EDITORIAL

Katie Cremin
Assistant Professor
Discipline of Occupational Therapy
Trinity College Dublin

Translational research - it’s a two way street.

As we come to the end of another year. We look forward to a fruitful and exciting 2013 for Occupational Therapy in Ireland. It is wonderful to see submissions from all domains of Occupational Therapy in Ireland, including university and practice, and indeed those that cross the boundary such as practice education. Assuming that there is a linear relationship between the production of research evidence and its implementation in practice would be a little naive. The use of research in practice is not only the responsibility of those in practice, but also those who commission the research, carry out the research and provide the service (Buckley & Whelan, 2009).

When we carry out research with the purpose of impacting Occupational Therapy practice and contributing to the knowledge base, from the outset it is important to consider how the research will do this. In this context, the application of the research becomes as important as the research itself. There is a growing trend for this type of research, and it makes complete sense. If we wish our practice to be evidence informed, the evidence needs to be applicable and accessible. Research that is applied is often referred to as translational research, i.e. it can translate to policy and practice. This type of research demands researchers and practitioners to communicate and work together. The linear relationship needs to be dissolved into a collaborative endeavor, where expertise are respected and end results mutually beneficial. Finding shared research goals is an important first step towards more translational research in Occupational Therapy. This is not always possible – but where the research is attempting to link directly to practice, it could be argued that this type of collaboration is imperative. Questions such as, ‘What will the impact of this research be?’ ‘Can we predict the impact of the research within the context of practice?’ ‘How valuable

will this impact be to service users?’ are all important questions to ask before embarking on translational research.

Within Irish Occupational Therapy practice we have seen so many wonderful developments in research and evidence informed practice initiatives over the last few years. From the appointment of a CPD officer in AOTI, through to workshops and initiatives to promote evidence informed practice and research skills. It is time to stop and ask, “How is our practice improving and changing through evidence in research?” and ‘How are practitioners incorporating new evidence into practice?’ And importantly, what are the barriers and enablers to this happening? We are arming ourselves with the skills and the knowledge, but do the effects seep through into service delivery and positive end gains for our clients?

Communication is key. Knowledge works both ways, it doesn’t filter its way down from “on high” to infiltrate practice! Most often practice creates knowledge and questions, which the research affirms and answers. Our Occupational Therapy researchers need to understand policy and practice in the same way as our practitioners are learning about research and evidence. We need to continue to collaboratively question policy and practice with new evidence bases and create new questions to collaboratively research.

REFERENCES

Buckley, H. & Whelan, S. (2009) Putting research evidence to work: Key issues for research utilization in Irish children’s services. CAAB
RESEARCH ARTICLE: OCCUPATIONAL CONSEQUENCES OF LIVING WITH PARKINSON’S DISEASE

Professor Gill Chard PhD, BSc(Hons), DipCOT, Formerly Head of Department/ currently Visiting Professor, Department of Occupational Science & Occupational Therapy, Brookfield Health Sciences, University College Cork, Cork.

Edwina Walsh, BSc(Hons)OT, Occupational Therapist, Occupational Therapy Department, Naas General Hospital, Naas, Co.Kildare.

Introduction: Persons with Parkinson’s disease face a range of physical, psychosocial and emotional challenges, which result in increasing limitations in their daily occupations and social roles. While the impact of physical and functional limitations is well documented, there is less written in the Occupational Therapy literature focusing on the psycho-social aspects of increasing inactivity, dependence and loss associated with Parkinson’s disease.

Method: This paper presents an occupational perspective of four persons aged 63 years and over living with Parkinson’s disease in Ireland. Using narrative qualitative inquiry, personal accounts were obtained through unstructured interviews, which provided insights of the impact of the disease on the lives and occupations, both retrospectively and prospectively of those interviewed.

Findings: Indicate that loss of roles and independence were identified as major issues; while the importance of their work role, driver role and acquiring new leisure activities with family support was seen as critical.

Conclusion: Parkinson’s disease resulted in significant changes to the occupations and roles of these four persons suggesting a need for occupational therapists to consider how participation in occupation-focused interventions that encompass work, driving and leisure can be facilitated.

KEYWORDS
Parkinson’s disease, occupational therapy, occupational perspective, work, leisure

INTRODUCTION

Parkinson’s disease (PD) is a progressive neurological condition that affects approximately 120 per 100,000 population in Ireland (Parkinson’s Association of Ireland, 2009). Parkinson’s disease is characterised by cell death in the basal ganglia, specifically dopamine producing cells in the substantia nigra. Core features include tremor, bradykinesia or poverty of movement and rigidity, which result in a loss of spontaneous movements and a slowing of fine repetitive ones. These features may eventually affect all areas of occupational performance (Cutson et al. 1995) including loss of or changes to a person’s ability to carry out self care (Meek et al. 2010), and work and leisure activities (Dixon et al. 2007; Aragon & Kings 2010). The purpose of this study was to develop a better understanding of the impact of PD from the perspective of those living with the condition. More specifically, others have found that Occupational Therapy tends to focus on improving and maintaining function in washing and dressing, eating and drinking, domestic and kitchen skills, and that social and psychological needs are often left unaddressed (Deane et al. 2003a; 2003b; Aragon & Kings 2010). It was our intention to try and uncover an...
occupational perspective of PD including what is important to those living with the condition. Such information might add to the body of knowledge assisting occupational therapists and others to undertake meaningful and occupation-focused interventions.

LITERATURE REVIEW

Enabling individuals to achieve health, well-being and life satisfaction through successful participation in everyday occupations is a core purpose of occupational therapy (WFOT 2012). Yet much of the work that has been carried out with PD has focused on self care. While it has been acknowledged that the clinical management of PD consists predominantly of drug and surgical therapies (Cutson et al. 1995; Dixon et al. 2007; Meeks et al. 2010) the role of Occupational Therapy to facilitate and maintain usual levels of self care, work and leisure activities for as long as possible has been well documented (Murphy and Tickle-Degnen 2000; Gaudet 2002; Deane et al.2003a; Deane et al. 2003b; Dixon, 2007; Meek et al. 2010). Deane and colleagues (2003a; 2003b) found that Occupational Therapy provision emphasised functional goals such as transfers, mobility and self care and that many therapists reported a lack of knowledge and training in social and psychological techniques. While studies have explored the positive effects of Occupational Therapy it has been difficult in the past for occupational therapists to demonstrate efficacy of their interventions because of a lack of consensus on best practice and outcome measures (Deane et al. 2003b; Dixon et al. 2007). Moreover, where randomised studies have been carried out, small sample size and inadequate methods of randomisation and concealment have resulted in there being insufficient evidence to support or refute the efficacy of Occupational Therapy (Dixon et al. 2007).

Some qualitative studies have been conducted that provide an insight into the lived experience of PD and how it impacts an individual’s participation in occupations. While participants described significant difficulties with mobility, grooming, dressing, cooking, eating, shopping and housework, they also described a range of occupations that contributed to their health. Participation in exercise programmes, choir (that helped speech difficulties) and leisure occupations such as art, photography, computing and reading have all been discussed (Marr 1991; Karlsen et al. 1998; Benharoch and Wiseman 2004). Aragon & Kings (2010) concluded that there was no reason why, with appropriate management, people with PD should not continue in their work role for many years. Additionally that social, recreational and leisure activities that promote meaningful physical and cognitive activity, enhance movement, mental activity and pleasure should all be promoted. Finally, people with PD have reported reduced quality of life and a change in self concept that impacted all areas of their life including social life, home life, sex life, interests, hobbies and holidays that resulted in social isolation and anxiety (Marr 1991; Friedman & Friedman 1993; Schrag et al. 2000; Gaudet 2002; Benharoch and Wiseman 2004; Wressle et al. 2007). In short, it would appear that PD involves personal losses of mobility, independence as well as a disruption to the flow and structure of social interaction resulting in a changed self-concept. In recognising that people with PD experience many changes and losses, our aim was to gain a better understanding of these in order to develop an occupational (rather than a functional) perspective of Parkinson’s disease.

METHOD

Design

A qualitative approach was used or, more specifically, narrative inquiry. Narratives, or stories, have been used to examine experiences of illness, caring and healer/patient relationships as they are a means to access events that otherwise could not be witnessed (Mattingly 1998; Elliott 2009). As narratives recount both actions and experiences, Mattingly believes they illuminate human character and create experiences for their audience. The narrative interview was used to collect rich descriptions of people as they exist in their natural spaces. The aim with this approach was to seek temporal and meaningful aspects of peoples’ lives through in-depth interviews (Elliott 2009). Elliott believes that if people are allowed to tell their story (through the unstructured interview) it provides an ideal method for understanding more about people’s experiences and the meaning of these experiences in their lives.

Participants

The sample was not intended to be representative of all people with Parkinson’s disease. A convenience sampling technique was used with people who met the inclusion criteria: a diagnosis of PD for at least 2 years (have experience of living with PD and not newly diagnosed), were over 50 years of age (did not have early onset PD) and were living at home (not in assisted living or residential care). Exclusion criteria included cognitive or communication problems sufficiently severe to prevent participation in an interview. The study was conducted in the Republic of in Ireland.

Participants were recruited through the Parkinson’s Disease Association of Ireland. The second author contacted the organiser of the local PD support group, who invited her to a meeting. The aims of the study were explained, information leaflets distributed and potential participants asked to contact the PDA Ireland organiser. Five persons volunteered to take part, however, one did not meet the inclusion criteria therefore four participants were recruited. None of the participants were known to the researchers prior to recruitment to the study. Very brief demographic details were gathered from participants, see Table 1 (pseudonyms have been used throughout). As the focus of the study was their experiences of living with PD, we did not collect medical or other information about disease severity, rather we allowed this to emerge from the interviews if it was felt important to participants.
Procedures

Approval was provided by the appropriate Research Ethics committees, and protocols for consent, confidentiality and anonymity were followed. The second author contacted each potential participant, and the study was explained and informed consent gained. Four participants consented to take part in one unstructured, in-depth interview and to having interviews audio-recorded. Each person chose to be interviewed at home. As the interviews were unstructured and were intended to facilitate the telling of a story, there was no formal interview guide and no pilot. The narrative interview is designed to encourage each person to speak with their own voice, and is therefore seen as empowering (as long as the interviewer is prepared to listen), (Elliott 2009). Therefore each interview began with the following statement:

Can you tell me about the changes in your daily life since the onset of Parkinson’s disease?

No prompts were given; if participants became ‘stuck’ they were encouraged to continue by the interviewer asking: Tell me more about…. or earlier you mentioned… can you give me an example of how that affected you?

The second author conducted all of the interviews. There was no time limit set on the interview length and all lasted between 45 – 90 minutes. A reflexive journal was completed after each interview to assist in capturing the essence of what had been said. This included taking particular note of events and the researcher’s own thoughts and feelings at the time. This was used later to raise the researchers’ awareness of their own influence and subjectivity during the interviews and the analysis process. More specifically, that the interviewer was a researcher and not a person with PD; this helped the researchers to be, as occupational therapists, more sensitive to the way each person constructed their story (as a person with PD) during the data analysis process.

Data analysis

In order to describe an occupational perspective of PD, narrative analysis was used and focused on content (rather than meaning) of each person’s story. Firstly, the interviews were transcribed verbatim and transcripts were read and re-read in order to develop a close familiarity with the material. During this first phase the aim was to enter into each narrative and try to understand the text from the participants’ stance (Silverman 2006). During this process concepts and ideas were noted and grouped into broad categories by the second author and reviewed by the first. This process was repeated several times until consistent themes emerged and agreement was reached by both authors. Finally themes were discussed, compared and contrasted with the literature and with each transcript.

To enhance trustworthiness participants were sent a copy of their own transcript, to confirm its accuracy and a summary for comment. Only one transcript was returned with no changes or comments. Due to the small sample size, saturation may not have been reached. The notes and comments in the reflexive journal together with frequent discussion between researchers throughout the data gathering and data analysis process were used to enhance reliability. An audit trail was maintained throughout detailing processes, thoughts, findings and decisions by the researchers (Krefting 1991).

FINDINGS

The themes that emerged paralleled many that had been noted in the literature, but two overarching categories summarised a dynamic process that had unfolded as participants described their lives with and without PD: looking back where participants described their life retrospectively and the changes that have occurred since their diagnosis of PD; and looking forward where participants described their life prospectively and discussed a future of living with PD. Within each overarching category a number of themes were evident; these can be found in Table 2 and are presented in more detail next.

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Looking back

In looking back, the impact of PD on participants’ lives was revealed. Three sub-themes were evident: Losing roles (work, driving, leisure for example); Making changes to the ordinary activities in life, such as the way personal care is carried out and different leisure pastimes; Living life more slowly which resulted in having to take more time and adjusting to changes in physical and cognitive abilities and mood.

