Starting a Level I Fieldwork Program

(education, fieldwork experience, occupational therapy)

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Because the occupational therapy program described in this paper serves two purposes (student training and patient treatment), frames of reference for each process must be addressed. As a form of experiential learning the level I fieldwork experience has its roots in learning theory, whereas the patient treatment program fits best into the model of human occupation.

Experiential learning has long been an essential part of occupational therapy educational programs. The clinical affiliation (level II fieldwork experience) has traditionally been the final proving ground for students to apply their academic knowledge and skills in the "real world" of patient treatment (1). During the 1960s and 70s, the preclinical (level I fieldwork) experience was begun earlier in the students' curriculum. And, as the American Occupational Therapy Association mandates in its Educational Essentials (2), "Supervised fieldwork [has] become an integral part of the professional education program" (p 820).

Experiential learning (e.g., fieldwork experiences) has its roots in the associationist theory of learning, most specifically in the theory of Edwin Ray Guthrie (1886-1959). Guthrie believed that learning occurs in only one trial; that is, "a stimulus pattern gains its full associative strength on the occasion of its first pairing with a response" (3, p 77). For example, a knowledge of schizophrenia might best be gained by observing and interacting with a schizophrenic patient. Guthrie also said, "All forgetting is due to interference" through a process called "retroactive inhibition" (4, p 197), by which an alternate response occurs in the presence of a stimulus pattern (4, p 196). Thus, according to Guthrie, forgetting, or modified learning, is much more difficult than new learning.

If Guthrie's theory is applied to the training of occupational therapy students, then the way students learn to be occupational therapists is by actually practicing occupational therapy. In other words, the student should be cast in the role of occupational therapist and put into the clinic as soon as possible. When the clinical learning situation is set up to resemble the end result and is supervised appropriately, the student's early initiation into the clinic will elicit more ac-

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accurate initial learning and prevent the formation of misconceptions. This type of initiation will make students keenly aware of what they need to know and will inspire and motivate their learning in the classroom, right from the beginning.

The treatment program developed follows the model of human occupation in its attempt to restore the patient's occupational behaviors that are currently a part of our culture (5, p 278). Problems in the areas of work, play, and self-care were identified by listing unmet treatment needs. The program itself uses structured activity to address problems in all three subsystems of the human system. The eight treatment groups use art, sports, games, woodworking, pottery, and structured group discussion as contexts for exploring interests and values (volition) and developing and practicing new roles and habits (habituation). They also provide a context for teaching skills (performance). Each group is labeled to identify both the activity used and its relevance to the problem being addressed (e.g., art for social skills and woodworking and pottery for aggressive expression). Patients were assigned to these groups on the basis of their primary problem areas. Therapists (students) worked to engage assigned patients in the activity and to give appropriate feedback. This process embodies the concept of the patient as an "open system" who receives input, processes it, and responds to it in an environment conducive to therapeutic change.

The model of human occupation was not intentionally used in the creation of this treatment program. However, the approach to treatment and the program design give evidence that its frame of reference closely resembles these concepts.

**Literature Review**

A few other models have been described for occupational therapy's level I fieldwork students who were creating new programs, but these were all in nontraditional settings. In 1974, Gill and others (6) described a practice experience for University of Florida occupational therapy students at a summer camp for diabetic children that "gave students a chance to assist in defining the role of occupational therapy in diverse environments." (p 284).

That same year, Grossman (7) described a supervised student field experience for the Downstate Medical Center in New York City in a parent education program, which was an early intervention study in preventive pediatrics. In 1976, Cromwell and Kielhofner (8) described a community service project in which students entering the occupational therapy bachelor's and basic master's programs at University of Southern California were given one-year assignments in community settings not previously serviced by such students. In that study, "students assume(d) all responsibility for negotiation, planning, and scheduling in conformance with their agency's policies and constraints" (p 629).

In 1978, students at Eastern Michigan University participated in a level I field placement at a Federal Correctional Institution (9). This program was begun by occupational therapy educators, groups were then taken over by students, and only off-site supervision was provided.

**Program Model**

Students traditionally begin the professional part of their training by learning basic occupational therapy assessment and treatment techniques in the academic setting. Educators believe that the students' learning is more effective when the students observe and experience these techniques with patients. Educational programs make this observation and beginning treatment possible through level I fieldwork experiences. However, at Quinnipiac College (in the summer of 1982), finding appropriate level I fieldwork in psychiatry presented a quandary, which ultimately led to the development of the model presented in this paper. Although there are some excellent facilities in the area that offer psychiatric occupational therapy, nearly all were unable to accept level I fieldwork students for the following reasons: a) confidentiality issues, b) occupational therapy staffing problems, and c) administrative unwillingness to allow occupational therapy clinicians to take time away from clinical practice.

