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Portrait of Occupational Therapy

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Summary

The profession of occupational therapy promotes individuals to achieve health and wellness through engagement in meaningful occupations of daily living. This occupation focused profession plays a critical role in health care in a multitude of settings with a wide range of clients. This paper highlights a global overview of the philosophies of occupational therapy, the current international practices in occupational therapy, the education of therapists, and the roles of law and professional societies that govern the practice of occupational therapy.

Keywords: Occupational Therapy, Theory, Practice, Regulation, Ethics

Occupation occupies our body, mind and spirit. Meaningful occupation must drive our inquiry and distinguish our practice. Our therapies must engage mind, body and spirit.

Suzanne M. Peloquin (Peloquin, 2003)

Overview

Health professionals worldwide are faced with globalization, flexible health care delivery and significant advances in sophisticated technology. There is also a greater disparity between availability and levels of care (i.e. preventive and basic health care vs. advanced health care) and between developed and developing countries. Occupational therapists play an important role in preventive health care, development of wellness programs and in promotion of greater participation in society for individuals with disabilities. Occupational therapists meet the challenges of rapidly altering health care systems by preparing therapists to practice in a dynamic environment and through continuing education.

The focus of occupational therapy is occupation and the belief that participation in occupation is essential to health (Law, 2002). The rapidly changing and dynamic nature of contemporary health and human service delivery systems now requires the entry-level occupational therapist to possess basic skills as a direct care provider, consultant, educator, manager of personnel and resources, consumer of research, as well as advocate for the profession and the consumer. Consequently, therapists have recognized that treating clients in a natural environment (i.e. home, work or school setting) with an emphasis on prevention and promotion of health is critical. The emphasis on preventative care is reflected by the World Heath Organization (WHO), in their development of the new International Classification of Functioning, Disability and Health that seeks to promote better health outcomes for all persons (World Health Organization, 2001).

This paper emphasizes the current consensus on occupational therapy, the theoretical constructs of occupational therapy, its practice areas and models, as well as the fundamental ethics, governance and education that guide the implementation of services. These aspects seem critical to the further development of the discipline.

Definition of Occupational Therapy

The World Federation of Occupational Therapists (WFOT) defines occupational therapy as:

> *Occupational therapy is a profession concerned with promoting health and well being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by enabling people to do things that will enhance their ability to participate or by modifying the environment to better support participation* (World Federation of Occupational Therapists, 2004).

The word occupation is used in the most comprehensive sense and refers to the common everyday activities that make up one's day. Frequently categorized as work, play/leisure, instrumental activities of daily living, basic activities of daily living, occupations may include dressing, bathing, eating; volunteer work, paid work, school, home maintenance; and sports, card games, hobbies (American Occupational Therapy Association, 2002). Additionally, occupations are generally viewed as activities which have unique meaning and purpose in a person's life (Christiansen & Baum, 1997). Occupations are central to a person's identity and competence, and they influence how one spends time and makes decisions.

Occupational Therapy Practice

Occupational therapists provide services and create opportunities for persons to achieve independence in their home, community and workplace despite impairments, limitations or participation restrictions. Occupation, in all areas of living, is defined as a key determinant of function and well being of humans (Kielhofner, 2004). Occupational therapists are client-centered and direct their effort toward helping clients to perform those occupations that they have identified as critical to their life. The following scenario highlights the way in which occupational therapists may use occupation to foster their clients to regaining skills after injury and to resume all of the tasks they feel are needed to lead a meaningful life.

> *Richard Thompson is an attorney, respected for his business skills, admired for his fashion sense and his love of golf. Four months ago Richard had a stroke. During his recovery he had to relearn many things, including how to use one side of his body, how to walk and talk. But his first goal was to face the world looking well. Richard's occupational therapist understood his need to present himself in a way that matched his self-concept. Together they found the right combination of adaptive tools and modified techniques, so that Richard could perform his personal grooming and dressing. They also worked on the other tasks he would need to manage his home and return to work and his golf game. From grooming to leisure and home management activities, occupational therapy helped Richard to recover the skills he needed to resume a rich life of diverse occupations.*

