In attempting to identify the legal issues relevant to occupational therapy practice, I was immediately confronted by the problems in defining occupational therapy and identifying the scope and content of occupational therapy practice and what was properly to be regarded as within the extended scope of practice and what was outside both the scope and the extended scope of professional practice. To link the work of the occupational therapist (OT) in caring for the mentally disordered with anorexia or in looking at feeding regimes and working with dietitians, with the role in assessing and prescribing for wheelchairs, seemed impossible. Similarly, what has the work of the OT in special care baby units in common with that of her colleague in a forensic psychiatric unit? To provide a definition of occupational therapy which covers such diverse activities is a major challenge. This was taken up in a major review conducted by Louis Blom-Cooper in 1989 into the theory and practice of occupational therapy.

The report,¹ which was commissioned by the College of Occupational Therapists (COT), explored the changing demographic pattern and the growth in recognition of the need for a support service like occupational therapy to assist people to regain or develop their full potential.

**Definition of occupational therapy**

The first definition of an occupational therapist used by the Association of Occupational Therapists² was:

Any person who is appointed as responsible for the treatment of patients by occupation and who is qualified by training and experience to administer the prescription of a Physician or Surgeon in the treatment of any patient by occupation.

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¹ Legal Aspects of Occupational Therapy, Third Edition By Bridgit Dimond
² © 2010 Bridgit Dimond
Occupational therapy was defined by the Council for Professions Supplementary to Medicine (CPSM) booklet\textsuperscript{3} as:

the treatment of physical and psychiatric conditions using specific selected activities in order to help people who are temporarily or permanently disabled to recover independence and cope with everyday life. Therapists work in one of three main areas: with the physically disabled, with those with mental health problems, and with people who have learning disabilities.

This is much narrower than the definition which Blom-Cooper suggested in his Commission of Inquiry. The Commission’s report adapted the definition of occupational therapy used by the COT and recommended its adoption:

Occupational therapy is the assessment and treatment in conjunction and collaboration with other professional workers in the health and social services, of people of all ages with physical and mental health problems, through specifically selected and graded activities, in order to help them reach their maximum level of functioning and independence in all aspects of daily life, which include their personal independence, employment, social, recreational and leisure pursuits and their interpersonal relationships.

\section*{Stereotypes and core philosophy}

The Blom-Cooper report discussed the outdated stereotypes of the profession associated with basket making and looked at changing the name to get away from the myths and out-of-date attitudes to the profession. It considered that the most suitable name would be ‘ergotherapy’, but recognised the limitations of this name because of its association with ergonomics and being too narrow. In the end the report abandoned the task of suggesting a name and made no recommendation on the title. The COT issued a statement on definition in May 1990\textsuperscript{4} in line with that suggested in the Blom-Cooper report. It identified four facets of the therapeutic role:

\begin{itemize}
  \item prevention
  \item habilitation and rehabilitation
  \item retraining and maintenance
  \item readjustment.
\end{itemize}

It also defined the other roles of the OT, i.e. the advisory and educational role and the management role.

In 2000 the COT suggested that an appropriate definition of the work of an occupational therapist would be:

Occupational therapists treat people of all ages with mental and physical problems through meaningful occupation to improve everyday function and prevent disability.\textsuperscript{5}

The heart of the OT’s function has been widely debated. Thus Phillips and Renton\textsuperscript{6} ask whether assessment of function should be the main aim of the OT’s role. Jenkins and Brotherton\textsuperscript{7} discuss an attempt to find a theoretical framework for occupational therapy. Some valuable insight into the philosophy behind occupational therapy as a profession was obtained from the third edition of Turner \textit{et al.}’s classic work on occupational therapy.\textsuperscript{8} The underlying thoughts and common links were identified as:

