Maltese Journal of Occupational Therapy

MJOT

Issue 14, October 2005

MJOT - Editorial

It is a great pleasure for us to present this issue of the Maltese Journal of Occupational Therapy. We consider this edition of considerable merit and interest to our readers. The quality of the papers, I am sure you will agree, is of a very high standard and the issues tackled are very topical and should prove to be pertinent to a range of practitioners. It is not the aim of this journal, or any journal for that matter, to be exhaustive of the subjects featured in the published papers, nor to say the last word on a particular topic or to give "the solution". Our aim is to stimulate our audience - through the presentation of research, discussion of practice issues and illustrative overviews of conceptual knowledge - to seek further information on matters of specific concern, as well as to develop a generalized healthy form of inquisitiveness which could better their condition as therapists and in the long run, the services of occupational therapy. If we manage to achieve some of these aims, we would be satisfied with having reached what we set out to do.

We take this opportunity to thank our contributors for their efforts which have made this publication possible. Writing is a skill which goes far beyond the mere mechanical manifestation of putting words on paper or a computer screen, but involves a profound cognitive process which takes up time and often veers thought from essential ongoing concerns. But all this dedication and focus pays dividends. Writing enriches our knowledge and world-view as it necessitates and goes beyond reading and through publication, will be of benefit to other professionals in a discipline. So those of you who have any information which you would like to share, please take some time to record it and keep in mind that the journal editorial board will be very grateful to consider it for publication.

Cultural Exploration: Nigeria

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(Project submitted in partial fulfillment of the requirements for the Cultural Diversity in Occupational Therapy course taken as part of the Distance Master of Science in Occupational Therapy at San Jose State University)

Malta is, and always has been, a common destination for people from all over the world. One such type of migration is that from Africa – just 290 kilometers south of our Islands. Amongst these, numerous Nigerians too, have found in Malta a place for study, work and even family.

The aim of this project was to learn about the Nigerian culture, its people's beliefs, their health issues and other concerns. These would be helpful for a health professional to know so as to be more culturally competent and therefore more client-centred during service delivery, especially in view of the possibility of having Nigerians as our clients. For this project, literature searches were carried out about Nigeria and about cultural competence, and three interviews were conducted with three Nigerians living in Malta.

Demographics

Nigeria is Africa's most populous country and has more than 250 ethnic groups (UNICEF, 2003). The main ethnic groups in the north are the Hausa and Fulani, while the Yoruba people are concentrated in the southwest and the Ibo in the southeast. Together, the four groups make up about 68% of the population of more than 137 million. English is the official language, but Hausa, Fulani, Yoruba, and Ibo are widely used. About half the population, mainly in the north, follows Islam, while some 40%, mainly in the oil-producing southern regions, are adherents of Christianity, and 10% hold to animist beliefs (World Geography, n.d.).

Cultural Competence

In striving to get to know another culture one works towards achieving cultural competence, which is a process that exists on a continuum and may never be fully recognized (MacRae, OCTH 235, 2004). Cultural competence can be taken to mean as having a sound knowledge about a specific culture; being open minded to that culture; accepting it (Perlmutter, 1997). This, however, does not necessarily mean that one has to follow it, to be part of it, to do the same. With cultural competence one needs to see the other culture within its own social context and not one's own, and without forcing one's ideas, beliefs and customs onto that culture.

McGruder (2003) stated that, "Values, attitudes, aesthetics, lifeways, arts, moral, customs, laws, and the many other things that are included in culture can change in response to the forces of history, politics, and economics. Culture is malleable and dynamic" (p. 82). This is also true of Nigeria. The three Nigerian persons interviewed for this project recounted traditional customs which are now somewhat changing. However, there are still places where there is great opposition to this change and indeed a lot of the traditions are still kept going to one degree or another. This depends mostly on the educational level and economic status of the families in question.

Family

The Nigerian family is at the core of Nigerian society. Alao (2004) wrote:

[The Nigerian family] is often an extended one, comprising members of related families who might need to be cared for. The traditional African societies were therapeutic communities where almost every one was related. The human values of love, care, passion and warmth were universally displayed by everybody and the extended family culture attempted to create a universal sense of caring. In such a setting, many modern-day adjustment problems like mental illness, cultism, and drug addiction, are less evident, as the ever caring and watchful society was there to notice and rescue prospective victims. The culture of being your brother's keeper has enormous psychological value (p. 252). These same sentiments were echoed and repeated by the three Nigerians interviewed.

Men are considered the absolute heads of the family in Nigeria, with the women having to accept their husband's/ father's/brother's decisions. This is not to say that women cannot give their opinion, but it is the men who have the final say. The women tend to feel somewhat relieved with this set-up since if something goes wrong, they are not blamed for it (Etim, personal communication, November, 2004). Elders, both females and males, are highly respected and are reserved special welcoming gestures, varying from full lying prone on the ground by the Yorubas, to kneeling by the Ibibios, and to enveloping the elder's hand in the Efik tribe.