Looking roles

Participants in this study described many losses. Three participants had to take early retirement from work due to the effects of PD which impacted emotionally and financially:

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<th>Table 2 – Categories and Themes that best describe living with PD</th>
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<td>Looking back</td>
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<td>Losing roles</td>
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...the whole body just slows down and you stop. (John)
I couldn’t afford to retire at that stage but then I gradually deteriorated. (Tom)

Driving was another major issue for all participants:
Driving was the hardest to get used to... it pains me to walk past the car all the time and know that I can’t sit in and drive. (John)

Only Billy is still driving:
I’d be lost... it would be a tragedy if I couldn’t drive. (Billy)

Driving cessation accentuated their dependence on others:
I have lots of appointments to attend, before I could go alone but now I am depending on others both to drive and stay with me. (John)

Anne had stopped driving at her family’s request; and John described his difficulties that ultimately led to him stopping driving:
I don’t drive for the simple reason that the reactions aren’t fast enough, there are no signals going from the head to the legs for about 10 seconds and that is too dangerous in traffic. (John)

Loss of independence was discussed in a number of contexts including difficulties with dressing, feeding and personal care due to physical limitations:
The hardest job of all is tying shirt buttons... you’ll laugh at that...opening more than closing that’s the hardest thing. (John)

My wife helps me put them (clothes) on and take them off. (Billy)

Embarrassment when requiring help with eating and drinking was described by two participants:
I would try to hold the fork but all the food would spill out because of my shaky hand... I am self conscious if people are looking. (John)

It’s awful embarrassing being a grown woman and having your food chopped up for you. (Anne)

Three participants described feeling self-conscious when they were out and in particular a change in attitudes of others towards them. This often resulted in feelings of discomfort:
People are tense, people aren’t relaxed around you. They keep repeating what they are saying... There’s nothing wrong with my hearing. (Anne)

Making Changes
All participants commented on significant changes to their leisure occupations, more specifically, that they had become spectators. Tom described going from an active soccer player to watching the game and even that was not without difficulties:
Now I am a spectator rather than a player... I would be uneasy in my seat and would have to leave half way through a game. (Tom)

Others had to change or give up their hobbies.
One thing that I was involved in was fishing and I had to give it up. You would be tying the line onto a fly (small fishing hook). I couldn’t hold it steady with my hand. I had to give it up, I was devastated. (John)

I was a very active golfer but it shattered my golf game. When I gave up golf I started playing bridge but that’s getting hard now, I can’t sort out the cards with my hands. (Billy)

He also added:
Bridge and golf seem like very sedate games but they meant a lot to me. (Billy)

Although there was a significant loss of some occupations, all participants also acquired new leisure occupations:
I love walking, I go every single day, and I’m like a new man when I come back. (John)

Seems as I spend so much time around the house I’ve started playing games on the computer like solitaire. Its not very testing but it keeps me going. (Anne)

Living slowly
All of the participants described the increasing length of time required to complete their occupations:
...everything is slower. It would take up to an hour to put on your clothes. If we were going somewhere at seven, I would have to start preparing at six. (Billy)

They also described the increasing effort required to complete activities resulting in them often staying at home or simply ceasing to do an activity:
Everything is so slow, which means everything is a problem and I tend to stay at home for that reason. (Tom)

Your movements are slow and you can be walking along anywhere and just stop. (John)

Looking forward
The over-arching category of Looking Forward focused on how PD impacted the lives and occupations of the participants now and in the future. Three main themes emerged: Keeping busy, Relying on a carer and Looking to the future.
Table 5 indicates the responses of physical needs assessed. This table indicates that large numbers of respondents felt their physical needs were assessed in each area.

**Keeping active/keeping busy**

Three participants spoke of the importance of keeping busy.

*Keeping active is about keeping positive. (Tom)*

*It’s important to be out and about, you’d crack up if you were in the house all day. (Billy)*

All the participants commented on sudden changes in their mood. Some had experienced depression, and this made engaging in occupations extremely difficult:

*You could be in good form some days, more days you would be depressed, you could be down and out and wouldn’t be able to do anything. (John)*

*There are often days that you could hit a block when you feel down. (Tom)*

*I feel so down... just down. At the moment I don’t know what’s wrong. (Anne)*

Keeping themselves motivated and positive about the future was also very important:

*Passing the time is important, you wouldn’t be thinking about yourself then. (John)*

**Needing your carer**

As time progressed, all participants spoke of the importance of having a carer in their lives, three of whom are family members, one was a paid carer:

*I’d be lost without my good wife, apart from the fact she tells me when to take my medication and do my exercises, she’s very motivating. (Tom)*

*I look forward to the day my carer comes, I’d be lost without her. (Anne)*

*Without my wife I’d be non-mobile. She’s completely involved. (Billy)*

The involvement of family members provided peace of mind and essential support to all the participants.

**Looking to the future**

Despite these difficulties, all participants showed optimism in talking about PD and the future. They spent some time reflecting on their present life as a person with PD, despite expressing feelings of despondency overall they were all positive:

*Until they find a cure, you have to stay positive. (Tom)*

**DISCUSSION**

It is clear that people with PD experience many changes and losses in their lives, and our study supports previous findings on this topic. Our aim was to gain a better understanding of what it is like to live with PD in order to develop an occupational (rather than a functional) perspective. Using narratives and taking this occupational perspective allowed us to gain insights into the lives of the participants who live with PD. They identified many changes to what they did and described the loss of important roles in their lives. Early retirement was seen as a significant loss by all the participants and is well supported by other literature. Schrag and Banks (2006) found that 46% of persons with PD had stopped working after 5 years and 82% after 10 years; Benharoch & Wiseman (2004) found that 62% of participants in their study had left paid employment because of their symptoms. The survey carried out by the Parkinson’s Disease Society in the UK in 2007 found that 17% of respondents had given up work because of their PD and wanted more support so that they could remain in employment (PDS 2008); Aragon & Kings (2010) state that in relation to work there is no reason why, with appropriate management, that people with PD shouldn’t continue to work for many years. Yet in the survey of 169 occupational therapists carried out by Deane and colleagues (2003b) work was mentioned in less than 1% of therapy goals suggesting that appropriate management by occupational therapists to keep people with PD in work, is not happening. Early retirement negatively impacts on income and over half of those surveyed by the PDS in the UK had additional spending because of their condition (PDS, 2008). This in turn impacted people’s abilities to engage in leisure, holiday and sporting occupations, something that was clearly very important to the participants in our study.

As participants were often forced into an early retirement because of PD symptoms, leisure activities took on a much more important role in their lives. Giving up or changing leisure activities has been reported by Wressle et al. (2007), and others have noted that engagement in meaningful leisure occupations can improve quality of life especially in older adults (Pereira et al. 2005; Aragon & Kings 2010). However, Deane et al. (2003b) noted that while occupational therapists consider social and psychological needs of people as important as their physical needs, their current practice emphasizes functional goals of transfers, mobility and self care and, in their survey, only 3% of occupational therapy goals related to leisure activities. This is not necessarily what people with PD want; the PDS (2008) found that while respondents all wanted access to appropriate equipment and support services, nearly half of those surveyed wanted to do activities outside their home such as pursuing hobbies and socializing. Aragon & Kings (2010) also recommended that people with PD should participate in activities that are pleasurable, social and recreational as many become socially isolated when they give up work and are unable to drive. Where participants had embarked on new leisure activities in our study, these clearly brought increased pleasure and satisfaction.
Community mobility and being able to drive for as long as possible was important to participants in this study as it enabled them to participate in other leisure and social occupations. Driving was named as an enjoyable occupation in itself, it also meant that participants were not dependent on carers for transportation. Yet despite driving deficits that are manifested occupationally, such as impaired visuo-spatial processing, planning and sequencing (Schrag, 2005), surprisingly few Occupational Therapy studies highlighted driving as an area of concern for people with PD (Gaudet, 2002; Deane et al, 2003a; PDS, 2008). Schrag (2005) suggests that overall driving safety in persons with PD is significantly impaired. Driver assessment and rehabilitation programmes therefore are important for continuing social participation, a lack access to this facility may result in individuals ceasing to drive earlier than expected or earlier than they might have wished (Stav, 2012). As noted by participants in our study, losing the ability to drive was the hardest to get used to. It meant they were dependent on their carers, increasingly socially isolated and with the potential to develop depression.

The participants described a range of strategies that enabled them to adapt to a new way of living. These included supportive family and carers, keeping active and keeping motivated. Marr (1991) highlighted the importance of family members but noted that PD may impact socially, emotionally and economically on the carer also. Occupations that were important to participants in our study included exercise, driving for as long as possible and hobbies such fishing, golf and playing cards. Marr (1991) noted that having family and others to help placed emphasis on the interaction between the person and their environment thus supporting occupations that were undertaken. Maintaining such occupations, that are enjoyed for the activity itself, appeared to describe something of the person, who they had been before the onset of PD. While they had a changed body and abilities, the essence of the person appeared to have been retained. This was evident through a dynamic process that they described: activities that they had engaged in, in the past, some they still engage in now and very much wanted to maintain for as long as possible in the future.

The participants also noted that activities such as exercise enhanced well-being and helped them deal with changing emotions, depression and isolation. Aragon & Kings (2010) recommended that cognitively complex exercise, such as playing games with rules (soccer or golf for example) is more beneficial than equivalent repetitive (rote) exercise. This cognitive aspect to exercise also enhances memory, thinking, planning and decision-making, thus improving mental as well as physical well-being, as noted by Anne when she began to play computer games and solitaire. Bloom and Munneke (2007) found that, for people with PD, keeping active was essential not only for preventing complications associated with PD but also because of the positive effects being active has on depression and sleep disturbance. Depression has been highlighted extensively throughout the literature and has been reported in 40-50% of persons with PD (Poewe & Seppi 2001). Schrag et al. (2000) found that depression is not always recognised when working with a person with PD. This is important as depression can have a major impact on quality of life (Schrag et al., 2000).

Participants in this study noted that while abilities change with age, the losses and changes experienced by those with PD occur in a shorter space of time and thus bring other issues with them such as self-consciousness and embarrassment. Individuals with PD often experience embarrassment (Chesson et al. 1999) and self-consciousness (Benharoch & Wiseman 2004) when eating and drinking in public and when cutting up food. Despite these negative effects being reported by our participants, our interviews highlighted that individuals remained optimistic about their future and retained a sense that they must ‘stay positive’. They found meaning in continuing to work and drive for as long as possible, and by engaging in active leisure occupations outside the home such as walking, fishing and golf. While maintaining independence in dressing, grooming, feeding and keeping mobile were all very important, and that a degree of dependence was inevitable, they wanted to maintain individual agency (Vik et al., 2008) including choosing and deciding for themselves which occupations they retained and which they gave up. In short, persons with PD expressed a desire for autonomy and a sense of control over their daily lives.

**STUDY LIMITATIONS**

This was a small-scale exploratory study conducted in the Republic of Ireland. While it is important to acknowledge the views and experiences of those interviewed these are not considered representative of all those with PD. All participants were Irish and Caucasian and belonged to one PD support group. It is not known if these findings would generalise beyond this sample, a larger study would be required to establish this. Reflexivity revealed that, as both authors have prior knowledge of PD and of Occupational Therapy literature, it is not known if this influenced the findings. However, the study offers insights into how PD has affected the lives of these four individuals from an occupational perspective. Further qualitative research would contribute towards a more comprehensive picture of this complex phenomenon.

**CONCLUSIONS**

This study aimed to uncover an occupational perspective of PD from those who live with the disease. For these four individuals, maintaining work and leisure occupations was particularly important to all of them. There would appear to be a tension between profession-led services that focus on personal and functional outcomes of self care and mobility, and what people with PD wanted: to have individual agency (Vik, 2008) to be seen, heard and supported to make choices in order to live their daily lives as they wanted maintaining normality for as long as possible (Marr 1991; PDS 2008; Wressle et al. 2007; Aragon & Kings 2010). While participants discussed personal care tasks, it was a small part of living with PD, and always in the context of a bigger picture of
retaining other occupations and their autonomy. All had accepted that while they needed to be reliant on another (carer) they also wanted and needed to maintain work, leisure and social roles that supported the essence of who they were and are. Those providing health and social care services need to remember that people with PD may have participation limitations caused by motor, cognitive and mood impairments but they are not ill and wish to be treated with dignity and respect. Occupational therapists need to consider how they can provide the social, emotional and practical supports that people with PD are seeking (PDS 2008; Aragon & Kings 2010) within the limitations imposed by the current economic climate and not simply focus on the physical symptoms. Organisations need to support and promote services that allow for the provision of community-based services that facilitate engagement in meaningful occupations, including physical and cognitive exercises, and recreational activities that are pleasurable and social. As Vik et al. (2008) point out occupational therapists do not always manage to be client centred and enable individuals to achieve health, well-being and life satisfaction through participation in meaningful occupations. Giving further attention a person’s individual agency including decision-making, choosing and being able to act in daily life, may challenge occupational therapists to find other ways of working in order to meet the occupational and social needs of clients.

ACKNOWLEDGEMENTS

We would like to thank our co-participants (Anne, Billy, John and Tom) for their time, willingness and honesty in sharing so much of their experiences of living with Parkinson’s disease. Also to Una Anderson-Ryan of the Parkinson’s disease Society of Ireland for allowing us to work with them and their members.

REFERENCES


CASE STUDY - REMEDIAL & COMPENSATORY APPROACHES IN THE OCCUPATIONAL THERAPY TREATMENT OF WERNICKE’S ENCEPHALOPATHY

Deirdre Deegan, MSc (Hons) OT, M. Litt. (Hons) Applied Social Studies, Senior Occupational Therapist, Community Mental Health Team, Bury Quay, Tullamore, Co. Offaly.

