psychiatry and social services, all reflective of the broad range of occupational therapy practice in the UK.

The inductive process of analysis resulting in many of the sub themes overlapping indicated an iterative rather than a linear process to reduction and interpretation of data.

For example, three major themes emerged with associated key categories, all being influenced by the over-arching themes of risk and communication;

- Client related issues

- Environmental issues

- Definitions

Each theme is described as an overview and then discussed to provide context and will be illustrated by original quotations taken from the transcript. Primary data excerpts from the transcript are noted with the respondent's allocated number in brackets after each quote to indicate the range of contributions.

Table 5.2 Summary of Themes

| Main Theme 1

Client | Main Theme 2

Environment | Main Theme 3

Definitions |
|---|---|---|
| **Key categories** | **Key categories** | **Key categories** |
| **Client**

The person

skills

Boundaries | **Home**

Client behaviour

Client identity

Client confidence | **Power**

Knowledge

Influence of others |
| **Relationships**

Connections

Engagement | **Hospital**

Client behaviour | **Skills**

Skills of therapists

Clients |
| **Goals**

Goals and expectations

Goal definition

Language | | **Engagement**

Meaning

Balance |

Table 5.3 Over-arching Themes

Overarching Theme 1 **Communication**	Overarching Theme 2 **Risk**
Key categories	**Key categories**
Informed choice Informed decision making Negotiation Skills Listening	Safety Knowledge of risks Information Barriers

Theme 1: Client related issues

The Client

A concern for therapists was not knowing about the client and their circumstances, their needs and goals and recognising that other influences, including health issues and family pressures, affected how therapists engaged with the client.

" you can be as client-centred as you like but until they are ready to listen, do something or are ready to accept some kind of change, you aren't going to go further" (9)

"you don't know what their expectations are" (13)

"there is family whose agenda is completely different to the person you are dealing with"(20)

Being able to understand the client's needs reflected the experience of the therapist and their skills in appreciating the client within the context of their lives, recognising the individual, a person's value and the need to respect them.

"having respect of the client and respect what they're wanting" (24) and "valuing the client" (23)

"getting a grasp of what that person is about" (14).

Informed choice was considered an important factor in establishing goals in client-centred practice, linked with honest communication, information sharing and risk taking. It was considered as guiding a client's decision making process especially in relation to;

"being honest with them about what your resources are and the limitations of what you are able to provide and re negotiate more appropriate goals which will meet their needs but within your limitations" (6)

The emphasis appeared to focus on sharing information so that choice was informed rather than imposed, but balanced with negotiation. The therapists considered that establishing what the client understands meant checking they have insight together with the need to *"minimise the risks" (17).*

Relationships

Part of the challenge of being client -centred focused on the relationship between the therapist and the client. Words used to describe the nature of the relationship itself were; co-operation, involvement, participation and the forming of "*therapeutic relationships" (23)*, implying a process.

> *"the scary bit when you start to build the relationship, when you start to engage is what you are going to find"* (13).

> *"It's also having an idea about the lifestyle of the client, what they do..It's finding out about that person, their function in that environment"* (14)

> *"If you haven't connected with them in the first place you wouldn't have the confidence to respect their choice"* (24)

Use of the COPM was identified as an important tool in achieving engagement with a client as it provided the means of demonstrating how a therapist values what is important in the client's life;

> *"the COPM really helped his engagement... that connection... to determine what was really the goals... the COPM was important for that"* (23).

> Goals

The question of goals and goal setting created some concerns for therapists, not least in relation to number and expectation but also in definition. Goal setting was linked to the skills of communication, in particular the use of language.

> *"Clients tell me they don't know what I mean by goals"* (12).

Also goals should be written in the language of the client.

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"using layman's terms rather than goals and action plans" (6)

Plus linking goals with outcomes measures such as the COPM, ensuring they expressed that which was of value to the client.

"From that engagement and learning process you arrive at what you come to do next... and if you use the COPM .. to determine ...the goals , the COPM was important for that" (23,13).

Goals were also considered as not static and *"were always moving" (25)* and that expectations change, with goal setting being *"a learning process" (13)* for both therapist and client enabling both to "*measure whether your intervention or the client has moved on" (14)*.

Theme 2: Environment

The environment influenced the behaviour and attitude of the client and the ability of the therapist to be client-centred. There was particular emphasis placed on the differences between home and hospital. The influence of the home environment was regarded as having a positive effect on clients' behaviour, allowing them more control over decisions.

"from a client centred point of view it is easier in the community, because you are there in their realm"(20).

This confidence was linked to engagement;

"I have found that people seem to find it easier on their own territory to engage with me" (13)

"in their own home they are more in charge"(21)

"In the community they are a lot more in control" (7)

Additionally for therapists, there was an appreciation of the client in the context of their own environment;

"when they are at home there are more clues as to how to engage with that person" (22).

"when they are at home they feel confident enough to then say what they really need" (17)

"have more insight and are more accepting of assistance" (14) when in their own environments. Hospitals were noted as being *"an alien environment" (14)* and *"disempowering" (17)* to people, where the perception of the clients was that they would be looked after. "*Pyjama paralysis" (20)* was suggested as occurring when clients went into hospital, with the perception that staff would *"look after me and make decisions"* (21).

There was also a suggestion that clients' behaviour whilst in hospital may be influenced by their desire to go home such that *"they just agree with everything"* (17).

Theme 3: Definitions

The themes in this category were power, skills and engagement which influenced the therapists in their relationships with clients.

Power

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The sub theme of power was noted as influencing clients' behaviour and challenged the client-centred approach. The hospital was considered a "*more controlled environment for the professional who is in a more powerful situation*" (13) because of a different "*power balance*" in that environment. This view appeared to be related to the influence of the medical profession which was identified as not being client-centred (8). Similarly with regard to the decision making processes which occur in hospitals it was stated that; "*The hospital environment is a disempowering one for people*" (17) as "*there are different agendas in hospital, there are different sets of people wanting things....it's not that person's agenda*" (7). Respondents reported that the family also exerted power over the client "*we've got two sets of power going on, you have the patient, you have the relatives*" (20,14,13). There was limited reference to the power of the therapist other than consideration of there being a different balance of power when a therapist engages with a client as the client is "*in a better position to take on a powerful role and you don't know what their expectations are*" (13) when the client is in their own home.

Skills

The skills of the therapist were considered as important in client-centred practice, in particular; being a "skilled negotiator" having good communication skills, being able to carry out a skilful interview and listening to the client to enable them to determine their needs and explore how to achieve their goals. The clarity of the information given by professionals and the accuracy of the information given by the client, were also identified as important issues. The use of language was noted as relevant in delivering goal directed therapy "*it's useful to write what they say*" (8) or "*using layman's terms*" (6, 18) and writing down goals from "*a clients point of view*"

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(14,23,6). Participants also recommended that therapists should explain occupational therapy clearly and clarify clients' understanding by encouraging feedback.

The skills of the client and their behaviour influenced how the therapist delivered the client-centred approach.

> *"that is one of the barriers the community therapist comes up against - trying to encourage that client-centredness- but it's so difficult because some clients are so used to a medical profession directing how things go"* (8)

This meant that recognising the skills clients have and the ways they have of doing things*.* *"Clients are a lot more resourceful than we think, they don't always need us"* (16).

Others acknowledged that client insight and knowing the implications of their actions also indicated a client's skills (13, 23, 24)

> *"They have more insight and are more accepting of assistance.. when they are at home"* (14)

> *"if she does fall then she knows the implications and has chosen that"* (23).

Definitions

Therapist's understanding of what it meant to be client-centred ranged from *"frightening"* (20), when dealing with the different agendas of client and family, to recognising client uniqueness.

> *"to determine what was really the goals, you might have your ideas as an OT but it may really shock you that the clients' views are so different"* (23)

The solution suggested was to establish a firm relationship with the client in order to understand their needs. Other factors creating challenges in client-centred practice were lack of resources, paperwork, insufficient documentation which did not reflect models of practice and the need to have client-centred documentation to support clinical reasoning.

The session included a discussion about the meaning of engagement which revealed several explanations:

> *"I think engagement is interesting; who defines what the rules are?"*(16)

> *"I see it as a learning process when as a therapist you learn about their life and what's important to them. You get a bit about what they can and can't do, a bit about what they like doing and then from that engagement and learning process, you arrive at what you come to do next"*.(13)

Engagement was associated with building the relationship with a client and considered as making a connection with them and respecting their choices with good communication being essential. A range of synonyms were used to describe the term which resonated with client- centred practice, these included;

> *"participation, motivation, therapeutic relationships, discussion, feeding back, listening, co-operation, being active, rules of the environment and timing"* (12,23,4,10,8,22,13,16,9).

Communication and risk

Communication and risk were emphasised throughout and pervaded all of the themes emerging from the data. Communication skills and clarity were linked to

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information, informed choice, goal setting and outcomes. The importance of listening and interpreting information and feeding back was agreed as crucial to engaging with the client.

Anticipation of risks by the therapist featured in relation to discharge planning, ensuring safety in the home environment coupled with concerns about the client's understanding of risk factors. Two clear imperatives emerged; firstly that an assessment of the risks must be undertaken and secondly there was the need to establish the client's level of insight. The latter to ensure that risk issues can be clearly communicated and understood. Negotiation with clients was considered optimal to achieve a safe balance. Managing risks was suggested as a process involving the therapist informing clients of the risks they are taking and ensuring they understand, then documenting that decision and having *"the confidence to respect their choice"* (24). It was considered that risks were part of delivering occupational therapy.

Discussion:

There is evidence in the literature that goal setting is considered one of the means by which client-centred practice can be achieved (Corring 1999; Pollock 1993; Rebeiro 2000; Sumsion & Smyth 2000; Sumsion 2005; Maitra & Erway 2006). In a study to audit patients' goals and outcomes of intervention in a community OT service in the UK, the authors found that the use of an individualised approach increased patient involvement in goal setting and appeared to help the patients to understand the role and relevance of occupational therapy (Eames, Ward & Siddons 1999). Fearing et al (1997) recommend that goal setting as a collaborative venture in the OT process,

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ensuring participation and engagement, whilst Sumsion & Law (2006) and Speechley (1992) identify it as a partnership with the client actively defining goals and outcomes and the therapist being the technical expert. A client's needs and goals are integral to how the occupational therapy process is delivered and intervention planned (Dressler & MacRae 1998; Sumsion 2006; Parker 2006). However, as there is evidence that therapist and clients' opinions differ in relation to goal definition, it was important to understand what factors influenced the process (Corring 1999; Wressle & Samuelson 2004; Sumsion & Smyth 2000). Goal setting by mutual agreement did not feature as a theme in the focus group data, however factors which influenced or constrained therapists in the process of determining goals was evident, for example environment and communication. This may have been indicative of concerns over the pressures around goal setting rather than failure to recognise the process as one of partnership.

The findings indicated a link between goals and expectations but there was no suggestion of how therapists could better use language to enhance understanding of professional terminology such as goals, expectations or aims, apart from using the client's own words. The ease of interchange between these terms would suggest that this may be common practice and if the terminology is unclear, then the meaning may be also. Lum et al (2004) cautioned that if clients and providers do not speak the same language, neither the issues requiring intervention nor the treatment itself may be understood. This has the potential to undermine a client-centred approach, with possibilities for misunderstanding and discord between therapist and client. The therapist is challenged to ensure clients share in the process of identifying goals so that treatment achieves agreed outcomes.

Client:

The client in this context is the person referred to and receiving occupational therapy. Sumsion (2000) advocates the need to know who the client is with the requirement for there to be a partnership between the individual and the health professional. Despite explanations of and references to client - therapist partnerships in much of current occupational therapy literature (Gage 2006; Law et al 1995; CAOT 1997; Fearing & Clark 2000; Restall, Ripat & Stern 2003; Parker 2006; Sumsion 2000), there is no professional definitive description of partnership. This may explain the limited reference to partnership in the findings. Despite the lack of specific reference to partnership as a term, various words related to partnership were noted in the data namely; mutual cooperation, responsibility for the achievement of goals, and shared risks. However there was a lack of familiarity with the term in relation to client-centred practice with this extract being the only reference;

> *"At home (I work in social services) people I see aren't ill as such, they may have a long term disability but are not ill and are quite able to make decisions, take control and form a partnership with you, as an equal person"*(23)

This lack of connection with the term and the meaning of partnership raise concerns about the application of theory to practice, given its prominence in the literature (Townsend et al 2003; Law, et al 1995; Speechley et al 2003; Sumsion & Law 2006; Falardeau & Durand 2002; Sumsion 2006; Hebert, et al 2000). It may also present a challenge to occupational therapists who espouse client-centred practice whilst appearing to have limited understanding of the meaning of partnership.

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Corring (1999) described clients as experts in their own situation, whilst others

recognise the value of client experience and knowledge of their occupations (Hebert

et al 2000). The findings supported this by acknowledging the value of a clients'

insight. However, there was little evidence in the data of the importance of the clients'

expertise and knowledge of their own circumstances. It could be argued that time

and operational pressures in some health / social care environments only allow for

the superficial exploration of client's skills. There was some evidence in the findings

that therapists considered their relationship with clients as a learning process

starting at first encounter hearing the client's story (in their own words), knowing

about a client's skills and limitations (assessment), recognising boundaries (goal

setting), establishing insight and finally identifying the need for change based on

shared goal setting (outcomes). This is reflective of the occupational therapy process

(Creek 2003; Duncan 2011). Understanding the client was based on listening to, and

appreciation of the person's story and acceptance of the client as an individual

(Rebeiro 2000; Donnelly & Carswell 2002).

Environment:

The influence of the environment on clients is well documented in the literature

(Sumsion 2006: Polatajko et al 2007), where it is referred to as contextual

congruence, a unique concept in client-centred practice (Law & Mills 1998). This

involves the therapist appreciating and assessing the client in the context of their own

circumstances and the various environments in which they live and work. Sumsion

(2006) recommends that therapists use assessment tools to evaluate the influence of

environments on the client. She argues that the environments in which clients

perform occupations are complex, embracing cultural, institutional, physical and

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social elements. Cultural influences are those of beliefs, values customs and behaviours shared by a group or society (Kielfhofner 2002) and the institutional environment also consists of the legal, economic and political elements which affect the client's health and ability to engage in occupations (French 2001). The physical environment is most familiar as the domain of the occupational therapist where the emphasis is on reducing barriers to independence in support of the client's ability to participate in activity (O'Brien et al 2002). The social environment has many components including the family, social groups and the presence of social cues which influence expected social behaviour, however this environment is valued by clients as it enables them to explore their potential (Rebeiro 2001).

Rebeiro (2000) recommended that clients be treated in an accepting supportive environment, and Ikiugu (2007) argued for therapists to empower clients by managing the environment, minimising barriers and improving their performance in occupational tasks. Current theoretical models, such as the Canadian Model of Occupational Performance (Townsend and Polatajko 2007), identify the importance of the person, their occupations and the environment in the occupational therapy process. Mosey (1986 p.171) argues that 'the individual cannot be understood outside the context of his environment'. People are dynamically linked to a range of environments especially in relation to the diversity of occupations carried out. The environment influences both the challenges faced by clients and the solutions considered by therapists in support of their occupations.

The findings from this study indicate that the environments of home and hospital influence client behaviour and attitude and the therapists' approach. It was suggested that hospital environments disempowered clients, whilst clients had the greatest

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sense of personal power and knowledge when in their own home. This indicates the importance of the environment in the delivery of client-centred practice, in particular the influence of the environment, on power and client engagement. However this may be more reflective of the pressures created by a medical or organisational hierarchy which may not supportive of a client-centred approach, rather than a 'hospital versus home' argument to support client empowerment. For example Christie & Cross (2003), Dalley (1999) and Williams & Harrison (1999) have all identified the challenge of being client-centred in a hospital environment and the conflict this creates with a medical model approach. It is recognised that clients in hospital are removed from the familiar context of home. However the influence of the environment, evident in the findings and the literature, appears to be less about location and more about the impact in that location of power issues (organisational rules, agendas and conventions) which affect the behaviour of those working in it.

It was reported by the therapists that the home was a more conducive environment for supporting client-centred practice, perhaps because the client could be seen in the context of other aspects of their lives, linked with cues from personal objects and settings within the home. There was consistency in the data with evidence in the literature of the importance of the environment and its influence on client-centred practice, supported by the theoretical framework of models of practice (CAOT 2002). Wilkins et al (2001) identified difficulties with client-centred practice occurring at system, client and therapist levels, with Mortensen & Dyck (2006) suggesting that system issues have been overlooked in terms of their impact on delivering client-centred care. Whatever the reason for this, there is some indication from the data of

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the influence of the environment on the ability to be client-centred and the impact it has on client behaviour.

It was interesting to note that client behaviour can be influenced by the environment, in terms of increasing confidence and control when at home to relative passivity in hospital. However the only consideration given by the participants in this study of the influence of the environment on therapist behaviour was the challenge of working in a medical model in hospitals which was noted in the data.

Definitions:

Sumsion & Law (2006) in their review of the evidence for client-centred practice recognised the importance of power and the need to understand its influence as fundamental to the success of implementing client-centred practice. They suggested that the emphasis is often on strength and control, indicating that health professionals' power over clients can influence goal attainment. This leads to the disempowerment of clients by the health system and can reduce their ability to participate in health care and make choices (Corring 1999; Hugman 1991; Sumsion & Law 2006).

Findings from this study indicate that therapists considered the influence of power in client-centred practice was often in relation to others – the family (influencing the client's agenda), the organisation (the influence of the medical model) and the client (being in control in their own homes). There was no indication they perceived that they held power themselves which may influence their role or the outcome of care. This may have been a reflection of their innate client-centred philosophy, focussing on the individual as the centre of treatment, reinforced by their exploration of the

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influence of others on the client, rather than consideration of their own influence. According to Sumsion (2006) all professional relationships have an element of power and she advises those working in a client-centred manner to consider how to achieve a balance in their relationship with the client. Falardeau & Durand (2002) also argue that the power imbalance in therapeutic relationships is inescapable and recommend that power be transferred to the client to move the interaction from the medical perspective to one focused on a client's needs. Whilst Sumsion (2006) argues that occupational therapists do not traditionally consider themselves as people with power, she points out that clients may not necessarily have that same perception. Clients may consider that therapist power should be transferred to the client in order for them to meet their own responsibilities' for their health and well being (Sumsion 2004)

The findings did not include any evidence to indicate how therapists address the passivity of clients who relinquish control in hospital, or offer solutions. However whilst this was not addressed as a direct question, it was noted in the data that participants suggested that the power and influence of medical colleagues combined with the trauma of being unwell, influenced the active engagement of clients. Bibyk et al (1999) whilst acknowledging their view may be unrealistic and unattainable suggested that absence of any power struggles was a tangible indicator of how it felt to the client to be with a client-centred therapist.

Addressing the power imbalance in relation to client empowerment was linked to client involvement in setting goals and the achievement of objectives and outcomes (Swaffield 1990; Sumsion & Law 2006). Whilst links were identified between power and the influence of others, there was recognition that partnership working could

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address the balance of power for both the therapist and the client. The only evidence from the findings that therapists had examined or considered modifying their own behaviour in order to empower clients, was a recognition that therapist confidence and skills contribute towards greater success in client-centred working. Evidence in the literature suggests peer support, team working and reflection as solutions to managing the change to a more client-centred approach (Duggan 2005; Sumsion 2000; Boniface 2002; Stern et al 2000).

The findings raise concerns about how therapists demonstrate being client-centred in their communication and behaviour. There was some disparity noted concerning the use of language, in particular in relation to defining goals which were also referred to variously as needs, aims, and objectives. The literature indicates that a change of language from professional terminology to a more lay vocabulary can support client empowerment, (Lum et al 2004; Parker 2006). There was some support for this in the data with therapists suggesting that goals were written in the words a client used, however there was no opportunity for further expansion on how the use of language could influence other forms of communication or information sharing within this focus group session.

Other factors which can present a challenge to the use of client-centred practice include the use of client-centred tools, models of practice and outcome measures. Ikiugu (2007) and Law et al (1997) advocated use of client-centred models as a framework for practice, whilst Restall et al (2003) suggested that a framework supportive of client-centred practice can reduce barriers to delivery. Warren (2002) and Parker (2006) expanded on this pointing out that when assessment tools are used in isolation from the conceptual framework which underpins them, then delivery
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of client-centred care can be impaired. These tools of practice however require skill and confidence to implement and this in turn can influence the outcome of intervention. Evidence in the data suggests a lack of connection between theoretical models of practice and client-centred assessment tools when working in partnership with clients as these were only mentioned by two respondents in the context of engagement. Use of the COPM however was seen as important in client engagement and client-centred goal setting and regarded as a means of recognising what was important in a client's life. This separation of the theoretical framework and the actual delivery of practice may be indicative of the challenge which therapists experience when trying to practice in a client-centred manner.

The personal aspects of client-centred care, in relation to respect and self worth are highlighted in the literature (Corring 1999; Cott 2004; Law, et al 1995). These were mirrored in the findings where the need to value and respect the client, developing a better understanding of their needs based on listening to and understanding their viewpoint was acknowledged. There was also recognition of the insight required by the client in order to make this approach meaningful, however no connection was made to establishing individual capacity in order to determine the level of insight (Hobson 1996; Wilkins et al 2001). Analysis of the data demonstrated links between building a relationship and achieving engagement with the client, without any indication of what skills were required to achieve this.

Respondents gave a clear account of the progressive nature of the client / therapist encounter, typified by finding out about concerns, exploration of issues, checking levels of understanding and making informed decisions, all backed by clinical reasoning.

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"It's about the skilful interview in the initial stages and communication to establish what the client is having difficulties with and negotiate with them the areas they want to work on..... being honest with them about what your resources are and the limitations of what you are able to provide and re negotiate more appropriate goals which will meet their needs but within your limitations". (6)

"It's only by assessing, by seeing what they're doing regularly, it's your opinion, it's the assessment you've done seeing them do it"(14).

"Using the assessment tools and outcome measure with the model brings a framework and yes you are using clinical reasoning". (24)

There was also a recognition that both therapist and client needed to make adjustments in order to accept and work with the client-centred approach describing this as a learning process. This was also found by Fearing & Clark (2000) who suggested a cyclical process in the client encounter, rather than a linear one, as suggested by Sumsion (1999).

The findings indicated that understanding the meaning of engagement was an active rather than a passive skill, but no suggestions were offered as to how this skill was acquired other than through therapist experience. Active engagement of clients was referred to in the occupational therapy literature but usually in relation to specific occupations rather than as an enabling process. Mee & Sumsion (2001) concluded that engagement in meaningful occupation was fundamental in helping to overcome the effects of disability and Doble & Santha (2008) described how occupational therapists play a vital role in enabling clients to compose or re-orchestrate their

occupational lives, so that they are able to meet their occupational needs more consistently.

Communication

In a review of the conceptual elements of client-centred practice, Sumsion & Law (2006) identified listening and communication skills as crucial in addressing issues of power between therapist and client. Data analysis demonstrated that skills for effective communication were key elements in delivering client-centred practice including the use of language, listening, explaining, interpreting, having awareness of expectations and being able to negotiate. All these skills were influenced by honesty and perception, as well as understanding the individual's opinion and communicating with clarity. There were links across the themes in the data which indicated that the skill of listening to what clients said, understanding what was said and feeding back information to the client contributed to enabling them to make informed decisions. However there was no suggestion that the use or change of language (the words themselves) can enhance and influence client-centred care. Delivering information in ways that the individual can understand, rather than relying on professional terminology to explain the process, reduces barriers. Such barriers could be explained as environmentally disabling (McCormack & Collins 2010) and are the responsibility of the therapist to address. Changing the language can contribute to client empowerment and partnership working. Some of the data on information were linked to organisational processes, in particular to documentation. There was no acknowledgment that style and clarity of information were linked directly to client-centred practice which could enhance and create a mutual understanding of issues.

This may indicate that therapists do not consider the use and style of language and presentation of information as practical applications of client centred practice.

Risk

Exploration of risks in the OT literature tends to focus on risk management in relation to client safety, (Law et al 1995; Clemens et al 1994; Hobson 1996) with little emphasis on the articulation of risks within the broader client encounter (Parker 2006). Some recommendations concern gaining greater active client participation to widen their choice, empower them and be more supportive in managing risks (Clark, Goering & Tomlinson 1991), however there was little support for this in the findings.

The range of concerns about risks in the findings was in relation to assessment, the environment and client safety, however there was limited evidence to suggest any practical solutions to risk management within a clinical perspective. The findings suggested this may be an assumed part of the functional assessment process, although there was no clarity of how to articulate or define risks with clients. This may reflect an assumption by therapists that it is their responsibility as part of assessment, with no consideration of sharing this with the client in a partnership approach. Therapists frequently try to balance risk identification and reduction with the competing dilemma of creating a safe environment (Moats 2007). Whilst there was some recognition that many clients were able to understand and acknowledge risks within their own environments, it was evident there was no connection with using client-centred language to communicate messages about risks to clients who were less able to define and understand them.

Conclusion:

This study set out to examine the understanding of occupational therapists about client-centred practice. The focus group methodology produced qualitative data which was analysed using a thematic approach. Whilst the sample was small the data generated, when combined with evidence from the literature, indicate that there remain challenges in applying the theory of client centred practice to occupational therapy practice, particularly with regard to partnership, power and risk management.

Whilst there is commonality between the findings and the literature supporting the client-centred nature of occupational therapy, acknowledging the individual as the central element of treatment (Donnelly & Carswell 2002; Sumsion & Law 2006), there is limited evidence about how the bridge between theory and practice is crossed.

Partnership working has been advocated as a solution for redressing the balance of power between the therapist and the client (Corring 1996; Sumsion & Law 2006), resulting in joint goal setting and agreed outcomes. This partnership approach reinforces the therapist as the technical expert and the client as having intimate knowledge of the impact of their condition (Sumsion & Law 2006; Corring 1999; Falardeau & Durand 2002). However there was some reticence on the part of the therapists in this study to address the true meaning of partnership and its application to practice.

The issue of power has featured consistently in the literature, with evidence indicating that institutional power can affect client-centred practice. This was confirmed in the study; however there was little consideration by the therapists' of

their own power in this relationship apart from some recognition of the balancing of power and knowledge required between client and therapist.

The findings indicate there are concerns about managing risks. Interestingly there is little guidance on risk management techniques in this context, with examples in the literature relating only to the assessment process. In addition, the findings suggested that the environment had a considerable impact on clients and influenced the client-centred behaviour of therapists. This was not widely discussed in the literature.

Communication issues were identified in the findings and the literature, with style and language seen to have a strong influence on client-centred practice and partnership building. However, the findings indicate that therapists had not considered how information giving and the use of language could enhance and reinforce partnership by creating greater harmony and understanding. There was some recognition though of the value of listening skills in understanding exactly what a client wants.

Only two respondents considered how the practicalities of client-centred care can be supported by a theoretical context by suggesting that adopting a framework for practice in the form of models, assessment tools and client-centred outcome measures would reinforce that approach. This poor response from the sample raises concerns and could be considered as a reflection of evidence in the literature where concerns have been identified about failures to link theoretical concepts with practical application (Sumsion 2006). If that is the case then this has implications for practice as barriers between therapist and client can be created if therapists lack knowledge about client-centred practice or if they fail to understand how to use theoretical

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models to support their practice and use client-centred tools to support client intervention (Sumsion 2006; Law et al 1995).

It could be argued that applying these readily available tools would support client-centred practice, raise therapist confidence and develop sound clinical reasoning skills, all of which are supported by evidence in the literature (Mew & Fossey 1996; Restall & Ripat 2008; Wressle et al 2002). It has been suggested that the concept of partnership expressed through joint goal setting is the means of practically delivering client-centred practice (Moats 2007; Ikiugu 2007)

The findings of this study indicate that there was limited recognition by therapists of the importance of partnership in practicing client-centred occupational therapy. There were however, several expressions of other practical ways of delivering client-centred care, such as communication of information to clients, shared risk evaluation and the impact of power on the relationship with clients. Comparing the findings from this focus group study with the evidence in the literature, there is support for the argument that therapists understand the theory of client- centred practice but face challenges in the practice of it.

CHAPTER 6

THE THERAPISTS' PERSPECTIVE OF CLIENT-CENTRED

PRACTICE: A PROFESSIONAL VIEW

The Survey Study

Introduction:

Modern health care is considered the most complex activity ever undertaken by

human beings (Kizer 2002), and involves highly complicated technology which has

the potential to both harm and heal. It is also a team activity involving a wide range of

specialised healthcare workers who are often focused on only one aspect of the

overall care of the individual. These complex and multifaceted interactions need to be

managed to ensure that they are satisfactory for both the individual person and the

care provider. Health care is also an integrated phenomenon with multiple

dimensions. The social, cultural, economic, and political dimensions are often as

important as the technical ones; however in the past the technical dimensions were

those which usually formed the main focus of training for healthcare workers, with

less time spent learning how to interact with clients and colleagues (Gage 2006). The

shift towards more person focused care was accelerated following enquiries into

clinical incidents, such as the failures in the performance of surgeons involved in

heart surgery on children in the Bristol Royal Infirmary cardiac unit, where Coulter

(2002) highlighted the importance of patient centredness as crucial for good quality

care in her recommendations. She emphasised the importance of engaging people in

decisions about their health and health care concluding that this message was relevant to all healthcare professionals in all clinical settings.

Client-centred practice in occupational therapy is the means of practising in partnership with the client. It is a collaborative approach used to enable clients to participate in life's occupations irrespective of their disabilities or environmental challenges. The client, as the centre of intervention, works in partnership with the therapist, to achieve their goals. This approach is fundamental to practice, however Wilkins et al (2001) in their analysis based on the findings from three studies using a qualitative methodology with 32 therapists, discussed the reasons for the difficulties experienced by occupational therapists in implementing client-centred practice. They found that at the level of the therapist, there was the need for greater clarity about what client-centred practice actually was on a day to day basis. The issues they identified are important and are relevant in broadening the understanding of client-centred practice. Some of the issues they highlighted were management support and commitment, the therapist's understanding and knowledge of this approach, how to shift from the traditional to a partnership relationship with clients and the ability of clients to engage in client-centred practice. These challenges highlight the need for greater consideration of the relevance to the therapist and the client of client-centred occupational therapy and the skills required to practice in this way which provides the reasoning behind the question in this research. To investigate the knowledge and understanding of therapists about client-centred practice, this study, adding to that undertaken in the focus group (Ch 5), set out to examine the views of a larger sample of therapists in the UK about client-centred practice and the use of the COPM in occupational therapy.

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Literature Review

A review of the literature which provides the underpinning elements to this study is located in Ch 2. A summary linking the key elements of the research, and identifying the evidence from the literature, cross referenced to results of the Focus group (Ch 5) and outcome of the questionnaire is included as an appendix (Appendix 6.1).

Concerns have been expressed in the literature (Sumsion and Law 2006; Hammell (2007b for example), that misconceptions exist regarding the key elements which underpin client-centred practice, in particular the role of the therapist in its implementation. From the practice perspective some authors suggest that pressures and organisational challenges affect the delivery of a client-centred approach (Christie and Cross 2003; Rebeiro 2000; Sumsion and Smyth 2000). Others, focussing on direct patient care, indicate that clients and therapists may have different views of occupational therapy intervention (Corring 2004; Corring & Cook 1999; Sullivan & Yudelowitz 1996), particularly in relation to goal setting and planning treatment (Wressle et al 2002).

Evidence from the systematic review of the COPM in Study 1 (Ch.4) indicates that these concerns about the differences between theory and practice remain with some authors reinforcing the importance of knowledge, practice and confidence when translating the theory of the client-centred approach into practice (Wressle et al 2002; Warren 2002; Heaton & Bamford 2001; Cup, Scholte op Reimer et al 2003). Others emphasise the importance of learning how to deliver client-centred practice (Healy & Rigby 1999; Wressle et al 2002; Dedding et al 2004). In particular it was noted that training in the underpinning theory of client-centred care and using a related

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outcomes measure were required (Mew & Fossey 1996; Ward et al 1996; McColl et al 2000; Chesworth et al 2002; Richardson et al 2000; Kjeken et al 2004).

This gave the context to the design of the questionnaire; with evidence from the literature and findings from the focus group both informing the construction of the questions. It was decided to focus on three topics: – application of theory; client centred practice; and the use of a client-centred outcomes measure. The questions were compiled to examine the respondents' knowledge and understanding of these areas of occupational therapy practice. Questions on each of these topics covered some of the key features of client-centred practice and the COPM to determine what was known and what the respondents' attitudes were to their application. For example one question on the COPM asked respondents to rate its relevance to their practice, with the options available taken from the literature. Questions about client-centred practice asked respondents to consider statements about its importance and relevance to practice plus the most difficult aspects of this approach and to rank their answers in order of priority, with the statements based on evidence in the literature (see appendix 6.2).

Aims

The aims of this study were:

> To explore occupational therapists' understanding of client centred practice
>
> To examine occupational therapists' accounts of the application of client centred practice in clinical care.

The objective was to determine whether the difficulties of relating the theory of client-centred therapy to practice as reported in the literature, was evidenced by this

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enquiry. Although the evidence in the literature emerged several years ago, the challenge was to see if this was still the case or whether occupational therapists had progressed in their practice.

The questionnaire was designed to address the following:

Firstly: The knowledge and understanding of theory into practice by exploring the use of models of practice and frames of reference, probing the process of learning about them and exploring whether they had any influence of practice.

Secondly: The knowledge and skills of practice by examining a broad spectrum of the core elements of client-centred practice and exploring whether these elements were important, difficult or rewarding to the therapist.

Finally: to determine whether practice is client-centred, questions were asked about a client-centred outcomes measure and the training in, use of and relevance of the COPM.

Rationale:

The plan for exploring the therapist perspective of client-centred practice had started with the focus group which comprised a small sample (25) of therapists. Whilst the findings were informative, the conclusions were limited as the data reflected evidence from a one off event and one disadvantage of focus groups is that conclusions cannot be generalised to the wider population (Robson 2002). It was always the intention to explore a wider view to understand the therapist perspective on client-centred practice. Focus groups complement the use of surveys in health research (Thomas et al 1992). Focus group interviews explore the feelings, views and

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understanding of the respondents on a given topic. The emerging themes from the group can be used to develop questions within a quantitative design to further explore the topic in a more structured manner. In a study by Elbeck and Fecteau (1990) reported by Thomas et al (1992) focus groups were used with psychiatric in-patients to explore issues of ideal care from a patient's perspective. The group interviews generated items which were used to develop a quantitative scale to measure patient satisfaction. Usually structured questionnaires are used in experimental-type designs however they can be incorporated into naturalistic enquiries by addressing specific questions which have arisen during the course of carrying out fieldwork (Depoy & Gitlin 2005).

Other means of data collection had been considered; for example face to face or telephone interviews could have been used however as a broad perspective was needed, this approach was considered inappropriate in reaching a larger population. Whilst one on one interviews provide more depth in data collection, they are limited in scope and numbers (Arksey and Knight 1999). So it was decided that the therapist perspective could be explored further by means of a questionnaire which was informed by themes from the focus group data and the literature. A survey is a form of planned data collection for predicting or analysing the relationships between certain variables using questionnaires and interviews as a means to gather the data (Oppenheim 1986). Carrying out a survey involves work to plan, design and pilot before a final specification for the questionnaire emerges. The function of a questionnaire is to measure specific variables which need to be clearly stated within the specification, however prior to the development of the questions consideration

needs to be applied to the data collection method, the sampling process and the sequence of questions all preceded by a careful piloting procedure.

Gray (2004) suggests that the popularity of questionnaires is based on the assumption that they are easy to design, despite evidence suggesting the contrary (Arksey & Knight 1999). When comparing this technique to other survey methods, Robson (2002) concluded that the cost of self –completed questionnaires is low when compared to face to face interviews which can be demanding in terms of time resources. The length of the data collection period may also be protracted with questionnaires especially if prompts are required to encourage returns, when compared to telephone interviews which can be short. The distribution sample for questionnaires can be large and not restricted to a specific geographical location especially if electronic mail is utilised, whereas face to face interviews need to be clustered together in order to maximise time and resources. However the response rate for questionnaires is difficult to control and it is not easy to obtain high numbers of returns unlike interviews because they are usually pre-booked. The complexity of the questions and the length of the questionnaire are crucial factors to consider with regard to encouraging responses, however the researcher has little control over question order as respondents can choose to answer in what order they like, which may affect the answers given. The main advantage of the self-completed questionnaire is that it is less susceptible to interviewer bias than face to face interviews and is cheap to administer (Polgar & Thomas 2008).