\begin{itemize}
  \item individuals are each in a state which they wish to improve;
  \item the therapist uses activity as the medium for this improvement;
  \item individuals are aiming for the restoration or achievement of the skills required for daily life and have the capacity for change needed to achieve this;
  \item each person is an individual and inherently different from any other.
\end{itemize}
In order to achieve these objectives the OT must be skilled as a teacher, as a craftsman, as a purchaser and assessor of equipment and clients, as a therapist in understanding all mental and physical conditions, as a communicator, as a provider of healthcare, and so on. The law impacts upon them all. In their fifth edition the editors of this work note that there has been an enormous change in culture which

has seen a growth in the need for occupational therapists to demonstrate that their interventions are based on sound clinical reasoning, with a specific brief to provide evidence for the efficacy of their practice. The introduction of clinical governance, evidence-based practice and quality audit has shaped the remit of therapists in health, social care and private practice.

The legal implications of this significant cultural change are enormous and can be seen throughout this text.

Annie Turner, in her first chapter on the history and philosophy of occupational therapy, suggests that a philosophy on which to base the profession’s practice, theory and research could consist of the following concepts:

- People are individuals and inherently different from one another.
- Occupation is fundamental to health and well-being.
- Where occupational performance has been interrupted a person can:
  - use occupation and/or activity to develop the adaptive skills required to acquire, maintain or restore occupational performance
  - modify their occupations and/or activities to facilitate occupational performance.

Since the Blom-Cooper report the attempt to define occupational therapy has been ongoing as the work of Jennifer Creek shows. In her MSc thesis she discussed the complexity of identifying what OTs do and considered:

Occupational Therapists’ inability to explain to others what they do … in terms of the difficulty of expressing the breadth, complexity and subtlety of practice in language which is structured to communicate singularity and visibility and in contexts where men’s styles of communication are privileged over women’s.

She defined occupational therapy as a complex intervention.

The difficulties of defining occupational therapy can be seen from the results of the COT commissioning Jennifer Creek in 2004 to develop standard terminology for OT which would include the definition of between 5 and 12 key terms plus the definition of occupational therapy itself. It was found that the Delphi approach (asking 42 expert OTs for their views in 10 rounds) whilst appropriate for producing a set of six definitions of key terms, failed to produce a single definition of occupational therapy. Instead of the number of possible definitions decreasing in each round it expanded as panel members struggled to find a way of capturing the complexity of occupational therapy within one or two sentences.

When 37 definitions of occupational therapy were analysed, 107 elements were identified. These were organised into 7 categories: social position or status, aims or goals, domain of concern, client groups, tools/processes, services and principles of intervention. Jennifer Creek suggested that it may be that different definitions of occupational therapy, incorporating different categories of elements in each one, would be appropriate for use in different situations.

The conclusion was that:

It is possible to conclude that no single definition of occupational therapy will be appropriate for all purposes. Using the materials, principles and processes described in this report, occupational therapists should be able to construct the definitions that they need to suit their own situations.
A COT/BAOT briefing note no 23 was published in 2006 on the definitions and core skills for OT. This used several definitions for use within the profession and for use with the public. Core skills were seen as collaboration with the client; assessment; enablement; problem solving; using activity as a therapeutic tool; group work and environmental adaptation. In 2008 the COT published a position statement on the value of occupational therapy and its contribution to adult social care users and their families. This considers the value, the commitment of the OT and gives examples of best practice.

### Ten roles of health professionals

In 2003 the DH set out the 10 key roles for allied health professionals. The following year the COT reviewed the ways these roles are being used by OTs and published a briefing note no 32 with BAOT. The 10 key roles were:

1. To develop extended clinical and practitioner roles which cross professional and organisational boundaries
2. To be a first point of contact for patient care including single assessment
3. To diagnose, request and assess diagnostic tests, and prescribe working with protocols where appropriate
4. To discharge and/or refer patients to other services, working with protocols where appropriate
5. To provide consultancy support to others promoting the AHP contribution to patient independence and functioning, training, developing, mentoring, teaching, informing and educating healthcare professionals, students, patients and carers
6. To manage and lead teams, projects, services and case loads, providing clinical leadership
7. To develop and apply the best available research evidence and evaluative thinking in all areas of practice
8. To play a central role in the promotion of health and well being
9. To take an active role in strategic planning and policy development for local organisations and services
10. To extend and improve collaboration with other professions and services including shared working practices and tools

### Occupational therapy and the spiritual dimension

In the Casson Memorial Lecture 2001 Gwilym Wyn Roberts considered the future development of higher level practice and stated that occupational therapy needed to consider a spiritual context of our work, our values and how we value ourselves.