Michaela Smith, MSc Clinical Therapies (OT), BAppSc in Occupational Therapy. Senior Occupational Therapist, Midlands Regional Hospital Tullamore, Arden Road, Tullamore, Co. Offaly.

Background: Wernicke’s encephalopathy (WE) is an acute neurological condition caused by a thiamine deficiency. It is characterised by oculomotor and/or cerebellar dysfunction and an altered mental state, often inclusive of memory impairment. This short paper describes a case study: a young woman, diagnosed with WE, and the Occupational Therapy treatment she received after presenting with a severe memory impairment that affected her ability to participate in her everyday occupations.

Purpose: The aim of the paper is to describe the treatment provided by the acute based and community occupational therapists as they both endeavoured to devise treatment plans to maximise function and enable this young woman return to her most personally meaningful and fulfilling role as a mother.

Practice implications: At a time when resources are decreasing and service demands are increasing it can be difficult to be able to provide intense rehabilitation over a long period of time, which is required for someone with WE. However, this case study attempts to promote awareness of the condition and highlights that a remedial and compensatory treatment approach may be successful when treating memory impairment in this population. Further research is required to determine the long term efficacy of treatments.

KEYWORDS
Occupational Therapy, Wernicke’s encephalopathy (WE), Korsakoff’s Disease, memory impairment, remedial, compensatory.

INTRODUCTION

Wernicke’s encephalopathy (WE) is an acute neurological condition caused by a thiamine deficiency and frequently associated with alcoholism. Although WE and Korsakoff’s disease are two distinct entities they are best regarded as two aspects of the same disease, separable chronologically into acute (WE) and chronic (Korsakoff’s disease). The thiamine deficiency seen in WE is found most commonly on a background of long standing dietary insufficiency conditioned by the excessive use of alcohol (Manacall, 2008). The awareness of this condition is important because although Korsakoff’s disease is seen as progressive and irreversible, if WE is treated early enough, patients can have a degree of recovery. If WE is left untreated, it leads to death in up to 20% of cases or to the Korsakoff syndrome in 85% of survivors (Day et al., 2008). Up to 25% of the Korsakoff group will require long-term institutionalisation (Kopelman et al. 2009).

Disorders in memory are a common consequence of neurological injury or disease and memory impairment is expected in WE cases. Memory is a performance component required to successfully engage in most everyday activities, hence a memory impairment can have devastating effects on functional abilities. As WE is often associated with alcoholism, it is also described in the
Sarah's acute symptoms were treated with intravenous thiamine. She was also initially treated by the physiotherapist as she was deemed to be a moderate falls risk on admission, scoring 40/56 on the Berg Balance Scale (BBS). The BBS is a performance based assessment used to determine independence/dependence in functional balance. She quickly restored her functional balance, scoring 56/56 after a brief intervention.

**OCCUPATIONAL THERAPY INTERVENTION AND EVALUATION**

**Inpatient care**
Sarah initially presented to the acute occupational therapist with confusion and disorientation, with a score of 21/30 on the Mini Mental State Exam (MMSE). Through further functional assessments she was found to be independent in personal care, however was unable to recall events over a matter of hours. Therefore, the Rivermead Behavioural Memory Test (RBMT) was administered to further examine her memory impairment. Sarah scored 8/24 on the standard profile score and 2/12 on the screening score, suggestive of severe memory impairment. Her main deficits were episodic, prospective and working memory.

Goals for Sarah were to improve working and long term memory to recall events, actions, routes and people over extended periods. Memory is a cognitive component that allows information to be processed, stored and retrieved. Thereby, a memory impairment will negatively impact on an individual’s ability to independently function across all performance areas (Nadar & McDowd 2010). Therefore, goals were also set for Sarah’s higher executive functions that she would need in her role as a mother/wife i.e. paying bills.

The treatment following initial assessment included the implementation of an orientation board, an activity diary and principally a remedial approach to her memory impairment. Remedial treatment seeks to improve functional performance by retraining specific perceptual and cognitive skill components of action and behaviour. It assumes that exercise and practice promote CNS function (plasticity) or generates new performance strategies that are transferable across all activities (Nadar & McDowd, 2010). For example, improved performance at remembering objects on a page after a 24 hour delay could be transferred to remembering important appointments or timing and dosing of medication.

These memory activities were then graded upwards to include delays of minutes, hours and eventually days. Within sessions Sarah was taught methods to enhance her memory such as chunking, mnemonics (organising and categorising information) and rehearsing. Errorless learning was at the basis of the treatment. Errorless learning is a method for clients to learn something by saying or doing themselves, rather than by the therapist telling or showing them after an error. The person is not given the opportunity to make a mistake, so there are no mistakes to be remembered (Piras et al. 2011). It has been shown that Korsakoff patients are capable of new learning.
Sarah made significant progress in her memory and higher executive functioning over a course of ten weeks and was evaluated by two standardised assessments. The Rivermead Behavioural Memory Test (RBMT) was administered and she scored 12/24 showing slight improvement in visual working memory and episodic memory. She continued to have problems with auditory memory especially when distracted. To evaluate her higher functioning skills the Executive Function Performance Test (EFPT) was used. This is a top down performance test designed to examine cognitive integration and functioning in an environmental context. It identifies what clients can do and how much assistance they need to carry out a task. It examines four basic everyday tasks: simple cooking, telephone use, medication management and bill payment. There is a lack of instruments that occupational therapist’s can use to discriminate executive function, however the EFPT has been found to be a valid tool to assess patients with mild stroke (Cederfeldt et al. 2011). Sarah scored 8/125 on the EFPT. A higher score reflects the need for more cueing and demonstrates more severe problems with memory function. Therefore, Sarah’s score showed minimal to no assistance needed for the higher cognitive tasks she completed.

Prior to discharge Sarah was referred to the community mental health team. This was the best service to follow up Sarah on discharge because it was the only service that would offer occupational therapy in the community. Furthermore she would have the chance to be assessed by the mental health and link her into the addiction services. Sarah was discharged after ten weeks of intense inpatient rehabilitation where the community mental health occupational therapist continued her care.

Community Care

After much discussion with Sarah, her husband and then treating occupational therapist it was deemed appropriate for her care to now focus on a compensatory approach for her residual memory impairment, especially her ongoing short-term auditory memory deficits. Sarah’s treatment approach would go from being devised using a cognitive or top-down model to now using a functional or bottom up approach. A comprehensive literature review conducted by Nadar & McDowd (2010) suggested that the evidence supported the effectiveness of compensatory methods with mild to moderate memory dysfunctions and that this approach was more easily generalised to daily activities.

Dirette (2002) wrote about the use of compensatory strategies being most successful when a client had insight into his or her cognitive deficits. Sarah had insight, which is, she recognised that her memory had been affected by her condition. As a result she understood the impact of her memory impairment on her everyday life and was therefore embracing of the techniques to compensate. It was also important that Sarah’s therapy take place between home and community settings as opposed to a clinical environment to facilitate generalisation of training. Boman et al (2004) completed a study regarding cognitive training in the home environment and indicated that home-based cognitive training did indeed improve memory functions and facilitate learning of strategies.

An intensive community based programme consisting of three sessions per week for six weeks was implemented with the primary focus being on developing a ‘memory book’. The memory book proposed to encompass Sarah’s daily/monthly daily and to be designed to assist her participate in all the activities associated with her role as a homemaker and mother. This would include meal planners/how to prepare a shopping list, when to take medications, how to record important information from medical appointments etc. The memory book or “planner” contents were based on the sample sheets designed by Jameson (2008) and edited by the occupational therapist to ensure they included all relevant information required by Sarah. The strategies and advice were then followed up with practical functional tasks. She was encouraged to use devices such as the alarm on her mobile phone, the timer on the cooker and a pill box to assist as reminders with everyday tasks. The memory book and medium of meaningful occupation were individualised to Sarah’s roles, responsibilities and particularly focused on the strength of her visual memory while compensating for her poor auditory memory.

Sarah’s husband was actively involved in her treatment and each memory aid or compensatory technique was discussed with him so as to ensure he encouraged the use of same on a daily basis in their home environment.

The treatment plan was evaluated after six weeks to determine if the memory book and practical memory devices were facilitating Sarah’s participation in meaningful occupations. The focus of evaluation was determining if Sarah’s occupational goals were reached. Sarah was now independently shopping, preparing meals and managing her own medication. She could engage in everyday childcare tasks without being in fear of her residual memory impairment causing a catastrophic functional deficit as she was now actively compensating for same.

The RBMT was re-administered and Sarah’s standardised profile score was 15/24 and her screening score 7/12. This was a marked improvement on her initial scores in June 2011; however the scores were generally similar to when she was assessed prior to discharge from hospital in August 2011. As expected Sarah appeared to have plateaued in regard to memory improvements hence the importance of the need for a compensatory approach at that stage. It appeared that her visual memory, while not unadulterated, was better than her auditory short-term memory and this was taken into account when devising her memory book and carrying out practical tasks. Sarah’s remote and long-term memory remained stable.
However, of most significance is that Sarah could now function independently despite her residual memory impairment.

CONCLUSION & PRACTICE IMPLICATIONS

This case study provided information on how Occupational Therapy had an impact on the life of a young woman with WE. There are a number of practice implications that should be discussed in relation to the case study. The first is the effectiveness of the treatment approach used for Sarah’s memory impairment. A combination of remedial and compensatory approaches provided across the hospital and community settings was successful. However, as no long term follow up has been completed, it is difficult to determine the long term efficacy of the treatment. In any case, as Sarah reached her Occupational Therapy goals, this treatment approach should be taken into consideration for future patients with WE.

Secondly, the length of time intervention is provided to this population may have an effect on the long term outcome. It is difficult to determine if Sarah may have continued to make gains or, on the contrary, relapsed to her previous state since discharge, since her treatment was for a limited period with no follow up. She was discharged from Occupational Therapy when she was functioning safely at home with a good level of supervision. In the literature, little is known about long-term outcomes as there are very few long-term follow-up studies. One Australian study found that half of a series of 104 Korsakoff patients who underwent a rehabilitation programme were functioning in the community after 1–2 years following discharge from hospital (Leenane, 1986). The authors indicated that the rehabilitation process is long and some results of improved cognitive function take years to be seen. Therefore Sarah may have continued to make further gains if treatment was prolonged. The length of time intervention is provided needs to be considered, as progress with WE and Korsakoff patients has been shown to be slow.

On the other hand, as Sarah has not been followed up, she may have regressed since discharge from Occupational Therapy. This is highly likely if she started to consume alcohol again. Day et al (2008) reports that improvement occurs in approximately 75% of Korsakoff patients over a matter of years only if the patient remains abstinent. Other literature on WE and Korsakoff’s also highlight the importance of abstinence and state that it is the cornerstone of any rehabilitation program. Therefore, another implication for practice is ensuring a multidisciplinary team approach. This is to allow the client access to mental health services and counseling in order to address their addiction; otherwise the rehabilitation program could be meaningless.

The last practice implication the case study has shown is not to presume that cognitive deficits automatically predict functional deficits (a top down model of thinking). If cognitive deficits are compensated for, then the impact of these deficits on function can be minimised, if not eradicated. Giles (2010) wrote a commentary on cognitive versus functional approaches to rehabilitation and observed that, while there has been a historical preference for cognitive rather than functional interventions, there is now significant empirical support for both approaches to intervention.

At a time when resources are decreasing and service demands are increasing it can be difficult to be able to provide intense rehabilitation over a long period of time which is required for someone with WE. However, this case study attempted to promote awareness of the condition and highlighted a combined treatment approach may be successful when treating memory impairment in this population. Further research is required to determine the long term efficacy of specific treatments.

N.B. The name and identifying references in this case study have been changed in order to protect confidentiality.

REFERENCES


THE USE OF THE 2:1 MODEL OF PRACTICE EDUCATION WITHIN A COMMUNITY REABLEMENT UNIT: PERSPECTIVES OF STUDENTS AND THEIR PRACTICE EDUCATOR

Ms. Gillian McHugh, BSc. (Hons) Curr. Occ; PG Dip. Clinical Therapies (Occupational Therapy), Senior Occupational Therapist & Practice Tutor Community Reablement Unit, Our Lady’s Hospice & Care Services, Harold’s Cross, Dublin 6W.

Ms. Jane Brownlee, BSc. (Hons) Curr.Occ, Occupational Therapist, Our Lady’s Hospice & Care Services, Harold’s Cross, Dublin 6W.

This small-scale study aims to explore the practical application of the 2:1 model of practice education in a rehabilitation setting from the perspective of two Occupational Therapy students and their practice educator in a Community Reablement Unit (CRU). The 2:1 model is a collaborative model where two students are allocated to one practice educator. Many advantages have been attributed to using the 2:1 model in practice in preference to having one student with one educator including the benefit of peer support and learning that exists when two students are working together (Gallagher & Cahill, 2008; Martin et al, 2004; Moore et al, 2003; Currens and Bithell, 2003).

