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THE ROLE OF A REMEDIAL PROFESSION IN SOCIAL SERVICES DEPARTMENTS

THE CASE OF OCCUPATIONAL THERAPY

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M.A. by thesis

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THE CASE OF OCCUPATIONAL THERAPY M.A. by thesis 1990

ABSTRACT

This study of 90 fieldwork occupational therapists representing ten local authority social services departments randomly selected throughout England was undertaken in 1981. It presents a detailed picture of the work that they carried out and of the influences upon that work. The departments were chosen to illustrate the varying ways in which occupational therapists were managed and deployed within social services departments so that these could be related to the work undertaken and to the respondents' subjective experience of their work. The subject has a wide frame of reference. Issues such as autonomy and the management of a discreet professional group within a large bureaucratic organisation are pertinent as is the whole subject of professionalism, and professionalisation. Status, identity strain and role clarity are themes which recur and which also relate to the process of accommodating a minority specialist group within a large organisation, equally role strain is seen to result from the necessity of having to ration limited resources and from compromising professional judgements with political pressures. The findings show that the occupational therapists in this study were involved in a wide range of activities using diverse skills and liaising with an extensive range of personnel. There was considerable variation between the areas studied although, in most cases, a large amount of the respondents' time was spent on aspects of work that did not require their exclusive skills. Where assistants were employed the occupational therapists concentrated on the more complex cases and did not have to deal with such high numbers of referrals. The findings provide guidance on the most effective deployment of occupational therapists within social services departments and implications for the conceptual model of occupational therapy within social services that training establishments and the British Association of Occupational Therapists should, perhaps, be promulgating.

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CHAPTER ONE

BACKGROUND TO THE STUDY1.1. INTRODUCTION

At the time that this study was undertaken the role of remedial professions and the best use of these resources in social services departments had been identified by the Department of Health and Social Security (DHSS) as a research priority by the Physically Disabled Research Liaison Group (PDRLG 1979/1980) and by working parties that had studied the future requirements to be met by these professions (Council for Professions Supplementary to Medicine (CPSM) 1979; the British Association of Occupational Therapists (BAOT) 1981). Occupational therapists were and still are a limited resource in the traditional hospital setting (DHSS 1974a) and also within local authority social services departments where they have been working in increasing numbers since the passing of the Chronically Sick and Disabled Persons' Act 1970. It was estimated that there were approximately 705 posts for occupational therapists 'in the community' (DHSS 1984) as opposed to in hospitals, which represented approximately 20% of all occupational therapy posts. These posts were distributed unevenly throughout England, Scotland and Wales and the deployment of occupational therapists varied greatly, from one occupational therapist (OT) to 13,000 capita population in an outer London borough, to one OT: 214,000 in a northern metropolitan borough.

The value of the skills that occupational therapists bring to social services departments is recognised by the DHSS, the Association of County Councils (ACCs) and the Association of Municipal

Authorities (AMAs) (ACCs 1978). Occupational therapists bring a dimension of service that is spanned neither by social workers nor any other social work staff, namely the application of medical knowledge and practical skills in meeting the environmental, practical, social and emotional needs of handicapped groups. This not only includes the physically ill and disabled, but also the elderly, the mentally ill, mentally handicapped and the socially handicapped. The duties imposed on local authorities by the National Assistance Act 1948, the Health Services and Public Health Act 1968, and the Chronically Sick and Disabled Persons' Act 1970 all led to the steady increase in the recruitment of occupational therapists by social services departments which led to the position in 1980. This was particularly true of the 1970 Act as a result of Section 2 subsection (1)(e) :-

'the provision of assistance for that person in arranging for the carrying out of any works of adaptation in his home or the provision of any additional facilities designed to secure his greater safety, comfort or convenience.'

The interpretation of this act led to the rather limited view of occupational therapists as being concerned only with 'aids and adaptations' and it was apparent that the best use of their skills was only realised in a small proportion of local authorities.

For a variety of reasons the employment of occupational therapists in social services departments has developed in an ad hoc fashion. One major reason may be that it was not until 1980 that the occupational therapy qualification was recognised by the National Joint Council (NJC) (the governing body which determines conditions of service in local authorities) and admitted to the NJC's 'Purple Book'. The 'Purple Book' lays down all the conditions of service of those staff recognised by the NJC. Because of this, qualified occupational therapists were employed in social services departments under a variety

of titles (Occupations Officers, Rehabilitation Officers, Aids Advisers etc.) on varying salary scales and with idiosyncratic lines of responsibility (ACCs 1978, BAOT 1979).

There was also considerable variation in the support services available to social services occupational therapists not only in terms of clerical, administrative and technical support but also in terms of the presence of occupational therapy assistants employed specifically to relieve the occupational therapist of some of the less skilled and more routine aspects of her work (McMillan 1973; COSLA 1979). The development of the work undertaken by occupational therapists seems to have been affected by these factors and by other issues, namely, the fact that occupational therapy is a female-dominated profession; the three year training has been primarily orientated towards producing qualified occupational therapists who will work in the hospital setting; the content of the occupational therapists' training, and therefore their potential, is not generally familiar to other staff employed within social services departments.

Despite the fact that, through the efforts of the BAOT, the employment of occupational therapists within social services departments is becoming more formalised and consistent (particularly in the south of England and in London boroughs) there is still considerable diversity in the range, depth and volume of work that occupational therapists undertake within different departments and in the manner by which they are organised (ACCs 1978, BAOT 1979, Bristow 1980).

The limited studies that there had been and the observations of the researcher indicated that social services occupational therapists undertook a wide range of tasks. These extended from the need to exercise considerable expertise and professional skill incorporating complex knowledge of psychological, medical and technical factors to

the execution of unskilled tasks such as collecting unwanted aids and disinfecting raised toilet seats. The second indication was that social services occupational therapists dealt with a high proportion of all referrals that were made to social services departments (Bristow 1980; Beazeley & Vile 1982; Scrivens 1983) and that the constant pressure of these referrals limited the amount of rehabilitative, preventive and supportive work that occupational therapists could undertake with the more severely handicapped, the younger handicapped and those people with progressive diseases. This also meant that social services occupational therapists were rarely able to work with other client groups such as the mentally ill and the mentally handicapped for whom they are trained, or to take on a greater educative and advisory role with other staff groups.

It seems probable that all these factors affected the type of work that the social services occupational therapist undertook, the time that could be spent with clients (or on their difficulties) and therefore the quality and depth of the service - in terms of the true resolution of difficulties rather than a superficial alleviation of the symptoms - that the occupational therapist was able to give.

In addition to these practical variables which affected the work there are other factors, such as the national and local political and economic climate, the particular characteristics and experience of each occupational therapist, and a number of theoretical issues which are discussed further on.

However, the degree to which all the factors mentioned above do influence the service that is provided by occupational therapists has

never been evaluated systematically¹. Therefore, any discussion concerning the most effective use of occupational therapy resources, and recommendations concerning the future role of occupational therapists within the community, have been based on subjective experience or the records of work undertaken within those individual departments sufficiently motivated to measure their own work. Neither of these methods is necessarily representative of the national picture.

This study was therefore undertaken with the following objectives:-

1. To obtain an accurate account of the work undertaken by qualified occupational therapists in social services departments, at fieldwork and management levels, from a randomly selected group of authorities representative of different organisational structures and geographic locations.
2. To relate the information concerning the work undertaken to the staffing structure, the organisational framework, the workload and the availability of additional support (e.g. occupational therapy assistants or social work assistants).
3. To consider, given occupational therapists' training and expertise, whether or not the best use is being made of their skills and whether or not aspects of their work could be undertaken by less highly trained staff, thereby releasing the occupational therapists to do more skilled work.

¹This study was planned in 1980 and the fieldwork was undertaken in 1981. Where possible, information has been updated in the writing up.

4. To consider which aspects of the occupational therapy training were of most value to occupational therapists in the social services setting and for which aspects of the work occupational therapists felt inadequately prepared.

5. To be aware of the possible existence of different typologies of social services occupational therapists and to record observations of them if they should become apparent.²

²Studies of professional and semi-professional groups have identified typologies of workers; e.g. the Professionalizer, Traditionalizer and Utilizer types of nurse identified by Habenstein and Christ (1955) and Dingwall's (1977) observations of health visitor students.

1.2. LITERATURE REVIEW

In England, in 1980, there had been little systematic study of occupational therapy as a profession and even less study of occupational therapy in social services departments. There were many individual studies of specific occupational therapy treatment techniques and texts on occupational therapy practice but few critical evaluations of the state of the profession or of occupational therapists themselves. Therefore, in seeking a starting point for literature which was of relevance to this study the researcher has turned to studies of other female-dominated health professions such as nursing, health visiting and physiotherapy and to the literature of occupational therapy in America.

However, literature concerning female-dominated health professions is only one aspect of the literature relating to this study which has a wider frame of reference. The literature examined both before and during the research process can be broadly described within the following categories.

1. Any studies of occupational therapists or other health professions working in the community and social services departments.
2. Policy documents relating to occupational therapists or other health professions working in the community and social services departments.
3. Historical studies concerning the development of social services departments.
4. The theory of processes within organisations and within social services departments in particular.
5. Role theory - relating particularly to status, types,

gender, disability and work.

6. Studies of professions and the process of professionalisation with particular reference to female-dominated professions.

7. The theory and practice of occupational therapy.

In practice the literature does not neatly divide into these categories, there is much overlap between the development and practice of occupational therapy and the study of professions and organisations. In addition, the sociological concepts of role, status and motivation are common threads to much of the literature studied. Therefore, in order to provide a background to this study which will help to set the findings and discussion within a wider historical and theoretical context the starting point for a review of the literature will be the theoretical basis of occupational therapy.

The theoretical basis of occupational therapy

Much of the more contemporary literature concerning the theoretical basis of occupational therapy is concerned with the growing recognition during the 1970s that modern day occupational therapy lacks a unifying theoretical base (Mosey 1981; Kielhofner 1983). Kielhofner states that -

'the fundamental problem in occupational therapy today is not as much a lack of information as it is a lack of coherence about knowledge that has been accumulated.'
(Kielhofner 1983)

Burke (1983) states that the lack of a unifying theoretical basis, a concomittant lack of identity in the field's clinical service and among occupational therapists and the dilemma of maintaining cohesiveness while allowing specialisation in practice result in -

'therapists who cannot define their service or articulate its basic worth . . . students lost in the seemingly unconnected bodies of knowledge and practice techniques that must be assimilated and . . . educators whose curriculum is long on content but short on integration.' (ibid)

Although these opinions relate particularly to occupational therapy in America similar concerns are expressed in the British Journal of Occupational Therapy (Atkinson 1980; Cracknell and Foster 1980; Tigges 1980; Aina 1981). In response to an article by Madden (1984) "Explaining psychiatric occupational therapy : an art in itself?", Midgeley (1984) argues that

'the root of the problem is the lack of concepts of occupational therapy . . . a comprehensive study of the various concepts of occupational therapy would, I believe, provide the missing link, that is answer "what is occupational therapy" and "why occupational therapy".

To understand why the profession is facing these fundamental questions it is necessary to examine its historical and theoretical development.

Kielhofner uses Kuhn's (1970) concept of paradigm and the schema of paradigm change to trace the development of occupational therapy. Paradigm is defined as a consensus-determined matrix of the most fundamental beliefs or assumptions of a field. It defines in the most fundamental sense what the practitioners will see when they view the world, and what kinds of puzzles they will seek to solve in their work.

'The OT paradigm would thus be the field's means of defining human beings and their problems in such a way as to provide a rationale for a course of action to solve them.' (Kielhofner 1983)

Kuhn's (1970) 'schema of paradigm change' provides a pattern for the formulation and evolution of paradigms because a discipline's paradigm is not a static phenomenon, it evolves in response to internal and external pressures. There are four stages of the schema :

1. Pre-paradigm, 2. Paradigm; 3. Crisis; 4. Return to paradigm.

The following pages describe the four stages and Kielhofner's application of the stages to occupational therapy.

1. Pre-paradigm

This stage occurs prior to the formalisation of a discipline when several schools of thought may have interest in the same phenomenon. Kielhofner (1983) identifies the moral treatment movement of the 18th and 19th centuries as the forerunner of occupational therapy. Exponents of this movement considered that mental illness was a result of external pressures and that disorganised behaviour could be normalised by the remedies of education, daily tasks, work and play as therapeutic processes.

With the rise of the pathological approach to mental health and the consequent use of drugs and surgery the moral treatment movement declined. However -

'a few energetic and dedicated individuals eventually re-applied moral treatment in several areas of caring for the ill and disabled, generating a new profession that became known as occupational therapy.' (Kielhofner 1983)

2. Paradigm

This is the stage where one school of thought predominates and forms its own collective. The discipline subscribes to a common definition of the phenomenon it confronts, the puzzles to be solved, and the ways of reaching solutions (Kielhofner 1983).

The paradigm for occupational therapy that was formed and that existed in the first four decades of the twentieth century was thus based on the philosophy of the moral treatment movement and can be described as the paradigm of occupation.

'The paradigm of occupation was based on the dogma that humans had an occupational nature. This included the tenet that the mind and body were linked in unity in which the mind governed the organism. Important features of the mind were awareness of time and morale that stimulated interest and commitment to one's daily occupations. Occupation was conceived as a dynamic rhythm and balance that included alternation between the essential components of work, play and rest. Finally, the whole organisation of the organism was

seen as structured in human habit and maintained through ongoing engagement in everyday occupation.' (Kielhofner 1983 p.14)

Within the context of this paradigm of occupation, occupational therapists were concerned with the results of a dysfunction in the occupational behaviour and sought to encourage involvement in an occupation that would exert a strong organising influence on the total function of the person. From his studies of the literature of the time Kielhofner (1983) states that this paradigm was empirically successful. Occupational therapists working with the physically or mentally ill had no doubts about the value of their work and there was an overwhelming enthusiasm for occupational therapy as a great asset to modern medicine (Kielhofner 1983). However, in the late 1940s and the 1950s there was growing pressure on occupational therapy to establish a scientific rationale for its methods and to engage in research to support its claims to efficiency. Licht (1947) pointed out that physicians openly criticised occupational therapy for its lack of a scientific rationale and called for research in the field. In the 1930s the depression had threatened job security and, to ensure professional survival, occupational therapy had sought a closer alliance with medicine, a move which had several implications, some of which are discussed in relation to the literature on professions (see page 26). These pressures brought about a crisis in the profession, typical of Kuhn's (1970) schema.

3. Crisis

In Kuhn's schema a crisis occurs when anomalies arise that cannot be handled within the boundaries of the paradigm. Part of the crisis was due to the changes that had taken place within the medical profession during the twentieth century. In order to become a scientific discipline, and achieve scientific status, medicine had

drawn upon the methodology of reductionism (Riley 1977). Reductionism postulates that everything in the world (be it a cell, a plant, or a social system) is nothing more than the sum of its individual parts and that in order to be understood it must be reduced to its most elementary parts whose effect on each other can then be studied.

Because of its new brand of science, medicine did not recognise as scientific the holistic concepts which characterised the paradigm of occupation. At the same time concepts of kinesiology, neurology, and psychiatric pathology, which had developed in the 1940s and which had originally been incorporated within the paradigm of occupation, now competed as primary concepts for occupational therapy and these areas of knowledge were more in line with the reductionist approach (Kielhofner 1983).

The literature of the 1950s and 1960s displays increasing attacks on the paradigm of occupation. The concepts of humans' occupational nature, the rhythm and balance of occupation were being replaced by narrower concepts of purposeful activity and function. As the understanding of occupation and its holistic healing influence slowly eroded, phenomena of the neuromuscular and nervous systems and intrapsychic dynamics became more plausible explanations for what occupational therapy did. (Kielhofner 1983 p.30)

4. Return to paradigm

The crisis in a profession continues until one of the competing schools of thought manages to incorporate the anomalies that have developed. The new paradigm has a completely new perspective to the previous one, a different way of viewing problems and solutions, but it also retains the knowledge and technology that had been developed under the old paradigm.

Kielhofner identifies the new paradigm of the 1960s as a paradigm

of inner mechanisms. This is because the developing scientifically-based approaches of neurology, kinesiology and psychiatric pathology are all based on a particular way of viewing human beings - through their inner mechanisms. He notes that therapists felt a greater sense of control over the processes they managed in therapy because procedures could be clearly articulated, and coherent bodies of knowledge and practice techniques were developed. Kielhofner considers that this paradigm resulted in both gains and losses for the profession. The gains were the increased technical ability based on increased knowledge in the medical and psychological disciplines. The major loss was the commitment to the occupational nature of humans.

'This (the occupational nature of humans) was the common thread of early practice, and without it, specialities of the field began to drift further apart . . . These and other losses eventually returned occupational therapy to a period of crisis.'
(Kielhofner 1983 p.36)

The situation in 1980

Thus we arrive at the current crisis in occupational therapy. Kielhofner proposes that the present crisis was brought about by three major factors.

1. The fall of reductionism. During the second half of this century the adequacy of reductionism as a scientific framework in biological and behavioural sciences had come into question.

'complex phenomena proved to be more than the simple sum of the properties of causal chains, or of the properties of their components taken separately.'
(Laslo 1972)

The occupational therapy reduction-based paradigm appeared incomplete with too narrow a perspective.

2. The inability of the paradigm of inner mechanisms to provide occupational therapists with a perspective and rationale for dealing with the problems of the chronically disabled. The

technology associated with inner mechanisms is primarily geared towards curing people whereas much of the occupational therapist's work is concerned with helping the individual to adapt to an unchanging or worsening situation.

3. The already identified dissatisfaction of occupational therapists at their loss of identity and lack of unifying principles.

'Jack of all trades - master of none.'

A new paradigm has not yet emerged. Once again within the profession several schools of thought compete for dominance. They include those who still adhere to the inner mechanisms paradigm ; the ontogenetic perspective ; the neurologic approach ; and, as discussed, Kielhofner's model of human occupation.

Whilst the development of occupational therapy in America or Canada is not identical to the development of occupational therapy in Great Britain it is very similar for it was from American occupational therapy that the British discipline developed. Alice Tebbitt was inspired by Dr. Elizabeth Casson to train as an occupational therapist at the Philadelphia School USA in order to start the first English school in Bristol in 1930 (Atkinson 1980). The current British literature displays the same lack of clarity of role definition and of unifying principles (Atkinson 1980; Cracknell and Foster 1980).

The development of occupational therapy in the community

Community occupational therapy started as a voluntary scheme in Surrey in 1936 (Birchall 1970) which was taken over by the local authority in 1938, and in Buckinghamshire within the health department soon after the 1948 Health Act, and in Birmingham in 1954 (Grove 1970; Scott 1970). In all areas the nature of the work was occupational - either using craft activities or industrial outwork primarily for tuberculous sufferers. Still in 1970, when Scott (1970) wrote about 'Domic-

iliary occupational therapy in Buckinghamshire, most of the discussion was related to the organisation of outwork with only two lines referring to 'aids to daily living' -

'an ever expanding field of our work. Main problem is storage of equipment.'

However, the nature of community occupational therapy began to change and, even before the implementation of the Chronically Sick and Disabled Persons Act 1970 which laid the responsibility for services for this group on the new social services departments (see page 7), occupational therapists working in some of the old welfare departments were concerned with the assessment for and provision of aids and adaptations.

The Chronically Sick and Disabled Persons Act 1970 and the setting up of the new social services departments led to the establishment of a much greater number of occupational therapy posts in local authorities and to a considerable degree of debate within the Association of Occupational Therapists. (The Association did not become the British Association of Occupational Therapists until 1974 when the English and Scottish Associations amalgamated).

The debate centred on whether or not occupational therapy in the community was, or should be, a social service or a medical service. There are several aspects to the discussion. One aspect is the viewpoint expressed, usually by senior members of the profession that the separation is destructively divisive in such a small profession - an argument which reinforces the importance of identifying the profession's unifying theoretical base so that cohesiveness of the profession can be maintained whilst allowing specialism in practice. On another level it can be seen in terms of part of the profession still identifying strongly with the medical model and defining the status of the profession by the closeness of its association with

doctors. Another aspect is related to the content of the social services occupational therapists' work and the degree to which it is, or should be, 'treatment`.

In 1970, at a meeting of eighty community occupational therapists set up to discuss the Local Authority Social Services Act, there was a division of opinion on whether or not there should be social service or health control (BJOT 1970). In 1972 the letters pages of the Journal of Occupational Therapy reflected the conflict between the old guard of domiciliary health service occupational therapists and the new guard of social services occupational therapists. The health service occupational therapists suggested that their social service colleagues were attracted there by the higher salaries and that these occupational therapists were predominantly -

'junior colleagues isolated from the main stream of development.` (Chick 1972)

Such attitudes were challenged by social services occupational therapists stating that they were -

'senior members of the profession committed to giving occupational therapists a new and essential role within the community care facilities.` (Pribisevic, Hart and Warren 1972)

In 1974, with the imminent re-organisation of the National Health Service, there were further moves to transfer local authority occupational therapists to the health service. There was great resistance to this both from the social services occupational therapists themselves and from their social services employers. The government proposed that occupational therapists should transfer from local authorities to new area health authorities if they were -

'engaged wholly or mainly on providing occupational therapy services under medical supervision for people with a condition for which they are receiving, or have received, medical treatment under the health service. They should remain in social services departments if they are engaged wholly or mainly

in providing social rehabilitation for conditions not requiring active medical supervision.` (Nixon 1974)

The occupational therapy council believed that it would be impossible to draw a precise line between health care and social support and, in the event, very few social services occupational therapists were transferred to health departments.

The theoretical issues concerned with being dependent on medical referral and direction are discussed further on (see p. 26) but are also of considerable relevance here. Very little, if any, of the work that social services occupational therapists undertake is under the direction of a medical practitioner although there is liaison over individual cases (see p. 128). This lack of medical referral caused certain difficulties within the profession until, in 1975, the BAOT approved a new code of professional conduct. Clause 2 of the constitution was revised to require occupational therapists to -

'...undertake treatment either when the patient has been referred by a registered medical practitioner or where the occupational therapist has direct access to the patient`s doctor.`

This, as Richards (1981) stated -

'officially recognised that much of the community occupational therapists` work might not constitute "treatment" per se.`

The rapid development of occupational therapy within social services departments is a phenomenon that does not occur in America but is one which aptly illustrates the inadequacy of the inner mechanisms paradigm and which diverges from the more reductionist methods employed by occupational therapists in hospitals. Also, the conflict within the profession concerning health or social services control of occupational therapists working in the community illustrates the dilemma of maintaining cohesiveness within the profession whilst allowing specialisation in practice.

Alaszewski et al (1979) describe the development of occupational therapy in terms of an occupational strategy. They consider that occupational therapy in rehabilitation developed its characteristic patient/person orientation rather than task orientation by filling the vacuum in chronic medicine left by the technique orientation of the precursors of physiotherapy (Alaszewski et al 1979 p.270). By stressing treatment of the whole person, that is, by selecting treatments and activities that will benefit the patient/person rather than selecting patients who will benefit from a particular treatment, occupational therapy can claim a dominant role in the remedial professions. This also means that they can expand into new areas such as social services and mental handicap by stressing their interest in the person rather than adherence to any particular technique or situation. However, Alaszewski considers that -

'with no special technology to call its own OT can be left with all the patients that nobody else can or wants to do anything with - the chronic permanently impaired, e.g. geriatrics, mentally handicapped and chronic psychiatric patients.'
(Alaszewski et al 1979 pp.272-273)

This seems to be a rather circular process as these are the groups that he states occupational therapy started with. It also seems to minimise the importance of occupational therapy being able and wanting to do something with these groups. However, his comments do re-affirm the present lack of an identified special technology in occupational therapy which has been the main theme of the discussion so far.

Professions ; professionals in organisations and female-dominated professions

Throughout the preceding discussion occupational therapy has been referred to repeatedly as a profession without any definition of the term nor justification for the use of the term. For the majority of practitioners the suggestion that justification might be needed would

probably come as a total surprise. Equally, the knowledge that occupational therapy is regarded sociologically as a semi-profession (Etzioni 1969) or a minor profession would also be a revelation.

The literature on professions and professionalisation is extensive. Much of the writing is devoted to the definition of a profession and the process of becoming a profession, further writing is devoted to the status and power of professions and to the processes of professional training. Finally there are studies of specific professional and semi-professional groups.

The issues that are of major relevance to this study are those relating to autonomy and the situation of professionals in bureaucratic organisations; socialisation of professionals; the particular problems associated with female-dominated professions and typologies developed from studies of these. However, before examining these it is perhaps necessary to outline briefly the debate on what constitutes a profession. Numerous writers - (Etzioni 1969; Goode 1969; Barber 1963; Wilensky 1964 and many others) have produced their own checklist of the requisite characteristics which entitle a discipline to refer to itself as a 'profession'. Leggatt's (1970) appraisal of sociologists' lists of characteristics produces five items which appear with the greatest regularity.

- ' 1. Practice is founded upon a base of theoretical esoteric knowledge.
2. The acquisition of knowledge requires a long period of education and socialisation.
3. Practitioners are motivated by an ideal of altruistic service rather than the pursuit of material and economic gain.
4. Careful control is exercised over recruitment, training, certification and standards of practice.

5. The colleague group is well organised and has disciplinary powers to enforce a code of ethical practice.'

(Leggatt 1970)

The law, medicine and the ministry are universally recognised as true professions and much of the literature is concerned with other groups struggling to achieve professional status. The motivation for achieving professional status is viewed by some with cynicism as an occupational strategy to establish control over expertise and reward (Parkin 1971). Whilst this may be the case for some occupations, the majority of disciplines which seek professional status probably do so with the aim of obtaining an independent status whereby they can determine their own priorities and future development. The classification of disciplines into professions and semi-professions (Etzioni 1969) is largely an academic exercise; however, some of the assumptions are open to question. Mosey (1981) doubts that the tenet that 'the hallmark of a profession is the uniqueness of its theoretical foundation' was ever true since lawyers use psychological theories and medicine uses physiological theories. Further, one of the approaches used by Etzioni (1969) to differentiate between professionals and semi-professionals was that the holistic orientation (i.e. the desire to give service and relate to the whole person) was semi-professional and the task orientation (i.e. the exercise of special skills to specific problems without a personal bond) was professional. The recognition that reductionism is an inadequate framework for medicine and the growth of a more holistic approach in medicine brings such classifications into question.

As far as this study is concerned the definition of a professional as proposed by Rowbottom (1978) is considered to be applicable.

'A person capable of applying special theoretical

knowledge or insight in cases where objective and impartial judgement of both needs and appropriate responses is called for.'

It will be seen that occupational therapists undoubtedly come into this category.

Autonomy

Within the discussion of the theoretical development of occupational therapy reference was made to the alliance with medicine (p.22)

'Occupational therapy, in its infancy, was somewhat insecure. Similar to other professions in this stage of development it sought to appear more legitimate through association with a more recognised and powerful profession.' (Mosey 1981)

As with nursing, wherein Florence Nightingale had refused to allow her nurses to do any work unless it was under a doctor's prescription, thus raising nurses from the level of maids to medical status (Friedson 1971) this led to a trap of dependency on doctors and a subsequent lack of autonomy. According to Friedson (1971) those paramedical occupations which are ranged round the physician cannot gain occupational autonomy so long as their work remains medical in character.

'To attain the autonomy of a profession, the paramedical occupation must control a fairly discrete area of work that can be separated from the main body of medicine and that can be practised without routine contact with or dependence on medicine.' (Friedson 1971 p.69)

It will be seen that the work of the social services occupational therapist is neither dependent on medical referral nor contact, however, other aspects of autonomy arise in relationship to a professional working in a bureaucratic organisation.

The issue of autonomy can be considered on three levels. On the first level it can be seen as a fundamental characteristic of a profession which thereby regulates and controls the performance of its members through professional associations or bodies (e.g. the British Medical Association) without outside interference (Leggatt 1970; Glaser

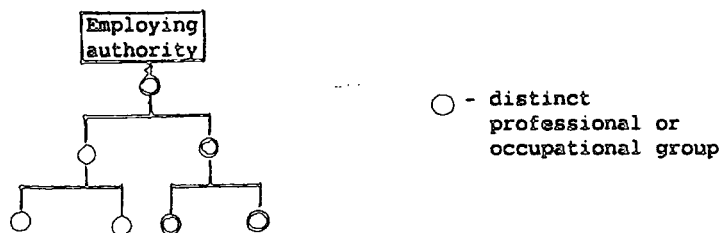
1966). On the second level autonomy can be seen to lead to monopolistic privileges to perform certain types of work (Turner & Hodge 1970). A profession may base its claim for its position on the possession of a skill so esoteric or complex that non-members of the profession cannot perform the work safely or satisfactorily - this particularly relates to medicine wherein 'dangerous consequences can follow improper work' (Friedson 1971). The third level is the individual practitioner level where it is argued that non-members of the profession are not fully competent to evaluate the knowledge and skills of professionals (Turner & Hodge 1970; Friedson 1971).

Rowbottom (1978) has carried out many studies of professionals within health and social service organisations and addresses the problems associated with their management. He defines a manager as -

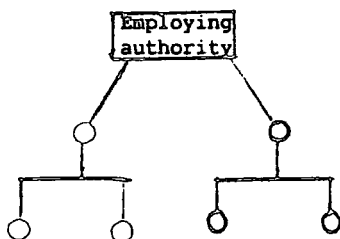
'One who is accountable for his subordinates' work in all its aspects; who is able to assess the quality and effectiveness of his subordinates' work as it is done, and who has the authority to make any further prescriptions or re-assignments of the work which he may judge necessary.....
He must understand the needs and characteristics of developing practice thoroughly enough to be able to represent their ideas and views adequately in external discussion and negotiation.' (Rowbottom 1978)

He considers, therefore, that the more developed an occupational or professional group becomes, the more difficult it is for a non-member, however generally capable, to perform these managerial functions adequately. Rowbottom offers three schema for incorporating professionals managerially into organisations and these are shown in Figure 1. For occupational therapists in social services departments either Figure 1 (a) or Figure 1 (b) might be applied. However, occupational therapists employed within a Figure 1 (a) type of structure are also subject to what has been called the 'dual influence situation' (Rowbottom et al 1974).

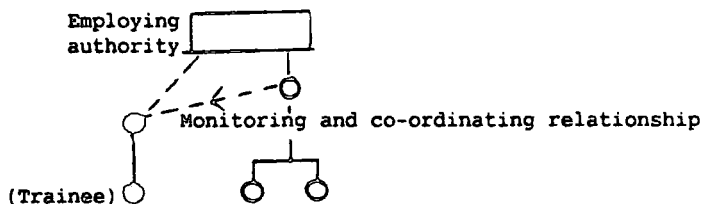
Figure 1 : The incorporation of professionals managerially into organisations



(a) Distinct profession or occupational group integrated into pre-existing managerial hierarchy



(b) Distinct profession or occupational group as separate managerial hierarchy



(c) Distinct professional in independent practice

(Source : Rowbottom 1978)

'Dual influence' refers to a situation in which the occupational therapist finds herself 'potentially at least' managerially responsible to a senior or head occupational therapist and a senior social worker. To deal with this situation one of four management strategies may be employed which Borsay (1983) in her study of occupational therapists in a midland authority paraphrases in the following manner -

1. Secondment - where B is transferred "from his original manager A1 to some other manager A2 for some limited period, such as the time for B to gain some desired training or experience."
2. Outposting - "where A is required to make the work of his assistant B available on some physically remote site, whilst retaining the main elements of managerial control of that work."

3. Functional monitoring and co-ordinating - " where it is desired to monitor the work of B in technical, occupational, or professional respects and to co-ordinate it with the work of other practitioners in the same function or field, whilst leaving intact...the managerial or directive relationship between A and B."
 4. Attachment - where responsibility for B's work is shared by a functional manager who oversees his professional competence and an operational manager who assigns workloads, distributes resources and appraises " his general performance and ability."
- (Borsay 1983)

Borsay explores the implementation of the attachment model wherein responsibility for the occupational therapist's work is shared by a senior occupational therapist who oversees professional competence and a senior social worker who assigns workloads, distributes resources and appraises general performance and ability. She concludes that, of the four possible options, attachment was the best solution despite doubts about the ability of a social worker to channel correct referrals to the occupational therapist. Caplow (1962) and Bendix (1956) also focus on the problems of the assignment of work and the fact that expertise removes specialists from control by superiors. Within this study the schema illustrated in Figure 1(a) and 1(b) are found and both attachment and outposting models are seen.

'Socialisation' and 'Identity strain'

Another aspect of incorporating professionals into large organisations is that relating to the conflict that can arise when the role expectations of the individual are not in harmony with those of the organisation or of other groups within the organisation. In addition to the imparting of academic and technical knowledge the training of a professional is also a process of socialisation. Olesen & Whittaker (1970) describe socialisation as ' the passive internalisation of an external normative order.' Students are indoctrinated explicitly and implicitly in the specific ideologies and sets of attitudes appropriate

to the different audiences i.e. laymen, other professionals, assistants and competitors they will encounter.

Friedson (1971) describes the 'reality shock' that newly qualified nurses sometimes experience.

'When paramedical students are imbued with a professional ideology emphasising their dignity and autonomy, but begin work in settings where they are distinctly subordinate they are in for a 'reality shock.'
(Friedson 1971 pp.56-7)

Hayes and Hough (1976) refer to the 'identity strain' which exists when an individual feels unable to implement his self-concept at work.

There may be parallels here for occupational therapists who feel that their potential is not recognised by social work staff (Scrivens 1983). Related to this is the important issue of status which is discussed in more detail later (see p.38). Whilst the attitudes of professionals and their approach to their work is clearly strongly influenced by what they have internalised during their training (Dingwall 1977) there is some evidence to suggest that the way in which people work i.e. their level of technical performance, approach to the client, 'cynicism', and ethicality (Friedson 1971) is more a result of the social setting in which they work.

' . . . people are constantly responding to the organised pressures of the situation they are in at any particular time. . . . what they do is not completely but more their present than their past, and . . . what they do is more an outcome of the pressures of the situation they are in than of what they have earlier 'internalised'. '
(Friedson 1971 p.90)

These issues may be borne in mind when the work undertaken by the respondents in this study is discussed.

Mechanisms for coping with professional expansion and development of work

Other relevant issues concerning professions are those relating to

the ways in which a profession copes with incorporating new areas of work and (wo)manpower shortages. Mosey states that new areas of work arise through -

- 'a) scientific information from outside the profession;
 - b) scientific information generated internally; and
 - c) a vacuum in services identified by the society to which a profession is responsible.'
- (Mosey 1981)

Thus specialisms develop and as specialisms grow the limited (wo)manpower becomes spread more thinly. A profession tries to cope with this in two ways, firstly by trying to increase its membership and secondly by re-assessing the work tasks and assigning those which require the lowest level of technical skill to assistants.

Habenstein & Christ (1955) describe this latter process in relation to the nursing profession. They state that the process has its basis in the question -

"What should professional nurses be doing in order to make the best use of their training, their talents and their skills?" The goal is 'Better Patient Care' but there is no doubt that it latently provides also a rationale for the delegation or sloughing off of the tasks which have come to bear little or no prestige in nursing.' (Habenstein & Christ 1955)

Friedson (1971) describes those who took over the traditional nursing tasks as 'sub-professionals'. Glaser (1966) draws attention to the fact that nursing leaders insist on a title such as 'assistant nurse' thus emphasizing to the incumbents and to the public the occupation's subordination to the graduate nurses. In his study of scientists Smith (1959) notes that -

'.....it is important that supportive personnel be so indoctrinated that they realise they are employed to help make the scientist productive.'

The issues of the best use of limited resources and the employment of assistants are crucial to this study and it is interesting to be confronted with the less altruistic aspects of the process.

In their work Alaszewski et al (1979) examine the relationship between remedial therapists and their unqualified helpers in hospitals. They noted differences in the relationships between occupational therapists and their helpers and between physiotherapists and remedial gymnasts and their helpers. Although occupational therapists considered that they should supervise the helpers they did this more by giving advice concerning the patients' needs than by giving directions without explanation which was more common amongst physiotherapists and remedial gymnasts. There appeared to be less conflict between occupational therapists and their helpers than there was between physiotherapists and their helpers.

Alaszewski suggests this may be because occupational therapy departments traditionally have a third group of personnel, the instructor who has craft skills, who may have a mediating influence. The difference may also be due to the fact that there are many more occupational therapy helpers (55.7% of whole time equivalent (w.t.e.) labour in occupational therapy departments, compared with 19.6% of w.t.e. labour in physiotherapy and remedial gymnast departments (DHSS 1976)) and, because occupational therapists have had to rely more on helpers, they have developed a way of working which reduces conflict. A third factor which Alaszewski does not mention is that the College of Occupational Therapists (COT) runs 'Helpers' courses' which many helpers attend which probably helps to raise their status.

Alaszewski et al (1979) also examine the meaning of knowledge dividing it into -

1. Theoretical knowledge - acquired through book learning and certification which gives the holder special insight; and
2. Practical knowledge - acquired through work experience and validated by co-workers.

Helpers varied in their attitudes towards the importance of the different types of knowledge. Whilst a greater number probably considered theoretical knowledge to be superior (stressing the qualified therapist's knowledge of anatomy and physiology) some stressed the importance of 'experience', particularly if, due to qualified staff shortages, they had been working unsupervised. Qualified staff unanimously stressed the superior importance of theoretical knowledge and gave examples of the dangerous consequences that might result from unqualified staff dealing with problems beyond their knowledge. 'Danger serves to legitimate the role of the qualified therapist' (see p.27).

Alaszewski relates the differing types of knowledge to Merton & Gouldner's (1959) concepts of 'locals' and 'cosmopolitans' and the conflict that can arise between these. Helpers can be compared with the 'local' whose power stems from his or her knowledge of the uniqueness of the situation, whilst the 'cosmopolitan' qualified worker's power stems from his or her knowledge of the general characteristics of the situation. All these issues concerning qualified staff and helpers may be borne in mind in the discussion in this study concerning the role of occupational therapy assistants.

The other method of dealing with staff shortages, by expansion of the profession, is discussed by Glaser (1966) who differentiates between self-interested professions who 'fear surpluses and prefer shortages' and those dedicated to the public service. The latter group is 'concerned with solving society's problems as defined by their own expert judgement' (Glaser 1966), and the number of problems that they perceive invariably outruns the (wo)manpower. He considers that the ablest members of the profession have a vested interest in expansion because their social prestige rises as the popularity of their career grows. He also comments that they try to gain better recruits as well

as more recruits in order to improve the profession's performance and prestige.