There are databases of published questionnaires (Eric database for assessment and evaluation in Stein & Cutler 2000), however a custom-devised questionnaire was adopted because the subject matter was not the content of a currently established
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questionnaire. A questionnaire is simply a standardised list of questions or opinions requiring answers directly from a sample population (Stein & Cutler 2000).The format requires consideration of content (demographics, background information etc.), form of question (open or closed) and level of data to be collected (objective or attitudinal). The question format is also important with the options available ranging from open-ended to closed response types. Open ended questions are less structured and allow for more detailed responses which require more time for the respondents to complete them. Closed response questions provide a pre-determined list of potential options which are likely to take less time to complete but which may frustrate respondents if no space is allowed for elaboration on the answers.

Designing the format using more closed questions is preferable when there is a lot known about the underlying topic (Bowling 2002) as in this case where client-centred practice was well documented in the occupational therapy literature. However the closed response format was blended with space at the end for respondents to add any personal comments. To address the aims of this study, the questions were designed to give respondents a range of factors for consideration to stimulate reflection on their own practice (Gray 2004).

Method:

The process recommended by Stein & Cutler (2000) and Bowling (2002) was followed namely; framing the initial research question, carrying out the literature review, identification of key themes for questions, devising the format, then piloting and revision before preparing the final version and distributing it.

A correlational design was used in this study which enabled a range of variables to be examined such that the degree of association between the scores on the variables could be analysed. A variable is used to describe the features of the concept or construct in a research study (Clifford et al 1997) and by definition they have more than one value. The variables in this questionnaire concerned the relationship between the theoretical elements of client-centred practice, the knowledge of theory and the practical knowledge demonstrated by use of an outcomes measure. Specifically the design set out to examine key relationships between being client-centred and understanding practice as being client-centred. For example whether there was a relationship between the use of models of practice and frames of reference in the respondents practice, whether being client centred was related to using a client-centred outcomes measure, understanding if there was a relationship between being client centred and the most important aspect of client-centred occupational therapy and exploring the relationship between being client centred and understanding about this approach.

Sequence of questions

The general design of the questionnaire was structured as follows, starting with some basic demographic details about the respondent's position and area of work. This was followed by factual and opinion questions providing respondents with a range of options to respond to: (Q. 1 -10) set out to examine the use of theoretical structures e.g. models and frames of reference; their use, learning processes and relevance. The second set (Q11 -14) examined the therapists' reported experiences of delivering client centred practice by asking them about the most important, difficult and rewarding aspects of it using ranked statements drawn from the literature. The

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final section (Q15 – 22) addressed the use of the COPM by examining therapists' understanding of its use and relevance to practice, with ranked statements drawn from the literature.

An introductory letter accompanied each questionnaire which described its purpose and how the information would be used (appendix 6.3). The questionnaire (appendix 6.2), was circulated by post and electronic mail to gather a breadth of responses within time and resource limitations (Robson 2002). Piloting the questionnaire was a crucial part of the design process and assisted in shaping the overall design and content of the questionnaire as well as determining the actual detail of the words used in the questions (Oppenheim 1986).

Pilot testing

In the early stage of development, discussion took place with colleagues about the knowledge base of occupational therapists of client-centred practice and outcomes measures to help determine some key topics, which helped to shape the design of the questions which focussed on models, client-centred practice and the COPM. Consideration of which demographic information was needed was also piloted with colleagues and reduced to basic information about grade and clinical work area. The design of the questions and the questionnaire format underwent five iterations until the final version was ready for circulation to a convenience sample for a final review. During the design process, the questionnaire was modified in response to feedback from colleagues and supervisors. The first revisions were considered by senior occupational therapy colleagues who commented on the language of the questions, the question flow and sequence. The layout and design of the questionnaire was

checked by the same colleagues who commented on ease of completion and expressed preferences for layout in landscape or portrait. A technical review for statistical guidance was undertaken so that scoring and analysis would be straightforward. Finally a content overview for context and congruence was undertaken by supervisors prior to an appraisal of the final version by a convenience sample of 10. At that stage the questionnaire was considered ready for circulation.

The process of the questionnaire development was iterative and responsive to feedback from the pilot testing process which informed modifications to the drafts resulting in the final version. The pilot testing had involved a range of professionals, one group with more experience in occupational therapy were approached to comment on the structure and the content of the questions, the currency of the language, ease of completion and the length in draft 1, as it was felt they would be more able to criticise the overall design of the questionnaire. Other colleagues, who had less experience, were asked to comment on the question sequence and language content as it was felt that they would be more responsive and comment on the flow of the questionnaire rather than the content. The technical review afforded greater rigour to be applied to the layout and data collection by consideration of the number and sequencing of the questions, the equality of all answer choices, language use and improved clarity of instructions to respondents. Those who critiqued the draft versions were not included in the final distribution sample (Gray 2004). This proved to be a useful process.

The questions were constructed to reflect current evidence in the literature (see appendix 6.1 for cross reference on emerging themes) and linked to themes emerging from the analysis of the focus group data. The questionnaire was designed

to incorporate closed questions (for ranked responses) multiple choice (for self reported experience), and Likert scales (for self reported attituds towards client-centred practice, models and the COPM). The level of measurement used for data analysis was a mix of both nominal (allowing data categorisation) and ordinal scales (enabling rank order categorisation) with two questions falling into the point scale category. The data collected was non parametric and was analysed using Spearman rank order correlation coefficient (Spearman rho) to examine the degree of association between the data. Whilst it is noted that ordinal scales are imprecise forms of measurement (Hicks 2004), they are commonly used in health care research as a means of establishing attitudes and opinions about topics in an objective and quantifiable manner. Whilst statements about rank can be made in ordinal scales, reports about the relative sizes of any differences cannot be made. A closed - response format and rank order design was used for questions analysed on a nominal scale which allowed for a tightly structured answer easily coded and evaluated. The attitudinal questions, measured on ordinal scales, were analysed using the traditional five-point Likert scales which has the advantage of providing for a middle 'undecided response' (Polgar & Thomas 2008) and were applicable in this questionnaire.

Sampling process:

Sampling in research is the process by which the representativeness of the information obtained can be assured and the findings generalised to other settings and people (Polgar & Thomas 2008). In qualitative research, the researcher is concerned with measuring experiences and meanings and the method is referred to as purposive sampling. This is the process by which the researcher selects the

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population who are best placed to provide them with the information they seek and are likely to reflect particular issues or circumstances.

Purposive sampling in this design provided the most suitable means to fulfil the aim of determining the understanding and practice of occupational therapists about client-centred practice. The criteria for participants in this sample were that they would be occupational therapists working with clients in any health or social care community. In this case it was known that the population from which the sample would be taken, would typically work across a wide range of clinical areas (adult, children, mental and physical health) and in organisations spread across areas of occupational therapists' employment in the UK (NHS, Social Services, community and education). Practitioners working in education were included in the sample because of the assumption that client-centred practice underpins the profession from undergraduate to post graduate education. To exclude educators would limit the scope of understanding how theory blends into practice. The questionnaires were sent to the heads of occupational therapy requesting they circulate copies throughout their service. The 230 questionnaires were circulated during the period of March - April 2007. Fifty were sent to www.copmnetwork.co.uk (a web based database of Occupational Therapists interested in or using the COPM in their practice and who adopted the Canadian Model of Occupational Performance (CMOP) as a model of practice). The sample comprised a nationwide membership and the number (50) was determined by those who had agreed to take part in research when joining the network. A further 180 were circulated via the managers and heads of service network to the occupational therapy services in the large local urban conurbation of and three co located rural shire counties. The sample size was determined by

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familiarity with the occupational therapy establishments in these organisations, however the total number of questionnaires circulated to this sample amounted to 12% of the registered occupational therapy membership (est.1500) for the area at that time. Therefore 100 questionnaires were sent to the urban conurbation confederation (known to have hospital bases with large numbers in the OT teams), 50 to the three shire counties (smaller dispersed rural community based services) and 30 to a large City Council (a large singe service group).

Data collection process:

The questionnaires were circulated with a letter of explanation about the study, this included background information about the researcher, the aim of the research, and a confidentiality statement. Respondents were requested to return the questionnaires by post or email by the three week return date. Those returned by email were printed out and a receipt and acknowledgment sent by email, however no record was made of the return email address. Electronic copies were then deleted. The non returns process was managed by follow up emails at week 3 and on two subsequent occasions sent through the circulation lists. After the final return date the questionnaires were logged and numbered. A data collection sheet was devised for collating and analysing results on a SPSS database (Statistical Package for the Social Sciences v.14) (Pallant 2007).

Ethics:

Ethical approval was sought and gained from the University of Birmingham School of Health Sciences Research Ethics Committee (May 8th 2006).

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Results:

Of the 230 questionnaires circulated, (58), 25% of those who responded were returned and the results are presented below. Not every respondent answered all the questions, the total number of respondents for each question are shown in the results.

The first group of questions asked about the basic clinical demographic profiles of the respondents**.** The specific questions exploring the knowledge base of respondents commence with the numeric questions.

Question: Grade of post held (Figure 4.1)

Response Options: Basic grade/ Senior 2 / Senior 1/ Clinical Specialist/ Head/ Lecturer

Total responses: 98.3% (57) with 1.7% (1) who failed to disclose

Results: 68.4% (39) of the respondents were senior practitioners (senior 1 and 2), 7% (4) were junior staff (Basic grade), 21.1% (12) were clinical specialist and head grades and 3.5% (2) were university lecturers. The grading system at the time was based on Whitley Council descriptions (Whitley Councils for the Health Services 1991). These consisted of basic grade (those newly qualified and up to an estimated maximum of 2 yrs experience), seniors (grade 2 and 1 with more than 2 yrs experience post qualification) clinical specialists (senior staff with recognised expertise in a specialty area) and head grades (service leads with operational responsibility).

Figure 4.1: Distribution of Respondents by grade
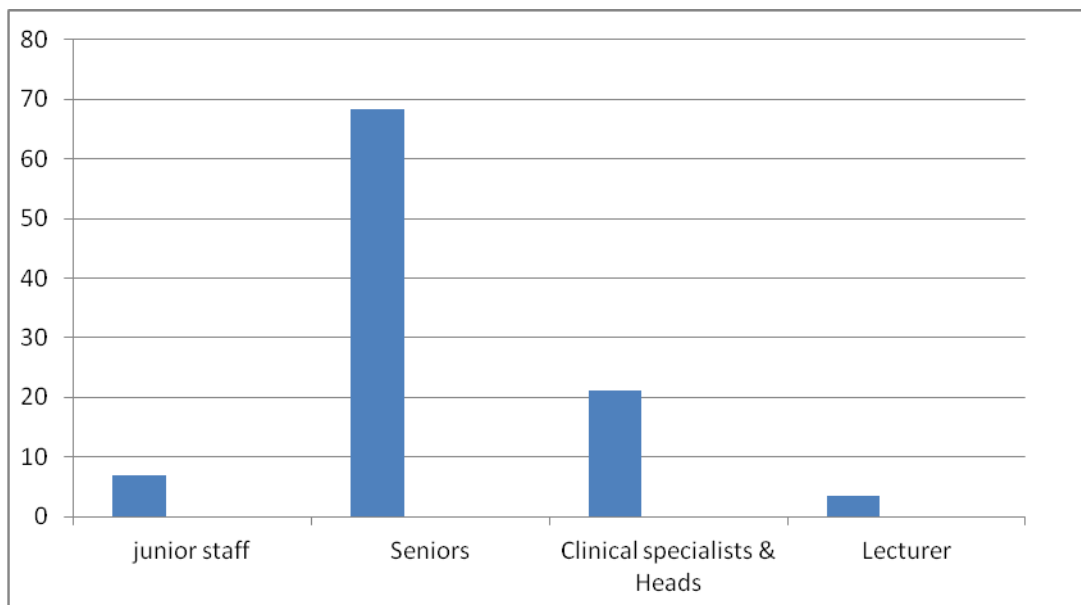
NB. At the time of this study the majority of employers in the NHS were still using the grading and titles devised as part of the Whitley Council structure for pay and conditions in the NHS. This has been superseded by the single pay system under Agenda For Change which had gradual implementation across the NHS from 2004 onwards (NHS Staff Council 2013)

Question: Length of time qualified in years and length of time in this post in years

The mean length of time qualified was 14.8 yrs with the length of time in post ranging from 6 months to 36 years. The mean length of time in the current post was 62 months, ranging from 1 month to 252 months.

Question: What is your current clinical specialty? (Figure 4.2)

Respondents used free text to identify their clinical specialty.

Total response: 96.5% (56)

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Results: The distribution of respondents' current clinical specialty indicated the greatest number worked in adult physical health 56.1% (33) followed by adult mental health 24.6% (14), Paediatrics 10.5% (6) and Learning disability (Adults & young people) 5.3% (3).

Figure 4.2: Range of Clinical specialties
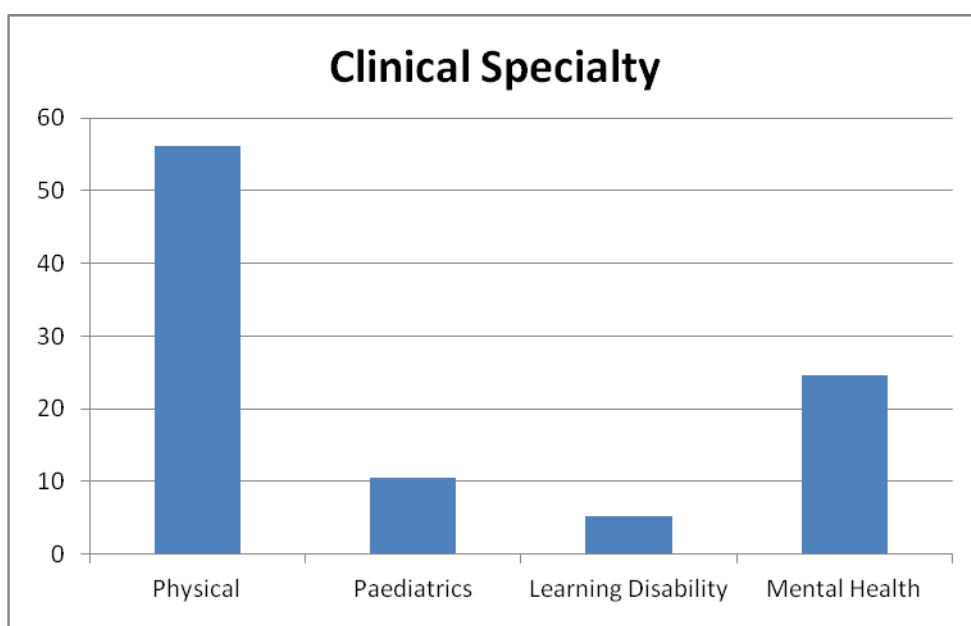
Question: Which clinical area are you currently working in? (Figure 4.3)

Response options ranged from hospital and community locations, physical health, mental health and paediatrics plus voluntary and private sector, prisons, rehabilitation and social care and health.

Total response: 98% (57)

Results: 24.6 % (14) of respondents recorded the 'physical' hospital as their clinical area with 22.8% (13) noting physical community and mental health community, with lower numbers reported for other clinical areas; 8.8% (5) in learning disability and

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community paediatrics, 5.3%(3) in social care and health, and mental health

hospitals and 1.8% (1) hospital based paediatrics.

Figure 4.3: Distribution of respondents' current clinical area (%)
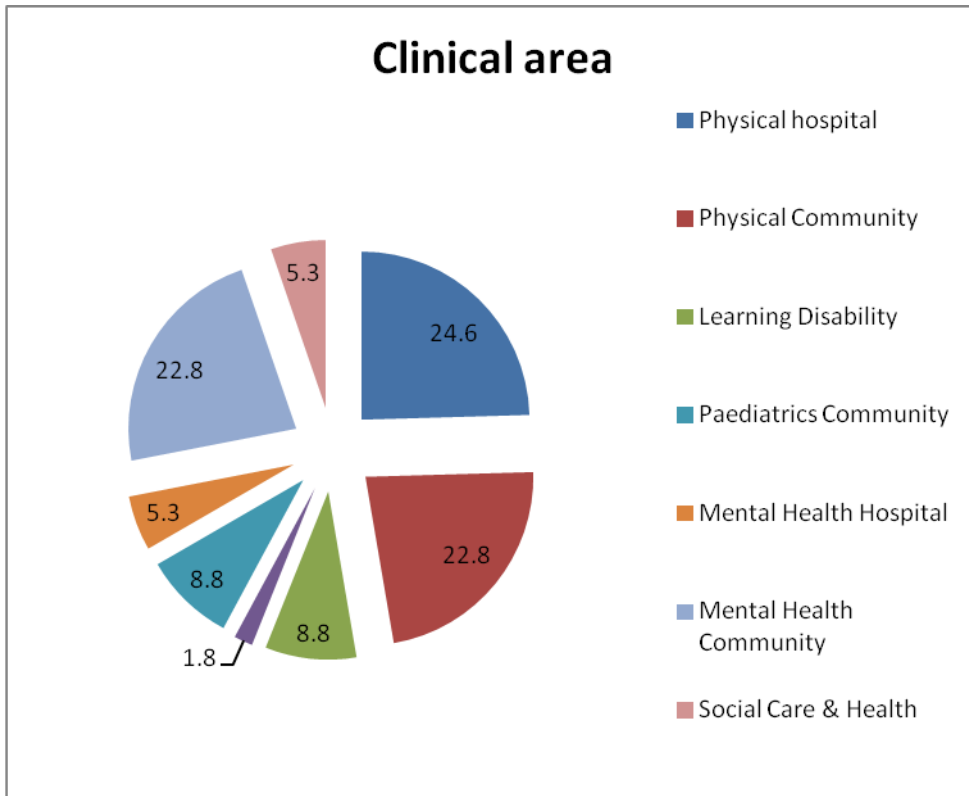
Question: Membership of the Copmnetwork

Response options were yes or no

Total response: 96.5% (56)

Results: Of those who responded 17.9% (10) of respondents reported being

members of the Copmnetwork with 82.1% (46) non members.

The next section of the questionnaire included specific questions exploring the

knowledge base of respondents about models, frames of reference, client-centred

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practice and the COPM. As the questionnaire design sought descriptive data, the results are illustrated with figures and descriptive text.

Question 1: Do you use a model of practice in your service? (Figure 4.4)

Response options: yes, no and don't know

Total response: 95% (55)

Results: 65.5% (36) of respondents reported using a model of practice, 34.5% (19) reported they did not use a model and 5.2% (3) did not know.

Figure 4.4: Use of a Model of practice
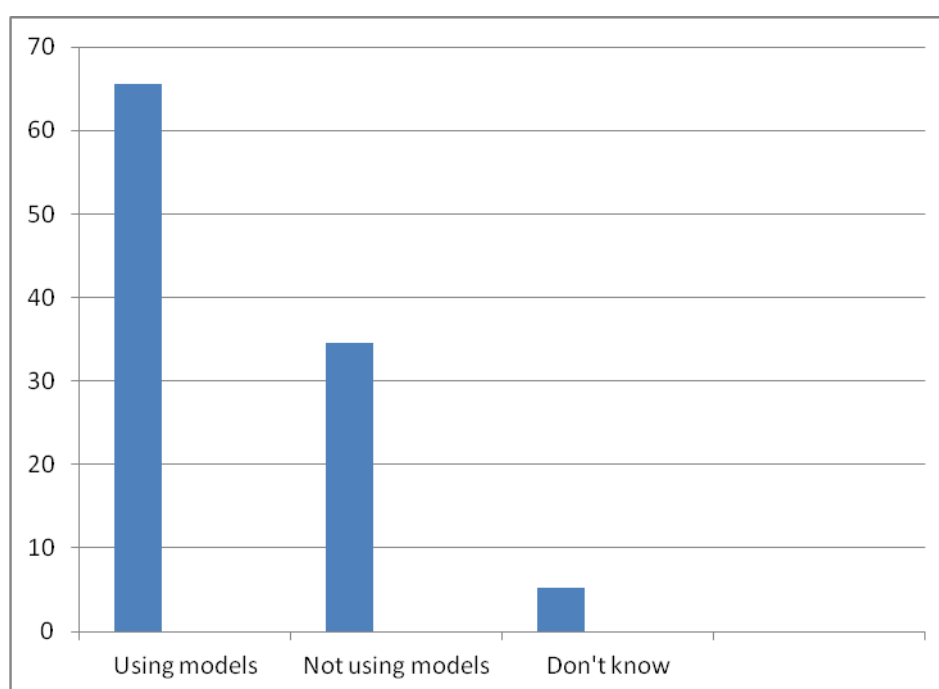
Question 2: If no to Q1 about using a model, which model are you most likely to consider? (Figure 4.5)

Response option was free text

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Total response: Of the 34.5% (19) not using a model, all except 1% (2), stated a specific model preference (fig.4.5) with CMOP and MOHO emerging as the most popular.

Figure 4.5: Models that were considered.

Ranges of models are listed below in %

Considered Models
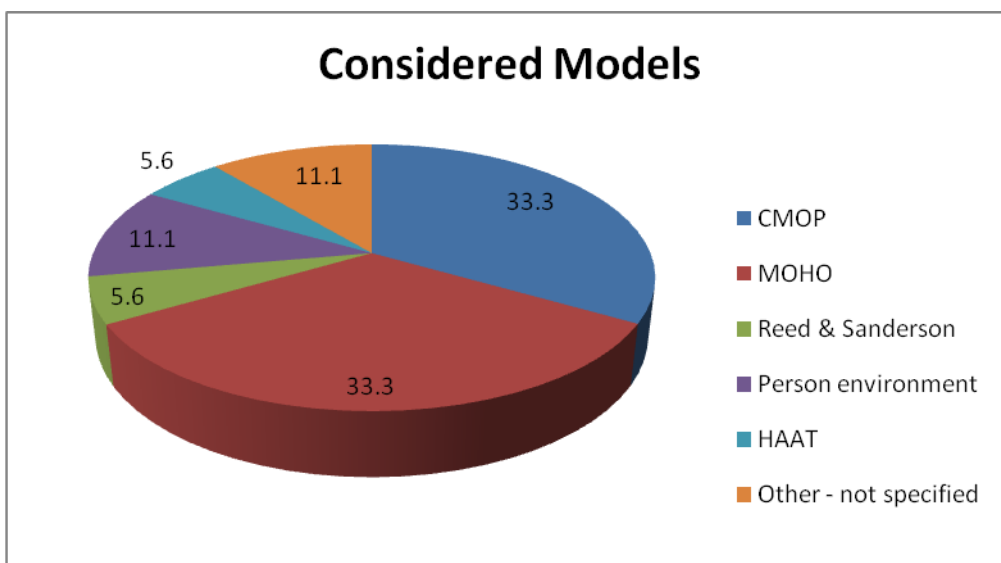
Question 3: If yes to Q.2, which are the most relevant models to your practice?

Response options ranged from most relevant to the least relevant.

Total responses: 65.5% (36) confirmed that they used a model of practice

Results: 58% (21) selected the Canadian Model of Occupational Performance (CMOP) as the most relevant model to practice with the Model of Human Occupation (MOHO) as the second most popular. All the models selected in the highly relevant categories (CMOP, MOHO, Person environment and Reed & Sanderson) are based on a client centred framework. A description of two of these models (CMOP and MOHO) is included in the narrative literature review.

Question 4: How much has working to a model of practice influenced how you deliver the OT process?

Response options ranged from models having no influence to those having the greatest influence.

Total response: 74.5% (41) of those responding yes to Q1 answered this question.

Results: 78% (32) considered that working to a model of practice was relevant to how they delivered the OT process, the remainder, 22% (9) identified that using models had some or little influence on their practice.

Question 5: How have you learned about models of practice?

Response options: The response options were a list of possible training choices for respondents to tick all those which were applicable, from 1 to 6 options.

Total responses: 96.6% (56) of respondents.

Results: The most frequently reported means of learning about models of practice was by reading 82.1% (38) and attending study days 66.1% (25). Learning from others by means of visits to other client centred teams, was the least reported method by 3.6 % (6) of respondents.

Question 6: Do you apply frames of reference in your practice? (Figure 4.6)

Response options were yes, no and don't know.

Total responses: 100% (58)

Results: A range of specific frames of reference described in the literature were used by 64% (37) of respondents whilst 12% (7) selected other non-specific ones and 24% (14) did not use frames of reference (fig 4.6).

Figure 4.6: Application of a frame of reference in practice (%)
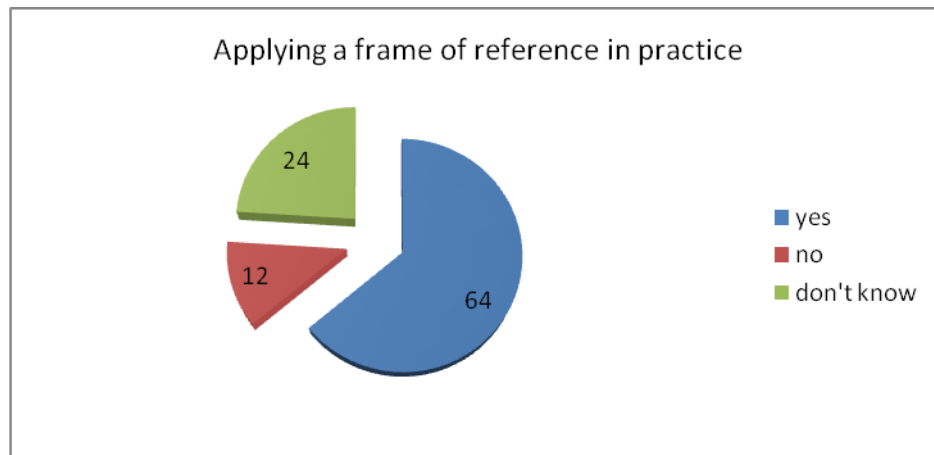
Question 8: If you use frames of reference which ones do you use? (Figure 4.7)

Response options: respondents were able to reply in free text judging frames of reference as most relevant through to least relevant.

Total responses: This question sought to identify the range of frames of references used by respondents; therefore the results are shown as the percentage of the total number indicated to show preference and relevance to practice rather than pure numbers.

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Figure 4.7: Frames of reference in use (%)

Frames of reference in use - most relevant

- Biomechanical — 13.5
- Compensatory — 8.1
- Neurodevelopmental — 21.6
- Cognitive behavioural — 13.5
- Humanistic — 2.7
- Rehabilitative — 13.5
- Normal movement — 5.4
- Client centred — 2.7
- Other — 18.9
- (0)
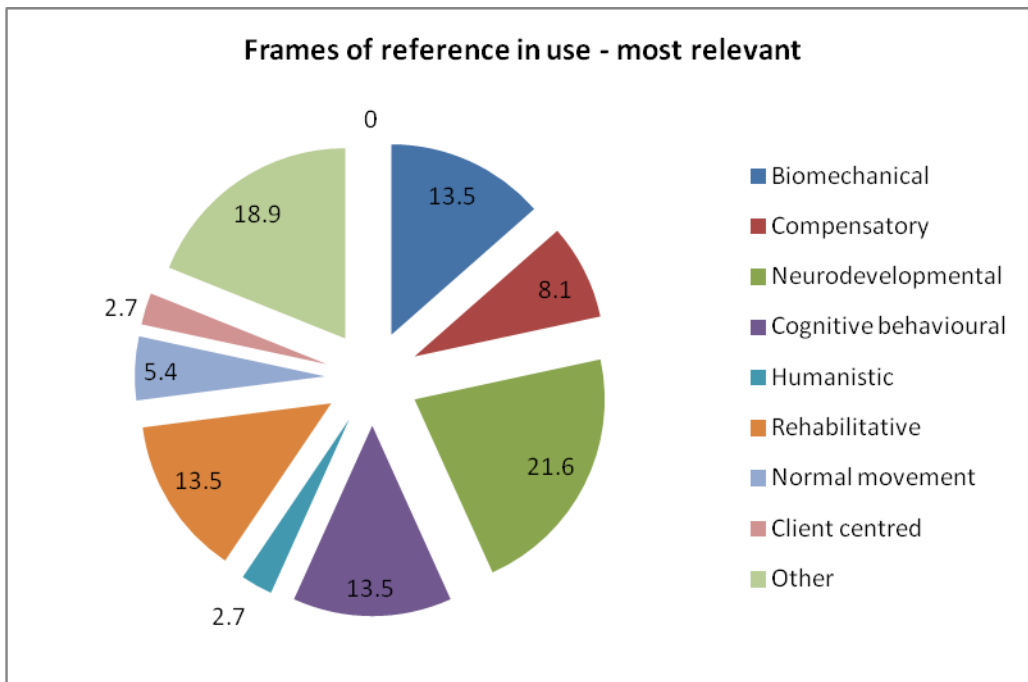
Question 9: How much has applying a frame of reference influenced how you delver the OT process?

Response options ranged from the least to the greatest influence.

Total responses: 64% (37) of respondents considered how frames of reference influenced delivery of the OT process.

Results: 24.3% (9) indicated that frames exerted little influence over practice, whereas the majority 75.7% (28) indicated that frames of reference greatly influenced how they delivered OT.

Question 10: How have you learned about Frames of reference?

Response options: The response options were a list of possible training choices for respondents to tick all those which were applicable, from 1 to 6 options.

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Total responses: 76% (44) of respondents reported applying frames of reference in their practice.

Results: The majority of respondents learned about frames of reference from study days and reading.

Client centred practice:

Question 11: Would you describe your practice as client-centred?

Response options were yes, no and don't know.

Total responses: 100% (58)

Results: 93% (54) responded of respondents described their practice as client centred, with 2% (1) not knowing and 5% (3) failed to respond.

Question 12: Consider and rank in order of priority the most important aspects of client-centred practice (Figure 4.8)

Response options were to rank each statement about client-centred practice giving a score for each based on 1 being the 'most important' to 10 being the 'least important' aspect.

Total responses: 93% (54) respondents completed this question with 7% (4) failing to respond.

Results: Those who responded ranked 'listening to the client', 'respecting their values', 'empowering the client' and working in partnership' as the most important aspects of client centred practice. Engagement in functional performance was scored the lowest (fig.4.8).

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Figure 4.8: Most important aspects of client centred practice
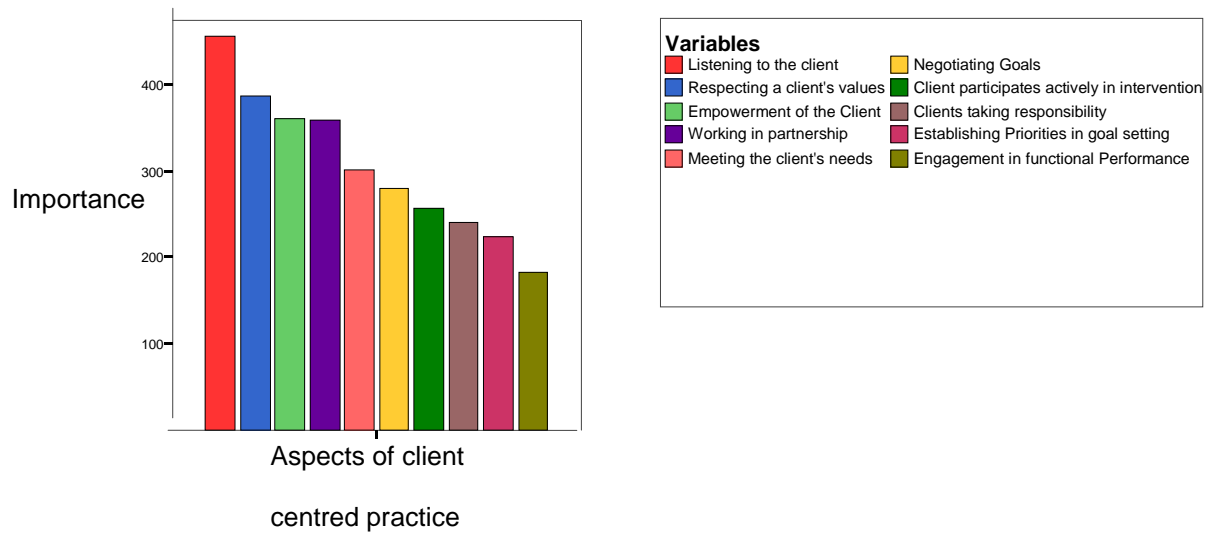
Question 13: Consider and rank in order of priority the most difficult aspects of client-centred practice (Figure 4.9)

Response options were to rank each statement about client-centred practice giving a score for each based on 1 being the 'most difficult' to 10 being the 'least difficult' aspect.

Total responses: 90% (52) of respondents answered this question.

Results: The most difficult aspects of client centred practice were identified as a client's 'lack of motivation', using a third person (advocate) in the process of assessment and completion of the COPM, and the 'client not being able to identify risks'. 'Establishing a relationship with the client' ranked as the least difficult aspect.

Figure 4.9: Most difficult aspect of client centred practice

Most

Difficult

Aspects

Aspects of client centred practice

Variables
- Client's lack of motivation
- Using a third person
- Client not identifying the risks
- Communication problems
- Having different goals to the client
- Letting a client set the goals
- Allowing the client to be the expert
- Agreeing goals together
- Identifying a client's needs
- Establishing a relationship with the client
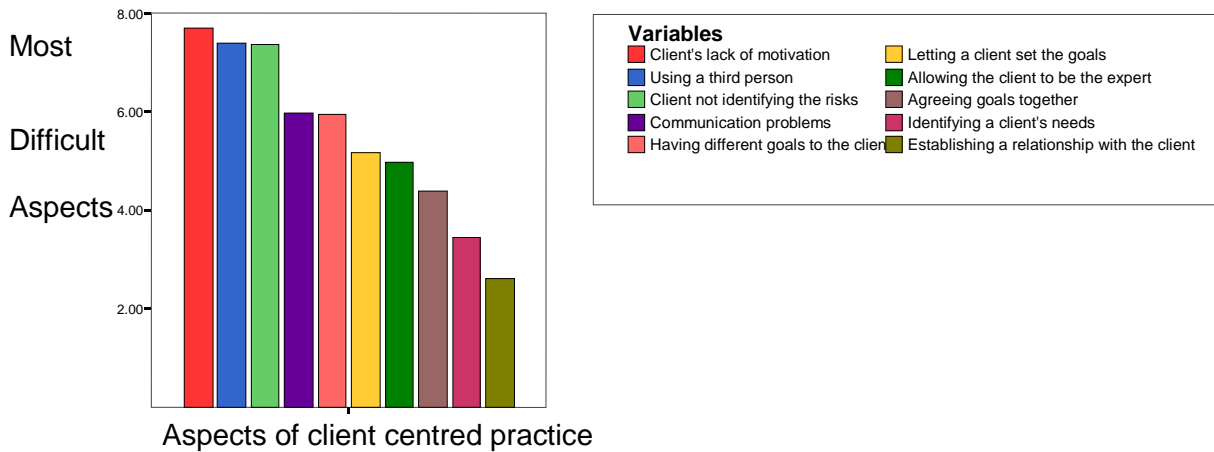
Question 14: Consider and rank in order of priority the most rewarding aspects of client-centred practice (Figure 4.10)

Response options were to rank each statement about client-centred practice giving a score for each based on 1 being the 'most rewarding' to 10 being the 'least rewarding aspect'.

Total Responses: 91% (53) of respondents answered this question.

Results: The most rewarding aspects of client-centred practice were identified as; 'working together with a client', ensuring clients are really listened to' and that it 'identifies goals which meet a clients' needs' with promotion of holistic working ranked as the least rewarding aspect of client-centred practice (fig.10).