Traditionally, a child is married into another known family so that the parents know that their offspring will be well cared for and possibly that the other family does not have known health problems that can be inherited by their grandchildren. It is the custom for the bride's family to ask for gifts from the groom's family and the promised bride cannot be taken in marriage before this dowry is paid. The dowry asked for will be what the bride's family may need materially such as curtains for the parents and dresses for the bride and her sisters. But then it is pay back time when the couple has their first child as with the Efik tribe. Here, the new mother and baby go live with the woman's family for the first month in which time the new father asks his parents-in-law for things that are still needed in the home so as to have the home completed by the time the mother and infant return. This because usually, the newly married couple go in their new home when the house is just built but still bare, and then it is filled little by little over time. Therefore, it is frequently not full at the arrival of the first child. The grandparents, eager to know that the new grandchild will have a completed home, give their son-in-law what he asks for (Umanah, personal communication, November, 2004). In other tribes such as the Yoruba, a female relative goes to help the mother with coping in the first few months after the birth (Tope, personal communication, October, 2004).

Having numerous children is the norm in Nigeria. It is a common notion that a couple with up to three children is considered as barren, even due to the high infant mortality rate. The United Nations (UN) gives the total fertility rate in Nigeria of five births per woman and the infant mortality rate of 79 per 1000 births for the period 2000-2005 (United Nations, n.d.).

Gender equality

Because society puts so much importance on the men, the arrival of a boy is more important than that of a girl because a daughter will eventually marry and move away from the family with her husband, while a boy will help provide for the family when the father cannot do so anymore. If a woman bears only girls, it is common that the man seeks another woman from whom to have males. The first wife has not much choice but to

accept the new wife because this will ensure that she and her children are taken care of even eventually after the husband is unable to do so (Etim; Tope; Umanah, personal communications, October 2004).

Adeyemi and Nelson (2004) wrote:

> In the African setting, the culture appears dominated by paternalism and stereotyped tendencies. The Nigerian culture...accords the male children priority over female right from birth, which transcends into schooling and even inheritance. Particularly among the very low income earners and illiterate parents who cannot afford western education for their numerous children, many choose to send the male children to school while giving out their female children in marriage even at tender ages to raise money for the education of their brothers (p.364).

Although Nigeria has had a National Policy on Education since 1981 to improve the equality in participation between males and females in education, it has not been implemented effectively and efficiently due to rapid population growth, insufficient political will, a long period of undemocratic governance, and poor management of scarce resources. Women and girls have been most affected by these negative factors. The national literacy rate for females is only 56%, compared to 72% for males, and in certain states the female literacy, enrolment and achievement rates are considerably lower than national averages (United Nations Children's Fund (UNICEF), 2003).

If all this seems so different than our own culture it must be added that the British *New Scientist* magazine reported Nigerians as the happiest people among 65 countries surveyed between 1999 and 2001 by an international group of social scientists tracking socio-cultural and political change (World Geography, 2003).

Health belief systems

"Health belief systems differ markedly from one culture to another and they tend to dictate how individuals with disability fare within their societies...Although disability tends to be viewed negatively in many societies, this is not always the case" (Groce, 1999, p. 37). In Nigeria, disabled persons are regarded as an act of Nature, an act of God, and are not cast out or hidden by society. They are accepted

and taken care of by the family within the community. Moreover, it is considered disgraceful to send your disabled or elderly family members to institutions.

Most women prefer the traditional forms of childbirth and receive the bulk of their health care in the traditional sector (Onolemhemhen & Ekwempu, 1999). Deliveries often occur at home and even in the fields or on the roads. This might contribute to the high mortality of infants. "Perception of the cause of complication, women's status in the immediate and extended family, and community values affect use of health-care services. When a complication occurs [during pregnancy or in labour], the decision of where to seek care depends on what is thought to be the cause of the complication" (Population Council, 1992, p. 282). Much is being done in Nigeria at present to create strategies for the reduction of mother and child deaths in pregnancy and labour (Onolemhemhen & Ekwempu, 1999) and this includes the need for co-operation between the two groups of physicians -- traditional and Western (Opaneye, 1998). The Yoruba tribe will console the mother who has lost a child by saying, "Omi lo danu, agbe o fo." This means, "The water spilt away, but the keg is still intact," an encouragement suggesting that the woman at least can still have more children.

The 'Babalawos,' as the Yorubas call the native doctors, are highly sought by Nigerians even though more and more Western medicine is being introduced. A "Babalawo" is always a generous, faithful, knowledgeable, and a good traditional counsellor to the members of the community (Alao, 2004). Alao continues to say that, "the "Babalawos" cannot turn away any clients on account of poverty...[they] use the traditional body of knowledge called "Ifa" [which] has information on almost all branches of knowledge. There is traditional geography, biology, chemistry, psychology, education, psychometry, etc." (pp. 250-251). Very commonly, the traditional doctor uses herbs for treatment. Different native doctors are sought for different types of ailments much as in specialized health services in the Western world.