The College of Occupational Therapists (COT) has recently recommended that all entrants should now have a minimum of two 'A' level passes in addition to the requisite number of 'O' level or GCSE passes. It can, no doubt, be argued that such an academic level is now required to cope with the demands of the current training and practice. However, prestige and status are important issues and the efforts of the COT to implement a degree course are relevant (COT 1983). Jackson (1970) states that, although degree status is not a criterion for professionalism it has been usual for aspirant professions to find incorporation within the structure of universities for their training courses.

Female dominance

Female dominance as a factor affecting the development of a profession and the associated fundamental issue of women working in a patriarchal society are of considerable relevance to this study. Occupational therapy probably has an even higher ratio of women to men than virtually all other professions that might be compared with it such as teaching, nursing, social work and physiotherapy. Information from the Chartered Society of Physiotherapists (1984) suggests that 8% of physiotherapists who qualify each year are men. Whilst information from the College of Occupational Therapists (1984) suggests that less than 1% of occupational therapists are men.

Traditionally, female-dominance of a profession is considered to lead to 'the unorganisability of the profession' (Lieberman 1956; Caplow 1962). As with other professions it is a major problem for occupational therapy that it loses the majority of its experienced practitioners when they have children. Although many return to work part-time this is usually (because of the employers dictate) at a basic

grade level, this often means that their experience and greater maturity cannot be put to the best advantage. Many later revert to full-time work and continue their careers but this is a minority (Alaszewski et al 1979).

The high turnover of staff has many effects. Because of a general shortage of occupational therapists, senior staff (particularly in rural or less 'professionally desirable' areas) cannot be sure that they will be able to replace staff which makes forward planning difficult. There is also the 'bureaucratizing effect'

'Turnover reduces the colleague solidarity that might protect professional autonomy.....It is difficult for informal group norms to develop, and without these, excessive formalisation of procedures may result.'
(Etzioni 1969)

Some writers describe the phenomenon of a woman giving up work to bring up her child as displaying a 'lack of commitment to a career' (Glaser 1966; Leggatt 1970; Dingwall 1977). The debate concerning the degree of choice that women have in combining a career and motherhood, and the extent to which primary responsibility for the intimate long-term care of children should rest exclusively with the female rather than the male parent (Bitten et al p.338 in Allen & Barker 1976) extend far beyond the limits of this discussion. However, the work that Alaszewski et al (1979) have done concerning remedial professions within the National Health Service is of considerable relevance.

With physiotherapists Alaszewski has examined the effects of marital status and the existence and number of dependent children on job-grade and career progression. It was found that full-time workers had a typical career structure with the majority of basic grades concentrated in the younger age groups. However, part-timers had no career structure, they were all grouped at the 'basic grade' level with a concentration aged in the 40-44 age category.

Alaszewski et al also note that basic grade part-timers (and helpers) are more prevalent in the 'lower status' areas of the work, e.g. geriatrics and the chronic mentally ill, than in 'high status' acute work. They compare this phenomenon to Barron & Norris's (1976) 'dual labour market'. They compare part-timers with the secondary sector of the labour market who have lower pay, restricted career progression and whose jobs are less secure, whilst full-timers come into the primary sector having the potential for higher pay, career progression and greater job security. Information concerning marital status and the incidence of part-time work is included in this present study. Also included are the related issues of job mobility, length of time in post and the reasons for choosing a post.

To encourage the recruitment of males as a solution to the difficulties associated with female-dominated professions is not necessarily desirable. Froggatt's (1983) appraisal of the effect of such a strategy in social work, wherein the numerically smaller group of men had the great majority of management posts, ends with-

'It would be sad indeed if the predominance of patriarchy in the professionalisation process left scope for little more than intermittent assertions of authority and status by women.'

However, Alaszewski et al (1979) note different attitudes towards the inclusion of more men in physiotherapy. Younger physiotherapists consider that it would help the profession, older ones are less enthusiastic - possibly perceiving the threat to senior posts.

Writers such as Friedson (1971) and Leggatt (1970) suggest that the most likely solution to the difficulty of reconciling family and work would be in changing the organisation of the job so as to accommodate to the demands of marriage and family. The concept of job-sharing, particularly of senior posts, has not been widely explored yet in occupational therapy, the experience of other occupations (Equal

Opportunities Commission 1981) suggests that perhaps it should.

Typologies of workers

Studies of professional or semi-professional groups have identified typologies of workers. Classically, Habenstein & Christ (1955) identified three nursing types.

- 'The "traditionalizer" - whose work performance, value orientations, and sentiments are largely patient directed.
- The "professionalizer" - whose stance is increasingly becoming shifted in the direction of clinical roles, and whose values are such that patient qua patient is largely cast adrift.
- The "utilizer" - whose goals are ego-centric and materialistic and whose ends are external to the means of her work.'

Dingwall (1977) in his study of health visitor students categorised them into three groups.

- '1) Young, fairly recently qualified - had one promotion maximum.
- 2) Older, ten years experience, diverse experience - probably unmarried or childless.
- 3) Married - returning to work, wanting more regular hours.'

Scrivens (1980) hypothesized that the community occupational therapists whom she interviewed leaned towards either a 'medical' orientation or a 'social work' orientation in the way that they worked. A similar comment was made by Rowlings (1980) who noted two types of professional orientation in the occupational therapists whom she interviewed. Some expressed greater interest in making assessments for aids and adaptations than in exploring the extent to which clients had adjusted to their handicap. There are parallels also to Alaszewski's (1979) observations concerning the curative orientation of remedial therapists in acute work and the alleviative orientation of those working with the chronically ill.

These types and observations raise the query that occupational therapists may have orientations that might influence the way in which

they work over and above the effect of any organisational systems and restraints. The possibility of the existence of different types of orientation has therefore been examined in this study.

Literature concerning the theory of occupational therapy and concerning professions forms the major framework for this study, however, many other texts have been consulted. Other studies which have been concerned, either wholly or in part, with the work of occupational therapists in the community include those by Goodworth (1974), Stevenson and Parsloe (1978), Collins (1980), Rowlings (1980), Borsay (1983) and Scrivens (1983). In general these studies are unanimous in their findings that community occupational therapists receive very high numbers of referrals and because of this they are unable to carry out the depth of work that they would like to with their clients. There is also a lack of clarity over the occupational therapist's role and Scrivens in particular noted the occupational therapists' dissatisfaction with their status in the social services department.

Status

Stevenson & Parsloe (1978) and Rowlings (1980) pursue the issue of status in so far as the client groups with whom occupational therapists mostly work (the elderly and the physically handicapped) have low status within social services departments. Social work respondents explicitly ranked the "pecking order" of clients as -

'first child care, second mental health, third the elderly.'

(Stevenson & Parsloe 1978)

There is a general assumption that the low status of the elderly and the physically handicapped is due to the permissive nature of the legislation concerning them. Rowlings (1980) discusses this, stating that legislation and government circulars relating to children impose wide ranging duties and responsibilities on social services depart-

ments. She also comments that historically children's departments contained higher proportions of trained social work staff than did mental health and welfare departments and thereby the social work qualification became a prerequisite for work with children and families. She also highlights the anxiety generated by child abuse cases, a contributory factor in the primacy of child care work. In addition, she sees the social workers' lack of interest in the elderly, the mentally and the physically handicapped as a result of their training course which concentrates little on the needs of these groups. Leggatt (1970) discusses the phenomenon whereby the status of the clients affects the status of the professionals who work with them. He quotes Geer (1966) who refers to this in relation to the teaching profession. Ironically, in this context children are clients of inferior status -

'.....it no doubt follows that their dealing solely with low status clients depresses the status of teachers.'

Role clarification

Another aspect to the social workers' lack of interest in the physically handicapped is the effect that this has on the readiness of the occupational therapist to refer her clients to them when the skills of a social worker may be required (Borsay 1983). This also introduces the debate concerning the extent to which occupational therapists may take on the more traditionally social work role of counsellor. In the course of their work Stevenson & Parsloe (1978), Collins (1980), and Rowlings (1980) encountered a proportion of occupational therapists who embraced dealing with clients' emotional problems enthusiastically, but equally they encountered other occupational therapists who were reluctant to deal with such problems.

Rowlings considers that at present the lack of a clear definition of occupational therapist and social worker roles is relatively unim-

portant. However, if substantially more occupational therapists were employed in social services departments, she argues, a close examination of the aspects of work they have in common would be required.

Sadlo (1981) sees a clear role for occupational therapists as counsellors. She considers that because they visit disabled people in their own homes and because the practical assistance that occupational therapists give inspires trust which often triggers emotional outpouring, from either the client or the relative, they are in the best position to counsel. However, she cautions unskilled counselling.

'Our basic study of psychology, interpersonal skills and disabling conditions must stand us in good stead. But we should not be complacent. Lack of knowledge in the counselling process can do more harm than good.'
(Sadlo 1981)

She encourages attendance on counselling courses such as those run by the Royal College of Nursing.

Rationing

The main theme of Scrivens work (1983) is the examination of community occupational therapists as agents who have to ration resources. She found evidence of primary rationing whereby applicants are refused a service because they do not meet necessary criteria; of secondary rationing whereby a need is established but cannot be met immediately due to lack of resources; and tertiary rationing whereby the needs are met but the quality of the service has to be diluted because of a lack of time or money to do more. She considers that tertiary rationing has a demoralising effect on the occupational therapists as they are rarely able to meet the professional standards for which they are trained leading to a lack of job satisfaction.

Charging for services is another aspect of rationing which is discussed by Judge (1978). A certain amount of research has been concerned with the effect that charging for a service has on the demand

for that service. The research has been almost exclusively concerned with charging for Home Help services where the limited data available suggest that the introduction of a charge does reduce the demand (DHSS 1974b).

As far as this author is aware little research has been done on the effect of charging for the loan of aids. The other aspect of this issue which seems to have received little attention is the discomfort that 'caring' professionals experience when they have to charge for services which they feel a disadvantaged person needs. This aspect of rationing and the effects of tertiary rationing are relevant to this current study.

Other relevant literature

The texts that have been discussed in this review have focused on particular areas of research and thinking which appear to have most relevance to this study. There are, inevitably, many other areas of associated interest, Schein's (1971) discussions concerning 'the individual, the organisation, and the career' for example, and a close study of the literature concerned with Exchange Theory (Blau 1967) would probably produce some reference points for the work of occupational therapists. Works associated with the meaning of disability (Blaxter 1976) and 'disabled careers' (Davis 1963) are also germane although this study is not really concerned with a close examination of the relationship between the occupational therapist and her client.

Throughout the text there are further references to relevant policy documents and to pertinent articles from the British Journal of Occupational Therapy.

CHAPTER TWO

ORGANISATION OF THE STUDY2.1. RESEARCH DESIGN AND METHODOLOGY

The research design and methodology can be described under the following headings : 1. Exploratory work. 2. The sampling process. 3. The pilot study. 4. The main study. 5. Data-analysis. 6. Response-rate.

Exploratory work

In the initial stages of the research, in addition to the literature search and background reading, contact was made with other research personnel who had carried out, or who were carrying out, related research and an exploratory study was carried out within one of the pilot areas.

The information obtained in this way was of value in helping to determine the approaches to be used in the research and in the compilation of the pilot questionnaires. Information from Keele University (see page 44) was of major value in helping to determine the process for selecting authorities which might participate in the study.

The exploratory study

This study was carried out in a north-eastern metropolitan district where occupational therapists were employed at a senior and main grade level and unqualified occupational therapy assistants were employed under the supervision of the senior occupational therapists. For the study, all grades of staff completed a diary for one week giving details of every activity undertaken each day concerned with their work. They also recorded the transactions that occurred on every third

visit made to clients in their own homes. Every third visit was chosen because to have recorded every visit would have been too time-consuming, and this method ensured that an unbiased and representative picture of the visits was obtained.

The aim of this exercise was to assess the effectiveness of the use of diaries in describing and analysing the range of work undertaken at different levels, the skills used when dealing with clients, and to clarify certain areas requiring to be covered by the questionnaire. The indications were that it would be an adequate tool and one that could be used in the pilot and main studies.

Related research - Cardiff

Access was given to 147 questionnaires that had been completed in 1978 by occupational therapists working in thirty-six local authorities. The main study had not been completed but subsequent articles relating to Rationing Theory based on this work have been published (Scrivens 1983). A detailed appraisal of these questionnaires helped to identify some of the 'problem areas' for occupational therapists working in social services departments and highlighted some of the organisational factors that appear to influence the occupational therapists' work.

The sampling process

The first stated objective of this study was -

'To obtain an accurate account of the work undertaken by qualified occupational therapists in social services departments, at fieldwork and management levels, from a randomly selected group of authorities representative of different organisational structures and geographic locations.'

The primary task, therefore, was to obtain the most up-to-date information available concerning the organisational and geographic deployment of occupational therapists within social services depart-

ments.

A research team at Keele University (Stevenson, Latto and Rowlings) was undertaking a survey concerning the delivery of services to physically disabled people by social services departments and they kindly allowed access to the preliminary survey data. The particular emphasis of the Keele study was on the role of specialist advisers who were employed above the level of team leaders and senior social workers which, therefore, excluded fieldwork main grade occupational therapists. However, in its preliminary stages information was collected on staffing structures within social services departments and this provided detailed up-to-date information concerning the employment of occupational therapists.

Combining these data with the Cardiff data, statistics from BAOT and knowledge through personal contact with several social services departments, the researcher was able to compile as comprehensive a national picture of the deployment of occupational therapists as was possible at that time.

Organisational structures

Two main types of organisational structure were identified which related to the presence of head or senior occupational therapists at social services headquarters, and to the type of responsibility, whether professional or managerial, that they had for the occupational therapy staff. These two types of structure were identified in the BAOT report 'The Way Ahead' (1981) as 'central' and 'devolved'. However, because of the risk of ambiguity they are referred to as 'intrinsic' and 'extrinsic' in this study.

'Intrinsic' - Where a principal occupational therapist has both managerial and professional responsibility for the provision of occupational therapy services and therefore of all occupational therapy staff who

may be based centrally or in area offices.¹

'Extrinsic' - Where main grade occupational therapists are based in a social work area office (possibly with a senior occupational therapist working alongside) and are managerially supervised by the social work team leader or area officer. The occupational therapists may receive professional supervision from a principal occupational therapist based at social services headquarters.²

The local authorities in which occupational therapists worked were categorised according to whether the occupational therapists were organised in an intrinsic or an extrinsic manner. They were then subdivided into the type of authority that they were, that is - county council, London borough or metropolitan borough. A further subdivision categorised the county councils as northern, midland or southern and the metropolitan districts as either northern or midland.

Authorities excluded from the sampling process

A number of authorities were excluded from the sampling process for the following reasons.

1. Wales and Scotland. Scotland was excluded because the research was being funded by the DHSS which did not have responsibility for the organisation of social work in Scotland. Wales was excluded because the information available on their occupational therapy staffing levels indicated that three out of the eight Welsh authorities did not employ occupational therapists and it was difficult to obtain accurate information on the other five.

¹The situation whereby occupational therapists who are under the professional and managerial supervision of a principal occupational therapist, but who are geographically distant from her (e.g. in an area office) is described by Rowbottom et al (1978) as 'outposting'.

²The situation whereby an area occupational therapist receives managerial supervision from a social worker and professional supervision from an occupational therapist is described by Borsay (1983) as 'attachment', (see page 29).

2. Those authorities which either did not employ occupational therapists or which, at the time of the selection (Spring 1981) had no occupational therapists in post. This represented three London boroughs (9% of all London boroughs); fifteen metropolitan boroughs (42% of all metropolitan boroughs); and two county councils (5% of all county councils).
3. Those authorities whose headquarters lay beyond a 270 mile limit from Durham (the research centre). This represented five south westerly and southern county councils. This limit was set because of the time and cost that would have been involved in travelling to these centres for personal contact.
4. Those authorities where occupational therapists may have been working in the community, but who were employed by and based in the area health authority. This represented five county councils and three metropolitan boroughs. Where occupational therapists were employed by the health authority, but seconded to social services departments and based in social services establishments (usually under joint funded schemes) they were included for sampling.
5. Those authorities which had been selected by the Keele University research team for their in-depth study so that these authorities would not be saturated by research requests and the staff inundated by questionnaires.

The remaining authorities were therefore categorised in the manner described above, i.e. intrinsic or extrinsic; county council, London borough or metropolitan borough; and northern, midland or southern. The sample was then weighted according to the number of authorities within each of these groups and a random sampling method was employed to select ten authorities which would represent the total picture of

distribution. Table 1 shows the distribution of the sample related to organisational structure, geographic location and local government type.

Table 1 : Distribution and type of intrinsic and extrinsic groupings

Local govern- ment type	Grouping and geographic location						Total
	Intrinsic			Extrinsic			
	north	midland	south	north	midland	south	
London bor	n/a	n/a	1	n/a	n/a	1	2
Metrop.bor.	1	-	-	-	1	-	2
County coun.	-	1	1	2	-	2	6
Total	1	1	2	2	1	3	
		4			6		10

Two additional authorities representing the intrinsic and extrinsic structures were selected from the northern area for the pilot study.

The pilot study

With the consent of their directors of social services, the occupational therapists working in the areas chosen for the pilot study were visited and the objectives of the research explained to them; arrangements had been made to meet the occupational therapists in groups. The proposed method of data collection was threefold.

1. Completion of a questionnaire.
2. Maintenance of a diary for one week.
3. The recording of every third home visit undertaken during that week.

Questionnaires

The questionnaire used structured and semi-structured questions and sought to obtain :

1. details of the type and volume of work that occupational therapists undertook;
2. the occupational therapists' perception of the work undertaken;

3. the extent to which they felt that their skills were being used;
4. aspects of their work for which they felt unprepared by their training;
5. their opinions on the supervision that they received and needed;
6. the nature of the occupational therapists' role in relation to other local authority staff; and
7. a general view of their experience of working in a social services department.

The Diary

The diary simply comprised five blank sheets of A4 paper divided into morning and afternoon periods, one for each day of the week. Accompanying instructions invited the occupational therapists to record every activity undertaken associated with work, giving approximate duration.

Client visit records

Ten sheets of A4 paper were supplied to each occupational therapist to record details of every third home visit (up to a total of ten in the case of full-time staff and five in the case of part-time staff). Basic details of each referral were itemised and space given to record the action to be taken as a result of the visit. (See Appendix I).

The pilot study was carried out and, as a result, some modifications were made to the design of the questionnaire and some minor modifications were made to the layout of the diary and client visit record sheets.

The Main Study

The main study comprised the following stages.

1. The approach to the selected authorities to gain their cooperation in the project. In the event of refusals, replacements were made by randomly selecting other authorities with similar organisational and geographic characteristics.
2. A meeting with the occupational therapists (including head occupational therapists and occupational therapy assistants, if in post), and any senior personnel within social services departments who wished to attend, to explain and discuss the research and to gain the cooperation of the occupational therapists. At this meeting a date was set for the completion of the diaries and the questionnaires. If any staff were unable to attend this meeting they were, with permission from appropriate senior staff, contacted by telephone to discuss the project and the completion of the questionnaires and diaries.
3. Subsequent to this meeting the participating occupational therapists were each sent the requisite forms, explanatory notes and a covering letter (Appendix I).

Respondents returned the completed questionnaires and forms direct to the research centre in a pre-paid, addressed envelope. To improve the response-rate a maximum of two follow-up contacts were made by telephone at one week intervals.

Data Analysis

Data from the questionnaires were coded and transferred to hand-punched cards for analysis and data from the diaries and client visit

records were classified and transferred to analysis sheets.³

In the process of analysing the client visit records, systems were devised to assist in ;

1. the analysis of the skills used by the respondents and of the resources on which they drew (see page 108);
2. the classification of the respondents according to their professional orientation (see page 67).

Charts were constructed itemizing different features of the interaction that occurred on the visits, which were broken down into the following groups.

1. Pure occupational therapy - this category included those features which illustrated the use of skills and areas of knowledge that are common to all occupational therapists whatever their work setting. (See page 108).
2. Community occupational therapy - this category included those features which illustrated the skills and areas of knowledge which have been identified in this study as specific to community occupational therapy. (See page 110).

Each time a respondent displayed the use of a particular skill , a record was made on the chart. Thus, when each respondents' client visit records had been analysed, the total number of times each feature had been recorded could be presented as a percentage of the number of visits undertaken to give a picture of the emphasis of each respondent's work.

In Chapter 1 (page 37) the possible existence of different types

³The fieldwork was planned and undertaken before home computers were widely available.

of professional orientation amongst social services occupational therapists was discussed. The information from the client visit records suggested that there were differing orientations amongst the respondents. In order to quantify these orientations, certain features from the aforementioned charts were selected and, depending on the emphasis of the respondent's work within the selected features, the respondents were included in one of three orientations (see Chapter 3 page 67).

Tests of significance

Throughout the report Chi-square tests have been used because of the different sized groups and the small numbers involved.

Response-rate

The selected authorities represented a total number of 17 principal or divisional head occupational therapists, six senior fieldwork occupational therapists, 106 main grade fieldwork occupational therapists, four social services officers and 15 occupational therapy assistants. Table 2 illustrates the distribution of this sample between the intrinsic and extrinsic groupings.

Table 2 : Distribution of sample by position and organisational grouping

Position	Intrinsic	Extrinsic	Totals
Principal/divisional head OT	7	10	17
Senior fieldwork OT	3	3	6
Main grade fieldwork OT	43	63	106
Social services officers	-	4	4
OT assistants	8	7	15
Totals	61	87	148

The initial response-rate was 66% (98) and this was increased to 80% (118) by the follow-up method described. A response-rate of 100% was received from two authorities, whilst the rate in the other areas ranged from 64% to 93%. Table 3 illustrates the numbers of respondents by position and organisational grouping.

Non-response

Of the thirty questionnaires not returned :- 5 people were ill at the time of the study; 4 people stated that they had sent off the completed forms which must have become mislaid; 3 people had left their post shortly after the period of the study and were therefore unavailable for follow-up contact; 18 were unable to make time to complete the forms.

Considering the great pressure of work experienced by the occupational therapists (see page 158) the response was high. The volume of work was the main reason given by respondents (during the follow-up contacts) for being unable to complete the questionnaires and forms.

The response-rate for the completion of the diaries and client visit records was slightly lower. Seventy per cent (81) of the fieldwork occupational therapists completed the diaries and 68% (79) completed client visit records.

Table 3 : The respondents by position and organisational groupings

Organisational position	Intrinsic	Extrinsic	Totals
Principal/divisional head OT	6	9	15
Senior fieldwork OT	2	2	4
Main grade fieldwork OT	33	51	84
Social services officers	-	2	2
OT assistants	6	7	13
Totals	47	71	118

2.2. THE PARTICIPATING AUTHORITIES

The ten local authority social services departments which agreed to participate in the study represented the varied settings in which occupational therapists worked at that time. Figure 2 illustrates some of the characteristics of each area so that they may be compared with each other. The areas are represented by capital letters throughout the report. The ratio of full time equivalent (F.T.E.) local authority occupational therapists per capita of population in each area has been estimated so that comparisons on staffing may be made between the areas. The minimum ratio of F.T.E. fieldwork occupational therapists recommended by the BAOT (1984) is 1:30,000 and the maximum is 1:20,000. It can be seen that in none of the participating authorities was this achieved.

The office base categories of enclave, semi-enclave and non-enclave are described on p.56 and relate to whether or not the occupational therapists were based together. The type of area categories indicate whether the authorities were :- urban i.e. totally built up; rural i.e. large agricultural areas with several small town centres; or mixed i.e. large country areas with city and large town centres. The square mileages are given to indicate the travelling distances involved in rural or mixed areas and are not therefore given for urban areas.

Summary

It can be seen that the selected authorities represent the wide variety of settings in which local authority occupational therapists work. The diversity of staffing structures illustrates the fragmentary fashion in which occupational therapy in the community has developed (see page 55). Some of the problems that the British Association of Occupational Therapists has experienced in trying to bring

about a nationally agreed and implemented management structure may be understood.

By studying Figure 2 one can see implications for caseload and caseload management. Factors such as the ratio of occupational therapists to the total population in the authority (which ranges from 1:31,862 to 1:132,200); the proportion of part-time staff and the presence of other associated staff; and the geographic characteristics of the area will all influence the time available to each occupational therapist to spend on each case.

The extent to which these and other factors do influence the work of the social services occupational therapist is examined in the following chapters.

FIGURE 2: CHARACTERISTICS OF THE PARTICIPATING AUTHORITIES

CHARACTERISTICS	ORGANISATIONAL STRUCTURE AND AREAS (represented by a capital letter)									
	INTRINSIC				EXTRINSIC					
	B	E	H	K	A	C	D	F	G	J
Administrative type	London Borough	County Council	County Council	Metropolitan Borough	London Borough	County Council	County Council	County Council	Metropolitan Borough	County Council
Ratio of F.T.E. O.T.s to population	1:45,828	1:83,330	1:99,540	1:86,125	1:31,862	1:109,781	1:88,084	1:82,662	1:132,200	1:64,525
Office base	Enclave	Non-enclave	Enclave	Enclave	Non-enclave	Non-enclave	Semi-enclave	Non-enclave	Enclave	Non-enclave
Urban/rural/mixed	urban	mixed	mixed	urban	urban	mixed	mixed	rural	urban	rural
Square mileage of authority	n/a	985 s/m	648 s/m	n/a	n/a	940 s/m	1,458 s/m	3,207 s/m	n/a	1,343 s/m
Part-time fieldwork O.T.s	-	7	8	2	2	4	12	1	1	7
Full-time main grade fieldwork O.T.s	7	7	8	3	10	3	12	7	-	7
Senior fieldwork O.T.s	2	-	-	-	3	-	-	-	1	-
Divisional O.T.s	-	2	-	-	-	-	3	-	-	3
Principal and deputy principal O.T.s	1	1	2	1	1	1	-	-	-	-
O.T. Assistants	-	8	-	-	1	4	-	-	1	2
Adaptation Officers	-	-	1	-	1	-	-	4	1	-

*F.T.E. O.T.s = Full time equivalent occupational therapists.

THE FINDINGS OF THE STUDY

Definitions of explanatory terms used

The findings of the study, in terms of information about the respondents and the work that they undertook, are presented to show the comparison between the intrinsic and extrinsic groups. However, for the evaluation of the findings, further terms are used to describe different features of the respondents in the sample. For the sake of clarity, all the terms are defined here.

1. Terms used to identify the two differing methods of professional management

1a. Intrinsic - Where a principal occupational therapist has both managerial and professional responsibility for the provision of occupational therapy services and therefore of all occupational therapy staff who may be based centrally or in area offices.

1b. Extrinsic - Where main grade occupational therapists are managerially supervised by someone other than a more senior occupational therapist. In some areas a geographically distant principal occupational therapist may have professional responsibility.
(See page 28 'outposting' and 'attachment'.)

2. Terms used to describe work base and proximity to occupational therapy colleagues

2a. Enclave - A situation wherein the occupational therapists working in a social services department are grouped together. This may be :- either all together at headquarters; or all together at a different base (e.g. a day centre); or (in larger geographic areas with more occupational therapists)

several groups at different bases throughout the authority.

2b. Non-enclave - A situation where one, or sometimes two, main grade occupational therapists are based in a social work area office.

2c. Semi-enclave - A situation where some of the occupational therapy staff are based together and others are based alone, or in pairs, in a social work area office.

3. Terms used to describe professional orientation of respondents
(see page 67)

3a. The practical orientation - Applied to those respondents who tended to be concerned purely with resolving the presenting practical problem.

3b. The community orientation - Applied to those respondents who dealt with the presenting practical problem with varying degrees of thoroughness, but who also probed more deeply into the circumstances of the individual and seemed to consider the total needs and the ways in which community resources could help.

3c. The combined orientation - Applied to those respondents who tackled the presenting problem thoroughly with evident application of their medical knowledge and who also considered the clients' wider social needs.

CHAPTER THREE

THE PRESENT ROLE OF FIELDWORK OCCUPATIONAL THERAPISTS3.1.CHARACTERISTICS AND PROFESSIONAL ORIENTATION OF RESPONDENTS

The respondents were asked to give certain biographical details and information concerning their employment history. There were some minor differences between the personal and professional backgrounds of the extrinsic and intrinsic occupational therapists as Tables 6 and 7 illustrate.

Personal background

The great majority of respondents were female, although there were four men. This bears out the comments in Chapter 1 concerning occupational therapy as a female-dominated profession. The proportion of men in this sample (4%) suggests that there may be a slightly higher incidence of male occupational therapists within social services departments than within the profession as a whole (see page 34).

The occupational therapists in the extrinsic areas were generally somewhat younger than those in the intrinsic areas, although in both groupings the highest proportions were aged between 25 and 34 years (see Table 4). The occupational therapists in the intrinsic group therefore tended to have completed their training longer ago (11 [31%] having qualified between 15 and 25 years previously) than the extrinsic occupational therapists whose years since qualification were spread fairly evenly between three and 25 years. However, in both groups occupational therapists who had been qualified for less than two years formed the smallest proportions even when allowance is made for the uneven spacing of the time categories (see Table 5).

Table 4 : Age of respondents

Age	Intrinsic n=35		Extrinsic n=55	
	n	% ⁴	n	%
less than 25	2	6	7	13
25 to 34	15	43	25	45
35 to 44	10	29	14	25
45 or more	8	23	8	15
not given	-	-	1	2

Table 5 : Years since qualification

Years	Intrinsic n=35		Extrinsic n=55	
	n	%	n	%
less than 2	2	6	5	9
2 and less than 5	4	11	11	20
5 to 9	8	23	11	20
10 to 14	4	11	11	20
15 to 24	11	31	10	18
25 or more	5	14	6	11
not given	1	3	1	2

Almost equal proportions of the respondents had taken time away from occupational therapy to raise their families, although the intrinsic occupational therapists had been away from work for a longer total period ⁵ (see Table 6). Very similar proportions of respondents

⁴Although some of the numbers in the Tables in this text are very small, percentages have been introduced to aid comparison. In all Tables percentages have been rounded to the nearest whole number.

⁵In several instances respondents had taken two or more periods away from work, returning between having children. In these cases the figure recorded is the total of their years away.

in each group were married, single, divorced or widowed (see Table 7).

Table 6 : Time away from occupational therapy to raise family

Time away in years	Intrinsic n=35		Extrinsic n=55	
	n	%	n	%
less than 2	2	6	4	7
2 to 4	1	3	8	15
5 to 9	6	17	7	13
10 or more	6	17	5	9
none (includes men)	20	57	31	56

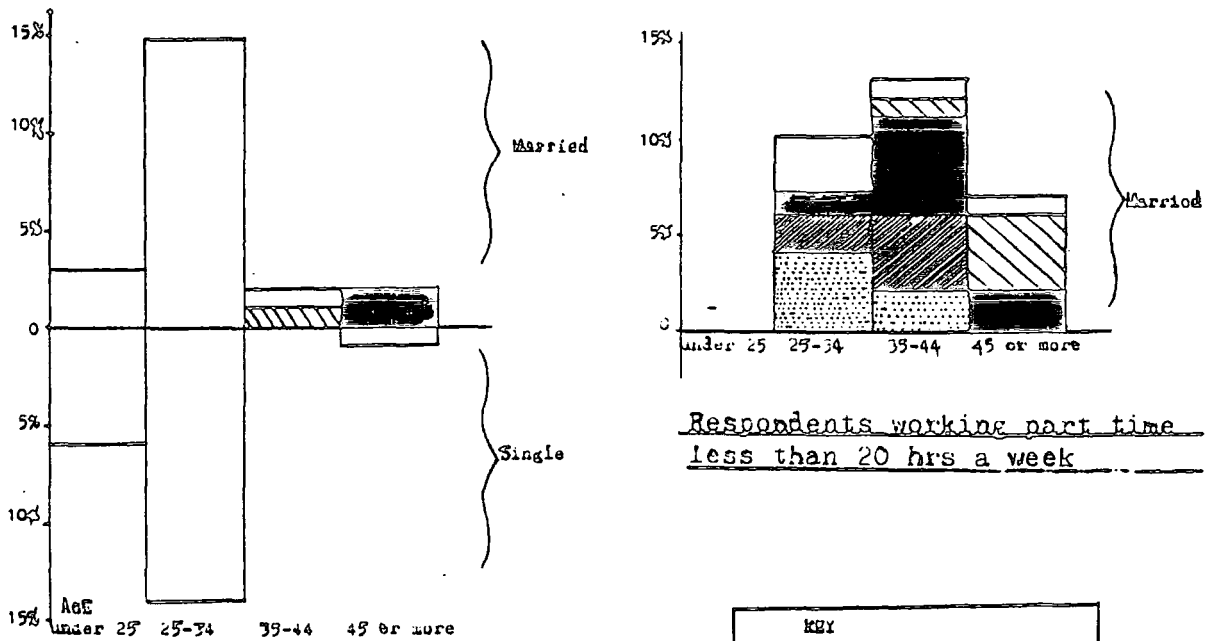
Table 7 : Civil state

State	Intrinsic n=35		Extrinsic n=55	
	n	%	n	%
married	24	69	39	71
single	8	23	13	24
other (divorced, separated, widowed)	2	6	3	5
not given	1	3	-	-

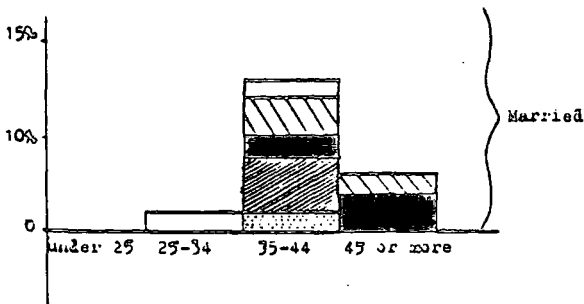
The histograms in Figure 3 illustrate the comparison between the age and working hours of married and single respondents. Alaszewski et al's (1979) study of the remedial professions in the National Health Service noted that married physiotherapists who had family responsibilities usually worked part-time and were thereby restricted to working at the basic grade level, whereas single women or married women without family responsibilities followed a more classic career progression of holding basic grade posts when younger and proceeding to more senior posts as they matured. The respondents represented in Figure 3 all worked at the basic grade level and it can be seen that the greatest proportion of full-time workers, both married and single, fall within the 25 to 34 years age bracket. The shaded areas indicate the number

of years taken away from work to raise children, and it is noticeable that within the 25 to 34 age group, there is a higher proportion of women who have taken less than two years away. This may indicate two factors, firstly that the respondents may have, so far, only had one child and have returned to work before having another. Secondly, it may imply that women are, generally, taking less time away from work now than their predecessors whose work history can be seen by examining the pattern for the 45 and over age group.

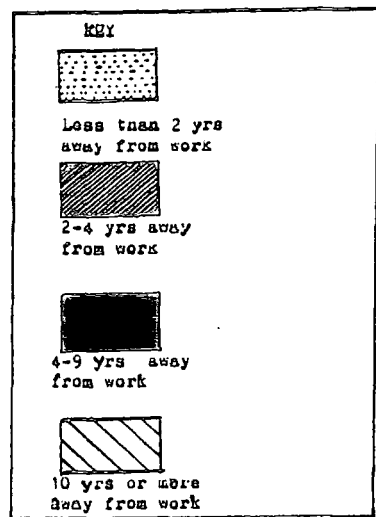
Figure 3 : Working hours by age and civil state



Respondents working full time



Respondents working part time
20 hrs a week or more



Professional background and work experience

As far as previous work experience was concerned, there was little difference between the intrinsic and extrinsic groups (see Table 8). Slightly higher proportions of extrinsic occupational therapists had psychiatric and geriatric hospital experience and slightly higher proportions of intrinsic occupational therapists had previous local authority experience. In both groupings the majority of respondents had experience in general physical hospitals. The greater part of their experience had been at the basic grade level, however nearly half of the occupational therapists had progressed to senior level and about a quarter had held or assistant head posts (see Table 9).

Table 8 : Previous professional experience (categories are not mutually exclusive)

Previous experience	Intrinsic n=35		Extrinsic n=55	
	n	%	n	%
General physical	23	66	37	67
Psychiatric	14	40	25	45
Geriatric	7	20	15	27
Local authority	13	37	17	31
Other	7	20	8	15
n/a (first job)	2	6	3	5

Of the married women who were working part-time at the main grade level, 42% (18) had previously worked full-time at a senior level in hospital; 26% (11) had previously worked at a head or assistant head level in hospital; and 5% (2) had previously worked at a senior or head level in a local authority.

Table 9 : Previous job level (categories are not mutually exclusive)

Job level	Intrinsic n=35		Extrinsic n=55	
	n	%	n	%
<u>NHS</u>				
Basic grade	17	49	26	47
Senior	8	23	12	22
Head/Assistant head	6	17	12	22
<u>Local authority</u>				
Main grade	8	23	13	24
Senior/Head	2	6	3	5

The respondents also gave details of work experience that they had had other than occupational therapy either before or after their training, and of any other qualifications (i.e. other than the diploma of occupational therapy) that they had. Proportionately more intrinsic occupational therapists had obtained other qualifications, 26% (9) as opposed to 13% (7) of extrinsic occupational therapists. However, proportionately more respondents in the extrinsic group had experience of other work before training, 36% (20) as opposed to 23% (8) of the respondents in the intrinsic group. Their experience of work other than occupational therapy since qualifying was proportionately similar 11% (4) of the intrinsic group and 13% (7) of the extrinsic group.

Job mobility

There was some evidence of greater job mobility within the extrinsic group which may partly have been due to the younger population and the fact that the occupational therapy services in some of the extrinsic areas had been established for a shorter period than most of the intrinsic ones. Of the extrinsic occupational therapists 42% (23) had been in their present post for from six months to two years compared with 20% (7) of the intrinsic occupational therapists, whilst 43% (15) of the intrinsic group had been in post for from two to five years com-

pared with 25% (14) of the extrinsic group (see Table 10).

Table 10 : Length of time in present post

Time in post	Intrinsic n=35		Extrinsic n=55	
	n	%	n	%
less than 6 months	4	11	8	15
6 months & less than 2 yrs	7	20	23	42
2 yrs & less than 5 yrs	15	43	14	25
5 yrs & less than 10 yrs	8	23	10	18
10 yrs or more	1	3	-	-

Reasons for leaving and choosing posts

There is a certain amount of speculation about why professional women choose particular posts, whether these be a first appointment (Toulouse and Williams 1984) or subsequent appointments (Alaszewski et al 1979). There is no doubt that the real reasons for such choices are complex and not necessarily easy to quantify (Moore 1984). The occupational therapists who took part in this study were asked to state why they had left their previous post and why they had chosen their present post. Their reasons for leaving their previous posts have been divided broadly into two main categories - 'professional` and 'personal`.