Figure 4.10: Most rewarding aspects of client centred practice

Most

Rewarding

Aspects

Aspects of client

centred practice
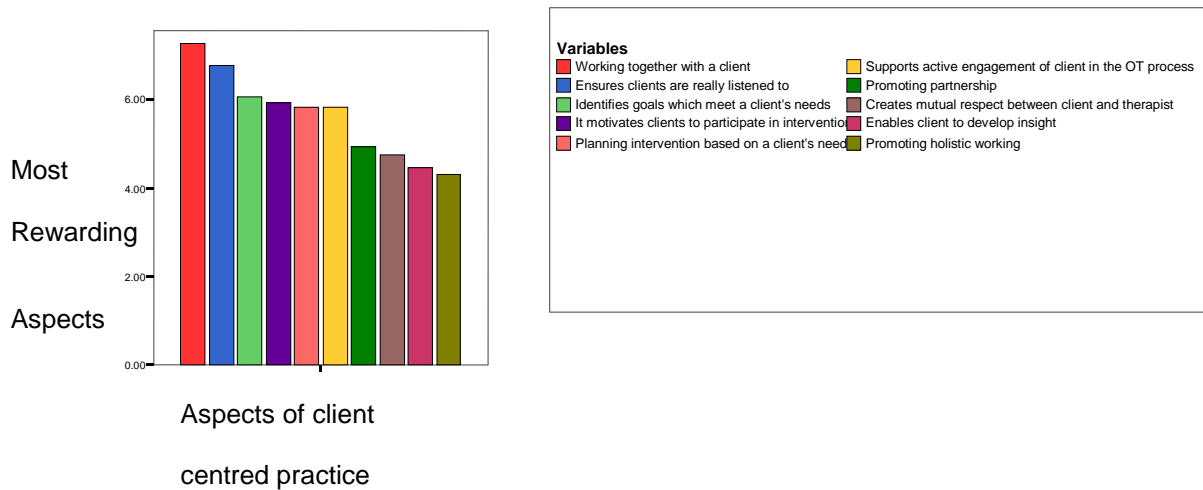
The COPM:

Question 15: Do you or have you used the COPM in your practice?

The response options were yes or no

Total responses: 96.5% (56) responded.

Results: 58.9% (33) of respondents reported using the COPM and 41.1% (23) confirming they did not use it.

Question 16: If you use or have used the COPM, did you receive any training on how to use it?

The response option was yes, no and don't know.

Total responses: 62.5% (35) of those who had responded to Q 15, who used or had used the COPM, answered this question.

Results: Of those 35, 82.9% (29) had received training on how to use it, whilst 17.1% (6) had not received any training or instruction.

Question 17: How was training on the COPM delivered? (Figure 4.11)

The response options were a list of training choices for respondents to tick all those which were applicable.

Results: Respondents noted a range of methods of learning about the COPM, rather than selecting one key method. The most frequently used methods reported were reading the literature, self instruction (reading the manual), advice from colleagues and formal taught methods. Other sources of training included informal support from colleagues and training received as part of undergraduate studies (fig.4.11).

Figure 4.11: Training methods on the COPM (%)
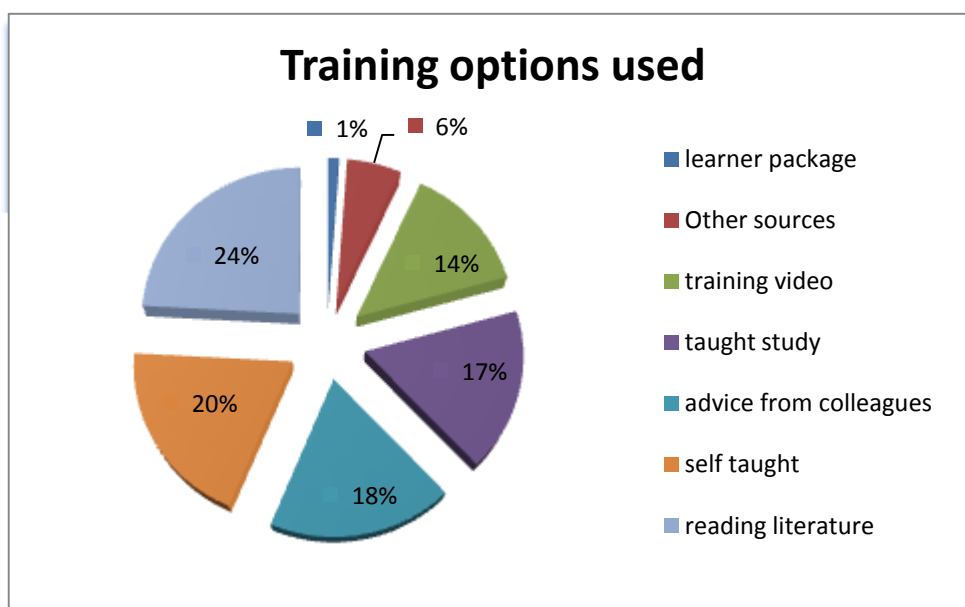
Question 18: If you use or have used the COPM how relevant is it to your practice? (Figure 4.12)

Response options were to rank each statement about the COPM giving a score for each based on 1 being the 'most relevant' to 10 being the 'least relevant to practice.

Total responses: 51.7% (29) of those who noted that they had used or were using the COPM responded to this question.

Results: identified that the most relevant aspects of using the COPM in practice were; 'focuses intervention on client's needs', 'increases client participation' and 'encourages partnership'. The use of the COPM; 'across all clinical areas' and its link of theory with practice were ranked as least relevant. (fig.4.12)

Figure 4.12: Relevance of the COPM to practice

Aspects of using the COPM
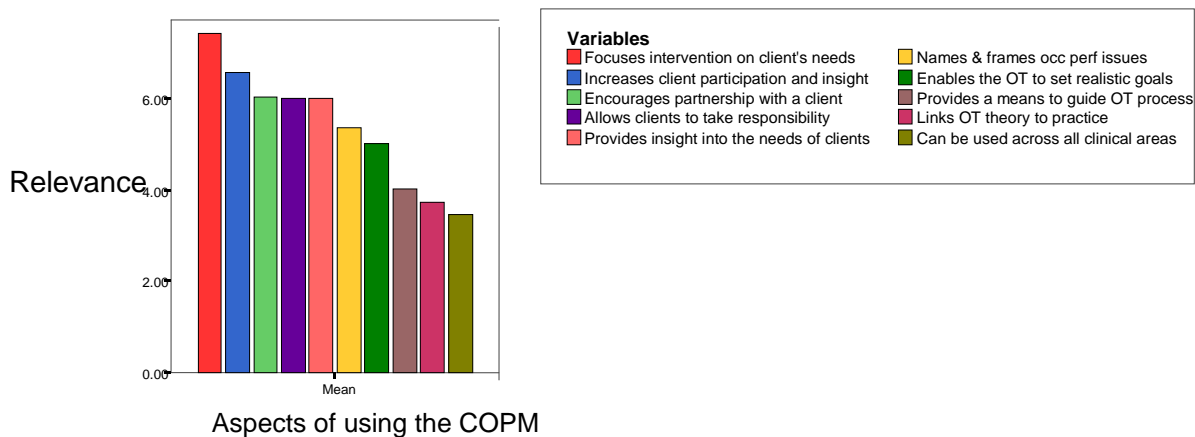
Question 19: What do you think about using the COPM? (Figure 4.13)

Response options were to rank each statement about the COPM giving a score for each based on 1 being the 'most important' to 10 being the 'least important' aspect of using the COPM in practice.

Total responses: 66% (37) of those who responded to Q.15 about using or had used the COPM answered this question about its importance to practice.

Results: Respondents identified that the most important aspects of using the COPM were 'understanding what client centred practice means is essential', 'the model CMOP' and 'facilitating client led goals', with 'using a semi structured interview' as least important (fig.4.13).

Figure 4.13: What respondents think about using the COPM

Aspects of using the COPM

Variables

■ Understanding what client centred practice means is essential	■ IT enables sharing about occupational performance issues
■ Understanding about the Canadian Model of Occupational performance is essential	■ Understanding how to use the scoring system is important
■ It facilitates client led goals	■ It facilitates holistic Occupational Therapy practice
■ Training in the use of Copm is essential	■ Extra time is needed when administering the Copm
■ Confidence is needed with interviewing skills to use it	■ Using a semi structured interview is valuable

Question 20: Consideration of statements about the COPM (Figure 4.14)

The response options were a set of statements about the COPM and respondents were asked to indicate their agreement with each statement.

Total responses: 59% (33) of the total respondents (56) who reported using the COPM responded to this question.

Results: Of the statements about the COPM (fig.4.14) respondents agreed that 'risk and safety issues should be explained to the client' as part of the COPM process. Whilst only 6% (2) agreed with the statement that the therapist should set the treatment goals, there was some agreement by 27% (9) of respondents to this question that 'the therapist has different goals to those of the client'. However there was greater agreement by 67.6% (22) that 'the client knew best when identifying their problems' and 70.3% (23) agreeing that clients must be 'able to identify areas of difficulty'.

Figure 4.14: Statements about the COPM
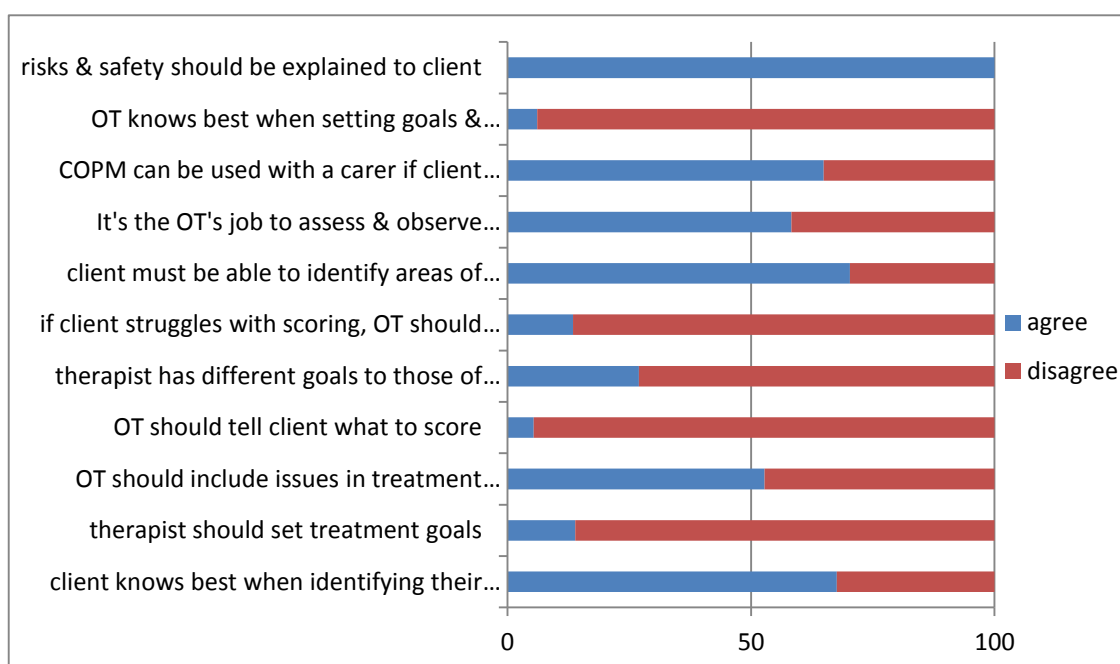
Question 21: Do you use the results from the COPM for any reason? (Figure 4.15)

Response options were yes, no and don't know.

Total responses: Of the 33 confirming they used the COPM (Q15), 78.8% (26) of respondents used the results from the outcome measure with 18.2% (6) not using them and 3 % (1) 'doing nothing' with the results.

Figure 4.15: Use of the results from the COPM
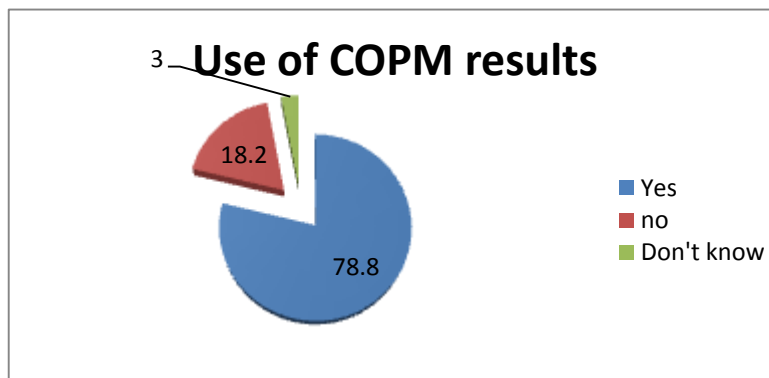
Question 22: What do you use the results for? (Figure 4.16)

The response options were a set of statements about how the results of the COPM could be used. Respondents were required to tick all those which applied to them.

Total responses: Of those who reported using the COPM (33), 78.8% (26) used the results of the outcomes measure.

Results: The most reported use of the COPM by 86.2% (22) concerned using the COPM results to give clients feedback, to share change scores with them and to discuss the outcomes of intervention with them (fig. 4.16).

Figure 4.16: How the results of the COPM are used
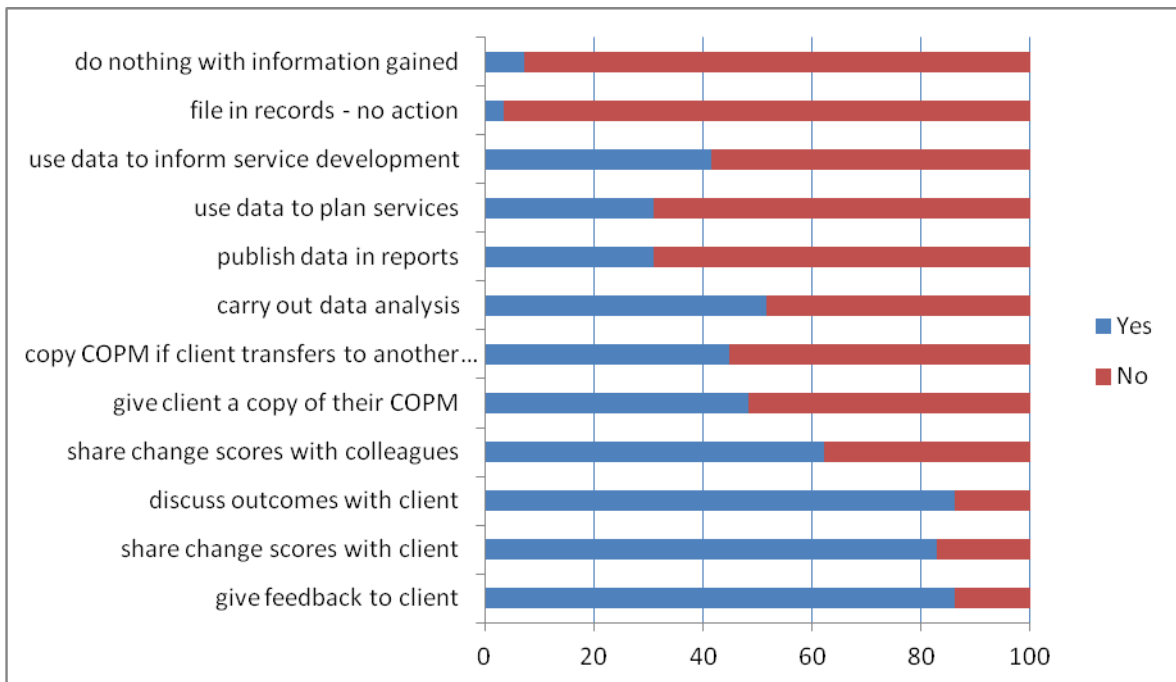
The final question asked those who had not used the COPM but had considered doing so, whether they would need training or not.

Response options were yes, no and don't know.

Total responses: Of the 23 respondents who had stated they did not use the COPM (Q.15), 69.5% (16) identified that they would need training, 17.4% (4) considered not and 13% (3) did not know (fig.4.17).

Results from the questionnaire were analysed using SPSS producing descriptive statistics, however the findings provided little evidence of any significance to add to the conclusions of this research.

Discussion:

The decision was taken to develop a questionnaire as it was considered to be one of the most appropriate ways of collecting the data necessary to address aims of the study. Other forms of data collection were explored, for example face to face and telephone interviews, which may have provided greater depth of data (Arksey and Knight 1999). However they were discounted in favour of a questionnaire as the need here was to explore a wide range of knowledge across a sample population. This research was a mixed methods design, using a focus group, face to face interviews and systematic review, all designed to gather the required data with the aim of exploring the perspectives and impact of client-centred practice. A mixed methods design allowed for greater flexibility in the development of the research as the results of each study were used to inform the shape of the next study as part of an iterative process. Objectivity was applied to both questionnaire design and construction with a range of styles incorporated to provide the most efficient format for each topic. Whilst this flexible approach suited the design process, it had the potential to cause inconsistency for respondents by presenting them with different question formats to consider, thus increasing the potential either for error or failure to complete. This may explain why some questions remained unanswered for example use of frames of reference and models of practice.

With regard to the sampling frame, distribution to the total UK Occupational therapy population (28,000 approx) was discounted, instead the sample was drawn from a national web database and the geographical area of the profession located in the West Midlands.

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Sample size:

The purposive sampling method was used to target a population of occupational therapists across a wide range of working environments to ensure, as far as possible, that they represented the range of views of practicing therapists in the UK. The sample of occupational therapists could be described therefore as homogenous (Polgar & Thomas 2008) as they are of the same profession, all working within a clinical or educational context and guided by the same ethical standards of practice. The potential population from which the sample was chosen was known to encompass a broad range of organisations, locations and clinical areas typical of occupational therapy practice in the UK. The sample population was drawn from NHS hospitals (acute and rehabilitation), community health and social care and educational organisations in both urban and rural locations. The sample size needed to be large enough to reflect the views of the population from which the sample was drawn. The membership population for the West Midlands in 2007 was estimated at 1500 (Parker 2012b) so a circulation of 230 was considered a reasonable circulation size. The return rate of 25% (58) was low when compared to suggestions that a 70% return rate mitigates against bias (Robson 2002). Attempts had been made to reduce non- response rates by attention to layout, wording and ease of completion of the questionnaire and a repeat mailing and emailing strategy was used to boost the response to the questionnaires, however Nakash et al (2006), who carried out a systematic review on maximising responses to postal questionnaires, found that there is a lack of evidence to suggest that incentives are useful to boost return rates. Lack of control over the final distribution was the most likely factor in the low response rate. However this survey was part of the examination of therapists'

knowledge and views which also included the focus group and individual interviews. This meant that the data from the questionnaire would be triangulated with the data from the other studies to add to the overall evidence base and indicate results which can be generalised to the population, albeit with caution.

Distribution can affect response rates and a disadvantage of postal distribution is the lack of researcher control unless systems are in place to prompt returns and ensure follow ups. Replacing these with electronic mail can increase response rates as prompts and reminders can be sent more quickly (Oppenheim 1992). By using electronic mail for both distribution and follow up prompts it had been anticipated that a greater number of responses would have been received. The response rate may also have reflected using a middle person – the service manager – to distribute questionnaires amongst the teams rather than by direct mail. It was necessary to fix the numbers of questionnaires circulated to each organisation in order to calculate the return rates. It was not possible to seek out a list of individual named therapists in each organisation to send a questionnaire to, so instead a set number were sent for internal distribution to the heads of service who were known from the professional managers distribution list. The researcher was then reliant on the service lead to approach members of their staff to seek their participation which may have impacted on the return rate. Time and work based pressures may also have reduced response rates.

Limitations

Greater consideration in the design phase of question construction and the type of data likely to be generated may have resulted in a stronger research design. The

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data produced in this design was a mix of ordinal and nominal. One criticism of the research is that the design could have been more robust, a stronger correlational design may have improved the comparison of the variables of theory and practice. However, this may not have changed the outcome of the results but may have created more focus and provided better understanding of the links between the two. The majority of respondents (98%) considered themselves to be client centred, however it was not possible to examine if there was any correlation between participants confirming that they were client centred (Q 11) and their consideration of the importance, the rewarding or difficult aspects of being client-centred because of the way the questions had been structured. Individual questions with answer choices reflected significant themes from the literature on client- centred practice for example – clinical practice, understanding of theory, training, the use of outcomes. These also echoed the results of the systematic review of the COPM (see ch. 4) and were reflected in the thematic analysis of the Focus group study (see ch.5). These were only reported response with no evidence of actual impact on practice as there was no facility for free text within the questionnaires. The structure of the questions was varied although similar scoring systems were used across groups of questions. The number of the ranked responses (Q12, 13, 14) may have contributed to respondents not completing all questions. Fewer choices may have prevented this.

The results from this questionnaire provided some interesting reflections of evidence in the literature and data from the previous studies (chapters 4, 5). The practice of client-centred occupational therapy was a key consideration by 98% of respondents who reported that working together with a client and ensuring they were listened to were the most rewarding aspects of this approach, reflecting findings from the focus

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group and in the literature (Law et al 1995; Sumsion 2006; Gage 2006). Interestingly there was some contradiction in the results about the most difficult aspects of client-centred practice. The focus group identified this as establishing a relationship with the client by communicating and negotiating with them to establish their goals, with evidence in the literature reinforcing partnership with clients, with failure to accept clients as equal partners preventing their active involvement in therapy (Sumsion 2006; Weston 2001). Results from the questionnaire identified a client's lack of motivation as the most difficult aspect of client-centred practice. Although establishing a relationship with the client was identified as the least important factor, there was a positive correlation with the most difficult aspects of being client-centred, suggesting that engaging with a client by addressing motivation and getting them involved may be part of establishing a relationship with them.

The knowledge of theory was another factor which had been identified in the literature as affecting therapist confidence in practice with Sumsion (2006) and Wressle & Samuelsson (2004) suggesting this could be a barrier to therapists implementing this approach. Results indicated that use of models of practice and frames of reference influenced practice, with those qualified the most recently more likely to use them, suggesting a knowledge gap for those whose training may not have included theoretical models. Training in client-centred practice and the CMOP was also identified as essential to the successful use of the outcomes measure (COPM). This has an implication for practice and may be an influencing factor in the uptake and use of outcome measures to evaluate practice and intervention.

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Conclusion:

The rationale for this study was the apparent disparity between the theory and practice of client- centred practice as identified in the literature (Clemens et al 1994; Sumsion & Smyth 2000; Sumsion & Law 2006) and the challenges which that poses to therapists based on the experience of clinical practice. A questionnaire was developed to examine the views of a sample of current practicing UK therapists to assess their understanding of this approach both as a philosophical underpinning of the profession and the process of its delivery in clinical care. The questionnaire was designed such that each question reflected and investigated specific themes emerging from the literature in relation to client- centred practice. The results from this sample indicate that the majority of therapists believe they practice in a client-centred manner and that the most important aspects of that practice are the skills of listening, respecting the client's values and working in partnership with them. Whilst the results indicate that the most rewarding aspect of being client-centred was working together to meet a client's goals, there was evidence of this being a challenge where the therapist and client may have different goals. The most difficult aspect of client-centred practice in relation to the client was their lack of motivation and their inability to identify risks. The most difficult aspect for therapists was the challenge of establishing a relationship with the client and overcoming communication problems. For those who used the COPM, learning about the measure and models of practice was important and the COPM was noted as reinforcing partnership and facilitating client led goals.

Although this study comprised a small sample of occupational therapists, it attempted to explore the knowledge and attitudes about client-centred practice and the use of a

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client-centred outcomes measure with practicing therapists in the UK. Whilst caution should be applied in generalizing the results, the conclusions drawn are indicative of themes already evident in the literature, supported by data in the earlier studies of this research. The key factors which have been noted and have implications for occupational therapy practice relate to the integration of theory and practice. Knowledge of the theoretical bases for practice is required so that models and frames of reference can be applied and outcome measures used. The relationship with the client and their motivation to engage in the process is a crucial part of practicing in a client-centred manner such that client led goals can be facilitated to achieve partnership working. Training and support to understand and apply models of practice, to acquire the skills of being client-centred and to use a client-centred outcomes measure with which to evaluate intervention are crucial in the delivery of client-centred occupational therapy. The key component of client-centred practice is the partnership between client and therapist which facilitates the identification of goals and their realization into outcomes thus meeting a client's occupational performance needs. Understanding the nature of this partnership by exploring how client-centred practice is perceived and experienced by the individual was the focus of the final study and results from the survey informed the design and content of the interviews undertaken with clients and therapists.

CHAPTER 7

THE INDIVIDUAL PERSPECTIVE

Introduction:

The adoption of the client-centred approach in occupational therapy practice has been accompanied by diverse interpretations as to what client-centred means (Corring & Cook 1999). Whilst a clearer refined definition of this approach has provided a theoretical structure for practice (Sumsion 2000a), evidence in the literature indicates there are concerns about the perception of this approach on the part of those experiencing it in practice (Wilkins et al 2001; Rebeiro 2000; Maitra & Erway 2006). These concerns relate to the differences between what the therapist understands by and perceives the approach to be, and the perceptions and experiences of clients receiving client-centred occupational therapy.

It has been some time since Corring and Cook (1999) carried out their qualitative study to explore client-centred care from a client perspective. They recognised at the time that whilst professionals had written about the characteristics of this approach, there were few studies reporting the client perspective. This caused some concern given the emphasis on partnership and client empowerment which is intrinsic to the client-centred philosophy (Sumsion 2000a; Sumsion & Law 2006). At the time of Corring and Cook's study, clients reported on the negative attitudes they had experienced in their relationships with service providers. They defined client-centred care as requiring the service provider to adopt a caring, positive and welcoming attitude, to develop a relationship with them, adopting common ground in order to build partnerships, and to ensure they were involved in informed decision-making in

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order to facilitate their recovery (Corring 1999, 2004a). Taking the time to listen, to be kind, to understand, to treat them like an adult and not to judge them were attitudes and behaviour emphasised as critically important to the person receiving services (Corring 2004b).

Maitra and Erway (2006), in their study analysing the perceptions of clients and therapists of their involvement in client-centred practice, concluded that the client's perception of client-centred practice is different from the perception of the occupational therapist in relation to the stated use of and participation in that approach. The perceptual gap centred on inconsistencies in the therapist's communication with clients and client involvement in goal setting. Strategies suggested for addressing these inconsistencies focused on the use of interview styles and assessment tools based on client-centred practice, the COPM for example (whilst it is an outcomes measure it is used in the assessment process) (Law & Mills 1998) and formulating practical task orientated goals with clients (Wilkins et al 2001).

Given that client-centred practice underpins professional practice, supporting clinical standards, guidelines and assessments, the need to explore the missing elements of client-centred practice - the perspective of the therapist and the client - is important in enhancing our understanding of this approach and its impact on practice.

This gap in our understanding informed the design of the final study in the research which was to focus on the individual perspective by exploring the perception and understanding of a sample of clients and therapists and their experience of client-centred occupational therapy.

The aims of this study were to:

- explore the experiences and perceptions of people who had received client-centred occupational therapy

- to explore the perception and understanding of therapists who had delivered client-centred practice

Rationale:

Whilst there may be a range of evidence in the literature which promotes occupational therapy practice as client-centred, there is limited evidence of how this is demonstrated by therapists in practice and what influence this approach has on clients (Hammell 2006). In simple terms client-centred practice is a process in which the client is the focal point of occupational therapy practice. Maitra & Erway (2006) suggest that client participation in that process can range from active involvement in discussion (Tickle-Degnen 2002), participation in goal setting and treatment planning (Gage 1994) to motivation to engage in treatment sessions. Corring (1999) noted that the client perspective was generally missing from discussions about client-centred care despite partnership and involvement being key aspects of this practice. In addition she also identified growing evidence of differences between client and therapist opinions with regards to goal setting priorities and rehabilitation (Corring 1999).   Some authors have approached this by examining potential barriers to client-centred practice (Wressle & Samuelsson 2004; Rebeiro 2000; Moats 2007) although usually from a service delivery perspective rather than that of the individual.

Some evidence has emerged from studies which have explored the therapist's perspective (Moats 2007; Sumsion & Law 2006), which recommend that the therapist should understand the influence of power as an organising framework from which

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other elements of client-centred practice can be derived. Those elements include listening and effective communication through the use of appropriate language, (Townsend 1998b), enabling choice by the provision of relevant information (CAOT 1983, 1991) and maintaining hope throughout the interaction (McColl 2003) all of which contribute to developing a successful partnership. Sumsion & Law (2006) argued that power held by therapists' influences goal attainment and that clients are disempowered by health systems such that their ability to participate and make choices may be affected. Corring (1996) advocated that therapists address the imbalance of power between themselves and clients, in order to initiate genuine client-centred practice. Townsend (1998b p.48) later emphasised that; 'client-centred practice shifts the power in a client-therapist relationship from one of dependence to one of mutual independence and partnership'. Empowering a client means enabling them to set goals, achieve objectives and attain the required outcomes. Gage (2006) continues this debate by suggesting that the issue of power should be resolved as the question is not about who is in control, rather that both partners in the relationship have skills and abilities and can work together in a synergistic relationship.

Other authors have acknowledged that the role of the client is becoming increasingly important in determining the care they receive (Corring & Cook 2006; Palmadottir 2006; Hammell 2007a). Maitra & Erway (2006) suggest that the environment in which a client is seen, together with their ability to engage in goal setting are factors which can influence the nature of client-centred practice. Others have examined clients' perceptions of client-centred practice in specific clinical areas such as rehabilitation and mental health services. Cott (2004) used focus groups to examine clients' perspectives of rehabilitation services, and concluded that clients felt they should be

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actively involved in defining their needs, setting goals and agreeing outcomes in collaboration with therapists. Involvement in goal setting as evidence of client-centred practice was established by Sumsion (2005) and Larrson Lund et al (2001) who pointed out that providing information to enable clients to make informed choices was perceived to be important for the client. Hammell (2006) concluded as ironic that whist client-centred practice had been the focus of much debate in occupational therapy little effort had been applied in exploring the meaning of this approach with clients.

Despite there being some evidence in the literature that the client's voice and view are considered to be valuable in understanding client-centred practice, the question asked by Corring (1999) in her discussion paper on the missing element in client-centred care ' why is the client perspective important?' remains an important one to investigate in our understanding of client-centred occupational therapy.

The justification for the present study was the need to explore and understand the individual perspective because if occupational therapy values the philosophy of client-centred practice by ensuring it underpins and influences practice, then examining how this is experienced by the therapist and client will determine whether these values and aspirations are reflected in accounts of practice and therefore influence outcomes.

The research so far has explored the worldwide literature for evidence of the application and impact of using a client-centred outcomes measure, the COPM, to determine how client-centred practice can be measured in practice (Ch 4). At a national level a survey was conducted to examine the knowledge and understanding

of a sample of therapists about what it means to practice using this approach (Ch 5, 6). The motivation for this part of the research was to understand the individual perspective in client-centred practice and to understand how client-centred practice was experienced in the face to face encounter between therapist and client. Having identified that this approach is dominant in occupational therapy and underpins its philosophy, education and practice, it was of concern to note that there had been limited exploration of what therapists and clients understand about it.

This study examined the knowledge and experience of a sample of clients and therapists using in-depth semi-structured interviews to explore individual perspectives. The aim was to explore the clients' and the therapists' experiences of respect, partnership, being valued, being listened to, making choices, negotiating goals and being engaged in the process of client-centred occupational therapy.

Method:

Research design:

A mixed methods approach was taken in the design of the research as a whole based on the nature of the research question which generated several strands of enquiry. This led to a mixed method design whereby evidence from the different research methods used (systematic review, focus group and questionnaire) were triangulated to form conclusions and indicate areas for future research about the impact on practice of client-centred occupational therapy. Mixed method designs enable different but complementary questions within a study to be addressed and so different methods for different tasks can be employed in this approach (Robson 226

2002). Consideration of the design for this study focused on how to address the aim of exploring the perception of individuals. The intention was not to obtain a mass of data from a wide range of people, as a study to explore a wider professional level perspective had already been undertaken by means of the therapist focus group and survey (reported in chapters 5 and 6). This study concentrated on the individual meaning and knowledge of client-centred practice and consideration of the most suitable method resulted in the design of an interview based study. The flexibility of a mixed method design meant that the survey results could be used to inform the design of the interviews and would enhance the interpretability of the results (Holloway & Wheeler 2002).

The decision to carry out face to face interviews was made because this provided a flexible and adaptable way of exploring the individual's experiences of the topic of study (Murphy et al 1998). Face to face interviews provided the means by which the researcher could meet with individuals in their own natural settings, explore lines of enquiry, follow up interesting responses and hear the person's story in their own words (King & Horrocks 2010). An interview is essentially a conversation between the researcher and those who are participating, with the purpose of gaining information for later analysis. They can vary in their structure and content and the way they are conducted which can be structured, unstructured or any variation in between (Polgar & Thomas 2008). Interviews are a valuable tool in understanding the experience of other people and the meaning they make of that experience and in health research they have become the basis for exploring the perspectives and understanding of clients (Holloway & Wheeler 2002; Seidman 2006). A criticism of interviews is the potential for the use of anecdotes, however this can be balanced by

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applying rigour to the research design and delivery using triangulation such that the reality of the participant is reflected in the data analysis (Holloway & Wheeler 2002; Brookes 2007). One advantage of interviews is that they enable the researcher to appreciate the language people use when talking about the topic of study and this can provide insight into the meanings behind their views and opinions.

The unstructured interview is used when the researcher knows very little about the subject of study and uses the interview to explore and learn more about the topic. This approach enables participants to tell their own story with the potential disadvantage that they meander into other topics not relevant to the one being studied. The quality of an interview can be determined by the degree to which the interviewer follows up and clarifies the meanings of the relevant aspects of the answers as the interview progresses (Kvale 1996) with the researcher using appropriate prompts and non verbal communication to encourage the participant. The danger of using more reflective responses to participant's comments, for example by sharing or welcoming their viewpoint, is that these may inappropriately lead them (Morse & Field 1998).

At the other end of the scale the researcher prepares a fixed set of questions which are delivered in a systematic order with little or no deviation from the text, whilst conducting a structured interview. The role of the participants is to provide the answers to the questions asked of them by the researcher with minimal additional information offered. This style of interviewing is useful where answers to closed questions are pre-determined as a limited set of responses and can be administered as a prepared questionnaire or interview schedule. Structured interviews are more likely to be used in quantitative research studies as they provide the means of

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matching anticipated responses to fixed questions with all participants asked the same questions in the same order (Streubert et al 2003).

Semi-structured interviews are often used in qualitative research where the researcher knows most of the questions they wish to ask but cannot predict the answers (Morse & Field 1998). This is a useful technique as it enables the researcher to obtain the information required by asking questions, but allows the participant the opportunity to expand on their responses and adopt a more flexible approach to the answers. The researcher prepares the questions which will ensure the topics of the enquiry are covered and these are contained in an interview guide. The sequencing of the questions does not have to be the same for each participant as it depends on how the interview proceeds and how each individual responds. This style of interview enables the researcher to explore the topic under study by use of specific questions, but also allows flexibility by exploring avenues of enquiry on an individual basis. The researcher needs to be responsive to the participant and be able to apply some structure in order to gain the information required.

The design of this research was qualitative and the semi-structured interview approach was adopted. This enabled specific topic areas in client-centred practice to be covered whilst retaining the flexibility to be able to explore individual issues of interest in order that the perception of client-centred practice emerged. The interviews were conducted with a sample of clients receiving occupational therapy and a sample of therapists who reported they were practicing client-centred occupational therapy. The study aimed to explore the everyday experience of client-centred practice from the provider and the client perspectives in order to explore how this approach was experienced by the two groups. Conducting the research through
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semi structured interviews enabled the researcher to focus on naturally occurring language, the individual's viewpoint and values, based in the natural setting of the therapist's work location and the client's home environment respectively.

The interview process comprised the design of the interview guide, the selection of the interviewees, recruitment of the sample, the interviews, data gathering and finally follow up actions.

Interview guide:

The interview guides (appendix 7.1 & 7.2) were based on a semi structured framework with flexibility to encourage the individual's response and included questions designed to examine the individual's perspective of client- centred practice. The narrative component of the interview was addressed in the opening question *(I would like you to tell me what it was like for you when you saw the occupational therapist)* which, as a general enquiry, was used to settle the participant and provide a non – threatening starter to the interview.