Extensive literature exists that counter the benefits of traditional healing practices such as traditional bone setting (TBS) (Alonge, Dongo, Nottidge, Omololu, & Ogunlade, 2004; Onuminya, Obekpa, Ihezue, Ukegbu, & Onabowale, 2000); deliveries by mostly untrained traditional birth attendants (TBAs), and female circumcision and vaginal mutilation that results in severe bleeding, sometimes leading to death (Alabi, 1990). The Abuja Declaration (1990) states that, "These practices often inflict permanent physical, psychological, and emotional damage, even death". Alabi continues to say that, "Women and children are exposed to many unhealthy practices in the name of tradition or culture." Nevertheless, traditional healers thrive even today, amidst the controversy. This is mainly because of the belief and faith that many Nigerians have in traditional healers and also because certain traditional healing practices really work. In fact, an attempt is being made at merging the two forms of medicine, allopathic and traditional, into something acceptable and beneficial for Nigerians and indeed for the rest of the world, especially where medicines are concerned (Kudi & Myint, 1999; Kudi, Umoh, Eduvie, & Gefu, 1999; Taiwo, Xu & Lee, 1999).

Communication

In Nigeria there exist a multitude of languages spoken by the various ethnic groups. Indeed each has its own language, possibly more than one, depending on the area lived in. In fact there is not one common Nigerian language that all understand. The one language that is used for communication between the different tribes and clans is pidgin English -- a very basic form of English without any syntax whatsoever.

Due to the close family network that exists, Nigerians believe that communication is very important. Tope (personal communication, October 2004), from the Yoruba tribe, said that members of the family sit together when something goes wrong to discuss things through. Emim from the Ibibio tribe said that communication is generally open, but that if personally she knew that something she would say will upset the balance of the family, then she would choose not to say it at all. Umanah, from the Efik tribe, recounted how much respect is accorded to elders, which

contrasts with what he sees here in Malta in the way youths speak to adults.

Time sense

Nigerians are generally polychronic time (P-time) people. "P-time systems are characterized by several things happening at once. They stress involvement of people and completion of transactions rather than adherence to preset schedules" (Hall, 1976, p. 17). It is, for example, usual for a person to turn up late for an appointment, even an hour or more. Nobody asks why, and nobody is offended by it.

Conclusion: Relevance to OT Practice

"The first step in the process of developing cultural competence is self-awareness. Each of us has a unique cultural background to bring to a therapeutic relationship with a client as well as to our personal relations" (MacRae, 2004). We must, therefore, be aware of what culture we are carrying with us when in contact with our clients and we must equally be aware of what culture our clients carry with them. "Rehabilitation professionals must...do more than simply deliver services in a clinical setting. Rehabilitationists must also take it upon themselves to learn what life is like in the community for the individuals they serve. Much can be learned by just talking (and listening) to individuals with disabilities and their families" (Groce, 1999). In considering transcultural implications, Ward-Collins (1998) said that, "We have our own beliefs and values that influence our thinking as care providers and must work to understand how, when, and why our values come in conflict with others. We must also understand that sometimes conflict occurs simply because of our differences".

"Any...client-centred practice would be radically incomplete without addressing the multiple faces of cultural environments that impact directly on the establishment of facilitative client/therapist partnerships," (Rochon & Baptiste, 1998). This places on us the responsibility of learning about our clients' culture and ultimately being able to bracket our bias, i.e., the way we think about other people's behaviours and beliefs and how much we let this thinking bias our reaction towards them. In the bracketing process we acknowledge our beliefs, get them to a

conscious level and set our biases temporarily aside in order to be able to determine our quest, i.e., understanding our clients and offering them client-centred service. We then go on to identify our perspective of the situation and be open to any possibilities available (MacRae, OCTH 208, 2004). Then, and only then, can we truly say that we are achieving cultural competence.

Acknowledgments

A special mention and thanks go to the three Nigerians who helped me in understanding their culture better: Ms. Grace Etim from the Ibibio tribe, Mr. Raphael Tope from the Yoruba tribe and Mr. Patrick Umanah from the Efik tribe. All three gave up their time to my quest. It must be said that their enthusiasm for sharing their life, and their love of Nigeria and their culture could be clearly felt and seen. They taught me much more than this paper can ever hold.

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What does positive participation in leisure occupations mean to people with complex neurological disabilities?

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Chronic illness and disability restrict people's access to work and leisure occupations, so that they experience a loss of valued roles, self-identity and self-esteem (Reynolds, 1997). Swanson and Chenitz (1993) found that people with a chronic condition commonly describe themselves as having to redefine their sense of self, roles and goals, re-framing their place in the world ... and learning to live with a "new me" Jenson and Allen (1994).

This paper sets out to review the literature and demonstrate that positive participation in a leisure occupation, which is meaningful and challenging, will combat boredom and will enable the person to maintain a social identity that may have been lost when work roles are no longer an option.

Leisure

Leisure time is free time or time with out the constraints of duty during which people have discretion to choose which occupations they undertake. Leisure time is therefore when someone is not "working" or performing self-maintenance tasks (Baxter et al 1995). Because the individual is not obliged to participate in the activity, they are motivated either intrinsically e.g. by enjoyment or extrinsically i.e. with an end goal/ score or to create a product (Baxter et al 1995).

Participation

Participation in Leisure occupations allows people to form friendships, develop skills, express creativity, and develop a social identity (Kinney & Coyle, 1992; Lyons, 1993). Satisfaction with leisure occupations is an important predictor of life satisfaction among adults (Kinney & Coyle, 1992) and is associated with adjustment and well-being (Brown & Gordon, 1987).