Furthermore, with increased integration of academic and clinical learning as a goal, it remained the occupational therapist educator's problem to find clinical placements for students where specific treatment techniques offered in the classroom could be observed and tried on patients.

Through a grant in 1974, Quinnipiac College established clinical contact for both occupational and physical therapy students with the West Haven Veterans Administration Medical Center (VAMC), an 800-bed hospital with two treatment buildings that offers a multitude of general and specialized medical services. These include eight psychiatric services: two with full-time occupational therapists on staff, two with part-time occupa-
tional therapists, and three with no occupational therapists. For various reasons (e.g., staff scheduling and ward philosophy, increased student load, and the educator's need to meet more specific objectives), it was not possible for the 16 to 30 level I fieldwork students to observe what they needed to learn in these clinical settings.

**Strategy**

Creating a new occupational therapy program for the VAMC psychiatric services seemed a likely solution to the problem. The new program was presented as a pilot study. To continue, the program had to prove itself beneficial to students, educators, administrators, and patients.

**Marketing**

Fortunately, both the Director of Rehabilitation Medicine Services and the Director of Occupational Therapy at VAMC supported the idea of establishing new occupational therapy services in which students could participate. The real marketing needed to be done with the Department of Psychiatry. The unit most receptive to the idea was a 28-bed, long-term (6-12 mo) inpatient unit. The ward chief was familiar with occupational therapy because of the part-time services already offered on that unit by the director of occupational therapy. Still, much of the patients' time was relatively unscheduled, and the ward chief was easily sold on the idea that patients' time could be used more effectively by providing additional occupational therapy services. Thus, the following agreement was made.

1. The ward chief would plan times in the patient schedule for student-run occupational therapy groups. Occupational therapy groups were scheduled to begin with six hours per week and were not to conflict with any other previously scheduled groups.

2. The occupational therapy educator would act as a liaison/communicator between students and ward staff and attend ward staff and community meetings. He or she would become familiar with each patient to ensure that the occupational therapy treatment provided by the students was appropriate.

3. The occupational therapy educator would have sole responsibility for the supervision of the students.

4. The ward staff would be involved in the assignment of patients to occupational therapy. The staff would a) help enforce the policy that all patients must attend their assigned occupational therapy groups and b) promote the groups as an important part of the patient's total treatment plan.

5. The ward psychologist would be assigned to oversee the program and to help evaluate its effectiveness. Weekly meetings were to be set up between occupational therapy educator and psychologist.

6. The program would be tried for one year and then would be reevaluated by both administrators and educators.

Facilities and supplies had to be negotiated with the Director of Occupational Therapy. Clinic time was available, but funds for supplies were difficult to obtain. Because the program was new, the supply budget began with minimal funds, only $50.00 per semester for all of the groups combined.

**Patient Assessment**

To plan an effective occupational therapy program for the unit, the needs of each patient had to be assessed. During the beginning weeks of the program, each student was assigned a patient on whom to administer three assessments learned in class. From these assessment results, students were asked to make a prioritized problem list for their assigned patient.

**Treatment Needs Assessment**

All 16 students pooled their assessment information and, as a class led by the educator, developed a list of unmet treatment needs for the unit. The problem areas to be addressed in occupational therapy are as follows: a) self-care (problems with leisure time usage, money management, and household skills), b) social functioning (problems with developing outside supports, inappropriateness of social interactions, excessive dependence on family, and social isolation), c) vocational cognitive (problems with setting goals, motivation, concentration and/or attention, frustration, tolerance, and self-confidence), and d) emotional functioning (problems with management of stress and anger, accurate response to safety hazards, self-awareness, and the development of empathy towards others).

**Program Proposal**

Together, the students and the educator created an occupational therapy program proposal based on identified needs. The original proposal included the following groups: a) art for social skills, b) fitness through movement activities, c) values clarification through structured activities, d) woodworking and pottery for aggressive expression, e) vocational skills training, f) task-oriented group for effective problem-solving, g) assertiveness, and h) daily living skills for independent functioning. Tra-
ditional occupational therapy modalities were used in some creative ways to achieve specific goals. Students learned the process of treatment and program planning by actually seeing it in action. The proposal was written and presented to the staff, and it was enthusiastically approved.

Implementation

Pairs of students chose one of the proposed groups to plan and lead. Given the limited supply budget, students had to be creative planners. They researched texts for activities and procedures, borrowed clay, glue, paper, and food supplies, and collected magazines, scrap wood, and newspapers.

Meanwhile, the educator met with staff members to collaboratively assign patients to the groups. Groups averaged three to five patient members. Patients were given written schedules, and occupational therapy groups were announced at community meetings. A large copy of everyone's schedule was posted on the unit.