The basis for the questions for both client and therapist were the key elements of client-centred practice as defined by Sumsion (2000a). This definition was acknowledged at the outset as central to this research as it had been developed and written for practice in the UK. It made sense therefore to take the key elements of the current definition as the basis for the design of the questions about client-centred practice. The key elements identified were: respect, partnership, being valued, being listened to, making choices, negotiating goals and being engaged in the process. This list reflected the terms featured as key words in Sumsion's (2000a) definition and was supported by evidence from the literature on what constituted the core

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elements of client-centred practice (Sumsion 1999; Law et al 1995). Using these as the basis for the questions was intended to focus the interview on key aspects of this approach.

An interview guide was written for the therapists and the clients (appendix 7.1& 7.2) and included the same question format but with the wording adjusted where necessary. For example 'how did you address the client when you first made contact with them?' (therapist question) and the client version 'tell me how the therapist greeted you when you first met?'

Each interview started with an open ended question inviting participants to tell the researcher about their experience of being seen by an occupational therapist (clients) or what it was like practicing as a client-centred occupational therapist.

The interview guides for the client and the therapist were piloted in a different service in order to test the flow and terminology used and to ensure there was flexibility in the question format. My own service was selected because it was local and accessible. As I held no direct clinical caseload responsibility in the service, it would be unlikely to create a conflict of interest as all clients who were approached to take part in the pilot process were being treated by other therapists. The interview guide for the therapists was discussed with three therapists who agreed to comment on the questions. They were not required to answer the questions, just to consider and comment on question length, wording (especially use of jargon), complexity and areas of potential bias. Word changes were made, questions were adjusted in length and the schedule adjusted to improve flow (appendix 7.1., 7.2, & 7.6). Therapists in the service approached three patients (in and out patients) who were asked and

agreed to offer their views on the wording and format of the interview guide for the clients. Once again these patients were not expected to answer the questions rather to offer opinions about wording, understanding and content. Changes were made to the sequencing of the questions and to the words used to make the questions simpler and easier to follow (appendix 7.1, 7.2, & 7.6). The changes were made prior to use with the study sample.

The sample:

Guidance by Morse and Field (1996), which is reinforced by Robson (2002) indicated that predicting the sample size in flexible designs can be difficult and depends on reaching saturation in data collection. In defending the small sample in this study the following factors, as suggested by Morse (2000) were considered:

Scope: *The more focused the study the better the quality.*

This was limited to the adult recipients of a specific community occupational therapy service who met the inclusion criteria. The caseload was limited to a geographical area and case prioritisation. All potential participants met the inclusion criteria.

Nature of the topic: *If the topic is obvious and clear, fewer participants are needed.*

Client centred practice is an international phenomenon and philosophy within occupational therapy, taught at undergraduate level and delivered in daily practice.

Data quality: *If data are on target then fewer participants are need to reach saturation*

The structure of each question was designed to reflect the key elements intrinsic within evidence based definitions of client centred practice.

Study design: *some studies produce more data per participant than others*

By adopting a semi structured interview approach, it meant that certain questions (as per the submitted question format) provided for the basic structure but allowed for more in depth probing and investigation by the researcher to explore the issues and experiences of the individual as they arose. The question format was enhanced to include prompts.

Research method: *a small number of in depth interviews produce richer data than larger numbers*

A small number of interviews was planned to gain depth of data rather than breadth, which had already been gained from the survey data. Plans were put in place if during the data collection process, there continued to emerge new data in terms of the words and language, then the researcher would have considered the need to increase the sample size accordingly.

The therapist sample in this study was taken from a community occupational therapy team in a shire county (table 7.1). The justification for selecting this team was based on the evidence of their commitment to client-centred practice. Firstly they had adopted a client-centred model of practice on which to base their service delivery, the Canadian Model of Occupational Performance (CMOP) (Canadian Association of Occupational Therapy 1997). This model was integrated into the design of their documentation as well as influencing their choice of clinical outcomes measure. Secondly the team had been trained in and had been using the Canadian Occupational Performance Measure, (COPM) (Law et al 2005) a client-centred outcomes measure for over 2 yrs. Staff turnover within the team had fallen following

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the introduction of the model and the use of the outcomes measure 4 yrs ago. Any new staff joining the team received training on the model and the outcome measure cascaded by the team lead as part of their induction process. On this basis, the assumption was made that this team of occupational therapists would have experience of client-centred therapy.

Therapist sample:

Therapists were invited to take part in the research study by letter of invitation; the main criteria for inclusion were that they were registered and practicing occupational therapists willing to be interviewed and to talk about their experiences of practicing using a client-centred approach. Letters and an information sheet for the therapists outlining the research project were distributed to the team (appendix 7.11) and individuals responded to the team lead if they were willing to take part (appendix 7.12). The team leader was not interviewed. The therapist' interviews were pre-arranged with the team leader to fit in with their work schedule and were carried out in the team work base. They were scheduled to last a maximum of an hour. A letter of thanks was sent to the team lead following the interviews.

Client Sample

The client sample was selected from the cohort of people known to the community occupational therapy service. They had to meet the inclusion criteria; they also had to consent to take part and had to have been in receipt of community occupational therapy in the sample location within the last 12 months. These criteria were confirmed in the ethical submission.

Inclusion criteria:

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- Have received occupational therapy intervention from the occupational therapy team in the last 12 months

- Were adult clients aged over 18yrs who have the capacity to give consent (as defined in the Mental Capacity Act 2005 (DH 2005a)

- Were able to speak and comprehend English

Exclusion criteria:

- Those who had a life limiting condition

- Those who lacked capacity to participate and /or give consent (as defined under the Mental Capacity Act

- Those who were unable to communicate in or comprehend English

- Those who were unable to respond to questions

- Those who resided in nursing or residential care homes

As the researcher would not have access to the team caseload, the team leader was identified as the person who would manage the recruitment of the client sample. A meeting was held with the team lead to discuss the process of how this would be done. This was carried out according to the process described in the application for ethical approval. The team lead reviewed the current active cases registered with the team and identified those clients who met the inclusion criteria. She then contacted them by telephone in the first instance to ask if they were interested in taking part in the research. If they expressed an interest then this initial contact was followed up with an introductory letter inviting them to take part in the research and an information sheet and a pre paid reply envelope for responses. These were sent out by post to potential participants. If clients were willing to take part in the study they confirmed their agreement to be contacted by the researcher by signing and

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returning a reply slip in the pre-paid envelope to the occupational therapy office base (appendix 7.3). The researcher was then alerted by the team lead and contact was made with the client directly to discuss the research further and address any questions they had, as well as arranging the interview date and time. The team lead made follow up telephone calls to those who had expressed an interest but who did not return the consent form and kept the researcher informed of progress. Each interview took place in the client's own home and was scheduled to last a maximum of 1 hour. The interviews were recorded for later transcription.

Follow up:

Following the interview the client was sent an acknowledgment letter thanking them for taking part in the study and their general practitioner was informed by letter of their involvement in the research.

Ethical issues:

Ethical approval was applied for and granted by the National Research Ethics Service for this study (12/SW/0061 appendix 7.7). Access to conduct the research in the sample location was sought and granted from the professional line manager of the occupational therapy team. In addition a formal request was submitted to and approved by the Audit, Research and Clinical Effectiveness manager in the host Trust as the site specific location of the study. Copies of the ethical submission and research proposal, supporting documentation for peer review and approval to carry out the study were sent to the Research and Development office in the Trust.

Participant consent was sought by means of a letter and information sheet (appendix 7.3). This was followed up with face to face confirmation of the research process and

purpose at the time of the interview with written consent obtained from each participant by their completion of a signed consent form (appendix 7.4). Clients also gave consent for their GPs to be informed of their involvement which was done by means of a letter informing the GP of their involvement.

The focus of this research was an examination of how an occupational therapy service was experienced and perceived by the client receiving the service. The nature of the interview posed no risks to the clients either in terms of the questions asked or of the care they received, as the questions were designed to examine perception rather than a review of the service. There was no direct benefit to the client in taking part in this study, apart from providing them with an opportunity to share how they felt about occupational therapy. The main benefit was the insights of OT which would be used to improve the occupational therapy service for clients in the future. There would be a burden of time for the client and the researcher however this was limited to one hour and was clearly explained in the introductory information. They were also assured of client confidentiality before consenting to take part (it was explained in the introductory letter) and again on the occasion of the interview. There was no conflict of interest either for the researcher or the clients as the study location and sample were independent of the work base of the researcher.

Client and therapist:

Each interview was carried out in the client's and the therapist's own environment. The interviews were recorded and transcribed verbatim for analysis of content to determine key themes and patterns. Analysis was undertaken by means of manual management of the data. The researcher was familiar with the data and considered

that due to the small sample size, the use of software packages such as NVivo which could have been used to analyse the data was not required and a manual approach was adopted. Data from the interviews was combined with field notes of observations taken by the researcher.

The approach taken to analyse the data from the interviews was qualitative and followed a process of thematic analysis (Polgar & Thomas 2008). This is a method for identifying, analysing, and reporting patterns (themes) within data where it organises and describes the data set in rich detail (Braun & Clarke 2006). The iterative process used here was designed to explore and analyse the perceptions of individuals about the core elements of client-centred practice which had already been defined and formed the basis for the questions.

Thematic analysis summarises key features in a large body of data, can highlight similarities and differences across the data set and generates unanticipated insights which can be explored within discussion of the research (Braun & Clarke 2006).

In order to organise the data, the process started with reading and reviewing each transcript to ensure overall familiarity with the data, noting down ideas from the transcripts. The next stage was to generate the initial codes systematically across the data set for each of the core elements of client-centred practice, for example respect, partnership, engagement (Miles & Huberman 1994). As a consequence of reviewing the transcripts, each code was given a description and label in order to make it easier to collate the data relevant to each code, for example 'Resp.act' described respect shown to and experienced by the client by means of therapist actions which formed the framework for coding the therapists' and the clients' interviews (appendices 7.9 &

7.10) (Thomas 2003). The transcripts were then read through and codes were attached to key phrases and words by manually highlighting them and noting the code in the data analysis sheet (sample appendix 7.8). Once each transcript had been coded they were reviewed and the codes grouped into major categories. The themes from the therapist and client transcripts were then compared for similarities, differences and links. Analysis of the themes has been combined with illustrative examples from the data (Braun & Clarke 2006)

Findings:

The findings will be presented and discussed in relation to the therapist perspective and that of the client so that the data can be considered in terms of similarities, comparisons and gaps. A total of four therapists and four clients agreed to take part in this study with participant demographics outlined in tables 7.1 (Therapist) and table 7.2 (Client) below. An outline of the OT service is provided in Table 7.3. In each interview all participants were asked about their general perception of the service and to describe it using some key words (appendices 7.1 & 7.2).

Table 7.1 Therapist sample

Therapist code	Length of time qualified	Length of time in current post	Post held	University – trained at
T1	15 yrs	7 yrs	Senior Occupational Therapist	Coventry
T2	4 yrs	3 months	Occupational Therapist	Exeter
T3	30 yrs	7 yrs	Senior Occupational Therapist	Wolverhampton
T4	7 yrs	3 yrs	Senior Occupational Therapist	Coventry

Table 7.2 Client Sample:

Client Code	Age	Length of time known to service	Time of current referral	Key factors	Client identified needs
C1	71	18 months	18 months	Chronic Obstructive Pulmonary Disease	stairs shower transfers night-time toileting
C2	83	New	5 months	Cerebral Vascular Accident (CVA)	stair lift chair advice post provision of private shower room
C3	81	2 yrs	6 months	Angina Asthma	over bath shower chair raising general advice
C4	35	21 months	6 months	Spina Bifida	bathing solutions level access shower

Table 7.3 Service Information

Profile	Description
Team profile	5 Occupational Therapists plus support staff and administrative team Average caseload = 250 patients Average active working caseload 50-90 depending on level of seniority of staff (not including those suspended whilst awaiting the outcome of grant applications)
Caseload profile	Elderly people Those with long term chronic conditions People with capacity and /or cognitive problems People seeking re-housing solutions those who are joint carers
Service priorities	1: Provision of specialist equipment: Minor equipment – Internal grab rails, steps, stair rails Major equipment – bathrooms, extensions, stair-lifts, ramps 2: Manual handling advice provision for carers, hoists, equipment

Findings from Therapist Perspective:

The profile of the therapists shows that the group was fairly diverse in terms of qualification, experience, time in post, plus different locations of undergraduate training at university (see Table 7.1). Using field notes as a reference, it was noted that all therapists answered the questions fluently and confidently. Responses to the final enquiry about reflecting on the key elements of client-centred practice produced some key phrases resonant with those in the definition (Sumsion 2000a). Namely: listening, partnership, focusing on issues important to the client, being open, honest

and able to communicate, giving them choice, respecting their views and values, and building a relationship whilst acknowledging that client-centred practice is a challenge. It was also noted that the therapists mentioned following a process in the way they worked with clients. This was consistent with the key steps of the OT process (Duncan 2011) focused on assessment, treatment planning, checking client needs, explaining and affirming actions. This process involves checking the client has understood what has been said and decided.

The thematic analysis of the therapists' interviews produced four main themes; the relationship, communication, power and risk which are summarised in Table 7.4 below

Table: 7.4 Thematic analysis of the Therapist Interviews: Summary

Codes	Key theme	Inferential meanings	Conflicts / comparisons
Resp.Tit Resp.Act List.act Part.wd Part.act Eng.dec	1: Relationship	Working in partnership by word and action Engaging the client Respect by action and words	Goal identification and negotiation with client - low
Comm.wds Comm. ex Comm.inf Goal.ID. Goal.neg	2.Communication	Communication by information & explanation	Shared risk identity –low
Emp.act Ch.giv	3: Power	Empowering clients by giving them control and choice	Acknowledgement of the impact of environment
Risk.ex Risk.ID	4: Risks	Sharing information	Discussion of risk factors shared with client-low

Theme 1: The Relationship:

The therapists placed importance on several elements of their relationship with the client, in particular their attitude towards them and their behaviour with them. Their perception of how this was communicated to the client was evident in how they addressed the client at first contact, respect being demonstrated by using their title and surname.

> *'I wouldn't address them any other way unless they asked me to specifically to call them by their Christian name' (T1).*

Respect was also shown by their actions towards the client, in particular at the first point of contact in the relationship.

> *'I always say hello, Mr or Mrs, is that what you want me to call you?...They generally like me to call them by their first name and then I'll introduce myself and say what my role is and give them a brief summary of how I am here to help them' (T4).*

> *'So when I see them I introduce myself, say who I am and say hello Mr and Mrs. I shake their hand possibly sometimes , depending on how they wish it to carry on and as I leave I'll always say thank you very much Mr and Mrs … Sometimes they actually ask you to call them by their Christian name but sometimes I don't. So unless they specifically say they wish to I'll just call them by your surname' (T3).*

Listening actively to the client was central to establishing the relationship with them.

> *'I think their views are really important, I mean you're there to satisfy them and help them with whatever difficulties they have. So I think it's really important*

that their views are taken into account. I may possibly come up with ideas about how to solve the problem and I'll talk that out with them and check if they're actually happy with that and check if they want to proceed in whatever the case may be and I'll always try and make it clear to them that their point of view is always very important' (T3)

'I think it's about listening to what they say and acknowledging that you're hearing that' (T4)

Therapists referred to partnership when describing the relationship they developed with the client and included reference to the term 'we' when discussing problem identification and solving.

'I try and let them guide me and most of the time that works, but clearly sometimes it is not going to work maybe because they're shy or they have you in authority and they expect you to lead that interview, which you do but on their grounds and on their terms'(T2)

'Certainly I would discuss with them exactly what I was planning on doing, and tell them what route we would have to go down to solve that problem. I would look at how we're going to manage that, how we're going to address the issue and which sort of funding streams for example; if we go down council route for adaptations or private GFG's I would explain the whole of that process to them. So it would be giving them as much information as possible to how we're going to come about the solution to their problem' (T1).

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Theme 2: Communication

Therapists emphasised several elements of communication which were important to them in their relationship with clients, with a focus on giving information and explaining issues to the client. Communication was a key component in building the relationship with the client and was referred to frequently in the data. When describing communication the therapists used words such as honesty, openness, explanation, discussion, repeating, and understanding.

> *'It's a continual discussion with them, by repeating to them...and I think communication is really important here and to be able to repeat back to them what they've said so they know that you're understanding what they're wanting. And continually doing that as you're going through the treatment with the' (T4)*

> *'Again it's a lot of explanation. So I will say to them "I will order three pieces of equipment" I will how say how I'm going to order it e.g. online or through paper trail. If it is something complex like disabled facilities grant I will go through it with them at least three times - Once they have mention of major rehabilitation and how it's funded and then again after the assessment and then finally I will group it all together. Tell them what you're going to do, tell them how you're going to do it and then tell them again and leave it open to questions and any queries. We also have a leaflet with information on bits of equipment which I will either send out if I haven't got it with me or give it to them there and then'.(T2)*

> *'really it's about that communication at the time and it's to do with what I say to them and how I express it. If someone tells me they have a real*

problem with the stairs I'll ask them to demonstrate that and I'll ask them to

show me what the issues are. So I guess the value or the way you say that is

the most important thing and the way you express how it's looking at what

their issues are and trying to analyse and break it down really, doing the task

analysis and see what can we do to solve that problem, and it's looking at that

and telling the patient or client what we can do to help resolve the problems

that they've got'(T1)

'Again it would be through discussion and sometimes you can tell through their

body language that they are not quite understanding, so I would try to explain

it in a different way to see if they can understand it in a different direction.

Obvious communication difficulties that you're aware of beforehand means

that you try to ensure that (for example), someone who knows sign language

is present – so it cuts down on those risks,but I do try to keep explaining and

discussing to try and ensure that the patient is able to understand. I do try to

encourage them to ask me questions if they feel happy doing that. And I

always try to recap what we've discussed, are they happy with it? (T3)

It was evident that the therapists valued communication as a means of establishing

the relationship with the client and as a means of exploring their needs, with some

consideration of the different approaches they could take to ensure communication

was effective.

Theme 3: Power

The influence of power in the delivery of client-centred practice was evident in the

choices given to clients, their independent decision making and their empowerment

facilitated by the therapists. In specific terms therapists did not speak about or refer to power as a factor in their relationship with the client. There was however consideration that it was the client who had control in the partnership and that choice and decision making was ultimately up to them.

Therapists demonstration of empowerment was seen by giving the client information on issues about which they could make decisions. For example information given to clients about equipment and resources placed the choice and decision making with the client, with the therapist being the source of information.

However, there was inference of power when it came to identifying and negotiating the goals for treatment planning. There was little reference to this being a joint process and whilst there was a connection with establishing a client's needs, the identification of goals tended to be an action undertaken by therapists

> '*We will have agreed where we're going to go with the equipment and the treatment plan. So I will always go through it again at the end of the interview "This is what we're going to do for that particular problem and this is how it will work, is there anything else you want me to do?"* '(T2)

> '*I think it's sometimes difficult for people to be able to look at things in the gradual way, in breaking down the activities. So if somebody has an overall goal, for example wanting to go home, then I'll try and break that down with them and talk about how they are going to get that and what do they need to do that? Do they need to be independent with their mobility? And then we can work on that. So if somebody has an overall goal then we'll try to break it down to identify how they're going to achieve that (T4).*

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'I look at the assessment, what happens within the assessment and look at those key problems, well all of the problems really and focus on the most important thing which, normally is what we've been brought in to look at anyway'. 'I think at the end of the day the client is the driver, they're the ones that are saying there's a problem and we're really responding to that (T1)

Where the issue of power was more evident in relation to goal setting was in the use of the COPM which, as a client-centred tool, was one example of how goals were determined and negotiated from a joint perspective.

" I like using the COPM because it focuses people on the problem that they've got and where they are at the time. And then they reassess themselves at a later date so hopefully you get a nice transition from problem to solve and its up them, it's not a therapist, it's not a therapeutic intervention, it's purely the individual making a decision on the intervention (T2)

'By getting the goals of what they want to achieve and asking them and talking to them about the ways in which we are going to do that. So then we'll plan that around their treatment.

Q: And do you link that with any outcome measures?
'Yes I link it with the ... outcome measures that we are using at the moment because COPM is very client centred and because you're working with them, you and they can see that they've improved, and I think it's important for them that they see that. Which is why when they understand the scoring system, they can see that, especially at the end (T4)

Those who used the COPM valued the focus it gave them in determining the goals of intervention and evaluating outcomes, however there was no reference by the clients of their awareness of the therapist using this tool with them.

Theme 4: Risks

Issues of risk were referred to by therapists and were recognised as part of the relationship, but the issue of risk identification and explanation was more prominent in their reporting than that of the clients. The relationship between risk identification and the communication of risk issues could be considered as a fundamental element in partnership.

> ' *If there are certain issues that potentially could be a risk then I would highlight those at that time before proceeding any further and I would say for example, there's a risk of entrapment or something, you know if there's a small child in the house. I would have to look at those at that time and it's a case of negotiating with them and saying 'this could potentially be a risk', how could we minimise or eliminate this risk or how could we proceed with whatever adaptation or equipment. Things like cot sides or assessment that sort of thing would have to be a formal risk assessment that I would be looking at straight away and talking with them, about that before it went any further' (T1).*

> *'Depends on what it is really. If it's things like their wearing fluffy slippers and holding a Zimmer frame with a cup of tea then we will say "well you'll be much safer with a trolley, may I suggest wearing slippers that fit"- something like that. I try and discuss it with them and hopefully in my mental tool bag I can*

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pick out a solution to that problem. But sometimes they don't want to know'

(T2)

'Part of your assessment is regarding risk and I'd always discuss that with the client and explain the risk of doing or not doing something in a certain way and also the consequences of that. And I'd also explain what we'd put in place to reduce that risk, explain why that would be beneficial

Sometimes they haven't quite seen it as a risk but sometimes if you explain it to them and explain why that would possibly be a risk then they tend to follow and understand what you're saying. But I do think it depends again on the individual client and their degree of insight into the possibility of risks. But again I think that's something you have to work out with the individual and failing that hope that there's a family member possibly there that you can liaise with and then they tend to understand the risk a bit better. But I think it's up to the individual and their understanding of that risk and to really keep explaining and discussing it in different ways'. (T3)

Findings from the Client Perspective:

The client sample comprised four individuals with a range of ages and health issues affecting their functional performance and presenting with problems commonly dealt with by community occupational therapy services (Table.7.2). Clients 2 and 3 were a couple but each had been separately referred to the Occupational Therapy service for different reasons, had different but overlapping needs and were known to the community service for different periods of time (see table 7.2).

Reflections on the interviews recorded in the field notes, noted that the clients were very confident in their own home environment and were aware of their own needs and the problems they wanted support with. The overwhelming impression of the client perspective was the importance they attached to how they were treated. This view was expressed in every interview and all of the respondents communicated a need to be valued as an individual. Importance was placed on the attitude of the therapist in their relationship with them, more so than the actions taken by them. There was also a strong impression of the clients being aware of their own needs and being able and wanting to make choices about them. The themes of the relationship, communication, power and risk are explored to determine their perspectives of client-centred practice.

For a summary of the findings, see below (Table 7.5).

Table 7.5: Thematic analysis of the Clients Interviews: Summary

Codes	Key theme	Inferential meanings	Conflicts / comparisons
Resp.tit Resp. act List. act Part. act Comm.wds Comm. ex Comm.inf	1: Relationship	Respect by words and actions Communication Listening by action Being treated with respect	Ability to make own choices valued highly. Identity of & discussion of Goals – low
Comm.wds Comm. ex Comm.inf	2.Communication	Communication by information & explanation	Risk discussion - low

Eng. act IDM Emp. act Env. home CH. made Ch.giv	3: Power	Being actively involved in decision making Making informed choices Being given choices	Environmental risks – low Partnership in words – not evident Engagement in decision making –low Empowerment by words -low
Risk. ex Risk.ID	4: Risks	Sharing information	

Theme 1: The Relationship

All of the clients noted that when they first met the therapist the impression made was important to them. All the clients noted that they were shown an identity badge as an introduction and were addressed formally by name and title. Subsequently they were asked how they wished to be addressed and all noted that their choice was respected. During successive contacts with the therapist all clients reflected on how they were treated and valued the respect shown to them in those meetings.

'well although she's a stranger, when you see someone for the first time it is a bit nervy, not nerve racking, but I wonder what they're going to be like' (C1).

' she treated me good, she was a nice friendly lady. If I can have a joke with somebody then I know they're ok, but if they're prim and proper then no.

Well they put you at ease, I mean, when you see someone for the first time it is a bit nervy, not nerve racking like you know, but, oh I wonder what they're going to be like, but she put me at ease straight away, very friendly and smiley and what have you. They make a big difference yes' (C1).

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'They asked me what my name was and I said R' (C2)

'Well they've always been pleasant, never had a problem with any of the, they've always been brilliant with me, anything I've needed they've done it for me, so I've never had no bad experience' (C4)

In their contacts with the therapists, the clients valued the fact that they felt listened to, despite any physical disability which may have impeded verbal expression (as in a CVA for C2).

'Well yes, they seemed to know what I was saying and the things I was saying to them yes (C2). I mean if you asked anything, if you queried anything they would tell him this is the so and so, you see, so that you'll be able to do so and so (C3)

'Well, it means a lot really, you're in control of your own life sort of thing. She wasn't saying I've got to have this, or I've got to do that, I was saying what I wanted and she listened, so I was in control' (C1)

'I had to go back and get referred again for my bathroom because I was put in the wrong category. But that could have been my not explaining my full situation. But fingers crossed it should all be sorted now, for my bathroom.

Q And how did deal with that?

Well, I phoned them back up and they said they'd come straight back out and reassess and then they reassessed it and put me in a better category' (C4)

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The way in which therapists' engaged clients in the therapeutic relationship was reflected by their attitude and how they connected with the client. The evidence suggests that clients felt involved in decisions made about any care options made by the therapist, equipment for example, and were comfortable with declining support when not needed. Whilst there was no mention of partnership as a term, there was consensus in this sample of a relationship existing where clients worked together with the therapist.

> *'they asked me you know obviously, how I got on in the house, and toilet and bedroom and what have you, and we discussed that', they listed off a few things and I said yes or no, and they asked why this particular thing and I explained, you know'(C1)*

> *'I had to get in touch when I moved here because of the things I needed. Oh yeah, because I needed a second perching stool for in the bathroom and I also need the bath changing and again bigger, and fingers crossed another few months, so depending on how I get on there. I don't need too much so long as I get what I need it doesn't really matter.... if not they would point me in the right direction anyway. Well, they've always been brilliant with me, anything I've needed they've done it for me, so. (C4)*

> *'well, it was to get him back into his normal way of living if possible, course it didn't turn out like that, they did do a lot of work with him trying to get his hand going and getting him about, yes, trying to build his confidence up as much as anything.*

Oh yes, yes, they call it promoting independence yes they gave us plenty of information, the information helped him, helped us to understand what was going on' (C3 and C2)

Theme 2: Communication

The way each individual was treated was linked with communication. The focus was on sharing information by both client and therapist and the explanation of issues. The way in which information was shared was associated with the attitude taken by the therapists in their use of language. Clients were very clear about what they valued, which was plain speaking in ways they could understand.

'well they did say like we've come to see if there's anything we can do to make life easier in the home, apart from that I can't really remember but they did explain why they were there so, you know, I knew they weren't nurses as such. I mean, she was, she was very good in explaining everything' they spoke in plain English. It is like having a normal conversation, it's not, you know, umm, not like being interviewed for a job or something, you know, no nerves or anything just talking naturally, just everyday language, you know, I could fully understand', (C1)

Oh no it's always been something that I could understand, never been anything complicated, cos it just confuses things then. But if it's nice and simple you can answer it and get to the bottom of things. If ever I've got any problems I just give them a ring and they'll sort it again, which is good' (C4).

'Oh yes, if they asked me something I answered them straight out unless I didn't know what they meant and then they explained to me what it was.

Sometimes I lose a lot because I forget a lot, that's what I find, and sometimes I say something I didn't hear' (C2)

' I think they tried to bring it down so that we understood it, mostly they spoke to R, they didn't speak to me because he was the one they were more interested in, you know he was doing all the work and everything, and I only picked up bits as I went along sort of thing, you know' (C3 of C2).

The frequent references to explanation by the clients indicated that therapists were checking and affirming that clients had understood both what was happening and what was being talked about.

Theme 3: Power

The term power, as in the therapists' interviews, was not mentioned by the clients however what was evident from the clients' interviews was evidence of their confidence in their own knowledge about their circumstances and their environment. The impression gained and logged in the field notes was that each individual had insight in and an understanding of their own needs. They were well informed and confident about knowing and taking their own decisions. Their strength was reflected in personal knowledge and clarity about the issues and problems they had. The respondents reported this independent decision making and making choices about their care as being what they valued.

' you're in control of your own life sort of thing. She wasn't saying I've got to have this, or I've got to do that, or I was saying what I wanted and she listened, so I was in control'(C1)

'Well as long as they can help with what I need then that's ok. I don't want to keep going to them because I don't need the things, as long as it's there when I need it that's fine by me anyway, and they've always done what they've needed to do. Well I've always had to have perching stools when I was home, just bits and bobs, and then they helped get in the ramps front and back and hopefully in a few months time they'll be helping with the bathroom as well. I've also had a switch, a porch light lowered they've come to do that as well. So anything that I've asked for them to do they've come and seen to it.' (C4).

' they were pointing out to you things that you didn't know about, but the choice was left to us wasn't it? (C3), yes, that's right (C2). You know, they would say, would you like this, would you like me to do this, well I thought if it was good, I said, straight away or I don't like that or something'(C2).

There was no reference in the client interviews to the identification and negotiation of goals of intervention. The word 'goal' or words related to it (for example, objectives, priorities and issues) were not used or referred to by the clients in their responses. Clients described their 'goals' in terms of problems or troubles for which they sought practical solutions or more often expressed as needs.

'Because actually what she said I was quite happy with her, what she said about the stairs, helping with the stairs, and straight away I said that's my biggest problem, the only problem I found was the stairs' (C2)

'Well they did point us in directions that we didn't even know about, you know what I mean, because unless you've had something like this before you don't have any idea really what's going on do you ?(C3)

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'cos I don't need too much so long as I get what I need,.... 'if ever I've got any problems I just give them a ring and they'll sort it' (C4)

'well they asked me you know obviously how I got round you know, how I got on in the house, and toilet and bedroom and what have you, and we discussed that' (C1)

There was limited evidence to suggest the clients were empowered by the words or actions of therapists apart from being given information in order to make choices about care solutions.

Yes she offered a stair rail and I said definitely ,yes, she offered a stool for my shower but I said I wasn't really sure about that, well she said we'll bring you one for you to try. I asked for a commode which fortunately I don't use very often but it's there and she offered me several other things that I didn't think were, you know, be any help to me, but umm, yeah at the end of the day I ask for them all.

Yes, yeah, 'cos I haven't had a bath for, can't remember the last time I had a bath, getting in and out of the bath and she actually went upstairs and she looked at the bathroom to see if there was anything she could give us to, but unfortunately we've got shower doors on the bath and she said she couldn't fit a bath thing because the shower rails would have to come down.

She offered the grabbing rails but I said no not really because I can't get in and out of the bath anyway, they'd be no good to me. She was very helpful, she was offering things that she thought I might be able to use which I suppose somebody else might have been, but it was no good to me ' (C1)

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'they were pointing out to you things that you didn't know about' (C3).

The client's sense of empowerment however was demonstrated in relation to their environment, with evidence supporting their own sense of control in their own homes especially when in relation to meeting their needs.

' it's important because they've got to see it, to see what it is you know. They need to see where the needs are, so it's very important that they come visit us'(C1)

What we've done is had a wet room put downstairs for him, when he can use it, it isn't quite finished, its been going on for months and months and months this has, and hopefully but you see the only trouble is he's got to go downstairs to it. And it isn't big enough really the room to have a bed in there in any case it wouldn't be right for him to be living downstairs, and I'm upstairs at night and he's two floors down, know what I mean, that wouldn't work' (C3)

Q: Was it important to you about being seen at home?

'Yeah, because then they can see the situation I'm in straight from here. So yes definitely' (C4).

Theme 4: Risk

The discussion and exploration of the risk issues which may impact on the client did not attract much attention, which was interesting bearing in mind that the clients were assessed in their own homes. One client (C1) denied that risks were discussed whilst others were aware of specific issues but had already considered their own solutions.

The interviews suggest that clients were cognisant of the risks in their lives and their own environment but little debate took place about them

'No, can't worry about risks, you wouldn't live otherwise. No, you sit there worrying and you wouldn't get out the house. It's just my way if you do things in a certain way or that you do things in risky way, perhaps in the bathroom. It's just my way, can't tell me to change it when it's me that's got to deal with it. If they make my life easier then I'll do it differently, but until that time I do it the way I do it. So when that bathroom's done it will be different' (C4)

'She offered the grabbing rails but I said no not really because I can't get in and out of the bath anyway, they'd be no good to me' (C1)

'I was having a bath in that thing that's fastened tight to you, well when I got into the bath put me legs over with what's his name John (pseud.), he said swing your legs over and I did, I swung my legs over and everything gave way' (C2).

' the bath board wasn't, whoever was doing it, should have tightened the bath up and it went over the top you know Well, what it is you see when you're cleaning the bath you've got to move the board and you know, I can't put it back right, it's probably my fault anyway but then it should have been checked before you sat on it' (C3).

'The only thing I've got to look out for is carpets and we haven't got no carpets here, not now, only that one (rug) yes and I've hung onto that one for the time being that's right, we've had to get rid of all of them' (C3).

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A summary of the thematic analysis of the interviews is presented below so that the relationship between all the themes can be visualised (Fig. 7.1).The relationship with the client is the key in client-centred practice with communication, power and risk influencing how this established.

Theme Map: Fig 7.1
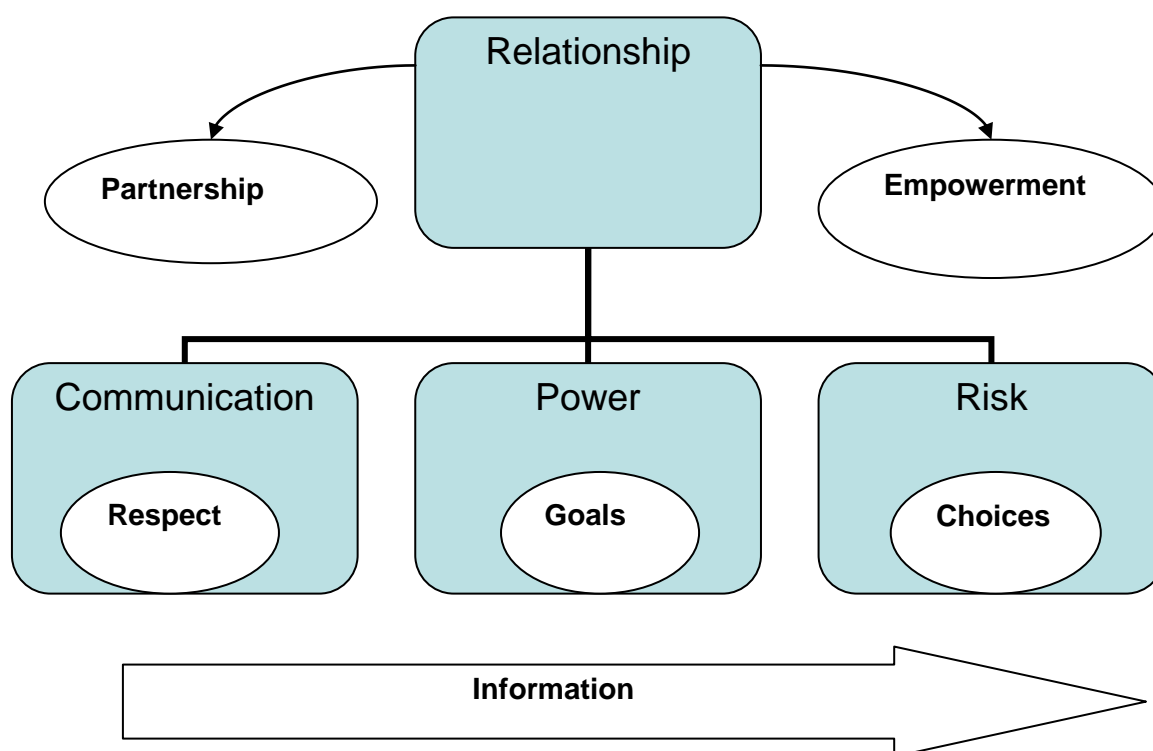
Discussion:

The analysis of the data has indicated that there are differences and similarities in the experiences of the client and the therapist which contribute to our understanding of the nature of client-centred practice.