- Professional - the need for a chance to use different aspects of professional skill; the feeling that community work was in some way more 'realistic' than hospital work; dissatisfaction with previous work situation.
- Personal - pregnancy; a move due to the spouse's work; innumerable individual personal reasons.

The extrinsic occupational therapists tended to give a single reason for leaving, thus one third gave professional reasons and nearly

two thirds gave personal reasons. Several of the intrinsic occupational therapists gave more than one reason for leaving so, although two thirds gave personal reasons over a third gave professional reasons. Table 11 shows that, for 20% (7) of intrinsic respondents and 15% (8) of extrinsic respondents, their present job represented a return to work after having children. The fact that 16% (9) of respondents in the extrinsic group and 9% (3) of respondents in the intrinsic group had left their previous work because of their husbands' career progression may reflect the slightly younger extrinsic occupational therapist population.

Table 11 : Reasons for leaving previous post

Reasons*	Intrinsic n=35		Extrinsic n=55	
	n	%	n	%
Professional	15	43	18	33
Personal -	23	66	33	60
- pregnancy	- 7	-20	- 8	-15
- husband's work	- 3	- 9	- 9	-16
- individual	-13	-37	-16	-29
N/A (first job)	2	6	3	5
Not given	-	-	1	2

* Categories are not mutually exclusive

The reasons that the respondents gave for choosing their present post were divided into six categories - 'change', 'expertise', 'autonomy', 'job-satisfaction', 'expediency', and 'other'.

- Change** - community work represented a change from their previous work and gave them an opportunity to use and develop other professional skills.
- Expertise** - they chose the job because they already had expertise in this field and knew that they enjoyed the work.
- Autonomy** - the attraction of the job was the freedom that it offered them to organise their own work and to have

greater responsibility.

Job-satisfaction - community work was considered to be more realistic, stimulating, varied, interesting and thereby more rewarding than other occupational therapy work.

Expediency - the job was the nearest suitable one that they could find, the hours of work fitted in with their other commitments.

Other - the particular OT service had a good reputation (9); the post offered promotion in terms of responsibility or money (9); the respondent was specifically offered the post (3); the respondent had been a student in the area (2); other reasons (6).

Table 12 shows the frequency with which these different reasons were cited.

Table 12 : Reasons for choosing present post

Reasons*	Intrinsic n=35		Extrinsic n=55	
	n	%	n	%
Change	17	49	22	40
Expertise	8	23	10	18
Autonomy	4	11	9	16
Job-satisfaction	3	9	9	16
Expediency	18	51	28	51
Other	8	23	21	38

* Categories are not mutually exclusive

Table 12 shows that in both groups a small majority of respondents gave reasons of expediency for their choice of post. The categories are not mutually exclusive and 70% of those who gave expedient reasons also gave other reasons. Because of some assumptions about married women and part-time work it might be expected that only married women seeking

convenient part-time work would have expedient reasons for choosing a post. This was not the case. Of the single respondents 57% (12) gave reasons of expediency whilst, of the married respondents, 49% (31) gave such reasons. However, proportionately more married women working part-time gave expedient reasons than did married women working full-time, but this was only 50% (22 out of 44) compared with 41% (9 out of 22).

It can be seen that the reasons for choosing particular posts are varied. The respondents were not asked to weight their responses in terms of importance, so only quantitative rather than qualitative conclusions can be drawn from Table 12. It is interesting to note however that only nine respondents (10%) made a point of stating that they had chosen the post because of the reputation of the particular occupational therapy service. Of these, five were intrinsic occupational therapists, three of whom wished to work in an authority which had an occupational therapy management structure; one wished to work where occupational therapists were based together; and one chose to work in a well staffed borough. Of the four who worked in extrinsic areas, three knew the occupational therapy service had a high status in the areas that they would be working and one chose an area where she would work alongside a senior occupational therapist for guidance.

Professional orientation of the respondents

One cannot interpret definitive portraits of the typical intrinsic occupational therapist nor of the typical extrinsic occupational therapist from the foregoing information. However, almost inevitably, images do emerge from the assembled data. The intrinsic occupational therapist appears as older, more settled and well-established with a narrower but deeper work experience than the extrinsic occupational therapist, and with considerable life experience. The extrinsic

occupational therapist appears somewhat younger, more mobile, more independent with a wider work experience but with less depth to that experience.

However, such factual comparisons suggest little about the ways in which occupational therapists approach their work and the people whom they help; in other words - their professional orientation. In Chapter 1 the possible existence of different types of professional orientation was discussed with reference to the findings of Alaszewski (1979), Rowlings (1980) and Scrivens (1980). During the analysis of the client visit records, completed by the respondents, a system was developed which portrayed the differing emphasis of the respondents' work (see page 108).

The varying emphasises of the respondents' work did suggest different ways of working and these were spread along a continuum from, a 'practical orientation' to a 'community orientation' with a separately identifiable 'combined orientation' midway on the continuum. These may be compared with the differing theoretical approaches to occupational therapy i.e. the holistic and the technique-oriented approaches (see p. 17).

The analysis of the client visit records of 80 respondents revealed the following proportions :-

practical orientation - 25 (31%);

community orientation - 24 (30%);

combined orientation - 31 (39%).

Having identified these three groups, it was then important to discover the extent to which the division into these orientations was related to other factors such as :- 1. volume and type of caseload; 2. organisational setting and structure; and 3. biographical details of respondents.

Professional type related to caseload

Volume of referrals

The histograms in Figure 4 illustrate the number of referrals received by the three types. It can be seen that, in general, those with a practical orientation received greater numbers of referrals than those in either of the other two types. This therefore suggests that a major influence on the occupational therapists' ability to examine the wider needs of their clients is the number of referrals that they receive. This point is further illustrated by Figure 5 which shows the amount of time they spent on average on each visit. Those occupational therapists with a community orientation spent longer on visits than either of the other groups. Another indication of the effects of the high numbers of referrals was that when the respondents were asked to describe the pressures upon them in their work (see page 158), 68% (17) of those with a practical orientation itemised the volume of referrals as a pressure whilst 54% (13) of those with a community orientation and 48% (15) of those with a combined orientation did.

Figure 4 : Number of referrals received by professional orientation

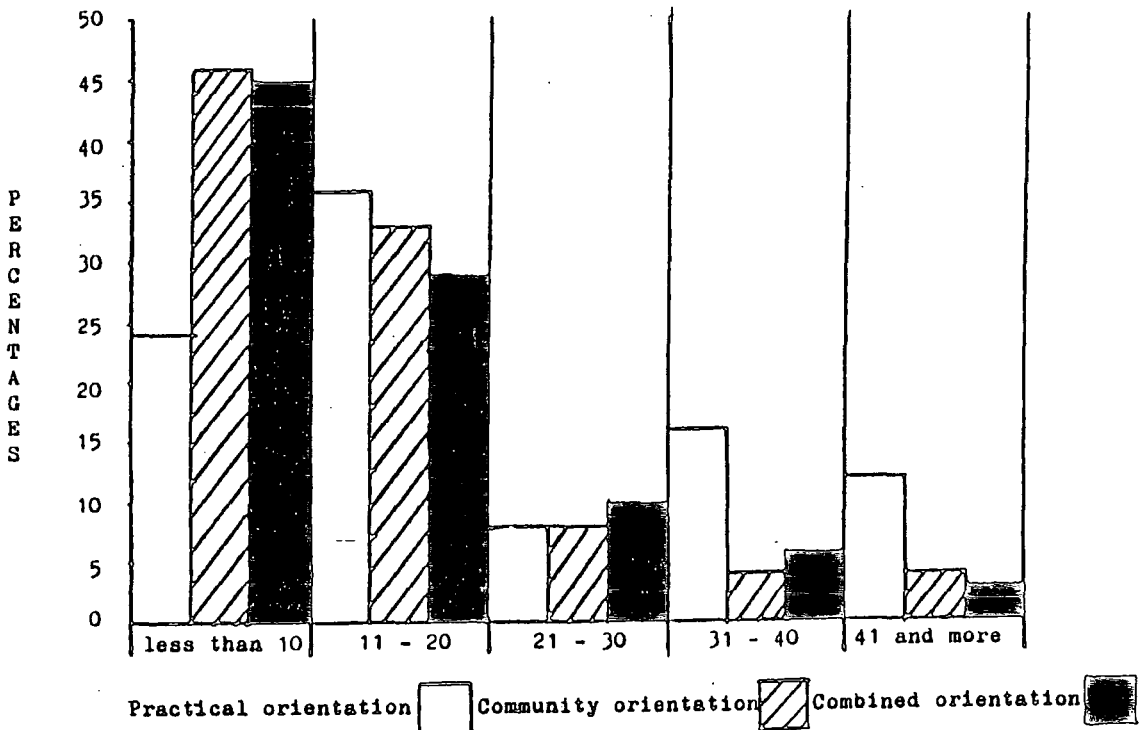
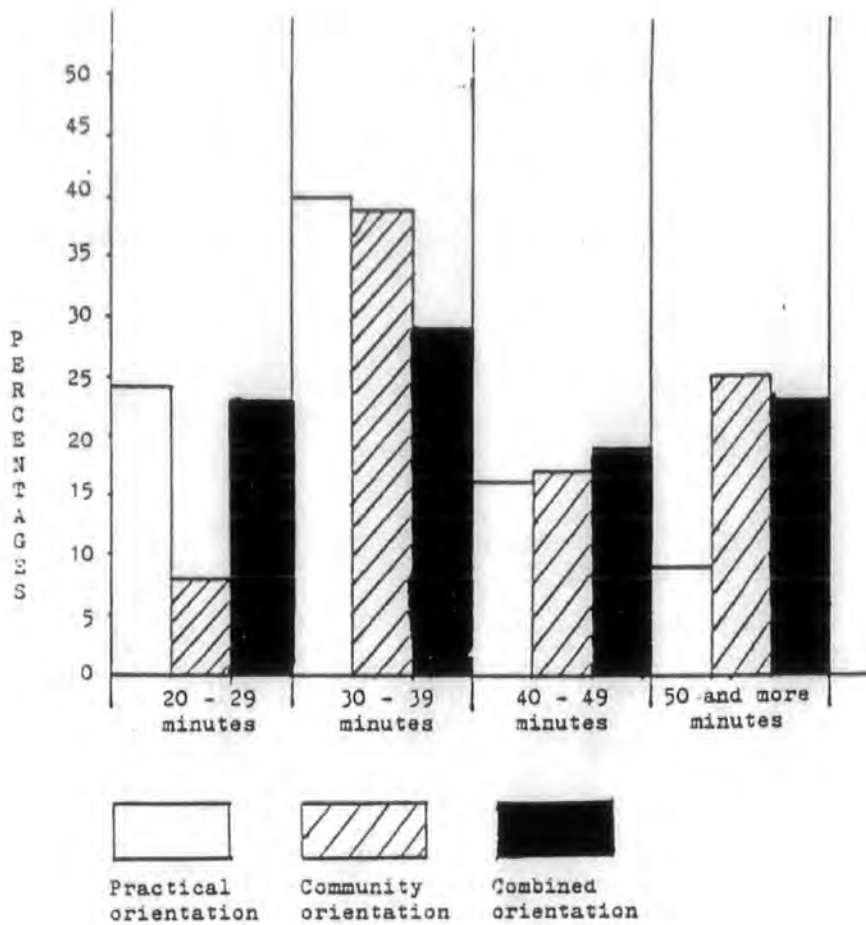


Figure 5 : Length of time spent on visits by professional orientation



Caseload complexity

Another factor which might affect the degree to which the occupational therapist probes into the wider needs of her clients may be the complexity of the cases presented to her. To assess the complexity of the cases three aspects of the caseload were studied, these were :-

1. Age group of client - young, i.e. 24 years or less; middle, i.e. 25 - 64 years; and elderly, i.e. 65 years or more.
2. Diagnosis of clients' condition - simple - i.e. predominantly arthritis, problems of ageing; average - i.e. mixed caseload of simple and complex cases; complex - i.e. predominantly severe neurological problems, multiple handicaps.
3. An assessment of the complexity of the work undertaken with the client:-
 - simple - i.e. predominantly bath/toilet and

walking aids; complex - i.e. predominately complicated and expensive equipment, range of services, major adaptations; mixed - i.e. simple and complex.

The histograms and pie charts in Figures 6,7 and 8 show the distribution of these features in the caseloads of the three professional types. It can be seen that all three types dealt with roughly equal proportions of clients who fell within the middle and elderly age groupings, but that a higher proportion of occupational therapists with a community orientation dealt with clients in the young age group.

Figure 6 : Professional orientation and age groups of clients

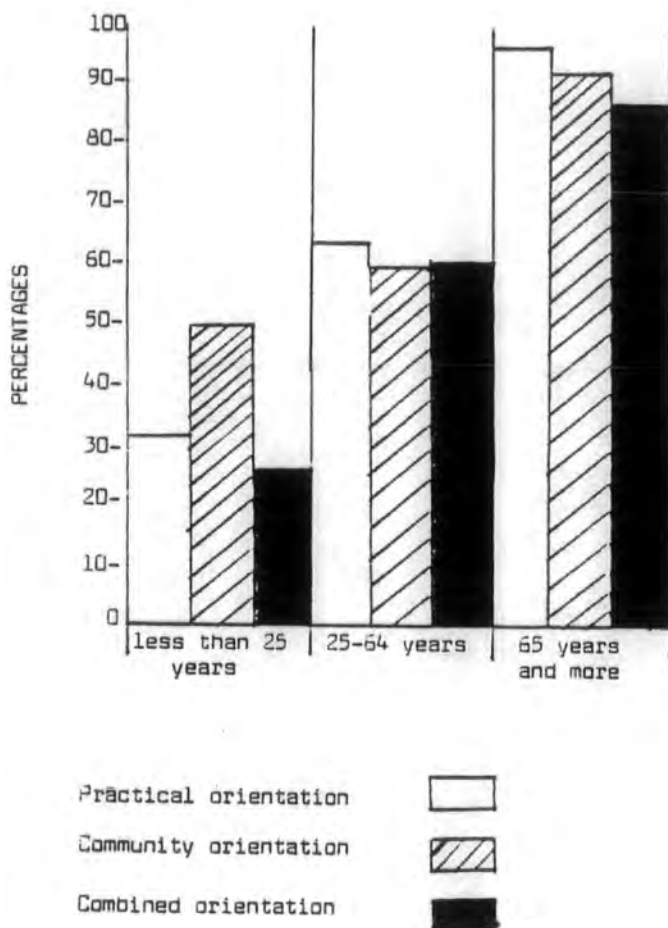
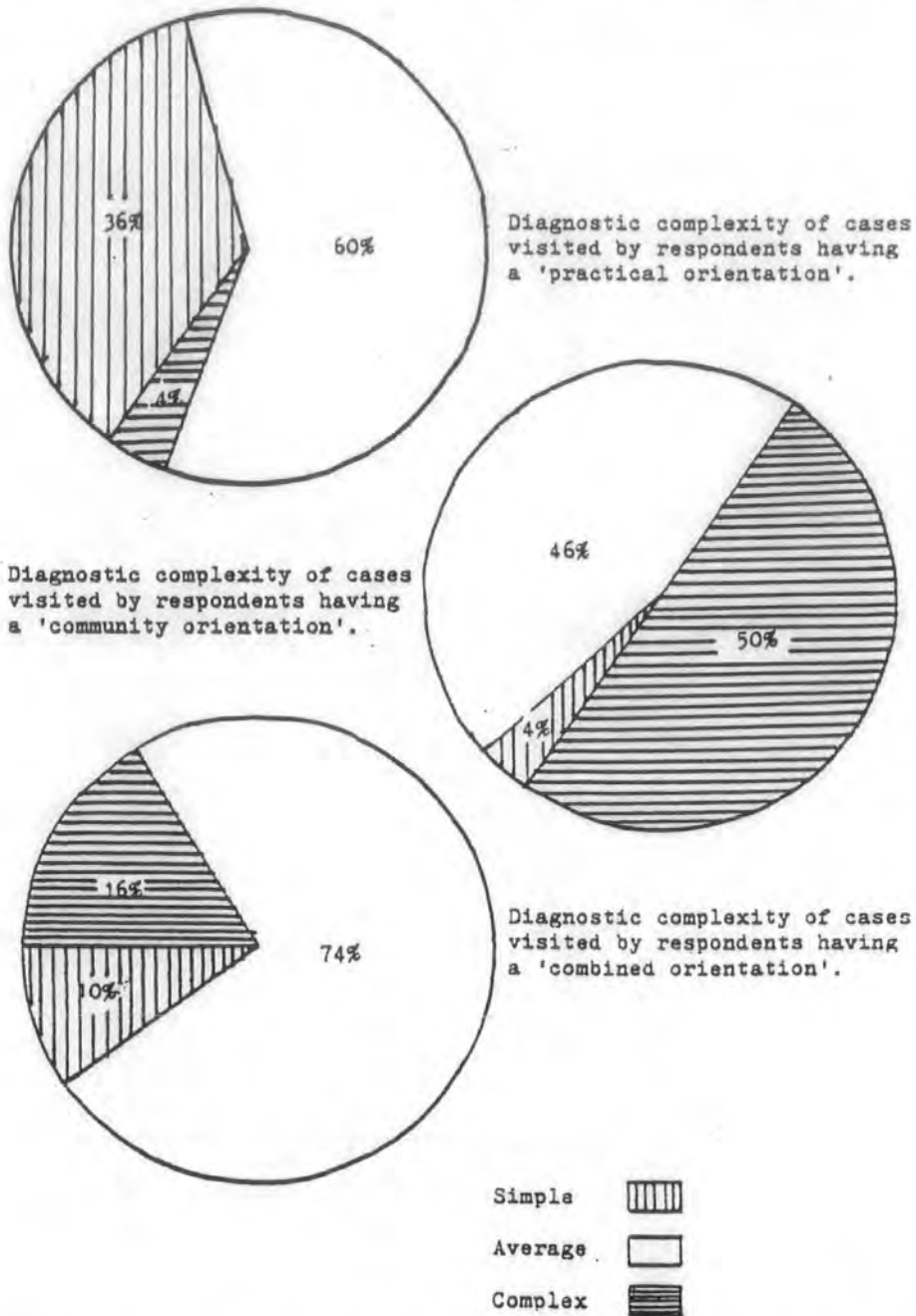


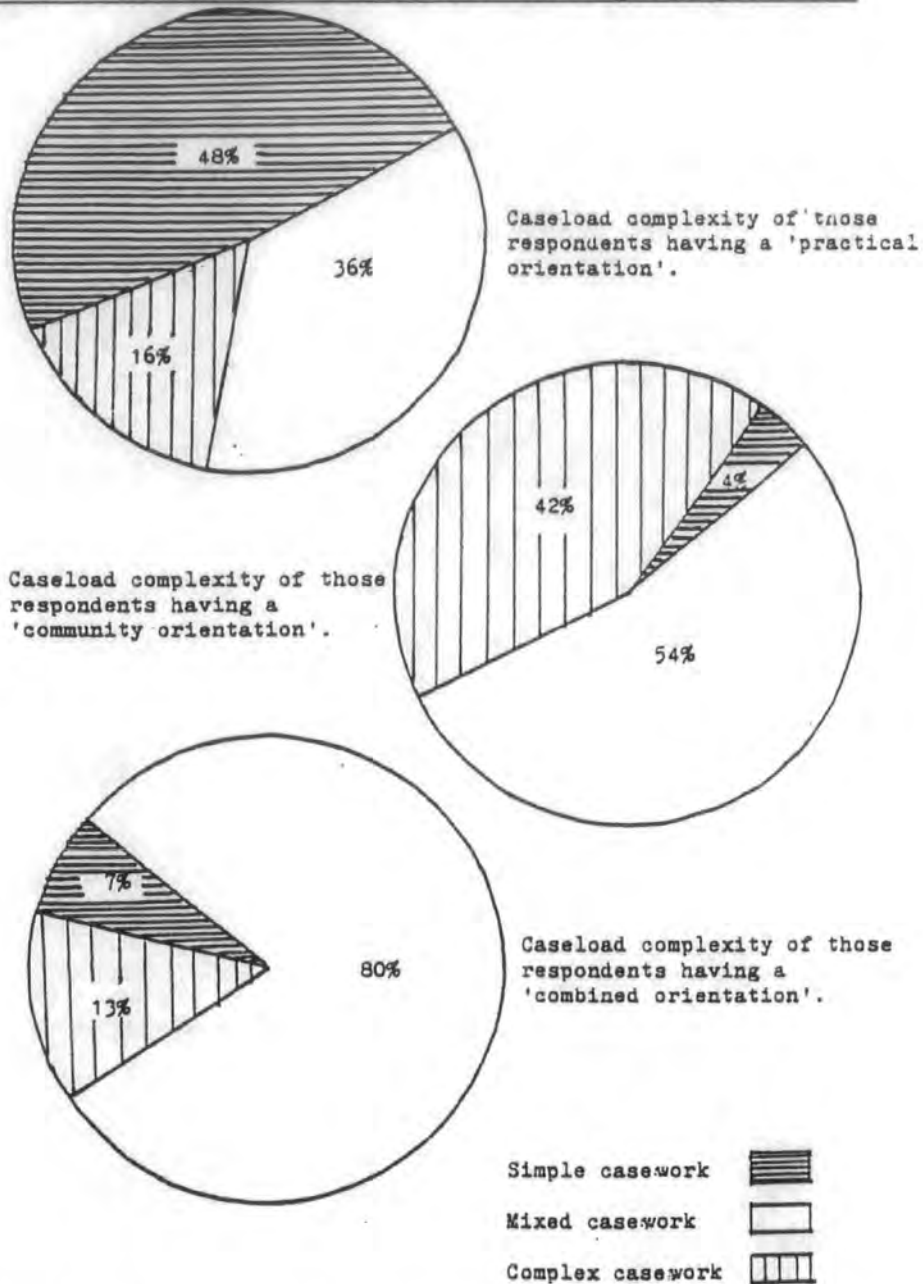
Figure 7 : Professional orientation and complexity of cases



There was a considerable variation between the three groups in the complexity of the work undertaken with the client. The occupational therapists with the practical orientation dealt with a higher proportion of simple cases than either the community oriented or combined oriented occupational therapists. The respondents with the community orientation dealt with a higher proportion of complex cases than the other two types, whilst the respondents with the combined orientation dealt with

the highest proportion of average cases. The difference between the complexity of the practical and community orientation is significant at the five per cent level.

Figure 8 : Professional orientation and complexity of work



The same emphasis is apparent in relation to the complexity of the work undertaken. However there were differences within the types in that whilst the greatest proportion of the practically oriented respondents' cases were a mixture of simple and complex conditions, the greatest proportion of the work undertaken with these cases was

categorised as simple. Also, the greatest proportion of community oriented respondents' cases were complex, whilst the greatest proportion of the work undertaken with these cases fell into the mixed complexity category. Meanwhile, the respondents with a combined orientation were more constant with 71% receiving a mixed caseload and 77% undertaking a mixture of simple and complex work with these cases. Once again the difference between the practical and community orientation groups was significant at the five per cent level.

Thus, respondents with a practical orientation seemed to receive high numbers of referrals nearly half of whom only required fairly simple work. Respondents with a community orientation received lower numbers of referrals nearly half of whom required somewhat complex work, and, respondents with a combined orientation received similar proportions of referrals to the community oriented respondents and the majority of these cases were of a mixed complexity. It is tempting therefore to surmise that the orientation of the respondents was a result of the pressures of work on them and of the problems presented to them. However, examination of some of the other characteristics of the three types shows that, whilst the pressure and complexity of the work appears to be a major factor in determining the orientation there are other contributory factors which are now discussed.

Professional types related to organisational setting and structure

Intrinsic/Extrinsic

One of the main foci of this study has been the influence of the organisational structure on the work undertaken by the respondents. The division of the respondents into two major groupings, intrinsic and extrinsic, has been explained (see page 56) and Table 13 shows the proportions of each professional type within the intrinsic and extrinsic groups.

Table 13 : Professional orientation and organisational structure

Orientation	Intrinsic n = 32		Extrinsic n = 48	
	n	%	n	%
Practical	12	38	13	27
Community	9	28	15	31
Combined	11	34	20	42

The practical orientation is most prevalent in intrinsic areas, the combined orientation is most prevalent in extrinsic areas and the community orientation is least prevalent in intrinsic areas and of secondary prevalence in extrinsic areas. However these differences are not statistically significant. There was considerable variation between the areas, in areas A and B none of the respondents had a practical orientation whilst all those in area C did. In areas D,E,F and K the distribution was more balanced, whereas in area H the emphasis was on a practical orientation and in area J on a community orientation.

Enclave/non-enclave

The bases from which the respondents worked have been described and Table 14 shows the proportions of each professional type within different bases. It can be seen that within the OT enclaves the practical orientation is predominant, within semi-enclaves the combined orientation is predominant and that within non-enclaves there is little difference in the prevalence of the three professional types. These differences are not statistically significant.

Table 14 : Professional orientation and work base

Orientation	Enclave n = 18		Semi-enclave n = 23		Non-enclave n = 39	
	n	%	n	%	n	%
Practical	8	44	5	22	12	31
Community	5	28	6	26	13	33
Combined	5	28	12	52	14	36

Other support staff

Another organisational feature which might have a bearing on the orientation of social services occupational therapists is the availability of other support staff. The information in Table 15 is interesting because there is little difference in the professional orientation of respondents who did or did not have occupational therapy assistants to help them, but there is considerable difference between those who had social work assistants to help them.

Table 15 : Professional orientation and support staff

Orientation	OT assistant n = 16		No OT assistant n = 43		Social work assistant n=21	
	n	%	n	%	n	%
Practical	6	38	16	37	3	14
Community	4	24	10	23	10	47
Combined	6	38	17	39	8	38

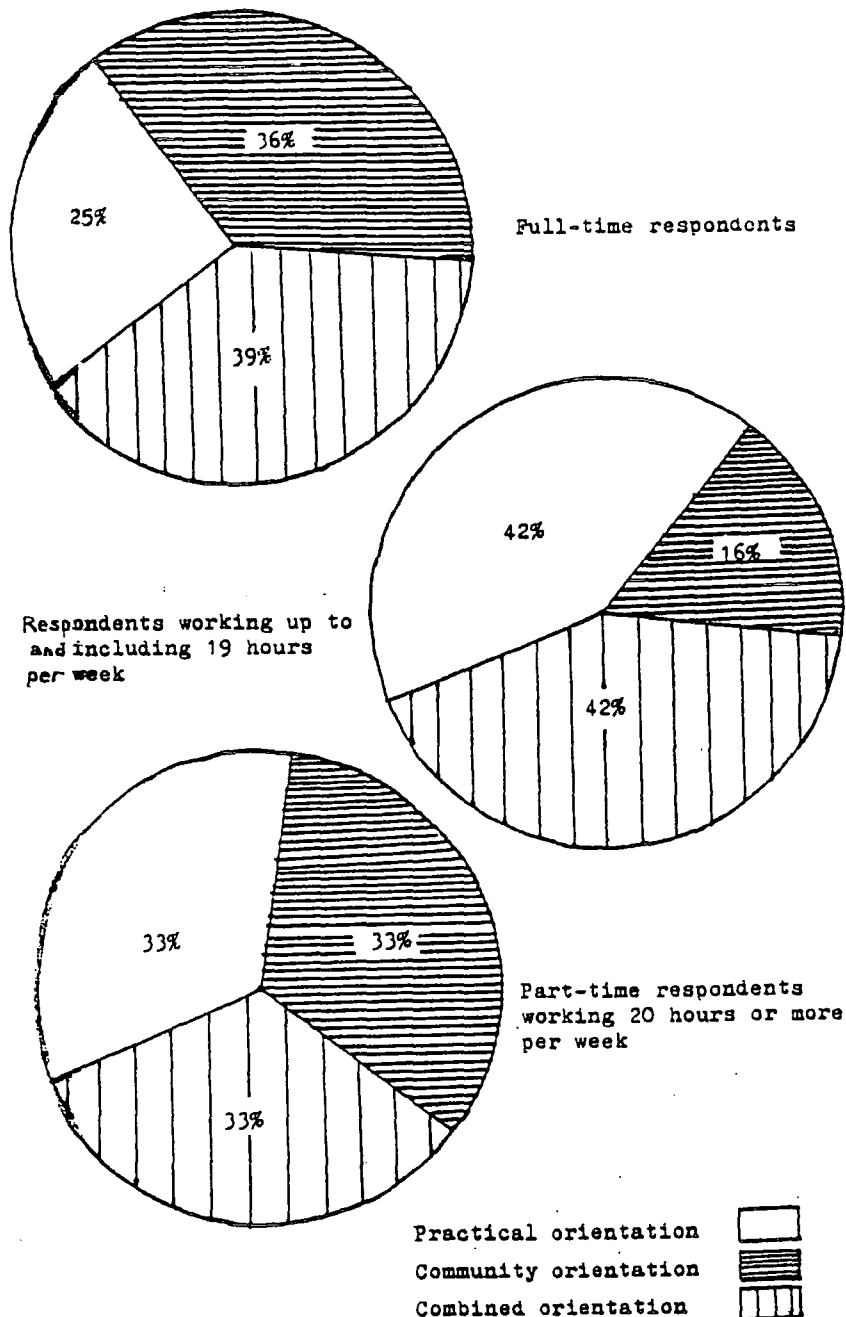
Table 15 shows that those respondents who received help from social work assistants were most likely to have a community orientation and least likely to have a practical orientation. This difference was significant statistically at the one per cent level.

Professional type related to biographical details

Full or part-time work

The conflicts of part-time staff and the possible effects on their work have been discussed (see page 35). The pie charts in Figure 9 show the distribution of the professional types within the categories of full and part-time work.

Figure 9 : Professional orientation and hours of working



It can be seen that combined and community orientations predominate amongst full-time workers, practical and combined orientations predominate amongst respondents who worked up to and including 19 hours a week and the orientations are of equal prevalence amongst part-time staff working 20 hours and over a week. The difference between the prevalence of the practical and community orientations amongst full-time staff and staff working up to 19 hours a week is significant at the five per cent level.

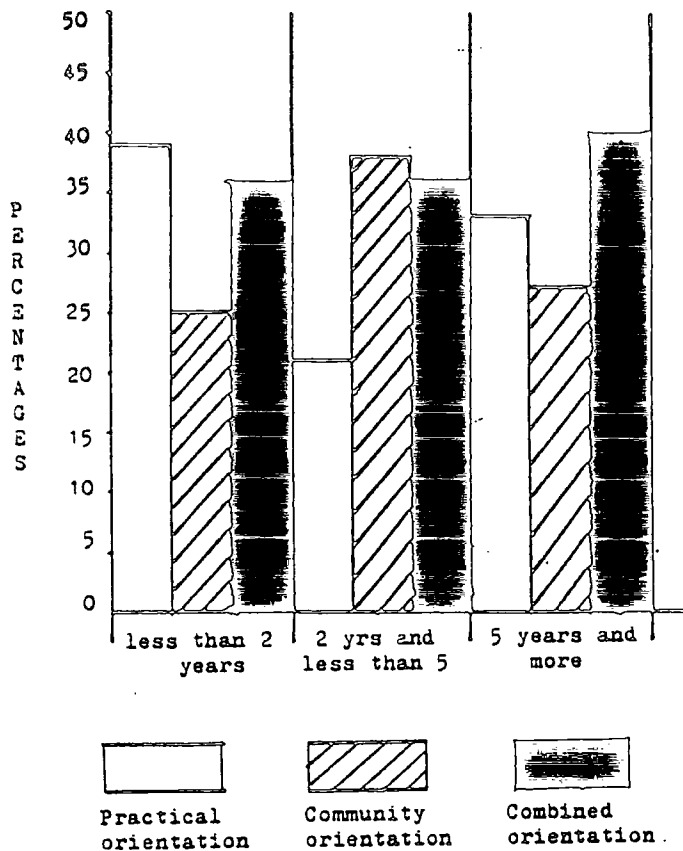
Length of time in post and community experience

As the main feature of the community oriented occupational therapist is her awareness and use of community resources, it might be supposed that such an orientation is more likely to develop through practice. Thus the relationship between length of time in post and professional orientation was examined as was the relationship between professional orientation and the total number of years worked by the individual in the community. The results are shown in the histograms in Figure 10 where it can be seen that practical and combined orientations predominate for those who had been in post for up to two years, combined and community orientations predominate for those who had been in post for between two and five years, and there was little difference in orientation for those who had been in post over five years. However, these differences are not statistically significant.

As far as total community experience was concerned, the community orientation was of least prevalence amongst respondents with up to two years experience and the practical orientation was of least prevalence amongst those who had between two and five years experience. The combined orientation was of greatest prevalence amongst both these categories and yet for those respondents with more than five years community experience, there was little difference in orientation. Once

again, these differences are not statistically significant.

Figure 10 : Professional orientation and length of time in post



Other qualifications

It is difficult to assess the extent to which the individual occupational therapists' professional orientation is a result of the setting in which she works or whether a particular type of therapist selects a setting that suits her orientation. An independent variable that could be assessed which gives some indication of the respondent's general orientation was whether or not they had obtained any qualifications in addition to their occupational therapy diploma. The types of qualification that were included in this were :- degrees and open university modules (4); teaching and art diploma/certificates (2); and secretarial diplomas (6). Table 16 shows that higher proportions of community oriented respondents had obtained other qualifications than either of the other two orientations, which is significant at the five

per cent level.

Table 16 : Professional orientation by additional qualifications

Orientation	Additional qualifications	
	n	%
Practical n = 25	2	8
Community n = 24	7	29
Combined n = 31	3	10

Discussion

The differing professional orientations appear to have a relationship with the theoretical approaches discussed in Chapter 1 (see page 17). Further studies would be required which took into account character analysis, an assessment of the work orientation of other staff at the occupational therapists' office base (i.e. the 'work atmosphere') and possibly information concerning the orientations of occupational therapy schools and colleges to understand why occupational therapists lean towards the differing approaches. It would also be interesting to examine the extent to which these, or similar, orientations are present amongst occupational therapists working within hospitals. A study of orientation would be useful at a later stage but was not within the remit of this study.

The following sections discuss the work undertaken by the respondents. The influence of their professional orientation on the range and content of the work should be borne in mind during the study of these sections. Equally, the nature of the work should be borne in mind as an influence on the respondents' professional orientation.

3.2. ALLOCATION OF TIME WITHIN THE SPECTRUM OF THE RESPONDENTS' WORK

The diaries that the respondents completed provide a detailed picture of the way in which their time was divided between the different aspects of their work (a randomly selected sample of the diaries is presented in Appendix II). There are certain limitations to the diary method. Firstly, 10% of the respondents commented that the week that their area had chosen to record was not a typical week for them; i.e. - they had just returned from leave, or were in their first or last week of employment. Secondly, the information collected is restricted to the information that the respondents wished, or had time to record. However, a great deal can be learnt from these diaries and it is considered that, given the number of diaries from which the information is taken, a representative picture is presented. For the purpose of analysis and discussion these aspects of work have been divided into time spent -

1. on administration;
2. in meetings and discussion;
3. on carrying out home visits;
- and 4. on any other activities.

The findings related to these categories are presented to show a range of the time spent in each activity within the intrinsic and extrinsic groupings (see Table 17), although within each area there was a considerable range from one individual to another in time spent on each aspect of work. The last column in Table 17 is introduced so that these findings may be compared with the figures on which the BAOT's report on future needs and numbers of community occupational therapy was based (BAOT 1984).

Table 17 : Average proportion of respondents' time spent on work activities by organisational grouping

Activity	Intrinsic areas	Extrinsic areas	BAOT
	%	%	%
Administrat.	19-38	27-39	43
Meet/discuss	6-18	12-22	13
Visits/travel	43-51	34-46	45
Other	5-11	5-14	*
Unaccounted	1- 6	1- 7	

* Within the BAOT figures the 'other' category is combined with the category for administration. (BAOT 1984).

Administration

Within the context of this study the title 'administration' is used to cover a wide range of office-based activity. Included within this category are :-

1. Sorting post, messages and referrals;
2. Making and receiving telephone calls;
3. Writing up notes, reports, letters, committee reports, drawing plans;
4. Making orders for aids, equipment and adaptations;
5. Preparation work for clinics, OT students, OT assistants, and for giving talks;
6. Obtaining information concerning aids, equipment, charities, social and recreational clubs and activities;
7. Sorting out the aids store, collecting/returning aids from/to the store, fabricating personalised aids;
8. Other - pay in monies, completion of statistics, intake/switchboard duty.

The volume of administrative work undertaken in social services departments is something for which most occupational therapists are probably unprepared. In fact, one respondent commented, in regard to the relevance of her occupational therapy training (see Chapter 6) that -

'in social services for every client contact the same amount of time can be spent on paperwork!'

Although 85% (77) of the respondents had a certain amount of clerical help (see page 174) over one third stated that further administrative support would relieve them of many aspects of their work

that did not require their professional discretion (see page 169). However, a certain proportion of the administrative work can only be done by the occupational therapist herself and this fact should not be overlooked. There is, perhaps, a tendency to think that the occupational therapists' skills are only being used to full capacity when in face-to-face contact with the client. This is not the case. As will be seen, much of the benefit to the client is derived from the negotiation that the occupational therapist undertakes on the client's behalf by liaison with other personnel, and through the results of the occupational therapist's involvement with long term planning.

However, administrative activities did occupy a considerable proportion of the main grade occupational therapist's time and it may be helpful to examine the elements more closely.

Telephone calls. The respondents spent between 5% and 24% of their working hours on the telephone. Both the median and the average for time spent on telephone calls was 10% which, for a 37.5 hour week is three and three quarter hours. Much of this time was frustratingly spent trying to get hold of people or in tracking them down, but the greatest proportion of calls were from or to clients themselves. The data relating to whom the calls were made and from whom received illustrates the wide variety of liaison contacts the social services occupational therapist has. This matter is discussed in Section 4.5 in relation to the contact that the respondents had with other personnel (see page 124 pp).

Writing reports, notes, letters, filling in forms etc. The greatest proportion of time spent on administrative work was that taken in writing up visits and carrying out all the necessary paperwork to bring about an improvement in the situation of the person visited. The percentage of the respondents' time spent on such work ranged from 5%

to 44%. The average proportion of time spent was 19% and the median was 17%, thus a full-time occupational therapist might have spent over six hours a week on this paperwork. Several respondents commented on the length of time that it took them to prepare reports to the social services committee usually when the occupational therapist has to write to support a client's application for a grant for adaptation work and it is important that such reports contain all the relevant facts and are well presented. Further reference is made for the need for skill in preparing such reports in the discussion on training needs in Chapter 6 (see page 194).