The spiritual content and context of occupational therapy has been widely debated, including the influence of Eastern and Western philosophies. Some have turned to Zen Buddhism as the foundation of occupational therapy practice. Kelly and McFarlane emphasise the value of Chinese philosophy in providing the basis for a new, modified, holistic approach to occupational therapy. They also show the extent to which the principles are already being used, albeit indirectly, in occupational therapy management and treatment, for example the general systems theory and sensory integration theory. Lorraine Udell and Colin Chandler discuss the role of the occupational therapist in addressing the spiritual needs of clients and note that in order to further discussion on this issue it is necessary to consider:
the extent to which spirituality has an impact upon health and well-being
the question of whether spirituality is a necessary component of holistic care
the specific training and guidelines that would be needed.

This philosophy also has importance in relation to the terms in which the OT views her relationship with her client and the rights of the client. Non-interference and self-help are important features of a client-centred therapy.

This concern with the philosophy of the OT is taken further by Barnitt and Mayers. They show that the starting point would appear to be an incompatibility in that humanists believe that individuals, not God, are responsible for their own existence while Christians look to God for rules and principles to guide behaviour.

Cunliffe asks what rights patients have with a treatment containing philosophy, theory or spiritual belief. The answer must be that it is impossible to divest the therapy from any such content and, as Cunliffe emphasises, it is important that within occupational therapy the patients have a right to be informed of the philosophy, or spiritual belief, contained in the treatment. He adds descriptively that ‘there is no difference between the surgeon’s knife and a treatment belief that cuts theoretically, psychologically or spiritually in the wrong place’.

Inevitably OTs have become concerned with the relevance of occupational therapy to issues relating to the quality of life. Katrina Bannigan urges every occupational therapist to communicate passionately what she or he does ‘so that our vision shines through’.

Core knowledge and skills required by OTs

This ongoing debate as to the philosophy and function of occupational therapy will have a major impact in determining the relevant skills required.

The Blom-Cooper report identified the core knowledge and skills required by OTs under four headings, shown in Figure 1.1. (Reference should also be made to Chapter 5 on education and definition of core skills and competencies.)

**Figure 1.1** Core knowledge and skill required by OTs as identified in the Blom-Cooper Report.

1. Knowledge of the intelligence, physical strength, dexterity and personality attributes required to perform the tasks associated with a whole gamut of paid and unpaid occupations and valued leisure pursuits.
2. The professional skill to assess potentialities and limitations of the physical and human environments to which patients have to adjust, and to judge how far these environments could be modified and at what cost to meet individual needs.
3. Pedagogic skills required, first to teach people how to acquire or restore their maximum functional capacity, and second to supervise and encourage technically trained instructors and unqualified assistants in their tasks of implementing and monitoring therapeutic recommendations.
4. The psychological knowledge and skills to deal with anxiety, depression and mood swings which are the frequent aftermath of serious threats to health or of continuing disability, and to motivate, or remotivate, those with temporary or persistent disabilities to achieve their maximum capacity.
Problems identified in the Blom-Cooper report

In discussing the attempt of the profession to establish its professional identity and autonomy, major problems were identified in the Blom-Cooper report:

- the dominant position of the medical profession in the provision of healthcare and the social work profession in the provision of social services
- the dependence of OTs on doctors and social workers for access to their clients
- the false and damaging stereotype that other staff and the public have of their function
- the pronounced female composition of the profession
- questions over occupational therapy’s efficacy, a matter of increasing importance in the internal market.