Participation is a complex issue, with many factors influencing the occupations that people do every day. (King, Cathers,

Polgar, MacKinnon, & Havens, 2000 and Webre & Zeller, 1990) The most important factors, which influence participation for people with complex neurological disabilities, include environmental factors (accessibility and attitudes of society), family factors (interests in recreation), and personal factors (functional ability, behaviour, cognition, communication or social competence).

This insight is vital because patterns of social restriction and isolation begin very early, after a significant disruption in occupation, supporting the need for early intervention (Brown & Gordon, 1987). Conaster, et al (2000) and Reid et al (2001) reinforced the observation that the level of disability has a significant impact on carer attitudes. This goes on to impact on whether the leisure occupation is sufficiently adapted to allow the person to participate as fully as possible.

Boredom may then be the inevitable accompaniment of the absence of meaningful social or leisure occupations, or even serious uncertainty about the stability, and reliability, of values, purposes, meanings and commitment (Healy, 1984, Farnworth 1998). Many occupational scientists have written about the human right to meaningful occupation (Clark, 1997; do Rozario, 1994; Farnworth, 1995; Toulmin, 1995) and thus avoiding boredom.

Passmore (1998) found that there are three types of leisure occupations that contribute to personal growth and the enhancement of mental health and well-being:

1. ***Achievement leisure*** - provides challenges, is demanding and requires commitment, such as found in sports and music performances;
2. ***Social leisure*** - is more obvious where engaging in leisure is primarily about being with others, such as dinner with friends;
3. ***Time-out leisure*** - for relaxation includes TV watching, lying on one's bed and reflecting or listening to music – occupations which tended to be more socially isolating, less demanding and frequently passive.

Identity through occupation

Laliberte-Rudman (2002) suggests that limitations in occupation could limit the

ways in which people perceive themselves and maintain a satisfactory social identity, whereas engagement in leisure occupations could lead to opportunities for growth and life satisfaction (Drummond and Walker, 1996). Social identity comes about because life is not usually a solitary experience. It usually involves interweaving our lives around the lives of others (Larson & Zemke, 2003).

Gender, age, educational level, ethnicity and socio-economic status all affect leisure and work patterns according to Allen Dickie (2003) and McKay (1986). Some leisure occupations facilitate social engagement and/or provide participants with challenges to overcome (Csikszentmihalyi, 1975; Passmore, 1998), whereas others involve rules, rituals, customs, and traditions that are important for the meaning that they give to the participant (Klapp, 1986., & Farnworth, 1998)

Leisure as a substitute for employment

It is important to consider the emotional aspect as well as the practical aspect of any occupation. Employment status is a source of developing and maintaining our identity, feelings of competence, sense of belonging as well as playing a major role in structuring society and the people position within it (Pettifer 1993). Csikszentmihalyi and LeFevre (1989) found that people experienced their most satisfying and engaging experiences more often at work, but were more likely to report increased motivation and relaxation when engaged in leisure occupations.

Some unemployed people and people with complex neurological disabilities may not anticipate working in the future. This has brought about a traumatised and divided society characterised by boredom, intolerance, desperation and resentment. Pettifer (1993) felt that the vision of a future 'leisure age' is unlikely to be a real substitute for purposeful work.

Csikszentmihaly, 1975) noted that pleasure and enjoyment are strongly associated with a perception of choice, which is missing in the free time of the unemployed with its associated financial and lifestyle stresses, loss of structure

and sense of purpose. It is not surprising therefore that unemployed people experience stress, depression, low self-esteem, diminishing sense of personal control and feelings of disengagement. (Pettifer, 1993).

Occupation to combat boredom

In the Csikszentmihalyi and Csikszentmihalyi (1988) model, boredom is a state where the person perceives the challenges of the occupation engaged in to be less than the skills they bring to the situation, leading to under arousal. Berlyne (1966) assumed that a fundamental human motive is curiosity, and that the nervous system was designed to be active, rather than merely a passive recipient of stimulation, (which is why time out leisure was found to have a negative impact on mental health outcomes) (Passmore 1998).

Meyer (1977) hypothesised that peoples daily occupations have two major dimensions: performance and personal meaning/ interest.

Klapp (1986) and Farnworth (1998) believed that meaning and variety, include qualities such as adaptation, learning and discovery, and are very important in combating boredom. While Baxter et al (1995) felt that leisure occupations could relieve boredom by providing "diversion from everyday routine."

Leisure and Neurodisability

Doble, Haig, Anderson, & Katz, (2003) indicate that people with complex neurological disabilities engage in a significant degree of social interaction. However, Moos and Schaefer (1984) argued that chronically ill people face four common adaptive tasks, namely;

- To preserve a satisfactory self-image and sense of achievement or competence
- To retain a psychological equilibrium (maintaining hope and humour; controlling anxiety, anger and other negative feelings)
- To maintain positive relationships with family and friends
- To prepare for an uncertain future.

The achievement and maintenance of an acceptable social identity is a key factor in adapting to life events and achieving well-being (Laliberte-Rudman 2002). Also there is documentary evidence that leisure participation decreases after a neurodisability (Sjogren, 1982; Feibel and Springer, 1982; Drummond, 1990), and that a significant number of patients are depressed after neurodisability (Collin et al., 1987; Wade et al., 1987). Feibel and Springer (1982) suggest that such depression may be part of the loss of social occupations experienced by people and thus having a more limited social identity.