Both the client and the therapist valued the importance of respect but approached it from different perspectives. Therapists placed importance on demonstrating it in words and actions and the client considered its importance by experiencing it. Both valued listening to each other as an important aspect of the relationship with the client noting the importance of being listened to as recognition of their contribution to the relationship. Listening can be considered as part of communication and this was important to both client and therapist with emphasis placed on explanation and discussion of issues and solutions. Sumsion & Law (2006) in their review of the conceptual elements of client-centred practice considered that the nature and level of communication between the therapist and the client deserved greater attention. Evidence from this study suggests that therapists may be acknowledging the need for focusing attention on how they communicate with clients by explaining and checking their understanding. There was also some indication that therapists recognised that the words they used were important in effective communication. This included explanation of technical terms if they were not understood by the client, for example

Another aspect of communication was the sharing and discussion of risks. Clients were aware of risks in their environment, loose rugs for example, with evidence that therapists identified them, but there was limited discussion about the consequences of risks and the impact on the client. This challenges assumptions that risk issues are communicated by therapists in an effective and understandable manner with clients. Therapists considered the relationship with a client as a partnership and their familiarity with the term and its meaning was evident in the frequent reference made to it in the interviews. Whilst they considered they demonstrated their understanding

of partnership by including the client in decision making and by the actions they took to remediate problems, the notion of partnership was not discussed by the clients. The clients considered themselves as equal in the relationship but they did not discuss partnership as a concept nor express this as the term to describe the relationship with the therapist. Whilst it may be understandable that clients may not describe their relationship with the therapist as one of a partnership, therapists need to be aware of how they communicate and demonstrate that their relationship with the client is one of a partnership in a more explicit manner. This is important given that partnership is a core element of client-centred practice.

The most notable aspects of client-centred practice from the clients' perspective was that of being valued as person, having the ability to make choices and having the information to be able to make independent decisions. Clients reported in the interviews that the manner in which they were treated by the therapists was an influencing factor in how they felt about the relationship with the therapist. The attitude of the therapist, in terms of how they spoke and behaved with the client, may be indicative of demonstrating that the client was valued, suggesting that this may support and reinforce client confidence and feeling of self worth as described in the literature (Rogers 1951; Law & Mills 1998).

The importance of power emerging as a major theme relates to several issues: independent decision making and the choices made by the clients as well as the influence of the environment. As noted in the literature (Maitra & Erway 2006) this study found that clients felt they were in control when in their own homes. They had the knowledge of their own circumstances and were better equipped to make the choices relevant to themselves. There was little evidence that therapists recognised

this aspect of client power nor did they acknowledge any power which they themselves may exert. Power was only mentioned in relation to resources where limitations of resources affected the choices made available to the clients. This may be because in this sample there was general evidence of agreement and therefore no requirement to exert power over another in order to influence or to achieve one's own goals, goals being mutually achieved.

The analysis of the interviews resulting in the emergence of the themes of the relationship, communication, power and risk has indicated that there are implications for practice which need attention and further exploration if the practice of the client-centred approach is to maintain and develop its relevance in occupational therapy.

Recommendations:

Communication, the use of client focused language in written literature or information leaflets should enhance verbal communication and support decision making. Involving clients in writing this type of information would also reinforce a client-centred approach.

Partnership: Acknowledgement of the client's expertise, knowledge and insight into their circumstances will also support partnership working.

The identification, sharing and explaining of risks should help create a more balanced relationship.

Goals: Discussion about goals needs to be explicit as this is the focus of intervention. Therapists should create more emphasis on goal setting in the relationship by using the information shared with them by clients to shape and specify the goals of

intervention. A suggestion is that goals are communicated as Client Identified Problems (CIPs) on all treatment plans to avoid the use of professional terminology. Outcome measures: one means of supporting client-centred practice is to use a client-centred outcomes measure. The COPM supports partnership and goal setting in a client-centred manner and provides the means for goals to be explicit and owned by client and therapist alike.

Conclusion:

This study examined the individual perspective of client-centred practice through semi-structured interviews with a small sample of clients and therapists. The interviews explored aspects of client-centred practice and individual views about the core elements of this approach in order to understand the individual perspective. The interviews were transcribed and analysed using a thematic approach which generated four key themes: relationship, communication, power and risk. These themes were explored in relation to the context of the literature and for their impact on practice.

Therapists readily discussed their approach to their clients and the relationship they established with them and perceived the relationship as one of partnership with the client. Using their skills of working together with the client and respecting their views and values, therapists have the potential to reinforce that concept of partnership and empower the client in a more robust way. The relationship between the client and the therapist was the basis on which intervention was planned and executed, which therapists perceived as the means of selecting goals based on a client's needs.

Partnership is a key element of client-centred practice and one which therapists in this study were familiar with, referred to it as a concept and considered that they applied it in practice. Clients however did not articulate or refer to their relationship with the therapist as being one of partnership. Although some of the core elements of client-centred practice were reflected in the words used by clients to describe the relationship they had with the therapist, for example being valued as a person, being acknowledged as having choices and being capable of making decisions in relation to their care, clients did not perceive having a partnership with the therapists. This may be explained as merely a difference in the use of words or it may be that the term is unfamiliar to clients because it is not spoken about by therapists. Whatever the reason, the importance here is that for client-centred practice to be evident to client and therapist alike, a partnership should exist between them whereby the knowledge and skills of each partner contributes towards the agreed focus (goals) of the intervention and is evaluated by both partners to confirm the outcome. Fundamental to their partnership with the client was communication, distinguished by explanation, demonstration and verifying a client's understanding about issues and risks.

Clients spoke with confidence about their needs and individual circumstances and valued communication as a vital part of the relationship. Further evidence of their perception of client-centred practice was found in the value placed on being listened to by the therapist and being spoken to as an equal. This is typified by a quote from one client who said:

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'Because sometimes, not being funny, but some of you official people they tend to look down their nose, some - I mean not many but there are some' (C1)

Clients attached importance to being treated with respect, being put at ease by therapists who were approachable and who could talk with them using words they understood. Swain et al (2004) described the barriers to effective two-way communication as being ingrained in the power relations between professionals and clients. One suggested solution is active listening which is responsive and can transform health and social care into a working alliance between clients and professionals and create a communication environment in which a client has control.

The theme of power, referred to in the literature about client-centred practice (Sumsion & Law 2006) as an important element, attracted little attention in this study and was not discussed or considered of importance by the therapists or clients. This study challenges the assumptions made in the literature (Falardeau & Durand 2002; Sumsion & Law 2006; Sumsion 2006) that power is inescapable in a therapeutic relationship, concurring with Gage (2006) that any struggle with regards to power should be ended. Conclusions drawn from this study indicate that this may not be an issue for therapists who did not refer to the term or allude to any knowledge of its impact on their practice, nor to any power which they hold as therapists. They recognised that clients were in control of their circumstances in their own environment and directed what type of intervention would take place but did not recognise this as a power issue. Clients also did not refer to power as such but their expressed confidence and insight into their issues and problems demonstrated clear evidence of self worth and determination in ensuring their needs were met.

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Contrary to evidence in the literature concerning differences in client and therapist goal setting, evidence from this study found that there was no perceived difference in the focus of intervention between the client and the therapist. What was evident was a difference in understanding about terminology where the clients' needs and problems were translated into goals by the therapists. Therapists regarded goal setting as part of the process of their intervention, following a logical step by step procedure, however this was not the experience of clients who, whilst able to express their needs explicitly, did not perceive that goal setting was part of a process which shaped the service they received.

The articulation of risk issues by the therapist with the client was not evident as an explicit part of the assessment and intervention process. What was evident in the data was the clients' insight and confidence in understanding their own circumstances and making choices of care which best supported them in their own environments. The process by which risks are assessed, explained and resolved should be part of the partnership working with the client to promote informed decision making.

One therapist summed up their perception of client-centred practice succinctly by saying:

> *It can be very challenging, especially because you have to be able to build a relationship with whoever it is you're working with and if you can't build up that relationship it's hard to work with them in a client-centred way. Not because you don't want to, but to be able to work with that person in that way is difficult if you can't build up a relationship with the. I think sometimes it is because when you have limitations of time that's when it's difficult but I'd like to think I*

work with people on an individual basis and I listen to what their concerns are

and try and work with them to overcome those. With the initial assessment I do

with everybody my treatment is always based around what their goals are and

the goals are negotiated with them and what they want to achieve. But it's also

about considering the bigger picture in terms of family, where they live and

trying to work out with them how achievable we can make those goals (T4)

The principal conclusion drawn from the data about the client's perspective of client-centred practice is that the most important aspects of this approach in occupational therapy were those of being valued and respected as an individual, being listened to and spoken to in words they could understand. These values reflect the core elements of client-centred practice as described in the literature (Law et al 1995). The therapists' perception was influenced by the relationship with the client, which they perceived as being a partnership based on communication. Goal setting did not form the basis of the relationship nor did it feature in the interviews. Understanding the nature of the relationship, the use of communication and the importance of joint goal setting and measuring outcomes were key themes which provide insight into the individual perception of client-centred practice. What matters in this approach is that there are two people in the relationship, both with knowledge and skills which when combined in partnership work together to fulfil the client's needs. Only when therapists understand the nature of the partnership with clients, by appreciating what they know and what they value, and we design our interventions based on mutually discussed and agreed goals, will the true impact of client- centred practice be realised.

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CHAPTER 8:

DISCUSSION

Introduction:

This research had its origins in concerns about occupational therapy practice in the UK. The research question; 'what are clients' and the therapists' perceptions of client-centred practice in occupational therapy in the UK? grew from my experience of managing and observing how occupational therapists worked with their clients in the identification and assessment of need, the creation and delivery of intervention plans, and the evaluation of the outcome. The philosophy of client-centred practice, which supports the process of occupational therapy, provided the basis for the whole research. This chapter evaluates the results of the studies which explored the client and the therapist perspectives of client-centred practice including the use of a client-centred outcomes measure (the COPM). The findings are explored in the context of the wider professional domain to determine how they can inform and influence occupational therapy practice and research.   The limitations of the research are discussed and personal reflections on the experience of conducting the research and its outcomes are explored as a valuable element of the research process.

Before discussing the outcomes of this research further, it is timely to reaffirm the context within which the studies took place, reflecting on the terminology in current use to prevent confusion and to reaffirm the roots of client- centred practice and its meaning within occupational therapy. It was noted in Ch.1 that the historical context of client-centred practice was heavily influenced by the work of Carl Rogers who

developed and articulated the person-centred approach to therapy. Although initially developed as a unique approach to understanding personality and human relationships through psychotherapy, Rogers and his colleagues believed their ideas could be transferred to other areas where people were in relationships, for example in patient care (British Association for the Person- Centred Approach 2013). In recent years it has found worldwide application in various domains and as a result the words used to describe concepts centred on people being partners in health care have emerged as either client -centred therapy or person- centred care. Considering the various aspects attributed to these terms, Gage (1995) noted that they appeared very similar. She concluded that systems of care were usually described as patient – centred when they originated from an institution or hospital setting, where recipients are usually referred to as patients. When people receive services outside of an institution or from a particular health discipline, such as social work or occupational therapy, then they tend to be referred to as clients. Both terms are in use in everyday practice., however when the CAOT published its guidelines for the client-centred practice of Occupational Therapy in Canada (CAOT 1991) in 1983, they demonstrated a considerable paradigm shift for the profession by moving from a medically based patient care practice to one centred on the needs of the individual, identified as the client (Gage & Polatajko 1995).

The use of both terms, patient and client-centred, should not however be confused with patient –focused care which described an organisational change model aimed at streamlining activities in institutions to make them more efficient (Gage 1995). For example The NHS Plan (2000a) reinforced the importance of 'getting the basics right' and of improving the patient experience by developing a set of operational

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benchmarks such as 'Essence of Care' to help practitioners take a patient-focused and structured approach to sharing good practice (DH 2003).

Despite both the terms, patient and client centred being in use, the focus is on the needs of the individual and both link with Rogers' emphasis on listening to the person, empowering them to make informed decisions about their care, and treating them with respect in relation to the choices they make. It is worth reminding ourselves that in Law's (1998) review of the core elements of client-centred practice, she reaffirmed that the key concepts of this approach were; partnership, respect, client responsibility for decision making, provision of information and communication, participation in individualised service delivery, enablement of clients and a focus on the person – environment – occupation relationship. These were also later reflected in Sumsion's (2000a) UK definition which highlighted partnership, empowerment, engagement, goal negotiation, listening, respect and enabling clients to make informed decisions.

The relationship between person-centred and client-centred appears to be determined more by the environment in which the systems of care are delivered rather than any philosophical differences (Law1998; Sumsion & Smyth 2000, Brooker 2004; Richards & Coulter 2007). Belief in and adherence to the core concepts of a 'person' centred approach reinforcing the core concepts of respect and valuing the individual are perhaps the most important elements in the delivery of our practice rather than practitioners becoming marginalised about the terminology we use to describe it.

In this research the therapist and the client perspectives were explored using survey and interview methodology, underpinned by evidence from the literature and examined in the systematic review, with the results of each of the studies discussed in detail in the relevant chapter (Ch.4, 5, 6, 7). A synopsis of the findings (Table 8.1) highlights the key messages and inherent values emerging from each study which are discussed in this chapter. The inherent values evident in the findings of each study illustrate the relationship of each element of this research with client-centred practice (Fig. 8.1). The findings are then discussed in the context of the literature, and analysed in relation to the therapist perspective, the client perspective and their impact on practice.

Table 8.1 Overview of the findings

Study	Key Messages	Inherent Values
1: Systematic review of the COPM	**Training** for OTs needed in: Models / Theoretical frameworks / The COPM / Client-centred practice Communication & language skills	The COPM supports: Client-centred practice Partnership Goal Setting
2: Professional perspective	**Training** needed in: Models/ Theoretical frameworks/ The COPM / Client-centred practice **Skills and confidence** in: Engaging the client Building a relationship Sharing information about risks and safety Having the same goals Power	Partnership Relationship with the client Listening Respect Empowerment
3: Individual - Therapist	Having the same goals Engaging the client Establishing an understanding with the client	Partnership Respect Listening Giving clients choices
3: Individual - Client	Understanding joint goals Being engaged in the process Being understood by the therapist	Attitude and behaviour of the therapist The manner of the communication Ability to make choices Being respected Being valued

Study 1: An international perspective

The systemic review of the COPM examined the impact of this outcomes measure on clinical practice to determine how it influenced and supported client-centred practice. The results identified that the OT process was a key element in supporting practice delivery, however training was needed specifically about the use of the COPM, the theoretical models which support it, and client-centred practice, in order to support that practice. The COPM measures clinical change in a client's performance and satisfaction with occupational performance over time and the results indicated the validity of the COPM in determining the outcomes of intervention. The results also found that the COPM verified client- centred practice by supporting the core elements of this approach, demonstrating it in practice and delivering it to the client encounter by supporting partnership and underpinning client focused goal setting. Clients needed to understand the language of occupational performance to identify and articulate their occupational performance issues, requiring insight and cognitive ability to be able to do this. The value of the COPM was that it provided a measure of client satisfaction and judgement of functional ability centred on their defined needs, rather than 'quantitative' targets that can fail to determine quality and satisfaction on a personal level. There was no evidence in this study of any dissonance between the therapist and the client in relation to goal setting, rather the study found that the COPM was a conduit for establishing a relationship with a client by enabling and reinforcing goal setting within a partnership approach, however it was noted that therapists need to demonstrate effective communication skills with their clients in order to achieve partnership working. Furthermore the COPM was a clinically

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relevant outcomes measure applicable across a wide range of client groups and environments whose use can impact on practice.

Study 2: A professional perspective

The results of the Focus Group indicated that therapists need to develop skills and confidence in order to practice in a client-centred manner and that those skills relate to the ability to engage the client in occupational therapy. The process of engagement centred on establishing a relationship with the client, achieved by developing respect and sharing meaningful communication. Effective communication using language clients understand and the sharing of information with accuracy and clarity, underpinned the whole process of delivering client-centred practice. The results indicated that this combination of skills is the key to supporting informed choice and decision making, achieving joint goal setting, understanding risk taking, and contributing to the outcome of intervention. The findings indicated that demonstrating the skills of listening enabled the therapist to understand a client's needs thus providing the basis on which joint goal setting could be achieved. Whilst understanding the influence of power was noted in the literature as a fundamental concern in client-centred practice (Hammell 2006; Sumsion & Law 2006), there was little reference to power made by the therapists in this study. The findings suggested that power was an influence rather than a key factor; for example in its relation to the environment, where for the professional power related to the hospital, whereas for relatives and the client this was the home environment. The influence of the environment impacted on a client's behaviour and the results indicated that the client has more confidence at home, the suggestion being that if a client has confidence

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they may be more engaged in occupational therapy. There was also little reference in the findings of this study to partnership which was surprising as it is a key component of client-centred practice. This may be explained by the therapists' view of the relationship with their client. One of the challenges of client-centred practice identified by them concerned establishing a relationship with the client. As the relationship provides the basis on which jointly agreed goals are set to shape intervention and evaluate outcomes, this challenge may reflect difficulties perceived by therapists in balancing power within the relationship in order to achieve a partnership with the client.

The results of the questionnaire identified that therapists rated the most important and influential elements of client-centred practice as listening, respecting values, empowerment and partnership. They identified the most rewarding aspects of client-centred practice as working together with a client and identifying goals to meet a client's needs. However training in the use of the COPM was identified as important as well as acquiring a better understanding of client-centred practice. Therapists recognised that the value of the COPM was that it reinforced partnership, increased participation and facilitated client led goals. However the results also indicated that a theoretical model was needed to underpin practice. The most difficult aspects of client-centred practice were the client's lack of motivation, using another person as an advocate to determine goals for intervention, and clients not being able to identify risks. They also recognised that establishing a relationship with the client and relating to clients with communication difficulties also made it difficult to practice in a client-centred manner. When it came to evidence about the COPM, therapists considered that the least relevant aspect of using the COPM was its function of linking theory to

practice, which may account for low uptake or reluctance to use outcomes measures (Cook, McCluskey & Bowman 2007) and poor application of theory into practice. The most difficult aspects of using the COPM concerned explaining risk and safety issues to clients, the therapist and the client having different goals and the client not being able to identify areas of difficulty or defining issues of concern. There was no evidence in this study of any dissonance between the therapist and the client in relation to goal setting, rather the study found that the COPM was a conduit for establishing a relationship with a client by enabling and reinforcing goal setting within a partnership approach.

Study 3: The individual perspective

Analysis of the interview data demonstrated that the therapists valued working in partnership with clients. This was achieved by showing respect for the client by listening and valuing their views, giving them choices about intervention options, and taking action to support the client. Partnership was not referred to by clients although they emphasised the importance and experience of being respected, having their opinions valued and being able to make choices about their care or treatment. Results indicate that the principal perspective of the client about client-centred practice concerned the attitude and behaviour of the therapist. Being spoken to and treated with respect was very important and considered an essential component of being treated as an equal. Clients valued the ability to make their own choices, with results indicating the importance to them of knowing their own needs and circumstances and being able to base treatment choices on meeting those needs.

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This was reinforced by therapists who reported that they gave clients choices and perceived that it was the client who made the decisions about which course of action to pursue. Communication was valued by therapists as an important means of sharing information, whereas for the clients it was the manner in which therapists communicated with them which was important.

Fig.8.1 Inherent values and client-centred practice
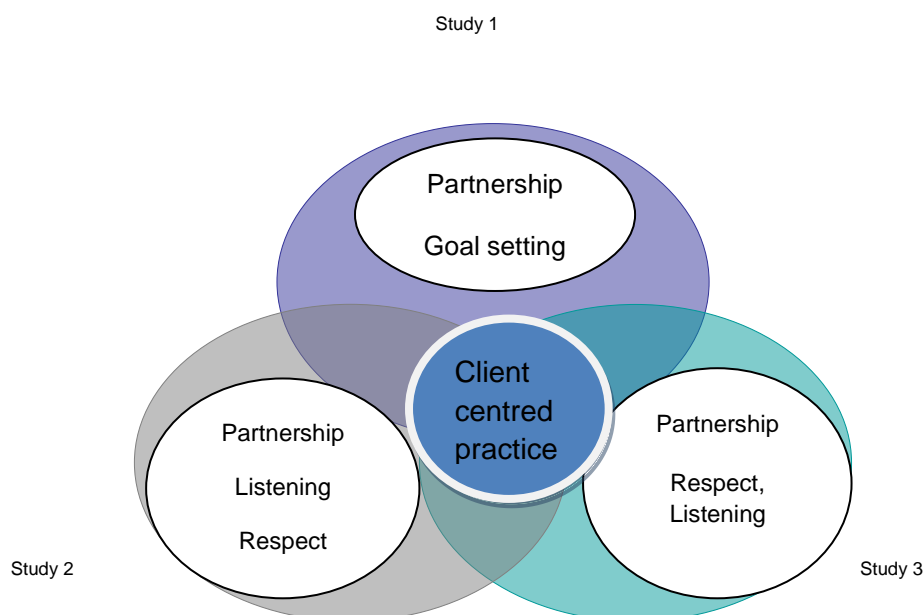
Therapist Perspective

The purpose of the studies which focused on the therapist perspective (the focus group, questionnaire and the interviews) was to examine their knowledge of client-centred practice and to explore what skills were required to demonstrate this in

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practice (see below). The client-centred approach underpins the way occupational

therapists are expected to practice, emphasised by its inclusion in the code of ethics

and professional conduct which provides the benchmark for the development of all

standards, guidelines, assessments and 'tools of the trade' (COT 2011). It was

interesting to note during the research that there had been few studies undertaken

which specifically examined occupational therapists' experience of client-centred

practice. Those which did address therapists' perceptions of this approach used

questionnaire, survey methodology, or literature reviews rather than examining the

individual perspective (Wilkins et al 2001; Sumsion & Smyth 2000; Sumsion & Law

2006). Those who explored the individual experiences (Maitra & Erway 2006;

Sumsion & Lencucha 2007; 2009) noted several challenges identified by therapists in

implementing this approach, notably power, partnership, and having different

perspectives to those of the client.

Knowledge:

Therapists appeared familiar with the terminology of client-centred practice and

readily used the words from Sumsion's (2000) definition when discussing it in relation

to their day to day practice with clients. There was evidence, for example in the

findings of the interview and the questionnaire studies that therapists referred to

respect for and partnership with their clients. However despite this familiarity with

terminology there was consistent evidence from the systematic review, the focus

group and the questionnaire that learning was required to apply this approach in

practice. Training to increase knowledge was identified in several areas notably; to

understand client-centred practice; to comprehend the theoretical models which

support practice; and to understand how to use client-centred outcomes measures

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such as the COPM. Findings from the questionnaire also confirmed that therapists acknowledged that the use of models and frames of reference reinforced the OT process and that models based on client-centred practice were those most frequently used. Perhaps the evidence indicating that more training is needed is not surprising given that some university departments identified that client- centred practice was not a specific core module in pre-registration training, rather it is taught as an integral part of modules on models of practice and approaches to occupational therapy. However this could be argued as an advantage as it means that this approach is integrated across the whole curriculum.

Skills:

The skill to practice in a client-centred manner was affected by confidence, with evidence from the focus group indicating that when therapists' confidence increased, their ability to deliver this approach also increased. The findings suggest that this confidence may be improved by greater use of reflection, which was noted in the literature as being a powerful tool in understanding client-centred practice (Duggan 2005; Boniface 2002)). Interestingly there was little direct reference made in the focus group to what therapists thought or understood about client-centred practice, despite the discussion topic focused on engagement and goal setting. This could be explained by a lack of connection with the approach or an acceptance of it as a given part of practice such that no reference was required.

Communication as a means of establishing the relationship with the client was valued by therapists in both the focus group and the interviews. Evidence shows that the ability to communicate requires the skills to convey issues with clarity and honesty.

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Demonstrating respect for a client's choice requires the therapist to listen to what a client says, to share information and to be able to negotiate how risks are managed with them. The therapist also needs confidence to acknowledge and respect the client's choices, using skills of negotiation to determine the focus or goals of intervention. Evidence from the therapist interviews concluded that the therapists valued communication, particularly the skill of being able to explain difficult concepts or issues. In the systematic review it was noted that effective communication is needed with clients to determine direction and outcomes.

Client Perspective:

This study specifically explored clients' perspectives of what it felt like to experience client-centred occupational therapy, to determine what was important to them. The results supported evidence from the literature that clients valued the interpersonal relationship with the therapist as being more important to them than the therapist's technical skills, because being more responsive to the client's individual needs rather than their conditions, was required (Hammell 2006).

As with the therapist perspective, there has been little evidence in the literature exploring how clients experience and define client-centred practice and what they perceive as important or of value in that approach (Hammell 2013). Of those authors who have examined the client perspective, specific aspects were addressed for example in rehabilitation (Cott 2004), mental health services (Corring & Cook 1999), barriers and opportunities (Sumsion 2005), and power within rehabilitation (Hammell 2006). These studies provided evidence of the importance of the core elements of this approach to clients notably participation in negotiating goals, enabling choice and being listened to. When Corring (1999) first addressed the issue of the client

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perspective, she brought into sharp focus the lack of understanding about the client perception of this way of working in occupational therapy practice. What clients have to say about the fundamental elements of this approach is vital in helping us to shape our practice and to determine the priorities for future service delivery.

Evidence from this study confirmed that clients placed great value on the communication skills of the therapist. Their perception was that the way information was communicated was more important than the technical information shared. The importance of communication to clients was that it had to be at the right level so that they could understand the information shared, the explanations given and the words used. They valued the way they were treated, being spoken to with respect, and being treated as an equal, even if communication (speech) difficulties made that difficult considering that respect was demonstrated by the way the therapist communicated with them.

Another important aspect which the clients valued was having choice in determining their care. They considered their strength was in knowing their own mind, understanding their own issues and needs, and being clear about them. Whilst there was no mention by clients of goals or objectives nor of a perceived process of negotiation to determine the focus of intervention, they considered that they had the ability to make independent decisions with regard to their care and valued being involved in the decision making process, making choices about the support they needed. The findings also suggest that the environment was important to the client, with the confidence they experienced in this setting giving them a sense of power in their own care.

Differences in perspective:

When reflecting on the findings from the studies and exploring the links and differences between each, it was apparent that client-centred practice in occupational therapy was important to both the therapist and the client, but was perceived and experienced in different ways. These key messages about the differences in perspective have implications for practice with indications for the training and skill building of therapists. Reflected in the findings of all the studies were the common values which clients and therapists believed should underpin therapy. These resonate with the core elements of client-centred practice, identified in the literature by key authors in the field, (Rogers 1951; Law 1998; Sumsion 2000 for example), which reinforce the value of this approach in occupational therapy practice. By understanding the similarities and the differences in perceptions about how client-centred practice is experienced and how the findings relate to evidence from the literature, we can determine whether this approach is an aspiration or a reality and identify what learning needs are required to make it a reality.

At an individual level, the findings reveal an interesting juxtaposition of the key themes of engagement, goals and understanding. Both clients and therapists identified these three issues as important elements of client-centred practice, although expressed in subtly different ways. For example the therapists considered having the same goals as the client was important, however whilst the clients referred to 'goals' as problems or concerns, they were unclear how to agree joint goals with the therapist which met their needs. Similarly therapists valued engaging the client in the OT process, and although the clients wanted to be engaged, they perceived that they were less involved in their own care than the therapists believed

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them to be. Likewise therapists placed greater importance on the process of establishing a relationship with the client in order to gain an understanding of their needs, whereas the perception of the client was they needed the therapist to understand the issues and circumstances from the clients' point of view.

The nature of relationship with the client provided further evidence of the differences in perception which characterise how this approach is experienced. Whilst there was a consistent element across all the studies and was referred to in study one and two, and by the therapists in study three, as a **partnership**, it was not a term recognised or used by the clients, despite the nature of their relationship with the therapist being valued.

Partnership

The Department of Health describes partnership between a healthcare professional and the patient, as the process whereby the patient and the professional meet as equals, each with different expertise, and that it should be adopted as an imperative by healthcare professionals in all parts of the NHS (Coulter & Collins 2011). Partnership is a key element in all the descriptions and definitions of client-centred practice in the literature (Law et al 1995; Sumsion 2000a) and could be considered as the 'glue' which connects the therapist with the client in the client-centred relationship. Partnership in this context is a relationship between individuals characterised by mutual cooperation and responsibility in the achievement of a goal (dictionary.com), with listening and communication being important elements (Sumsion & Law 2006). Sumsion & Law (2006) confirmed the key component of partnership closely reflected a central element in Rogers' work, namely the

understanding achieved through taking in another's experiences. Other authors identified that partnership included flexibility, recognising that the relationship can change, and a sense of equality where the therapist facilitates intervention and the client determines the actions needed, based on access to full information (Banks, et al 1997; Kjellberg et al 2012). Sumsion & Law (2000) confirmed the importance of an effective partnership based on communication using appropriate language emphasising that the skill of listening can help address issues of power and client choice in interventions.

Within the wider political context this study reflects the progress of some national initiatives developed following several significant incidents of poor care involving lack of respect in the care and treatment of people receiving health and social services (Coulter 2002). Current drivers in the NHS, the Commission for Improving Dignity in Care for Older People (2012) for example, advise that engaging with patients and the public strengthens accountability and helps NHS bodies develop a relationship of trust and confidence with their local communities, improving both the quality of care and health outcomes (NHS Confederation 2012). The government's ambition is to achieve healthcare outcomes that are among the best in the world, "this can only be realised by involving patients fully in their own care, with decisions made in partnership with clinicians, rather than by clinicians alone" (DH 2010a p.13). Another initiative designed to achieve this has been the establishment of HealthWatch England a national organisation that enables the collective views of the people who use the NHS and social care services to influence national policy (DH2010a). By acting as the new consumer champion for health and social care in England, it aims to ensure that people are at the centre of care, giving them more choice and control,

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providing easy access to the information they need, and placing them in charge of making decisions about their care. Furthermore, despite what may appear to be political rhetoric there is a focus on delivering quality and outcomes which matter to people, and that shared decision-making will become the norm. For example: 'no decision about me without me' and the provision of personalised care that reflects individuals' health and care needs, supporting carers and encouraging strong joint arrangements and local partnerships. Recently the community health partnerships have been developed to serve the needs of the local community contributing towards improving people's health and well being (DH 2013b).

The Dignity in Care campaign in 2006 was launched to focus on raising dignity in the hearts, minds and actions of service providers, changing the culture of care services and placing a greater emphasis on improving the quality of care and the experience of people using services including NHS hospitals, community services, care homes and home support services (Social Care Institute for Excellence accessed 19.7.12). This resulted in the 10 point Dignity Challenge which described how high quality services should respect people's dignity and have a zero tolerance policy with regard to all forms of abuse. It also included advice that services should support people with the same respect each individual would want for themselves or their family member, that people are treated as an individual by being offered a personalised service, and that people are enabled to maintain the maximum possible level of independence, choice and control. This has been recently enhanced by the introduction of Compassion in Practice, a strategy aimed at building a culture of care in the nursing profession (DH 2012) and the 'Friends and family test' a government initiative aimed to show hospitals what patients and staff care about most, which will be used to

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trigger improvements in services and performance and raise the standards of care in the NHS (DH 2013a). Also listening and supporting people to express their needs and assisting them to maintain confidence and positive self-esteem form part of these initiatives which resonates with the core elements of client-centred practice. The ability to deliver all this is however affected by the constraints placed on services by workload pressures, staffing levels and the requirement to deliver against performance targets. Despite these constraints, partnership is central to the realisation of all of these aspirations relating to dignity, respect and equality.

The prominence of the term partnership as used by the therapists was evident in study 3, (therapists valuing working in partnership with clients), study 2 (questionnaire -identified it as one of the most important aspects of client-centred practice) and in the conclusions drawn from the systematic review in study 1(use of the COPM supported partnership). Therapists reported the most rewarding and influential aspects of client-centred practice were listening to clients, respecting their values, and working with them to achieve their goals. However further examination of the evidence from the findings of study 2 identified that establishing a relationship with the client was seen as a difficult and challenging aspect of client- centred practice, which may explain the limited reference to partnership by therapists in the focus group element of Study 2 and by clients in the client interview data (Study 3). Analysis of the focus group data however, revealed that other words were used which are reflective of partnership for example, 'engaging with a client by communication and showing respect'. The lack of reference to partnership by clients is more likely to reflect their lack of understanding or awareness of this term.

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Gage (2006) suggests that synergy in healthcare relationships is achieved where power is shared by creating a partnership approach to care. Evidence from the focus group (study 2) and the interviews (study 3) support engaging the client in a partnership by their active involvement and cooperation thus building a relationship with them. Sumsion & Smyth (2000) reinforced the need for mutual cooperation and understanding in order to prevent barriers to client-centred practice by linking successful partnership with joint goal setting, suggesting that balancing the power between client and therapist was vital as an imbalance of power impeded the development of partnership.

The issue of power in occupational therapy has gained a lot of attention and attracted considerable debate of late (Gage 2006; Sumsion & Law 2006; Sumsion 2006; Falardeau & Durand 2002), however this was not reflected in the data. Is power tangible and explicit or is it purely a perception or impression held by both client and therapist? Wilkins et al (2001) suggest that power issues are often difficult to recognise whilst Sumsion (2004) suggests that clients feel therapists, like other healthcare professionals, hold considerable power. It may be that the question of power is inescapable as all professional relationships involve an element of power therefore therapists working in a client-centred manner, need to appreciate how to maintain this balance by working in partnership with their clients (Falardeau & Durand 2002). Sumsion defines partnership as empowering the client to engage in functional performance to fulfil their occupational roles (Sumsion 2000a), rather than using the word power. Examination of both these terms – power (noun) and empower (verb) - casts some light on our understanding of what it might mean in practice. Power concerns the ability to do or act in a particular way, having rights, authority or

control over others, whilst adding the prefix 'em' to the noun, changes the focus to that of giving authority or control to someone, making them stronger or more confident (COED 2005).

In a recent critical reflection on client-centred practice, Hammell (2013) acknowledged that some clinicians are engaged in genuine attempts to realign power and ensure that their interventions are relevant to clients' priorities and needs. However the focus group data revealed that therapists believed the influence of the environment on the client's behaviour and the perception by therapists of its power and influence, presented challenges when trying to adopt a client-centred approach, particularly in the community setting. The power of the environment has attracted little attention in the literature but was reported to be a genuine concern by the therapists. The power exerted by the therapist who has the professional and clinical knowledge, was easier to demonstrate when in a hospital. The therapists' perspective was that the hospital was considered a "*more controlled environment for the professional who is in a more powerful situation".* This could be because in the hospital the professional holds more information about a client's condition and prognosis, and the way in which services operate; also the client may be preoccupied with getting better and may appreciate others taking control over what happens to them. The importance of the environment is supported by the data which indicated therapists perceived the clients to have more power and control when being cared for in their own home. This may be related to the client's familiarity with their environment rather than knowledge of their own circumstances.

Perhaps the answer then is less about power and more about making the effort to achieve a balance wherever the therapeutic encounter takes place and having the
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skills necessary to develop a partnership with a client to achieve satisfactory outcomes. Wressle & Samuelsson (2004) and Kjellberg et al (2012) suggest that therapists' power lies in their ability to guide and help the client, not in controlling them. After all if a client-centred partnership is to be achieved, it is important to recognise each other's knowledge, listen to the needs expressed, explore and agree goals or focus of intervention in order to attain satisfactory outcomes. The therapist needs to acknowledge that power differentials may exist in the relationship with a client but these can be addressed by becoming more skilled in negotiation and collaboration (Wilkins et al 2001).