There is unfortunately no clear evidence since the Blom-Cooper report was published, that all these weaknesses have been corrected. Whilst the internal market has been abolished, occupational therapists still need to show value added to the quality of life of their patients/clients and that they are a service which can provide significant benefits. Both the commissioners of OT care, consultants and clients must be convinced of the benefits which OTs can bring in the rehabilitation and social and healthcare of the vast majority of patients and clients.

Conclusions of the Blom-Cooper report

The report considered the role, function and organisation of the profession and reached the following conclusions:

- Occupational therapy is needed as an integral part of health and social service provision.
- Although there is room for devolution of some of the work at present performed by trained OTs to their helpers and clerical staff, there will be a continuing and expanding need for fully professional OTs.
- Further consideration should be given, in the long term if not in the immediate future, to the creation of a united profession of rehabilitation therapist, permitting post-qualification specialisation.
- In the decade following the report and increasingly into the twenty-first century occupational therapy should be largely relocated in the community care services.

Recommendations in the report addressed to the COT cover the topics shown in Figure 1.2.

**Figure 1.2** Recommendations of the Blom-Cooper report.

- number and norms
- deployment
- recruitment
- preparation
- qualifying standards
- negotiating machinery
- professional enhancement
Developments since the Blom-Cooper report

The Blom-Cooper report was written at a time when the Government of the day had not indicated its intentions following the response to its White Paper, *Working for Patients: Caring for the 1990s* or following the Griffiths report, *Care in the Community: Agenda for Action*, 1988. It was therefore impossible in that uncertainty for the proposals of the inquiry to be precise. Since that time there have been fundamental changes in the organisation and management of health and social care; these are considered in detail in Chapters 17 and 18. These developments include: the implementation of the NHS and Community Care Act 1990, the Health Act 1999 and major changes in relation to the management of healthcare; the introduction and the abolition of the internal market; the establishment of NHS trusts; primary care trusts and care trusts and the introduction and the abolition of GP fundholders. New unitary authorities for local government with social services taking over responsibility for the purchase of places for clients in nursing and residential homes for those admitted after 1 April 1993. Significant new institutions of inspection for health and social care have been set up and were established in April 2004. Subsequently the Care Quality Commission has taken over the regulation, inspection and monitoring of all health and social care establishments.

These major structural changes in the organisation of the NHS present significant challenges for the OT. A useful analysis of the impact of organisational change upon the role and future of occupational therapy is given by Chris Lloyd and Robert King. They consider that whilst the scope and complexity of the restructuring of the NHS present considerable challenges, OTs are well placed to meet these. The core values of the profession are congruent with community-focused, client-centred and outcome-oriented models of service delivery. In addition, the emphasis on enablement occupation provides opportunities to add new roles to occupational therapy. OTs have the skills that are consistent with working at the level of case management and in health promotion.

A COT study in April 2003 commissioned Jennifer Creek to identify the components of OT intervention, the defining features of OT and the limits of OT. The Core skills identified by the study are seen in Figure 1.3. The study did not seek to establish the value of OT. The assumption was made from the beginning that OT is of value. The study considered descriptions of Occupational Therapy, the Occupational Therapist and external influences on the OT process.

In the glossary OT was defined (as practised by the OT) as:

An approach to health and social care that focuses on the nature, balance, pattern and context of occupations and activities in the lives of individuals, family groups and communities. OT is concerned with the meaning

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**Figure 1.3** Core skills identified in COT study 2003.

Collaboration with the client
Assessment
Enablement
Problem solving
Using activity as a therapeutic tool
Group work
Environment adaptation
Analysis of thinking skills: clinical reasoning (scientific reasoning, narrative reasoning, interactive reasoning, conditional reasoning, pragmatic reasoning and ethical reasoning)
Reflection.
Legal Aspects of Occupational Therapy

and purpose that people place on occupations and activities and with the impact of illness, disability, social deprivation or economic deprivation on their ability to carry out those occupations and activities. The main aim of OT is to maintain, restore or create a balance, beneficial to the individual, between the abilities of the person, the demands of her/his occupations in the areas of self care, productivity and leisure and the demands of the environment.