Behavioural difficulties such as aggression, non-compliance, self-injury, impulsiveness, and disinhibition are common manifestations of neurological disabilities (Willis & LaVigna, 2003) which prove a great challenge to integrating into social activities (Willis & LaVigna, 2003; Ylvisaker, Jacobs, & Feeney, 2003).

It may take more than 6 months after discharge for the side effects of a reduction in hobbies and interests to become apparent.(Drummond and Walker 1996). However, creative leisure occupations allow people to 'make their mark' on the world, empowering them, promoting feelings of self-worth and enhancing the sense of control, particularly if the body is experienced as 'out of control'/ choice (Szepanski, 1988). Conversely, therefore, people who participate in a variety of leisure occupations may be able to diminish their depression or better still avoid its onset.

Finkelstein and French (1993) defined Disability as "the loss or limitation of opportunities that prevents people who have impairments from taking part in the normal life of the community on an equal basis with others due to physical and social barriers'.

Summary

Leisure occupations are important to the self image of participants! some recent writers say that disabled people engage in them to a significant degree (Doble, Haig, Anderson, & Katz, 2003), but the level of depression following neurological disability would suggest that this is still not enough (Collin et al.,

1987; Wade et al., 1987) and that people with complex neuro disabilities are at risk therefore of occupational deprivation. People who are stuck in front of a TV all day or who are passive recipients of leisure activities will become socially isolated (Passmore, 1998), with all the impacts on mental health that this brings.

Achievement leisure occupations are important (Passmore, 1998), and will require everyone's sense of ingenuity to adapt them in order to make them accessible for people who are dependent on ventilators, wheelchairs or who have limited dexterity, cognition or social skills. Above all society needs to acknowledge the right of all human beings to engage in meaningful occupations to maintain their identity as people and avoid boredom (Laliberte-Rudman, 2002).

Facilitating an engagement in leisure activities should begin as soon as the person is medically stable, alongside other therapies such as Speech and Language Therapy, Physiotherapy and Occupational Therapy. This will allow them to begin to define the sense of self, roles and goals (Jenson and Allen, 1994) and stave off the negative psychological impacts of such major life events as acquiring a complex neurological disability.

After all as J F Kennedy is supposed to have said, there is no point in adding years to a life, if you don't add life to those years.

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Occupational Therapy: Effectiveness & Efficiency

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Market forces and quality development have driven the move towards increased effectiveness and efficiency within all industries, including health care. In order to survive as a profession, occupational therapy must keep abreast with these changes and partake in this paradigm shift.

This article examines and appraises the concepts of effectiveness and efficiency as they relate to the occupational therapy process within a client-centred framework. Strategies that can be adopted to increase effectiveness and efficiency within practice are also presented.

From Business Practices to Our Doorstep

Over the last twenty years there have been unparalleled changes within health care with an increasing focus on ensuring that health care services are of high quality, effective in terms of outcomes, and that resources available are deployed in the most efficient and cost-effective way (Lloyd & King, 2002). This move towards increasing effectiveness and efficiency did not occur in a vacuum. It was the result of a wider paradigm shift of the economic and social spheres towards a market mentality (Morrison, 1998).

Of course health is not a commodity to be bought, sold and haggled over as one would a house or an item of clothing; of course our departments are not production lines; of course clients are not passive objects. However, quality development, brought about by the 'quality gurus' from America such as Deming, Juran, Crosby, and Feigenbaum, has resulted in a transformation in all industries including health care (Morrison, 1998).

Market forces within health care promise increased efficiency, increased equality and equity, enhanced standards and quality, increased motivation, as well as increased accountability and

responsiveness (Morrison, 1998). These claims cannot be dismissed easily, especially since they may offer a solution to the many challenges health care is currently experiencing, including population aging resulting in a concomitant increase in the number of people with lifelong disabilities and chronic illnesses, pressures for cost containment, as well as an exponential growth in the types of health care professions along with a misdistribution in the geographical location and in the actual numbers of certain professionals (American Occupational Therapy Association Inc., 1996).

In terms of health care, the influence of market forces were evidenced in a number of reforms and government policies (e.g. United Kingdom: Department of Health 1997, 1998a, 1998b) designed to touch and change every aspect of health care – the total jigsaw (Lloyd & King, 2002). The principle aim of these reforms has been to increase effectiveness and efficiency. This translates into greater clinical accountability for occupational therapists (Roberts & Barber, 2001; Lloyd & King, 2002).

This shift towards greater effectiveness and efficiency has been perceived by rehabilitation professionals as being threatening as they fear that their work may not be understood to the full due to inadequate measurement of outcomes and, hence, be undervalued (Smith et al., 2001). Others have argued that the pressure for effectiveness and efficiency has resulted in feelings of frustration, rather than motivation, amongst professionals since they feel robbed of their freedom of activity and have become confined to implement decisions which have been taken by others (Lloyd & King, 2002).

In the light of the above considerations, this article aims to explore the principles of effectiveness and efficiency and the way these concepts influence the occupational therapy (OT) process.