Other administrative activities. The list presented above gives an indication of the wide-ranging activities that the respondents carried out at their office bases. Some of these activities are, perhaps, not purely administrative, however, they are mostly concerned with facilitating the provision of a service to the client or with the occupational therapist fitting in with the general management of the base. Some of these activities quite clearly do not require an occupational therapist's skills, e.g. manning the switchboard ; sorting out the aids store; and cataloguing new equipment and it is unlikely that other equally specialised professionals such as psychologists or speech therapists would be used in this way. The question of whether or not it is appropriate for the occupational therapist to do these tasks should, perhaps, be addressed individually in each area. However, some form of central guidance from the BAOT might be valuable.

Table 17 shows that the total amount of time spent on administrative activities did vary from 19% to 39%. One of the reasons for the smaller proportion of time spent on administration may be that in some areas the occupational therapists had no involvement in the organisation of adaptations. Adaptations do concern most occupational thera-

pists with a considerable amount of paperwork and telephoning. In two areas as soon as the need for an adaptation was identified the matter was referred to an adaptations officer. The attitude of some of the respondents to this system is discussed in Chapter 4 (see page 154). In those areas where there was no, or only minimal, administrative support the time spent on administration by the occupational therapists was much greater.

Meetings and Discussion

A considerable amount of the social services occupational therapist's time is spent in work-associated meetings or in informal discussions with other personnel. The respondents were asked to record brief details of any meetings that they attended and any informal discussions that they had with anyone at their office base. For the purpose of analysis and discussion these interactions are classified under one of two headings-

1. Pre-arranged meetings - i.e. interaction that has been pre-arranged, often involving three or more people.
2. Spontaneous discussion - i.e. interaction that has not been pre-arranged, usually involving the respondent and one other.

Table 18 ; Proportion of time spent in 'pre-arranged meetings` and 'spontaneous discussion`.

	Intrinsic	Extrinsic
Interaction		
	%	%
Pre-arranged	3-10	6-13
Spontaneous	3-8	5-9

The individual variation was great. In one area alone one full-time respondent spent one day (i.e. 18% of her working hours) in a special allocation/team meeting (see case study, Appendix II) whilst another full-time respondent spent only 2% (i.e. 45 minutes) of her

working hours in an allocation meeting. Furthermore, in another area eight of the eleven respondents each spent about three hours in a special bi-monthly meeting which greatly increased the amount of time spent in pre-arranged meetings. However, these variations are inevitable and do not distort the overall picture. There was little difference in the total proportions of time spent in meetings between enclave and non-enclave areas.

One factor was noticeable from studying the individual percentages of time spent in meetings and that was, because of the inflexible nature of the duration of many meetings, the part-time staff spent a greater proportion of their time in meetings than did the full-time staff. For example, the same meeting lasting three hours would represent 17% of the 18 hours that a part-timer worked, but only 8% of a full-time member of staff. For this reason some part-time respondents mentioned that they did not attend meetings because too little time was left for their other work.

' I am excused most meetings because of the short hours I work`.
(a respondent who worked 9 hours a week)

Pre-arranged meetings

The pre-arranged meetings that the respondents attended can be sub-divided into three groups - 1. regular work meetings; 2. regular committee meetings and working parties; 3. occasional attendance at voluntary groups.

Regular work meetings. Of the regular meetings that the respondents attended as a direct result of being the incumbent of their post, there were ten which predominated.

1. Allocation meetings - Usually held weekly, at which the team leader would allocate new referrals. In an OT enclave area this would comprise only occupational therapists, in a

non-enclave area this would comprise a team of social workers with one or two occupational therapists.

2. Team meetings - Ranging in frequency from once a week to once a month, comprising all staff in a team to discuss any issues relevant to the smooth running of the team. Sometimes held in conjunction with an allocation meeting
3. Area meetings - Held from once a month to once every three months, comprising all staff in an area office to discuss relevant issues of policy and administration.
4. Occupational therapists' meeting - Held from once a month to once every six months, exclusively for occupational therapists in a division or a department to meet to discuss issues of relevance to them.
5. Individual supervision - Held from once a week to once a month. (See page 143).
6. Adaptation reviews - Held monthly to once every three months. Meeting with relevant personnel (improvement grant officers, administration, architects, senior OTs) to review progress on adaptations.
7. Hospital/Clinics OTs, Drs. - Held from once a week to once every three months primarily to discuss individual cases, sometimes to discuss joint planning of services.
8. Primary care team - Held weekly to three monthly at health centre/ clinic with district nurses, health visitors, family practitioners, to discuss individual cases.
9. Housing - Held once a month to once every three months to discuss allocations, adaptations and future planning with housing officers.
10. Community liaison - Once a month to once every three months. Often a lunch-time meeting with all personnel who work in a 'community area' i.e. community workers, voluntary groups, pastors, district nurses and health visitors, community action groups etc.

Committee meetings and working parties. In addition to the meetings that they attended as a function of their post, the majority of respondents were also on committees, which they attended regularly throughout the year, or on working parties which would meet for a finite period.

Examples of these committees and working parties are -

1. Community transport committee;
2. Crossroads Care Attendant Scheme Committee;
3. Day Centre Advisory Council;
4. Elderly working party;

5. Housing association committees.;
6. International Year for Disabled People working parties;
7. Liaison with schools for the handicapped;
8. PartIII/Fieldwork liaison group;
9. Registration working party;
10. REMAP;
11. Riding for the disabled;
12. Sexual counselling working party;
13. Standing committee for the handicapped;
14. Stroke club committee;
15. Voluntary services agency.

Voluntary groups and charities. Further to their executive function on committees and working parties, many respondents also attended other meetings concerned with local charitable groups. These groups would probably meet regularly once a month and the occupational therapists would probably attend occasionally to keep in touch. Such groups included -

1. British Rheumatism and Arthritis Clubs;
2. Local associations for the disabled;
3. Multiple sclerosis societies;
4. PHAB clubs;
5. Spastics societies; and many others.

Clearly, all the respondents did not attend all of the meetings listed above, however, they were all involved in several. Table 19 shows the proportion of respondents within the intrinsic and extrinsic groups who attended particular meetings.

Table 19 ; Proportions of respondents who regularly attended particular meetings

Meeting	Intrinsic	Extrinsic
Allocations	11%	24%
Team	14%	53%
Area	26%	36%
OTs	86%	84%
Supervision	3%	13%
Adaptations	9%	35%
Hosp/OT/Clin	23%	16%
Primary care	20%	16%
Housing	9%	18%
Comm.liaison	17%	2%
Comms./work parties	23%	27%
Vol.groups	11%	4%
Other	46%	29%

It was noted that, overall, the non-enclave respondents did not spend more time in pre-arranged meetings than did the OT enclave respondents (p. 86), however, proportionately more occupational therapists in non-enclave areas attended area and team meetings. Further reference is made to time spent in meetings in Chapter 4 (p. 153).

There was considerable variation between the areas in the type of meetings attended except for OT meetings where, in all areas, most of the respondents attended such meetings. Higher numbers of extrinsic occupational therapists were involved in meetings concerning adaptations and housing, whilst higher numbers of intrinsic occupational therapists attended community liaison meetings.

The 'other' group included at the foot of Table 19 covered many varied meetings, however in two non-enclave areas respondents listed regular weekly meetings with social workers to - as one respondent in area H stated -

'keep communication going`.

Function at meetings.

Table 20 : Proportions of respondents fulfilling particular functions at meetings

Function	Intrinsic	Extrinsic
Discuss cases	60%	58%
Advisory	29%	24%
Chair/coord/sec.	11%	11%
Represent OTs/team	11%	7%
Represent soc.serv.	11%	4%
Other	11%	4%
General participation	89%	80%

It can be seen that the majority of respondents defined their function at meetings as one of general participation. Apart from that, over

half the respondents in each group attended meetings to discuss individual clients' needs and about a quarter had an advisory function. The prevalence of other functions varied somewhat from area to area.

Spontaneous discussion

A certain amount of any person's work is 'invisible' because it is not necessarily recorded. In the case of the social services occupational therapist a considerable amount of this invisible work takes the form of discussions with other social services personnel or with other personnel and clients who visit the office base during the course of the working day. As Table 17 (page 82) showed, the total proportion of the respondents time spent in spontaneous discussion, as recorded in the diaries, could range from 3% (about one hour a week) to 9% (about three hours a week). Table 21 illustrates the number of recorded occasions that the respondents in each area had spontaneous discussions with different personnel.

Table 21 : Number of recorded spontaneous discussions in one week

Second party	Intrinsic				Extrinsic					
	B n=4	(E)* n=10	H n=11	K n=5	(A) n=6	(C) n=3	(D)** n=20	(F) n=7	G n=1	(J) n=10
Social worker	-	12	-	2	6	6	36	11	-	13
Area Director	-	4	-	-	-	-	-	-	-	-
SW assistant	-	2	-	-	-	3	-	8	-	7
OT assistant	-	4	-	-	-	3	6	-	-	-
Reception/duty officer	-	-	-	-	1	4	1	1	-	-
Home help organiser	-	4	-	-	4	3	2	3	-	5
Technical officer	3	1	18	2	-	-	7	-	-	-
OT colleague	2	3	2	5	3	-	7	3	3	9
OT student	3	-	-	-	-	-	8	2	-	-
Craft instructor	-	-	4	-	-	3	1	-	-	-
District nurse	-	1	-	-	-	-	6	1	-	-
Client	3	3	5	6	1	5	5	5	-	1
Clerical/admin	2	3	4	2	1	2	7	2	1	2
Other	3	4	8	2	-	-	4	4	2	9

n = number of respondents

* () - bracketed areas are non-enclave areas.

** () - semi-bracketed indicates semi-enclave area.

The length of the discussion is not included and the discussions were concerned with work and did not include social interaction.

There were noticeable differences between the areas. The personal contact that the respondents based in area social work offices (the bracketed non-enclave and semi-enclave areas) had with social workers, social work assistants and home help organisers is evident as is the contact that respondents had with technical officers and craft instructors where these were employed. These differences are discussed further in Section 3.5. (see page 124) in regard to the respondents' contact with other personnel.

The range of other spontaneous contact that the respondents recorded at their office base was extensive and the content of the discussions was extremely varied. Several had contact with day centre managers, local government councillors, aids delivery drivers, storemen, voluntary and community workers. Those respondents who were based at day centres sometimes found themselves involved in time-consuming activities unconnected with their work simply because there was no-one else around. In two cases this involved helping an elderly person in the w.c. or in taking a workman to repair the boiler.

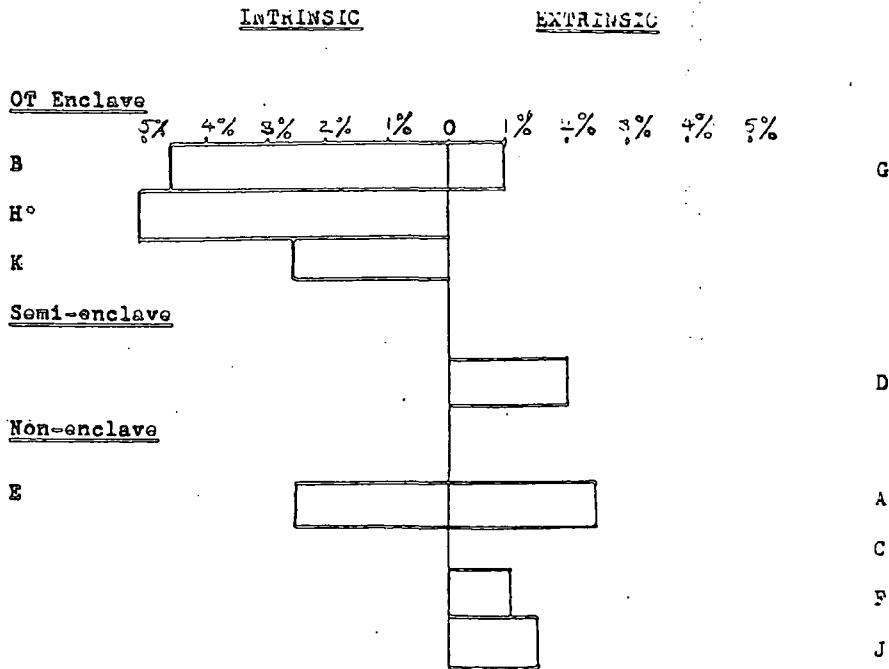
Contact with occupational therapy colleagues

Finally, the data that were collected from the diaries relating to meetings and discussions illustrate the amount of contact that the respondents had with their fellow occupational therapists employed within the authority. Both pre-arranged and spontaneous contact have been combined in the bar charts in Figure 11.

The areas where the respondents had least contact with their colleagues - areas C, F, and J, were all large rural areas where the respondents were the only occupational therapists at their area base. The issue of the amount of contact that social services occupational

therapists have with other occupational therapists and the relative value that they attach to this is discussed in Chapter 4, p.139.

Figure 11 : Proportions of working time spent in contact with occupational therapy colleagues



° The proportion shown for this area is, perhaps, unrealistically high, because of an extra-ordinary bi-monthly meeting that was held during the week of the study (c.f. Case Studies, Appendix I) If the hours spent in this meeting are subtracted, the proportion of time spent in contact with other occupational therapists is only 1.5%

Visits and Travel

The major emphasis of the social services occupational therapist's work is the time spent in visiting clients in their own homes. During the week of the study the respondents recorded all the visits that they undertook and the time that this involved away from the office.

Aspects of time spent in travel

The time spent in travelling is relevant because this varied between the large rural areas, the quiet suburban areas and the dense city areas. However, as several areas comprised a mixture of rural and urban areas, there was considerable individual variation in the time spent on travel between the respondents in each area.

When an average is taken for each area, the overall range of time spent on travelling was relatively small, from 7% to 12%. However, the individual range was much greater. In one area, where only three of the eleven respondents gave details on travelling, the figures were 7%, 14% and 21% of total working time. It is clear that, in any discussions concerning the use of social services occupational therapists' time, that time spent on travelling to clients and to other work settings must be taken into consideration.

Aspects of time spent on visits

The detail concerning the content of the client visits and the interaction between the occupational therapists and their clients is presented in Sections 3.3 and 3.4 (pages 104 to 119). However, it is appropriate to record here some of the statistical data relating to the carrying out of visits which was derived from the diaries.

The average proportion of time spent in clients' homes ranged from 26% to 37%, that is, from 9.75 hours to 14 hours a week. Study of the information relating to individuals showed that the range for the proportion of time spent on visits (not including travel) was from 18% to 46%.

Table 22 presents information concerning the total number and duration of visits undertaken in a week by those respondents who provided sufficient data.

Table 22 : Range of the number and duration of visits undertaken during week of the study

Average total number of visits in one week			
	Intrinsic	Extrinsic	BAOT*
Full-time OT average	18-30	15-23	15
Part-time OT average	10-20	4-10	n/a
Average length of visit in minutes			
	29-46	33-56	45

* Needs and Numbers Report (BAOT 1984)

Table 22 shows that there was a considerable range between the areas in the average number of visits undertaken weekly and in the average length of time spent on visits. In general it will be seen that, the more visits undertaken, the shorter the length of time spent on each one. Comparison with the BAOT figures in the final column (Table 22) shows that, in only one of the authorities in this study, did the occupational therapists have such a low average number of visits.

Other features of visiting

1. Abortive visits - These were usually because the client was out when the respondent called. Many respondents commented when the client did not have a telephone and therefore an appointment was not easily made. On some occasions the client had died shortly before the visit, on others the address had been incorrect. Represented 4%-13% of visits.
2. Joint visits - These were visits undertaken with another person e.g. social work colleagues; architects; improvement grant officers; hospital occupational therapists and social workers; technical officers; stairlift and hoist manufacturers; and senior or principal occupational therapists. Represented between 2%-8% of visits.
3. Hospital discharges - These were visits undertaken at very short notice because of the client's imminent discharge from hospital. Represented between 1%-16% of visits.
4. Evening visits - These were noted because they can be a particular

feature of social services work. Although during the week of the study only one respondent undertook an evening visit.

The issue of dealing with hospital discharge visits at short notice has been one which has vexed some social services occupational therapists (see page 162) as it has seemed to epitomise the notion that staff within hospitals have little appreciation of the pressures under which social services occupational therapists work. Hospital discharge visits did represent quite a high proportion of the total number of visits undertaken in most areas. As such visits are perceived as priorities each one means that an ordinary referral has to wait a little longer for a visit.

The final observation in this section concerning home visits is to note the unpredictable nature of the social services occupational therapist's life. In three cases the client was so unwell when the occupational therapist called that she had to call a doctor, wait for him to arrive and, in one case, then wait for the ambulance to arrive. In another case the respondent went to visit a client who had just been discharged from hospital, the occupational therapist had to go out immediately to buy food for the client who had none in the house and who was incapable of going shopping for herself. In another situation the respondent had to call the fire brigade to break their way into the bathroom because the bath aids had fallen against the door thus preventing it from opening!

Other activities - the wider function of social services occupational therapists

Although home visits may be seen as the major focus of the occupational therapists' work, the activities of the respondents in this study illustrate that this is by no means the limit of their function. In Section 3.5. the wider role of social services occupational

therapists is discussed whilst within this section the proportion of time spent on these other activities is considered and the type of activities is listed.

Table 17 showed that the average time spent on 'other activities' ranged from 5% - 14%, that is, from about two to five hours a week. Once again, the individual range was great, from 0 - 29%, that is, up to eleven hours a week.

The type of activity was extremely diverse and difficult to classify. However, the list on p. 97 groups them into broad categories showing the areas where they were undertaken. It is noticeable that the intrinsic occupational therapists appear to have been involved in a greater number and a greater diversity of these 'other activities', particularly in relation to other statutory provision (e.g. schools, Part III accommodation, day centres, etc.). This may have been due to the work of the principal occupational therapists at social services headquarters who were in a position to promote the role of fieldwork occupational therapists and to negotiate the arrangements required. It is, however, noticeable that the extrinsic occupational therapists were more involved in the local community projects, such as alterations to public buildings to make them suitable for disabled people.

SUMMARY

The information from the respondents' diaries has illustrated the wide range of work that was undertaken by these social services occupational therapists and the manner in which their time was divided between the different activities. There were local variations, some of which appear to be due to the differing organisational structures and methods. However, a major influence on the work of the respondents was the volume and type of referrals that they dealt with. These factors are examined in the following section.

3.3. CASELOAD AND OBJECTIVES OF VISITS

Caseload

The respondents were asked to state how many referrals they had received in the previous ten working days and to state how many cases they were working on at the time of the study. The results are presented in Tables 23 & 24 to show the differences between the areas and between the full and part-time staff.

Table 23 : Referrals received by hours of working

Number of referrals recev`d in 10 days	Intrinsic			Extrinsic		
	-18	18+	F/time	-18	18+	F/time
10 & under	5	1	2	10	5	7
11-21	3	2	4	5	2	5
21-30	2	-	5	1	-	6
31-40	1	1	4	-	1	-
41 and more	-	-	2	-	-	2

Table 24 : Current caseload by hours of working

Number of current cases*	Intrinsic			Extrinsic		
	-18	18+	F/time	-18	18+	F/time
15 & under	-	-	1	1	1	3
16-30	2	-	3	6	1	4
31-50	5	1	3	7	3	11
51-100	1	2	10	-	2	7
101-150	-	-	2	-	-	-

* The intervals in Table 24 were derived from the data.

There was a very wide range in the numbers of referrals received. There was also a wide range in the numbers of cases which the respondents were working on and had visited within the previous three months (see Questionnaire page 4 Appendix I).

There were differences between the intrinsic and extrinsic groupings. In general, the respondents in the extrinsic areas received lower numbers of referrals and carried smaller caseloads than did the respondents in the intrinsic areas. Reference to Figure 2 (page 55) will show that these differences are not related to the ratio of occupational therapists to the total population of the area. One factor may be that, in most of the intrinsic areas, virtually all referrals

concerned with the physically handicapped were passed through to the occupational therapists, whereas in the extrinsic areas there was greater participation from other social services staff.

Cases "kept open"

Another aspect of the workload was whether or not the occupational therapist kept some cases permanently 'open' (or 'active'). These cases were usually the more severely handicapped people with progressive conditions, or handicapped children who faced new problems as they matured. Many of the respondents itemised multiple sclerosis (MS) and rheumatoid arthritis (RA) sufferers as those most likely to receive regular support, with explanations such as these :-

'e.g. RA,MS. I feel it's important to get to know these people well and yet not create a dependence on me, at the same time try and help plan for future - or at least be one step ahead as far as what may well happen even if the client can't accept this.'

'In deteriorating cases people's needs alter, so different aids are needed - but too many aids given at once frequently go unused. Also give moral support for both patient (sic) and family, problems can be thrashed out in the open.'

'Children's cases. Placed on register, visits made at intervals as needs are continually changing.'

One or two respondents also commented on the nature of their role with such families.

'.....some cases need and benefit from support from an authority figure more accessible than the GP, less rushed than the district nurse. Often district nurse, home help or social worker are not involved.'

'Clients who do not want social work involvement but whose needs are recurrent.'

The issues concerning the extent to which social workers are willing to deal with the handicapped and elderly have been discussed in Chapter One (page 39). The comments presented above illustrate some of the points made in that discussion.

Cases were kept open for one of four main reasons -1. To provide

- regular support to the disabled person. 2. To carry out special reviews (e.g. safety of stairlifts). 3. To support specifically the relative.
4. Cases never closed in order to avoid the bureaucracy of closing and re-opening the files on a large number of less severely handicapped people who had recurrent minor problems.

Table 25 ; Number of respondents who gave different reasons for keeping cases open

Reasons	Intrinsic				Extrinsic					
	B n=7	E n=11	H n=12	K n=5	A n=8	C n=5	D n=22	F n=9	G n=1	J n=10
Regular support	6	8	3	4	5	2	13	6	1	10
Cases never closed	1	2	2	-	-	-	5	-	-	-
Support to relative	1	-	-	-	1	-	2	1	-	1
Special review	-	1	-	-	-	-	3	-	-	-

n = number of respondents in area

In general, a higher proportion of extrinsic occupational therapists (58%) kept cases open than did intrinsic occupational therapists (43%). This may have been because they had more time to do so because they had a lower caseload. An interesting feature of these cases is that they do not necessarily require very frequent visiting. Once the relationship has been established much of the contact may be by telephone and the occupational therapist may spend a considerable amount of her time on the client's behalf in her own office (e.g. contacting other agencies, obtaining information relevant to their needs etc.). Such activities may therefore be reflected in a greater amount of time spent on administration (see page 82).

It can therefore be seen that, in all areas of the study, the respondents had very considerable caseloads. Studies carried out in other areas confirm this fact (Scrivens 1983; Rowlings 1980) and it is not uncommon for one occupational therapist working in a social services area office to deal with 25% of all the referrals to that office.

Age and diagnosis of clients

The clients' age is a slight indicator of the severity of the handicap and, thus, of the technical complexity of the work involved in helping them. All studies of handicapped populations reinforce the findings of Harris et al (1971), which was that the preponderance of registrably handicapped people are aged over 65 years. Combined with this fact is the fact that the majority of the handicapped elderly suffer from conditions such as arthritis, or cardiovascular and respiratory conditions. These conditions are not necessarily disabling in a younger person, but when combined with the infirmity of old age have a more disabling effect.

There is a general tendency for elderly clients, who are referred to occupational therapists in social service departments, to be suffering from minor mobility problems which can be overcome by the use of comparatively inexpensive aids (such as bath seats, walking aids, toilet aids), whilst younger and middle-aged clients referred to occupational therapists often have more severe handicaps caused by trauma, degenerative neurological conditions or handicaps that have been present since birth. This group often requires more expensive items of equipment which may have to be specially designed and they may require expensive alterations to property. Notwithstanding these generalisations there are many elderly handicapped people who have very complex problems (not only of a practical nature) and many younger handicapped people whose difficulties can be overcome quickly and simply. Younger people may also be better equipped to resolve some of their own difficulties.

The histograms in Figure 12 illustrate the proportions of clients within the young, middle and elderly age groupings for each area and Table 26 gives a breakdown of their disabling conditions.



Figure 12; Proportions of recorded visits undertaken in each area which were to young, middle or elderly age groupings.

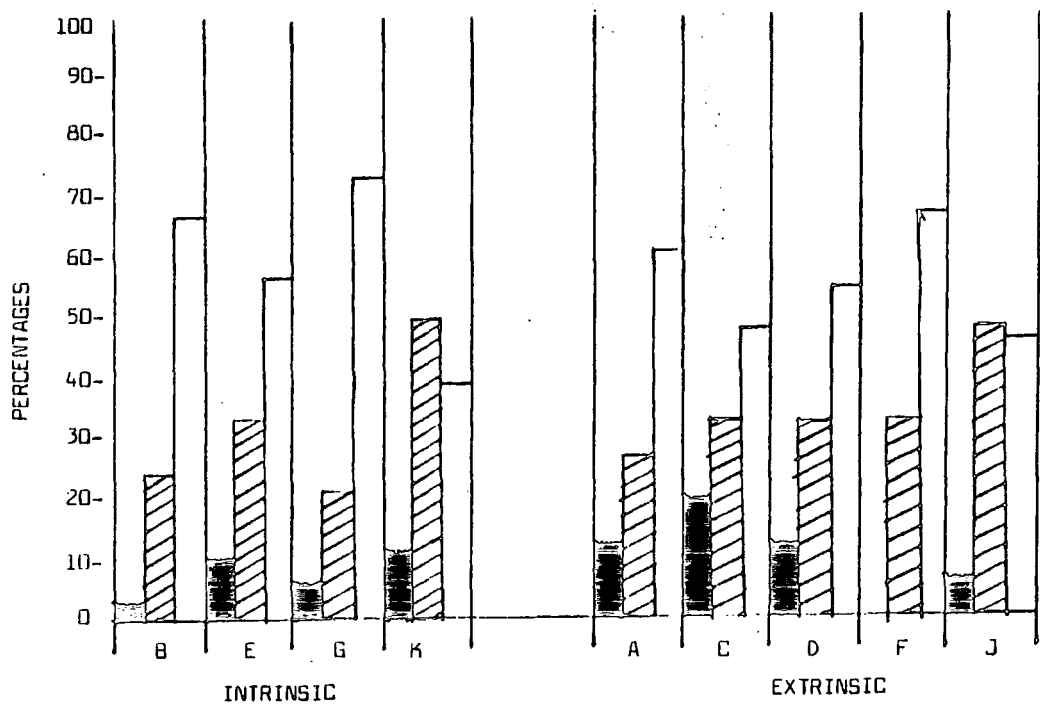


FIGURE 12: Proportions of recorded visits undertaken in each area which were to young, middle or elderly age groupings.

AGE GROUPS




- Less than 25 years 
- 25 to 64 years 
- 65 years and more 

Table 26 : Proportions of respondents' clients by disabling conditions

Disabling conditions	Intrinsic	Extrinsic
Arthritic	26%-45%	24%-35%
Neurological (MS)*	11%-17% (1-6 cases)	14%-31% (1-13 cases)
Circulatory/ respiratory (CVA)**	15%-29% (3-11 cases)	15%-23% (2-16 cases)
Present at birth	2%-11%	0-10%
Trauma (para & tetraplegia)	0-9% (2 cases in total)	0-24% (5 cases in total)
Senility/ frailty	0-5%	3%-7%
Carcinoma	2%-9%	0-4%
Blindness	0-2%	0-6%
Psychiatric	0-4%	0-7%
Amputation	0-5%	0-7%
Other	0-7%	3%-12%

(* MS = Multiple sclerosis ** CVA = Cerebro-vascular accident)

By studying the histograms and Table 26 a general picture of the respondents' caseloads can be built up. The particular categories of disabling conditions have been chosen because of the implications of the work for the respondents. Because of this, in those cases where a client had more than one condition, the condition causing greater practical difficulties has been recorded. The incidence of certain conditions has been highlighted (e.g. multiple sclerosis, cerebro-vascular accidents and para and tetraplegia) within the broader categories because of the work implications.

The characteristics of the caseloads varied from area to area. In some areas, the occupational therapists were dealing with higher proportions of elderly people whilst in others, the respondents visited higher proportions of people in their middle years. In other areas, the age range was more evenly spread. In some areas the higher age groups coincided with a higher incidence of arthritic conditions and elderly senile clients. However, the factors of age and diagnosis only give an indication of the sort of problems that the occupational therapists might have been tackling.

Objectives of visits - new referrals, re-referrals, current cases

The respondents were asked to state the reasons why each of the visits that they recorded was undertaken. This included stating whether or not the visit was -

1. a new referral - i.e. a first visit to a new referral;
2. a re-referral - i.e. a visit to a previously known case which had been re-referred;
3. a current case - i.e. a visit to a client with whom the occupational therapist was already working.

The implications are that, if a high proportion of visits were new referrals, then the occupational therapists in that area generally only had time to make one visit to that person and no time to follow up the case. Also, there is the implication that, perhaps, the needs of the client were not very complex and did not require much more time to be spent on them.

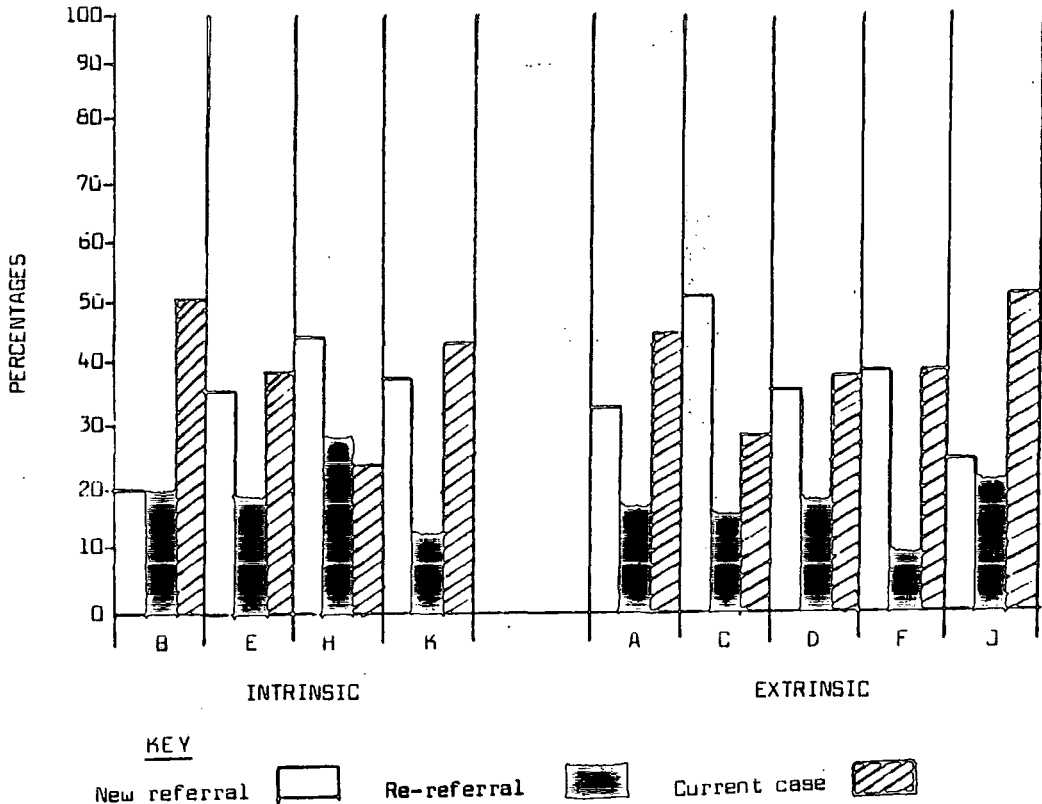
If there was a high proportion of re-referrals the implication might be that the client had changing needs and should, ideally, be kept on a current caseload. Or it might be that, for whatever reasons be it lack of time or thoroughness, the needs of the client had not been met previously.

If there was a high proportion of visits to current cases, the implications are that the occupational therapist had more time to deal with a case thoroughly and/or that the cases were more complex and required more detailed work (see page 70). The histograms in Figure 13 show the proportion of visits in each area that were new referrals, re-referrals or current cases.

The histograms in Figure 13 show high proportions of visits to new referrals in some areas which is consistent with the higher number of referrals received there. The histograms also show higher proportions of visits to current cases in areas where lower numbers of

referrals were received.

Figure 13 : Proportions of recorded visits undertaken in each area to new referrals, re-referrals and current cases



Objectives of visits - subject matter of visits

The subject matter of the visits is described in the following manner.

1. Small aids - e.g. bath aids, walking aids, kitchen aids, eating and dressing aids. (Visit counted if only one or two of these were required.)
2. Equipment and management - when the total management of the client was discussed and several different small aids were recommended.
3. Minor adaptations - includes grab rails, stair rails, small ramps, minor alterations, shower installations
4. Major adaptations - ground floor wcs/extensions, major structural alterations.
5. Specific assessments - for wheelchairs, stairlifts, expensive equipment (eg hoists), day centre placements.
6. Housing - when rehousing was discussed or potentially suitable accommodation was visited and

assessed.

7. Support and discussion - of a general nature. Also included any rehabilitative activities (see page 110).
8. Holidays, telephones, bus passes, parking discs - when applications for these were discussed and assessed. (In some areas these applications were dealt with by social workers or social work assistants).

Table 27 shows the incidence of these issues during the visits recorded by the respondents. By studying Table 27 it can be seen that there were differing emphases within the areas when the subject matter of their work is examined. Certain differences were possibly due to demographic factors, for example, in city areas such as B and K rehousing may have been discussed more commonly than in areas which had higher

Table 27 : Proportion of recorded visits undertaken in each area by subject matter of visit (categories are not mutually exclusive)

Subject matter	Intrinsic				Extrinsic					
	B	E	H	K	A	C	D	F	G	J
	%	%	%	%	%	%	%	%	%	%
Small aids	26	37	55	39	33	33	28	44	-	20
Equip and man.	26	14	21	29	33	10	28	23	-	34
Minor adapts.	9	13	14	13	-	24	9	5	-	18
Major adapts.	4	6	1	-	-	5	10	-	1	2
Spec. assess.	26	25	11	8	10	19	15	12	1	26
Housing	9	3	1	13	3	10	1	5	-	2
Supp/discuss	4	2	3	5	17	5	5	9	-	4
Hols/tel/bus	9	3	3	-	3	-	1	7	-	-

proportions of owner occupiers, where there was a correspondingly higher incidence of discussion concerning major adaptations. The high proportion of visits associated with minor aids (mostly bath aids), in one or two areas, was undoubtedly associated with the higher ratio of elderly and arthritic people referred to them (see Table 26 and Figure 12, pages 102, 103).

One of the central issues of this study has been to consider whether or not the best use was being made of the skills of social services occupational therapists. In Chapter One it was suggested that these skills need not be confined to individual work with clients. However, insofar as individual client work is concerned the information presented in this section has illustrated some pertinent points.

The complexity of the problems presented to the respondents is an indication of the level of work required from an occupational therapist. The complexity of the respondents' caseloads was considered in Section 3.1. where it was suggested that the more complex caseloads comprised clients who had more severely disabling and progressive conditions. In addition, the subject matter of the more complex caseload was unlikely to be solely the assessment for a provision of one or two basic aids, but to be more concerned with the total management of the client, the need for specialised equipment and the organisation of major adaptations. Thus the information in this section concerning the age and disability of the clients and the subject matter of the visits suggests the requirements that were made of the occupational therapists. These requirements are examined in the following section which describes the skills and resources that the respondents employed to achieve their objectives.

3.4. SKILLS AND RESOURCES USED DURING HOME VISITS

The client visit records (see Appendix I) also provided the basis for an analysis of the skills used by the occupational therapists and the breadth of the resources on which they drew. The method for this analysis was described in Chapter Two (page 50) wherein it was explained that charts were constructed itemizing different features of the interaction that occurred on the visits. The frequency with which respondents in an area presented these features on their client visit records provides a picture of the emphasis of the occupational therapist's work.

Skills and resources used

For the sake of analysing the skills used by the respondents in this study, the required skills have been divided into two main groups.

1. Pure occupational therapy - i.e. those skills and knowledge that are common to all occupational therapists whatever their work setting.
2. Community occupational therapy - i.e. those skills and knowledge which have been identified in this study as specific to community work.

Pure occupational therapy

Six features were identified as demonstrating pure occupational therapy skills.

1. Application of medical knowledge
2. Application of psychological/psychiatric knowledge
3. Assessment of the individual
4. Teaching techniques
5. Making/designing aids
6. Treatment/rehabilitation

Medical knowledge - Whilst it might be maintained that a trained occupational therapist draws on her medical knowledge at all time, it was apparent from this study that some respondents utilised this knowledge more extensively than others. A respondent was recorded as using medical knowledge according to her observations and behaviour

rather than according to the severity of the client's condition. In general it was the case that there was more evidence of the use of medical knowledge with the more severely handicapped clients. For example :-

'on arriving.....I found her slumped in her chair. She has pressure sores over the coccyx area, but was not using a rubber ring. My first job was to improve her sitting position, putting the ring in place and try to keep her spine straight with pillows and cushions.'

'discussed extent of RA (rheumatoid arthritis) - examined affected joints.'

'Contacted the hospital OT to discuss Mr. M's prognosis and his current treatment.'

Psychological/psychiatric knowledge - A respondent was recorded as utilising this knowledge if it was apparent that the client's mental state was a major consideration in the case management, or if the client's presenting problem was psychiatric rather than physical. For example :-

'Contact GP if, after discussion with other agencies, depression seems to be causative factor.' (Client had personality clashes at day centre and refused to attend.)

'.....I will in particular keep an eye on I.W.'s mental state for early signs of a possible relapse.' (A chronic schizophrenic who had discontinued medication.)

Assessment of the individual - A respondent was recorded as utilising her assessment skills each time a general or specific assessment was carried out, this might have been during an initial assessment visit or a subsequent check/follow-up visit.

Teaching techniques - A respondent was recorded as utilising her knowledge of the techniques of managing a disability when she taught specific methods or instructed clients and their families in the use of specialised equipment. This did not therefore include demonstrations in the use of less complex aids such as bath aids and pick-up sticks, nor did it include general advice on the management of a disability.

For an example of what was included:-

'I explained rocking and counting methods of initiating movement in early Parkinsons and Mr. and Mrs. W practised this.'

'I tried the client with taller sticks and showed her how to use two sticks properly as her four point gait was not good.'

'I showed his wife the easiest way to transfer with her husband.....and how to dress his lower limbs by 'bridging'.'