Qualitative methods using self-developed questionnaires were used to elicit participants experiences of participating in the 2:1 placement. Individual participant responses offer insight into the benefits and challenges of completing a 2:1 placement in a Community Reablement Unit for older people. Findings include the impact of student compatibility and their preparation before placement for working within a 2:1 framework along with the professional development opportunity a 2:1 models offers the practice educator with support from a practice tutor. Practical aspects of planning for and facilitating a 2:1 placement such as management of individual learning styles, providing access to caseload and managing group supervision sessions are discussed. Similarly the role of the practice tutor in development collaborative placements is also discussed and implications for future use of the 2:1 model are identified.

KEYWORDS
2:1 model; practice education; occupational therapy; Reablement.

INTRODUCTION

This study aims to offer example from practice on the practical application of the 2:1 model for Occupational Therapy students in a rehabilitation setting. The Community Reablement Unit (CRU) is a twenty-four bed unit offering short-term intensive multi-disciplinary rehabilitation within a reablement model for well older adults living in the Dublin Central, South Central and West areas. The aim of reablement is to enhance independence and participation in daily life with a focus on health promotion and wellness. Although the traditional 1:1 model of student education has been pervasive in Occupational Therapy student education, the literature has more recently highlighted other feasible alternative models such as the 2:1 (Gallagher and Cahill, 2008). By definition, a collaborative model offers “a collaborative or cooperative model of clinical education in which two or more students are assigned to one clinical instructor” (DeClute & Ladyshewsky, 1993, p. 684).

Many advantages have been attributed to using the 2:1 model in practice in preference to having one student with one educator. The literature recognises the valuable peer
support and learning that exists when two students are working together (Gallagher & Cahill, 2008 p.23; Martin et al, 2004 p.193; Moore et al, 2003 p.493). There is recognition that students may take responsibility for their learning at an earlier juncture with increased opportunity for peer reflection to support learning (Morris & Stew, 2007 p. 424) when engaged in a 2:1 model.

This qualitative study aims to explore the experience of completing a 2:1 model of practice education from the perspective of two Occupational Therapy students and their practice educator in a Community Reablement Unit.

LITERATURE REVIEW

Although Lekkas et al (2007) in their systematic review found that ‘there is currently no ‘gold standard’ model of clinical education’ (p.19), collaborative models of practice education feature widely in the literature in recent years in response to increasing demands for healthcare student placements, the changing nature of the healthcare environment and the perceived benefits of employing collaborative models to the development of the competent healthcare student (Dawes and Lambert, 2010; Fisher and Savin-Baden 2002; Huddleston 1999).

The 2:1 model is a collaborative model where two students are allocated to one practice educator (DeClute and Ladyshewsky, 1993 p.684). The opportunity to learn alongside another student, to share ideas and learning experiences has been highlighted as a clear advantage to using the 2:1 model over more traditional 1:1 models (Currens 2003; Martin et al, 2004). The literature acknowledges this opportunity for peer learning and support offered by a 2:1 model as well as recognising the potential for enhanced skill development and competency. DeClute and Ladyshewsky (1993) suggested that collaborative learning using the 2:1 model can contribute to:

“achievement of clinical competence in patient evaluation, program planning, implementation of treatment, communication, management skills, professional behaviour and documentation were enhanced through collaborative learning” (p. 683).

More recently Blakely et al (2009) recognised the benefit of using a range of supervision models within a 2:1 placement in allowing consolidation of student learning thus offering a CPD opportunity for the educator (p.515). Similarly, better professional socialisation and team work skills have been attributed to students participating in a 2:1 model (Currens 2003).

Equally however, challenges exist as do barriers to the implementation of such a model within the practice setting. Perception of increased time commitment along with the anticipated challenges of effectively supervising two students at the same time have been identified as potential challenges to collaborative models in the literature (Currens and Bithell, 2003 p.204). Moreover, competition between students for supervision and access to a caseload may challenge the success of the practice education experience (Currens, 2003 p.550). Traditional subscription to the 1:1 model on behalf of educators and lack of knowledge regarding the collaborative models of practice education such as the 2:1 may also be a challenge to its successful implementation (Fisher and Savin-Baden, 2002 p. 279).

Although well represented in the international literature, few studies have addressed the Irish perspective to date in highlighting the potential benefits and challenges of using this model with our growing healthcare student population. The only Irish study sourced for this review (Gallagher and Cahill, 2008) recognised that the 2:1 model offers “a more feasible alternative to the traditional model...and may meet the demands in a more efficient and sustainable way” (p. 24). This study aims to provide experience from practice on the preparation for and implementation of a 2:1 model of practice education for Occupational Therapy students in a reablement unit.

METHODOLOGY

A qualitative approach was used to explore the experience of participating in a 2:1 model of practice education from both students and practice educator’s perspectives. The researchers included the practice educator and the practice tutor involved in facilitating this 2:1 placement. Purposive sampling identified the two students and practice educator involved in participating in a 2:1 practice education placement in the Community Reablement Unit over nine weeks from April – June 2010. Ethical requirements from the college and the placement site were satisfied for this study and signed consent from the participants was obtained. Data was gathered via self-developed questionnaires, completed by the practice educator and both students, following the end of the placement. The questionnaires were developed following consultation with the literature, and reflected those previously used in similar studies (Currens & Bithell, 2003). Two separate questionnaires were designed, one for the practice educator and the other for the students. Information was sought on a range of topics relating to the 2.1 placement. See Table 1 and 2 for details of the topics addressed in the questionnaires. To ensure reliability of the data collection tool, an independent observer adept at research, reviewed the questionnaires. The researchers adapted the questionnaires according to feedback received from the independent observer. The researchers employed thematic analysis to read and re-read the data, eliciting themes to best describe the participants experience of participating in a 2:1 placement model.

<table>
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<th>Table 1: Topics addressed in Practice Educator questionnaire</th>
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<td>• Initial Expectations of 2.1 placement</td>
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<td>• Preparation/ organisation for 2.1 placement</td>
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<td>• Ways to improve preparation for 2.1 placement</td>
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<td>• Advantages/Disadvantages to time in having 2 students at once</td>
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<td>• Benefits and challenges in facilitating group supervision</td>
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<td>• Perception of benefits/challenges for students in a 2.1 placement</td>
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• Skills developed as a supervisor of a 2:1 placement
• Tutor role in supporting 2:1 placement
• Ways tutor could further support/assist practice educator in 2:1 placement
• Clinical caseload handed over to students – approximate percentage
• Suitability of placement setting for facilitating 2:1 placement
• Suitability of student levels for 2:1 placement
• Ways to improve future facilitation of 2:1 placements

Table 2: Topics addressed in Students questionnaires

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<td>Most challenging aspect of 2:1 placement</td>
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<td>Group supervision – positive and challenging aspects</td>
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<td>Practice educator’s methods in handling two students at one time</td>
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<td>Tutor role in supporting 2:1 placement</td>
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<td>Ways tutor could further support/assist practice educator in 2:1 placement</td>
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<td>Access to client caseload</td>
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<td>Experience of managing a shared caseload</td>
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<td>Suitability of placement setting in facilitating 2:1 placement</td>
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<td>Suitability of student levels for 2:1 placement</td>
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<td>Ways to improve future 2:1 placements for students</td>
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FINDINGS

Advantages

Both students and the practice educator recognised the advantages that a 2:1 placement can bring over a traditional 1:1 placement model. The support of having another student present particularly in the early stages of the placement was valued by both students “it is so daunting on your first week and it was a great help with confidence to have a peer” (Student 1). Having another student with which to share ideas and to discuss case examples with, allowed for more in-depth discussion and questioning. This was found to be the most positive aspect of this placement for both students. The opportunity to share ideas and jointly reflect on experiences was valued by both students. “Individually we may not have been able to come up with a solution but together we were always seeing clients from different perspectives and therefore got a fuller picture” (Student 1). This peer reflection was also recognised by the practice educator as facilitating more independent learning among the students and contributing to their development of clinical reasoning. The practice educator noted the development of new supervisory skills in facilitating the 2:1 model. The practice educator reported to adopt new teaching strategies in order to allow for student differences and styles. Sensitivity towards individual student needs was identified as a necessity by the educator.

“I had to encourage honest feedback and reflection from both students to ensure inclusion” (PE).

Challenges

The dynamic of students working collaboratively through this placement was identified as challenging at times. Learning to work together and managing different communication styles in clinical learning situations was identified by both students as a challenge initially. One student noted that: “it was hard not to stay silent if the other student was leading a session; we both felt on occasions that we were stepping on each others toes” (Student 1). This was reflected as a challenge by the practice educator who noted that: “it was challenging at times to adapt teaching styles to suit the two students” (PE).

Dealing with different opinions and making collaborative decisions on case examples was recognised as often difficult. Comparison between the students to offer an opinion or to perform better was noted by both students and practice educator. “You could sometimes feel deflated if the other student had a better week than you and could feel a bit silly if you were having trouble with something the other wasn’t” (Student 2). Access to client contact and facilitating equal access for both students to a wide range of learning experiences was recognised as important by the practice educator within this model.

2:1 Supervision

The students and practice educator identified both benefits and challenges to 2:1 supervision. Peer learning in 2:1 supervision was outlined as an advantage by both students and the practice educator:

“You could see different skills and behaviours that the other student was good at that you may possibly improve on” (Student 1).

“The opportunity for the students to bounce ideas off each other was positive” (Practice Educator).

One of the students noted that the 2:1 supervision setting was less intimidating than 1:1 supervision. It was recognised that a deeper level of clinical reasoning and discussion was developed in 2:1 supervision; “the students could challenge each others reflections, resulting in a deeper level of clinical reasoning” (Practice Educator). One student also stated that “having a small group made discussion easier and more in-depth” (Student 2).

Both students felt that their individuality was respected in 2:1 supervision and that they received an equal amount of time from the practice educator.

“The practice educator made sure we weren’t treated as one but as two” (Student 2).

“She (practice educator) considered both of our strengths and weaknesses and enabled us to improve by giving us appropriate clients” (Student 1). However, the importance of providing individual supervision time should not be underestimated as an essential component within any collaborative model and was highlighted by one students: “In the middle of our nine weeks, I found it challenging working in a 2:1 ratio and I would have liked...”
In relation to the challenging aspects of 2:1 supervision, one of the students expressed a concern about feeling compared to the other student. The same student identified the difficulty in getting her opinion across as she stated: “The other student was a bit more vocal” (Student 2). The practice educator outlined the challenge of ensuring that supervision was sensitive to the individual needs of each student; “It was challenging at times to encourage individual students to speak from their own point of view” (PE).

Preparation for 2:1 Model

In planning for this placement, the educator recognised the need to become familiar with the evidence and theory behind the 2:1 model to better anticipate the challenges and benefits of applying it in their setting. Consideration was given to the physical environment in a shared office space to support student learning and interaction, and to the learning opportunities that would be on offer. While the educator reported to feel adequately prepared, the students were less confident in undertaking a 2:1 placement. As one student noted:

“I didn’t feel adequately prepared. We both knew we had the same practice educator but I didn’t realise how closely a student works with their practice educator. Therefore I was surprised when I realised that I would be working so closely with the other student” (Student 1).

Equally, better preparation of the students prior to the placement within the college setting was sought: “Some information around the 2:1 model during our preparation for practice education lectures would have been helpful to get an understanding of how it works” (Student 2).

Consideration of the choice of placement setting was valued in preparing for the placement. The rehabilitation setting of the Community Reablement Unit was found to be most supportive of a 2:1 placement as “the regular changeover of clients gives plenty of opportunity for both students to have equal change to observe and practice at every stage of the OT process” (PE).

Similarly it offered several opportunities to “develop aspects of the service further allowing both students to get involved in programme development and planning” in furthering personal and professional development (PE). The students became involved in the development of the use of computer consoles in therapy with CRU clients, which offered further opportunity for collaborative learning and working between students.

The compatibility of the students was found to be a key consideration when planning for use of the 2:1 model by both students and educator. The educator acknowledged that an understanding of the student’s individual learning styles was useful in preparing the placement: “When reviewing the student’s CV’s I looked for similar or varying perceived strengths and weaknesses and interests between students” (PE). This need for compatibility was echoed by the students who surmised that: “It worked as well as it did (the placement) for us because the other student and I were good friends and could both voice our opinions” (Student 1), and that “Some people may not like working in twos and also personalities may clash” (Student 2).

Tutor Role

The tutor worked initially with the practice educator in matching the evidence and theory behind the 2:1 model with the demands of the practice education site and the style of the educator in preparing for this placement: “The practice tutor guided me prior to the commencement of placement (with regard to) managing the students together. We discussed best options for supervision, time with each student, use of other OTs for assiting students clinical observation, linking with the multidisciplinary team, time tabling and subjects to cover within tutorials” (PE).

This was found to be of value to the educator who noted that: “It was a collaborative approach and gave me the confidence in facilitating a 2:1 placement” (PE). In addition, the tutor played a supportive role to the practice educator throughout the placement in complimenting student learning: “I could link with the practice tutor for advice at any point and could also request that the tutor spend some time with students during tutorials on particular topics related to placement” (PE). Similarly, the students appeared to value having another person to go to within the 2:1 model to gain additional feedback and encouragement throughout the process. The tutor was seen to enhance involvement of the students in the placement: “The tutor supported participation by checking in with us both... and getting both our opinions and feedback” (Student 2). As with 2:1 supervision, one of the students noted that further individual time with the tutor would be desirable for support during the placement.

