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Issue in Applying Occupation-based Intervention in Clinical Practice: A Delphi study

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Abstract

A Delphi study with three rounds of inquiry was conducted to identify the challenges of implementing Occupation-based Intervention (OBI) in occupational therapy practice in Malaysia. Fifteen occupational therapy practitioners and educators consented and completed all the Delphi rounds. The first Delphi round began with an open-ended questionnaire asking the participants a broad question on issues for applying OBI into clinical practice. Data was qualitatively analysed to develop statements about the issues of applying OBI were grouped under five categories: client factors, occupational therapist factors, contextual factors, occupation as treatment modalities and logistic issues. In the second and third round, the participants were asked to rank their agreement with the statements about the challenges in applying OBI. Level of consensus was set for this study at ≥ 70% and twenty-seven statements finally achieved the pre-set consensus level.

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Keywords: Delphi technique; occupational therapy; occupations; activities of daily living

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1. Introduction

Since the early 20th century, occupational therapists have been using occupation as their primary intervention medium for people with mental illness and physical disability. The development of the profession was influenced by the moral treatment that prevailed in the 18th and 19th centuries as a therapy for people who were mentally ill. The assumption of the moral treatment was that engagement in various daily occupations could restore the individual's health and functioning (Keilhofner, 2009). Occupation includes: Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), work, education, play, leisure, rest and sleep, and social participation (American Occupational Therapy Association, 2014). Occupational therapists continued using occupation as the core therapeutic means of intervention until the profession was pressured by the modern biomedical model that insisted on providing rationale for practice, which led to development of the mechanistic paradigm (Keilhofner, 2009). The influence of this mechanistic paradigm had caused occupational therapists to distance themselves from using occupation and its more holistic process to the mechanistic paradigm that tends to focus on understanding and addressing body functions and impairments (Keilhofner, 2009).

Malaysian occupational therapist perceived OBI as a means and as an end (Che Daud, Yau, & Barnett, in press). Occupation as a means refers to occupation as an agent to improve impaired function, while occupation as an end refers to occupation to be accomplished by the clients (Gray, 1998; Trombly, 1995). The benefits of OBI has been well documented in the literature. For instance, a recent study found OBI was effective in improving ADLs and quality of life for the clients with stroke (Shinohara, Yamada, Kobayashi, & Forsyth, 2012). Although OBI benefits the clients, there are challenges for many occupational therapists to use OBI within their practice context, particularly for those who are working in the medically-oriented facilities. This study aimed to identify issues in applying OBI in clinical practice.

2. Literature review

Several challenges in applying OBI were identified in literature. One of these challenges is the dominance of the biomedical model in health care practice (Colaianni & Provident, 2010). This mechanistic paradigm that was derived from the biomedical model had diverted the central idea of the profession, which was to concentrate on occupation as a health-restoring measure and to focus on remediation of body functions and impairments (Keilhofner, 2009). As the biomedical model mainly focused on curing disease by reducing impairments and eliminating symptoms, practising occupational therapy in medically-oriented facilities led to the impairment-based treatment practice where the body functions and impairments became the primary outcome of the intervention (Gray, 1998). It is also difficult to incorporate health, wellness and functions within the medical paradigm of care (Baum & Baptise, 2002). For instance, occupational therapists found it was difficult to fit occupations such as play, cooking, craft, self-care routine and pleasurable activities within the biomedical model dominated setting as it was felt that these tasks were not scientific enough to address body functions and impairments of the clients (Burke, 2001). As a result, occupational therapists tended to neglect the use of occupation in practice, which may have indirectly contributed to the profession struggling with professional identity (Golledge, 1998a; Gray, 1998).

Lack of facilities was another issue in applying OBI in clinical practice. A study conducted by Stack and Barker (2011) found that the occupational therapy students would eagerly translate OBI in practice setting, but environmental factors prevented them from doing that. Limited space and the availability of equipment and supplies were the main issues highlighted by occupational therapists in their use of OBI (Chisholm, Dolhi, & Schreiber, 2004). As the settings are built up in the medical-oriented facilities, most of the available equipment is focused on remediating impairments and body functions. Pragmatically, occupational therapists often use what is typically available in the department or clinical setting (Gray, 1998). Equipping a department that is suitable for OBI requires funding from the organisation. However, not all organizations could provide the money or the equipment, and these supplies are lacking in the practice setting (Chisholm et al., 2004).

Time was also a factor that influences the occupational therapists to use OBI. Literature indicates that OBI was described as too complicated and consumes much time to be implemented (Goldstein-Lohman, Kratz, & Pierce, 2003; Stack & Barker, 2011). Occupational therapists also agree that they could do more for the clients. However, addressing each client's occupational needs takes more time and results in another client not receiving an