Making/designing aids - On occasions clients have a need for some equipment which has to be made especially to suit them, respondents therefore scored on this item if they were involved in such work, e.g:-

'.....I unpacked the basically made seat in untreated state (expanded foam seat for stairlift), cut off pieces that weren't needed with hacksaw blade and sanded down. Will cut and sand holes for straps and finish sanding the seat ready for dipping in fibre glass.'

'Meanwhile I was sticking leather shaver holder together. I will also make some form of pen holder.'

'Mr. F. (client's husband) agreed to manufacture aid as drawn by myself.'

Treatment/rehabilitation - Respondents were recorded as using their treatment or rehabilitation skills if they were working on a specific treatment programme with a client, e.g. :-

'Treatment was mainly setting up tasks, e.g. doing washing up etc....She also told me that she had succeeded that morning in making her bed.'
(Client had an aneurysm causing forgetfulness and lack of confidence.)

'I have been visiting N.P. regularly to teach him domestic skills following his parent's death.'
(Client had poor sight, was spastic and subnormal.)

Community occupational therapy

Eleven features were identified as demonstrating community occupational therapy skills.

1. Knowledge of equipment.
2. Knowledge of social services facilities.
3. Involvement of family in case management.
4. Discussion of finances/rights/grants.

5. Knowledge of local resources.
6. Assessment of lay support.
7. Knowledge of housing options.
8. Assessment for minor structural alterations.
9. Involvement with building plans/specifications.
10. Discussion concerning wheelchairs.
11. Discussion of emotional reactions.

Knowledge of equipment - Respondents were recorded as utilising such skills when they demonstrated knowledge of a wide range of aids and equipment; awareness of the possible disadvantages of certain aids; or a calculated decision to chose one type of aid from several apparently similar ones.

Knowledge of social services facilities - Respondents were recorded as utilising such skills when they considered other social services facilities that might have helped their client.

Involvement of family in case management - Respondents were recorded as demonstrating this feature of community occupational therapy when they particularly involved the client's family in their considerations and/or advised the family on the client's management. For example :-

'Advised husband against fatigue as the client is becoming more dependent on him....advised about Home Help service.'

'Met all the family.....discussed what their expectations of M.B.'s abilities are....what they wanted for her.' (Spina bifida child aged 12).

'To visit possibly fortnightly for a while to check on progress and what affects looking after her husband is having on Mrs.M.'

Discussion of finances/rights/grants - Respondents were recorded for this item when they discussed these issues with a client and/or when they gave relevant advice. If a handicapped client is referred to the social services department purely because they require advice concerning his/her statutory entitlements their queries may be dealt with by a social work assistant or they may be referred to their local DHSS office. However many respondents considered that it was part of their

role to ensure that the clients whom they visited were aware of all the help that they could obtain and therefore covered this subject in their general assessment, or if it should crop up in general conversation. Included within this item, though, were discussions relating to home improvement grants for adaptations which are more specific to the occupational therapist's work.

Knowledge of local resources - Recording of this item depended on the occupational therapist demonstrating her knowledge of local resources to help her client. For example :-

'...contacting a local care group re doing B.S.'s shopping for her.'

'...and discussed local hairdressers as Mrs.F. has recently had her long hair cut and permed as she could not manage to get it up.'

Assessment of lay support - Respondents were recorded as demonstrating this feature when they took note of the lay support available to clients, particularly in the case of elderly people living alone.

Knowledge of housing options - A record was made each time a respondent demonstrated a knowledge of the housing options available to a client and/or if the respondent was involved in helping the client to obtain suitable accommodation.

Assessment for minor structural alterations - This item differs from the assessment of the individual (see page 109). Respondents were recorded for this if they assessed the suitability of the house for fitting hand rails etc., or if the respondent took relevant measurements for rails or minor alterations.

Involvement in building plans/specifications - Respondents were recorded as utilising skills associated with this each time that they were involved in drawing up plans for a major adaptation and/or discussed plans and progress on work with architects/builders.

Discussion concerning wheelchairs - Although occupational therapists in

orthopaedic, general and geriatric hospitals may be concerned with the assessment of individuals for suitable wheelchairs, this item is included under 'community occupational therapy skills' because it is a recurrent feature of community work. Thus, a record was made every time a respondent was involved in assessing a client for a wheelchair or for some modification or a repair to a wheelchair.

Discussion of emotional reactions - The discussion of and the working through of emotional reactions in a client/patient is not exclusive to community occupational therapy, in particular such skills are used in the psychiatric field. However, in this context much of the discussion may take place with the client's family also, either separately or together with the client, and it is this aspect which is more specific to community occupational therapy. This is also an area of work in which it might be anticipated that there is an overlap with social work staff. Several texts (Stevenson and Parsloe 1978; Rowlings 1980; Borsay 1983) refer to the low level of interest that social workers have in the physically handicapped and this is further illustrated in the discussion concerning the respondents' experience of working in a social services department (see page 157). Rowlings (1980) also noted that some occupational therapists whom she interviewed displayed a much greater enthusiasm for dealing with a client's emotional difficulties than did some others. This is further illustrated in Section 3.5. where some of the respondents specifically considered that they should deal with the client's emotional reactions and some others specifically considered that they should not do 'counselling'. This term differs from 'involvement of family in case management' (see page 111) because it refers to occasions when time was taken specifically to talk through an emotional problem. For example :-

'She spoke for a long time about having to be dependent and losing her job etc. She mentioned difficulty with

her husband not understanding her condition...difficulty with son now at home...to visit again to meet son and explain problems as client feels unable to do this.

'General discussion of the family, attitudes of the husband, the regret of the wife about the mental handicap of her daughter, about her sadness at not being able to have a much longed for normal relationship with a teenage daughter.'

Discussion relating to 'pure occupational therapy' skills used by respondents

The bar charts in Figures 14 and 15 illustrate the proportion of visits undertaken in each area during which particular features of 'pure' and 'community' occupational therapy skills were demonstrated.

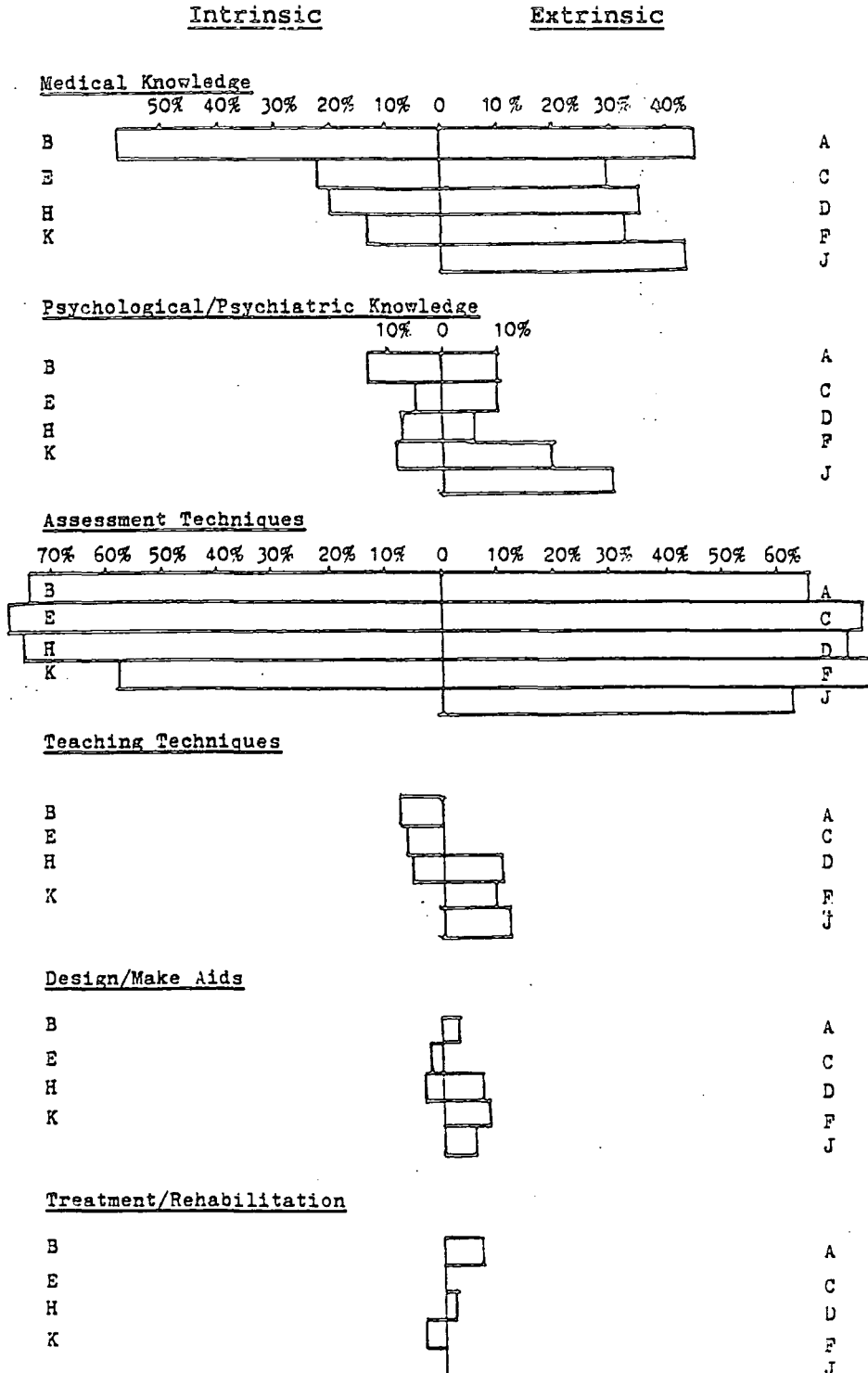
Figure 14 clearly shows that, in all areas, the most frequently used skills were those of assessment. Assessment skills were not only used on initial visits but on follow-up visits to assess the suitability of aids provided and during general support visits to ascertain the client's progress.

The second most frequently used skills were those of the application of medical knowledge. It was pointed out earlier that a trained occupational therapist undoubtedly draws on her medical knowledge at all times, but that certain respondents appeared to be required to use this knowledge more practically than others. This variation is borne out by the results shown in Figure 14 where there is a range from 13% of visits undertaken in area K to 57% of visits undertaken in area B demonstrating this feature. The greater use of medical knowledge was apparent in those areas where caseloads were smaller, where there was a higher incidence of more severely disabling conditions (eg neurological disorders) on the caseload and where the average amount of time spent on visits was longer.

The application of psychiatric/psychological knowledge also varied from area to area and was, to some degree, associated with a greater readiness on the part of the respondent to become involved in discuss-

ing the client's emotional reactions (see page 37) and with a greater supportive role.

Figure 14 : Proportion of visits demonstrating 'pure occupational therapy skills



The noticeable feature of Figure 14 is the minimal use that was

made of the other 'pure' occupational therapy skills. In only five of the 467 visits that were carried out was the occupational therapist involved in a treatment/rehabilitation programme. Increasingly there is discussion concerning the changing emphasis of health care from institutional care to primary care, and the increasing likelihood that some of the treatments carried out in hospital will be carried out in the community. The evidence from this study shows that, due to the volume of work, social services occupational therapists had little time to carry out treatment programmes unless they were specifically employed to do work with the mentally ill or the visually handicapped. However, many respondents commented that they would have liked to be able to spend more time on such activities. The teaching of specific techniques in order to cope more effectively with a disability was also rather limited as was the respondents' involvement in the design and making of aids. Once again there appears to be some relationship between the complexity and size of the caseload and the extent to which respondents undertook these aspects of work.

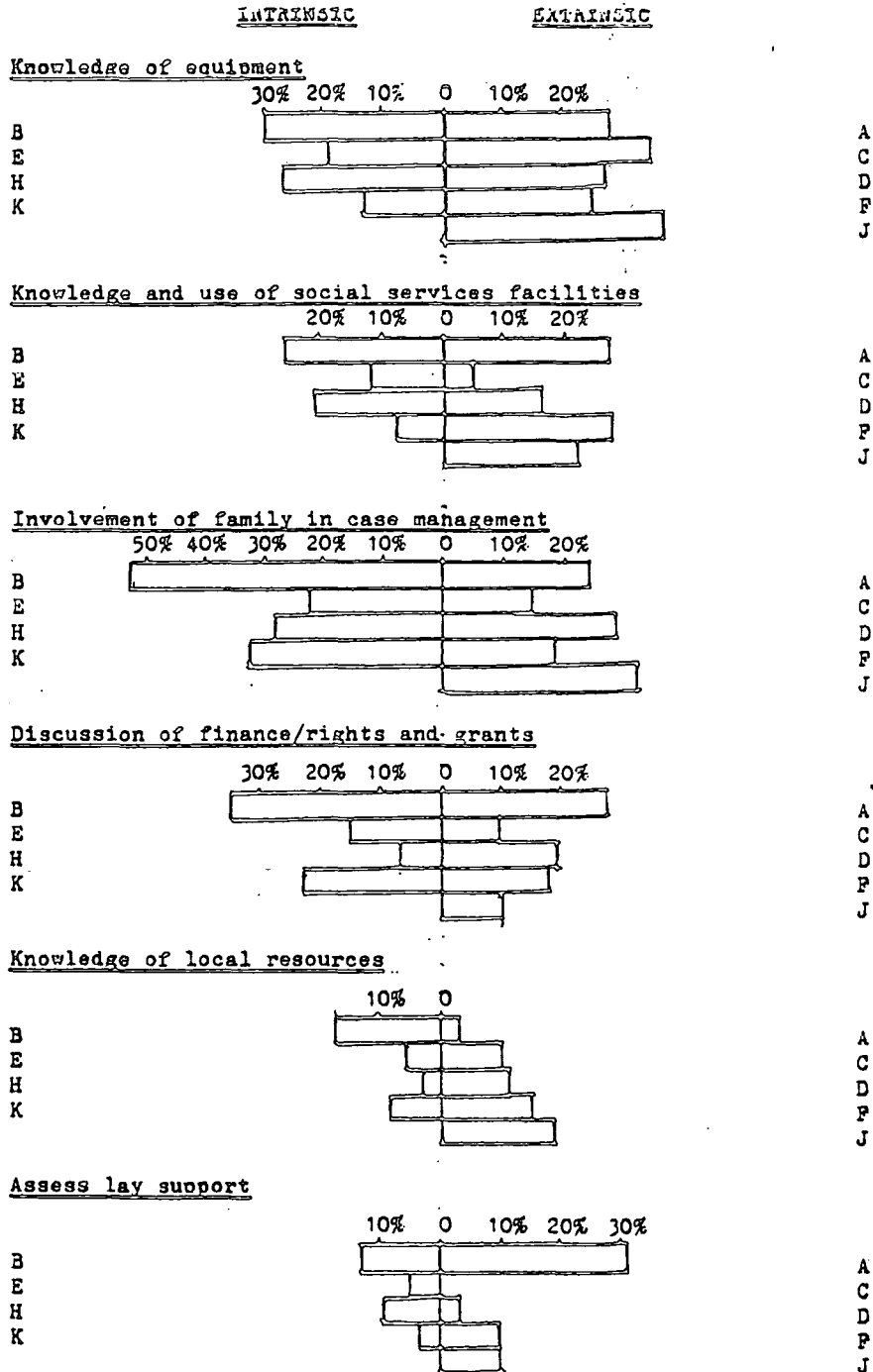
The issues concerning the degree to which the work of social services occupational therapists can be described as 'medical' or 'social' in nature were described in Chapter One (see page 21). It is clear that generalised statements cannot be made as there was considerable variation between the areas. However, it should be understood that the two categories - 'medical' and 'social' are not mutually exclusive and Figures 14 and 15 show that in most of the areas in which 'pure' occupational therapy skills were used, there was also shown a greater involvement in the wider needs of the clients.

Discussion relating to 'community occupational therapy' skills used by respondents

Figure 15 shows that the most frequently used 'community occupa-

tional therapy' skills were those associated with :- involvement of the family in case management; knowledge of equipment; and the assessment for minor structural alterations. Knowledge of social services facilities and discussions concerning finance, rights and

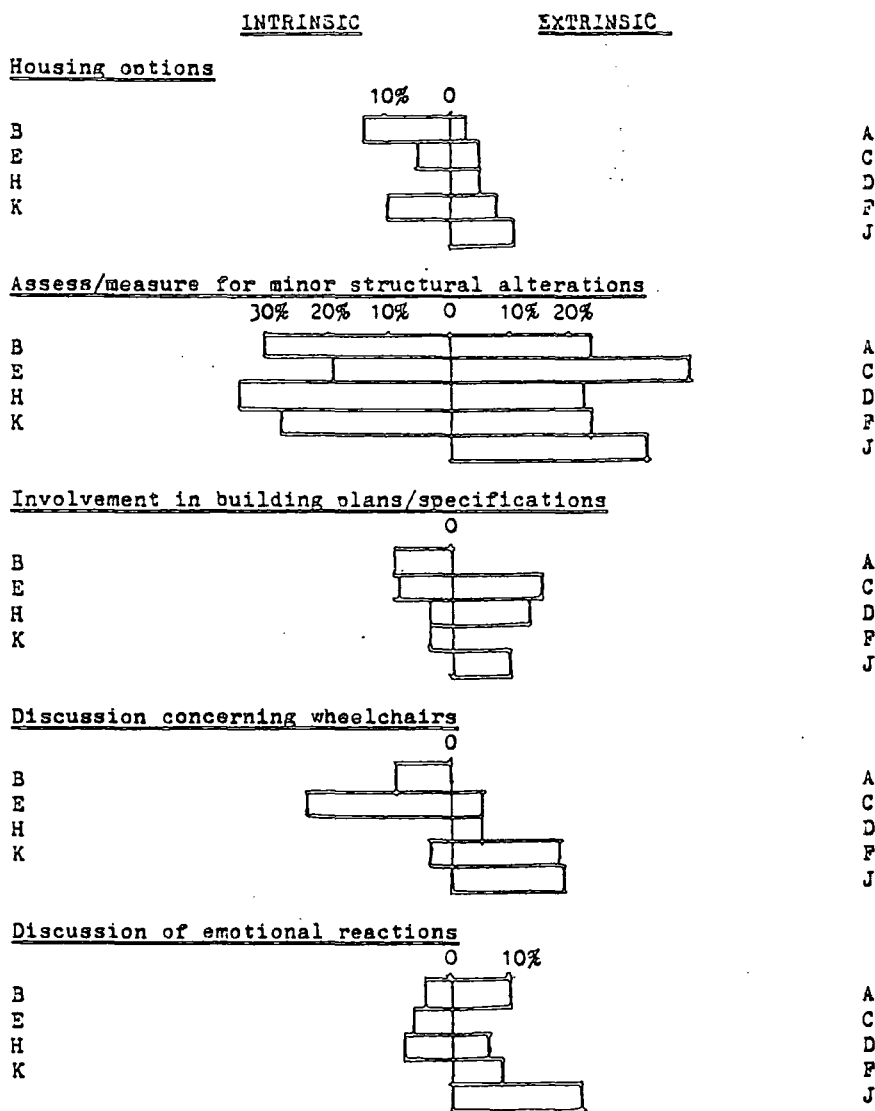
Figure 15 : Proportion of visits recorded in one week which demonstrated 'Community occupational therapy skills'



grants also featured quite frequently. However there was considerable variation between the areas for each feature.

The high incidence of work with families presents a fundamentally different perspective to the work of the hospital occupational therapist who may only rarely see relatives of the patient and, even then, have little time to build up a relationship with them.

Figure 15 cont. : Proportion of visits in one week which demonstrated 'Community occupational therapy' skills



Some of the variations between the areas may be explained by known facts. For example, the respondents in areas F and H had little invol-

vement in the process of major adaptations and therefore had little to do with builders plans and specifications. Also, areas such as E, D and J had a relatively high proportion of owner occupiers who would probably have preferred to adapt their own property rather than move, so these respondents had a greater involvement in major adaptations. There appeared to be a greater involvement in discussions concerning finance, rights and grants in the urban areas of B, K and A where financial hardship may have been greater. In some areas there was a relatively high incidence of work concerned with wheelchairs (particularly in area E), whilst in others this was not so, possibly due to other arrangements, eg wheelchair clinics at hospitals. The work in areas E, F and J, was mostly related to wheelchair-bound clients rather than to less severely handicapped people who may have required a chair to go out in - a situation which arises more often in the summer.

Thus it can be seen that the nature of the skills used in the areas did differ. Part of this difference would appear to be associated with the volume and type of problems presented to the respondents and part of it to geographical and organisational factors. The professional orientation of the respondents is also relevant as are the observations referred to in Chapter One (see page 30). Reference was made to Friedson (1971) who stated that the way in which people work ie their level of technical performance, approach to the client, 'cynicism' and ethicality is more a result of the setting in which they work than of what they have earlier internalised. Although the information in this study is based on only one week's work for each occupational therapist and is based on diaries rather than observation, it does give a strong indication of the extent to which the respondents were able to use their skills and of the requirements of the type of work that they were undertaking.

SUMMARY

The information in this section concerning the skills and resources used by the respondents adds qualitative meat to the factual bones of the previous section concerning the objectives and subject matter of the client visits. It is clear that there were differences between the areas, some of the differences appear to have been due to facts such as the volume of referrals, the problems presented and the demography of the area. However, there is also a rather indefinable factor connected with the approach of the occupational therapist to her work and her clients which may be related to her status within the department in which she works and the value that she perceives is attached to her contribution. These more subjective issues are discussed further in Chapter Four.

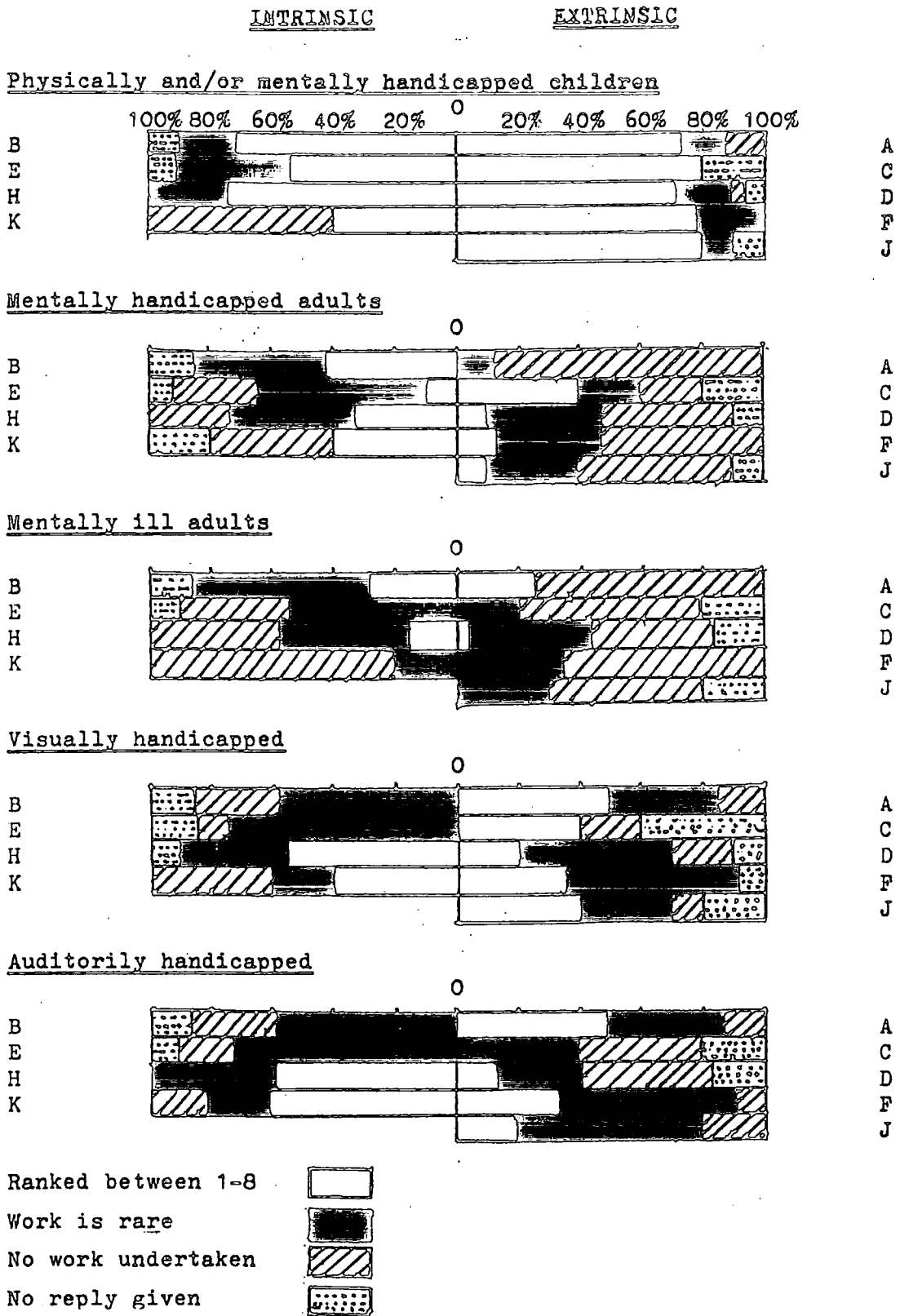
3.5. THE WIDER PROFESSIONAL FUNCTION OF SOCIAL SERVICES OCCUPATIONAL THERAPISTS AND THEIR LIAISON WITH OTHER PERSONNEL

The information in section 3.3 showed the type of referrals that the respondents received during a ten day period. To give a more comprehensive picture of the work the respondents undertook they were asked to rank different aspects of their work according to the frequency with which these were encountered.

Range of client groups with whom work was undertaken

In all areas, physically handicapped and the elderly predominated as the client groups with whom most work was undertaken. The bar charts in Figure 16 illustrate the extent to which other client groups were encountered. It is apparent that, apart from a few specific exceptions, the majority of the respondents had little opportunity to work with other client groups. This was particularly true of work with the mentally ill, a group with whom occupational therapists are trained to work to the same level as their work with the physically ill. Sixty five per cent of the respondents felt that they could have made a greater contribution to client groups other than the physically handicapped and elderly. They listed the mentally ill and handicapped; physically and/or mentally handicapped children; and work with specific groups such as hemiplegia, rheumatoid arthritis, and multiple sclerosis. There was a general impression that many of the respondents felt that they had a greater role to play with many client groups and that much of this was concerned with wider aspects of clients' needs such as social integration and support to families.

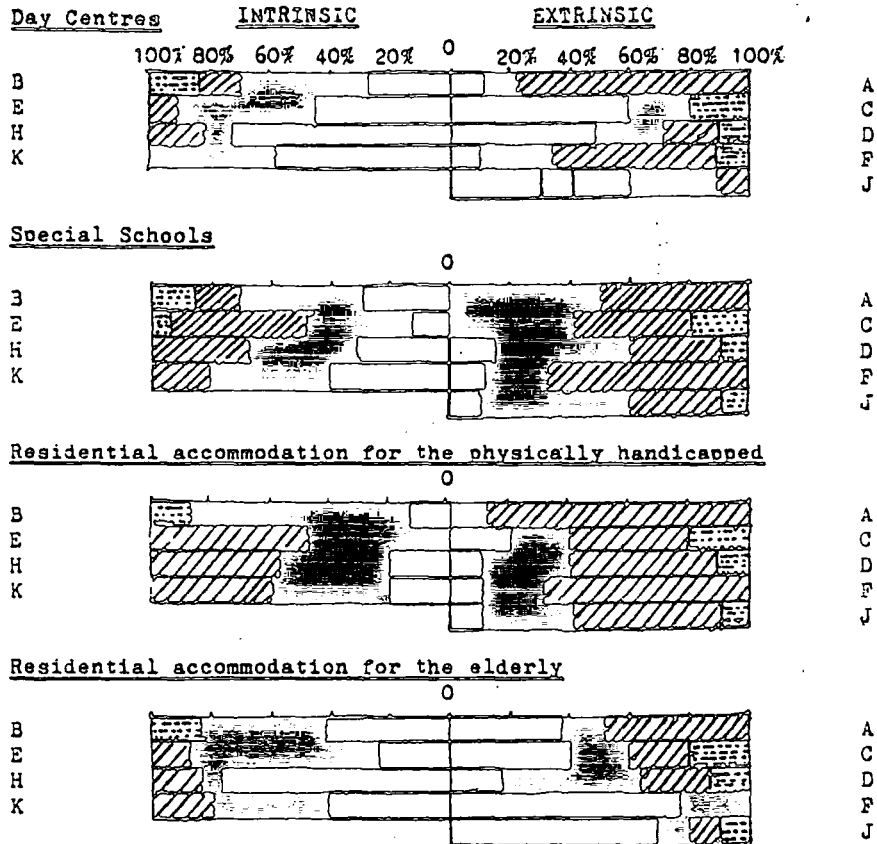
Figure 16 : Ranking of work with client groups other than the physically handicapped and elderly.



Range of work settings

The client's own home was ranked by all respondents as the most frequent setting for work. The preponderance of other work settings then varied as is shown in Figure 17.

Figure 17 : Ranking of work settings other than the clients' homes



Other settings suggested by respondents

Setting	Number of respondents in each area who suggested setting (not ranked).									
	A n/8	B n/7	C n/5	D n/22	E n/11	F n/9	H n/12	J n/10	K n/5	
Hospital		2		4	1	3	4	3	2	
Respondent's office	1	3	1	2	1					
Aids assessment centre				3	1		1	1		
Client's place of work						1	2			
Clubs/classes/playgroup	1				1	1	1	1		
Other			1	2						

N.B. Key as for Figure 16.

The work undertaken in day centres, special schools and residential accommodation is discussed in the next section. As far as other settings were concerned a number of respondents mentioned that they also undertook work with clients in other settings which had not been listed in the questionnaire (and which had not been highlighted by the pilot study) and these are included in a table at the foot of Figure 17. It can be seen that assessment of the client in hospital prior to discharge was mentioned by 21% (19) of the respondents. Other settings were not mentioned so frequently but include clients visiting the respondent's office (see page 91); visits to aids demonstration centres to assess the most suitable pieces of equipment for the client; visits to the client's place of work to advise on adaptations to the environment or equipment; and work with clients in clubs, classes or playgroups (see page 97).

Thus it can be seen that social services occupational therapists were involved in work with clients other than in their own homes and that this was mostly in residential accommodation for the elderly and in day centres. However, there was some variation between the areas and, on the whole, those respondents working in intrinsic areas appeared to have a wider involvement than those working in extrinsic areas.

Professional function vis-a-vis other personnel

One of the features of the work of the social services occupational therapist, which the hospital occupational therapist does not share to the same degree, is the very wide range of other personnel (be they from social services, other local government departments, health, community or lay backgrounds) with whom she works and liaises. The majority of contact that is made is related to individual cases, but a considerable amount of contact concerns wider issues.

To obtain a complete picture of the nature of the interaction with others the respondents were asked, in the questionnaire (Appendix I) to indicate whether or not the contact they had (face to face, by telephone or in writing) came into the following categories.

1. Contact concerning own clients - in which contact made by or to the respondent was concerned with the respondent's client.
2. Advisory - in which the respondent had an advisory function either of a general nature or concerning the other person's client.
3. Work on joint ventures - in which the respondent worked with the other person on special projects or working parties.
4. Training - in which the respondent helped in the training or staff development of another group.

Information was obtained regarding the type of contact in relation to 45 different categories of personnel, hence the results were rather lengthy to tabulate. However, the relevant tables are presented in Appendix III and reference is made to them in the following text.

The volume of data gathered concerning the respondents' professional function vis-a-vis other personnel was, therefore, considerable, and broadly divides into the type of contact made and the frequency with which contact was made. In the following pages the type and frequency of contact is described for each personnel group and related generally to the intrinsic and extrinsic groupings and specifically to the different areas.

Social work staff

In all areas virtually all the respondents stated that they had contact with social workers concerning some of their own clients, and slightly fewer (77% [27] of intrinsic and 85% [47] of extrinsic respondents) stated that they had an advisory function towards social workers. Smaller proportions of respondents worked on joint ventures with

social workers; however of the extrinsic group, most of whom worked in area offices, this represented 49% (27) whereas of the intrinsic group, most of whom worked in OT Enclaves (see page 56), this represented only 29% (10). Similar variations were apparent in the involvement in training where 40% (22) of the extrinsic group and 26% (9) of the intrinsic group had a contribution to the training of social work staff.

In terms of frequency of contact most of the respondents who were based in area offices spent between 20 and 30 minutes a week discussing cases with social workers in addition to any time spent with them in meetings (see page 86). The contact that the respondents based in OT enclaves had with social workers was dictated by the frequency with which the occupational therapists visited the area offices. There was little difference in the volume of telephone communications that the intrinsic and extrinsic groups had with social workers (intrinsic = 9% and extrinsic = 10% of all telephone calls). In both groups the respondents had more telephone contact with social workers than with any other group apart from the clients themselves.

The frequency with which respondents made contact with social workers as a result of a home visit varied from area to area with a range of 0 to 12% . The factor of whether or not respondents worked from an OT Enclave did not appear to affect the contact that they planned to make with social workers concerning a client, however a slightly higher proportion of the respondents in intrinsic areas planned to make contact than did those in extrinsic areas.

Intrinsic occupational therapists had a slightly higher level of contact with social work assistants concerning individual cases than the extrinsic occupational therapists did although, once again, those in the extrinsic areas were more likely to be involved in joint ventures or in the training of social work assistants and had more frequent

informal contact in the office.

In relation to principal social workers, the respondents who were based in area offices (predominantly extrinsic areas) tended to have more contact over individual cases whereas respondents in intrinsic areas more frequently had an advisory function or worked on joint ventures with them.

Home help staff

Most of the respondents stated that they had contact with home help organisers at some time concerning their own clients. The extrinsic group had a greater input of an advisory nature, on joint ventures and through being involved in training programmes for home help staff than did the intrinsic group.

Only five per cent of first visits (contact with other personnel more often occurred as a result of the first assessment visit) by both intrinsic and extrinsic respondents required the occupational therapist to make contact with the home help organiser, and very little telephone communication was made despite the fact that home helps work so much with the physically handicapped and elderly. Respondents who were based in area offices had more contact than those based in OT enclaves, but these were mostly brief discussions of a few minutes duration (see page 90, Table 23). In the course of their home visits social services occupational therapists often meet home helps in the client's home, such interaction was not specifically recorded in this study.

Specialist officers for the sensually impaired

The extent to which local authority social services departments employ specialist officers for the blind (e.g. mobility officers, home teachers) and the deaf (e.g. hearing therapist, social worker for the deaf) varies greatly from area to area. In one of the selected author-

ities specialist officers for the visually and auditorily handicapped worked from the same base as the occupational therapists and consequently there was considerable interaction and involvement in training, however they did not work together on many joint ventures. In another area an occupational therapist specialised in working with the visually handicapped and consequently worked very closely with the mobility officer on individual cases and joint ventures. Otherwise most of the respondents had some contact with these officers, usually when referring one of their own clients, but this only occurred as a result of about two per cent of first visits.

Primary Care Teams

In six of the areas a proportion of the respondents had regular contact with the primary care teams through meetings (see page 88 Table 19) or by calling in at the health centre (see page 97). Nearly all the respondents stated that they had contact with district nurses (DNs), general practitioners (GPs) and health visitors (HVs) concerning individual clients and between a half and two thirds had an advisory function towards these staff. The respondents were more likely to be involved on joint ventures with DN's and HV's than with GPs and were more involved with the training of DN's than of other members of the primary care team.

The extent to which social services occupational therapists work under medical direction and the issues surrounding this have been discussed elsewhere (see page 26). In order to ensure that the client's GP is aware of any services that the occupational therapist may provide (regardless of whether or not the GP regularly sees the client) many authorities operate a system whereby a standard letter is sent to the GP of every client visited. Normally the letter tends to put the onus on to the GP to inform the department if he knows of any medical reason

why certain equipment or services should not be provided. The client visit records show that, in addition to any standard procedures that may have operated, in 18% of the extrinsic respondents' first visits and in 16% of the intrinsic respondents' first visits the occupational therapist planned to contact the GP. A considerable proportion of this contact was to obtain the GP's consent to the provision of a wheelchair.

The intrinsic occupational therapists had more telephone contact with DNs than did the extrinsic occupational therapists and also had more liaison resulting from visits. The intrinsic group also had more contact with community physiotherapists than did the extrinsic group, although this did vary from area to area probably in accordance with the incidence of the employment of community physiotherapists.

Day Centre and Residential Establishment Staff

The information in Appendix III, Tables 3.1-3.5 reinforces the findings that respondents in intrinsic areas participated more actively in these settings, although respondents in the extrinsic areas had a greater input in the training of residential care staff.

Between five per cent and seven per cent of first client visits resulted in contact being made with day centres whilst only up to two per cent resulted in contact being made with Part III establishments (social services residential homes for the elderly). The respondents were, therefore, more involved in referring clients to day centres than to Part III where they were more likely to carry out assessments on residents or to advise on provision. Work undertaken by the respondents in day centres included interviewing clients at the centre; taking them to visit to determine whether or not they should attend; carrying out specific assessments using equipment at the centre; or in at least three cases taking a group or class.

Staff in Special Schools and Playgroups

Most of the contact with staff in special schools and playgroups was concerned with individual children but, overall, about one quarter of the respondents had an advisory function. The work would mostly have been concerned with carrying out assessments and designing special equipment. Apart from one or two respondents who specialised in working with children the majority of respondents had fairly infrequent contact and two per cent of first visits to clients resulted in contact being made with schools. This was of course affected by the proportion of handicapped children who were initially referred to the occupational therapists.

Contact with playgroup organisers (either of ordinary playgroups or specialist groups for handicapped children) was even more rare and non-existent in three areas. However, in four areas, a single respondent had regular contact and many more wished to do so.

Community workers

There was greater involvement with community workers in urban areas than in rural areas and nearly a fifth of all respondents were involved in joint ventures with them. In general, respondents in intrinsic areas had more contact with community workers than did those in the extrinsic areas. Such projects as the construction of 'access guides' for the disabled or events for the International Year for Disabled People were typical of the type of joint venture undertaken.

Hospital Staff

The volume and type of contact that social services occupational therapists have with hospitals in general and their hospital occupational therapy colleagues in particular is a source of some interest and conjecture (Scrivens 1980). It has already been noted that in most

areas some of the respondents had regular meetings with hospital colleagues or called in regularly (see page 97). The information from the questionnaires shows that virtually all the respondents had contact with hospital occupational therapists concerning their own cases and over half had an advisory function concerning the hospital occupational therapists' cases (Appendix III Table 3.2). There was little difference in the amount and type of contact with hospital occupational therapists between the extrinsic and intrinsic groups and there was no difference as far as work on joint ventures was concerned. The respondents were more likely to be involved in joint ventures with their hospital colleagues than with any other group apart from social workers and architects.