Occupational therapy is most often offered as a part of health care services in hospitals (for psychiatric and physical impairments), day care hospitals, rehabilitation centers, long-term care facilities, home care programs, social services and housing, public and private schools, clinical outpatient settings, and preventive community programs. Occupational therapist uniquely insure that a client can perform tasks essential to their daily life, through modified and graded performance of the tasks, adaptation of the tools needed to perform the action or through adjunctive therapies within their environment. To achieve these goals, therapists work in close conjunction with other rehabilitation and education specialists, primarily physical therapists, nurses, physicians, teachers, psychologists and social workers. The goal of intervention is to enhance functioning within the client's chosen environment(s). There can thus be considerable overlap between disciplines. However, occupational therapists' expertise is in their knowledge of of occupation and the recognition of the importance of occupations within a particular environment to improve performance and the effects of disease and disability. Occupational therapy may be indicated for any of the following health issues:

• Development, modification or restoration of activities of daily living, work, or leisure skills
• Identification and facilitation of meaningful occupations
• Improvement, development or restoration of motor, sensory, cognitive or psychosocial components interfering with occupations
• Evaluation, intervention, adaptation, provision of equipment and training, within the environment and context in which occupations will be performed

• Acute care intervention to assess the ability to return to one's home environment safely
• Consultation with, and education of, clients, families and health care collaborators to provide a comprehensive rehabilitation approach.

Range of Current Practices

The importance of occupation as the focal point in the profession has generated an energetic debate on redefining the conceptual foundations and models of practice (Fisher, 1998). The profession, in the early 1900's, recognized "bedside" activity (e.g., weaving, needlepoint and crochet) and creative arts and crafts (e.g., wood work, cooper tooling, and leather work) for ameliorating the negative effects of both cognitive and physical impairments. Early treatment then reflected occupations which were representative of that era. An emphasis on the arts and crafts movement pervaded the effort to minimize the effects of industrialization. There was a gradual progression in the 1970's to incorporate more body-focused techniques, modalities and motor control theories and to embrace medical science into treatment. It was assumed, in this period, that improvement in functional performance skills would be generalized, if the underlying skills were present. As the profession evolved, scholars and therapists found that a richer description of occupational therapy was required to fully understand the underpinnings of the profession. The current understanding is that techniques need to be directly connected to activities that are interesting and motivating to our clients (Schwartz, 2003). In the past decade there has been considerable discussion of occupation and the developmental study of occupation, and occupational science (Clark, 1993; Clark & al., 1993). This discussion has sought to place occupation versus specific body functions at the forefront of practice and in doing so underline our unique contribution to our client's health and to health care systems (Wood, 1998). Broadly, occupational therapists and scholars agree that a relative balance of occupational performance is an essential force influencing the human being's state of wellbeing (Bruce & Borg, 2001; Kielhofner, 2004; Law, 2002; Law *et al.,* 1997).

In order to assist their clients therapists use the knowledge that engaging in occupations requires specific performance skills and those components are both constrained by the meaning which clients assign to an occupation and the context in which the occupation is embedded. This stance invites clients to engage in a wide range of activities and promotes the notion that engagement in occupation is essential for an individual's restoration of function and should be directed by the meaning which an occupation has for that individual. In addition to practice frameworks to guide occupational therapy practice, occupational therapy associations publish a list of standards to which occupational therapists are accountable. For example, The AOTA and the British Association for Occupational Therapists/College of Occupational Therapists publish standards of practice and education for Occupational Therapy. They delineate the requirement for the occupational therapy practitioner in the delivery of occupational therapy services, which are client centered and interactive in nature (American Occupational Therapy Association, 1995;College of Occupational Therapsits, 2003). The American association arranges its standards under the four headings of Referral, Screening and Evaluation; Intervention Planning; Intervention/Treatment; and Discontinuation of Services. These are matched by the British association and college with Referral and Consent; Assessment and Goal Setting; Intervention and Evaluation; and Discharge, Closure and Transfer of Care.