Terms Defined

Effectiveness refers to outcomes. It considers whether an intervention works in the 'real world' (Smith et al., 2001). With specific reference to OT one may ask "What gains in functional status did a client achieve?" (American OT Association Inc., 1996).

Efficiency, on the other hand, considers the use of resources – e.g. time, space, materials, people, money – employed in order to achieve a particular outcome (Morrison, 1998). An occupational therapist may pose the question "How many resources were utilised in order to gain a specific measurable change in functional status?" (American Occupational Therapy Association Inc., 1996). Increasing efficiency means reducing the expenditure whilst not reducing the intensity and quality of care (Eastaugh, 1993).

In summary, effectiveness refers to attaining goals, whilst efficiency refers to minimising the cost of resources employed to attain these goals. (American Occupational Therapy Association Inc., 1996).

Quality versus Cost – Value for Money?

Stamatis (1996) states that the survival of health care depends on the success of improving quality whilst at the same time reducing costs. The ratio of quality to cost is known as value. Therefore, value is the main principle, which brings together effectiveness, efficiency, and cost. Providing the highest quality service for the lowest price means providing the service with the highest value (American Occupational Therapy Association Inc., 1996). This may seem to be a daunting task to achieve as, in the words of Gaucher and Coffey (1993, p. 90), one may ask "How can you talk about quality when you are cutting costs?"

The term "money makes the world go round" cannot be truer since lack of funding delimits health care and consequently OT service delivery. However, there are lessons to be learnt from America as this delimitation has not only resulted in constraints on practice but also in great opportunities to demonstrate the value of OT and to critically examine forces which shape OT practice (Jongbloed & Wendland, 2002).

The question here is, therefore, not about whether to treat a particular client, but about how to treat in order for the client to achieve most benefit with the least expenditure of resources (Petitti, 1994). Demonstrating the value of OT is, therefore, essential as otherwise the

profession has no scope for existence and will be replaced by alternative services that manage to demonstrate their effectiveness and efficiency. This is not impossible especially since there already are mechanisms and strategies in place to demonstrate the value of interventions. These include clinical audits in the evaluation of services, the adoption of outcome measures and standardised assessments, and the implementation of evidence-based practice to guide intervention (Packham, 1999; Smith et al., 2001; Jongbloed & Wendland, 2002; Corr, 2003).

America's shift towards effectiveness and efficiency, unfortunately, has not come without a price. Reducing costs has resulted in a reduction in the quality of the service provided. The staff/client ratio (caseload management) adopted in order to increase efficiency has influenced the time members of staff spend with clients. Moreover, reimbursement practices dictate which functional outcomes are considered to be valid treatment goals (Jongbloed & Wendland, 2002). This is in direct conflict with client-centred practice where the client's active participation in negotiation of goals is central to assessment, intervention, and evaluation (Sumsion, 2000). Furthermore, the whole OT process is affected in a way which inhibits treating the client holistically since occupational therapists are constrained to work on improving skills that can be easily demonstrated such as feeding and dressing rather than the management of leisure time and psychosocial skills (Jongbloed & Wendland, 2002).

Client-Centred Practice, Effectiveness & Efficiency – the Challenge

American occupational therapists have come a long way to demonstrate that OT can be effective and efficient yet their position can hardly be enviable as they have traded one good thing for another. They have drifted away from their values and philosophies in order to survive in the changing environment by embracing effectiveness and efficiency. Since it seems they have lost touch with their client's needs and seem no longer able to see the client as a whole person, whether they are really and truly practising OT is debatable (Jongbloed & Wendland, 2002).

The current situation in America can only be considered as a starting point in the journey towards incorporating effectiveness and efficiency into practice. Occupational therapists must be wary of adopting an 'out with the old and in with the new' attitude as we may easily lose sight of our aims. It is not about losing principles for others but about striking a balance, finding a symbiotic relationship with these principles derived from the business industry in order to flourish - finding the way of turning the vicious win/lose circle into the virtuous win/win circle. As Chesworth et al. (2002, p. 30) put it "the challenge for occupational therapy is to ensure that they are providing clinical effective interventions whilst at the same time involving clients within their own treatment planning."

Standardised Assessments and Outcome Measures

Standardised assessments have been developed as scientifically sound instruments designed to measure change in the status of a client more precisely, to provide an accurate basis for documentation, and to demonstrate, in turn, the effectiveness of treatment (Managh & Valiant Cook, 1993). They have been described as being the closest thing to date to the reliability of weighing scales or rulers that health care professionals have to measure changes in clients objectively. The clinical judgement of experienced occupational therapists is undoubtedly valid and of great importance, however, it will always be subjective (De Clive-Lowe, 1996; Stearst, 1999).

Standardised assessments cannot be thought of as being 100% reliable because of the very nature of what they are designed to measure. In the 'real world' there are numerous influences acting on clients during an assessment including motivation, medication, and distraction. Yet they are said to provide a fair and unbiased view of the value of treatment (De Clive-Lowe, 1996).