Attitude and behaviour:

The extent to which the attitude and behaviour of both the therapist and the client influenced the establishment of a client-centred relationship can be seen in the findings of studies 2 and 3. It was evident that establishing an understanding between client and therapist was crucial to ensuring engagement of both in the therapeutic partnership. There was evidence that the clients had a strong sense of their own needs, that they had knowledge and experiences which were of value to the therapist, and were very clear about their support needs. The perception of the clients of their relationship with the therapist was influenced by their experience of how they were treated. Clients valued being treated as equals and regarded the attitude and the behaviour of the therapist to be as important as their technical expertise. They felt being spoken to with respect, given information in words they understood, and being supported to make decisions about their care was important. Similarly the attitude of the therapist was to use his/her technical knowledge and the resources available to them to support the client, demonstrating behaviour supportive

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of partnership. However concerns about the lack of skills and confidence in building a relationship with clients in order to engage with them indicates that greater emphasis is needed on learning how to communicate effectively with clients.

The attitude of clients and therapists to managing risk was also an important reflection of their relationship indicating different perspectives. Evidence of some disparity in goal setting had highlighted concerns about risks to therapists in study 2 especially where a client's course of action raised issues of safety. However evidence in study 3 showed clients were pragmatic and acknowledged risks as a reality in their daily lives. The difference in perspective concerned the identification and explanation of risk which clients considered as poor, whereas therapists reported that they devoted considerable time and energy to explaining issues of risk to clients. Evidence from the focus group study confirmed that the issue of risks and risk taking was linked with the type of information shared with the client (instruction or explanation) and how that information was communicated to the client.

Despite professional guidance on risk management provided by COT (COT 2010b) which explains principles of practice rather than delivering specific training and tools of assessment, the exploration and management of clinical risk does not feature prominently in the literature apart from some discussion of its practical challenges (Parker 2006), however this remains a key concern for therapists and a factor which influences their practice. Those practical issues - client attitude to and inability to identify risks which may affect them and the clients' need for insight and cognition in order for them to appreciate risk factors which were raised with them - were identified as one of the most difficult aspects of client-centred practice by therapists (study 2). Communication was crucial as therapists also noted the need to have appropriate

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information about risks in order to share and negotiate with clients enabling them to make informed choices about future actions of remediation or management. There was no evidence that a formal process of risk assessment was undertaken, apart from its inclusion in the general assessment process carried out by the therapist. However the focus group data indicated that risk ownership was one means of achieving safety and a balance in risk management. Moats (2007) in a study on discharge decision making with older people, recommended that negotiated decision-making processes can be a client-centred solution where issues of risk and safety need to be balanced.

An interesting contrast with the literature was identified by therapists in the focus group who considered that if they were to over-rule a client's views where there was evidence of risk, then this action would dis-empower clients. Sumsion (2006) recognises this dilemma and suggests that a client has a right to make their own decisions about their plans if they understand the risks. Therefore if a therapist provides them with accurate information on which to base this decision then clients have the right to make their decision which in turn can be interpreted as an empowering process rather than a disempowering one. The issue of joint goal setting and risk assessment takes the discussion back to the skills of communication and negotiation, sharing of information between client and therapist, documenting decisions, and gaining managerial support for actions taken.

Skills:

Skills in communication and the ability to share information in a manner which is understandable to the client was recognised as fundamental in all the studies as a key underpinning of client-centred practice and was valued by clients as part of

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understanding and being understood by the therapist. In study 1 specific skills in communication and the use of language were identified as crucial to delivering client-centred practice, whilst in study 2 this was expressed as having the necessary skills and confidence to engage the client and share information about risks and safety issues with them. In addition the findings from studies one and two identify the need for training in the theoretical knowledge and practical skills underpinning client-centred practice and the use of outcome measures such as the COPM.

One of the challenges of client-centred practice was for therapists to have confidence in the skills defining client-focused goals with the client in order to shape and direct intervention. Goal setting in OT provides the focus for intervention, the structure for applying time and allocating resources, and the benchmark against which outcomes of intervention can be evaluated .The literature suggests that discord in goal setting, where the client and the therapist have different goals when determining intervention, is a barrier to client-centred practice (Corring 1999; Sumsion & Smyth 2000; Wressle & Samuelsson 2004). Whilst there was no evidence of disagreement about goal setting in the interview data, different terms were used to describe what drove the focus of intervention. Clients referred to needs and problems, and therapists talked of goals. The potential for dissonance between client and therapist was increased if the specifics of the needs and goals were different. For example conflict was noted in the evidence from the systematic review and the survey data about goal setting, which arose from the external pressures of family agenda or organisational politics influencing the ability of the therapist to focus on clients' needs.

Corring (1999) suggested that differences in goal setting centred on the priorities of treatment goals and the words used to define rehabilitation or 'getting better'. In the
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present research the issue of language and the words used to explain key aspects of intervention was raised by clients as an illustration of them being treated as an equal. The language used in goal setting was clear to the therapist as a process of identifying the potential outcomes of intervention achieved through specific goals and objectives. For the client, this language was unfamiliar and their needs were not articulated by the therapist to them as goals. Evidence from the focus group indicated that therapists did link the term goal with a client's expectations but there was limited confirmation from either the focus group or the interview data that therapists took part in active goal negotiation and goal setting with clients. What was found in the results of the systematic review was that clients need to have insight and cognition to support their reasoning when identifying their needs in the goal setting process.

Sumsion and Smyth (2000) concluded that the barriers to client-centred practice which related to goal setting, included having different goals and the difficulties involved in letting the client choose their own goals. Therapists may assume that the clients' goals and their own are the same when they may not be (Law et al 1994), and the present research found that using a client-centred outcomes measure supported client-focussed goal setting. Colquhoun et al (2012) examined the administration of the COPM and its association with changes in practice during the OT process and found that the COPM had an impact on the relationship between goal setting and intervention. They also discovered that building rapport with a client could help in the complex process of identifying occupational performance issues. Through the medium of the COPM the therapist and the client can share a common language where performance issues are identified and recorded using the clients' own words which helps ensure client-centred goal setting occurs (Cott 2004). It could

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be argued that by not working with the client's needs, the client may not understand or be motivated to take part in any intervention as they cannot see its value. This was endorsed by Parks (2009) who considered the greatest challenge was ensuring goals reflect the occupational changes sought by clients rather than the simple interventions prescribed by therapists during the process of therapy. The data from this research reflects others' findings (Falardeau and Durand 2002) that therapists need to communicate with clients by discussing their priorities with them and listening to their needs in order to negotiate jointly agreed goals of intervention. Careful use of language when discussing those needs, using the words expressed by the client, will ensure that clients and therapists understand each other. The common themes in the goal setting debate are language and communication. The words used to describe goals are, in effect, a means of identifying the focus of occupational therapy intervention.

The use and understanding of language is an important skill of communication, identifying and understanding risks, agreeing and setting goals and in the context of client-centred practice is central to building a relationship with the client. At a professional level there is no specific guidance from the COT on how to develop client-centred information, although some has been developed by other bodies, The Picker Institute for example. Although their study is dated and the guidance directed at specific medical conditions, Coulter et al (2006) advised that good quality health information is essential for greater patient involvement in healthcare, the quality of patient information materials needs to be improved, it should be up to date and accurate and all technical terms should be explained so that information can promote shared decision-making. The application of client-centred practice requires that the

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language used by therapists is understood by clients such that different ways of explaining terms are employed to support client understanding (Sumsion 2006). Therapists' need to consider how they can translate professional language into a form more accessible to clients (Parker 2006), for example meeting a client for the first time could be approached by saying, 'your doctor asked me to assess you' (non client-centred version) or 'can we talk about how I may support you if you have any concerns or problems I can help with' (client-centred version).

Whilst challenges have been noted in the literature (Sumsion & Law 2006; Wressle & Samuelsson 2004; Sumsion & Smyth 2000; Kjellberg et al 2012) with differences in goal setting and therapists' lack of knowledge about client-centred practice highlighted as being of particular concern, this research found that skills and knowledge acquisition (systematic review, the focus group), was a means of improving client-centred partnerships and therapists' confidence in client-centred practice (Sumsion 2006) and addressing how this can be achieved is important as it has implications for practice.

Limitations of the research:

Reflecting on the progress and outcomes of this research it is appropriate to consider its limitations in order to learn from this experience.

Firstly the design of the research could have been approached from a different perspective based on an alternate philosophical framework, however as this research was intended to contribute to the knowledge base of occupational therapy, an approach consistent with that knowledge base was adopted. Duncan (2011) explains how a number of philosophies have shaped occupational therapy

throughout its history and have moulded the profession through its paradigmatic

shifts resulting in the practice we have today. He argues that it would be erroneous to

seek one theoretical foundation for the profession as the eclectic historical influences

have encouraged the development of a wide theoretical basis and encourage

continuing debate which further our understanding of the impact of occupation on

health and well being (Duncan 2011). This study, by basing its theoretical framework

around occupation is consistent with the historical eclectic approach to knowledge

development within the profession.

An ethnographic study could have been undertaken which would have immersed the

researcher in the subject and culture of client-centred practice. This could have

included some 'in the field' observational analysis of client –centred practice by

carrying out observations of assessments and interventions between therapists and

clients. As ethnography is the description and interpretation of cultural patterns,

adopting this design would have enabled me to determine how client-centred practice

was carried out in practice (Streubert et al 2003). However whilst this method may

have provided a lot of fieldwork data about the human experience of this approach, it

would also have presented me with considerable ethical and resource pressures

which would have been difficult to resolve within the timeframe for this research.

Locating a service where such a study could be carried out may have been an issue

if potential clients and therapists were unwilling or unable to take part in the research,

as well as organising time away from employment commitments. The other

consideration is that an ethnographic design may have limited my ability to address

the range of different questions and strands of enquiry I wanted to explore in this

research, in particular where questions developed out of one study and influenced

the design of the next. It may not have been possible in an ethnographic design to incorporate the multiple facets of therapist, client and the outcomes measure as prominent topics, as this may have influenced the selection of the study location. Also the scope of an ethnographic study may have meant that data would be limited to one OT environment rather than, as in the mixed method design, being able to widen the scope and gather data from an international and the wider professional perspective thus potentially being able to generalise the results to determine implications for the profession.

One limitation of the systemic review was that the final review of the literature was undertaken by a single reviewer, this occurred because the review was carried out over a period of time and consequently the second reviewer had left the area. However this was compensated for by adopting a rigorous process of review, using objective recognised methods of selection and filtering, for example the Critical Appraisal Skills Programme (CASP) (PHRU 2006) and processes from the Centre for Reviews and Dissemination (CRD 2009). The systematic review comprised a mixed range of studies of qualitative and quantitative research which may have resulted in limited consistency and synthesis of results. However it provided an objective review of the range of studies undertaken, which examined the COPM in clinical practice and reflected a realistic appraisal of the types and scope of research undertaken in occupational therapy. It also provided the means of determining the quality of research and reports across qualitative and quantitative methodologies providing the clinician with a broader perspective of application of the COPM in clinical practice.

There were some limitations in the survey method which were noted earlier (p216). The size of the focus group was large and was a one off event rather than a series of

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group meetings. However a one off group can be useful in focus group research as the purpose is to obtain members' opinions about the phenomenon of interest as generated by the research question, rather than by a large number of one to one interviews (Holloway & Wheeler 2002) which was appropriate in this case. Even though the group was large it was manageable and the participants were keen to contribute. The return rate on the questionnaire was poor and may have affected the results. Alternate means of circulating the questionnaires could have been considered using postal or electronic mail circulation to specific named therapists rather than relying on the heads of service to distribute them amongst their staff cohort. This would have generated other problems as individual names would have had to be accessed in order to send personal questionnaires to named therapists; this may have been intrusive and difficult to obtain.

Having considered the findings from the interviews, it could be argued that the main limitation was the small sample. Whilst the sample size was small (four in each of the client and therapist sample as opposed to six identified in the original proposal), it was never the intention to explore the views of large numbers of individuals and create large amounts of data. The aim was always to explore the individual perspective in depth and in a qualitative study the emphasis is on small samples of people, based in their context and studied in depth rather than producing quantity (Miles & Huberman 1994). Sampling in a qualitative methodology such as this, is set by the boundaries of the criteria which defined the clients and the therapists studied within the limits of time and resources, and is well suited to researching the complexities and richness of occupational therapy (Ballinger 2004). Feedback which was informally communicated to the researcher gave some explanation why it was

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not possible in the time frame to complete any further interviews. Some clients did not want to be interviewed and recorded, seeing this as invasive and a 'breach of human rights' whilst others declined due to a change in health. The active case register for the occupational therapy service provided a good resource for identifying participants; however feedback from clients who had been approached but who then declined to take part, accounted for a large number of those who originally met the inclusion criteria. Another consideration was that of interview fatigue, many clients were known to their GP, the district nurse and the occupational therapist and the effort of having another person visit to interview them may have been a deciding factor for some to decline. The number of therapists was dictated by those in the team at the time of the study, and it was not considered appropriate in this study to seek others beyond this team. However it is the detail and quality of the data provided by both the client and the therapist sample aimed at getting to the heart of what their perspective is of client-centred practice which has contributed towards the conclusions of this study.

Practice implications:

Carrying out research is all very well but has little impact on the individual or professional development unless the results are interpreted for their impact and implications for practice. To support evidence-based practice, therapists are encouraged to become more involved in research and to investigate aspects of practice which may influence and improve patient care (Conneeley 2002). This study explored client-centred practice, an approach familiar to and applied by therapists in accordance with their code of conduct and practice standards. Part of that exploration was to determine what this approach meant to the individual, how it was

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practiced and experienced from the personal perspective. It seems only appropriate that in a client-centred relationship where the client is at the centre of intervention, there is a requirement to explore their views and experiences. Their voice has attracted limited attention in understanding the impact of this approach on occupational therapy practice. The following issues have been identified as having key implications for practice.

Knowledge and Training:

A recurring theme is that training is required for therapists in the theoretical models and frameworks which underpin client-centred practice. The findings from the systematic review and the questionnaire indicated that training was essential for respondents to improve their understanding of client-centred practice, use of the COPM and the client-centred models, for example the Canadian Model of Occupational Performance (CMOP). Whilst client-centred practice is one of the core elements in curriculum design (COT 2009b), there does not appear to be a structured framework for teaching this as a core element in degree courses.

Models of practice and frames of reference are usually taught in undergraduate education as integrated elements in the foundations of practice modules, however as therapists have identified that further training is needed in the application of these models within practice settings, then it raises concerns that potential gaps in the application of theory to practice could be addressed by a more structured approach. Fieldwork education, where undergraduates get the opportunity to experience clinical practice, is an opportunity for students to apply theoretical frameworks in practice. However the knowledge gap lies in the clinical departments, as the majority of

respondents in this research were qualified practicing therapists and identified the need for further training. The application of theoretical models and frameworks needs to become part of the service and individual responsibility for continuing professional development. Reinforcing the theory / practice links can be addressed by each occupational therapy service identifying which model of practice their service applies and to make that specific in service documentation. This has been demonstrated by Boniface et al (2008) who describe the process of embedding the theoretical principles of the CMOP and its structures so that staff were able to use them as part of an integrated service in the UK.

The same applies to outcome measures such as the COPM, which are also less likely to be part of pre registration training and are more likely to be offered as the subject of a post graduate study day. Setting up the COPM Network was one solution to providing support for therapists wanting to use this outcomes measure. Findings from all the studies indicate the value of the COPM as an outcomes measure for client-centred practice however, the use of outcome measures continues to be a challenge for therapists (Corr & Siddons 2005: Bowman 2006) resolved by training and education in their use and application (Cook, McCluskey and Bowman 2007). This could be addressed by specific post graduate training in the use of outcome measures, adoption of measures in each service and practical methods of recording data so that outcomes can be used as learning tools for service development or change.

Skills:

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Evidence from the studies identified that therapists had concerns about their skills in client-centred practice, particularly with regard to communication, the challenge of establishing a relationship with the client, and confidence in being client-centred. This ability to meet and greet a client, listen to their concerns, talk with them in words they understand and negotiate the focus of intervention requires the skills of interviewing. If interview skills are poor then the relationship with the client will be affected and partnership difficult to establish. As working in partnership is such an important part of client-centred practice, then the skills of how to interview need to reviewed, reflected on and practiced to improve therapist skill and confidence and ultimately enhance this relationship.

The ability to communicate was also evident in the issue of risks. Evidence from the individual perspective indicates that little communication took place with regard to identifying risks, risk assessment and negotiation. This is an important aspect of practice and requires developing confidence in communication skills (Parker 2006). Most training on risk assessment follows the health and safety model of hazard recognition and control management as a means to mitigate against the risk. This approach can be applied to practice, but must be accompanied by skilled discussion and negotiation between the therapist and client and supported by specific guidance on assessment processes. If the therapist has provided all the necessary information to ensure the client understands the risks of their decision then the client has the right to make a seemingly unsafe choice (Clemens et al 1994). However training and support for therapists should be carried out in the department to ensure clinical risk assessment is carried out using a structured tool for guidance and that interviewing

skills are deployed to ensure effective communication takes place. This can be reinforced by means of case study reflections explored in team meetings.   Language:

Guidance about the language of client-centred practice has received little attention but has implications for practice as the type of words used and how they are expressed are important. All professions have their own technical language and codes which are used in communication with peers and colleagues, however if clients are at the centre of intervention, then the language used when working with clients as partners in client-centred practice should reflect that approach and be understandable. The clients value being listened to and treated as equals therefore to respect them requires that communication with them is conducted on the basis of them being 'equals', and therapists speaking to them in words they understand. This respect for clients should extend to the information shared in paper and electronic formats with any documentation produced for clients written in a manner that is easy to understand. Organisations which advocate the screening by service users of all written documentation for clients should be applauded and followed as this supports greater equality in the therapeutic relationship and enhances the quality of information sharing. For occupational therapy practice this should extend to determining the intervention plan, not in terms of goal setting, but based on the development of I would suggest, Client Identified Problems (CIP) or the three Is – Individual Identified Issues- to ensure intervention truly reflects the client's needs. Based on the analysis of this data it is proposed that instead of writing goals, client issues, concerns or problems are written using the words expressed by the clients. If this approach is supported by using the COPM, it will reinforce client-centred

intervention planning as well as client- centred outcomes in creating the likelihood of patient satisfaction and quality of care.

Partnership:

Evidence from this research demonstrates that partnership with the client is the key ingredient in being a client-centred therapist confirming guidance in the literature (Sumsion 2006). Considering the time that has passed since Sumsion defined client-centred practice in 2000, emphasising partnership, it appears this concept still requires attention. The most important factors about client-centred practice found in this research were respect and being valued as an equal, with the therapists' attitude and behaviour of paramount importance to the client - in other words it mattered how they were treated. Therapists should note that to achieve a partnership with the client they should acknowledge the individual contribution each makes to the relationship. This is the process of achieving a partnership; respect the values, recognise the knowledge, skills and hopes which the client has of their own circumstances which should be complemented by the therapists' technical knowledge and access to resources and information. With any partnership the balance can shift in response to external pressures (time, facilities, family, carers), change in health (affecting the ability to make informed decisions) and assimilation of knowledge. The focus should remain on the relationship between therapist and client being maintained and called a partnership, which is at the heart of client-centred practice.

Personal reflections:

When I started this research, it was with the intention of exploring the reality of client-centred practice in occupational therapy, to understand what therapists' knew about

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it, how they practiced it and what impact it had on our clients, such that by applying this approach in daily practice would make a difference. The reality of planning, developing questions, formulating a research design, carrying out the various elements of that design, then analysing the results over a long time period has been a challenging but positive journey of discovery. The length of time of the whole research process has proved beneficial as studies suggest that greater time for reflection allows a deeper level of learning to occur (Boniface et al 2012). Self reflection about this journey raises questions about what motivated me to ask the question in the first place, what I would have done differently, and what do I feel about the process.

Models of reflection provide structure to the process and focus on the experience of the learner, the specific learning which takes place and the reflective activities needed to extract the learning from the experience (Boud, Keogh & Walker 1985). It involves learning from actions we have taken and may involve critical review, self development or personal empowerment (Moon 2004).It is a valuable process in self understanding and is recommended as a means of developing one's practice (Duggan 2005) and is an important human activity in which people recapture their experience, think about it, mull it over and evaluate it (Boud, Keogh & Walker 1985) . Boniface (2002) recommends that reflection is recognised as a circular process which, can be a taught but relies on an individual's basic ability and a safe but challenging environment for it to be practiced successfully.

For my own learning, I have reflected on what I would have done differently and have concluded that I would still ask the same questions about knowing whether we are client centred and what it involves. My approach to the research would remain a
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qualitative one as that approach best suited the question to be answered. I recognise the skills involved in starting with core questions and exploring avenues of enquiry by building ideas. My reflections have taught me that I would have approached the construction of the survey differently had I had greater confidence in understanding and managing data. Although the long time period of this research could be interpreted as a disadvantage, it provided an opportunity for personal growth, gaining academic knowledge and the ability to learn from each aspect of the research before progressing to the next phase. This meant that the whole journey of the research became self motivating and an empowering process of discovery. My research journey has confirmed my belief in the value of client-centred practice and reinforced the importance of skilling therapists to work in true equal partnership with their clients. I am inspired to share this knowledge with the wider professional community to ensure that the voice of our clients and that of the individual therapist is reflected in discussions about direction of future healthcare.

Conclusion:

When client-centred practice was first articulated in relation to occupational therapy, by Law et al (1995) they reflected that one of the most important points Carl Rogers had made about client-centred practice, was the importance of the skill of listening and the quality of the therapist- client interaction. Sumsion (2000) developed this by defining it as a partnership between the therapist and the client which empowers the client to engage in functional performance in the fulfilment of their life roles. The research reported here explored the impact of client-centred practice in occupational therapy, in particular the individual perspective of this approach in order to understand what implications there may be for practice.

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Therapists acknowledged that this approach was a challenge, not least in establishing a relationship with the client but recognised the importance of showing respect for the client and their values working in partnership with them to achieve their goals. For the client the important issues were the attitude and behaviour of the therapist in showing respect and being valued as an equal person in the relationship. The key aspect of client-centred practice which has implications for practice is one of practice by partnership; achieving this balance needs the skills of interviewing, communication, use of language, information sharing and risk assessment to develop intervention which focuses on a client's needs and is measured using a client-centred outcomes measure to enhance quality of care and life satisfaction.

CHAPTER 9

CONCLUSION

"Coming together is a beginning; keeping together is progress;

working together is success."

- Henry Ford (n.d.)

Introduction:

I started this research wanting to know whether it mattered that occupational therapists practiced according to the principles of client- centred practice. This approach has influenced occupational therapy for the last two decades and yet concerns persist about its challenges, the barriers it presents in practice (Sumsion & Smyth 2000: Wressle & Samuelsson 2004; Wilkins et al 2001) and the role the client has in its implementation (Corring 1999). As a service manager for many years I have witnessed the disconnection of occupational therapists from the philosophy of client-centred practice. I have investigated complaints by patients about poor communication and lack of involvement in care which have been exacerbated by resource limitations placed on therapists when trying to meet the needs of clients within a health service increasingly driven by performance targets and constrained by financial restrictions (Kjellberg et al 2012; Health Development Agency 2004). I have also observed poorly defined pathways of care where the link between theory and practice is weak, a serious concern for a profession committed to client-centred practice. To an extent all of these 'problems' are a consequence of the disconnection between the client and therapist.

Therapists need to set aside their view of themselves as the 'expert' and replace it with a focus on understanding the client's perspective of their illness or disability in order to facilitate the client in the achievement of occupations in an environment of their choice. Occupational therapists should abandon practice elements that have their roots in the medical model and target intervention and practice on what the client 'wants and needs to do' rather than on what current practice suggests they 'should do'. There have been many learned publications explaining, describing, challenging and providing examples of the clinical application of this approach in practice (Rebeiro 2000; Wilkins et al 2001; Corring & Cook 1999; Restall & Ripat 2008; Sumsion & Law 2006; Sumsion & Smyth 2000; Hammell 2007b), therefore it is time that client-centred practice became an accepted part of practice and subsumed into everyday service planning and delivery of care.

However any approach of this nature requires the cooperation of those involved, and in the case of client-centred practice, the commitment of the therapist and the client, together with the support of managers and professional leaders. The rationale for this research required that the individual perspective was explored so that this view can inform occupational therapy practice and enhance the way we work with our clients in supporting their health and well being.

The conclusions drawn from this research provide answers to the research question, 'What are clients' and the therapists' perceptions of client-centred practice in occupational therapy in the UK?'. This chapter concludes the exploration of client-centred practice from an international perspective, exploring the clinical application of the client-centred outcomes measure (the COPM), a survey of therapists' views, and an examination of the individual experiences of clients and therapists to highlight

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implications for practice and to suggest areas for future research. The results of all the component studies in this research have been discussed in detail in chapters 4, 5, 6 and 7 but are summarised here as a basis for making recommendations for clinical practice.

Client-centred practice

The Core elements of client-centred practice (Partnership, respecting a client's needs, the importance of listening, engaging the client in functional performance and enabling clients to make informed decisions) as identified in the UK definition (Sumsion 2000a) were evident. Less evident however were reports of empowering the client and actively involving clients in goal negotiation.

- **Partnership:**

  This was apparent as a concept within the literature

  There was limited evidence of its relevance to therapists

  The term lacked meaning to clients

  A definition is needed.

- **Power:**

  o There was no evidence of conflict between the therapist and client

  o The challenge of power was to achieve and manage a balance in the relationship with a client

- **Goal setting and goal negotiation**

  o The process of discussion, negotiation and translation of clients needs into goals lacked clarity and was poorly articulated by therapists

  o Goal negotiation was enhanced by effective communication skills

- o Sharing information and risk management was enhanced by use of language understood by the client.

- o Goals should be described as 'Client Identified Problems (CIP's)

- **The COPM**

  - o It endorses client-centred practice, supports partnership and facilitates client focused joint goal setting

  - o It is applicable across a wide range of clinical fields and environments, it measures clinical change and enables clients to evaluate their performance and satisfaction with intervention

The Client:

Placed importance on:

- o Being valued, respected and treated as individuals.

- o Being treated as an equal in the partnership with the therapist.

- o The attitude and behaviour of the therapist

- o Communication and the words used to explain issues and concepts.

- o Knowing their own strengths and needs

- o Valuing the importance of having and make choices about their support nature of the intervention they received.

- There was limited evidence of active client involvement in shared goal (problem) identification and negotiation.

The Therapist:

Placed importance on:

- o The practice of client-centred practice.

- o Working in partnership with their clients, respecting and listening to them in understanding their needs

- o Valuing explanation and discussion to identify goals and enable clients to make choices

Challenges:

- o Establishing a relationship with the client

- o Building confidence in the skills of client-centred practice especially interviewing and engaging the client.

- o Developing and using client focused language

- o Being confident in the knowledge and understanding of theoretical models which support client-centred practice and the COPM

Recommendations:

The recommendations listed below, identified from this research are suggested as the means by which deficits in practice may be addressed which should enable occupational therapists to demonstrate client-centred practice with confidence.

Training

- Learning about the specific theoretical models which underpin the COPM is needed to ensure that theory relates to and is applied in practice.

- A module or component in the pre registration course curriculum should be designed to cover all aspects of client-centred practice. Inclusion of the philosophical framework, core elements, definition and application in daily practice together with the use of case studies for reflection and peer learning may provide consistency across pre registration programmes.

- Greater emphasis on the skills of effective interviewing should be adopted in clinical practice using technology to provide feedback on interview style, management of challenging situations and the use of language.

- Involvement of client trainers may enhance the potential for developing partnership and appreciating communication from a client's perspective.

- Clinical risk assessment could be included as a skill in clinical practice to improve identification, negotiation and resolution.

- Exploring how goals of intervention, expressed as Client Identified Problems, using words familiar to the client could be incorporated within service documentation to enhance the client- therapist interface.

Skills:

Communication skills and the use of language, both written and verbal in client specific language, should assume greater priority within services to ensure that client-centred practice is demonstrated to clients.

- Developing client-centred information should be adopted as a principle and organisations should support this process by utilising client reviewers to ensure currency of the language

- The skills of using the COPM could be developed by formal training which includes theory, practice and application of the measure. An online data analysis tool should be developed to standardise the results and enable quick and easy interpretation of the results to support service evaluation and development. The COPM should be developed such that it can be integrated into clinical documentation.

- A clearer definition of partnership is proposed which could be incorporated into training about client-centred practice.
  Partnership is;

  The relationship (association) between therapist and client as equals (partners) participating in agreed occupations (undertaking) with mutual recognition of risk.

- Routine use of outcome measures in practice to evaluate intervention and ensure client satisfaction. Results should be shared with clients to reinforce engagement in the care process

Future research:

The nature of occupational therapy practice is complex and the client-centred approach challenging, so if we are to enhance our understanding of how this approach benefits our clients, then it is recommended that further research is undertaken by professional service leads at a local level to examine their own service practice.

In addition, based on the findings from this research the following is recommended at a professional level:

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1. Adopt a profession specific definition of partnership in relation to client-centred practice. This should create greater consistency in practice and improve understanding of how to deliver client-centred practice through the relationship with the client.

2. Explore the notion of 'Practice in Partnership' as a mission statement for the profession which should reinforce the client-centred philosophy into everything occupational therapists do.

3. Develop software to provide an online tool to calculate and analyse data from the COPM. This would provide reinforce the use of outcome measures, in particular a client centred tool and provide therapists with the means by which outcomes data can be used effectively to enhance service delivery and practice.

The conclusions of this research confirm what McKinnon (2000) found, that clients who were listened to and had their views respected and valued the professional competence of the therapist, felt more satisfied with the service they received and the outcome of occupational therapy. Similarly Corring and Cook (1999) argued that asking, listening, and learning are extremely important components of effective client-centred care. However it is the quality of the client's interpersonal relationship with the therapist, the manner in which the therapist communicates with them, the inclusion and engagement of the client in deciding and agreeing on goals of intervention and the partnership with the therapist in evaluating the outcomes of intervention, which have emerged as the key issues in this research.

The reason for embarking on this journey of enquiry was to explore the evidence of client-centred OT in practice and to determine how it was perceived from various perspectives, particularly that of the client. We should take pride in the heritage of our
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profession and its roots in humanism and the Quaker movement (Reed & Sanderson (1999), learn from the teaching of Carl Rogers and the value placed on people's individuality and experiences (Law & Mills 1998), and embrace occupation as the core philosophical basis of the profession (Hinojosa et al 2003). We should also absorb the knowledge generated and the evidence provided by peers and colleagues in the field of occupational therapy about client-centred practice in order that we can move on and accept the client-centred approach as a given, regardless of whether it is an aspiration or a reality. Whichever path we choose, we should practice in partnership with our clients, treating them as equals in the process of improving the quality of their lives, increasing their health and well being and satisfaction with our services. Achieving this requires all occupational therapists to understand the theoretical basis for practice, to listen, learn and engage with our clients, to share risks and negotiate goals of intervention with them and to determine jointly the outcome of that intervention, using that information to inform practice and improve service delivery. If we can achieve all that and grow the next generation of therapists to be confident practitioners working in partnership with their clients, then we can truly say that client-centred occupational therapy is an approach which is valued by therapists and clients and be proud of the influence this has on our profession and applaud its integration into our practice.

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Appendix 1.2:
The Ottawa Charter for Health Promotion

First International Conference on Health Promotion
Ottawa, 21 November 1986 - WHO/HPR/HEP/95.1
The first International Conference on Health Promotion, meeting in Ottawa this 21st day of November 1986, hereby presents this CHARTER for action to achieve Health for All by the year 2000 and beyond.
This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialized countries, but took into account similar concerns in all other regions. It built on the progress made through the Declaration on Primary Health Care at Alma-Ata, the World Health Organization's Targets for Health for All document, and the recent debate at the World Health Assembly on intersectoral action for health.

Health Promotion
Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

Prerequisites for Health
The fundamental conditions and resources for health are:
_ peace,
_ shelter,
_ education,
_ food,
_ income,
_ a stable eco-system,
_ sustainable resources,
_ social justice, and equity.
Improvement in health requires a secure foundation in these basic prerequisites.

Advocate
Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

Enable
Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to

information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

Mediate
The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organization, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health
Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

Health Promotion Action Means:
Build Healthy Public Policy
Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.
Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

Create Supportive Environments
Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.
Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.
Systematic assessment of the health impact of a rapidly changing environment – particularly in areas of technology, work, energy production and urbanization - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

Strengthen Community Actions

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities - their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

Develop Personal Skills

Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

Reorient Health Services

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services which refocuses on the total needs of the individual as a whole person.

Moving into the Future

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

Commitment to Health Promotion
The participants in this Conference pledge:
_ to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
_ to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
_ to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
_ to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;
_ to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and, most importantly, with people themselves;
_ to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.
The Conference urges all concerned to join them in their commitment to a strong public health alliance.

Call for International Action
The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.
The Conference is firmly convinced that if people in all walks of life, non-governmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, Health For All by the year 2000 will become a reality.
CHARTER ADOPTED AT AN INTERNATIONAL CONFERENCE ON HEALTH PROMOTION*
The move towards a new public health, November 17-21, 1986 Ottawa, Ontario, Canada
* Co-sponsored by the Canadian Public Health Association, Health and Welfare Canada, and the World
Health Organization

Appendix 2.1 Literature Review: Client – centred practice

No:	Paper	Themes
1	Doble & Santha CJOT 2008	OT's can enable clients meet their needs of occupational well being. This can be done directly with clients or by influencing at organisational & environmental levels
2	Wressle & Samuelsson SJOT 2004	Barriers to CCP = therapist not knowing enough about CCP, different goals Solution = management & peer support for client-centred practice CCP takes time, commitment, education, training, interview skills, discussion with colleagues, reflection on own attitudes

3	Townsend, Langille & Ripley AJOT 2003	Professional tensions of CCP:
		    1. working at cross purposes with prevailing hierarchical structure
		    2. being celebrated but subordinated in medical & management hierarchy
		Professional reflection & dialogue
		Partnership with clients
		Work for institutional change or abandon CCP?

4	Moats CJOT 2007	Negotiated decision making Exclusion of clients despite therapists being client centred Competing issues of safety & autonomy Neglect of occupations Client defined models of decision making are insufficient for frail or cognitively impaired
5	Sumsion CJOT 2005	Opportunities & barriers to CCP Enable choice Participate in negotiating goals Overcoming fear & severity of illness Therapist response to client's illness Client knowledge of CCP
6	Law 1998 client centred OT	Respect & collaboration are key predictors of rehab outcome
7	Verkerk, Wolf, Louwers et al Clinical Rehab 2006	Problems identified by COPM are consistent enough for the identification of goals for OT & paediatric rehab based on client centred approach

8	Clemens, Wetle, Feltes et al Journal of aging & Health 1994	Differences between client centred theory & direct practice:
		    1. client wishes vs system constraints
		    2. keeping clients at home vs nursing care
		    3. CCP vs case manager's care plan = difference in goals
		    4. client self determination vs strategies of persuasion
		    5. informing client vs realities of practice

9	Corring 1996	Clients: deserve respect, being valued Being able to participate in decisions about their care
10	Cott Disability & Rehab	Client centred rehab is more than goal setting & decision making between clients & professionals.