Guidelines that address practice for such a broad spectrum of clients, settings and treatment help to provide a focus for the unique role of occupational therapists (American Occupational Therapy Association, 2002). In the initial phase of treatment the therapist will be interested in evaluating which occupations are causing difficulties (e.g., work, leisure and/or activities of daily living), the occupational history and balance of occupation, the client's priorities and targeted outcomes and, finally, the context in which the client will be performing the desired occupation. The therapist then concentrates on an analysis of occupational performance capabilities by observing the performance of occupations by collecting data about factors that limit completion of the occupation. This leads to an analysis of the demands of the activity and delineation of the areas for intervention, based on best practice evidence. Intervention strategies can then be implemented and are broadly classified as either establishment or restoration of function, maintenance of function, promotion of health, modification of the context of the occupation or prevention. Therapists may use occupationally based activities (e.g., meal preparation, adaptation of a keyboard to prevent a repetitive injury), purposeful activity (e.g., practicing a golf swing), or a preparatory method (e.g., splinting and exercise). The benefits of collaborative efforts with other professionals and the unique preventive services provided by the occupational therapist are illustrated below.

Tommy weighed just three pounds at birth. Doctors warned his parents to be on the lookout for problems that might affect his development. His family was invited to become part of a community developmental screening program that provided periodic evaluations for children. As an infant Tommy had difficulty coordinating his breathing and ability to nurse or take a bottle. While the occupational therapist developed an adaptive aide to enable Tommy to use a bottle and guided his parents in adaptive feeding techniques, a speech and language pathologist help Tommy to improve tongue movements and feeding strategies. As a toddler Tommy, who was later diagnosed with a developmental disability, attended a early education program where an occupational therapist, provided opportunities to promote his physical and mental development during play and in the classroom. For youngsters like Tommy, the occupational therapist identified occupations such as eating, playing, and interacting successfully with family members and friends as the most critical to the child and the family. Working together as a team, the family, teachers and therapists helped to both promote typical development and prevent secondary impairments.

Models of Practice

Occupational therapists agree that participation in occupational is the core element of therapy and by which they are able to influence health (Kielhofner, 2004; Law et al., 1997). Our practice then reflects the active engagement or facilitation and identification of relevant occupations during therapy sessions. This would support the provision of opportunities for clients to engage in occupations, actively determine whether modification of environments and tasks are required and to provide adaptations to related occupations (Fisher, 1998). A number of treatment models reflect the pragmatic needs of therapists and clients during treatment sessions (Kielhofner, 2004). Several models of practice influence both the initial assessment of the client and how intervention is approached. These conceptual models attempt to bridge the core constructs of occupational therapy and provide guidance for clinical practice. The following are commonly used in practice to direct assessment and intervention:

Biochemical model (Trombly & Radomsmski, 2002); Cognitive disability model (Bruce & Borg, 2001); Cognitive perceptual model, (Katz,1998); Group work model (Bruce & Borg, 2001); Sensory integration model (Bundy *et al.,* 2002; Motor control model (Mathiowetz & Haugen, 1994); Model of Human Occupation (Kielhofner, 2002); Canadian Model of Occupational Performance (Canadian Occupational Therapy Association, 2002) and Person-Environment Occupational model (Law *et al.,* 1996).

Roles of Professional Organizations in Supporting Occupational Therapy

The WFOT, with over fifty member countries, acts as the official international organization for the promotion of occupational therapy (World Federation of Occupational Therapists, 2002a). It maintains the ethics of the profession and advances the practice and standards of occupational therapy internationally. WFOT also promotes internationally recognized standards for the education of occupational therapists (World Federation of Occupational Therapists, 2002b).

The World Health Organization (WHO) and the WFOT provide both organizational structures and act as governing bodies of accepted countries. The WHO, in its effort to broaden the understanding of the effects of disease and disability on health, has recognized that health can also be affected by the inability to carry out activities and participate in life situations.

Many countries have established an overarching governing body that helps to shape and promote the practice of occupational therapy. These organizational bodies serve to promote laws, and practices that reflect the importance of engaging persons with disabilities/impairments in citizenry and promote access to all avenues of living (i.e., discrimination in work settings). The professional organizations also screen the educational courses offered as part of occupational therapy programs to ascertain if they meet the standards of, and report to, WFOT every 5 years.