Telephone liaison with hospital occupational therapists was also comparatively high (six per cent of all calls in both intrinsic and extrinsic areas) and liaison resulting from first visits to clients occurred in eight per cent of intrinsic cases and seven per cent of extrinsic cases.

There was little difference between the extrinsic and intrinsic groups as far as their contact with other hospital staff was concerned, the only noticeable feature being that intrinsic respondents had a greater advisory function to hospital consultants than did respondents in the extrinsic areas.

Architectural staff

It has already been noted (see page 106) that the amount of contact that the respondents had with architectural staff varied considerably from area to area depending on the arrangements that existed for dealing with adaptations and the housing provision in the area. However, only nine per cent (5) of the extrinsic group and 17% (6) of the intrinsic group stated that they had no contact with architects.

In general, the extrinsic group seemed to have more contact with architects and a greater involvement on joint ventures (e.g. design of new build housing and community facilities). As far as consultation with architects concerning the design of major adaptations were concerned, the information from the client visit records shows that five per cent of first visits by extrinsic respondents would have resulted in contact being made with architects whilst none of the visits of the intrinsic respondents during the week studied would have done so.

Housing department staff

Social services occupational therapists have always had close links with council housing departments primarily because contact must be made when adaptations to council housing are required and because of applications for transfers to more suitable housing. Increasingly occupational therapists have become involved in assessing the suitability of properties offered to disabled people and in the planning of future provision of specially designed housing (British Journal of Occupational Therapy 1981). The occupational therapist's role in relation to housing departments has developed to the extent that in one authority at least (Potton 1982) an occupational therapist has been permanently seconded from the social services department to the housing department.

In this study only two per cent (1) of the respondents in extrinsic areas and six per cent (2) of the respondents in intrinsic areas had no contact with the housing department (these were staff who worked between six and 12 hours a week). In addition, 18% of extrinsic first visits and nine per cent of intrinsic first visits resulted in contact being made with the housing department.

Most of the contact was concerned with the needs of individual clients, but there was also a high level of contact regarding an advis-

ory function. Respondents in intrinsic areas provided more advice to senior housing officers whilst those in extrinsic areas provided more advice to staff members. However, extrinsic respondents indicated a greater involvement in joint ventures with senior housing officers and equal proportions of respondents in both groups worked on joint ventures with housing staff.

Improvement grant officers/Environmental health staff

The introduction of the Improvement grant procedure in 1974 (HMSO 1974) with the special provision that the grant procedure could be used to enable a disabled person to have access to certain necessary facilities in the house (HMSO 1978b) opened up a new area of work for social services occupational therapists. Occupational therapists were soon recognised as being the professionals who had the expertise to advise the improvement grants officers on the suitability of an applicant and then to advise on the house alterations that would be required to meet the needs.

Most of the respondents in this study had contact with improvement grant officers, who are usually based in environmental health departments but may also be based in housing or architects' departments. In general, the respondents in extrinsic areas were more likely to have contact than respondents in intrinsic areas in all aspects of contact apart from advice to senior environmental health officers. For the extrinsic respondents eight per cent of first visits resulted in contact with improvement grant officers and five per cent of telephone liaison was with them, whereas for the intrinsic respondents six per cent of first visits resulted in such contact and only one per cent of telephone contact was with them.

Technical officers; Builders; Works department staff

Minor alterations (or adaptations) to council housing are

frequently carried out by employees of the local authority works departments, whereas minor alterations to private property are carried out either by technical officers employed by social services or by private contractors. Technical officers not only do minor alterations but can make custom-built aids designed by the occupational therapist to meet a 'one-off' need. Where technical officers are not employed, social services occupational therapists are sometimes helped by technicians working in hospital occupational therapy departments to make 'one-off' aids.

The information from the client visit records suggested that 26% of first visits carried out by intrinsic respondents and 14% of first visits carried out by extrinsic respondents resulted in contact being made with the technician or private contractor; 89% (31) of intrinsic respondents and 62% (34) of extrinsic respondents had technical officers working for them (see page 174) and intrinsic respondents may have been more ready to prescribe alterations for the fabrication of aids. Also, in those areas without technical officers the occupational therapist would often either supply grab rails for the family to arrange the fitting, or would ask the family to get in touch with a carpenter who would do the work.

A study of the work undertaken by occupational therapy technicians in social services departments by Underhill (1982) found that only 50% of the technicians who worked in social services departments produced aids. In 24 out of the 31 authorities studied the technicians were used to fit manufactured aids.

Other local authority departments (Planning, Education, Recreation, Research and Development, Training)

The extent to which the respondents had contact with staff in other local authority departments varied from area to area and between

the extrinsic and intrinsic groups. At the client level contact with planning officers would have been concerned with discussions relating to planning consent on adaptation works, and with recreation officers on the involvement of disabled clients in recreational activities. At an advisory level the respondents would have been concerned with the planning of community facilities, facilities in schools for handicapped children and adaptations to sports and leisure facilities to enable disabled people to participate. Fewer respondents were involved in joint ventures with staff from these departments than was the case with staff in departments mentioned earlier, however 18% (10) of the extrinsic group worked on joint ventures with planning staff. Telephone contact with staff in these departments was minimal during the week of the study as was contact arising from visits to clients.

Local authority councillors and chairmen

One of the aspects of working for a local authority for which most occupational therapists may be unprepared, and which was identified as a source of conflict for some of the respondents (see page 153), is the political influence on their work. The difficulties of providing a consistent service when policies change is discussed in Section 5.2. but the actual contact that the main grade fieldwork occupational therapists had with councillors varied considerably. There was little contact with council committee chairmen, but well over half of the respondents had contact with councillors. The contact was mostly concerned with the needs of individual clients/constituents but in certain areas, particularly one intrinsic one, there was a relatively high incidence of an advisory function.

Voluntary organisations

Reference has already been made to some of the contact that the

respondents had with voluntary organisations in the discussion concerning attendance at meetings (see page 87). Social services occupational therapists do have quite strong links with these groups. Most respondents had contact concerning individual clients, nearly half had an advisory function towards them and several respondents were involved in joint ventures and staff training, the latter two functions were more prevalent within the extrinsic group. Contact was made with them arising from client visits and two per cent of all telephone contact was with members of voluntary groups (this did not include the Red Cross which, in one area, had responsibility for issuing aids).

Other contacts

Visits to clients not only resulted in contact being made with local authority and health personnel, but also with equipment manufacturers and suppliers, aids demonstration centres, housing associations client's employers and the Disabled Resettlement Officer (DRO), the DHSS and, in quite high proportions (five per cent of all first visits) to the Artificial Limb and Appliance Centres (ALACS) for the provision of wheelchairs; and many more.

Implications of such far reaching contacts

Social services occupational therapists do therefore come into contact with an extraordinarily wide range of people whilst working on the behalf of their clients or in helping to plan and provide for wider needs. The skills required in dealing effectively with so many people should not be underestimated. To be effective the occupational therapist must :-

1. know about all the available resources;
2. be able to represent her client's needs in a way that will be understood;
3. demonstrate her competence to do the above so that agencies will know when to refer to her when her expertise is required on individual cases or wider projects.

Whilst a great deal of the occupational therapist's expertise in drawing on resources will depend on her knowledge of local facilities, systems and methods, which therefore have to be learnt 'on the job', this does not preclude the fact that she can be trained to know where and how to discover them and in how to approach and use them. The emphasis on 'teamwork' in the occupational therapy training syllabus and on the importance of realising the parameters and extent of her own and other people's skills probably help occupational therapists in this process of liaison.

SUMMARY

The information in this section concerning the wider professional function of social services occupational therapists has shown that many of the respondents in this study had spread their professional wings and moved away from the limiting confines of the aids and adaptations nest. However, such initiatives, whether they were with the mentally ill, within Part III accommodation, in playgroups, carrying out rehabilitation programmes or advising on access to public buildings, occupied a relatively small proportion of the occupational therapists' total working hours.

The amount of involvement in other activities and in the nature of the respondents' contact with other personnel did vary from area to area and between the intrinsic and extrinsic groups. The great majority of respondents would have liked to have developed their work with other client groups and to have given more time to many aspects of their work. In particular they demonstrated a need to utilise their professional skills and knowledge more fully and to be more involved in the wider needs of the client, the family and in community provision.

CHAPTER FOURORGANISATIONAL DEPLOYMENT AND THE EXPERIENCE OF WORKING IN A SOCIAL SERVICES DEPARTMENT

This chapter is concerned with the occupational therapists' experience of working in their particular setting, the pressures that they perceived were upon them and the aspects of their work that gave them the greatest and least satisfaction. The differing methods of organisational deployment were described p. 56 .

The line management responsibility was fairly clear cut for the respondents in the intrinsic areas, particularly as the majority of them were based in OT enclaves (p. 56) . In two of these intrinsic areas, the principal occupational therapist was located at the same base whilst in the other two the principal occupational therapist was geographically distant at County Hall. The line management responsibility was less clear-cut for the respondents in the extrinsic areas, where a variety of management models existed - 'attachment', and dual responsibility and secondment arrangements (see p. 28). The arrangements for managerial and professional responsibility of the respondents varied greatly from area to area and render it difficult to make comparisons between the areas.

4.1. OPINIONS ON MANAGEMENT STRUCTURE

In the questionnaire (Appendix I, Qs 2b,3c,4) the respondents were asked certain questions which brought to light their opinions concerning the appropriateness of their base and the degree of contact they had with other social services occupational therapists and their attitudes towards the type of supervision they received. These issues are all related to the type of organisational deployment that applied

to each respondent. Their comments are discussed generally under the following headings.

1. Operational base.
2. Supervision.

Operational base

The respondents were not specifically asked to comment on their operational base and the degree to which they felt that it was appropriate. However, certain attitudes were expressed in the discussion concerning the amount of contact that they had with other occupational therapists and in their replies when they were asked to comment on their role within social services departments.

Contact with other occupational therapists. The respondents were asked how frequently they had contact with other occupational therapists. Their answers depended on whether or not there were other occupational therapists based at the same office and whether the respondents worked full or part time, their replies are shown in Table 28.

Table 28 : Frequency of contact with other occupational therapists

Frequency of contact	Intrinsic n=35	Extrinsic n=55
Daily	31%	36%
2/3 per wk	20%	18%
1 per wk	26%	9%
Fortnightly	3%	2%
1 per mth	11%	27%
Less than 1 per mth	9%	7%

Almost equal proportions of intrinsic and extrinsic respondents had contact daily or two or three times a week (51% and 54%). However, less frequently than this there were noticeable differences between the two groups. Only 9% (5) of extrinsic respondents had contact once a week compared with 26% (9) of intrinsic respondents, and 27% (15) of

the extrinsic group had contact once a month only compared with 11% (4) of the intrinsic group.

Some of the issues surrounding the possible professional isolation of lone members of one discipline being located with large numbers from another discipline were discussed in Chapter One (page 27). The respondents were asked whether or not they felt that they would have benefitted from more frequent contact with other occupational therapists. Interestingly, over half of those respondents who already had daily contact and nearly half of those who had contact two or three times a week felt that they would have benefitted from more contact, whilst over a third of those who only had contact once a month did not feel the need for more frequent contact.

The need for professional contact would appear to be a personal matter. It is possible that those respondents who already had frequent contact derived great benefit from it, and could see even greater benefit from further contact, and that those who had less contact either did not realise what benefit could be derived or preferred to work in their own fashion and by their own wits.

Several respondents made the comment that, although they worked from the same office as other occupational therapists and exchanged greetings, they had little time to discuss cases and exchange ideas and it was for this reason that they wished for more contact. The comments they made reflected the need to discuss cases with other occupational therapists.

'Keep a wider and more objective outlook - one learns from others` techniques and knowledge. Second opinions are very valuable, even for minor aids.'

'Because one tends to be fairly isolated when actually visiting clients it helps to have the opportunity to discuss methods of work and share anxieties about difficult decisions. It can be too easy to concentrate on problems rather than

achievements if you're not careful.'

In fact 56% (50) of the respondents gave reasons related to the need to discuss cases and exchange information whilst only 12% (11) said that they felt isolated.

One respondent who had contact with other occupational therapists two or three times a week, and who did not feel the need for more contact, commented on the relative merits of an OT enclave, which can become isolated from the rest of social services, and the non-enclave where occupational therapists are based in social work teams.

'The advantages of a group service (such as shared knowledge etc.) are outweighed by not working directly with social workers and others who are also involved with a particular client; and by not being available for casual consultation (both ways) which would reduce the effectiveness of the service to the client and the standing of community OT because of lack of communication.'
(Area D)

The extent to which the respondents who were based in area offices did have informal contact with their fellow workers (social workers, social work assistants and home helps) has been discussed in Chapter Three (page 126).

In general there appeared to be a need to have some regular opportunity to discuss professional matters with other occupational therapists. This does not mean, therefore, that all those respondents who wished for more contact favoured an OT enclave arrangement but that, whatever their operational base, a regular and fairly frequent opportunity to exchange information would have been considered valuable.

Advantages/disadvantages of being based in an area office. Being the only occupational therapist amongst a large group of social workers seemed to affect the respondents in one of two ways. Some seemed to feel overwhelmed and to feel the need to preserve their professional and medical identity. The comments presented below also reflect the

'medical' or 'social work' orientation of the respondents (see page).

'Only OT in department of 30 SWs. Different philosophy preached by SWs than by OTs - this is difficult to work alongside.' (Area E)

'Need to maintain separate identity - overshadowed by masses of SWs.' (Area A)

'Constant need to preserve health links to keep professional identity.' (Area F)

Whilst others regarded this as a challenge or perceived benefits to the client.

'Only one who knows about physically handicapped. Key worker to whom others flock for advice. Only team in area with an OT so feel my team has to give better service. I like these pressures, make me work better, more efficiently.' (Area F)

'Working closely with multi-disciplinary team in which colleagues are not all clinically biased goes a long way towards making realistic and balanced decisions.' (Area F)

'Working in SW team gives broad spectrum of other skills to draw on.' (Area J)

Advantages and disadvantages of OT enclave. Only one respondent specifically emphasised the importance to her of the OT enclave as a base.

'Maintain professional identity - stay as a group, not split into area offices.' (Area B)

Whereas several comments were made by the respondents reflecting some dissatisfaction in an area where the respondents were based in groups geographically distant from their principal occupational therapist.

'OT role would be better understood if our base was within an SW office.' (Area H)

'Poor management; would prefer to be linked direct to district SW office.' (Area H)

'Frustration at the comparative isolation of the OT from easy access to information on clients.'

'Difficult not having an area that matches either health or SSD.'

Thus a range of views was expressed by the respondents. The general impression gained is that clients would be best served if the occupational therapists were based in area offices so that a wide range of skills could be drawn on and the occupational therapist could also be consulted easily by others. However, there should be more than one occupational therapist in the office and they should have regular opportunities to discuss cases with each other and their colleagues from other area offices.

Supervision

Some of the respondents' comments concerning the need to discuss cases and exchange information with a fellow professional are pertinent to the subject of supervision. In Chapter One there was a certain amount of discussion concerning the management of professionals by people from outside their profession (see page 27). It was observed that the more developed an occupational or professional group becomes, the more difficult it is for a non-member, however generally capable, to perform these managerial functions adequately (Rowbottom et al 1974). Borsay (1983) observed the discomfort experienced by some senior social workers who had to fulfil a professional management function of occupational therapists.

The respondents in this study were asked to state whether the type of supervision that they received came into one of the following categories.

1. Formal - i.e. at a regular set time.
2. Informal - i.e. as and when required.
3. Formal and informal - i.e. a combination of the above two.
4. Any other system.

The information in Table 29 illustrates the type of supervision received and in Table 30 the main content of the supervision.

Table 29 : Type of supervision received

Type of supervision	Intrinsic	Extrinsic
Formal only	-	7%
Informal only	69%	53%
Form. & inform.	26%	31%
Other	-	2%
Not supervised	-	7%
No answer	6%	- -

There was a slightly higher level of formal supervision within the extrinsic group which was possibly a result of the more well-established methods of supervision employed by social workers (Rowbottom et al 1974; Stevenson and Parsloe 1978).

The comments that the respondents made on the type of supervision that they received suggest that to describe the 'informal' methods as 'supervision' is erroneous. The informal methods really represented advice and guidance given in a non-cumulative, ad hoc fashion. The following comments are representative of many who had 'informal' supervision.

'Not supervised at area office level but over telephone or on joint visit with the senior OT from central office.' (Area D)

'Main 'supervision' is when a large adaptation is required and joint visits are necessary.' (Area E)

In the study of social work teams Stevenson (1978) discusses the terminology relating to 'supervision', 'formal' and 'informal'. She points out that in social work parlance the word 'supervision' has a different meaning to the everyday usage which is usually concerned with surveillance and over-seeing.

'When social workers use the term supervision they are referring to a process of consultation about cases and methods of work....It almost always does imply....a process which provides support, advice to be considered but not necessarily acted upon, and further professional development.' (ibid).

Stevenson also differentiates between 'formal' and 'informal' super-

vision.

'Formal supervision referred to meetings arranged in advance for the purpose of looking at some aspect of the social workers's work..... Informal supervision was used to describe more spontaneous meetings.'
(ibid)

In their comments some of the respondents described the different supervisory arrangements that they had with their senior social worker and their senior occupational therapist.

'Formal every 3 weeks with Head OT, informal with senior SW as and when needed.' (Area A)

'Formal session once a month with senior OT. Informal and formal session once a month with team leader - SW.' (Area J)

Table 30 shows that for most of the respondents the content of their supervision could be described under the headings :-

1. Handling clients.
2. Departmental procedures.
3. Exchange of information.

There was little difference between the intrinsic and extrinsic groups as far as 'handling clients' and 'exchange of information' were concerned, but it is noticeable that a larger proportion of intrinsic respondents (86% - 30) received supervision concerning departmental procedures than did the extrinsic group (67% - 37). This may imply a greater consistency of service provision within the intrinsic areas.

Table 30 : Content of supervision

Content of supervision	Intrinsic	Extrinsic
Handling clients*	51%	49%
Dept. procedures	86%	67%
Exch. informat.	69%	65%
Other	14%	13%

* i.e. Management of clients' problems.

Ibbotson (1983) discusses the desirability of the application of

the social work mode of supervision to fieldwork occupational therapists by their senior/principal occupational therapists. She discusses the initial apprehensions that there may be, but emphasises the importance of setting a regular, inviolate time aside to provide support to the individual who works alone in clients' homes; to help in her professional development; to ensure consistency of service and to monitor standards of work.

Several of the issues that Ibbotson raises are illustrated by the respondents replies when they were asked - 'What type of supervision (if any) is, or would be, most useful to you?'. The replies also reflected the differing needs of individuals and groups. The situation of several intrinsic occupational therapists who, theoretically, had access to guidance and supervision from fellow professionals illustrates the point that, unless supervision was formal with time regularly set aside for it, the respondents often had great difficulty contacting their senior occupational therapists and also felt that they were being intrusive.

'Formal time (for supervision) is important so as not to feel you are interrupting the senior, and so that special cases are given the correct time they need.' (Area B)

'It would be more helpful if the Head OT was available for advice if needed by having a regular timetable. It is an awful waste of time to have to ring up all round the county sometimes and frequently to no avail. A set time in a set place each week would be a great help.' (Area H)

A large proportion of respondents in both intrinsic and extrinsic areas expressed a desire for regular contact with a more senior or more experienced social services occupational therapist. This was, perhaps, more noticeable amongst those respondents who were geographically distant from their seniors.

'Would like the supervision of a senior OT based at the area office where I work.' (Area D)

'Would appreciate supervision from a fellow professional who could comment and advise on the unique problems and aspects of working with the disabled. This person would probably be an OT.' (Area F)

Six respondents stated that their present system was satisfactory, they came from areas which represented the attachment model. In addition, several respondents who received regular supervision from a social worker pointed out the values of this.

'My supervision is ideal. It gives me the opportunity to review my work with someone who is not directly involved, who asks relevant questions and yet respects my specialised knowledge.' (Area D)

'I have found 'supervision' from social work team leaders quite helpful if they are well-informed and question what you are doing. It's useful sometimes to have a non-OT looking at problems from a different viewpoint.' (Area J)

The extent to which supervision by social workers was found helpful appeared to depend on the interest of the social workers and the extent to which they were informed about the training and potential role of occupational therapists in the community.

'.....I would also appreciate more of an interest in my work from senior SWs who leave me to carry on as I wish.' (Area D)

Another, more narrow, view was expressed by one respondent

'No-one in my office knows more about OT than I do and therefore supervision would not help.' (Area D)

These comments illustrate much of the discussion in Chapter One concerning the ability of a non-member of a particular profession to direct the work of a member of that profession. The foregoing discussion seems to suggest that where an occupational therapist has easy and regular access to a member of her own profession for certain advice then advice from a well-informed non-member concerning other wider issues is also acceptable.

4.2. SOURCES OF GREATEST AND LEAST SATISFACTION IN WORK

In order to obtain a wider view of the respondents' experience of working within a social services department they were asked to describe the aspects of their work that caused them the greatest and least amount of satisfaction.

Sources of greatest satisfaction

The replies that the respondents gave to this question were diverse and individual, however, they can be broadly divided into, and discussed within, the following groupings.

1. Enabling - i.e. being the agent who brings about an improvement in the client's situation. Described by one respondent as 'The Magic Wand Syndrome.'
2. Client contact/work with families - working with people in their own homes/ being a long term link; providing support; counselling.
3. Unique skills - respondent's skills seen to be unique and valuable - leading to rewarding professional relationships; team-work; liaison; proselytising.
4. Successful outcome to challenging and complex work - e.g. dealing with major adaptations, problems requiring research.
5. Control of own skills in response to changing demands - i.e. autonomy; flexibility; responsibility; variety; self-development.
6. Other individual sources of satisfaction - e.g. preventative work/ early intervention; paperwork; work with terminally ill; social rehabilitation of clients; advising on benefits.

The proportions of respondents who gave these types of reply are shown in Table 31.

Table 31 : Sources of greatest satisfaction in respondents' work

Source of satisfaction	Intrinsic	Extrinsic
Enabling	77%	82%
Client contact/ work + families	54%	56%
Unique skills	20%	27%
Success.outcome	17%	33%
Control skills	20%	38%
Other	17%	20%
		24%

Table 31 shows that the greatest source of satisfaction was in being able to bring about an improvement in the circumstances of the people whom they visited.

'To make someone totally independent when they have been helpless because of quite minor snags.'

'Being able either by skill or resources to bring about some improvement particularly in desperate situations (the magic wand syndrome!) (sic).'

This might also refer to bringing about changes of a more far-reaching nature, such as alterations to public buildings or advising policy makers.

'Affecting policies and attitudes towards the handicapped. I am able to influence housing, local amenities, quality of life far more than from a hospital department.'

These comments give a very direct illustration of job satisfaction, that is, because the respondents could see that, as a result of their intervention, a visible improvement had occurred.

The source of satisfaction derived from client and family contact was the opportunity that community work can give to building up relationships with disabled people and their families over a period of time and the fact that working with people in their own homes is more realistic than hospital work. The following comments illustrate the respondents' feelings on these subjects.

'Meeting clients in their own homes makes the work of assessing so much more realistic than in the rarefied atmosphere of a hospital.'

'Getting a rapport with a client so that I feel they will call me if they need to.'

'Continued contact and preventing situations deteriorating.'

'Working with families where one adult has a long term insidious handicap and being able to advise on all aspects of maintaining independence and helping the whole family to accept the condition and live as normal and full a life as possible.'

The third category in Table 31 'Unique skills' is an amalgam of

varied comments which really seemed to be saying 'I get great satisfaction from being recognised as a specialist who has a unique contribution to make.' Included in this category are many comments that were made concerning the pleasure that the respondents derived from acting as a consultant to other local authority departments, from being an essential member of a multi-disciplinary community-based team and from proselytising the value and benefit of occupational therapy. The following comments are typical of many that were made from particular areas.

'Being able to work as part of a community service, particularly with social work and housing departments. (Hospital work is too isolating and inward-looking.)' (Area D)

'Recognition universally in (name of town) of OT role as a very specific job that nobody else does.' (Area D)

'Telling people what I do - training OT students, residential care staff, clubs and societies.' (Area F)

'Liaison with other professional groups making them see what an OT can achieve for a client.' (Area F)

'My services are sometimes uniquely necessary to a client and without me he would manage far less well. This rarely happens in a hospital setting, I have never felt essential in the same way.' (Area J)

The force of these comments suggest that to be thus appreciated was a rather novel experience for many of these respondents. It is noticeable that there was a higher level of satisfaction concerning the appreciation of unique skills in extrinsic areas (33% - 18) than in the intrinsic areas (17% - 6).

The fourth main source of satisfaction was that derived from challenging and complex problems and their successful completion - typified by work on major adaptations. Once again there was a higher level of satisfaction as a result of this type of work in extrinsic areas (38% - 21) than in intrinsic areas (20% - 7). The following

comments illustrate the respondents' feelings.

'Successful completion of an adaptation - this can be a long process - frustrating for OT and client en route but eventually is the result of liaison from so many different departments.' (Area K)

'Completion of adaptations - such a long wait for thing to be completed so it's really satisfying when they are finished.' (Area D)

'Solving difficult and longstanding cases which involve various agencies - more interesting than quick one-off visits.' (Area J)

'Unusual requests which require researching information.' (Area C)

Table 31 shows that the fifth category of sources of satisfaction is described as 'control of own skills'. Once again this was an amalgam of varied comments and these were all related to the pleasure that the respondents derived from being responsible for organising their own work and timetable and from the variety of the work and the professional growth that developed from this. In some respects this is related to the autonomy of professionals within organisations (see page 27) and some of the respondents' comments illustrate aspects of this.

'Frankly, I enjoy the freedom and variety of the work. The fact that each day is different and one is constantly meeting new people helps to sustain one's interest and enthusiasm.' (Area F)

'The opportunity to innovate - to expand the scope of the work.' (Area D)

'Variety/flexibility/job is constantly a challenge.' (Area E)

'Governing own timetable and input to job - flexibility etc. especially of hours of work.' (Area J)

The sources of greatest satisfaction in the respondents' work therefore ranged from the content and outcome of the work to the working relationships and methods of working. In general, the respondents in the extrinsic areas appeared to derive more satisfaction from their work, if this can be assessed by the overall frequency with which they

itemised different sources of satisfaction. The information in this section can now be compared with the factors itemised by the respondents as sources of least satisfaction in their work.

Sources of least satisfaction

The aspects of the respondents' work that caused them least satisfaction were even more numerous and varied than the aspects which caused greatest satisfaction. Some causes were common to all areas, others to specific areas and others to specific individuals. For the sake of discussion and description the respondents' replies are presented under the following headings.

1. Volume of referrals- particularly for minor aids and minor problems.
2. Routine clerical procedures.
3. Delays/time-wasters - includes length of time taken for major adaptations to proceed; waiting for aids to be supplied; wasted time on telephone; time spent in meetings.
4. Lack of resources - refers to insufficient time; finance for provision, staff and facilities.
5. Specific area problems - particularly associated with charging for services and systems for supplying aids and equipment.
6. Difficulties with clients - ranging from intractable problems to unmotivated and aggressive clients and families.
7. Inappropriate work - i.e. doing work that could or should be done by others.
8. Professional conflict - i.e. poor relationships with social workers, GPs, senior managers and administration.
9. Politicians and their influence.
10. Other factors - includes more individual aversions, such as writing reports, or individual problems relating to specific procedures.

Table 32 shows the frequency with which respondents listed the varying causes of least satisfaction within each area.

The volume of referrals and dealing with routine clerical procedures were seen to be the greatest sources of least satisfaction in the

respondents` work in intrinsic areas and nearly the greatest sources in extrinsic areas. In fact, the issue of the volume of referrals was also given as the greatest pressure upon the respondents (see page 158) and because an even greater proportion of respondents itemised it as such their experience of this will be discussed in the following section. The proportion of the respondents` time that was spent on administration and clerical work was discussed in Chapter Three (p.82) and it is perhaps not surprising that it should have been a source of little satisfaction to the respondents.

Table 32 : Sources of least satisfaction in work

Source of least satisfaction	Intrinsic	Extrinsic
Volume referrals	37%	33%
Routine clerical	37%	33%
Delays	26%	35%
Lack resources	14%	24%
Area problems	37%	16%
Problem clients	17%	16%
Inapprop. work	14%	15%
Profess.conflict	6%	15%
Politicians	-	7%
Other	14%	20%

The third greatest source of least satisfaction in the work of the extrinsic group were factors which caused delays in the process of their work or which wasted time, over a quarter of intrinsic respondents also itemised these factors. The following comments illustrate some of the difficulties.

'Ordering special items through our main stores and having to wait weeks even months for them.'

'Timewasters - searching for files/waiting on phone.'

Many other hindrances or timewasters were listed including three respondents in non-enclave areas who commented on the time wasted in certain social work oriented meetings (see page 89).

Frustration caused by a lack of resources was itemised by many

respondents and, once again, more respondents in extrinsic areas made comments relating to this than did the intrinsic respondents.

'Being unable to expand service into other areas due to amount of outstanding work - (position for 2nd OT vacant for 15 months).' (Area C)

'Lack of money. Not enough technical support.'
(Area D)

'Having to explain to clients that they cannot have a piece of equipment due to cut backs.' (Area E)

'Insufficient supplies of aids due to council spending cuts with increased demand.' (Area H)

This frustration and lack of job satisfaction that occurs as a result of a lack of resources illustrates the discussion in Chapter One (page 40) concerning the demoralisation of people who are agents of 'tertiary rationing' whereby the quality of the service has to be diluted because of a lack of time or money to do more (Scrivens 1983).

Further examples of the effects of rationing were particularly evident in two areas where the respondents had to impose a charge for all aids that were issued. In one of these areas a quarter of the respondents, and in the other, over a half the respondents commented on their discomfort. This remark illustrates the more far-reaching effects of this policy -

'Collecting cash from clients - this seems to put a barrier between OT and client. It is difficult to assess for aids when several items would be beneficial but each has its own price.' (Area K)

These difficulties are recorded in Table 32 as specific area problems. Other sources of least satisfaction, which seemed to be related to particular systems operating in certain areas, were the dissatisfaction expressed by some respondents in two areas that they had little involvement in major adaptation work and problems associated with the supply of aids in another area.

'Lack of opportunity to follow through advice given on rehousing, adaptations, grants etc. - all done by

senior assessment officer. I feel that the OT should be given the opportunity to develop the necessary skills and accept overall responsibility. Frustration develops with this lack of opportunity to learn and develop.'

(Area H)

'The joint-aids store, and all that covers, gives me the screaming ab-dabs not infrequently.' (Area J)

Other factors were itemised by individuals in other areas and some are worth noting because they illustrate wider issues. One respondent emphasised the 'unprofessional' situation whereby she had to pass for approval certain items of equipment to a social worker, which demonstrates one of the points concerning the autonomy of professionals within organisations (see page 27).

Almost equal proportions of respondents in the extrinsic and intrinsic groups commented on the effect on job satisfaction of particular difficulties with clients. Some of the respondents' comments illustrate the frustration of being unable to fulfil their 'curing' role (or of being unable to wave their 'magic wand', see page 148), either because the client's problems were insoluble or because the clients or their families would not accept any help.

'Visiting clients for whom there is virtually nothing one can do.'

'Seeing clients be more dependent than is necessary and not interested in helping themselves.'

'When carefully assessed aids are returned by the family.'

Other comments illustrate judgements about 'difficult' clients. Any worker in social services departments becomes familiar with the terms 'difficult', 'demanding' and 'manipulative' that may be applied to those clients whose files become thick, about whom there is correspondence with councillors and MPs and whose needs never seem to be met. The following comments demonstrate some of the respondents' attitudes and experiences. (Also see Appendix II Case Studies).

'Client greed rather than need.' (Area C)

'Coping with clients who are unpredictable and difficult to reason with.' (Area D)

'Dealing with clients who are very demanding because they reckon they are entitled to umpteen things because they are disabled.' (Area J)

As the 'sharp end' of the welfare wedge fieldworkers bear the brunt of the consumers' antagonism and anger if they have to be denied something which they consider to be their right. The pressure experienced by the respondents as a result of these occasions is discussed further in the following section.

Five intrinsic respondents and eight extrinsic respondents (14% and 15% respectively) referred to aspects of their work that caused them little satisfaction because they really considered that they did not come within the remit of their work. These included activities such as carrying out means tests for telephone assessments; having to fight for resources; the collection and cleaning of aids and the transporting of clients to and from a social club. The issues concerning the aspects of the respondents' work which might have been undertaken more appropriately by other people are discussed in Chapter Five (page 168).

A number of respondents in both extrinsic and intrinsic groups mentioned particular difficulties in liaison with other personnel as a source of little satisfaction. The other personnel groups most frequently mentioned were social workers, GPs, administrators and higher management. If Tables 31 and 32 are compared it will be observed that in both the extrinsic and the intrinsic groups the incidence of happy relationships with other personnel ('unique skills' - Table 31) outnumbered the incidence of 'professional conflict' (Table 32) by about 3:1. The following comments illustrate the type of conflict experienced.

'Dealing with snappy GPs.' (Area B)

'Being used by other team members to get them out of awkward situations with handicapped clients - this seems to happen quite frequently.' (Area F)

'Dealing with administrators who seem to think that social services would run more efficiently without clients.' (Area J)

Some of the comments relating to conflict with other personnel illustrated the lack of understanding of the occupational therapists' role which was experienced in some areas. This issue was itemised as a major pressure upon the respondents and is therefore discussed in the following section.

The influence of politicians and political decisions on the work of occupational therapists was discussed in Chapter Three (page 135). Although only four respondents from two areas referred to the political influence on their work, it is included separately in Table 32 because it is an important aspect of community work.

'The pressure applied by various people to give the client what is not needed for political reasons.' (Area C)

'Inconsistent policies - difficult to advise on grants when don't know if money will be available.' (Area D)

The sources of least satisfaction in the respondents' work can be seen to be related to the volume of their work; certain aspects of the content and organisation of their work; frustration resulting from a lack of resources and the conflict that can occur with clients or other personnel. Some of the issues that have been discussed in this section are raised again and discussed in greater detail in the following section concerning the pressures experienced by the respondents and their comments relating to their role and status within social services departments.

4.3. THE PRESSURES EXPERIENCED BY THE RESPONDENTS AND ASPECTS OF STATUS AND ROLE

The foregoing sections concerning the aspects of the respondents' work that caused them the greatest and least satisfaction, and the issues arising out of their organisational deployment, present a fairly comprehensive picture of the respondents' assessment of the influences upon their work. Another aspect of working is the extent to which people consider that the function that they fulfil in their work and the role that other people define for them concurs with their own concept of their role and function (see page 30 'identity strain'). The following information illustrates the degree of identity strain experienced and completes the picture of the respondents' perception of their work within social services departments. The issues raised can be discussed under the broad headings of :

1. Issues relating to the respondents' perception of their role.
2. Issues relating to other people's perception of the respondents' role.
3. Other individual pressures.

Issues relating to the respondents' perception of their role

The overwhelming impression gained from a study of the respondents' comments is the amount of role strain experienced by the majority of occupational therapists because they were unable to fulfil the ideal role that they envisaged for a community occupational therapist. The main reason for this was that they did not have enough time. They did not have enough time because of the volume of referrals that they received which was, in some areas, compounded by a shortage of occupational therapy staff. In extrinsic areas 62% (34) of the respondents, and in intrinsic areas 57% (20) commented on the pressures caused by the

volume of referrals and the lack of time to carry out their work to the standards that they desired.

'21 hours a week inadequate to cover needs in area.
Deal with urgent ones, others may wait 8 months.
No-one else to cover when on leave/sick.' (Area K)

'I deal with 25% of referrals to social work team,
unable to be as involved as I would like.' (Area J)

'Should be a ceiling on the number of referrals passed
to OTs - not able to work thoroughly enough.' (Area D)

Another source of role strain was the professional isolation experienced by some respondents (15%, 8, of extrinsic respondents and 11%, 4, of intrinsic respondents). This professional isolation was experienced in three ways;

1. Working alone in clients' homes -

'You are responsible for that client....decisions
are taken independently in the field.' (Area B)

2. Lacking contact with fellow occupational therapists -

'Isolation - lack of continued contact with other
OTs.' (Area E)

3. Needing to preserve a professional identity amongst many social workers -

'Need to maintain separate OT identity - over-
shadowed by masses of SWs.' (Area A)

The issue of professional isolation has been discussed in relation to the merits and demerits of being based in social work area offices (see page 141) but was experienced specifically as a pressure by 13% of the respondents.

A third aspect to the respondents' perception of their role was highlighted by the question -

Q. 'In your opinion, what criteria do you think should determine whether or not a referral is passed to you?'

Their replies were broadly divided between respondents who felt that all referrals concerning the physically handicapped should be referred to them, 42% (38) -

'No hard and fast rules should really apply. Anyone with a disability could benefit from an OT - as difficulties of managing their disability may not be mentioned in a referral.';

those who felt that the client referred should be experiencing specific independence difficulties or problems with carrying out activities of daily living, 63% (57) -

'All referrals concerning difficulties with independence whether or not needing aids and adaptations.';

and those who had more specific criteria, 28% (25) -

'If the case concerns a severely handicapped person with multiple problems or a condition which is progressive. If the referral obviously is going to involve an adaptation or liaison with other specialist agencies i.e. improvement grants.'

It has already been noted (page 113) that some of the respondents considered that counselling was a part of their role and, indeed, three respondents specified disabled people in need of counselling as cases that should be referred to them. However, another three eschewed the counselling role with comments such as -

'Not a marital problem that could occur in any family whether handicapped or not.'

'If it concerns 'provision' of an item, not if counselling is required.'

The issues surrounding the employment of occupational therapy assistants who might undertake the less complex work are discussed in Chapter Five so they will not be pursued here. However, the comments concerning criteria do illustrate some of the difficulties relating to the social services occupational therapists' role. The main source of pressure on the respondents was the volume of referrals, however, 42% of the respondents considered that all referrals concerning the physically handicapped should be passed to them. These issues relate to the discussion in Chapter One concerning monopolistic privileges to perform certain types of work (Turner and Hodge 1970). If occ-

occupational therapists do seek to monopolise work with the physically handicapped (whether or not the situation arose because of social workers' lack of interest and subsequent lack of skills in dealing with them - Rowlings 1980) then it is unlikely that social workers will develop a greater interest. If social workers do not develop a greater interest in the needs of handicapped groups then the potential of occupational therapists will continue to be underestimated and the status of their work under-rated. The following section shows that these points were sources of conflict to some of the respondents in this study.