Time Considerations

As reflected in the literature, extra demands on time were anticipated by the practice educator, “I expected that I would need to invest more time into the placement than I would with just one student” (PE). Time needed to adequately prepare for the arrival of two students, to plan for their joint supervision and to research the concept of a 2:1 placement were all recognised as this was the first time such a placement had been facilitated by the educator. Similarly extra time spent in informal supervision as well as completing two assessment forms was reported. However the educator recognised that this was mostly the ease in the preparation and early stages of the placement before the students gained skill and confidence: “After a few weeks the students began to document progress notes after sessions which saved me time overall” (PE). From an organisational perspective, the educator reported to develop organisational skills in order to structure the students placement optimally. The opportunity this provided for skill developed was identified by the educator: “My time management skills developed in taking two students. For the placement to run well I needed to be more organised” (PE). From the students perspective, both reported that they felt they had enough 1:1 time with their educator, and the environment
chosen supported this: “Because of the shared office it made it easier to have individual time with our practice educator in an informal way” (Student 1).

Caseload
The educator estimated that approximately 30% of the clinical caseload was handed over to the students by the end of placement. Both students indicated that they had adequate access to a client caseload. The students felt that it was positive to have both a shared caseload and an individual caseload. “I had someone at the same level as me to help plan sessions and give me feedback...this was a reassurance for me” (Student 2). One student reported challenges in sharing a case load and co-facilitating sessions in the early stages of placement. “It was good to see the other student’s point of view but as our confidence built I wanted to take a more directive role.” (Student 1).

DISCUSSION
The themes emerging from this study, add to the knowledge base on the successful use of the 2:1 model as an alternative to the traditional 1:1 practice of healthcare student education. The overall experience of participating in this 2:1 placement is reflected as being positive, with much valuable learning for the future use of this model. The opportunity for peer learning through group and peer supervision weekly was found to be beneficial by both students and educator in facilitating better pooling of ideas and in-depth discussion that was found to enhance clinical reasoning early in the process. This supports similar findings from previous studies (Secomb, 2008; DeClute & Ladyshewsky, 1993; Martin et al, 2004). Skill development on behalf of the educator in this study was an interesting result. Better time management and supervision skills emerged through the process of facilitating this 2:1 placement which reflects a clear opportunity for continued professional development for a practice educator in participating in a 2:1 placement.

The challenges particular to this study included that of facilitating differing learning styles, equal access to learning opportunities and the element of competition that became evident at times between the students. As with previous studies (Currens and Bithell 2003) this study found that this was not and unhealthy competition and was not problematic in practice. Similarly, compatibility of student personalities to close working was recognised: “If the two students were in anyway shy or didn’t get on, I think there would be difficulty” (Student 1). Compatibility of students for such close working was a recurring theme in this study and demands careful consideration in future planning for use of this model including strategies to manage incompatible students as identified by Secomb (2008, p.714). Similarly time considerations such as access to sufficient one-to-one support for the students emerged as a challenge from this study, reflecting the findings of Dawes and Lamb (2010 p. 24) and warranting consideration for future use of this model. Interestingly, apart from completion of the assessment forms, which was acknowledged as time consuming, the practice educator had anticipated increased time demands in facilitating two students at the same time, which was found to only be the case in the preparation and initial stages of the placement. In addition, access to sufficient caseload for the students to gain experience emerged as a point for considerations. Approximately 30% of the practice educator’s caseload in this study was handed over to the students; however other studies have suggested that 50% is the optimum amount to better facilitate a 2:1 ratio and ensure a positive learning experience for the students (Currens and Bithell, 2003). For students on this level of placement (2nd year; Level 1) holding approximately 30% of the educator’s caseload was found to be optimum in this setting.

From this study, professional support and careful preparation for a 2:1 placement within a supportive environment were recognised as being essential to its success as supported by previous studies (Dawes and Lambert 2010; Martin et al 2004). However as with Blakely et al (2009) the planning time was less than was anticipated by the practice educator. The practice tutor role was identified by the Therapy Project Office (2008) as one of developing “the quality of the practice education programme, and to support both students and practice educators” (p.15). In this study, tutor support was clearly valued in the preparation stage by the educator as well as during the placement by both students and practice educator. For future planning, the students in this study acknowledged that although they felt well supported during the placement, they did not feel adequately prepared for the level of co-working a 2:1 placement would involve. This study highlighted a gap in this knowledge for these students and acknowledges that this should be included in the preparation for placement curriculum as supported by previous research (Secomb, 2007 p. 703)

CONCLUSION/ RECOMMENDATIONS
This study offers clear, practice-based examples for the successful planning of a 2:1 Occupational Therapy student placement.

Implications for Future Use of 2:1 model:
Consideration should be given to:
• The compatibility of both students to work closely together to enhance learning,
• The choice of setting – to allow sufficient access to learning opportunities for both students,
• Consideration of the level of student placement,
• Careful planning preparation of both students and practice educator for participating in a 2:1 model,
• The practical and supportive role that the practice tutor plays in successful facilitation of a 2:1 model.

The students commented that one reason for the placement working as well as it did was that the two students were friends prior to placement.

“Consideration of the students involved in the 2.1 should be taken into account as some personalities may clash” (Student 2).

This study recognised that careful attention to differing learning styles of the students and the potential for personality clashes in the preparation stage is warranted to
support participation in the 2:1 model. Similarly the placement setting, environment and access to a suitable client caseload requires consideration. The educator and the students indicated that the rehabilitative setting was suitable for facilitating a 2:1 model of supervision: “I think the structured sessions of CRU and the short admission time for clients makes using the 2:1 model suitable as both students get plenty of opportunity to be involved with different clients” (Student 2).

The educator outlined the practical consideration of sufficient space in order to facilitate a 2:1 placement. It is important to have “Enough office and treatment space available to facilitate two students easily.” (P.E).

Both students and practice educator indicated that the 2:1 model could work well at all placement levels except for final year placements. The students identified a potential risk of 4th years becoming dependent on fellow students in a 2:1 placement: “I don’t feel we would get enough of a directive lead having to share a caseload from the beginning of placement” (Student 1). Mirroring findings from Blakely et al (2009 p. 517) the education indicated that a 4th year student working in a 2:1 model may not have the same opportunity to hold an autonomous caseload as within a 1:1 model.

In this study, a clear role for the practice tutor emerged in supporting the educator and students during the placement but also in preparing the students for participation in a 2:1 model prior to the commencement of the placement. The tutor may be best placed to tailor the demands of the placement site with the theory underpinning such a collaborative model, to ensure a successful practice education experience for the students, and to fostering a supportive environment conducive to the application of the 2:1 model as identified by Dawes and Lambert (2010 p. 20).

LIMITATIONS

This study aims to offer example from practice on the practical application of the 2:1 model for Occupational Therapy students in a rehabilitation setting. Due to the self-designed nature of the research tool, completion of a pilot questionnaire could have strengthened the validity of the questionnaires. Use of member checking with the participants may have enhanced reliability of results, however the time frame did not permit this in this study. The tutor and practice educator involved in this placement acted as principal researchers which is a recognised bias in the research process; however the participant-researcher focus of this qualitative study aims to offer insight directly from practice. Rigour could have been enhanced here by using an independent researcher in the data collection. This would be beneficial in future studies, and further attention to the placement level of the students participating in a 2:1 placement is recommended.

ACKNOWLEDGEMENTS

Thank you to Cathy McCormack, practice education co-ordinator in the Discipline of Occupational Therapy at Trinity College, Dublin for her supervisory support with this study. We would like to acknowledge the contribution of the students involved in this study, to thank them for their enthusiasm and co-operation in participating. Thank you also to the rest of the Occupational Therapy team and to the members of the Community Reablement Unit team at Our Lady’s Hospice & Care Services, Harold’s Cross.

REFERENCES


A Vision for Change (2006) is a national policy which sets out the direction of mental health services in Ireland. It outlines the specific number of occupational therapists necessary to adequately staff mental health teams based on population. The Association of Occupational Therapists of Ireland Mental Health Advisory Group carried out a survey to collect data on the numbers of occupational therapists working in the mental health services nationally. This article presents the results of this survey.

The survey found 190 whole time equivalents (WTEs) occupational therapy posts in the mental health services as of January 1st, 2010. If Vision for Change staffing recommendations were fully implemented there should be 561 occupational therapists working in the mental health services. Therefore a significant occupational therapy staffing shortfall remained at 389 WTEs. However, the figure of 190 WTEs represented a small improvement since December 2008 – the date of a similar survey. This survey also clearly illustrated the fragmentation of mental health services in Ireland, with specialist teams being absent from large geographical areas.

The Association of Occupational Therapists of Ireland believes that having fully staffed teams throughout the country is one of the fundamental building blocks of Vision for Change and essential to quality mental health service provision.

KEYWORDS
Occupational Therapy, Mental Health, National Policy, Staffing

INTRODUCTION

Occupational therapists are one of the five key disciplines that constitute mental health teams as per Vision for Change (Government of Ireland, 2006). This current policy document driving mental health service development in Ireland details a comprehensive model of mental health service provision and describes a ‘framework for building and fostering positive mental health across the entire community and for providing accessible community-based specialist services for people with mental illnesses’ (p8).

The Expert Group on Mental Health Policy, detailed infrastructure requirements as well as workforce requirements based on population. Therefore Vision for Change (2006) outlines specific numbers of occupational therapists necessary to adequately staff mental health teams. However, the Report of the Independent Monitoring Group for Vision for Change (Vision for Change Monitoring Group, 2010) highlighted that there has been little progress in establishing and resourcing fully staffed teams. Many of the recommendations in Vision for Change to ensure a high quality, recovery focused, service user led mental health service cannot be
implemented or sustained without the manpower of fully staffed teams. This was the rationale for carrying out this audit of occupational therapy staffing.

Tighter employment controls and recruitment restrictions have been a reality for all mental health services. Within this economic context the Mental Health Advisory Group of the Association of Occupational Therapists of Ireland (MHAG AOTI) recognised the importance of having clear, concise data on actual staffing figures; their service type and geographical location. Having a national picture would be valuable in lobbying for occupational therapy service development and resources. As a result it carried out a survey to collect data on the numbers of occupational therapists working in the mental health services nationally. This report, based on the survey, illustrates the staffing levels of occupational therapists in January 2010; how these compare to the Vision for Change recommendations and changes since December 2008. The same authors had carried out a similar survey to capture staffing levels as of 31st December, 2008.

This report forms part one of a two part series. With the announcement of the inclusion of €35m from the health budget to develop community mental health teams in the 2012, numbers of occupational therapists working in mental health are expected to rise. A further survey is currently being carried out. Part two should show how far this allocation has gone to alleviate the low level of therapists and whether the Government has a chance of getting the numbers up to par by the 2016 deadline for the delivery of the recommendations in Vision for Change.

BACKGROUND

The establishment of multidisciplinary teams was proposed in ‘Planning for the Future’ (Department of Health, 1984), the Government’s policy preceding ‘A Vision for Change’. Planning for the Future directed that psychiatric services should be comprehensive and community orientated, aimed at delivering continuous, coordinated and multidisciplinary care. The formation of community based multidisciplinary teams was to be a central element in the process of deinstitutionalisation and the transformation from a bed to a community–based model of care.

Following Planning for the Future the numbers of people admitted to psychiatric institutions decreased significantly. However the formation of multidisciplinary community teams was never completed and there was still considerable concern about the adequacy of community based services for adults with mental illness and the development of specialist services to meet the needs of particular groups such as children, adolescents, elderly people, the learning disabled and the forensic population (Mental Health Commission, 2003).

In 2006 A Vision for Change was published and adopted as official government policy for the future development of mental health services in Ireland. It was drafted following a comprehensive consultation with all stakeholders, including occupational therapists, and when it was published it was broadly welcomed and received international acclaim as a progressive and enlightened policy. It sets out a modern community based mental health service with a value system enshrined in the recovery ethos. One of the major conceptual shifts from Planning for the Future is that people are seen to be active participants in their care who need to be helped and enabled to recover rather than as passive recipients of care.

Occupational therapists warmly welcomed Vision for Change. Its focus on recovery and on community participation was seen as being completely compatible with OT thinking and practice. Recovery has been a huge theme in mental health Occupational Therapy for the last decade, for example, in 2006 the British Association of Occupational Therapy published it’s strategy for OT in the mental health services in the UK entitled ‘Recovering Ordinary Lives’ in which it called for mental health services to be ‘designed and delivered in ways that meet the occupational needs of those who use them’ (p.x) (College of Occupational Therapists, 2006)

Vision for Change quantifies the numbers of professionals necessary per head of population to deliver this service. The expert group involved in drafting the policy did not give their rationale for the staffing numbers they recommended. Other than stating that ‘the range of interventions should be comprehensive and should reflect best practice for addressing any given mental health problem (p5).’ Vision for Change also steers clear of being prescriptive on what interventions should be offered (presumably as clinical practice is constantly evolving whereas government policy needs to stand the test of time, and should make possible this evolution in care delivery).

Following on from A Vision for Change, several publications developed the theory and emphasised the importance of multidisciplinary team work in mental health (Mental Health Commission (MHC) 2006 & 2007), analysed the determinants of team effectiveness (De Burca et al, 2010) and provided practical guidance on developing teams (Byrne and Onyett, 2010).