Ethics

The ethical standards of WFOT are reflected in the standards set by many governing organizations. The four basic principles: beneficence, nonmaleficence, autonomy/confidentiality/privacy, veracity, fidelity and justice have guided the development of the minimal educational standards adopted by WFOT and of many of the professional organizations. For each principle, the professional organizations have defined how they are to be applied to practice (American Occupational Therapy Association, 2000; College of Occupational Therapists, 2001; Occupational Therapy Association of South Africa, 2000).

Educational levels and certification to practice occupational therapy

Occupational therapists have been able to adapt occupational therapy conceptual foundations and therapeutic approaches to different cultures and environments. The certification to practice occupational therapy is typically tied to the educational background achieved by the individual. In most countries eligibility to practice occupational therapy is granted on completion of the appropriated education program. The latter must follow the minimum standards set forth by the WFOT (World Federation of Occupational Therapists, 2002b). As an example, to practice occupational therapy in Australia, Canada, Denmark, Sweden, and the United Kingdom requires completion of an educational program that is typically 3-4 years in length and addresses the standards for education set by WFOT. The WFOT minimum standards are specific about each of the general requirements, and countries must meet these standards to qualify for members. The latter include supervised fieldwork experience prior to independent practice. Because most countries, even if they are not official members of WFOT, use these educational standards, the practice of occupational therapy demonstrates many similarities worldwide.

In addition, some countries may require a national board examination for qualification to practice. This examination is intended to reflect both knowledge of theories and practice. For example, in order to practice in the United States, occupational therapists need to pass the National Board for Certification In Occupational Therapy Certification Examination. In order to sit the examination, therapists, including internationally-trained occupational therapist need to have graduated from a WFOT approved school or have been determined eligible following review of their educational and fieldwork qualifications. In the United Kingdom all programs in occupational therapy education follow the curriculum framework as developed by the Curriculum Framework Steering Group, College of Occupational Therapists (1998). While these guidelines allow a diversity of emphasis and delivery, programs are required to meet the minimum standards for state registration and the minimum requirements of the WFOT.

The WFOT standards indicate that each program will include statements of the conceptual framework, program objectives, the structure and content organization (including subjects to be taught, the sequence of subjects and their interrelationship, learning experiences and teaching methods, and the learning and teaching resources to be used. A program outline would include basic sciences, theory and application of occupational therapy and therapeutic activities, including 1,000 hours of fieldwork experience. Basic sciences would include anatomy and physiology, kinesiology, psychology, research methods, statistical analysis, social and industrial legislation, medical and surgical conditions, psychiatric conditions and cognitive impairments. Theory and application would include a survey of occupational therapy, professional procedures, use of activities/occupations as treatment, as well as management and administration.

The majority of educational programs are based in universities, while others are located in technical schools or in hospital-based training schools. Post-graduate and doctoral education has now been developed in 20 countries. As of 2002, there are 41 countries with 355 schools that are full members in the WFOT. For example, in the United Kingdom, there are currently 38 validated programs being delivered in 27 higher education institutions with a total of 1,500 students enrolled in each year. In 2000, 1,325 new graduates entered practice as state registered occupational therapists (Quality Assurance Agency for Higher Education, 2001).

Most recently, professional Master's degrees (often referred to as an entry-level Master's degree programs) have been introduced as an alternative entry into the profession. These degrees, similar to those in physical therapy, require that a student enter the occupational therapy educational program with a Bachelor degree. On completing the program a student is awarded a Masters degree in occupational therapy. In the United States, this type of Masters

degree will be required to practice occupational therapy by 2005. Canada and Australia have introduced four Master's degree programs, and the UK has a Masters degree program at the University of Brighton. Other countries are debating the merits and the consequences of changes in educational standards in their country.

The European Network of Occupational Therapy in Higher Education (ENOTHE) is striving to promote and advance the education and body of knowledge in occupational therapy education (ENOTHE, 2000). The establishment of an inter-country Masters degree will, it is hoped, facilitate both development of a wider use of evidence-based practice and the consistency of philosophical and educational standards. ENOTHE has made substantial gains through work on problem-based learning, credit transfers, and in developing a occupational science based curriculum (Renton, 2002; Van Brugge, 2002). Three other European nations (The Netherlands; Sweden; and Denmark) have recognized the need for enhancing professional needs in clinical, managerial, education and research and have developed a European Master of Science in Occupational Therapy (Fitinghoff, 2002).