Another strategy proposed to increase efficiency and effectiveness is the single assessment process (Cohen, 2003). By using a shared assessment method each health care profession, whilst maintaining its standardised assessment, will contribute to a large assessment framework. This should result in less

time wastage for all, since duplication will be avoided, and savings with respect to salaries as general information in the assessment process could be collected by unqualified/less qualified staff. It may also be seen as being more of a person-centred approach since a client will not have to answer the same question over and over again (Cohen, 2003).

Unless outcomes are systematically measured, one cannot know whether interventions are effective and efficient (Jongbloed & Wendland, 2002). Measuring outcomes appropriately may help in improving clinical practice through an improved monitoring, evaluation and planning of a service (Smith et al., 2001).

Townsend et al. (1997) encourage occupational therapists to document outcomes using language congruent with OT's core concepts. This means that outcomes should be described in terms of occupation, occupational performance, and client-centred practice rather than self-care, productivity, and leisure, as it is believed that this will provide "a valid information base for demonstrating OT's effectiveness, efficiency and cost-benefits" (Townsend et al., 1997, p.142).

When investing in a standardised assessment it is important to select one that can also be used as an outcome measure. Standardised assessments cost money, however, the high costs incurred in the short-term in order to buy the instrument and, possibly, to train staff in its use, will lead to greater efficiency and proven effectiveness in the long term and, thus, result in greater savings in terms of time and cost (Smith et al., 2001). In making the right choice, there are several points to take into account. The most basic points to consider are:

- suitability for target population (in terms of age, diagnosis, and time taken to administer),
- suitability for the particular setting (e.g. inpatient/community-based)
- reliability and validity,
- whether it meets practical needs for efficiency (e.g. time to administer, need of specific training prior to use, ease of administration and scoring, how easily results can be communicated, and sensitivity to changes in client status)

- limitations (e.g. in terms of normative sampling and validation) and
- client-centeredness (De Clive-Lowe, 1996; Unsworth, 2000; Roberts, 2005).

Another question that needs to be tackled when selecting a standardised assessment or an outcome measure is whether to choose a multi-professional tool (one that can be used by different professions) or a uni-professional tool (one that is specific to, for e.g., OT). On one hand a multi-professional tool can be seen as efficient especially in terms of time and money, however, it is unable to distinguish between the effectiveness specifically resulting from different services. Thus, in a sense a multi-professional tool would fail to demonstrate the unique contribution of OT, and, therefore, would hardly do any favours in supporting the need for OT and would not contribute to OT's evidence base. By using a uni-professional tool, occupational therapists would be able to attribute the outcomes to the therapy being provided and, therefore, therapy effectiveness can be shown more specifically (Unsworth, 2000; Edmans, 2001; Roberts, 2005).

The Canadian Occupational Performance Measure (COPM; Law et al., 1991) has been put forward, as a possible link between effectiveness, efficiency, and client-centred practice (Chesworth et al., 2002). This individualised measure can be used both as an assessment as well as an outcome measure (Townsend et al., 1997). However, it must be emphasised that, to date, there is no single tool which targets all the needs in OT and the COPM cannot be used in all situations, and, furthermore, it should be used in conjunction with other measures (Chesworth et al., 2002).

Clinical Reasoning and Intervention

The current health care environment also requires effective and efficient clinical reasoning (Neistadt, 1996). The efficiency and effectiveness of a therapist's clinical reasoning increases proportionally with experience. Mattingly and Fleming (1994) state that experienced practitioners are described as being efficient in their clinical reasoning because they "'get it right' in very few tries" (Mattingly & Fleming, 1994, p. 15)

In order to dampen the effects of the decreased efficiency and effectiveness of clinical reasoning in novice practitioners, Fortune and Ryan (1996) have proposed a caseload management system in which, following initial assessment, cases are graded according to the amount of clinical reasoning skills required. In this system simple cases are given the value of 1 whilst complex cases are graded at 3. This ensures that caseloads are varied in such a manner so as to find the best mix to match the background and experience of practitioners, maximise efficiency and effectiveness, and promote continuing professional development and experiential learning at an adequate and practical level. It is proposed that this system will not only provide greater efficiency in terms of time but also in the use of expertise. Although it seems to be feasible and useful at face value, it is important to note that no formal evaluation of such a system had been conducted at the time this article was published and conclusions are based on informal feedback received (Fortune and Ryan, 1996).

With regards to intervention, efforts to decrease costs have resulted in clients being discharged as soon as possible and in treatment moving into the community (changing location). This decrease in the number of times therapists see their clients has, in turn, resulted in a greater sense of responsibility in questioning practice and in carrying out efficient evaluations. Limited funds have also resulted in increased delegation of tasks to OT assistants i.e. increased skill mix (Jongbloed & Wendland, 2002).

One of the ways of guaranteeing effectiveness and quality in health care services put forward by the government within the United Kingdom (Department of Health 1997, 1998a, 1998b), is evidence-based practice (Roberts & Barber, 2001) - an approach that involves acquiring and making use of the most recent research into the effectiveness of health care interventions in order to inform the decision making process (Bannigan, 1997). It does not only ensure that OT intervention is effective but also increases efficiency since resources are not wasted on less effective interventions (Bannigan, 1997).

Another pathway towards ensuring best practice is through continuing professional development and life long learning. This is because they provide the chance to reflect on current practice and to research effective interventions (Roberts, 2002).