Issues relating to other people's perception of the respondents' role

Most of the discussion relating to other people's perceptions of the respondents' role is concerned with role clarity. In most cases this refers to lack of role clarity and consequent identity strain, but in some it refers to a clear definition of role and the consequent job satisfaction.

The lack of role clarity led to two sources of pressure for the respondents in this study. The first of these was the expectations that the respondents felt were upon them, from the public, politicians and other agencies, to supply a service based on demand rather than on a professional assessment of need. The result of this was that they had to deny people whose expectations had been falsely raised. One quarter of the extrinsic respondents and one fifth of the intrinsic respondents itemised this source of pressure.

'Staff from other disciplines who make their own assessment and present a 'shopping list' for aids.'
(Area H)

'Political pressure - nearing elections departments persuaded to respond because of other involvement - 'I'll scratch your back' syndrome.'
(Area C)

'Expectations of many clients especially in International Year of Disabled People.' (Area F)

The second aspect was that several respondents (15%,8, extrinsic and 20%,7, intrinsic) felt that their role (actual and potential) and the needs of their clients were misunderstood by some of their fellow workers.

'Constantly having to convince colleagues of your worth! I am first OT in post - large amount of education to be done in terms of putting forward my role.' (Area F)

'Lack of understanding of SWs for handicapped and lack of interest. Any cutbacks mean physically handicapped and mentally handicapped lose out even though 25% of referrals are for these. Work of OTs vastly under-rated.' (Area E)

'Hospital OTs in general fail to appreciate the nature of community work and the procedures which have to be followed to complete even the smallest adaptation.' (Area K)

A total of five respondents referred to the difficulties associated with dealing with hospital referrals that required immediate action when the respondent was already fully booked and overwhelmed with referrals. However, most commented that the hospital discharges took priority and that the other clients had to wait.

The comments that the respondents made concerning the need to prove their worth and the fact that they felt under-rated, illustrate the demoralising effect of identity strain and reality-shock that occur when the individual's self-concept is not reinforced by his/her reference group (see page 30). A different picture was presented by eight respondents who commented happily that their role was clearly defined, this included four respondents from one area (40% of respondents in that area) who were regarded very highly by their social work colleagues.

'SW team consider me to be a highly qualified and useful member of the team. Very satisfying

work as there is great need for my services.' (Area J)

'Regard for OTs and what they have to offer is very high. OTs have a clear cut role, no professional jealousy with SWs (as with physiotherapists in hospital).' (Area J)

'This office and its higher management are supportive, helpful and encouraging. OTs seen as being desirable and valuable.' (Area J)

The respondents in this area dealt with more complex cases and carried out more supportive, long term work than many of the respondents in other areas did.

Thus, although nearly a third of the respondents suffered pressures because of the expectations upon them and the lack of understanding of their role, a small proportion of respondents felt appreciated and appropriately used. A number of respondents made more individual comments concerning the pressures that they experienced and these are discussed in the following section.

Other individual pressures

The discomfort that the respondents felt when they had to deny clients aids or equipment because of a lack of resources was highlighted in Section 4.2., the pressures associated with this were experienced by one third of the respondents in one area. Some of the respondents commented on having to bear the brunt of the clients' displeasure when a provision could not be made or there was a delay in provision.

'Clients frequently and justifiably become exasperated with the long-winded procedures in connection with major adaptations.' (Area J)

'Clients whose requirements have been passed to the council building department have to wait an age - because the OT made the initial assessment enquiries are always directed to her and not to housing.' (Area H)

Another burden, experienced particularly in another area, was

coping with the poor image of social services.

'I feel, along with SWs, that I have to take 'great care' when dealing with clients to do everything 'properly'. We are very sensitive to public criticism (especially after the case of 'X') and feel all our actions could at any time be scrutinised and must therefore be above reproach.'
(Area K)

It can therefore be seen that occupational therapists in social services departments are exposed to a wide variety of pressures emanating from both within and outside the department in which they work. It is unlikely that their hospital colleagues experience such pressures and it is questionable that the hospital-oriented training course prepares occupational therapists for coping with and managing these powerful influences on their work. The extent to which the respondents felt prepared for their work is discussed in Chapter Six.

Aspects of work on which respondents would have liked to spend more time

Because the lack of enough time seemed to be a major contributory factor in preventing the respondents from fulfilling their conception of what the role of a social services occupational therapist should be, they were asked to describe how they would have spent more time if they had it.

1. Treatment and rehabilitation- (see p.110) In particular respondents referred to early rehabilitation and management of hemiplegics sometimes in groups.
2. Follow-up/regular visiting - This related mostly to spending more time with people suffering from degenerative conditions and with the elderly to ensure understanding of use of equipment.
3. Counselling - Particularly with the relatives of severely disabled children and adults.
4. Updating own knowledge - On new equipment, medical techniques, treatments, drugs, revision of aids and benefits, research into local facilities, new procedures.
5. Specific conditions - Several respondents wished to concentrate on the needs of particular disability groups e.g. rheumatoid arthritis, multiple sclerosis, hemiplegia.

6. More time with all clients visited - In order to carry out extremely thorough assessments and go into detail of clients' problems.
7. Liaison with others - Particularly GPs, DNs, HVs and hospital occupational therapists.
8. Work with relatives - Not in 'counselling' but in general support and in teaching management of the disability.
9. Design/adaptations/planning - To be thoroughly familiar with aspects of design and research fully lay-out of kitchens/bathrooms. More involvement in planning of public buildings.
10. Other - included work with occupational therapy students; work in day centres; assessments prior to discharge; designing special aids; groupwork.

The respondents' comments seemed to demonstrate their need to utilise their professional skills and knowledge more fully and to ensure that this knowledge was as advanced as possible. In addition their comments illustrate the wider perception that they had of their role and their desire to be involved fully in the wider needs of the client, the family, and in community provision.

Eighty per cent (72) of the respondents commented on aspects of their work on which they would have wished to spend more time. The most frequently mentioned aspects were 'Treatment and Rehabilitation' and 'Follow-ups'. In Section 3.4. it was demonstrated that few of the respondents were able to carry out specific treatment or rehabilitative activities, almost a third of the respondents felt that they were not doing enough in this area of work. The desire or need to do more follow-up work varied from area to area. In two areas this referred to generally following-up cases, because they had particularly high rates of referrals and no social work or occupational therapy assistants to carry out follow-ups. In three other areas this was more concerned with a desire to spend more time with people suffering from degenerative conditions.

It would appear that for every aspect of work there were some

respondents who wished to be able to give more time to it. This also included the routine referrals and visits.

'Each individual visit - due to pressure of work we cannot spend as much time as we would like with each client.'

'On initial visits, getting to know the client, looking deeper into problems.'

SUMMARY

This section has closely examined the experience of working as an occupational therapist in a social services department. The impression received is that clients would be best served if occupational therapists were based in social services teams in cells of one senior and at least two main grade workers. It seems that there would be value in having a regular and inviolate time set aside for professional supervision and in the provision of more general supervision available from an objective but well-informed senior social worker.

Thus supported it may be easier for the occupational therapists to deal with the considerable pressures upon them - pressures of unreasonably heavy case-loads, the ignorance of their true potential, and the frustration and conflict produced in trying to maintain professional standards. In those areas where the respondents were recognised as having a unique and valuable contribution to make levels of job satisfaction were higher and more complex work was undertaken with the more severely handicapped and the chronically ill. The next chapter examines more closely the contribution that unqualified staff can make in ensuring that professional skills are directed where maximum benefit is derived from them.

CHAPTER FIVETHE EMPLOYMENT OF SUPPORT STAFF

The third listed objective of this study was stated thus -

'To consider, given occupational therapists' training and expertise, whether or not the best use is being made of their skills and whether or not aspects of their work could be undertaken by less highly trained staff, thereby releasing the occupational therapists to do more skilled work.'

In Chapter One, 'Background to the study' (pages 6 & 8) reference was made to the McMillan Report (1973) and a DHSS Report (1974) which were concerned with the subject of making the best use of limited resources and which proposed the employment of occupational therapy assistants to work under the direction of occupational therapists. In the Literature Review (page 31) there was some discussion concerning the process whereby professions respond to the requirement that they should make the best use of their training, talents and skills by -

'.....delegation, or sloughing off the tasks which have come to bear little or no prestige.'
(Habenstein and Christ 1955)

Occupational therapy 'helpers' have been employed in hospital departments in large numbers for many years (particularly in the 'lower status' areas of chronic mental illness and geriatrics) and, in fact, outweighed qualified staff by 56% to 44% (Alaszewski et al 1979). The employment of helpers or assistants highlights two issues which are both related to supervision. The first is associated with the 'dangerous' consequences that might occur if assistants, lacking adequate supervision, take on tasks which are beyond the limit of their theoretical and technical knowledge (Alaszewski et al 1979; Turner and Hodge 1970 'monopolistic privileges'). The second is the situation that can arise when 'local' helpers remain in post for many years, sometimes unsupervised, whilst the 'cosmopolitan' qualified staff come and go (Merton and Gouldner, 1959) (see page 33).

5.1. ASPECTS OF THE OCCUPATIONAL THERAPISTS' WORK THAT COULD HAVE BEEN UNDERTAKEN BY OTHERS

The occupational therapists in the sample were asked if there were any aspects of their own work which they considered could be undertaken by someone other than a qualified occupational therapist. Their responses to this depended, to a certain extent, on the help that they already received and the range of work that their existing workload encompassed.

Table 33 : Aspects of work that could be undertaken by others

Aspects of work	Intrinsic	Extrinsic
Collect/deliver/ check/follow-up	46%	51%
Administrative/ clerical duties	31%	33%
Maintain aids/ stock control	9%	13%
Handling money	26%	-
Ass. minor aids/ ADL practice	6%	13%
Other	11%	5%
None	9%	16%

Collect/deliver/check/follow-up

Table 33 shows that in both the extrinsic and the intrinsic groupings there was a general consensus that much of the delivery and fitting of minor aids could be undertaken by an unqualified person after the initial professional assessment. There was also a similar consensus that the checking of the suitability of issued aids and the general follow-up visits to ensure that minor adaptations had been carried out satisfactorily could also be delegated. In some areas where occupational therapy assistants were already employed they already

undertook such work.

'Pure aids delivery is and should be undertaken by the storekeeper. Follow-up/check visits are undertaken by OT aid.' (Area J)

The follow-up category also included the need to have someone to carry out general supportive visits to people whose needs were not changing.

'Follow-up, cases of disability in families which are not deteriorating but would appreciate an interested caller.'

Also included within this category are the occasions when respondents commented that the issue of simple standard aids (e.g. helping hand, stocking aid), when the item was requested by a district nurse or health visitor, did not require the intervention of an occupational therapist at all.

'Issue of simple standard aids. HVs and DNs often ask just for these and know it will suit a particular client.'

Certain administrative/clerical duties

About one third of the respondents in both intrinsic and extrinsic groups considered that much of the routine clerical work could be delegated. Most of the respondents had some clerical help (see page 174 Table 34) however in most cases this represented the shared services of a team's clerk/typist. Most respondents itemised factors such as form filling; aids orders; filing; keeping records of occupational therapists' cases; keeping statistics. In addition some respondents suggested other aspects of this -

'Admin. procedures i.e. paperwork concerned with grant applications - could be monitored and dealt with by a clerical assistant with special knowledge in that area.'

'Certain aspects of secretarial as against clerical work - someone to take the initiative in acknowledging letters, converting messages to referrals, filing of information.'

These comments illustrate the perceived value in having an office helper who has a particular responsibility for dealing with the occupational therapists' work and who fully understands all the relevant procedures.

Maintenance of aids/stock control

Whilst several respondents included some aspects of record-keeping concerning aids and equipment in their lists of clerical help required, 9% (3) of the intrinsic respondents and 13% (7) of the extrinsic respondents commented on the time that they had to spend in maintaining the stores of aids, cleaning dirty equipment and in making enquiries to suppliers. This appeared to be more of a problem for the extrinsic respondents who sometimes had responsibility for a small aids store (or cupboard) at their office base. The intrinsic respondents were more frequently based together and had a storeman in charge of the aids store, or (in the case of one intrinsic and one extrinsic area) the respondents had access to a joint aids store (used by health and social services personnel). However, some of the respondents commented on problems of access and acquisition of aids when joint aids stores were used.

Handling money

Some of the ethical and professional difficulties associated with charging for a social service were discussed in Chapter Four (p. 154). Table 33 now shows that this was an aspect of their work which they felt could be delegated, not only because of the barriers that it created between the client and the therapist but also because of the time wasted.

'Charges are made for aids - cash collecting involves me in making visits specifically for that purpose - time could be used more beneficially.' (Area K)

The information from the diaries kept by the respondents in one area

revealed that 15% of their visits were undertaken purely for the collection of loan charges.

Assessing for minor aids - ADL practice

All the items so far discussed have been aspects of work which clearly do not require an occupational therapist's training in order to be able to carry them out. At the beginning of this Chapter reference was made to the suggestion that professionals respond to demands to make the best use of their talents and skills by 'sloughing off' those aspects of their work which have come to bear little or no prestige. The only aspects of work listed by the respondents in Table 34 that could seem to come into this category is this section concerning the delegation of the assessment of minor aids and the use of unqualified staff to carry out ADL practice and programmes.

Only 10% (9) of the respondents suggested that unqualified staff should undertake such work. However, of the 13 respondents who stated that all the work that could be undertaken by other staff was already being done, five stated that the other staff were carrying out minor assessments. Most of the respondents who suggested that such assessments and programmes might be undertaken by unqualified staff also stressed the need for unqualified staff to be closely supervised.

'Some first visits for simple equipment such as bath and toilet aids - but only with proper training, an excellent perception of other possible problems and the ability to report back cogently.'

'OT aid with interest, sufficient instruction and supervision could carry out follow-up visits and even assessments on minor aids - with ability to report back adequately.'

Other respondents had reservations about the use of unqualified staff for such assessments.

'I am ambivalent re OT aides - can dilute our already tenuous position especially by 'bad' example. Often simple 'bath aids' referrals develop into more complex problems.'

'It is difficult to delegate work to other staff as often a cry for help for some minor aids reveals other great needs.'

However, the implication that 'often' simple referrals mask more complex problems is questionable. The evidence of the diaries shows that in eight per cent of referrals (not only of the 'simple' referrals) the outcome of the visit extended widely beyond the subject matter of the referral and that these were frequently social or medico-social problems which a district nurse or health visitor could have perceived.

These respondents' comments hint at the 'danger' that might occur if unqualified staff take on work beyond their abilities (see page 27), and suggest that they seek to monopolise all work with the physically handicapped. If the theories of Habenstein and Christ (1955) and Turner and Hodge (1978) are applied rigorously it would seem that professionals' motives are never creditworthy whichever course of action is pursued. If they do relinquish some work in order to apply their skills more effectively they are accused of 'sloughing off' unpleasant tasks (Habenstein and Christ 1955). If they retain all aspects of their work they are accused of seeking to monopolise it (Turner and Hodge 1970).

The most important practical point to emerge from this issue is that, if unqualified staff do take on aspects of work which might hitherto have been regarded as requiring a 'professional' input, then it is important that they have a thorough in-service training, that they are well supervised and that they know when to refer back to a qualified member of staff.

Other aspects of work

A further eight per cent (7) of the respondents itemised other aspects of their work which they felt could be undertaken by unquali-

fied staff. These included the point that district nurses ought to supply purely nursing aids (such as commodes, incontinence pants etc.) and that purely social or craft classes could be run by someone other than a qualified occupational therapist.

SUMMARY

It was found that the respondents considered that a considerable proportion of their work could be undertaken by unqualified staff. A variety of different groups of staff could carry out these tasks - drivers, clerical staff, storekeepers, social work assistants and occupational therapy assistants. There were differences between the areas which reflected the type of help that they already received and the manner by which some procedures were organised. In the following section the support staff who were employed and their impact on the work of occupational therapists are described.

5.2. EMPLOYMENT OF SUPPORT STAFF IN THE AREAS STUDIED AND THE EFFECT OF THE OCCUPATIONAL THERAPY AND SOCIAL WORK ASSISTANTS' WORK ON THE WORK OF THE OCCUPATIONAL THERAPISTS

The foregoing section has outlined some of the aspects of the social services occupational therapists' work which they considered could be undertaken by someone other than themselves. The respondents were asked about the groups of staff from whom they already received assistance and the variations between the areas and the effect of the help is discussed in this section.

Table 34 illustrates the groups of staff from whom the respondents received some assistance and it will be noted that the different bases from which they worked are reflected in the type of support that they received.

Table 34 : Type of support staff by area

Support staff	Intrinsic					Extrinsic						
	B	E	H	K	Tot. %	A	C	D	F	G	J	Tot. %
OT assistant	-	11	-	-	31%	1	4	2	-	1	3	20%
SW assistant	-	-	-	-	-	4	1	9	5	-	5	44%
Clerk/admin.	7	7	11	5	86%	7	2	20	8	-	10	85%
Typist	7	10	8	5	86%	6	4	18	8	-	10	84%
Technician	7	11	11	2	89%	8	-	19	6	-	1	62%
Craft instruct.	-	-	10	-	29%	-	2	1	1	-	-	7%
Other	-	-	-	-	-	-	-	1	-	-	1	4%

There was considerable variation between the different areas in regard to the support staff employed and particular differences between the extrinsic and intrinsic groups. The occupational therapists in the extrinsic groups had a wider distribution of support from occupational therapy assistants and social work assistants than did the intrinsic occupational therapists. In only one of the intrinsic areas were occupational therapy assistants employed and this was the area where occupational therapists were based in social work area offices in contrast to the other intrinsic respondents who were based in OT enclaves. Thus none of the intrinsic occupational therapists received help from social work assistants. Three respondents received assistance from both an occupational therapy and a social work assistant.

However, a considerably higher proportion of intrinsic occupational therapists received assistance from technicians or handymen. This may, in part, be due to the nature of the work base because of the scope in day centres for technicians to have their own workshops. The distributions of clerical, administrative and typing help were very similar in both intrinsic and extrinsic groupings, however, it has already been noted (see page 169) that most of this was shared help.

Craft instructors were employed on a wide scale in one of the intrinsic areas and to a lesser extent in three of the extrinsic areas. Information collected from the diaries (see page 48) suggests that the

occupational therapists with craft instructors spent between one and five per cent of their working time in discussion with them. The minimal involvement of social services occupational therapists in the traditional craftwork image of occupational therapy was evident from the breakdown of the work undertaken with clients (see page 106). This clearly illustrates the move away from the paradigm of human occupation (see page 15). However, although the craftwork element has declined, the community and combined orientations of 61% of the respondents illustrates the concern that the majority of respondents had for the wider needs of their clients.

The effect of the occupational therapy assistants' work

Of the 22 respondents who received assistance from an occupational therapy assistant, 21 commented on the effect that this had on their work. The effects were mostly concerned with lessening the pressure on the occupational therapist or enabling the occupational therapist to concentrate on the more complex cases. Several respondents also commented on the type of work that these assistants undertook.

'Takes away time-consuming work like delivering aids which have been recommended.'

'Work is now mainly concerned with major adaptations and more serious disability.....I now rarely have to supply only a bath board and seat.'

The respondents' comments concerning the content of the occupational therapy assistants' work showed that most of the assistants were used to follow-up the occupational therapists' initial assessment by delivering, fitting and instructing in the use of aids and equipment. However, three respondents commented that the assistants undertook minor assessments (following an induction course) and others stated that they undertook some clerical work or check visits on clients already visited in the past.

The great majority of the respondents' comments emphasised the benefit of having an occupational therapy assistant -

'A good assistant helps tremendously.'

'Great benefit - the OT aid can do general assessments and refer to OTs should there be complications. Meanwhile the OTs can carry the load of major adaptations and long-term cases.'

However, this was dependent on the hours worked by the assistant. Most worked full-time (see Table 35) but one respondent only had an assistant one day a week and stated that it reduced a small amount of the workload. Only one respondent made an adverse comment -

'increases my workload.'

This respondent worked in an area where the assistants were employed under the Manpower Services Commission STEP scheme. Her assistant was involved in a major re-assessment of the physically handicapped persons' register and the weekly reviews of his work took some time.

The effect of the social work assistants' work

Unlike the support that they received from the occupational therapy assistants, which was mostly on a full-time basis, the help that the respondents received from social work assistants was mostly for a few hours a week. However there was some variation and this is shown in Table 35.

Table 35 : Amount of help received from social work assistants per week

Amount of help per week	Areas (all extrinsic)				
	A n=4	C n=1	D n=9	F n=5	J n=5
3 days	-	-	1	-	-
1 day	2	-	-	-	-
Half day	-	1	-	-	1
1-2 hours	-	-	1	2	3
very occasional	-	-	4	1	-
variable	1	-	2	1	1
other	1	-	1	1	-

Apart from those who were only helped very occasionally the occupational therapists found the social work assistants valuable mostly for the delivery and collection of minor aids and for checking that issued aids were being used appropriately. Those respondents who had help for longer periods of time were able to pass some of the more routine referrals to the social work assistants. One sixth of respondents who received help from a social work assistant mentioned the fact that it was necessary to set time aside for supervision and some felt that they had insufficient time to do this satisfactorily.

Some of the respondents mentioned particular aspects of the work that the social work assistants undertook.

'She takes the obviously simple jobs direct as referrals which gives me the time to spend on the more complicated work. If I am away from the office and she is there she can deal with queries (my urgent phone calls etc.).'

(Area D)

'Relieves the regular visiting e.g. in trying to alter social habits, to get nervous clients to venture outside.' (Area F)

'SW assistant delivers and collects aids mainly. He also cleans dirty aids. I can leave all the time-consuming mundane work to him.' (Area J)

The last comment would appear to illustrate rather graphically the phenomenon of 'sloughing off' the less desirable tasks which Habenstein and Christ (1955) refer to as the 'dirty work'.

It would appear that even a few hours assistance a week is of value to the occupational therapists even if this does involve the associated time spent discussing cases.

Discussion concerning the employment and potential employment of Occupational Therapy Support Staff

The information in this chapter suggests that there are several aspects of the work currently undertaken by social services occupational therapists that could be undertaken by someone other than a qualified occupational therapist.

The areas of work which could be undertaken by others centred on aspects of clerical work; the delivery, collection, control and cleaning of aids and equipment; the carrying out of minor assessments and the routine checking of the chronically sick and the disabled.

Occupational therapy assistants and, to a certain extent, social work assistants were able to carry out routine assessments for minor aids. Where such staff were employed as full-time assistants to the occupational therapists, they appeared to require less supervision and direction (after an initial training period) because they continued to develop their own skills within the pre-determined limits of their work. This system appeared to operate successfully as long as there was a qualified occupational therapist easily accessible from whom advice could be sought when required. In only one area did an occupational therapy assistant not have immediate access to a qualified occupational therapist. She expressed concern over the amount of responsibility she had and commented on her difficulties in assessing for more complex items of equipment.

The people who were employed as occupational therapy assistants seemed to bring a range of relevant experience to the work which was helpful to them. However, several of the assistants felt that they would have benefitted from a more comprehensive in-service training programme and that a continuing programme of study days would have helped them to apply the training to their experience.

There was no spontaneous evidence of any conflict between the occupational therapists and their assistants, however, specific questions aimed at producing such information were not asked. There appeared to be a general consensus that the occupational therapists found the assistants to be a great asset to them in their work by enabling them to concentrate on the more complex cases.

CHAPTER SIXTRAINING NEEDS AND PREPARATION6.1. COMMUNITY OCCUPATIONAL THERAPY WITHIN THE TRAINING SYLLABUS

There is little question that the profession of occupational therapy faces a dilemma in trying to provide a basic training which will equip the newly qualified occupational therapist to work in one of its many possible applications (Stewart 1979). The basic training and qualification have been described as a 'license to practice' in one of the many settings (Stewart 1979) and it is generally understood that the newly qualified occupational therapist's first post should be one wherein she is supervised by a senior occupational therapist.

Historically this has been difficult to ensure in the community setting because of the limited number of senior posts, and newly qualified occupational therapists have been discouraged from working in the community until they have had two years post-qualifying experience.

'....to allow them to consolidate their professional knowledge and ability in the more structured and closely supervised environment of a hospital setting.'
(BAOT 1984)

A more significant influence on the introduction of occupational therapists into the community setting has been the limited amount of preparation that they have received within their training for such work. A minimum of 1200 hours of the three year course has been allocated to clinical practice (i.e. working alongside qualified occupational therapists within practising departments), but the vast majority of this clinical practice has been undertaken within general physical and psychiatric hospitals. A very small proportion of students have had placements within the community and these were rarely for longer

than six weeks, compared with the three month hospital placements. However, with the implementation of the Diploma '81 Syllabus a greater emphasis is now being placed on community occupational therapy in the taught section of the course in college.

Seven out of the ten authorities included in this study took students for placements and 24% (22) of the respondents stated that they had responsibility for student supervision. However this was frequently intermittent and in only three of the authorities did they have a continuing programme of student placements.

One reason for the small number of placements has been the difficulty experienced by colleges in obtaining regular placements with authorities which have not had a large occupational therapy staff or that have not had a senior member of the occupational therapy staff to carry the responsibility of student supervision.

'where there is one occupational therapist working in an area office, it does not provide the overall supervisory standards that are considered essential. Periods of holiday and sickness can create a crisis and interrupt the learning experience.' (BAOT 1984)

The members of the working party who compiled the 'Future needs and numbers' report from which the above quotes were taken recommend the employment of Fieldwork Teachers to overcome these difficulties.

Two of the four extrinsic areas in this study which took students had occupational therapists at senior adviser level who, presumably, co-ordinated the occupational therapy students' programme. In the other two extrinsic areas the occupational therapists were employed by the AHA and seconded to the social services department so the students' placements were probably organised through the district occupational therapist. The three intrinsic areas which provided student placements had head occupational therapists through whom student placements would have been arranged.

However, another influential factor in the lack of preparation for community work within the training syllabus has been, in the past, the traditional medical orientation of the training and an attitude held by some of the principals of training colleges that community work was of an inferior nature to hospital work and in some sense not 'true' occupational therapy. As one respondent in this study commented :-

'Very little relevant training apart from physiology and general medicine....OT training included one hour lecture on domiciliary OT and the principal opposed any application for social services jobs.'

Considering that at least 20% of the occupational therapy workforce is in the community (see p. 6) and considering that this has been an increasing trend it is appropriate that the training needs to meet this demand have been re-assessed. The view is sometimes expressed that, because of the nature of community work, it can only really be learnt 'on the job'. Or that, because community work is so different from hospital work, preparation should be made for it on special post-graduate courses. These assumptions are both open to question and the information in the following pages will help to illustrate some of the reasons why.

The respondents in this study were asked to state which aspects of their occupational therapy training they considered to be most relevant in the context of their daily work and for which aspects of this work (if any) they felt unprepared by their training. It should be remembered that the 90 respondents had undertaken their training between six months and over 25 years previously during which time many changes had taken place in the training syllabus. Also, they represented many different training schools and, whilst the basic course content has been consistent within the schools there has also always been considerable individual variation on the emphasis given to different aspects of the course.

6.2. ASPECTS OF TRAINING RELEVANT TO WORK UNDERTAKEN

Medical knowledge

Table 36 illustrates the aspects of training that the respondents considered were most relevant to their work. It can be seen that the great majority of occupational therapists found that their knowledge of anatomy, physiology, medicine, surgery and orthopaedics (i.e. medical knowledge) was their greatest asset. This was not only from the point of view of understanding the client's condition and thereby being able to help them appropriately, but also because of the confidence that it gave to the occupational therapist.

'I very often have to explain medical and surgical terms and what is wrong with the client as doctors have not explained the terms.'

'Training in how the body moves and functions - very important basis of identifying the solution to many of the problems of our clients - e.g. a person who can no longer get up out of a chair; the best way to transfer or a difficulty getting in and out of bed.'

'Knowledge of medicine, surgery and orthopaedics....
.....to radiate confidence.'

'Without medical knowledge the provision of aids or adaptations would be very haphazard and, in theory, could be done by anyone with a little commonsense. Sound knowledge is the basis for good assessment.'

The degree to which the respondents explicitly used their medical knowledge was described in Chapter Three (see p. 108). A higher proportion of respondents in both extrinsic and intrinsic areas commented on the value of their medical knowledge than the proportion who explicitly used it. This supports the suggestion that a social services occupational therapist probably draws on her medical knowledge at all times but that it is used more extensively by some therapists than others (see p.115).

Table 36: Aspects of training relevant to work undertaken

Aspects of training	Intrinsic n=35	Extrinsic n=55
Medical knowledge	74%	71%
OT approach	57%	47%
ADL	40%	49%
Psychiatric knowledge	43%	42%
Clinical practice	31%	27%
Role of others	3%	22%
Plans/drawing	3%	5%
Woodwork	11%	-

The fourth comment given above is relevant to the discussions in the previous chapter concerning the use of occupational therapy assistants and the potentially dangerous consequences of unqualified personnel undertaking assessments (see p. 27).

Some of the respondents who were based in social work offices made the point that other members of the team (social workers, social work assistants) looked to them as the one with medical knowledge :-

'I am thus the 'medical' contact in the office.'

'I am the only one who knows about physical handicap - key worker to whom others in the team flock for advice.'

One can speculate on the possible feelings of power and exclusiveness that occupational therapists may have as a result of their 'special' medical knowledge. Such an attitude has been attributed to members of other professions where specialist knowledge adds mystique which is exaggerated by the use of jargon and forms of verbal shorthand (Jackson 1970; Dingwall 1977). Many of the respondents in this study were characterised by their willingness to share their knowledge with other staff for the benefit of individual clients and the service in general (see p.150). In part this attitude may be seen as a result of the low status attributed to staff working with low status client

groups. Job satisfaction and status are enhanced by the individual being seen as the holder of specialist knowledge and by being able to pass this on.

The occupational therapy approach

The second most commonly mentioned aspect of the training which the respondents found most relevant was what may be described as the occupational therapy approach. This is a rather broad category which encompasses all those features of the training which give occupational therapists their specific orientation and mode of working.

i.e. The abilities to observe, assess, interview and report;
 to plan, carry out and revise treatment programmes;
 to establish priorities and organise their own work;
 to deal with groups and communicate at all levels;
 to be flexible, adaptable and have a problem-solving approach;
 to have an holistic approach;
 to maintain a professional, empathetic attitude in regard to clients and their needs.

Some of these are rather intangible qualities and they illustrate the process of socialisation that occurs during training. 'Socialisation' was discussed in Chapter One (see p. 29) and was described as 'the passive internalisation of an external normative order' (Olesen and Whittaker, 1970). That is, that students are indoctrinated explicitly and implicitly in the specific ideologies and sets of attitudes appropriate to the different audiences whom they will encounter in their professional career. From many of the respondents it was clear that they had gained a certain ideology and an identifiable 'approach' to their work.

'Most useful aspect (of training) is developing an observant nature and a problem-solving approach.'

'Ability to adapt to all types of situation - essential with social service work, and improvisation.'

'Organising of time-seeking priorities - generally organising myself.'

'Seeing the person as a whole - more obvious

in community than hospital.'

'A more structured, and I do not exaggerate by saying, more professional, attitude to confidentiality of clients.'

'The opportunity to get to know myself better through all the activities done during training, so I feel confident when dealing with people and their problems.'

Over half of the respondents made comments related to these aspects of the training and although the training they had may have lacked much specific preparation for social services work it would appear that the variety of the training, the practical approach and the levels of responsibility experienced helped to prepare the individuals for the variety and independent nature of the work.

ADL - Activities/Aids of/to Daily Living

The third most frequently mentioned relevant aspect of training was ADL. ADL can alternatively be defined as Activities of Daily Living or Aids to Daily Living. Both definitions are relevant in this context as the respondents stressed the value of their basic grounding in the techniques of assessment in and retraining of daily living activities (i.e. dressing, bathing, toileting, feeding, cooking and domestic activities) and their knowledge of the range of aids and equipment available to help. Figure 14 p.115 illustrated the very high proportion of instances when respondents used their assessment skills during the course of their visits to clients. In addition several respondents also mentioned the value of knowing which resources to use to gain further information about aids, equipment and services.

Psychiatric/psychological knowledge

Despite the fact that the occupational therapists in this study were working almost exclusively with the physically ill and handicapped it is interesting to note the comparatively high proportion of respondents (42%) who stressed the value of their knowledge in psychology and

psychiatry. The respondents illuminated their reasons with comments such as :-

'Ability to listen and feel clients' mood and thus create a rapport which gives them the confidence to divulge difficulties which we could perhaps help to overcome.'

'Psychological aspects of disability also need to be understood as motivation is the key to achieving independence in the community.'

'Psychiatry and psychology increases my perception of the client's needs and behaviour and makes me a more useful and professional person to him.'

Reference to Chapter Three (see p. 109) shows that the actual explicit use of psychological knowledge occurred relatively infrequently in most areas. However, this is a very difficult aspect of work to measure and it is clear that the respondents found their knowledge valuable. Two respondents also commented on the value of their psychological knowledge in dealing with other staff in the department, an application of such knowledge which might not initially be considered.

'Psychological knowledge helps me to understand the behaviour of other staff.'

'Knowledge of this (psychiatry and psychology) helps in some conversations with social workers.'

Clinical practice/visits undertaken

The fifth most frequently mentioned aspect of training which the respondents found relevant to their work was their clinical practice and specific visits that they had undertaken. The clinical practice did not only relate to those respondents who had had a placement within a local authority as this applied to a small proportion (9% - i.e. five for a six week placement, and three for a placement of one to three weeks). Those who had had a placement for more than a week found it very helpful in preparing them for the specific characteristics of dom-

iciliary practice. Other respondents found their general hospital practice helpful insofar as it prepared them for working with clients, and several had accompanied hospital occupational therapists on home assessment visits when patients were due to be discharged.

The type of visits that the respondents had found useful were to :- day centres; sheltered workshops; sheltered housing and Part III accommodation. Such visits had broadened their knowledge of the type of facilities available in the community.

Knowledge of the role of other personnel

For most of the categories itemised in Table 36 there was little difference between the extrinsic and intrinsic groups. It is interesting, therefore, to note the different stress placed on the value of having learnt about the work of other professionals and of having had experience of working with on hospital practice. The extrinsic respondents, who were largely based in social work area offices, stressed the value of this experience more than the intrinsic respondents who were more often set apart in an 'enclave' (see p. 56) with other occupational therapists.

Other comments regarding relevance of training

Very few other aspects of training were selected by the respondents as being relevant to their daily work. Only four respondents stated that they had had adequate preparation for dealing with architect's plans and drawings (see p. 112). A further four respondents, all from intrinsic areas, commented on the value of their knowledge of woodwork and practical skills in helping them to design specific aids or in assessing for minor adaptations.

6.3. ASPECTS OF WORK UNDERTAKEN FOR WHICH RESPONDENTS WERE UNPREPARED BY THEIR TRAINING

It has already been pointed out that the content of the training courses undertaken by the respondents in this study will have varied somewhat according to the years since qualification and the school attended. However, there was considerable consistency in their replies to the question concerning the aspects of their work for which they felt unprepared by their training. In general, those respondents whose training had been undertaken 10 to 15 years previously (i.e. pre 1971) commented that there had been very little mention of community work, whilst those who had trained over 15 years previously (i.e. pre 1966) stated that community work was virtually unknown and that no mention of it was made during training. Those respondents who had trained within the previous ten years mentioned that they had had some lectures on community work and all those who had undertaken a clinical placement within the community of more than one week had qualified no more than six years previously (i.e. after 1975). Table 37 illustrates the proportions of respondents who itemised different aspects of their work for which they had felt unprepared by their training.

Table 37: Aspects of work for which unprepared by training

Aspects of work	Intrinsic n = 35	Extrinsic n = 55
Building/design	40%	56%
Domiciliary practice	34%	42%
Local government	23%	25%
Chronic disability/counselling	14%	15%
Specialist equipment	23%	16%
Other	20%	16%
Most of it	14%	15%
Fully prepared	6%	2%

Adaptations/building/briefing architects

The most frequently mentioned aspect of work for which respondents felt inadequately prepared was work concerned with building and design, i.e. major adaptations and their organisation and work with architects. Reference to Chapter Three (see p. 106) will show that, within the week of the study, only 6% of the visits undertaken were concerned with major adaptations. However, time spent on the administrative processes relating to a major adaptation is disproportionate to the time spent on visits associated with it. In addition, major adaptations represent a considerable proportion of the aids/adaptations budget and the respondents were very conscious of their responsibility in making the correct decisions. Respondents from all areas commented on the lack of preparation for this work in the training regardless of whether or not they undertook such work.

The organisation of a major adaptation involves a complex sequence of events. Whilst many of the administrative procedures are peculiar to each authority, the respondents clearly felt that a basic grounding in the practical aspects of the process could be gained during training.

'Practicalities of dealing with major adaptations from design, drawing plans, writing specifications, dealing with architects and builders, pacifying clients when jobs are not completed, chasing people to find out why and tying up the financial side.'

'All aspects of planning, building, site inspection, plumbing and plan reading.'

'More detailed information needed on the practicalities of building construction, reading architects' drawings - we had a certain amount of this, but not nearly enough.'

Several post-graduate courses are organised to provide this type of experience, which respondents referred to and had found useful. However, there would appear to be a need to provide a broader understanding of the adaptation process within the basic training.

Domiciliary practice

Thirty nine per cent of the respondents referred to various aspects of their work which can be broadly be described as 'domiciliary practice'. This category represents many facets of what 'being' a social services occupational therapist really means and involves.

This includes :- - working on one`s own in people`s homes;
- managing a large caseload; - needing a thorough knowledge of aids, equipment and back-up resources;- having an understanding of all the relevant legislation and social security benefits.

Some of the respondents` comments illustrate certain aspects of this important category.

'How to say 'no' to unwanted cups of tea (i.e. dealing with clients in their own homes).'

'Coping with aggression'. (i.e. if the occupational therapist was unable to provide what the client wanted.)

'A basic grounding in social security benefits.'

'Coping with large numbers of clients.'

It is probably true that many of these aspects of the work can only be fully learnt by actually doing the work. However, clinical placements within social services departments, as a matter of course during training, would go a long way towards preparing occupational therapists for the realities of the job. In addition, a certain amount of preparation can be provided within the theoretical content of the course through appropriate lectures and problem-solving exercises.