Another publication focused on the economic arguments for change. In their review of the economics of mental health care in Ireland commissioned by the mental health commission (O’Shea & Kennelly, 2008) make the economic argument for increased investment in mental health problems in Ireland, they comment that ‘Innovative programmes to help people with mental health problems live at home and continue at work are particularly merited’(p.xi).

The implementation of Vision for Change is being independently monitored by many bodies. Serious concerns on the slow pace of implementation have been raised in several quarters. The Independent Monitoring Group for Vision for Change publish an annual appraisal, their latest report (Vision for Change Monitoring Group, 2010) highlighted that there has been little progress in establishing and resourcing fully staffed teams. Amnesty International’s Review of Government Spending on
Mental Health and Assessment of Progress on Implementation of A Vision for Change (Indecon, 2009 & Amnesty International, 2010) highlighted that it would be several decades (38 years) before staffing levels get to the rate specified in Vision for Change. The Mental Health Commission separately raised concerns in their analysis ‘From Vision to Action? An Analysis of the implementation of A Vision for Change’ (Kehoe, 2009). The most common explanations of the fundamental changes envisaged when the policy document was being written having not occurred, is lack of an adequate management structure to deliver the necessary changes and lack of resources (or mis-allocation of resources to old ways of working or lack of transitional funding to allow new types of services to develop).

This survey adds to this body of work focusing on one element of the policy, the occupational therapy staffing levels.

METHODOLOGY

This research was carried out using an email survey designed by the authors. The Mental Health Commission Annual Report of 2009 (Mental Health Commission, 2010) was used as a guide to the mental health service structures in Ireland. This report was the most recent at the time of the survey i.e. approved centres, community mental health teams, child and adolescent services etc.

All Occupational Therapy managers with responsibility for Occupational Therapy in mental health services under the purview of the Mental Health Inspectorate were surveyed. Managers were identified using the list of managers compiled and maintained by the MHAG AOTI.

The questionnaire, which sought numbers of staff in their service areas, was administered by email to each service manager in January 2010. For those who did not reply reminder emails were sent in March & April. As a 100% response rate was necessary the e-mails were followed up by a phone call where there was no response or the data was unclear. The figures were member checked, to ensure accuracy, with all respondents in July 2010.

Procedures for Data Analysis

1. All the information was amalgamated onto a single excel spread sheet according to HSE areas.
2. Data was filtered to examine both service areas e.g. Community Mental Health Teams and geographical areas e.g. Dublin West and South West.
3. Using the catchment area’s population, the number of therapists that should be in post if Vision for Change recommendations were implemented in full was calculated.
4. The actual numbers of occupational therapists in post in each service was compared to this figure and expressed as a percentage.
5. The information was mapped using Health Atlas Ireland mapping software.
6. For the purposes of mapping, catchment area level information had to be used as sector details were not available using the mapping software. (Supercatchment area details were also not available).

Provisions for Trustworthiness

The survey system had been used successfully in December 2008 for the report published in September 2009 (AOTI, 2009). To ensure accuracy, the information gathered was member checked in July 2010 with each manager. Information relating to specialist teams e.g. Psychiatry of Later Life as well as Child & Adolescent services was double checked with occupational therapists working in that clinical area.

Critique of Methodology

This methodology generally proved to be a quick and efficient way of obtaining the required information. However the following limitations applied. Not all services have Occupational Therapy managers assigned to mental health. In some areas, occupational therapists work across several teams and some services incorporate both approved centres and community teams, therefore making it more difficult for managers to assign numbers of staff to services. A small number of services are not yet sectorised, and hence it was difficult to apply the methodology in these cases. The population totals listed in the Mental Health Commission Report 2009 for some areas were different from the Annual Report 2007 and this made like for like comparisons more difficult.

Limitations of the Survey

The boundaries of some service types e.g. Child & Adolescent, Intellectual disability, Forensic were not co-terminal with mental health catchment boundaries and hence it was not possible to map them using Health Atlas Ireland’s technology.

The survey did not adequately capture the number of posts vacant due to leave (e.g. maternity leave). It also did not capture whether a post had existed in the past, but had been lost in one of the several moratoria.

RESULTS

Vision for Change outlines specific numbers of occupational therapists necessary for mental health teams based on population. The results describe the numbers of occupational therapists in post on January 1st, 2010 and compares these with the numbers that would be employed if Vision for Change recommendations were implemented in full. The results in this article are presented according to clinical area.

General Adult Community Mental Health Teams

The national population of 4,239,848 (Central Statistics Office, 2006) equates to just over 84 (84.80) 50,000 population sector areas as per Vision for Change. For general adult community mental health services Vision for Change recommends 2-3 occupational therapists per 50,000 residents. Therefore if Vision for Change was
implemented at the lower recommendation (2 occupational therapists per 50,000) the Health Service Executive (HSE), as a whole, would require a minimum of 170 occupational therapists to staff general adult community mental health teams. Calculating figures at the Vision for Change recommendation of 3 occupational therapists per 50,000 residents, the HSE should have a total of 254 occupational therapists in general adult community services.

On January 1st, 2010 the number of occupational therapists working in general adult community mental health teams within the HSE was 71 (70.985) which is only 42% of the Vision for Change lower recommendation (2 occupational therapists per 50,000) and only 28% of their recommended number of 3 occupational therapists per 50,000 residents (as shown in chart 1 & 2). This means there was shortfall of 99 - 183 occupational therapists in general adult community mental health services. This, however, was an improvement in numbers of just over 9 WTE OTs since December 31st 2008 working in the HSE as part of general adult community teams.

Chart 1. The percentage of occupational therapists in post on General Adult Community Mental Health teams on 1st January, 2010 compared to the Vision for Change recommendation 2 occupational therapists per 50,000 residents.

![Chart 1](image1)

HSE West had the highest percentage of occupational therapists working in community mental health teams. It had 24 occupational therapists, which includes an additional 3.27 WTE since the previous survey in 2008. However this is only 59% of the recommended Vision for Change requirements of 2 occupational therapists per 50,000 residents and only 39% of the 3 per 50,000 recommendation.

HSE areas Dublin Mid Leinster & South had similar percentages of occupational therapists in post. With 20.7 occupational therapists HSE Dublin Mid Leinster has 43% - 28% of the Vision for Change requirements (2 per 50,000 - 3 per 50,000).

Chart 2. The percentage of occupational therapists in post on general adult community mental health teams on 1st January, 2010 compared to the Vision for Change recommendation 3 occupational therapists per 50,000 population.

![Chart 2](image2)

Table 1. The number of occupational therapists working in HSE areas in community mental health teams as of January 1st, 2010; the number of OT’s that should be in post according to Vision for Change recommendations and the comparison between both figures.
With 17.735 occupational therapists working on general adult community mental health teams HSE South had 41% - 27% of the Vision for Change requirements (2-3 per 50,000 residents). HSE South showed the biggest improvement in terms of additional staffing since December 31st, 2008 with an additional 4.955 WTEs.

HSE Dublin North East was the least staffed in terms of occupational therapists. It had only 23% - 15% of the Vision for Change requirements (2-3 per 50,000) with only 8.55 occupational therapists working in community mental health teams. It also showed the least change since 2008.

In summary, there was an increase of just over 9 WTEs since the previous study. However the shortfall of occupational therapists in adult community mental health teams in HSE areas was 30.50-52 in HSE South; 20-40 in HSE West; 29-48 in HSE Dublin North East and 28-53 in HSE Dublin Mid Leinster.

Rehabilitation teams

Of the 31 HSE catchment areas in the country, only 19 of them provide specialist mental health rehabilitation teams.

The population of 4,239,848 equates to just over 42,100,000 sector areas. In terms of Rehabilitation and Recovery services, Vision for Change recommends two occupational therapists per 100,000. Therefore if it were implemented in full there would be 84.8 occupational therapists working in specialist rehabilitation mental health services. As of 1st January, 2010 there were 14.8, which is only 17% of the number required; leaving a shortfall of 70 occupational therapists. This was an increase of 1.3 WTEs since the previous survey on 31st December, 2008.

The HSE with the lowest percentage of occupational therapists in Rehabilitation teams is HSE Dublin Mid Leinster – here the number of occupational therapist posts in rehabilitation (two) on 1st January, 2010 was only 8% of the number recommended by Vision for Change. There was no change in Occupational Therapy staffing levels since the last survey in 2008. HSE West had the largest number of occupational therapists in rehabilitation with six posts but this remains only 30% of the number recommended by Vision for Change.
Table 2. The number of occupational therapists working in HSE areas in rehabilitation teams as of January 1st, 2010; the number of OT’s that should be in post according to Vision for Change recommendations and the comparison between both figures.

*Figures taken from Census, 2006.

In summary, there was an increase of 1.3 WTEs.

<table>
<thead>
<tr>
<th>HSE Area</th>
<th>Population (in 100,000)</th>
<th>No. of OT’s in post</th>
<th>WTE OT change since 31.12.2008</th>
<th>Number of OT's required @ 2 per 100,000</th>
<th>% of OT’s in situ</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSE SOUTH</td>
<td>1,061,968</td>
<td>10.82</td>
<td>2.3</td>
<td>21.64</td>
<td>13%</td>
</tr>
<tr>
<td>HSE WEST</td>
<td>1,012,413</td>
<td>10.125</td>
<td>6</td>
<td>29.25</td>
<td>30%</td>
</tr>
<tr>
<td>HSE DNE</td>
<td>928,619</td>
<td>9.285</td>
<td>-0.2</td>
<td>18.57</td>
<td>22%</td>
</tr>
<tr>
<td>HSE DML</td>
<td>1,216,848</td>
<td>12.17</td>
<td>-</td>
<td>24.34</td>
<td>8%</td>
</tr>
<tr>
<td>TOTAL 2010</td>
<td>4,239,488</td>
<td>42.4</td>
<td>14.8</td>
<td>84.80</td>
<td>17%</td>
</tr>
<tr>
<td>TOTAL 2008</td>
<td>4,239,488</td>
<td>42.4</td>
<td>11.5</td>
<td>84.80</td>
<td>16%</td>
</tr>
</tbody>
</table>

However the shortfall of occupational therapists in rehabilitation teams in the HSE was 70, which includes 19 in HSE South; 14 in HSE West; 15 in HSE Dublin North East and 22 in HSE Dublin Mid Leinster.

Psychiatry of Later Life teams

Within the 31 catchments areas of the HSE there are 22 Psychiatry of Later Life teams in place. Two of these teams work across sectors in Dublin.

The population of the HSE, in terms of Vision for Change figures, equates to just over 42 100,000 sector areas. Vision for Change recommends one occupational therapist per 100,000. Therefore, if it were implemented in full there would be 42.4 occupational therapists working in specialist mental health services for persons over sixty five. As of January 1st, 2010 there were 16.33 in post - which is only 39% of the number required, a shortfall of 26.07 occupational therapists. This is decrease of 1.17 WTE since the previous study in 2008, which can be partially accounted for by the reassignment of one WTE to an approved centre for psychiatry of later life.

Chart 4. The percentage of occupational therapists in post on Psychiatry of Later Life teams on 1.1.2010 compared to the Vision for Change recommendation of one occupational therapist per 100,000 population.

The following map (Map 3) illustrates the staffing level of occupational therapists in Psychiatry of Later Life services throughout the HSE as a whole.

Table 3. The number of occupational therapists working in HSE areas in psychiatry of later life teams as of January 1st, 2010; the number of OT’s that should be in post according to Vision for Change recommendations and the comparison between both figures.

*Figures taken from Census, 2006.

**1 WTE re-assigned to PLL approved centre in 2010 survey.
In summary, the shortfall of occupational therapists in Psychiatry of Later Life teams in the HSE was 26, which included seven in HSE South; five in HSE West; seven in HSE Dublin North East and seven in HSE Dublin Mid Leinster.

**Child & Adolescent Mental Health and Specialist Services**

According to Vision for Change there should be 85 Community teams each with one occupational therapist for Child and Adolescent Services. There should be seven liaison teams each, with one occupational therapist and one specialist eating disorder team nationally. There should be five inpatient units with two occupational therapists per unit.

As of January 2010, there were 30.8 WTE occupational therapists employed in Child and Adolescent services. There has been an increase of almost 10 Occupational Therapy posts in Child and Adolescent Teams since the last survey. In percentage terms this represents a 50% improvement. This is due to development monies received in 2009 specifically for therapy posts in Child and Adolescent Mental Health Services.

Table 4. The number of occupational therapists working on Community Mental Health Teams Child and Adolescent Mental Health Teams as of January 1st 2010 and its comparison with the number of OTs recommended by Vision for Change.

*Details taken from Mental Health Inspectors Report, 2009.

