The Issue Is

Should Occupational Therapy Adopt a Consumer-Based Model of Service Delivery?

A colleague and I were recently discussing the frustrations of a student who had completed a Level II fieldwork in a community mental health center that is consumer directed (i.e., the service recipients choose the services and activities in which they will participate rather than having them prescribed via a treatment plan). The student was frustrated because despite the many occupational therapy services she was capable of providing, the consumers often chose not to take advantage of them. From this conversation, I was struck with the realization that the medical models of service delivery to which most educators socialize students have traditionally given health care professionals extensive latitude in making decisions for consumers rather than asking them what issues they want to address.

Through my conversations with consumers, observations shared by students on fieldwork assignments, and my own observations of occupational therapy practice, I have found only limited consumer involvement in decision making. Too often, collaboration with consumers (which is required by the American Occupational Therapy Association’s [AOTA, 1994] code of ethics) is interpreted to have been achieved if the therapist asks during the evaluation process what the consumer’s goals are or what he or she would like to be able to do before leaving the hospital. During treatment, the therapist may reintroduce the topic of goal setting for additional input. Even if the consumer provides this information, rarely does a therapist use the consumer’s stated desires as the sole (or even primary) basis for determining treatment goals. Instead, the therapist continues, albeit beneficently, to create a treatment plan that is predominately his or her own.

I believe that not only should there be collaboration between the therapist and consumer, but also that no occupational therapy service should be performed without obtaining consent from the consumer. I further believe that because the consumer is paying for the services, either directly or indirectly through insurance or government assistance with limited health care dollars, he or she has the right to choose which occupational therapy services to participate in, much like he or she would choose any other professional services (e.g., dental care, legal advice). As Shapiro (1994) put it, “No one—not even doctors or therapists—knew more about the needs of disabled people than disabled people themselves” (p. 73).

Current Practice in Consumer-Based Service Delivery

Some settings use service delivery models that require consumer involvement, for example, independent living programs, public school systems (parental involvement and choice is mandated by law), and some community-based psychosocial rehabilitation programs (Kleinman, 1992); however, few occupational therapists work in these consumer-based programs. Although Bowen (1994) found that 46% of independent living programs use occupational therapy services, the AOTA’s 1990 Member Data Survey revealed that only 2.7% of registered occupational therapists and 5.9% of certified occupational therapy assistants are employed in independent living or residential settings (these two settings being combined in data gathering) (AOTA, 1991). The survey further revealed that public and private school systems employ 18.6% of registered occupational therapists and 17% of certified occupational therapy assistants. Finally, Newman (as cited in Kleinman, 1992) found that only 11% of 212 community-based psychosocial rehabilitation programs surveyed employed one or more occupational therapists.

Literature Pertaining to Therapist-Consumer Collaboration

The Canadian Association of Occupational Therapists (CAOT) published its official guidelines for client-centered practice in 1983 (Department of National Health and Welfare &
AOTA's Position Regarding Consumer-Based Practice

Although the AOTA has not taken a stance with regard to consumer-based practice, Principle 2, A. of the Occupational Therapy Code of Ethics states, "Occupational therapy personnel shall collaborate with service recipients or their surrogate(s) in determining goals and priorities throughout the intervention process" (AOTA, 1994, p. 2). This standard of practice is based on the ethical principle of autonomy: the right to be independent and self-governing. Although therapist-consumer collaboration is currently required by the code of ethics, I propose the adoption of a consumer-based model for service delivery to ensure that the consumer is autonomous in establishing treatment plans and goals.

A Proposed Consumer-Based Model

In a consumer-based model, the person (potential consumer) referred to occupational therapy services is interviewed so that the therapist can facilitate the identification of specific goals and a description of the contexts in which activities or tasks are performed. Two instruments are available for use in the interview. Payton, Nelson, and Ozer (1990) developed a manual that provides specific questions therapists can ask to help consumers identify their concerns, goals, desired outcomes, and the means to obtain the goals. Law et al. (1991) developed a similar, yet more detailed, instrument called the Canadian Occupational Performance Measure (COPM) to involve consumers in determining occupational therapy intervention. The COPM parallels the Guidelines for the Client-Centered Practice of Occupational Therapy (Department of National Health and Welfare & CAOT, 1983).

After the interview, the therapist, using traditional evaluation techniques, evaluates only those areas of concern identified by the consumer. At the same time, the therapist remains aware of the environment (the context) in which the consumer performs activities to evaluate the compatibility of the environment to the person.

After the evaluation, the therapist meets with the consumer (or his or her surrogate[s]); explains, in lay terms, the evaluation results; and describes alternatives for addressing the consumer's goals. A mutual education process, between therapist and consumer, is required so that the consumer can make informed decisions and identify realistic and achievable goals. The consumer and therapist collaborate on developing a treatment plan, with the consumer choosing and prioritizing treatment goals (ideally the consumer and therapist discuss their motivations and rationales in the decision-making process). While the therapist is presenting the treatment options, the consumer has the opportunity to provide input, choose the services he or she will use, and prioritize his or her own goals. If the consumer requests a treatment option that the therapist believes would not be beneficial (or would be potentially harmful), the therapist has a moral and ethical obligation to decline provision of such an option, explaining to the consumer why the treatment would not be indicated or perhaps even contraindicated. Consumers have the right to change the priority of treatment goals as they deem necessary throughout the treatment process. Consumers also have the option of choosing or changing therapists if the therapist is not doing what the consumer deems necessary or if the consumer prefers to work with another therapist.

Implications of Using a Consumer-Based Model

The consumer-based service delivery model has the potential of investing the consumer in the treatment process and subsequently requiring the consumer to take more responsibility for his or her health care. The model also assumes that consumers are comfortable in challenging the recommendations of a health care professional. Whether all consumers can reasonably assume the role of directing their own treatment, especially when under the duress of a medical (and perhaps life-threatening) emergency, could be questioned. When evaluating the consumer comments after completion of the COPM, Law et al. (1994) found that "it was difficult for some clients to..."
Conclusions

Adopting a consumer-based model for occupational therapy practice would require a shift in decision-making power from the therapist to the consumer. A necessary first step is a thorough discussion of the model and its implications on practice, which would help ensure that, if adopted, it is understood and used. Adoption of a consumer-based service delivery model would allow consumers to choose our services based on their sense of worth of what we have to offer.

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