Appendix 2.1 Literature Review: Client – centred practice

	2004	It's an approach to delivering services that reflects needs of clients. Includes shift from acute illness curative model to one acknowledging long term chronic nature of illness
11	Sumsion & Law CJOT 2006	= review of lit re CCP in healthcare Overarching theme of power, with important underpinning themes of listening, communicating, partnership, choice & hope
12	Fuller, Harvey 2004 Health & social care in the community	CCP approach valued because it was perceived that it enabled clients to better accept & deal with long term management of their condition
13	Christie & Cross 2003 BJ Therapy & Rehab	Adopting CCP in hospitals is a challenge & conflicts with medical model. Clients are removed from their familiar environment / context. Community reflects stronger ethos of ccp
14	Law, Baptiste & mills 1995 CJOT	Partnership, client involvement & empowerment = fundamental principles of CCP Autonomy, choice, responsibility, enablement, accessibility, respect for diversity Canadian definition: respect for & partnership with people receiving services. Benefits of client / therapist partnership
15	Corring 1999 OT Now	Client & professional opinions differ –esp. definition of goals CCP fits with OT especially respect for client, holistic care, clients as experts, value of client choice
16	Falardeau & Durand CJOT 2002	Respect, power & partnership = 3 core concepts of ccp. Suggestion made that negotiation is better term than partnership
17	Iwama 1999 OT Now	CCP should recognise culture & beliefs
18	Hebert, Thibeault, Landry CJOT 2000	Client experience & knowledge about occupations must be valued Clients are active partners Necessary to take risks to facilitate positive change Promotion of occupation
19	Hobson CJOT 1996	Being client centred with cognitively impaired is a challenge CCP not easy to operationalise
20	Larrson Lund OT International 2001	No consensus on meaning of participation Therapists need to be more aware of pts desire for participation & work in more individualised way. Need to give pts opportunity to exercise autonomy
21	Lewin, Skea 2004 Cochrane	Shared control Holistic consultation
22	Lum et al OT Now 2004	Need to speak same language OT needs to be aware of Cultural context of client

Appendix 2.1 Literature Review: Client – centred practice

		Challenge of diversity
23	McKee & Rivard CJOT 2004	Iterative collaboration & follow up achieve client identified objectives. Use of CMOP & Copm for intervention planning & outcomes
24	Pollock AJOT 1993	Use of COPM for client centred assessment Reinforces clients taking responsibility for own health
25	Restall, Ripat & Stern CJOT 2003	Barriers to CCP is a challenge to OT – framework suggested. CCP is multi dimensional & manifests itself differently with different clients & situations.
	Fearing 2000 Individuals in context – practical guide to ccp	Therapists can co create healthy & enabling environments with clients through presence, communication & presentation
26	Rebeiro CJOT 2000	CCP =challenge Activity, lack of choice & focus on illness diminished partnership with client Client should be seen as individual, given occupational choice, provided with accepting supportive environment
27	Rebeiro OT Now 2000	CCP should be an aspiration rather than a given reality because so many find it hard to implement in practice. Challenges are –listening to clients, allowing them to determine own goals
28	Sumsion 2000 OT Now	Challenge of being client centred in reality. Education about ccp in teams, raising alarm if clients views not listened to. Meeting clients goals. What strategies are there for removing barriers to CCP?
29	Stock 1999 OT Now	Ethical challenges to being client centred in a fee paying health service
30	Sumsion & Smyth CJOT 2000	Barrier which most prevented ccp = therapist & client having different goals Values, beliefs & attitudes of therapist can make ccp difficult to use Not enough time to be client centred Lack of knowledge/lack of desire to change to ccp/ reluctance to take risks/medical model opposed to CCP
31	Sumsion CJOT 1993	CCP is a challenge to clinical reasoning skills & is more challenging than making a decision for the client. Use a cc outcome measure like COPM
32	Tickle Degnen AJOT 2002	The partnership of CCP requires ongoing Communication process which involves the exchange of information
33	Townsend OT Now 1999	Key organisational barriers can prevent practice of cc peg accountability, decision making, risk management & outcomes are designed for medical care not client centred occupation focused intervention
34	Whalley Hammell CJOT 2007	Little evidence that philosophy of CCP has had any impact on OT research
35	Wilkins, Pollock, Rochon & Law CJOT 2001	3 key challenge areas to implementation of CCP – system, therapist & client **system:** – needs to be commitment from all levels of the organisation

		time constraints – ccp takes longer & organisational constraints policies & procedures limit ability OT practice CCP **therapist**: CCP = v familiar -it's always been done. Others less well defined CCP. power & partnership. Skills needed of negotiation, collaboration & consultation. Client: ideal is someone who is insightful, cognitively intact with good problem solving skills. CCP occurs along a continuum depending on ability of clients to take control of situations Services should be Respectful, supportive coordinated flexible & individualised
36	Toomey, Nicholson & Carswell CJOT 1995	Therapist should act as collaborators & teachers educating clients about therapeutic process & how they can take control of that process
37	Whalley Hammell BJOT 2007	OTs have failed to address the practical & ethical issues of being client centred and serving 2 masters - client and the organisation. In particular where OTs act as gamekeepers to services or resources
38	Clark, Scott & Krupa CJOT 1993	Involvement of consumer is central to core values of OT. This results in a relationship between client & therapist which supports client taking control & making choices – self determination
39	Clark, Goering & Tomlinson 1991 International association of psychosocial rehab	Encouraging clients to be active participants in own rehab gives them choices & empowers & supports them in taking risks
40	Carswell et al CJOT 2004	Use of COPM enables client centred practice
41	Donnelly & Carswell 2002 CJOT	Client centred nature of OT acknowledges the individual as central element of treatment. Strength of using COPM (cc outcomes measure) is its strong theoretical foundation within CMOP
42	Kjeken 2006 participation, involvement & functional assessment in RA (phd thesis)	Explains about models of decision making & distribution of power. Interactive model suggested as means of achieving shared knowledge. For patients to feel competent OT participate they need to know about diagnosis, medications & options
43	Townsend 1997 enabling occupation P54	Ethical responsibility to identify harm if clients' goals appear unsafe or put people at risk
44	Fearing & Clark 2000 individuals in context	Clients confidence & acceptance increase with successes in achieving goals. Therapist & client both have a voice in the OT process. In a strong Partnership each takes ownership which enhances each other
45	Ikiugu ch 16 Psychosocial conceptual models	Collaborative partnerships enable achievement of satisfactory performance in occupations of choice In guidelines on CMOP the OT enables & empowers client by managing the environment, minimising barriers, educates, rates performance, establishes goals to improve performance. CMOP is

Appendix 2.1 Literature Review: Client – centred practice

		consistent with current OT paradigm
46	Sumsion 2004 BJOT Pursuing the clients goals really paid off	CCP can only be achieved if OTs consciously engage clients in understanding their perspective, experiences & needs. Listen value & understand
47	Lim & Iwama ch 10 in Duncan 2006	Appreciation of client's perspective & priorities is essential to promote recovery & health & well being
48	Townsend & Wilcock 2004 CJOT	OT's values support clients active involvement.
49	Sumsion ch 1 in 2nd ed bk 2006	Daily work constraints mitigate against that – clash with organisational issues of budget/ resources. Balance needed enable engagement in productive partnership
50	Speechley et al 2003 Stewart et al 2003 Levestein et al 1986	Partnership needed between pt & professional – therapist has expert knowledge, pt has experience of disease Power sharing & self awareness must be considered to enhance the pt /Dr relationship. Also being realistic - time & resources Potential for different agendas – pt & Drs – reconciling these brings about integration & positive outcome All of these authors stress importance that each brings to relationship & strength of combining them. Client centred approach not simple

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_____

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Appendix 3.1

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Approval to carry out a research study

Appendix 4.1 METHODOLOGICAL EVALUATION – Example of analysis by PICO's data tool

Title Study date	Method: Study design, Type Sample size Clinical field Statistics & tests used	Particip ants: Clients views consider ed	Interventions: Positive issues Negative issues	Outcomes: Impact on practice Change initiatives	Notes:	Hierarch y of evidence
Validity & community utility of the COPM. McColl, Paterson et al 2000 CJOT	Cross sectional design Community – disabled adults Sample - 61 Multivariate analyses used which showed that construct validity was supported. Criterion validity supported	Recruited from wide community	Client satisfaction noted	Supports utility of COPM in community practice Age, gender or disability were not predictors of copm scores Interview process helps client to name & frame problems	Study addressed validity & community utility of copm using package of self administered measures including COPM.	QT 2 Cross sectional
Use of the COPM as an outcome of a pain management programme. Carpenter et al 2001 CJOT	Mixed Quant: data from measures evaluated using Spearman rank correlation coefficient to test level of association between COPM& other measures between baseline & end of treatment. SPSS for analysis Qual: interview to determine motivation 87 – completed baseline, end of programme & 3/12 follow up COPM. Age 19 -72	Clients reported no difficulty completing COPM	(+): encourages partnership Gave OTs greater insight into client needs	Copm showed gd concurrent criterion validity & sensitivity to change Enhances therapeutic relationship	Explored validity of COPM as outcome measure in pain management programme 2nd ed used. COPM compared with other tests in use in the programme	QT 2 before & after
Validity of COPM as a client centred outcomes measure.	Cross sectional study Comparison of COPM with DIP (disability & Impact Profile) & SIP68 Self administered questionnaire	Clients given open ended question at end of formal	(+) links theory to practice Provides information not obtainable from	Training needed in CCP & semi structured interviews. Introducing COPM in mDTs may need re	Results provide evidence for convergent & divergent validity of COPM	QT2 cross sectional

Dedding et al 2004. Clinical Rehab	& Interview Adults 105 recruited (99 data reported) Out pts in 2 academic hospitals. Spearmans rank correlation coefficient to assess convergent & divergent validity	questionnaire to expand in own words	other standardised instruments. Valid measure of occ.perf. (-) not useful for clients with 1 specific issue / field of activity	consideration as team practice may conflict with ccp		
Reliability & validity of copm with stroke. Cup et al 2003 Clin rehab	Multi centre study Comparative study on test retest reliability Interviews Sample – 26 Hospital & community Stroke – adults Descriptive stats, scatterplot, spearmans RHO coefficients Spss used to evaluate data	Clients confirmed copm covered broad range of activities	(+) copm results correlate with Barthel Supports joint planning with pt Client centred Discriminant validity established (-) semi structured interview may give different results on different occasions	Responsiveness of copm to change confirmed Style of interview important factor – research needed on interview style	To research test / retest reliability & discriminant validity of COPM	QT 1 cluster randomised trial
COPM: is it a reliable measure in clients with COPD? Sewell & Singh BJOT 2001	Prospective study of repeatability. Pilot pre study to RCT Convenience sample = 15 COPD out pts Spearman 's rho correlation coefficient (non parametric data) Scores for perf & sat statistically significant	yes	(-) therapists may need to encourage pts to identify problems if insight is an issue (+) useful with this group Test – retest reliability confirmed	Reproducible with COPD pts COPM process dependent on OT's interviewing skills Good therapeutic relationship needed. Sharing experiences of using COPM recommended Reliable but not sensitive to this gp	Pilot to larger RCT study with COPD pts Random sampling not used due to time constraints	QT 2 before & after
Measuring occupational performance	Quantitative repeat measure design Inferential stats used to analyse	yes	(+) reflects change in occ perf & in OT Focuses OT	Useful tool for measuring outcomes Importance of reporting	Changes in occ perf in community setting	QT2

and client priorities in the community: the COPM.. Roberts et al IJTR 2008	data Sample = 62 clients (14 OTs) Adults – hospital & community SPSS T test		attention on occ.perf. Enhances ccp	on outcomes		
Client centred aspects of clinical reasoning during an initial assessment using the COPM Mew & Fossey 1996 Ausjot	Qualitative design Single case study Sample – 1 OT, 1 client Exploratory research questions Triangulation (field notes, observation, transcriptions) member checking & peer examination used to enforce rigour	Yes actively noted & validated	(+)partnership is key concept in CCP (-) OTs need to convey clearly meaning of therapy goals in relation to client ones to create collaborative goals	Collaboration between OT & client in process of problem definition & gaol setting is central to client centred reasoning. Client centred approach can cause feelings of discomfort. Challenges further clarification of CCP	Study highlights need to define what CCP means in OT practice. Results are descriptive & context specific	QL 4
COPM: what do users consider important? Ward et al 1996 British Journal of Therapy & Rehab	Comparative study exploring COPM scores with occ. Perf. issues identified by OT Sample = 29 (20 at 6/12 follow up) Acute orthopaedic in pts No statistical analysis used	Yes but not actively explored	(-) difficult to focus on broader aspects of clients needs when trend is to consider intervention for discharge. (+) useful for identifying client priorities & use as an outcomes measure	Training on copm needed. Cross over from in pt to community impacted on outcomes – because of environment Appropriate for use in community & rehab	Study didn't identify which users they were studying – OT or client? No in depth analysis of views	QL3
Promoting independence for teens & young adults with physical disabilities. Healy & Rigby	Descriptive design Sample = 10 aged 17 -21yrs Young adults with physical disability in a summer independence programme. Clinical change scores noted but not analysed by statistics	Comments actively recorded at follow up interview & complement ed the	(+) individualised Supports CCP Has content validity & gd test, retest reliability	COPM can be enriched by contextual information e.g. diaries, interviews. Useful to evaluate long term rehab programmes	COPM used to evaluate an Independence programme for young adults	QL3

		COPM scores				
1999 CJOT						
Clinical utility of COPM Swedish version. Wressle et al 2002 CJOT	Qualitative study testing clinical utility of this version Focus group Sample = 27 OTs Adult physical - mixed Semi structured interview Constant comparative method used to identify themes of clinical utility	Not actively explored but noted – see own improvement, become reflective & increase sense of responsibility	(+) reinforced partnership Detects change over time Useful with caregivers Helps with goal formation (-) less suitable in acute & with those with ltd insight	Training in COPM Interview skills needed Need to focus on occupational Performance OT to use experience & knowledge to support client. CCP central Further research to test its use as a tool for use in teams		QL 1
Measuring clinical effectiveness in mental health: is COPM an appropriate measure? Chesworth et al 2002	Study – evaluation Sample – 60 adults over 4 yrs Community mental health Pearson product moment correlation test to determine significance of copm scores	Yes – enthusiastic. Helped focus on progress	(+) appropriate instrument to detect change Useful initial interview tool (-) poor mental health function can impact on outcome	Sets realistic goal planning +ve effect on mental health status Closer work with other agencies as improves better referrals Clarifies needs for client & OT More focused treatment		QL1
The application of client-centred occupational therapy for Korean children with developmental disabilities. Hyuk Kang et al 2008 OT International	Study design – hard to determine - mixed Sample = 31 Children phys disabilities Korea Spearman ranked correlation coeff. – relationship between change scores of AMPS & COPM SPSS – all other data	yes	(+) significant improvement shown by use of COPM Measures change in occ.perf	Sensitive to clients progress Effectiveness of client centred practice confirmed using COPM Caregivers must be educated about rationale underpinning ccp to maximise usefulness of COPM	Effectiveness of client centred practice using COPM & AMPs	QL2

Appendix 4.2: Systematic Review Studies – Final Sample of 16 papers

What was the impact of using a client centred outcomes measure, the COPM, on clinical practice?

1 QT2 before & after study	The use of the COPM for the assessment of outcome on a neuro-rehabilitation unit. Bodiam C.1999					
	Method:	**Methodological quality**	**Interventions:**	**Outcomes:**	**Strength of study**	**Limitation of study**
	Study design / type not specified ? quasi experimental as testing hypothesis Sample = 17	Good range of literature. Some limitations in rigour applied to study design	COPM enables self rating Statistically significant change scores between admission & discharge. Supports Client Centred Practice Some clients found transferring problems into numerical form hard	Significant change in clients' evaluation of performance & satisfaction as result of OT in neuro-rehabilitation Further research suggested in rehabilitation & hospital environments	Study aimed to assess usefulness of COPM, setting 3 hypotheses – all found to be accurate: 1.Performance & satisfaction scores will increase between admission & discharge 2. satisfaction scores will change more than performance 3. self evaluation will be affected by cognitive deficits	Design not specified small sample
2 QT2	Validity and Utility of the Canadian Occupational Performance Measure as an Outcome Measure in a Craniofacial Pain Center. Rochman D., Ray S., Kulich R., Mehta N & Driscoll S 2008					
	Method:	**Methodological quality**	**Interventions:**	**Outcomes:**	**Strength of study**	**Limitation of study**
	Before & after study Sample = 29 Adults attending pain centre	Well constructed study, clearly written with relevance to practice	Copm generates unique information about occupational Performance & satisfaction with treatment.	Copm has potential as outcomes measure in orofacial pain centre. Further study needed in this area	Identified gap in clinical area	Small sample size. One clinical setting

		COPM easy to use Scoring easy				
3 **QT2** **Before** **& after** **study**		**Utility of the Canadian Occupational Performance Measure in community based brain injury rehabilitation** Jenkinson N, Ownsworth T & Shum D 2007				
	Method:	**Methodological quality**	**Interventions:**	**Outcomes:**	**Strength of study**	**Limitation of study**
	Part of a larger intervention study – before & after	Good literature review with sound context. Findings and implications for practice are less well defined	Copm is sensitive to group therapy Relatives' ratings may be less sensitive than those of clients.	Subjectivity & self reports may be unreliable in determining rehab outcomes. Further study needed on influence of cognitive impairment on Copm self ratings Clinical utility of Copm with ABI needs further investigation	Client centred practice reinforced	Small sample which may impact on outcome of study conclusions
4 **QT2**		**Measuring occupational performance and client priorities in the community: The COPM** **Roberts AEK., James A., Drew J, Moreton S, Thompson SR & Dickson M 2008**				
	Method:	**Methodological quality**	**Interventions:**	**Outcomes:**	**Strength of study**	**Limitation of study**
	Quantitative repeat measure design in a natural setting	Well designed study. Findings clearly set out. Good examples of clinical practice	COPM reflects change in occupational performance & in OT Focuses OT attention on occupational performance Enhances client centred practice	Useful tool for measuring outcomes Importance of reporting on outcomes. Measures changes in occupational performance in community setting	Related findings to other studies to provide context for results.	Study related to clients in a community setting
5		**Home based OT: stroke pts satisfaction with occupational performance & service provision**				

QT1	Gilbertson L & Langhorne P 2000					
	Method:	**Methodological quality**	**Interventions:**	**Outcomes:**	**Strength of study**	**Limitation of study**
	Single site blind RCT Sample = 138 adults	Good methodological rigour, limitations in literature review and context	COPM is difficult for those with cognitive & perceptual problems. COPM cannot be administered as a postal follow up	COPM is a valuable tool to evaluate OT Supports other studies which confirm that hospital rehab can benefit from outreach OT	COPM is a meaningful outcome measure for patients because it is client centred & more sensitive to change over time	Difficulty blinding rehabilitation trials. Follow up was done by postal questionnaire which was limited in data rich information
6 QT2	The COPM: is it a reliable measure in clients with Chronic Obstructive Pulmonary Disease? Sewell L & Singh S 2001					
	Method:	**Methodological quality**	**Interventions:**	**Outcomes:**	**Strength of study**	**Limitation of study**
	Prospective study of repeatability. Pilot pre study to RCT Convenience sample = 15	Clearly written. Small sample	Pulmonary rehab improves domestic function & physical activity Therapists may need to encourage patients to identify problems if insight is an issue Test – retest reliability confirmed	COPM reliable tool in clients with COPD. COPM process dependent on OT's interviewing skills Good therapeutic relationship needed. Sharing experiences of using COPM recommended	Great care taken over study limitations	Small sample Random sampling not used due to time constraints
7 QT1	Reliability & validity of Canadian Occupational Performance Measure in stroke patients Cup E. , Scholte op Reimer W. , Thijssen M. & van Kuyk-Minis M 2003					
	Method:	**Methodological quality**	**Interventions:**	**Outcomes:**	**Strength of study**	**Limitation of study**

	Cluster RCT Multi centre study Comparative study on test retest reliability	Fair. Sample randomised Generalisability of findings - Good clinical examples given	COPM results correlate with Barthel Index COPM supports joint planning with patient Client centred discriminant validity established Semi structured interview style in COPM may give different results on different occasions	Responsiveness of COPM to change confirmed Style of interview important factor – research needed on interview style COPM focuses on needs of individual	Clear abstract Test retest reliability is good.	Stronger conceptual framework would have enhanced the study. Sample size small
8 **QT2** before & after study	**The use of the Canadian Occupational Performance Measure as an outcome of a pain management programme.** **Carpenter L., Baker G & Tyldesley B 2001**					
	Method:	**Methodological quality**	**Interventions:**	**Outcomes:**	**Strength of study**	**Limitation of study**
	Study design not specified	Fair. Well set out study with good context. Lacked specificity in relation to implications	COPM encourages partnership Gave OTs greater insight into client needs	Copm showed good concurrent criterion validity & sensitivity to change COPM enhances therapeutic relationship with client	Reasonable sample size = 87 COPM correlated with other instruments used in study	based on 2nd edition of COPM
9 **QT3**	**The validity of using the Canadian Occupational Performance Measure with older adults with and without depressive symptoms** **McNulty M. & Beplat A. 2008**					
	Method:	**Methodological quality**	**Interventions:**	**Outcomes:**	**Strength of study**	**Limitation of study**
	Retrospective comparative study using pre existing data from broader	Sampling process, reflexivity and data analysis was clear throughout.	COPM enables OT to gain rapport with client & provide client centred intervention.	Link between depressive illness & reduced occupational performance skills.	Compared results with larger study. Supports use of COPM with older adults with	Small sample & use of convenience sampling limits ability to generalise the results.

	study Matched Sample =20				depressive symptoms.	Collection of data at 1 point only. Limited ethnic spread & geographical region may impact on generalisation of results.
10 **QL3**	**Recovery after hip fracture: What can we learn from the Canadian occupational performance measure?** **Edwards M., Baptiste S., Stratford P. & Law M. 2007**					
	Method:	**Methodological quality**	**Interventions:**	**Outcomes:**	**Strength of study**	**Limitation of study**
	Primarily descriptive design Mixed methodology Sample =50	Rigorous methodical approach used although study design not specific.	COPM confirms primary focus on self care issues with this population	Confirms utility of copm as outcome measure with this group.	Affirms evidence for OT intervention with hip fracture patients early post surgery. Results relevant to clinical practice	Small sample size. Length of time of funded study impacted on ability to recruit additional numbers & carry out follow up
11 **QL3**	**The reproducibility and validity of the COPM in parents of children with disabilities.** **Verkerk G., Wolf MJ., Louwers AM., Meester-Delver A. & Nollet F 2006**					
	Method:	**Methodological quality**	**Interventions:**	**Outcomes:**	**Strength of study**	**Limitation of study**
	Descriptive study using qualitative interviews	Lacked qualitative depth as parent data not included. No triangulation of evidence to support findings	Client centred approach endorsed & requires cooperation & communication	Issues noted on COPM are consistent enough to provide basis for setting treatment goals	COPM detects child specific occupational performance issues perceived by parents	Lack of justification for methodology. High drop out in sample
12 **QL3**	**The Canadian Occupational Performance Measure as an outcome measure and team tool in a day treatment programme.** **Wressle E., LIndstrand J., Neher M., Marcusson J. & Henriksson C. 2003**					
	Method:	**Methodological**	**Interventions:**	**Outcomes:**	**Strength of study**	**Limitation of study**

		quality				
	Design used mixed data collection - interviews before & after use of COPM	Good. Evidence of rigour demonstrated plus sound rationale for design, method, sample & findings	COPM focuses on occupational performance. Therapists considered COPM increased client participation, created distinct goals & was good outcome measure	COPM can be considered as tool for team use. Support needed at implementation of COPM	Highly relevant study for using COPM in teams. Training needed to use COPM	Small sample used in 1 focus group. Cultural bias of study location

13 QL3	**Measuring clinical effectiveness in mental health: is COPM an appropriate measure?** **Chesworth C., Duffy R., Hodnett J. & Knight A. 2002**					
	Method:	**Methodological quality**	**Interventions:**	**Outcomes:**	**Strength of study**	**Limitation of study**
	Retrospective case evaluation	Literature & data lacked detail.	Reinforced client centred approach. Focused treatment on individual need rather than group work	Added to evidence base for outcomes in mental health – paucity of studies. COPM confirmed as clinically effective measure in mental health	Findings can be applied to other mental health areas.	Rural setting of study may have impacted on clients' expressed difficulties

14 QL1	**Clinical utility of COPM - Swedish version.** **Wressle E, Marcusson J. & Henriksson C 2002**					
	Method:	**Methodological quality**	**Interventions:**	**Outcomes:**	**Strength of study**	**Limitation of study**
	Focus group design justified to meet aims of study	Good. Recruitment strategy, data collection, ethics & findings clearly described.	Theoretical knowledge of COPM needed by therapists. Less suitable in acute areas & with those with	COPM ensures a client centred approach & facilitates communication. Supports goal setting &	Triangulation of results Confirmed clinical utility of Swedish COPM	Results may be culturally specific

			poor insight.	treatment planning.		
15 QL3	**An evaluation of the Canadian Occupational Performance Measure.** **Parker DM 1995**					
	Method:	**Methodological quality**	**Interventions:**	**Outcomes:**	**Strength of study**	**Limitation of study**
	Mixed study using multi method design Small sample = 22 clients	Triangulation of data used Study design matched study aim	COPM determines client centred goals & treatment planning. Intervention focused on clients needs. COPM can be used in acute environment but time pressures are an issue	Relevant to development of use of COPM Training in use of COPM needed & understanding of model CMOP Interview styles & techniques need recognition Reported on client & therapist view of using COPM	Mixed approach using interviews, client feedback, and quantitative data. Data triangulated	No control group Limited to acute hospital environment.
16 QL3	**Are we really client centred? Using the COPM to see how client's goals connect with the goals of the occupational therapist** **Richard L. & Knis-Matthews L 2010**					
	Method:	**Methodological quality**	**Interventions:**	**Outcomes:**	**Strength of study**	**Limitation of study**
	Descriptive study small sample = 7 clients	Good. Well written with sound rigour. Study designed & described, easy to follow	Goal statements on COPM create opportunity for mutual negotiation & understanding. challenges the understanding of terms & language in goal setting	Adds to evidence for dissonance between therapist & client in goal setting. Training in use of COPM & client centred practice is essential	Thorough. Challenged the reality of being client centred.	Single setting & single therapist so impact limited.

Systematic Review:
Appendix 4.3: Clinical profile

Study	Clinical specialty	Health environment
The use of the COPM for the assessment of outcome on a neuro-rehabilitation unit. Bodiam C.1999	Cerebro-vascular accident (CVA) Acquired brain injury spinal cord injury	Neurological rehabilitation unit UK
Validity and Utility of the Canadian Occupational Performance Measure as an Outcome Measure in a Craniofacial Pain Center. Rochman D., Ray S., Kulich R., Mehta N & Driscoll S 2008	Cranio facial pain	University based facial pain centre – urban USA
Utility of the Canadian Occupational Performance Measure in community based brain injury rehabilitation Jenkinson N, Ownsworth T & Shum D 2007	Acquired Brain Injury	Community rehabilitation Australia
Measuring occupational performance and client priorities in the community: The COPM Roberts AEK., James A., Drew J, Moreton S, Thompson SR & Dickson M 2008	CVA Joint disease Orthopaedics Neurology Surgical	Community hospital in & out patients Community & residential rehabilitation UK
Home based OT: stroke pts satisfaction with occupational performance & service provision Gilbertson L & Langhorne P 2000	CVA - Stroke	Urban Teaching Hospital UK
The COPM: is it a reliable measure in clients with Chronic Obstructive Pulmonary Disease? Sewell L & Singh S 2001	Chronic Obstructive Pulmonary Disease COPD	Pulmonary Rehabilitation – Out Patients UK
Reliability & validity of Canadian Occupational Performance Measure in stroke patients Cup E. , Scholte op Reimer W. , Thijssen M. & van Kuyk-Minis M 2003	CVA - Stroke	Hospital & community The Netherlands
The use of the Canadian Occupational	Pain management	Centre for Neurology &

Performance Measure as an outcome of a pain management programme. Carpenter L., Baker G & Tyldesley B 2001		Neurosurgery UK
The validity of using the Canadian Occupational Performance Measure with older adults with and without depressive symptoms McNulty M. & Beplat A. 2008	Older adults with depressive symptoms	Community USA
Recovery after hip fracture: What can we learn from the Canadian occupational performance measure? Edwards M., Baptiste S., Stratford P. & Law M. 2007	Older adults with hip fractures	Regional teaching hospital Canada
The reproducibility and validity of the COPM in parents of children with disabilities. Verkerk G., Wolf MJ., Louwers AM., Meester-Delver A. & Nollet F 2006	Parents of children	University hospital & rehabilitation units Amsterdam
The Canadian Occupational Performance Measure as an outcome measure and team tool in a day treatment programme. Wressle E., LIndstrand J., Neher M., Marcusson J. & Henriksson C. 2003	Physical Inflammatory joint disease	Acute Hospital Adults Day treatment unit Sweden
Measuring clinical effectiveness in mental health: is COPM an appropriate measure? Chesworth C., Duffy R., Hodnett J. & Knight A. 2002	Mental health: anxiety, depression, psychosis	Therapy unit NHS Community UK
Clinical utility of COPM - Swedish version. Wressle E, Marcusson J. & Henriksson C 2002	Therapists only	Representative of wide variety of practice areas Sweden
An evaluation of the COPM. Parker DM 1995	Acute physical conditions: neurology, oncology, medicine	Teaching hospital Acute adult UK
Are we really client centred? Using the COPM to see how client's goals connect with the goals of the occupational therapist Richard L. & Knis-Matthews L 2010	Mental health: Schizophrenia	Long term residential programme USA

Appendix 4.4

Journal article on:

A Systematic review of the Canadian Occupational Performance Measure

By

Parker DM and Sykes C

Appendix 5.1 - Focus Group
Delegate Letter of Introduction

April 2006
Dear Colleague

                    Client Centred Practice workshop – Whose Goals matter?

Thank you for selecting this workshop at the Conference on the Canadian
Model of Occupational Performance. Your contribution and opinions are
highly valued and will contribute towards the development of Occupational
Therapy practice.

Before you join the workshop I need to inform you that I will be leading this
session as part of some research I am carrying out on;

                    The Engagement of clients in Occupational Therapy

As well as Head of Occupational Therapy, I am also a student at Blank
University studying for a PhD. My interest is in the whole interface between
client and therapist, especially in goal setting and outcomes.

If you join this workshop, your consent to take part in the research will be
assumed by your participation.
The workshop will be audio-taped to enable analysis to take place at a later
date. In addition, my colleague Jane (pseud.) will be noting key themes as
they emerge in the discussion.

All the views expressed will be confidential and will be used solely for
research purposes. No one attending the workshop will be identified
individually or by name.

Thank you for agreeing to join the workshop and take part in my study, your
participation is appreciated.

Yours sincerely

Post graduate student- University of Birmingham

Appendix 5.2 Focus Group data analysis

Transcript data 1st level	2nd level	Key Categories	Inferential meanings/inks	Conflicts / comparisons
Client – Person related				
Partnership. Connected, equal, Co-operation, Participation, involvement, engagement, Relationship, Client centred, Cooperation	Relationships Engagement connections	Partnerships	Link = connection Relationship>participation>involvement> engagement	Motivation – both Insight – client Desire –both Understanding -both
Who, Individual, Know client, Person's story, Person, Themselves Client choice, Limitations, Empowered Client centred Client Skills, Learning Process Client's Perception, Insight, Grieving Difficulties Accept change Adjusting to client- centred practice Client centred Therapeutic relationships Boundaries	Client centred practice Who is the client? Client skills boundaries	Client	Link = knowing the client, individual, person's story Knowing(client skills/limitations /story) >learning process>insight>ccp	Boundaries –both Acceptance of change –both Adjusting to ccp – both
Language. Communication skills, Feeding back, Honest, Connect, Talk, Explain, Discussion Agree, Accept, Not agree Don't listen / Listening Negotiate, Different views Negotiating Safe balance Respect, Issue Layman Terms Implications	Negotiation Skills Listening Decision making	Communication Informed choice	Link = communication skills/language Listen> feeding back>negotiating>honesty>respect & acceptance	Not listening = both Different language – words & meanings especially use of professional speak Acceptance Understanding – client

26/06/2013

Appendix 5.2 Focus Group data analysis

Decision making. Informed decision making, Decisions, Informed decision				
Goals and expectations, conflict with goals. Other's goals, Goals & number. Impact of illness on goals. Goals focused on client need. Needs, Problem, Relate Goals, aims, Want goal, Agree goals, Objective, Fulfilling Goal, Changing Focus, Client statement Issues. Problems	Whose goals Agreement Meeting goals Goal definition	Goals	Link = definition Problems>needs>expectations>agreement> change >fulfilment>	Needs/goals/ aims/problems /wants/ expectations No clarity on terms so how can there be clarity on meaning?
Risk & safety, Safe, , Comfortable risk, Knows risk, Realise Risk Reduce risk, , At risk, Minimum risk	Safety Knowledge of	Risk	Link = knowing the risk Knowing>realising> reducing risk>safety	How is risk articulated? Risk acceptance not defined
Environment				
Easier to be client centred Honesty of client Client more confident & in control Acceptance of support – greater Supportive Improves engagement with client More cues at home Familiar surroundings Lifestyle	Client behaviour identity confidence	Home environment	Link = control Familiarity> confidence> honesty> engagement	Why is it easier to be client centred – is that about accepting/seeing client in context?