The imperatives leading to the introduction of post-graduate Master's degree programs include the increased qualification base of applicants and the need for practice to be evidence based, as well as the concurrent qualifications of other health professions. The benefit of a Masters degree as an entry program to the profession is perceived as a mechanism for increasing the skills of practitioners who will contribute to the research base of the profession.

There is increasing interest in the use of problem-based learning (PBL) approaches in the education of health professionals (Sadlo, 1997). "Problem-based learning" is an approach to learning where students focus from the beginning of their course on a series of real professional issues, and where the knowledge of the various academic disciplines that relate to these issues is integrated (Barrows, 1985, 1994). The process evolved from dissatisfaction with the usual teaching methods in higher education, particularly in medicine (Barrows, 1985, 1994). It seems eminently applicable to the education of occupational therapists, and wider adoption has been advocated.

While many faculties in Australia, Canada, UK and USA possess advanced degrees, this is are still not common in occupational therapy where approximately 1-5 % of therapists hold advanced doctoral degrees (Association of Schools of Allied Health Professions, 2001).

Continuing Education

The basic principles of continuing education are directed at delivering effective, efficient and safe client-centered, occupation-based intervention. One of the stated goals of both WFOT and numerous national professional organizations are to provide and encourage the participation in continuing education. Many organizations expect continuing education by their members, and this requirement is incorporated in national charters (American Occupational Therapy Association, 1995; Australian Association of Occupational Therapists, 2002; Canadian Occupational Therapy Association,1997; College of Occupational Therapists, 2002; Occupational Therapy Association of South Africa, 2000). Although there are some arguments that oppose the existence of mandatory continuing education requirements, they may be overshadowed by the many benefits, which can be achieved by such standards. In the United States, the National Board for Certification in Occupational Therapy (NBCOT) recently established the National Commission on Continuing Competency in Occupational Therapy. This body is developing national standards for continuing competency in occupational therapy in the US. The Canadian Association of Occupational Therapists, College of Occupational Therapists in the UK and the Australian Association of Occupational Therapists have also developed a core set of competencies with which therapists are able to demonstrate their fitness to practice.

Much of the continuing education for occupational therapists happens at the local level in the form of in-service within the workplace, through Web-based courses, courses taught at a local university/college and through locally sponsored courses. Some of the most popular courses include: occupation and occupational science, evidence-based practice, neurodevelopmental treatment, craniosacral treatment, myofascial release, sensory integration, and training in specific testing procedures. The tremendous interest and growth of the study of occupation and occupational science is evident in conferences and scholarship from Australia, Canada, Denmark, Japan, New Zealand, Spain, Sweden, Taiwan, the United Kingdom and the United States (Clark, 2001; Molineux, 2000; Zemke, 2000).

Occupational science, the study of how engagement in occupations (e.g., activities of daily living, leisure and work) is central to the human experience, has been the subject of presentations at conferences in many countries.. Consistent with this level of interest many graduate level programs are being founded in occupational science in Australia, Denmark, Sweden and the United States.

Conclusions

Occupational therapy is a complex intervention that focuses on enabling clients to achieve the balance and pattern of meaningful occupations. Occupation is here defined as all the actions required for of daily living, within their chosen environment (Creek, 2003). This paper has briefly outlined some of the activities of occupational therapists. It has highlighted the role that occupational therapists assume to function as partners with their clients to create successful matches between the person's abilities, their environment and the occupational demands.

Therapists work with a diverse client population of all ages and abilities and practise collaboratively with other team members and with many of their clients. The unique contribution of occupational therapists is their focus on engagement in meaningful occupation as the primary goal for achieving better health and regaining active participation in life. Thesetherapists use occupation as both a means and an end to help their clients perform the activities essential to their daily life. (Law *et al*., 1996). Occupational therapists strive to understand how to provide therapy to a diverse cultural client population, improve efficacy of treatment and apply a more evidence-based practice to implement treatment effectively (Fletcher & Fletcher, 1997; Ottenbacher & Maas, 1999).

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Figure 1

Relationship between conceptual foundations and the practice of occupational therapy