<table>
<thead>
<tr>
<th>Area</th>
<th>Population</th>
<th>OT Staffing</th>
<th>Vision for Change Recommended (2/100,000)</th>
<th>% In Situ</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Dublin (Mahee + Vincents Fairview)</td>
<td>380,658</td>
<td>4.5</td>
<td>7.7</td>
<td>58%</td>
</tr>
<tr>
<td>Louth, Meath, Cavan, Monaghan</td>
<td>392,889</td>
<td>0</td>
<td>7.9</td>
<td>0%</td>
</tr>
<tr>
<td>Dublin South West, City, North West and Kildare (Linn Dara)</td>
<td>500,000</td>
<td>0</td>
<td>10</td>
<td>0%</td>
</tr>
<tr>
<td>South Dublin, Wicklow (Lucena)</td>
<td>600,000</td>
<td>7.9</td>
<td>12</td>
<td>66%</td>
</tr>
<tr>
<td>Laois, Offaly, Longford, Westmeath</td>
<td>250,000</td>
<td>2</td>
<td>5</td>
<td>49%</td>
</tr>
<tr>
<td>Galway Mayo and Roscommon</td>
<td>413,383</td>
<td>5</td>
<td>8.2</td>
<td>61%</td>
</tr>
<tr>
<td>Donegal</td>
<td>145,000</td>
<td>0</td>
<td>3</td>
<td>0%</td>
</tr>
<tr>
<td>Sligo Leitrim</td>
<td>91,053</td>
<td>0</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Limerick, Clare and North Tipperary</td>
<td>361,028</td>
<td>0</td>
<td>7.2</td>
<td>0%</td>
</tr>
<tr>
<td>Kerry</td>
<td>139,565</td>
<td>0</td>
<td>2.8</td>
<td>0%</td>
</tr>
<tr>
<td>South Tipperary</td>
<td>83,221</td>
<td>0</td>
<td>1.7</td>
<td>0%</td>
</tr>
<tr>
<td>Carlow, Kilkenny</td>
<td>120,671</td>
<td>0</td>
<td>2.4</td>
<td>0%</td>
</tr>
<tr>
<td>Westport</td>
<td>133,900</td>
<td>0</td>
<td>2.6</td>
<td>0%</td>
</tr>
<tr>
<td>North Laois</td>
<td>176,692</td>
<td>1.5</td>
<td>3.6</td>
<td>42%</td>
</tr>
<tr>
<td>North Cork</td>
<td>88,795</td>
<td>1.5</td>
<td>1.6</td>
<td>94%</td>
</tr>
<tr>
<td>South Laois and West Cork</td>
<td>86,000</td>
<td>0</td>
<td>1.7</td>
<td>0%</td>
</tr>
<tr>
<td>Waterford</td>
<td>120,017</td>
<td>2</td>
<td>2.4</td>
<td>83%</td>
</tr>
</tbody>
</table>

Table 5. The number of occupational therapists working in approved centres for Child and Adolescent mental health.

<table>
<thead>
<tr>
<th>Approved Centre</th>
<th>Bed Numbers</th>
<th>WTE OT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warnerstown House</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>St Vincent's Fairview</td>
<td>6</td>
<td>0.5</td>
</tr>
<tr>
<td>St Anne's Galway</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>St John of Gods (private)</td>
<td>12</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 6. The number of occupational therapists working on specialised Child and Adolescent mental health teams.

<table>
<thead>
<tr>
<th>Specialist Teams</th>
<th>WTE OT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex Presentations (Temple St)</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatric Liaison (Temple St)</td>
<td>1</td>
</tr>
<tr>
<td>Dun Laoghaire Adolescent (Lucena)</td>
<td>0.5</td>
</tr>
<tr>
<td>YPU Day Hospital (Lucena)</td>
<td>0.5</td>
</tr>
<tr>
<td>Benin Casa Special School (Lucena)</td>
<td>0.9</td>
</tr>
</tbody>
</table>

**Intellectual Disability Services**

Vision for Change specifies two teams per 300,000 (28 teams) for adults with intellectual disabilities, each with one occupational therapist. It also specifies 14 teams for child and adolescent mental health of intellectual disability.

Adult learning disability services do not correspond to the geographic area covered by the mental health catchments. Many of these services consist of a psychiatrist only, without any multidisciplinary team. There were only two occupational therapists working in this specialist area in the country – North Dublin and Laois Offaly. This is 7% of the number required but represents an increase 1.5 WTE since the previous study.

**Approved Centres**

According to the 2008 Annual Report, (Mental Health Commission, 2009) there were 3346 beds in approved centres – 2666 were under the care of the HSE and 680 were in Private & Independent Hospitals. As of January 1st, 2010 there were 47.77 occupational therapists based in these services. These units fulfil a variety of functions including acute admissions; rehabilitation; psychiatry of later life, child & adolescence and continuing care. As many of the approved centres are mixed function e.g. acute care, continuing care, psychiatry of later life, this study was unable to quantify the number of occupational therapists in the various specialities. Additionally, there were five WTE occupational therapists for the 93 beds in the Central Mental Hospital, a designated centre.
Table 8. The number of occupational therapists working in HSE approved centres.

*Figures taken Census 2006

**Figures taken from MHC Annual Report, 2008

Forensic Services

There were 5.8 Occupational Therapy WTEs working in forensic mental health service. Five of these were part of the Central Mental Hospital Service and 0.8 worked in HSE South. According for Vision for Change there should be 16 WTEs in forensic community teams around the country. Vision for Change makes no provision for Occupational Therapy on forensic inpatient units.

Liaison Services

There are 11 liaison teams in the HSE. Vision for Change specifies a multidisciplinary liaison team should include one occupational therapist. However there are no occupational therapists on any of these teams.

Other Specialist Teams

There is a mental health for homeless service in Dublin North West which had two occupational therapists; this represents 50% of the Vision for Change recommendation. There is an early intervention service serving three catchments in Dublin Mid-Leinster, and there was one occupational therapist on this team. None of the community drug and alcohol teams (two) have an occupational therapist in situ. There is no occupational therapist on the eating disorder service based in Dublin South East.

DISCUSSION

The overall picture that emerged from this survey is that the vast majority of mental health services in the country are seriously deficient in Occupational Therapy staffing. The finding of critically low levels of staffing is remarkably consistent through different geographical areas, different service types and specialist areas. These findings echo the Mental Health Commission’s Annual Reports and Amnesty International’s Review of Government Spending on Mental Health and Assessment of Progress on Implementation of A Vision for Change.

This survey also clearly illustrated the fragmentation of mental health services in Ireland, with specialist teams being absent from large geographical areas.

Staffing levels did improve, from a very low base, in 2009. The largest positive impact was achieved through targeted development monies being allocated to child & adolescent services. The effectiveness of the exemption from the ‘moratorium on recruitment in the public service’ in preventing a reduction in services also must be acknowledged.

While the number of people in psychiatric hospitals continues to fall, Ireland still has a relatively high number of residential care beds. A comprehensive report into the Efficiency and Effectiveness of Long-Stay Residential Care for Adults within the mental health services (HSE, 2008) found that in 2006, 30% of the national mental health budget was spent on the provision of long stay residential mental health services: this equated to ?249 million. This report also documents the wide regional variations in the provision of residential care and the overprovision in bed capacity as compared to Vision for Change recommendations.

As there are many confounding elements (such as the availability of long stay beds, social and economic factors etc), it is difficult to directly link the large amount of people in long stay residential care with the lack of the skill set within the mental health services to deliver evidence based care. However, it can be assumed that some of this group would avoid finding themselves needing long stay residential care if the services to deliver community based care existed in the first place. This would allow this group to consistently access all of the tools they need for their recovery and to be provided with the information and support necessary for them to navigate through the complexities presented by the onset of an illness.

Transforming Ireland’s mental health service is an enormous challenge. The transition from the old psychiatric institutions requires massive structural and cultural change. As can be seen from the review of the literature in the background section a huge amount of good will exists towards the policy and also a huge amount of practical work has been done to facilitate its implementation.

Staffing is only one part of the delivery of the system of care outlined in Vision for Change. It is part of the structural change necessary and it is essential to the delivery of the service, and is an easily measurable benchmark. Many of the recommendations to ensure a high quality, recovery focused, service user led mental health service cannot be implemented or sustained without the manpower of fully staffed teams.

CONCLUSION

Vision for Change clearly outlines the number of occupational therapists required to provide a
This survey identified 190 occupational therapy posts within mental health services in Ireland as of January 2010. The majority of occupational therapists (91%) worked in HSE funded services, the remaining 18% worked in private and independent services.

- Whilst geographically every area of the country is covered by a general adult community mental health team, for the most part, these are under resourced and understaffed. Of the 31 catchment areas in the HSE, only two catchment areas have adequate Occupational Therapy staffing.

- The situation is bleaker in the specialist rehabilitation and recovery teams. These do not exist in twelve of the 31 catchment areas. Of the 19 rehabilitation teams in existence none are adequately staffed with occupational therapists and four have no Occupational Therapy service at all.

- Of the 24 Psychiatry of Later Life teams in existence, only one (Sligo/Leitrim) is adequately staffed with occupational therapists and four have no Occupational Therapy service at all.

- Particular effort has been put into setting up child and adolescent teams throughout in the past year and many teams have been set up (HSE 2009). Numbers of OT’s working in this area have increased by 10 WTE or 50% in 2009. However, no service as yet has achieved the number of occupational therapists specified in Vision for Change. Occupational Therapy remains one of the most under represented professions on these teams.

- Community teams within Intellectual Disability and Forensic services are very patchy, with only small areas of the country covered. Within the teams that do exist, staffing levels are very low. The survey did show an increase in 1.5 WTE in learning disability teams. Other mental health services e.g. Peri-natal Psychiatry, Substance Abuse, Neuropsychiatry have no Occupational Therapy staffing despite the Vision for Change recommendation of multidisciplinary teams.

- If Vision for Change recommendations were fully implemented there should be 561 occupational therapists working in mental health services in the HSE. The survey found 190 occupational therapists working in the mental health services. Therefore, as of January 1st, 2010, there was a shortfall of 389 WTE occupational therapists.

ACKNOWLEDGEMENTS
We would like to acknowledge Carmel Cullen & Derek Doyle, HSE Health Intelligence, Dr Steevens Hospital for training & support in mapping the results using Health Atlas Ireland.

We wish to thank the external reviewers for their feedback which helped us place our survey in the context of the wider literature relating to mental health policy development and the implementation of Vision for Change.

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IMPLEMENTING OCCUPATION-FOCUSED AND OCCUPATION-BASED SERVICES

A report by Gill Chard, AMPS UK and Ireland Country Coordinator, from the International AMPS Symposium that took place in Copenhagen, Denmark in September 2012
gill@ampsukandireland.com

On 11th – 14th September 2012, almost 200 occupational therapists gathered together for a day of workshops and three days of research paper and poster presentations that focused on occupation-based practice. Delegates had travelled from across the world from twelve European countries including Ireland, UK, Norway, Denmark, Sweden, Finland, Netherlands, Germany, France, Switzerland, Spain, Slovenia and from almost every other continent including the USA, Canada, New Zealand, Australia, Japan, Korea and China. The Symposium takes place once every four years; the last one in 2008 being in Halifax, Nova Scotia, Canada. It provides an opportunity for occupational therapists from across the world to present, discuss, learn and share good practice on occupation-focused interventions and occupation-based services using the AMPS (Assessment of Motor and Process Skills), School version of the AMPS, and ESI (Evaluation of Social Interaction) assessment tools together with the Occupational Therapy Intervention Process Model (OTIPM), a theory driven occupation-based model of practice.

Two optional workshops explored theory-based practice (led by Professor Anne Fisher from the USA) and occupation-focused assessments (led by Professor Anders Kottorp from Sweden). The workshops explored questions such as: Which occupational therapy model will support the theory-base to my practice? Are occupation-focused assessments a pre-requisite for interventions? Do we need generic or diagnosis specific assessments? Workshops provided an ideal opportunity to learn and discuss occupational therapy theory and practice in small groups with distinctive international input.

Professor Anne Fisher opened the symposium by defining three terms that are typically used interchangeably: occupation-centred, occupation-focused and occupation-based practice. She reminded delegates of the historical context of occupation and that without it we cannot be occupational therapists. That we are concerned with people as occupational beings facing challenges to their every day occupations and thus occupation provides us with a method for assessment and intervention. She framed the forthcoming paper and poster sessions with the mandate that occupational therapy should be occupation-focused and services should be occupation-based. Keynote lectures each day supported this theme by
exploring how this can be done in three very different areas of practice: health promotion, theory-based practice and client-centred interventions. Each keynote provided much food for thought and provoked stimulating discussions during breaks and intervals on how our practice is similar and different internationally.

Over the three days of the symposium, 39 research papers and 16 posters were presented. Every area of occupational therapy practice was discussed and evaluated: children, adults and older people; physical and mental health, intellectual disability, sensory impairments, neuropsychiatry and forensic practice; occupational therapy in schools, the work place, community, acute and long term care settings, health promotion, occupational therapy education programmes and practice placements. It felt like occupational therapy was everywhere. It felt good to be an occupational therapist.

There were five research papers from occupational therapists in Ireland and it was exciting to see Irish research so well represented in a world forum on occupation-based assessments that included the Assessment of Motor and Process Skills (AMPS) and the Evaluation of Social Interaction (ESI).