26/06/2013

Appendix 5.2 Focus Group data analysis

Home, Her house Community				
Client passive, Disempowerment it's an alien environment, Unfamiliar Lack of control for client Perception of client & effect on decision making Lack of feedback from client Safety & risk Assessing risk Environment & control Realm, Territory, community Setting Discharge package ,Resources Protective setting	Client behaviour Confidence risks	Hospital environment	Link = lack of control Unfamiliar territory>lack of control>passivity> impact on decision making>communicati on>risk Challenges of being client centred & client control relates to environment.	How is the gap / passivity bridged? Giving client control – how? How risk is assessed Risk vs giving control
Power of relatives and patient. Timing of power. Power in the home. In charge Influence of medical profession. Agenda Poor therapist Organisation Hospital, Services Family. Paid carers	Illness vs disability Knowledge Others	Power & influence	Link = power lines Influence of others on person	Is power linked to knowledge /influence / organisation?
Information, Expectations, Decisions Risks paperwork, Risks Barriers, Rules, Tick boxes, Pressure, Resources Timing		Pressures	Link = external pressures Information>rules> decisions>barriers > expectations	Knowing the barriers / constraints = both Risks may conflict with client expectations
Confidence, choice	Professional'	Skills	Link =skills	Poor skills – OT

Skills, Skilled, Skilful, Assessment, Assessment tool, Model of practice, Framework Agendas, Action plan, Clinical reasoning, Concept, Interview Documentation , Terminology Negotiator Disempowering, Valuing Outcome Measure, Copm, Indicator	s skills , techniques, language		Model>tools> assessment> confidence>intervi ew>outcome	Clin reasoning & assessment tools not matched with model disempowerment what about client skills?
Definitions				
Knowledge & information. Informing, Views, Decisions, Presumption, Finding out, Cues, Understand, sense, Understands, Know, Insight, Viewpoint, Informed decision Skills of being client centred. Skills & reasoning of the OT, Experience, confident Concept, Insight , Be ok Being valued, Respect Understand/ understood Different	Knowing & understanding Insight Skills Being valued respect	**I**nformation	Link **=** communication skills Exploration>inform ed decisions>reasonin g>insight> understanding> respect	Insight – both Poor skills -OT Lack of experience – OT How to show respect
Engage, Meaning of engagement, Engaging, Connection, Engagement Partnership, Sides, Same hymn sheet, Making connections, Balance, Passive /Active Facilitate, Encourage	Connecting Active skill	Engagement	Link = connections Understanding differences/ different views>create balance>relationsh ip>engagement	Not recognising the other =both

26/06/2013

Appendix 5.2 Focus Group data analysis

Relationship				
Communication skills. Listening. Negotiation Honesty, Articulate, Reality, Language, communication, What they say, chosen conversation, Acknowledging, Explaining, Tease out, Break it down Wrong interpretation, Carefully discuss, Alien, Differences, Wrong, False perceptions, Different agendas Opinion, choice, Ideal view, Point of view, Viewpoint Expectations, Understanding wants, Means, Perceive, Perceptions, Perception of the OT.	Skill range Need to listen differences	Communication	Link =communication skills Listening>language >explanation/explo ration>interpretat ion> perception> understanding	Lack of ability to listen/hear -OT Conflict with different agendas / perceptions
Known & unknown, Frightening, Troubling, Difficult, Change, Deteriorates, Worry, Worried, Dilemma, Changes, Struggle, Failures, Traumatic Devastating, Intense, Happier, Laugh, Scary, Passionate Spirituality, Core Spirituality	Negative Positive Change / dilemmas Impact on individual	Emotions	Link= threat	Impact of fears/ negative emotion on change / outcome Conflict with organisational pressures Time conflict

26/06/2013

Appendix 6.1
Thematic links across each research study and the literature

Key theme from Systematic Review	Reference	Focus group Link	Questionnaire link	Question No;
Results evaluated & brought together under main headings with key themes identified	*Key texts / references which have keynote items in this category*	*Theme emerging from Focus group discussion*	*Focus of question in the therapists' questionnaire*	*Evidence from the literature & systematic review which mention / ref / identify this issue*
Training		1. Main theme Sub theme a) 2nd level theme linked to whole section		Questions linked to whole section

Occupational Therapists need the ability to actively engage clients in a partnership
 Therapist experience – not so much length of practice more knowledge of the measure
 Occupational Therapists ability to communicate their clinical reasoning process to the client when establishing goals and assist the client in understanding the wider context of occupational performance
	Healy & Rigby 1999; Wressle et al 2002; Dedding et al 2004
	 37, 7,9, 41,45,4,12
	 50,41,43,46,13,16,29,33
	 53,37,2
		1) Influences: Information
		    a) Skills of therapist
		
		 2) Client partnerships
		    a) Engagement
		    b) connections
		 3) Values engagement
		    a) Making connections
		    b) Skill of engagement
			What training has been experienced and in what form - formal or informal, taught or acquired. What training needs are required, how can these be met
			 Learning about models of practice & frames of reference.
			 Training in use of COPM & how that was delivered
				5, 10, 16, 17,

Occupational Therapy	53,37,2			

training in client centred practice and semi structured interviews				
The experience and training for Therapists especially in the understanding of the theory behind the measure	Mew & Fossey 1996; Ward et al 1996; 1,3,4,5,6,7,19,20,21, 35, 41, 45			
knowledge, practice and confidence in client centred therapy Need for therapists to learn and consider their interviewing techniques, understanding about the theoretical model on which it is based, understanding of scoring scales Training in how to use the measure access to the video and manual or other training opportunities	Wressle et al 2002; Warren 2002; Heaton & Bamford 2001; Cup, Scholte op Reimer et al 2003). 1,3,4,5,6,7,8,19,20,21			
Training especially to help client understand wider context of occ perf probs	41,45			
Clinical practice		linked to whole section		Questions linked to whole section

It acts as a framework for partnership and enhances the relationship with the client
Whilst for those clients who understand this approach, it
	Law et al 1990; Law et al 1994b; Pollock 1993; Heaton and Bamford 2001).	1. Client Partnership
		  a) Relationships
		  b) Connections
		
		Goals
			Application of frames of reference & their influence on practice
			
			Relevance of using COPM to practice
				9, 18, 19,

can increase insight and understanding Occupational Therapists need to develop rapport with a client prior to using the COPM Care is needed when using the COPM with caregivers as they have different needs Supports reintegration into society by focusing on real problems		a) Goals & expectations b) Goal definition	Consideration of using COPM	
The COPM helps to stage the Occupational Therapy process and assists the Occupational Therapist establish goals based on clients perceived needs	Brown et al 2001; Ripat et al 2001; Cup et al 2003; Wressle, Marcusson et al 2002 9,10,11,12,13,14,			
It is not suitable for clients who lack insight particularly those who are cognitively impaired	(Law et al 1994a; Scull 1997; Norris 1999; Tryssenaar et al 1999			
Using the COPM may demand change of or may compliment existing documentation	Parker 1995 12			
Passive sick roles in some cultures may mitigate against using a client				

centred tool				
Measures consumer satisfaction	Chesworth et al 2002; Warren 2002 15, 16			
Evidence available of convergent & divergent validity of the COPM with other tools Correlation of COPM with other tools e.g. Barthel, Reintegration to Normal Living Index (RNLI), Functional Independence Measure (FIM) Disability of Arm, Shoulder, Hand (DASH), Health Assessment Questionnaire (HAQ)	(Brown et al 2001; Ripat et al 2001; Wressle et al 2002; Cup et al 2003). 17, 46,49,,58, 48, 1			
Research		linked to whole section		Questions linked to whole section
Expand its use in research within wider clinical fields Further development of the conceptual foundation for practice Determine the effect of interview styles on results Determine ability to detect clinically meaningful change Translation of the COPM into languages relative to	Veehof et al 2002; Cup, Scholte op Reimer et al 2003; Chen et al 2002; McColl et al 2000; Warren 2002) Parker 1995 25,26,27, 8(24) 46, 47, 49, 2, 21, 7, 9, 11, 12,21, 20,51	1. Influences Information a) skills of therapist	Do you use the COPM results What do you use them for	21, 22

the population Combined Occupational Therapy assessment form including COPM, the model and Occupational Therapy intervention plan				
Client centred issues	*Some of these papers may cover the whole topic – any papers including cc are listed in 1st box so check them to link with other sub themes*	linked to whole section		Questions linked to whole section
Client enablement and the partnership which the COPM encourages were consistent themes	Veehof, Sleegers et al 2002; Channine & Clark 2003; McColl et al 2000 22,41,20, 41,46,4, 3, 39,44,11,21,25,30, 43, ,12, 9, 36, 7, 37,13, 35,	1. Client Partnerships a) relationships b) connections c) engagement Informed choice a) informed decision making b) negotiation	Is current practice client centred Most important aspects of client centred OT Most difficult aspects of client centred OT Most rewarding aspects of ccOT Use of COPM in practice Statements about COPM	11, 12, 13, 14, 15, 20
The semi structured interview was noted as being supportive to the individual in the identification of their problems	Donnelly et al 2004 23, 57, 47, 53, 39, 41			
an excellent medium for sharing occupational performance problems and actively engaging the client in that discussion	Healy & Rigby 1999; Ripat, et al 2001; Carpenter et al 2001. 21, 45, 48, 36, 58, 46, 47, 49,25			

Medium for developing client competencies	Healy & Rigby 1999 21, 41, 43, 35, 25			
facilited client led goals	(Samuelsson, 2004; Veehof, Sleegers et al 2002; Kjeken et al 2004; Chesworth et al 2002). 23, 57, 47, 53, 39, 41	1.Client Goals a) goals & expectations goal definition		
client truly understanding what occupational performance really means in order for them to accurately identify occupational performance problems	Law et al 1990; Chan & Lee 1997; Warren 2002; Healy & Rigby 1999. 21, 11,12,16,26,30, 55, 37, 40,33,	1. Client Person a) influences b) skills c) boundaries		
Similarly those with poor insight into occupational performance issues, clients with cognitive problems, poor concentration, restricted communication or unstable mental health may not be suited to using this measure	Toomey et al 1995; Chan & Lee 1997; Gilbertson & Langhorne 2000; Wressle et al 2003; Chen et al 2002 24, 50, 54, 56, 41, 49, 45, 43,7(28)			,
Timing of when to use the COPM emerged as an issue for clients	Channine & Clark 2003			? relevant as ?re is OT related
From the therapist's perspective issues of partnership and collaboration and the role of the COPM in facilitating holistic OT practice emerged as key themes	Pollock 1993; Channine & Clark 2003; Wressle et al 2002; Cup et al 2003 14			

COPM encapsulated the Occupational Therapy approach	Brown et al 2001; Fedden et al 1999; Wressle et al 1999 19, 29			
gave greater insight into real goal planning	Chen et 2002 22,24			
the measure clarifying and complimenting the OT role and the clinical decision making	Tryssenaar et al 1999. 24,22			
OTs and clients have different goals and that being the case were therefore reluctant to let clients select their own goals	Wressle et al 2002 22,24			
promotion of client centred practice	McColl et al 2000; Kjeken et al 2004 23, 41,20			
Process issues		linked to whole section		Questions linked to whole section
needs to be supported by the Canadian Model of Occupational Performance to understand its theoretical background	Chesworth et al 2002; Richardson et al 2000; Kjeken et al 2004 22, 53,37,2 45, 35, 9, 2, 3, 21, 50	1. Influences Information a) skills of therapists	Use of model of practice If no, which might be considered Yes – which model used Influence of using model of practice on delivering OT process Application of FOR If no – which would be considered If yes – which FOR is used	1,2, 3, 4, 6, 7, 8
backed up by the well	Jeffrey 1993;			

developed manual	Steeden 1994; Gaudet 2002 20, 11,22, 40,22,29			
Others however reported that the measure was time consuming and difficult to administer	Donnelly & Carswell 2002; Ripat et al 2001 23 8(24), 38, 48, 19, 37, 26, 12, 49, 58, 31			
Others associated the elderly in particular, as having problems discriminating between satisfaction and performance	Warren 2002; Wressle et al 2002 24			
that the scoring process can be a barrier to the Occupational Therapist and client	Stancombe & Young 1996; Trysenaar et al 1999 24, 49, 13, 12, 16, 19, 31, 32, 41, 38, 39			
clearly endorsed the semi structured interview as a positive part of the process of administering the measure commenting on its usefulness and validity).	Tryssenaar et al 1999;Cresswell 1997; Healy & Rigby 1999; Tryssenaar et al 1999 23			
review of existing documentation may be required to avoid duplication	Parker 1995 50, 22, 40, 12			
value of the COPM as an outcomes measure and its ability to detect change in occupational performance	Chen et al 2002, Barry 1997; Pollock 1993 22, 53, 42, 49, 11, 26, 3, 6, 45, 16, 19, 29			

adaptable tool for clients with both physical and mental health issues	(Warren 2002; Chesworth et al 2002 22			
the COPM was not suitable for all situations and conditions	Norris 1999; Scull 1997; Tryssenaar et al 1999			
conflicts arising from operating within a medical model	Chesworth et al 2002; Wressle et al 2002			
difficulties posed when implementing the tool within teams using inconsistent or single treatment approaches for e.g cognitive behavioural therapy	Channine & Clark 2003			
using the COPM with a care giver may present the therapist with different priorities and raise issues not relevant to intervention	Heaton & Bamford 2001; Law, et al 1990; Pollock 1993 24,2, 25, 41, 20,32			

[   ]

Research Questionnaire:

The effect of patient engagement on the outcomes of Occupational Therapy

Dear Colleague,

Thank you for considering this questionnaire.

Please return it to me by:

March 31st 2007

Grade of post held [……………………..] or Band [ ] Length of time qualified in yrs [ ] Length of time in this post in yrs [ ] What is your clinical specialty? ……………………………….	

Which clinical area are you currently working in?

Please tick One box which best describes that clinical area

Physical - hospital		Paediatrics - hospital	
Physical - community		Paediatrics - community	
Mental health - hospital		Social Care and Health – Social Services	
Mental health - community		Private sector	
Voluntary sector		Rehabilitation - hospital	
Prison services		Rehabilitation - community	
Other – please specify			

Are you a member of the COPMNETWORK?

Yes [   ]   No [   ]

	Question – Please answer all questions	Response – please tick or rank as appropriate
	Models and Frames	
1	**Do you use a Model of Practice in your service?** Go to **Q3**	Yes [ ] No [ ] Don't know [ ]
2	**If NO, which is the one you are most likely to consider**? Go to **Q 5**	Model………………………………………..
3	**If yes which are the most relevant to your practice?** *For example*; Model Of Human Occupation (MOHO)	Please list 1 = most relevant, 5 = least relevant 1…………………………………………………….. 2…………………………………………………….. 3…………………………………………………….. 4…………………………………………………….. 5……………………………………………………..
4	**How much has working to a model of practice influenced how you deliver the OT process?** Please indicate the level of relevance on a scale of 1 to 5 by circling the appropriate number; 1 2 3 4 5 little greatest influence influence	
5	**How have you learned about Models of Practice?**	Please tick all those applicable
	Taught study day	
	Training video	
	Reading	
	Work shadowing	
	Visits to client centred teams	
	Other	
6	**Do you apply Frames of Reference in your practice?**	Yes [ ] No [ ] Don't know [ ]
7	**If NO which is the one you are most likely to consider**? Go to Pink section	………………………………………………………
8	**If yes, which do you use?** ***For example*** Biomechanical	Please list 1 = most relevant 5 = least relevant 1…………………………………………………….. 2…………………………………………………….. 3…………………………………………………….. 4…………………………………………………….. 5……………………………………………………..
9	**How much has applying a Frame of Reference influenced how you deliver the OT Process?** Please indicate the level of influence by circling the relevant number 1 2 3 4 5 little greatest influence influence	
10	**How have you learned about Frames of Reference?**	Please tick all those applicable
	Taught study day	
	Training video	
	Reading	
	Work shadowing	
	Visits to client centred teams	
	Other – please specify	

Appendix 6.2

		Client Centred Practice				
11	**Would you describe your current practice as "client centred"?**		Yes [ ]	No [ ]	Don't know [ ]	
12	**Consider the following and rank them in order of priority to reflect the <u>most important</u> aspects of client centred occupational therapy and what it means to you:** **1 = most important to 10 = least important.** For example if you think *"negotiating goals"* is the most important aspect of client centred practice then write 1 against that statement					
	Working in Partnership					
	Clients taking responsibility					
	Empowerment of the client					
	Engagement in functional performance					
	Establishing priorities in goal setting					
	Negotiating goals					
	Respecting a client's values					
	Listening to the client					
	Meeting the clients' needs					
	Client participates actively in intervention					
13	**Consider the following and rank them in order of priority to reflect the <u>most difficult</u> aspects of client centred practice:** **1 = most difficult to 10 = least difficult** For example if you think that "a*greeing goals together*" reflects the most difficult aspect of client centred practice then write 1 against that statement					
	Identifying a client's needs					
	Agreeing goals together					
	Client not identifying the risks					
	Establishing a relationship with the client					
	Communication problems					
	Using a 3rd person					
	Letting a client select the goals					
	Having different goals to the client					
	Allowing the client to be the expert					
	Client's lack of motivation					

14	Consider the following and rank them in order of priority to reflect the <u>most rewarding</u> aspects of client centred practice: 1 = most rewarding 10 = least rewarding For example if you consider *"promoting partnership"* is the most rewarding aspect of client centred practice, write 1 against that statement.		
	Identifies goals which meet a client's need		
	Working together with a client		
	Promoting partnership		
	Promoting holistic working		
	Planning intervention based on client's needs		
	Creates mutual respect between client & therapist		
	Enables client to develop insight		
	Supports active engagement of the client in the OT process		
	It motivates clients to participate in intervention		
	Ensures clients are really listened to		
	The COPM		
15	**Do you or have you used the COPM in your practice?** If NO proceed to the Blue section	Yes [ ] No [ ]	
16	**If you use or have used the COPM, did you receive training or instruction on how to use it?**	Yes [ ] No [ ] Don't know [ ]	
17	**If yes how was that delivered?**	Please tick all those applicable	
	Formal taught study day		
	Self taught using the manual		
	Learner package		
	Advice from colleagues		
	Use of the training video		
	Reading the literature		
	Other please specify		

18	**If you use or have used the COPM, <u>how relevant</u> is it in your practice?**	
	Consider the following and rank them in order of priority from 1 – 10 **1 = most relevant 10 = least relevant**	
	Links OT theory to practice	
	Can be used across all clinical areas	
	Provides a means to guide the OT process	
	Provides insight into needs of clients	
	Enables the OT to set realistic goals	
	Increases client participation & insight	
	Helps name & frame occupational performance issues	
	Focuses intervention on clients' needs	
	Allows clients to take responsibility for their own health	
	Encourages partnership with a client	
19	**What do you think about <u>using</u> the COPM?**	
	Please consider the following and rank them in order of priority on a scale of 1 – 10 where **1 = most important 10 = least important**	
	Training in the use of the COPM is essential	
	Understanding about the Canadian Model of Occupational Performance is essential	
	Understanding what client centred practice means is essential	
	Confidence is needed with interviewing skills to use it	
	Extra time is needed when administering the COPM	
	It facilitates client led goals	
	It enables sharing about occupational performance Issues	
	Using a semi structured interview is valuable	
	It facilitates holistic Occupational Therapy practice	
	Understanding how to use the scoring system is important	

20	Consider these statements about the COPM and indicate whether you agree or disagree by ticking the relevant box			
		Agree	**Disagree**	
	The client knows best when identifying their problems			
	The therapist should set the treatment goals			
	The therapist should include issues in the treatment plan which the client has not raised			
	The therapist should tell the client what to score			
	The therapist has different goals to those of the client			
	If the client struggles with scoring the therapist should score for him/her			
	Clients must be able to identify areas of difficulty			
	It's the job of the OT to assess & observe function prior to setting goals			
	The COPM can be used with a carer if the client cannot communicate with the OT			
	The therapist knows best when setting goals and planning treatment			
	Risks and safety issues should be explained to the client			
21	**Do you use the results from the COPM for any reason?**	Yes [ ] No [ ] Don't know [ ]		
22	**What do you use the results of the COPM for?** Please tick all those relevant			
	Give feedback to client			
	Share change scores with client			
	Discuss outcomes with client			
	Share change scores with colleagues			
	Give client a copy of their COPM			
	Copy COPM if client transfers to another OT service			
	Carry out data analysis			
	Publish data in reports on OT service			
	Use data to plan services			
	Use data to inform service development			
	File in medical records without action			
	Do nothing with information gained			

	If you have not used the COPM yet, but have considered using it, would you require training? Yes [ ] No [ ] Don't know [ ]
	If you have any additional comments you wish to make, please feel free to use the space below

Thank you for your time

Please indicate if you would be prepared to take part in a telephone interview as part of this research. This would involve no more than 20 mins of your time. If you tick Yes please indicate your first name and a contact telephone number	Yes [ ] No [ ] Name: Telephone no:

APPENDIX 6.3 Letter to Questionnaire respondents

Occupational Therapy Dept

Hospital
March 2007

Occupational Therapy Research:
<u>The effect of patient engagement on the outcomes of Occupational Therapy</u>

Dear Colleague,

Thank you for agreeing to participate in research about the Canadian Occupational Performance Measure. I really appreciate the time taken to complete the attached questionnaire.

I am Head of Occupational Therapy in an Acute Foundation Trust and am carrying out some research as part of my post graduate studies with the University of Blank, into the impact of outcomes on patient engagement in Occupational Therapy.
The purpose of this questionnaire is to examine the effect of using a client centred outcome measure on the result of occupational therapy intervention in the UK

Completing the questionnaire should take no more than 15 minutes of your time.
Please complete all sections of this questionnaire by following the instructions given for each question.
All answers are confidential and non attributable.
The results of this questionnaire will only be used for research and will contribute towards the evidence base of the profession. They will be destroyed once the data is analysed.

When you have finished, please return it in 'word format' and email it back to me on;
xxx@yyy.co.uk (pseud.)

Or post it to me at the above address and return in the stamped addressed envelope.
I would appreciate returned forms by:
Easter: Friday April 10th 2007

The results of this research will be published on the Copmnetwork website – www.copmnetwork.co.uk but if you wish to have an individual copy of the results please let me know by email.
Thank you for your time and effort

Research student

Appendix 7.1 Therapist Interview Guide

What does it mean to you to practice client centred occupational therapy?

Therapist: Number:

Introductory question:

Tell me how you consider that you demonstrate client centred practice in your everyday contact with clients

Specific questions:

	Therapist question	Code
Q1	How did you address the client when you first made contact with them? How did you address the client when you met with them subsequently	
Q2	How did you explain about your role to the client ?	
Q3	What value did you put on the client's own views and how was that communicated to the client?	
Q4	What value did you put on your client's contribution to the treatment plan & did it reflect their needs	

Q5	How did you involve the client in treatment planning?	
Q6	Did the environment affect how you worked with the client?	
	how did you respond to the client choosing what mattered to them	
Q7	How did you decide what treatment goals to work on?	
Q8	How did you ensure that the client understood what you were doing and why?	
Q9	Did you identify any risks and explain the consequences to the client?	

Appendix 7.2 Client Interview Guide

What does it mean to experience client centred occupational therapy?

Introductory question:

Client:

I would like you to tell me what it was like for you when you saw the occupational therapist?

Client Question	Prompts
Tell me how the therapist greeted you when you first met?	How did that make you feel? How was that different to when you met other health professionals?
Tell me how the therapist explained why she was seeing you?	Did she use words that you understood? How did this compare with other health workers?
Were you given enough information about this so that you could understand how she could help you?	feeling of being informed needing more / different information how was this different?
Did you feel that the therapist was listening to what you were saying?	How did that make you feel? How did you know that?
Tell me how you knew what help you needed?	working together Was any decision taken for you?
Did you feel that you and the therapist worked together?	What was that like? was there any sense of the therapist taking over / letting you take the lead?
When you met with the Occupational Therapist did you feel in control of what was happening ?	being included Were you in charge / or the therapist?
What was important to you about being seen at home?	How did that feel? How was that different to anywhere else / being in hospital? What did it mean to be in your own home?

Did you feel able to choose what was important to you?	Confidence? Being able to say what you wanted? How was that different to other health workers?
Did the occupational therapist speak to you in ways that you understood?	What did that feel like? Did it make sense?
Did the therapist talk to you about any risks which might affect you?	What did that mean to you? Did you have concerns? What were they and did it make a difference?

Appendix 7.3 PARTICIPANT/ CLIENT INFORMATION SHEET:

Study:
Client-centred practice in occupational therapy
REC. Reference Number: 12/SW/0061

I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. Please take a few minutes to read through this information.

- **Part 1:** tells you about the purpose of this study and what will happen if you take part.

- **Part 2:** gives you more detailed information about the conduct of the study

Please feel free to contact me if there is anything that is not clear.

It is up to you to decide to join the study. If you do not wish to take part then there is nothing you need do – please ignore the rest of this information.
If you are willing to take part, then please complete the reply slip at the end of this information sheet. I will then contact you to arrange to meet and at that point I will then ask you to sign a consent form.
You are free to withdraw at any time, without giving a reason.
This would not affect the standard of care you receive.

Part 1:

The purpose of this study is to understand what your experience was like when you were seen by an occupational therapist.
Your involvement will mean talking to me about your experiences of being seen by an occupational therapist, as well as answering some questions about how you feel about this. This should take no longer than 1 hour and will take place in your own home.
The interview will be recorded using a tape recorder.
Taking part in this study will not affect any current or future occupational therapy treatment which you may require.

There are no risks identified which may affect you if you decide to take part in this study.

I cannot promise the study will help you but the information I get will help improve how occupational therapists work with their clients in the future.

I will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering taking part, please read the additional information in Part 2 before making any decision.

Part 2:

Your right to withdraw:

You may withdraw from the study at any time but keep in contact with me to let me know your progress. Information collected from the interview may still be used.

Complaint:

If you have a concern about any aspect of this study, please contact me and I will do my best to answer your questions. My telephone number is:

If you remain unhappy and wish to complain formally, you can do this via the NHS Complaints Procedure. Details can be obtained from the Blankshire Health and Care Trust PALS Department Tel:

Confidentiality:

All information which is collected about you during the study will be kept strictly confidential, and any information about you will have your name and address removed so that you cannot be recognised.

GP:

Your GP will be notified of your participation in this study, and I require your consent for this. Your GP will only be notified of your involvement and will not receive any details about the information you share with me.

Data Storage:

Once the interview has been completed, the tape will be labelled by number and will be retained in a locked safe in a swipe accessed office (the researcher's NHS Trust premises). Only NHS Trust employees have access to the office and the safe has restricted access by researcher and limited named personnel. Once the tape has been transcribed, it will be retained in medical records archives for 5 years according to NHS guidance, after which it will be destroyed.

Results:

The results of this study will contribute to my PhD thesis and will add to our understanding of how occupational therapists work with their clients to ensure they meet their needs. It is intended that the results will be published within professional publications. You will not be identified in any report or publication.

Ethics:

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the National Research Ethics Service.

Thank you for your time

Mrs   X   MSc DipCOT

PhD Researcher

Client Reply Slip:

Name:..

I am interested in taking part in this research study and consent to my name and contact details being given to Mrs X for the purpose of arranging an interview.

Signed:..

Date: ....

Appendix 7.4   REC. Reference Number: 12/SW/0061

Patient Identification Number for this trial: [   ]

CONSENT FORM

Title of Project: Client centred practice in occupational therapy – a study to explore the client's perspective

Name of Researcher: Mrs X

Please initial box

1. I confirm that I have read and understand the information sheet dated

Feb 12th 2012 version 3, for the above study

I have had the opportunity to consider the information, ask questions and have had these

answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to

withdraw at any time without giving any reason, without my medical care

or legal rights being affected.

3. I agree to my GP being informed of my participation in the study.

4. I agree to take part in the above study.

_____   _____   _____

Name of Patient: Date: Signature

_____   _____   _____

Name of Person   Date: Signature:
Taking consent
When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in medical notes.

V3 12.2.12

Appendix 7.5　　　　　**Letter to GP**

Date: <dd month 2011>

Dear Dr.....................................

I am an Occupational Therapist working at the Blank Hospital Blankshire NHS Foundation Trust (*pseud.*) undertaking research within Community Occupational Therapy.

Your patient:

Name:

Address:

Has given consent for me to inform you that they have agreed to take part in a research study I am undertaking as part of my PhD at the University of Blank

The purpose of this study is to understand what the experience was like when being treated by an occupational therapist.

Your patient's involvement will mean talking to me about their experiences of being seen by an occupational therapist, as well as answering some questions about how they feel about this. This should take no longer than 1 hour and will take place in their own home. The interview will be recorded.

Taking part in this study will not affect their current or future occupational therapy treatment. There are no risks identified which may affect them and this study has been reviewed and approved by the National Research Ethics Service.

The results of this study will contribute to my PhD thesis and will add to our understanding of how occupational therapists work with their clients to ensure they meet their needs.

If you have concerns about any aspect of this study, please contact me on:

Yours sincerely

Appendix 7.6   **Draft 1** Aug 2011 Interview schedule

What does it mean to you to experience client centred occupational therapy?

= central concepts of client centred practice (Sumsion 2000)

All other themes have been cross matched with the 2000 definition of Client –Centred Practice & all key aspects are included

Introductory question:

Client:

I would like you to tell me what it was like for you when you saw the occupational therapist?

Therapist:

Tell me how you consider that you demonstrate client centred practice in your everyday contact with clients

Specific questions:

Client Question	Main Theme	Underlying Theme	Therapist question
How did the therapist address you when you first met?	Respect	Being valued	How did you address the client when you first made contact? and subsequently
Did you feel that the therapist was listening to what you were saying	Listening	Being considered	what value did you put on the client expressing their own views
Did you feel that you and the	Partnership	being equal	what value did you put on your client's

therapist worked together			contribution to intervention
How did the therapist explain about why she was seeing you	Engagement	being Involved	How did you explain to the client about your role?
Were you given enough information about this so that you could understand how she could help you?	Informed decision making	Being informed	Who did you think was making the decisions about intervention?
Did you feel in control of what was happening when you met with the OT	Empowerment	Feeling in control	how did you manage the interview /s
What was important to you about being seen at home	Environment		Did the environment affect how you worked with the client?
Did you feel able to choose what was important to you	Choice	feeling confident	how did you manage the client choosing what mattered to them
How did you decide what help you needed?	Negotiating goals	joint working	How did you decide what treatment goals to work on?
did the therapist speak to you in ways that you understood	Communication		How did you ensure that the client understood what you were doing?
Did the therapist talk to you about any risks which might affect you?	Risks		Did you identify any risks and explain the consequences to the client?

Appendix 7.7

NHS Health Research Authority

NRES Approval

Appendix 7.8 Client Interview Sample of coding analysis:

Q5	How did the therapist explain why she was seeing you?	
63	I think the nurse, the district nurse might have got in touch with them to get in	
64	touch with me, I think that's how it went.	
65	*And did you know when they came and, and were getting to know you, did they*	
66	*explain what they were there for, did you understand why you were seeing them*	
67	Yes	
68	*As opposed to a nurse*	comm. Ex
69	Yeah	
70	*So what sort of words did they use, do you remember, how did that seem*	
71	Can't really remember	
72	*but somehow you knew the difference between seeing the nurse and the*	
73	*therapist.*	
74	Oh yes, yeah, well they did say like we've come to see if there's anything we can	ch.giv/comm. ex
75	do to make life easier in the home, apart from that I can't really remember.	
76	But they did explain why they were there so, you know, I knew they weren't	comm. Ex
77	nurses as such.	
78	Yes, good	
79	*How did you decide what help you needed*?	
80	How did I decide?	
81	Mmm	
82	Well on how I'd get about. She offered a stair rail and I said yes	ch.made/ch.giv
83	(phone rings) oh sorry.	
84	*That's alright*	
85	Yes she offered a stair rail and I said definitely ,yes, umm, she offered a stool for	ch.giv/ch.made/ch.giv
86	my shower but I said I wasn't really sure about that, well she said we'll bring you	
87	one for you to try (cough). I asked for a commode which fortunately I don't use	ch.made
88	very often but it's there, umm, and she offered me several other things that I	ch.giv
89	didn't think were, you know, be any help to me, but umm, yeah at the end of the	
90	day I ask for them all.	ch.made
91	*And the things that you felt you didn't need did she listen to that?*	
92	Yes, yeah, 'cos I haven't had a bath for, can't remember the last time I had a bath,	list.act
93	getting in and out of the bath and she actually went upstairs and she looked at	
94	the bathroom to see if there was anything she could give us to, but unfortunately	
95	we've got shower doors on the bath and she said she couldn't fit a bath thing	comm. Ex
96	because the shower rails would have to come down.	comm. Ex
97	She offered the grabbing rails but I said no not really because I can't get in and	ch.giv /IDM
98	out of the bath anyway, they'd be no good to me.	
99	She was very helpful, she was offering things that she thought I might be able to	ch.giv
100	use which I suppose somebody else might have been, but it was no good to me.	ch.made
	That's about it I think.	

Appendix 7.9   Therapist Interviews Analysis Tool

What does it mean to you to experience client centred occupational therapy?

Introductory question:

Therapist:

Tell me how you consider that you demonstrate client centred practice in your everyday contact with clients

Specific questions:

	Core elements from literature	**Attributes / underlying values**	**Therapist question**	**Code**	**Descriptor**	**Theme**
1	Respect	Being valued	How did you address the client when you first made contact? and subsequently	Resp: tit Resp: act	Shows respect by addressing person with their title Respect shown by actions	Relationship
2	Listening	Being considered	what value did you put on the client expressing their own views	List: act	Active listening to concerns	Relationship
3	Partnership	being equal	what value did you put on your client's contribution to intervention	Part:wd Part;act	partnership demonstrated by words said partnership demonstrated by action	Relationship

4	Engagement	being Involved	How did you explain to the client about your role?	Eng:dec Eng:act	actively involving person in decisions actively involving person in actions	Relationship
5	Informed decision making	Being informed	Who did you think was making the decisions about intervention?	IDM:	evidence of person acting /deciding on action based on information given	Power
6	Empowerment	Feeling in control	how did you manage the interview /s	Emp:act Emp:wds	giving control to person giving control by wds spoken	Power
7	Environment		Did the environment affect how you worked with the client?	Env: home Env: rsk	impact of environment risk of environment	Risk
8	Choice	feeling confident	how did you manage the client choosing what mattered to them	Ch: giv ch; made Ch: imp	choice given to person choice made by person choice - issues impacting on	Power
9	Negotiating goals	joint working	How did you decide what treatment goals to work on?	Goal:neg Goal:ID	goals discussed & agreed goals identified	Communication

10	Communication		How did you ensure that the client understood what you were doing?	Comm: wds Comm: ex Comm:inf	Words used wds of explanation information shared	Communication
11	Risks		Did you identify any risks and explain the consequences to the client?	Risk: ex Risk: id	risks explained risks identified	Risk
12			Words to describe client centred practice			Listening importance Partnership Respecting values

Appendix 7.10   Client Interviews data Analysis

What does it mean to you to experience client centred occupational therapy?

Introductory question:

Client:

I would like you to tell me what it was like for you when you saw the occupational therapist?

Therapist:

Tell me how you consider that you demonstrate client centred practice in your everyday contact with clients

Specific questions:

Core element in literature	Underlying Value / attribute	Client Question	Code	Descriptor	Theme
Respect	Being valued	How did the therapist address you when you first met?	Resp: tit Resp: act	Being shown respect by Title Being shown respect by actions	Relationship
Listening	Being considered	Did you feel that the therapist was listening to what you were saying	List: act	Having concerns actively listened to	Relationship

Partnership	being equal	Did you feel that you and the therapist worked together	Part: wd Part: act	Partnership demonstrated by words said Partnership demonstrated by action	Relationship
Engagement	being Involved	How did the therapist explain about why she was seeing you	Eng:dec Eng:act	Being actively involved in decisions Being actively involved in actions taken	Power
Informed decision making	Being informed	Were you given enough information about this so that you could understand how she could help you?	IDM:	evidence of acting /deciding on action based on information given by therapist	Power
Empowerment	Feeling in control	Did you feel in control of what was happening when you met with the OT	Emp:act Emp:wds	Being given control by therapist Being given control - by wds spoken	Power

Environment		What was important to you about being seen at home	Env: home Env: rsk	Impact of environment Risk in the environment	Power Risk
Choice	feeling confident	Did you feel able to choose what was important to you	Ch: giv ch; made Ch: imp	Choice given by therapist Choice made Choice - issues impacting on	Power
Negotiating goals	joint working	How did you decide what help you needed?	Goal:neg Goal:ID	Goals discussed & agreed Goals identified	Communication
Communication		did the therapist speak to you in ways that you understood	Comm: wds Comm: ex Comm:inf	Words used Wds of explanation Information shared	Relationship Communication
Risks		Did the therapist talk to you about any risks which might affect you?	Risk: ex Risk: id	Risks explained Risks identified	Risk

Appendix 7.11

THERAPIST INFORMATION SHEET:

Study:
Client-centred practice in occupational therapy
REC. Reference Number: 12/SW/0061

I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. This should take about a few minutes

Please ask me if there is anything that is not clear.

It is up to you to decide to join the study. You are free to withdraw at any time, without giving a reason.

Part 1:

The purpose of this study is to understand how occupational therapists practice in a client-centred manner and what this means when we work with our clients.

1. Your involvement will mean talking to me about your experiences of seeing clients, as well as answering some questions about how you practice as a client centred occupational therapist.

2. The interview will be recorded using a tape recorder and will take no longer than 1 hour.

3. Taking part in this study will not affect how you practice as an occupational therapist. There are no risks identified which may affect you if you decide to take part in this study.

4. I cannot promise the study will benefit you but the information I get will help the profession understand more clearly about the nature of client centred practice.

5. I will follow ethical and legal practice and all information you share with me will be handled in confidence. The details are included below.

If the information in Part 1 has interested you and you are considering taking part, please read the additional information in Part 2 before making any decision.

Part 2:

Your right to withdraw:

You may withdraw from the study at any time during the interview. Any information collected from the interview may still be used.

Complaint:

If you have a concern about any aspect of this study, please contact me and I will do my best to answer your questions. My telephone number is: 012345678.

Confidentiality:

All information which is shared with me during the study will be kept strictly confidential, and any information about you will have your name removed so that you cannot be recognised.

Data Storage:

Once the interview has been completed, the tape will be labelled by number and will be retained in a locked safe in a swipe accessed office (the researcher's NHS Trust premises). Only NHS Trust employees have access to the office and the safe has restricted access by researcher and limited named personnel. Once the tape has been transcribed, it will be retained in medical records archives for 5 years according to NHS guidance, after which it will be destroyed.

Results:

The results of this study will contribute to my PhD thesis and will add to our understanding of how occupational therapists work with their clients to ensure they meet their needs. It is intended that the results will be published within professional publications. You will not be identified in any report or publication.

Ethics:

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the National Research Ethics Service.

Therapist Reply Slip:

Name:...

I am interested in taking part in this research study and consent to my name and contact details being given to Mrs X for the purpose of arranging an interview.

Signed:...

Date: ....

Appendix 7.12   REC. Reference Number: 12/SW/0061

Therapist Identification Number   [   ]

CONSENT FORM

Title of Project: Client centred practice in occupational therapy – a study to explore the client's perspective

Name of Researcher: Mrs X

Please initial box

1. I confirm that I have read and understand the information sheet dated

Feb.12th 2012 version 2, for the above study

I have had the opportunity to consider the information, ask questions and have had these

answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at

any time without giving any reason.

3. I agree to take part in the above study.

_____   _____   _____

Name of Therapist: Date: Signature

_____   _____   _____

Name of Person   Date: Signature:
Taking consent
When completed: 1 for participant; 1 for researcher site file;

V3 12.2.12