Communication channels were established. Students were required to write problem-oriented progress notes (SOAP notes) on each patient after each session—a procedure they learned in class. These were corrected by the educator and then given to the staff. Later, notes were returned to the students with written feedback and suggestions. Once a month, these progress notes were put in the patient's chart. This induced students to write notes carefully and thoughtfully. The educator reported patient progress in occupational therapy at staff meetings and dealt with questions (and resistance) from patients at community meetings.

Because students were cast in the role of professionals, they were allowed to read patients' charts and were also expected to observe the patients' rights to confidentiality. Students were encouraged to approach the patients' doctors when they had concerns about the patients in their groups.

Supervision was a key issue in the success of this project. Level I fieldwork students are often apprehensive about their first contact with psychiatric patients. Having specifically defined tasks and structured groups using familiar modalities gave them needed confidence. But more importantly, supervision by the educator was constantly available. All the groups took place over two 3-hour periods (8 students at a time) in one large room. Because the educator was present in that room the entire time, students could ask for one-to-one supervision as needed.

Evaluation

After the first year, this pilot program was shown to have advantages for educators, students, administrators, and patients.

From the educational point of view, students were exposed to patients while taking courses in psychopathology, group dynamics theory, counseling skills, and treatment techniques. This made it possible for them to associate theory with practice on a daily basis. It was evident from the questions students asked in the classroom that they were thoughtfully struggling with the integration of didactic learning and actual experience.

This association with the clinical setting has added advantages for the educator. It allowed her to keep her own clinical skills current and to update her knowledge of diagnosis, medication treatment theories, and research through association with doctors and other professional staff.

A major disadvantage for the educator was the amount of time involved in setting up and maintaining such a program. (Each hour of class time means another hour of staff-related duty.) Supervision of student-led groups can be hectic with several going on at one time, and clinical issues can sometimes get in the way of teaching (e.g., when a patient scheduled for assessment is discharged without notice).

To evaluate the effectiveness of this experience, senior students presently involved in level II fieldwork experiences were surveyed (see Table 1). Of the 36 seniors who participated in the pilot program, 28 responded anonymously, with the following results. All categories received a mean rating from 4.85 to 7.29, a rating of somewhat helpful or better. The experience was rated most helpful in the areas of “level of comfort in working with patients” and “attitude about patients”; it was least helpful in “knowledge of psychopathology.” Comments were predominantly positive, for example, “I think the VA experience in Psych was a definite plus” and “The most beneficial experiences were learning to establish rapport with patients, learning not to stereotype patients based on their diagnosis, and learning to feel comfortable with psychiatric patients.” Suggestions for improvement were in the general area of supervision. Students felt more feedback on their group leadership, assessment, and note writing would have been helpful.

Twenty-six patients in the pilot program were asked to comment on their experiences in writing. There was an 80% compliance rate.
in filling out the forms, and the response was consistently favorable. Here are a few typical comments: "The OT group was enjoyable," "The students were very helpful and knew what they were talking about," "It really helped me find out a little more about myself," and "Overall, it was fun and very relaxing." Criticisms included requests for more "mature" activities, more time in occupational therapy and less say in which group they were assigned to, better tools, and students who wouldn't have to leave at the end of ten weeks.

Six administrators from the Department of Rehabilitation Medicine Service (RMS) and Psychiatry were asked to rate the program. An RMS representative said, "The student program has meant a substantial increase in patient care activity on the units involved. On an average treatment day, approximately 18 patients are involved. An average of 24 different patients are seen in a month. This has meant the ability of RMS to offer patient care services not otherwise available." Psychiatry administrators commented that the program "provides information about patients not available through other sources" and acknowledged occupational therapy's function in the assessment of patients. In treatment, the program provides "valuable pressure spurring development of adaptation and community orientation." The head nurse on the ward commented, "The program enhances the (ward) treatment program by providing a service only minimally available through the VA." She also said that occupational therapy assessments "confirm data postulated for patients and sometimes reveal more profound deficits." The Director of Occupational Therapy showed her support by increasing the supply budget from $50 per semester to $480 per quarter, an increase of almost 800%. The program is now completing its second year and will continue.

Summary

Finding meaningful level I fieldwork experiences for occupational therapy students in today's clinical setting has become increasingly difficult for the following reasons: a) the increased pressure on educators to provide students with early experiences that can be better integrated with the classroom curriculum, and b) the growing unwillingness of clinical administrators to accept student "observers" (because of increased pressures for productivity in treatment and other clinical concerns).

One approach to this educational problem is to develop an occupational therapy program using the services of students who are under the careful guidance and supervision of the occupational therapy educator. The experience described in this paper provided the students with the observation and structured participation they needed to facilitate and reinforce the specific knowledge and techniques learned in the classroom.

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REFERENCES