OT intervention = actions taken by the therapist, on behalf of the client and in collaboration with the client and/or carer, to assist the client to acquire, maintain or regain the adaptive skills required to support his/her life roles and occupations.

OT process = a sequence of thought and actions used by the therapist to structure intervention in order to provide services to a client.

**Occupational therapy and physiotherapy**

Blom-Cooper suggested that consideration should be given to the creation of a united profession of rehabilitation therapist. This idea has not in general found favour but the relationship between occupational therapy and physiotherapy has led to closer communication between the professional associations of OTs and physiotherapists. Whether there is unnecessary duplication of skills between occupational therapists and physiotherapists is considered by Janet Golledge, who emphasises that occupational therapists should be using purposeful activity and occupations as their therapeutic media, with limited use of activity. Activities could be used by physiotherapists, but not purposeful activity or occupation. This is where the two professions could see the distinctions in their therapeutic media. She notes however that the enduring concern is whether managers, purchasers and users of healthcare can understand the distinctions sufficiently. The establishment of the Health Professions Council and the greater flexibility that it can give to the recognition of new state registered professions may facilitate closer associations between physiotherapy and occupational therapy.

**Client-centred occupational therapy**

Thelma Sumsion discusses the definition of client-centred practice that was developed from 67 OTs participating in nine focus groups; 165 components of client-centred practice were generated and analysed to form seven themes. The final definition was:

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

The author states that if therapists are working according to this definition, they should be able to ensure that clients do feel like valued human beings. See also her edited work *Client-centred practice in occupational therapy.*

**From interface to integration strategy**

In January 2002 the College of Occupational Therapists published a consultation paper on a strategy for modernising occupational therapy services in local health and social care communities.
considered a new model of a community-based OT practice and sought responses to this concept. The College stated that:

The development of a new community-based occupational therapy general practitioner model is central to its wish to resolve the problems around the interface between health and social care. We see this as pivotal to an integrated approach that enables services to be developed as a continuum that is focused on, and responsive to, the needs of all service users and their carers.

The COT considered that this model would assist the OT in responding to the current national and country-specific Government policies and priorities including:

- promoting independence (COT prefers the term ‘inter-dependence’)
- preventing avoidable or unwanted dependence
- addressing social isolation
- reducing waiting lists
- delivering on the objectives and standards in the National Service Frameworks
- working in partnership with individuals and their carers
- working collaboratively
- eliminating duplication
- supporting public health and prevention
- seeking to provide services on an increasingly sound evidence base
- supporting value for money and best value regimes
- promoting recruitment and retention.

The COT published its response to the consultation in 2002. In April 2003 the College of Occupational Therapists commissioned an independent company, PCA Consulting, to review progress towards the integration of services and to investigate different approaches to service integration and models of care. The review showed that the organisational changes being made around the country ranged from small scale and informal developments; semi-formal development such as integrating management structures; through to major organisational redevelopment, incorporating all occupational therapy services under a single employer. It suggested that initiatives in integrating working needed to be governed by some form of clear inter-agency agreement which could be in the form of a service level agreement or some other form of financial or secondment agreement. A briefing paper on integrated occupational therapy services gave examples of different forms of integrated occupational therapy services.

Conclusions on definition of occupational therapy

Edward Duncan analysed in 1999 the core skills required of an OT working in mental health and concluded:

It is time for the profession to move from its adolescent identity crisis, within which at times it appears to be stuck, to its rightful sense of a coming of age. This step, as painful for a profession as it is for an individual, would allow the fruitless search for a prescriptive definition of what and what is not occupational therapy to end. Studies of occupational therapy and the further development of an understanding of occupational performance could then develop.