The first presentation of the symposium was from Susan Kehoe and Bridget Harney from Dublin who described how they had used the AMPS in a mental health rehabilitation service. More specifically, how they had used the AMPS cut-offs to predict levels of assistance for clients with severe and enduring mental illness being discharged to live in the community. They used the client’s AMPS ability measures (motor and process) to band them according to levels of ability and need for assistance to live in the community. Following a 10-week occupational therapy programme that focused on acquiring living skills, they were able to more accurately predict those who would benefit from the programme as well as band clients into a programme that met their needs more effectively. In other words, by using the AMPS they could group clients and target group content according to functional needs; this in turn helped the team to limit over-provision of service on discharge.

Mark Morgan Brown from Cavan had exploring the use of interactive occupation and social engagement for persons with dementia living in a nursing home. His work was presented by Gill Chard as Mark was not able to attend the symposium. The paper generated much discussion as the research focused on comparing a traditional model nursing home environment with a homelike model. Using a specially devised Assessment Tool for Occupation and Social Engagement (ATOSE) Mark was able to record the occupations and social engagements of all residents, staff and relatives present in the room environment, first in a traditional nursing home environment and again after it had been converted to a homelike environment. He found significant changes for residents with regard to an increase in interactive occupation and social engagement in the homelike environment. Rooms where people with dementia sat and stared into space were transformed into alive environments that stimulated occupational and social engagement and with staff that supported this. He concluded that it is more effective for occupational therapists to modify the environment and train residential care staff than to provide individual therapy for people with dementia. Further research using the ATOSE is needed in order to explore its effectiveness in measuring whole environment change for example in nursing homes, mental health ward environments or other long term or institutional care settings. Contact Mark if you are interested in using the ATOSE: mark.brown@hse.ie

Claire Hennigan from Dublin presented the findings of a practice evaluation in a specialist memory clinic for persons with suspected or diagnosed dementia. Using the AMPS she examined differences in ADL process and ADL motor ability measures between those with a formal dementia diagnosis and those with mild cognitive impairment (MCI) or no specific memory deficits, together with information on skills that were retained or lost. The memory clinic team adopted the AMPS as one of the assessment tools of choice because it helped identify specific skill deficits, guided interventions and provided useful information relating to which skills support or limit task performance. The motor and process ability measures depicted on the AMPS graphic report provided evidence for the team of the level of assistance likely required for persons to live in the community. Persons with low process ability measures (below 0.0) are brought to team discussions and AMPS results are used to guide the need for supervision or assistance or the need for higher level community-based services such as home-care packages, as the AMPS provides evidence of higher levels of need. The AMPS with its ability to detect clinical and statistical changes over time makes it a prominent evaluative tool and outcome measure for the memory clinic service.

Andrea Tobin’s work at the Central Remedial Clinic in Dublin focused on a case study of a boy with Duchenne Muscular Dystrophy (DMD). Gill Chard presented Andrea’s work as she was unable to attend the symposium. Andrea has used the AMPS to identify specific skill deficits and guide occupational therapy (and team) intervention processes in order to make recommendations for future care. Typically interventions for boys with DMD focus on the motor/physical deficits that are observed in home and school settings. Andrea had noticed that many process problems, especially related to learning in the classroom were not being detected or addressed. By using the AMPS she was able to demonstrate that process scores were often lower than age expectations, resulted in occupational performance difficulties in sustaining performance (endures, paces, keeps, attends); applying knowledge (chooses, handles); temporal organisation (initiates, continues, sequences, terminates); organising space and objects (searches/locates, organises, navigates) and all adaptation skills (notices/responds, adjusts, accommodates, benefits). Through the case study Andrea was able to demonstrate how she used the results from the AMPS to work with the child and his parents, the school staff and multi-disciplinary team to raise awareness of the impact of process skill deficits on the child’s everyday occupations.
Una McGovern and Orla O’Conor’s paper reporting on a How does your engine run programme, providing strategies for persons with intellectual disability manage their energy levels, was withdrawn as the presenters were unable to attend. The symposium was challenging, stimulating and thought-provoking and generated much discussion as to how we can really put occupation first in our practice.

AMPS courses in Ireland
The success of the input to the AMPS symposium was due in part to a strong partnership between the Irish occupational therapist researchers and AMPS UK and Ireland. AMPS UK and Ireland provide all AMPS, School AMPS and ESI courses in Ireland and offers support to any occupational therapist using these tools in research. They also provide one-day follow up AMPS-2 interpretation and documentation workshops for those who want to develop their skills in using and interpreting the AMPS better in their everyday work with clients.

Two 5-day AMPS courses have run in Dublin during 2012, one organised by St Michael’s House in January 2012 and one organised by St John of God Carmona Services in November 2012. There is no AMPS course currently organised for 2013. Any occupational therapy service interested in organising an AMPS course should email: gill@ampsukandireland.com

Updating your AMPS software and manuals
AMPS 9 software and the 7th edition of the AMPS manual are the most recent versions that therapists should be using. If you have older software or manuals you are strongly encouraged to update these by going to the AMPS International website at: http://www.ampsintl.com/AMPS/software/aboutupgrade.php

In early 2014 it is expected that a new generation of AMPS, School AMPS and ESI software will be released. It is anticipated that this generic software will work on Mac and PC computers, tablets, i-pads, i-phones and smart phones. We have no further information at this stage but you can keep up to date with any new developments by checking the AMPS UK and Ireland website: http://ampsukandireland.com/

ESI courses in Ireland
The next 3-day Evaluation of Social Interaction (ESI) course will take place at St Patrick’s University Hospital, Dublin on 16th – 18th April 2013. The cost for the 3-day course, including ESI manual, software and calibration, is €720. Anyone interested in attending this (or other AMPS or ESI courses or AMPS-2 follow up days) should visit the AMPS UK and Ireland website: www.ampsukandireland.com.
BOOK REVIEWS:
Group dynamics in Occupational Therapy: The theoretical basis & application of group intervention


Reviewer: Sarah Carter, Senior Occupational Therapist, St Patricks Hospital, Dublin 8

This is the book 4th edition. It has been substantially updated from its previous versions, but follows the same core layout.

The author has written extensively on group processes in Occupational Therapy, and her backgrounds in Psychology as well as Occupational Therapy in mental health are evident in the examples of group plans given throughout the book. The authors' American roots are evident in the working examples she uses throughout the book and one of the biggest changes to this book is the inclusion of a chapter in section 1, referencing the AOTAs practice framework 2. The text is still divided into 3 main sections plus appendices.

The first section, titled “acquiring group skills” explores leadership styles, expands on Coles 7 step group planning method, and includes some up to date evidence on group work. It is an excellent source of learning material for students about to embark on group work, and for anyone starting new groups or returning to group work after a time away from it. The work sheets throughout this section can be used or adapted easily to help reflect on, learn from and evaluate different aspects of group work. There is a helpful, if a little brief, description of problem behaviour often experienced in group work and some helpful suggestions are made to help deal with these behaviours. In earlier editions, Cole included a specific chapter on the humanistic approach, and in this edition it is included in a chapter in this section called client centred practice. However she does expand on and reference humanistic group principles, development of the therapeutic relationship, as well as the use of empathy, immediacy and self disclosure.

The final chapter in this section looks at the impact of AOTA practice framework 2. This framework expanded on the types of “clients” Occupational Therapy can work with and what that work can be. It pairs aspects of the framework with example of group interventions in new areas of work. Cole even suggests the use of your group process knowledge covered earlier in the book, to understand how MDTs may work.

The second section, titled “Group guidelines from six frames of reference”, aims to discuss and give examples of five frames of reference and five models and how they are used in practice.

The author highlights her view at the beginning that the use of frames of reference has become “underground practice” in Occupational Therapy, and that their purpose was to address specific client issues and to be used in conjunction with models of practice. However rather confusingly, despite the title of this section, its final chapter (Chapter 10) presents five occupation based models.

I feel that Cole needs to expand this Chapter and work on re-integrating it into the books layout. The description of each models view on function & dysfunction, examples of group topics and tasks are too brief, compared with the previous five chapters, each addressing individual frames of reference. Perhaps Cole intended this layout to support her view that the occupation based models inform and influence practice, but frames of reference determine the specifics of the group process. But most students I have tutored come well briefed on models and would benefit from a more integrated approach. Some group plans where both a model and frame of reference are combined would be very useful. Appendix E, does help demystify some aspects of theoretical application of both the frames of reference and models to the group process, and again some expansion would move this section from helpful to very informative.

In Section 3, titled “Planning an Occupational Therapy group” looks at developing group protocols, and cites several experiential projects for students to expand their group knowledge. Again, Cole gives examples and evidence from other authors and research of how best to write a group protocol. Chapter 13 focuses on developing cultural competency, based on evidence that health professionals require a high degree of cultural awareness. This could be a particularly useful in services where diverse populations are treated, and could be easily adapted for use amongst groups of working therapists as well as students.

The final chapter, looks at developing community intervention in role emergent settings. This chapter is a new addition to the book reflecting modern practice and developments internationally. However at just seven pages long, it will no doubt be expanded for future editions. It is an interesting addition but too brief to give either students or practitioners much more than a little inspiration.

Overall the books emphasis is for students experiencing group work for the first time, however I feel this book is a helpful core text and reference for those of us who use group work regularly, or who need to re-design/develop groups to address emerging service demands. Overall it is clear and concise and uses helpful examples and sample group plans to bridge the gap between theory and practice.
Role Emerging Occupational Therapy: maximising occupation-focused practice


Reviewer: Alison Warren, Regional Placement Facilitator, University of Limerick.

This book shares valuable insights into developing and completing role emerging placements. An overview of the philosophy of the profession is charted in a concise way to frame the value of role emerging placements in occupation focused practice now and in the future.

Different models of role emerging placements are described from an international perspective with practical advice on how to implement the model effectively. The lists of organisations used in Canada and the UK are useful to generate ideas of potential partner organisations to link with here in Ireland.

The students accounts of their experience are honest with both positives and challenges acknowledged. They highlight the value of the supervision being occupation focused and realistic about what can be achieved. The student accounts are from working in a traveller organisation (UK) and Family Health Team (Canada). It is interesting that the Canadian example took place with a physical therapist student also on site.

It raises the importance for students to learn about change management and project management within Occupational Therapy programmes. The authors advocate that to develop role emerging placement opportunities; partnerships are crucial, students should select the site for learning and the occupational therapist who provides the supervision need to be strong clinicians. This book is an excellent introduction to role emerging placements in Occupational Therapy. It will be of interest to students, educators and clinicians with an interest in developing the profession into emerging areas of practice.

1001 Solution-focused questions

Author: Frederike Bannink
2010, NY: Norton and Company

Reviewer: Margot Barry AOTI CPD Officer

Credentials of the Author
Dr Frederike Bannink is a clinical psychologist with nearly 30 years clinical experience. She specialised in the field of solution-focused coaching and solution-focused mediation. She is the author of several books on solution-focused therapy and mediation and is the trainer for the mental health team of Doctors Without Borders. Dr Bannink has used solution-focused therapy widely with her own clients and passes some of her expertise on in this book, which was originally published in Dutch in 2006 and then translated for English publication in 2010.

Audience
The book is primarily targeted at those who use and or intend on using solution-focused therapy, namely psychology graduates and students. This implies that a reader with an Occupational Therapy background has to be discerning with regards to the content that is applicable to Occupational Therapy practice.

Main Content
The book presents theory as well as practical workshop-style elements that are designed to equip the reader with basic skills in solution-focused interviewing. It invites professionals to assist their clients to view themselves and their difficulties in terms of what is going right as opposed to what is going wrong for them. The difference between problem focused-therapy and solution-focused brief therapy is elucidated. The book offers information on a very specific use of language in formulating questions that allow clients to uncover their own expertise and formulate individualised solutions for themselves. The book categorises questions into those that are for general use with all clients and those that are of relevance to specific groups of clients such as children and families. Chapter 10 indeed lists 1001 solution-focused questions that are to be read in the context of the preceding chapters, which offer theory and up to date references on elements of solution-focused interviewing. In addition, exercises and homework suggestions are given throughout the book. These invite the reader to reflect on the content of the book and apply it in the practical situation. Each chapter begins with a quotation that stimulates interest and draws the reader into the issues discussed subsequently. Chapter one for example begins with a quotation from Winston Churchill: “The pessimist sees the difficulties in every opportunity. The optimist sees the opportunity in every difficulty.”

At the end of the book eight appendices provide protocols and rating scales that can assist the reader to consolidate this technique in practice.

In essence, the book attempts to equip practitioners with...
an understanding and a set of skills that support the clients to find their own solutions through the interview process.

**Applicability to Occupational Therapy**
The book is easy to understand even, for those who are not trained in solution-focused therapy. It is comprehensive in that it offers theory and practical application as well as protocols for use by professionals. Elements of this book are very applicable to Occupational Therapy practice as they challenge professionals not to work from a deficit based vantage point but strengths based approach. The book can be an excellent reflective tool that allows occupational therapists who use interviewing as one of the main assessment techniques to reflect on and improve their own skill. It offers a distinct manner of addressing issues and difficulties with the focus being on finding a solution. However, it is important for occupational therapists reading this book to be clear on their professional boundaries in order to prevent them from using techniques or lines of question that are outside of the scope of Occupational Therapy.

**Limitations**
There are elements of the book that allow occupational therapists to understand solution-focused therapy better, but are not directly applicable to Occupational Therapy practice as they may be outside of the scope of practice of Occupational Therapy.