Simple strategies that may be adopted in OT intervention in order to increase efficiency include orderliness and neatness to ensure that resources are stored in places to which there is easy access. Cleaning and checking the condition of equipment and resources should be done by everyone on a regular basis (Morrison, 1998). Regular maintenance makes equipment last longer, thus, saving resources and, also, provides enough time for re-ordering of equipment should this be needed.

Evaluation...not just about outcome measures

Evaluation is an essential aspect of an intervention or a service. Its purposes are manifold and include assessing effectiveness of an intervention or service, establishing whether the outcomes can be really attributed to the service or whether they have been the product of other external factors, and also as a basis for making recommendations for change (Corr, 2003). The use of outcome measures has already been considered, however, outcome measures are not the only tool available for evaluating OT.

Clinical audits are another tool and need not be considered as a tool which is best left in the hands of specialists (Packham, 1999). Clinical audit has been described by Packham (1999, p. 278) as "one of the dynamic factors that drive clinical effectiveness and the allocation of resources, and assists in meeting the perceived needs of the client".

As part of their role in ensuring best practice, in 1998, the COT's in the UK launched a 'Clinical Audit Information Pack' (Edmans, 2001). The purpose of this guide was to portray the clinical audit as being something which was not only possible for ordinary occupational therapists but also desirable (Edmans, 2001).

Any knowledge gained from evaluating OT services and intervention should be published in order to substantiate the currently scant evidence base of OT.

Contributing to the evidence base of OT should be viewed as an obligation towards the profession and most of all towards our clients.

Conclusion

Whether or not OT should become aligned with market forces and the principles of effectiveness and efficiency is a non-question, because: 1) market forces are already in place due to funding arrangements; 2) clients' current market mentality and expectations of for example information, accountability, efficiency, and 'standards' are here to stay as they are rooted in a broader current of economic and social change (Ball, 1994). Despite being subject of trenchant criticism, due to the fact that the principles of effectiveness and efficiency have been wrongly perceived as a threat to health care professionals, this assignment has argued that they are principles without which our service may in fact be of a threat to our clients.

In OT terms, the impact of effectiveness and efficiency is evident in every step of the process. These principles have brought about an increasing emphasis on standardised assessments, outcome measures, evidence based practice, continuing professional development, and clinical audits, as well as a conscious effort to prove the value of OT. So let us leave aside prejudices, suspicions and the distrust that we may have of changes in management practices and let us not let OT become the graveyard of creativity, flexibility, adaptability, and problem-solving capabilities.

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BOOK REVIEWS

DEVELOPMENTAL DYSPRAXIA: Identification and Intervention
A Manual for Parents and Professionals. 2nd Edition
Madeleine Portwood
David Fulton Publishers London
201 pp- ISBN 1-85346-988-2

This comprehensive manual tackles dyspraxia from all its aspects namely biological, neurological, behavioural and psychological. Intervention is also discussed in detail. The author is an educational psychologist who has worked with children with dyspraxia and who has researched this subject thoroughly for several years.

This book deals with normal brain development and its relationship with the production of movement. It highlights how the immaturity of a child's brain might relate to dyspraxia. The condition is described in simple language, which parents can understand and relate to. It includes comprehensive tables that can be used to compare normal developmental milestones with the developmental milestones of children with dyspraxia. Also highlighted are the characteristics of dyspraxia and its early developmental signs and behaviors.

Strategies for identification and diagnosis of this condition are discussed and a well illustrated Motor Skills Screening form details the tests that can be carried out.

An extensive part of this book is dedicated to various intervention programmes starting from the early years to well into primary school age. Remedial activities that tackle perceptual and motor difficulties are also highlighted.

This book concludes with a variety of appendices ranging from screening forms, remedial activities and information about where to look for help, thus making it an invaluable resource for both paediatric occupational therapists and the parents of children with dyspaxia.

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Psychosocial Occupational Therapy: A Clinical Practice (2nd edition)

E. Cara and A. MacRae

Thomson Delmar Learning 2005. 745pp

ISBN - 1-4015-1232-5

The revised edition of Psychosocial Occupational Therapy: A Clinical Practice brings together the experience and expertise of various clinicians and academics thus offering both qualified occupational therapy practitioners and students the latest knowledge in a variety of areas pertaining to psychosocial practice.

Its focus on the clinical application of Psychosocial Occupational Therapy shows the reader how to best deal with actual clients and real-life contexts thus helping in the selection of the best treatment option/s.

This edition uses the recent Occupational Therapy Practice Framework (AOTA, 2002) as its basis. Whilst encouraging occupational therapists to focus on holism as outlined in this framework, it also takes into account the current trends in mental health care delivery. To address the latter, the book dedicates specific sections to evaluation and community - based intervention.

The book is divided into 8 sections that deal with the mental health context, theoretical concepts, diagnosis and dysfunction, mental health across the lifespan, mental health with physical disorders, occupational therapy intervention in mental health, expanded roles for occupational therapy in mental health and clinically related roles.

The reader can look forward to obtaining a broader knowledge regarding the family experience of mental illness, environmental and cultural considerations, psychosocial issues in physical disability including psychosocial aspects of chronic pain and occupational therapy in the criminal justice system.

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