A similar attitude is revealed in a light-hearted paper, but dealing with a very serious topic, in which Adam Goren explores the identity of the occupational therapist and concludes that it
is still a profession in its youth, unsure of its own identity, sensitive to its own environment, rebelling against its own conformity, (and in need of some direction and boundaries), highly adaptable, creative, curious and impressionable.

He suggests that this youthfulness may also be the key to a more sensitive, nourishing and mature way of working with clients and patients.

The debate on the role and function of occupational therapy may possibly never end. There is perhaps a danger of too much navel gazing, too much worrying about what OTs should call themselves and their work. Perhaps, as Edward Duncan suggests, it is better to move on and provide the service.

The HPC has published proficiencies for each of the professions registered by it. Each registrant has a copy of these proficiencies and it is clearly incumbent upon each person to ensure that they maintain and develop their competence. (See Chapter 5 for further discussion on this.)

From the legal perspective it is clear that any book which attempts to be relevant to all aspects of the role of the OT needs to be comprehensive and far reaching in its coverage, and it is hoped that this book will provide the necessary framework.

Conclusions

The epic work of Ann Wilcock traces the journey of occupational therapy from the earliest times to the present day. Her concluding hopes for the work are that it

will encourage a greater range of questions, research and initiatives to facilitate the growth and direction based on in-depth and investigative practices.

The two volumes of the history of occupational therapy sponsored by the British Association and College of Occupational Therapy should give OTs a sense of their history and their significance in the field of health and social care. In spite of major changes since 1989, the recommendations of the Blom-Cooper report are still of value, and perhaps another inquiry to establish what now needs to be done in the light of changing circumstances would be an advantage. Major changes to the professional registration machinery and the nature of professional conduct proceedings were introduced in 2002 and these are discussed in Chapter 3. Their impact upon the status and role of the occupational therapist needs to be evaluated. The initiative of the College of Occupational Therapists in developing new core professional standards in 2003 and updated in 2007 to define standards for processes that are central to all practising occupational therapists in all settings is ongoing and will foster the unity of the profession and assist in identifying those practices which are central to all occupational therapists. These core standards are supplemented by clinical guidelines or practice guidance which are relevant to a specialist group working in a particular clinical area or care group. Practice guidelines outline the nature and level of intervention that is considered best practice for specific conditions in specific settings. They incorporate or abide by the College’s professional standards for OT Practice. Both the core standards and the clinical guidelines will be referred to throughout this book, since they are pertinent to the reasonable standard of professional practice which the law requires of all health professionals. A review of the standards is due to start later in 2009 and will be published in 2011. It is planned to hold a think tank/workshop at COT in December 2009 to gain feedback from members to help inform the revision of the standards. The development of specialist sections within the College of Occupational Therapists has been an important feature in ensuring high standards in specific clinical areas. The criteria for the approval of new specialist sections facilitate consistency across the whole field of OT activity and support continuing professional development. Email networks for
OTs specialising in learning disabilities, mental health, vocational rehabilitation or condition management and supervised by the professional affairs officer and professional enquiries co-ordinator enable effective communication across the COT membership.

An edited work by Jennifer Creek and Anne Lawson-Porter should prove a useful introduction to an analysis of the contemporary issues in occupational therapy and assist in the debate on the nature, direction and focus of occupational therapy. In an article on professionalism and OT, Teena Clouston and Steven Whitcombe consider the history and identity of OT as a profession and the threats resulting from the modernisation agenda for the NHS and suggest a way forward. The necessity to prove that occupational therapy is a research-based, cost-effective intervention across all fields of health and social care will provide an ongoing challenge both to individual practitioners and to the profession as a whole.

Questions and exercises

1. How would you define the core work of the OT?
2. How appropriate do you consider the present title of occupational therapy is for the profession? Would an alternative title be more suitable?
3. Do you consider the personal beliefs and philosophies of OTs are relevant to their work? To what extent, if any, should they be taken into account by prospective employers?

References