The mechanics of local government

The third major aspect of work for which the respondents felt unprepared was an understanding of the mechanics and working of local government. It has already been noted that the pre-1981 occupational therapy training was geared almost exclusively to work in the National Health Service and the majority of clinical training placements still

are in hospitals rather than in social services. Thus the newly qualified occupational therapist has some understanding and experience of the working of the NHS but little practical experience of local government when so much of the social services occupational therapist's work is concerned with liaison with other departments (see Chapter Four p. 124). Other aspects related to this are the influence of the decisions of elected council members (see pp. 135, 153, 157) and the necessity sometimes to negotiate for limited resources; some of the respondents' comments illustrate these features.

'Basic grounding in the workings of housing departments.'

'The general set-up of local county council s.s. depts. including role/job description of social workers.'

'Political decisions affect one's job i.e. financial allocations, staffing etc.'

Whilst it may be considered that such information is rather highly specific to be included in a generic training, much of the information would be of value to occupational therapists working within the hospital service. A large proportion of the hospital occupational therapist's work is concerned with preparing patients for a return to the community and a better understanding of the organisation of services within local authorities would make this preparation more realistic and facilitate a smoother transition between hospital and home.

Implications of chronic disability

Some of the other categories that have been highlighted in Table 37 are somewhat smaller than the three main groupings and it might be thought that their subject matter could have been included within the previous headings. However, they have been singled out because, although a smaller percentage of the respondents discussed them, they are issues which are of fundamental importance to social services work

and they are, perhaps, issues which could be examined much more closely during training in order to produce occupational therapists who could realise their potential more quickly in social services.

Of greatest importance, perhaps, is the need for a greater understanding of the practical aspects and the emotional implications of chronic disability. It has already been stated (see p. 40) that social services occupational therapists are in a prime position to deal thoroughly with the practical and emotional problems associated with adjusting to severe and/or deteriorating conditions. The respondents described their need for a more thorough preparation for dealing with these important issues in the following terms -

'Implications of various diseases on people's lifestyles.'

'Practical lifting of heavily handicapped persons; more about problems of ageing; incontinence problems; sexual problems of the physically handicapped.'

'The specific needs of individuals functioning at home in their own particular environment.'

Coupled with this need for a deeper understanding of the full implications of living with a deteriorating condition or chronic disability is a need to be able to discuss the associated problems constructively with the disabled person and the family. The issues associated with occupational therapists undertaking counselling work have been discussed (see pp. 40, 113, 160). To some extent it is a matter of degree as to whether the type of constructive discussion referred to above is labelled 'counselling'. Only 9% of the respondents referred to counselling as an area of work for which they felt unprepared. It is not known whether the other respondents therefore considered that they were adequately prepared for counselling or whether they did not consider that counselling was a standard part of their role with clients. Of the respondents who stated that they felt unprepared by their training for such work, one comment illustrates the perceived

need.

'How to cope with parents who feel guilt-ridden when they find they have produced an abnormal child. How to help relatives cope with the problems of the return home of patients with long-term illnesses such as multiple sclerosis or short-term cancer.'

Specialist/expensive equipment

The category 'domiciliary practice' included the comments of those respondents who expressed the need for a more detailed knowledge of all the aids and equipment that are available to help disabled people. However, several respondents made specific reference to a need for a more discerning knowledge of the more complex and expensive items.

'Larger aids - hoists/slings/lifts/stair seats/vertical lifts/possum equipment/telephone adaptations/intercoms/alarm bells.'

'Feel insecure re. stairlifts/hoists.'
'Basic knowledge of larger aids - i.e. stairlifts, bath hoists and their use.'

For a social services occupational therapist to work effectively she needs to be able to select the most appropriate aid for each individual and she therefore needs a working knowledge of a wide range. Much can be gained from visits to aids demonstration centres (e.g. the Disabled Living Foundation) and evaluative guides relating to some major pieces of equipment have been produced (e.g. stairlifts). However, it is short-sighted to presuppose that such an important part of social services work should be learnt 'on the job'.

Another major area of technology with which social services occupational therapists should be familiar is the potential application of microcomputers within the home which is now encompassed more thoroughly within the training.

Other aspects of work for which respondents were unprepared

Several other aspects of work were mentioned for which the resp-

ondents felt unprepared and which might perhaps receive greater emphasis during training. These included : - letter and report writing; - a greater understanding of the work of charities, voluntary groups and pressure groups; - the potential for community involvement;- the work of other social service and health personnel; - assessing, treating and prescribing for babies and children.

The respondents` comments illustrate why such preparation is required.

'Letter writing at level liaison is carried out e.g. directors of housing.'

'Public speaking, official document and letter writing - form an integral part of some social services occupational therapists` role.'

'Working with local pressure groups (access,sports etc.)'

'Close liaison with college of further education.'

'Understanding fully the role of other professionals, i.e. social workers, health visitors, district nurses.'

These comments highlight the reality of social services work and set it apart, at a practical and an ideological level, from the preparation that is required for the more prescribed work that is undertaken within the confines of hospital.

Other comments relating to preparation for work

Many comments were made by the respondents concerning the aspects of work for which they felt unprepared by their training. However, it should also be pointed out that several other comments were made which indicated the readiness with which many of the respondents (particularly those who had returned to work after a period away raising their families) were prepared to learn from their more experienced colleagues attend appropriate courses, or study relevant texts in order to broaden and up-date their knowledge.

'Since doing community work I have had a considerable amount of help from experienced community OTs and consider that I am adequately trained for the job I am now doing.'

'Most of my present knowledge was acquired through post-graduate training and experience.'

'Knowledge gained from experience, lecture courses, text books etc.'

Only three respondents considered that their training had fully prepared them for social services work and these had all received a placement of at least six weeks during their training.

In addition to the aspects of work that the respondents noted for which they felt unprepared, other sections of this study have highlighted one or two other aspects of social services work for which greater preparation could be given. In particular are some of the aspects which were identified as creating notable pressures on social services occupational therapists. (see p. 161). Some of these have already been mentioned, such as managing a large caseload and working on one's own. However, other aspects which could be anticipated through advice, problem-solving exercises and role-play are :-

- the expectations of the general public and other professionals;
- coping with limited resources and clients' reactions to this; and
- preparation for the fact that many colleagues may have little understanding of the scope of occupational therapy.

Discussion concerning preparation for social services work

From all the foregoing observations it would appear that the majority of respondents felt equipped by their training to assess accurately the needs of the clients whom they visited and to tackle the resolution of their problems in a practical fashion. They felt less well prepared for the process of working with the clients and their relatives within the home, for the business of dealing with the mechanisms of local government and for the skills required in mobilising community resources. It is clear that the respondents learnt these

skills (with varying degrees of confidence) 'on the job'. However, it is questionable that these skills should be learnt entirely through practice and trial and error. The amount of time that is wasted, and the number of clients who receive a less thorough handling of their needs during this learning process, is unknown.

It would appear that there are areas of work, that are not exclusive to social services work, for which a more comprehensive preparation could be provided within the basic training. These are :

- the realities of living with severe disability;
- the organisation and practice of local government departments;
- legislation, social security benefits;
- the work of other personnel/groups and their roles in relation to different client groups;
- comparative benefits of different types of complex, expensive equipment.

However, the fundamental question would seem to be 'How much of the basic training should be geared towards producing qualified occupational therapists who will work in social services?'. In these days, when increasingly care is becoming community based, it is questionable that it is realistic to regard social services occupational therapy as a specialism that should only be undertaken after two years post-graduate work.

Anxieties are expressed about newly qualified occupational therapists going and working alone in social work area offices, supervised only by a social worker (see p.141). These anxieties are valid given the lack of senior occupational therapist posts, the present state of the occupational therapy syllabus and the limited true preparation that is given for social services occupational therapy. The newly qualified occupational therapist does not have a clear conceptual model of what an occupational therapist should be striving to achieve within social

services and, without such a model, each lone occupational therapist can only respond to the demands that are made on her. The demands that are made on her will reflect the expectations of the people who make the demands and these will vary according to custom and area differences.

For a newly qualified occupational therapist to have a clear conceptual model of what occupational therapists should be striving to achieve within social services necessitates that such a model exists and that it could be propounded through training. One of the obstacles that has existed for the BAOT is that there has been no nationally recognised job description for social services occupational therapists. Although the work is generally concerned with 'aids and adaptations' the evidence of this study has illustrated the diversity of work undertaken. Each authority, depending very much on the influence of individuals working within that authority, has developed its own parameters for the work of occupational therapists. If the work of social services occupational therapists were to be more clearly prescribed at a national level according to advice from the BAOT, then it would be important that the occupational therapy training was able to produce occupational therapists able to fulfil the prescribed parameters.

CHAPTER SEVEN

CONCLUSIONS AND POSTSCRIPTCONCLUSIONS

The findings show that the occupational therapists in this study were involved in a wide range of activities using diverse skills and liaising with an extensive range of personnel. However there was considerable variation between the areas studied and, in the majority of cases, a large amount of the respondents' time was spent on aspects of work that did not require their exclusive skills i.e. clerical work; delivery/collection of aids; stock control; routine administration and simple assessments.

It was clear that where occupational therapy assistants were employed in a comprehensive manner, i.e. full-time allocation to one or two occupational therapists, the qualified occupational therapists were relieved of much of their routine work and they were able to concentrate their skills on clients who needed more attention. Moreover, there was more opportunity for them to undertake other areas of work with different client groups or work of an innovative nature for which their training had prepared them.

The organisational framework within which the respondents worked had a variety of effects on their work. The advantages of the intrinsic system (whereby respondents were ultimately managerially responsible to a head occupational therapist) were a greater consistency in provision; the potential for a better application of the skills of occupational therapists in many areas of the responsibilities of local government; appropriate professional support and scope for professional

development; and the existence of a career structure with the associated benefits. Many of these advantages could only occur when the field-work occupational therapists were in regular and frequent contact with the principal occupational therapist or her suitably empowered deputy and when the principal occupational therapist was placed at a high enough level in the social services hierarchy and was involved in long term planning of services.

The majority of intrinsic respondents were based in OT enclaves, isolated from their social work colleagues, frequently based at day centres for the physically handicapped. Whilst this benefited the respondents in that they received professional support from each other it did mean that social workers covering the same geographic patch were less able to benefit from the exclusive skills of the occupational therapists and were frequently left in ignorance of their potential. Equally, the isolated occupational therapists were unable to refer easily to the social workers, to benefit from their exclusive skills and obtain a different perspective to their work. In either case it is the client who ultimately suffers if professional staff are not able to work from the full spectrum of resources. In general, extrinsic respondents, based in social work area offices with a social work or occupational therapy assistant, commented on higher levels of job satisfaction and felt that other staff appreciated their skills and contribution to a greater extent than did the intrinsic respondents based in OT enclaves.

Many factors had an influence on the work that the respondents undertook and the nature of the experience of work that they had. A major factor was the very high volume of referrals with which the majority of them had to cope because in some areas every case related to physical handicap was passed to them no matter how minor the problem. The

essential question seems to be whether or not occupational therapists are to be regarded as a specialist professional resource. It is highly unlikely that other professionals employed by or seconded to social services departments, such as psychologists or solicitors, would be expected to man the switchboard or have their specialist skills equally underused. So why is it that occupational therapists seem to have failed to establish their specific role?

It would seem likely that a major reason for this lack of clarity and definition is because the British Association of Occupational Therapists was not prepared to recognise early on that occupational therapists were needed in social social services departments. The argument over whether or not community occupational therapy should be a health or a social service responsibility meant that insufficient importance was attached to the inclusion of occupational therapy within the 'Purple Book' (the National Joint Council's conditions of service). Thus occupational therapists continued to be employed by social services departments with no centrally agreed job description, title, nor rates of pay.

Another reason for the lack of attention given to the work and working arrangements of occupational therapists appears to be the low status of the client group whom they principally serve, the physically handicapped and elderly. Thus it has not had the same urgency when these clients have had to wait weeks or months for a visit when the occupational therapists have been overloaded with referrals without the back-up of assistants or clerical and administrative help. Other client groups helped by social service workers have a much higher public profile and thereby it seems a greater claim to resources, support and investment.

The very nature of occupational therapy, that is - its holistic

approach and the coordinating catalytic skills associated with this may have contributed to the non-specific application of the occupational therapists' skills. Because, as Alaszewski (1979) observed, the patient/person orientation rather than the technique orientation, i.e. choosing the activity/treatment to suit the person rather than selecting patients to suit particular treatments, means that the therapeutic skills employed vary and are not always overt when they are employed in the guise of everyday activities. It may be, therefore, that guidelines need to be established to clarify the types of case that require the specific skills of the occupational therapist.

This study has produced some data on the situation that women find themselves in when they attempt to combine a career and motherhood. The extent to which female-domination of the profession has contributed to its haphazard development within social services is difficult to quantify. Certainly, very few of the respondents who had left work to have a family and then returned at a later date had returned at the same level of responsibility that they had left. They were not therefore able to apply their management and personnel skills nor could the departments in which they subsequently worked benefit easily from the breadth of their experience. Several respondents commented on the frustration that they felt in being restricted to a main grade post because they could only work part-time. Since this study was carried out there has been an increase in job-sharing schemes generally but it is at the higher levels of management that job-sharing is really needed if professional women are to be attracted back to work. More mature, experienced women at these levels would bring a greater stability to the service and benefits in terms of consistency of support and provision and in in-service training programmes. There would also be benefits resulting from long-term professional relationships with

colleagues in other departments and the joint working derived from these leading to a better service to the clients.

Whilst much of the data from this study has implications for the management and deployment of occupational therapists within social services departments there are, equally, implications for the occupational therapy profession. Questions arise concerning the ideology and conceptual framework on which the work is based and the extent to which the training is preparing students to cope with the demands of community work, in an era when 'community care' is a much vaunted ideal, is also debatable.

The identification of the three professional orientations, community, combined and practical, also has implications for the profession as a whole and for the training syllabus. The community orientation is most closely allied to the holistic model of human occupation which considers the needs of the whole person within their social setting. The practical orientation is more allied to the technique oriented paradigm of inner mechanisms. Further studies of different groups of occupational therapists in both hospital and social services settings are required to discover whether or not these orientations are more widely applicable.

It can be seen therefore that the subject matter of this study has had a wide frame of reference. Issues such as autonomy and the management of a discreet professional group within a large bureaucratic organisation have recurred as has the whole subject of professionalism and professionalisation. Associated with these have been the themes of status, identity strain and role clarity; equally role strain has been seen to result from the necessity of having to ration limited resources and from compromising professional judgements with political pressures.

This study has produced a very full picture of the work undertaken

by social services occupational therapists, the influences on that work and their experience of working in social services departments. It has also examined one method by which the skills of qualified occupational therapists can be used more selectively, i.e. the employment of occupational therapy assistants, and considered the relevance of the training syllabus.

POSTSCRIPT

For unavoidable personal reasons there has been a ten year time span between the conception and completion of this study. The questions inevitably arise as to how valid are the findings of a study of occupational therapists working nearly ten years ago to the work that they do today; what effect will more recent policy recommendations (Government White Paper - Caring for People, HMSO 1989) have on the work that they do in the future; and also what other developments have there been with implications for occupational therapists working in social services departments?

A study of recent documents (HMSO 1986, HMSO 1988, Blom-Cooper 1989) indicates that many of the issues identified in this study are still viewed as central problems :

'...the number of OTs remains pitifully small... less than 1,000 whole-time equivalent posts in local authorities. Many local authorities do not employ OTs at all; and in those that do, the OTs carry enormous caseloads - often limiting their work to the provision of aids which is only a part of their potential contribution.'
(HMSO 1986)

'Examine rigorously procedures and practices to ensure that qualified OTs do not undertake work which could be undertaken by other less highly trained staff, and ensure that untrained staff are not left to undertake work for which they are not properly prepared.'
(Blom-Cooper 1989)

However, there does seem to be a greater understanding of the potential of occupational therapists within the community.

'The skills of occupational therapists are in many ways central to the implementation of community care.....these skills should be at the forefront of an 'enabling' service.....The skills are too important and too fundamental to the new community care service to be restricted to a small specialist cadre that cannot hope to meet demand in the foreseeable future. Some way of making these skills more widely available is needed, freeing the specialist OTs for specialist tasks that only they can do.'

(HMSO 1986)

The Commission of Enquiry into the profession of occupational therapy (1989) made references throughout to the importance of redeploying occupational therapists to the community from hospitals and ended by stating that:

'Whatever the outcome of the government's discussions on the future of the NHS and the Griffiths Report, an early opportunity to be in the forefront of community care presents itself to OTs who should prepare themselves for the developing opportunities in the field of community care.'

(Blom-Cooper 1989)

The Commission also recommended that the BAOT should :

'seek to obtain more opportunities for senior OTs in local authorities to be considered for management posts at all levels.'

thereby recognising the important role senior occupational therapists can play in the most effective deployment of specialist staff, their potential input to long-term planning and policy and the training of other staff and the value of providing supervision from the same professional background.

Whilst the long-awaited White Paper (1989) also identifies areas of work for occupational therapists the general ethos of local authorities being 'arrangers' and 'purchasers' of services that are 'bought in' presents inherent problems for obtaining the maximum benefit from the specialist occupational therapy skills. Within some social services

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departments occupational therapists have been asked to prepare themselves for 1992 when they should set up a service outside the social services department. Whilst there might be advantages to the occupational therapists in the mutual support that they might derive there would also be the disadvantages outlined earlier. This study suggests that clients derive the greatest benefit where occupational therapists and social workers work side by side drawing on each others expertise as required. Occupational therapists' skills were used more exclusively for more complex cases when they did not have to deal with all the physically handicapped and elderly cases because social work assistants were able to take the less complex cases, obtaining guidance from the occupational therapists if required.

Working within the department means that it is easier to forge and maintain links with other staff and other departments, e.g housing, education, planning, recreation and leisure. Linked with the presence of senior occupational therapists in management positions their skills can touch many more people by bringing their holistic philosophy of the attainment of the maximum possible independence to their involvement in staff training programmes; the design of new housing, residential accommodation and community provision.

Another aspect that does not co-exist easily with the philosophy of 'buying in' occupational therapy services is the training of future occupational therapists. The time involved with guiding and supporting students may become a luxury. The occupational therapy training is undergoing some major organisational changes. There is more movement towards incorporation within larger educational establishments. The advantages of this are that the students have a broader experience, mix with students from other faculties, and have access to better library facilities and staff from other backgrounds. The possible

disadvantage is the dilution of the 'socialisation' process, the adoption of a set of norms that make occupational therapists view problems in their specific way, the holistic problem-solving approach.

Another development in the training is the prospect that in 1991/2 the funding for para-medical training will be given to health regions. There are anxieties that in a time when the numbers of occupational therapists needs to be increased in a nationally consistent manner, places may become restricted with regions only seeking to meet their own local targets. The situation may arise where regions are only prepared to fund places for students from their own regions who would then be committed to work for them afterwards. This could lead to an insular service and a lack of consistency of standards throughout the country. In general, training colleges are moving towards community placements for all their students during the course, but problems still exist in finding enough suitable placements where students will be adequately supervised. Degree courses are also being introduced in many training establishments that have sufficient involvement with suitable centres of higher education and, linked with this, there is also discussion concerning future combined training with physiotherapists and arrangements with European schools.

It is clear that these are changing times for all those concerned with health and social care and, whatever new systems finally emerge, it is important that occupational therapists are situated and deployed where their professional skills will have the greatest and most far-reaching impact. This can only be achieved by recognising that they are a specialist resource which should be used selectively .

APPENDICES

APPENDIX I

INFORMATION SENT TO RESPONDENTS, RECORD SHEETS AND QUESTIONNAIRE

QUESTIONNAIRES, RECORD SHEETS AND INFORMATION SENT TO RESPONDENTS

Within this Appendix is a copy of the questionnaire that was completed by the respondents; an example of the daily record sheets that the respondents were asked to complete (one for each day of the week) and the client visit records that the respondents completed for every third visit; and the covering note that was sent to each respondent.

1. SAMPLE : Covering note sent with formsUniversity of DurhamHealth Care Research Unit
Department of Sociology and Social Policy

DHSS Research : The role of occupational
therapists within social services departments

The DHSS has funded this research project which is concerned with examining the role of occupational therapists (OTs) within social services departments. The aim of the research is to provide a description of the work that OTs carry out within different types of departments and to consider the factors which influence this.

It is hoped that the results of the research will provide information that will indicate the ways in which occupational therapy skills can be used most effectively within different organisational and administrative structures. It is also hoped that information may be forthcoming on the appropriateness of the current occupational therapy training courses for the work that OTs undertake in social services departments.

The director of your department has kindly allowed me to seek your co-operation in this project. Your co-operation will be very valuable and will enable me to obtain the comprehensive picture that is required.

Many thanks for your help.

Anna K. Bristow
Remedial Research Fellow

2. SAMPLE : Daily Record SheetFriday1981

Morning
Time (approx)

LUNCH BREAK

Afternoon
Time (approx)

3. SAMPLE : Client visit record

1. Initials of client 2. D.o.B. 3. Sex

4. a. Primary diagnosis

b. Secondary diagnosis (if any)

5. Is this - i) A new referral? Please tick
 ii) A re-referral?
 iii) A current case?

a) If i) or ii) - Why was the visit requested?

b) If iii) - What is the reason for this visit?

6. Brief description of what took place during visit (include duration)

7. What actions (if any) are you taking as a result of the visit?

THE ROLE OF OCCUPATIONAL THERAPISTS
WORKING IN SOCIAL SERVICES DEPARTMENTS

QUESTIONNAIRE FOR
FIELDWORK OCCUPATIONAL THERAPISTS

University of Durham
Health Care Research Unit
Department of Sociology and Social Policy
1981

QUESTIONNAIRE FOR OCCUPATIONAL THERAPISTS
WORKING WITHIN SOCIAL SERVICES DEPARTMENTS

This study is being undertaken by staff of the Health Care Research Unit in the Department of Sociology and Social Policy at the University of Durham. It is financed by the DHSS and its aim is to study the role of the occupational therapist working in the community. All the information that you give will be treated with the utmost confidence and in reporting on the study no information will be related to individuals or individual authorities.

Please try to answer all questions. If a question is not applicable to you, please write N/A rather than leaving a blank space. Some questions require a tick to be placed beside the appropriate response, others require factual information or request you to express your opinion or to give a brief explanation.

Please feel free to write in any explanation or comments at the back of the questionnaire.

If you have any queries, please do not hesitate to contact:

Anna Bristow Dip COT, SROT.
Health Care Research Unit
Department of Sociology and Social Policy
University of Durham
Elvet Riverside
New Elvet
Durham DH1 3JT

Telephone: Durham (0385) 64466 ext. 238 (office number)
038 576 284 (home number)

Section One

tick

- 1. a) Are you based - a) in an area/division office ? _____
- b) at social service headquarters ? _____
- c) other (please specify) ? _____

b) If you work part-time, how many hours a week is this ?

_____ hours

- 2. a) How frequently do you have contact with other domiciliary OTs working in your social services department ?

tick

- daily _____
- 2 or 3 times a week _____
- once a week _____
- once a month _____
- less than once a month _____
- never _____
- N/A (no other OTs) _____

- b) Do you think there is (or would be) benefit from more frequent contact with other OTs ?

YES _____

NO _____

If YES - please give details

3. To whom are you directly responsible - tick
- a) an occupational therapist ? _____
 - b) a social worker ? _____
 - c) other (please specify) ? _____

- a) Is your supervision - tick
- i) formal (e.g. a session each week) ? _____
 - ii) informal (e.g. as and when required) ? _____
 - iii) formal and informal ? _____
 - iv) N/A (not supervised) ? _____
 - v) other (please specify) ? _____

- b) Which of the following apply to the form of supervision that you receive ?
(please tick any that apply)
- advice on the best methods of handling clients difficulties _____
 - advice on departmental procedures and policies _____
 - exchange of information concerning progress of individual cases (e.g. adaptations etc.) _____
 - other (please specify) _____

c) What form of supervision (if any) is, or would be, most useful to you ?

4. Please comment on the degree of access you have to senior management and policy making channels .
5. For how long have you held this post ?
_____ years _____ months
6. Why did you choose this particular post ?
7. Why did you leave your last post ?
(Only reply if this is not your first post)

Section Two - the following questions are concerned with the work that you do.

8. How many referrals have you received in the past two working weeks, i.e. ten working days ?
(Please include re-referrals of closed cases)

tick

less than 11

11 — 20

21 — 30

31 or more *(Please specify number)*

9. How many cases are you dealing with currently ?
(Do not include cases that you keep permanently open if you have not visited them within the last 3 months).

10. Do you keep some cases permanently open ?

YES

NO

If YES :

i) Approximately how many cases do you keep open ?

ii) Why do you keep them open ?

11. Are all referrals concerning requests for aids/adaptations for physically handicapped people passed to the OT section (or to you if you are the only OT) ?

tick

YES

NO

If NO:

Which of the following most closely describes the manner by which your referrals are selected ?

tick

i) You select those cases that you will take

ii) Your supervisor selects those cases that you will take

iii) Some other method (please specify)

12. In your opinion, what criteria do you think should determine whether or not a referral is passed to you ?

13. If you (or you and your OT colleagues) do not deal with all referrals concerning requests for aids/ adaptations for the physically handicapped, to whom are they passed ? (Please give job title(s)).

14. Do you receive assistance from any of the following ? -

tick

OT assistant/aid

social work assistant

clerk/admin.

typist

technician/handyman

a) If you receive assistance from an OT assistant/aid please describe the effects that this has on your work (if any).

b) If you receive assistance from a social work assistant -

i) Approximately how many hours a week is this _____

ii) What effects (if any) does this have on your work ?

15. Are you required to supervise/direct anyone else's work ?

tick

YES

NO

If YES:

Please give their job title(s)

(please include students - OT social work etc.)

16. b) Please study this list of the type of work that you may undertake when you are with your clients. Place a figure 1 beside the type of work that occupies most of your time spent with clients, and 2 beside the second most time-consuming and so on.

NB Please mark X in the appropriate column if you do not undertake a particular type of work.

NB Please mark R in the 'not undertaken' column if you only do such work rarely.

NB Please add to this list any other type of work that you do with clients and number accordingly.

Type of work	Time spent	not undertaken
Assessment for aids/equipment/adaptations		
Instruction in use of aids/equipment		
Instruction in special techniques (e.g. dressing, climbing stairs,)		
Specific treatment/rehabilitative activities		
Counselling (e.g. adjustment to and management of disability/entitlement to benefits/future occupation, employment)		
Discussions specifically concerned with rehousing		
Discussions specifically concerned with major adaptations		
Other -		
-		

16. c) Please study this list of the settings in which you may work with clients. Place a figure 1 beside the setting in which you do most work with clients, a 2 beside the second most likely setting and so on.

NB Please mark X in the appropriate column if you do not work with clients in a particular setting.

NB Please mark R in the 'no client work' column if you only work there with clients rarely.

NB Please add to this list any other settings in which you work with clients and number accordingly.

Setting for work with clients	Most client work	No client work
Client's home		
Day centre		
Special school		
Residential accommodation		
- children		
- physically handicapped adults		
- elderly		
Other -		
-		
-		
-		
-		

16. d) Please consider all the meetings that you regularly attend in connection with your work (i.e. yourself and one or more other person(s).)

Please describe the purpose of the meeting, the frequency (or approximate frequency) with which they occur, and briefly describe your role at the meeting.

Purpose of meeting	Frequency	Your role (i.e. the contribution you make)

(Continue overleaf, if necessary)

17. Please list other activities which form a part of your regular work (that have not been included in previous questions) stating the approximate frequency with which they occur, e.g. daily, weekly, monthly, 6 monthly etc.

18. Are there any aspects of your work (either with clients or of a general nature) on which you would like to spend more time ? If so, please give details.

19. Are there any client groups with whom you do no work (or do little work) but to whom you consider you could make a useful contribution? If so, please give details and a brief explanation.

20. In your opinion, what aspects of your daily work (if any) could be undertaken by someone other than a qualified OT? Please give brief details.

21. What aspects of your OT training do you consider are most relevant in the context of your daily work ?
(Please list not more than six in order of priority with a brief explanation.)

22. Are there any major aspects of your present work for which your OT training did not prepare you ? If there are please specify and give a brief explanation.

The following two questions are concerned with clarifying your role in relation to different groups of staff. Please complete the charts by ticking as many boxes as apply for each group.

NB If you have no contact with a certain group mark X in the 'no contact' column only.

NB If contact is rare, mark R in the 'no contact' column in addition to ticking the type of contact.

NB If you have some other role, tick 'other' and describe it briefly on the back of the pages, giving the group to which it refers.

NB If you have contact with other groups not listed in the following two questions, please add at end of questionnaire.

23. What is your role in relation to each of the following groups ?

Staff Group	Contact concerning your own clients	Advisory (see note) 1	Work on joint ventures See note 2	Training (See note 3)	Other	No contact
Social workers						
Social work assistants						
Principal social workers						
Home helps						
Home help organisers						
Officers for the blind						
Officers for the deaf						
District/community nurses						
Senior nursing officers (community)						
G.P.s						
Community physician						
Community physiotherapists						
Health visitors						
*Day centre organisers						
Day centre staff						
*Residential establishment supervisors						
Residential care staff						
Playgroup organisers						
Head teachers - special schools						
Staff in special schools						
Community workers						
Hospital staff -						
- Consultants						
- OTs						
- Physios						
- Social workers						

* Applies to any type of centre/home - elderly, mentally handicapped, physically handicapped, disturbed children etc.

Notes

1. Advisory - i.e. advice of a general nature or on their clients.
2. Joint ventures - i.e. special projects, working parties.
3. Training - i.e. you help in their training/staff development.

Some of the departments in your local authority may be organised in a different way from those listed below -

e.g. architects and planning may be combined, or environmental health and public works may be combined.

Please use your discretion and record the type of contact you have in the appropriate box even if the departments are not separate.

NB The term 'senior officers' used below refers to staff in high level management positions, e.g. the chief officer, his/her deputy, principal officers in charge of sections.

Staff Group	Contact concerning individual clients	Advisory	Work on joint ventures	Training	Other	No contact
Senior officers-architects dept.						
Staff in architects dept.						
Private architects						
Senior officers - housing dept.						
Staff in housing dept.						
Senior officers - environmental health dept.						
Staff in environmental health dept.						
Senior officers in planning dept.						
Staff in planning dept.						
Senior officers in public works/ - building dept.						
Staff in public works/building						
Senior officers - education dept.						
Senior officers - recreation/ leisure dept.						
Research/development staff						
Training section staff						
Local authority councillors						
L/A committee chairmen						
Voluntary organisation organisers						
Voluntary organisation staff						
Housing associations.						

25. Which aspects of your work give you the greatest satisfaction ?
Please list them and give your reasons.
26. Which aspects of your work give you the least satisfaction ?
Please list them and give your reasons.
27. What do you feel are the pressures upon you (if any) as
a worker in a social services department ?
(Continue overleaf if necessary.)

Section Three - It would be helpful for our analysis if you would complete the following personal details.

28. Female _____
Male _____

29. Age - under 25 yrs. _____
25 - 34 yrs. _____
35 - 44 yrs. _____
45 yrs. or more _____

30. Marital status: _____

31. Please give any qualifications that you may have in addition to your OT diploma.

32. Please give brief details of your working life, starting from when you left school.
(Please include any time spent in training and at home, e.g. raising family.)

Dates (eg 1967-1970)	Employer (where appropriate) (For OT posts please state client group)	Position (eg student, basic grade OT etc.)

33. Please add any further comments that you may have concerning your work and role within the social services department

THANK YOU VERY MUCH FOR YOUR CO-OPERATION

APPENDIX II

CASE STUDIES : DETAILS OF DIARIES AND VISITS

CASE STUDIES - Relating to visits undertaken during the week studied

Within this Appendix are some randomly selected samples of the Daily Record Sheets and Client Visit Records which were completed by the respondents. The daily record sheets illustrate every activity undertaken associated with their work during a full working day. The client visit records show the interaction that occurred during visits and the actions that the respondents intended to carry out as a result of the visits. The selection was made to portray examples from full and part-time workers within the Intrinsic and Extrinsic groups.

DAILY RECORD SHEET 1 (Extrinsic part-time)

Wednesday

Time

- 9.00 Arrive ----- Area Office (OT 'surgery' has been held at this office during staff shortages once a week for past nine months. Some cases visited, others advice only given to social workers.) Morning to be spent handing over cases temporarily covered in absence of OT staff to two new OTs (one full-time, one part-time).
- 9.05 Check typing, reports, letters etc. since previous week's visits.
- 9.15 Checking information received re.cases during previous week.
- 9.30 Division of cases for handing over into geographical areas.
- 9.40 Handover time with brief discussion of each case. Approx 20 cases involved.
- 11.40 Interview with social worker wanting advice on a case.
- 11.50 Interview with a second social worker wanting advice on a case.
- 12.05 Tour of store room (aids).
- 12.15 Discussion with new OTs of some office procedures.
- 12.30 (approx) Lunch break.

- 1.15 Still at ----- Area Office.
- 1.20 Phone call from Mrs.W (a very muddled and difficult lady) concerning -
1. Plans for extension for wheelchair-bound husband
 2. Planning permission, building regs. etc.
 3. Her lack of confidence in architect of her choice - this is the third architect!
- Call lasted 1hr. 20mins!
- 2.40 Phone call to Senior Environmental Health Officer re. above case for clarification of certain queries on procedure.
- 2.55 Call to Mrs. W. to outline procedures re. planning etc.
- 3.30 End of phone call ! (New OT could not believe this would be one of her cases!)
- 7.00 Brief notes written on afternoon phone call - 15 minutes.

DAILY RECORD SHEET 2 (Extrinsic full time) Monday

Time

- 9.00 Arrive at office. Check message book. Make coffee. General conversation between staff.
- 9.30 Northern Team meeting. Matters discussed included :-
1. Standby duty.
 2. Volunteer scheme.
 3. Circulars were read out.
 4. Notification of Magistrates meeting.
 5. I gave a brief resume of the IYDP I had attended on Saturday at which I had been representing social services.
 6. Notification of procedures with electricity arrears.
 7. Minutes of DMT were read out.
 8. New referrals were allocated.
 9. Part III vacancies were discussed.
- 11.30 Phone calls - OT at H----- re. meeting to be held on 8th.
 - HQ re. collection of screens from IYDP exhib.
 - Housing dept.
 - T----- re. a client who needs bannister rails.
 Writing up records, movement sheets from previous friday.
- 12.30 Lunch break.
- 1.30 Continue with admin. and recording until candidate arrives for

interview at -----.

- 2.15 There is a vacancy in the team for a level III Social Worker and we have been asked to remain in the office to meet the only applicant who has been accepted for interview.
- 2.45 Leave office to go to the local clinic. I am looking for a mattress for a handicapped child who has recently undergone a spinal op. and the clinic have one which they think might be suitable. It is not, but I spend some time chatting to the D.N.s and H.V.s about mutual clients.
- 3.15 I return to office for supervision which has been scheduled for 3.30 pm. This I discover has had to be cancelled, and retimed for Thursday at 9.30 am.
- 4.15 Reply to two people who phoned whilst I was out (OT in B---- and a client).
- 4.30-5.00 Complete some of questionnaire and today`s diary.
- 7.30-9.30 Meeting. Final session of Volunteers` course.

DAILY RECORD SHEET 3

(Intrinsic part-time)

Tuesday

Time

- 9.00 Arrive at day centre base. Make telephone calls, look at new referrals.
- 9.45 Go to meeting at which SW for the Deaf explains her role. This clarifies several points.
- 12.00 Visit
- 12.30 Social Services Centre A----- House. See Home Teacher for the Blind and discuss shared clients.
- 1.00 Visits. Two in sheltered flats for the blind.
- 2.00 Visit clients, married couple - husband asking for help.
- 2.30 Write report.
- 3.00 Finish.

DAILY RECORD SHEET 4

(Intrinsic full time)

Wednesday

Time

- 8.25 Admin. open post, sort through messages and new referrals.
Talk to student re. log book etc.
Check typed letters.
- 9.00 Arrange lunchtime drink for student leaving.
Write referral in book.
- 9.30 Phone call from Medical Loans dept. re. aids collected by our dept. (2 mins)
- 9.40 Phoned housing manager re. works being done to house with a handicapped child. (10 mins)
- 9.50 Phoned Functional Assessment Unit King's College for possible adapted trolley for loan. (5 mins)
- 10.10 Phoned GP re. medical condition of client.
- 10.15 Admin., letters, case notes.
- 10.40 Client interview for a bus pass (at office).
- 11.00 Collect portable ramps and rubazote from stores for clients.
- 11.15 Joint visit made with teacher at mental handicapped centre to discuss progress at centre and future programme to be co-ordinated at centre and at home. (1.25 hrs)
-
- 12.30 Visit to client already known to dept. for advice on exercises to improve grip, and larger handled cutlery.
- 1.05 Travel.
- 1.15 Visit to client already known to deliver portable ramps. Client not back from physiotherapy as being pushed by wife in wheelchair Spoke to mother and left instructions and ramps.
- 1.35 Admin. in car. Diary sheet, case notes.
- 2.00 Garden party held by Good Neighbour scheme in NW Area. Met good neighbours, Home Help Organiser, social workers, volunteers,

sheltered flats warden.

- 3.00 Visit. Follow up possible adaptations to trolley for gutter arm supports.
- 3.45 New referral. Client having problems picking things up from the floor.
- 4.30 Travel.
- 4.35 New referral for a telephone.
- 5.10 Travel.
- 5.30-7.00 Meeting on group supervision and groupwork within the borough to try to start and develop more of this. Social workers mainly.

DAILY RECORD SHEET 5

(Extrinsic full time)

Thursday

Time

- 8.45 Area office. Collection of post/messages etc.
- Letters - 1. From Training Officer re. talk on 'Aids for the handicapped' for home helps.
 2. From client informing me that council have completed a ramp and grab rails.
 3. To arrange an appointment.
 4. From carpenter re. problems fixing grab rail.
- Phone calls - 1. From HV re. 2 referrals - both need bath aids, one needs a telephone.
 2. From client requesting collection of wheelchair.
- 10.00 Team meeting. Meet with all SWS, HHO, SWA etc. Referrals allocated and discussed.
- 10.45 Arrangements made with Home Help organiser for new OT to spend half day doing visits with them.
- 11.00 Clinic appt. at hospital.
- 12.00 Collection of aids needed for visits.
- 12.30 Travelling to W-----.
- 12.45 Lunch break.
- 1.15 Visit. To client re. difficulty of fixing grab rail above bath.

To re-assess problem.

- 1.45 Travelling to W-----.
- 2.00 Visit for collection of wheelchair from Master P.
- 2.30 Visit to check stair rail put up by council and to see that client is coping after recent discharge from hospital.
- 2.50 Visit re. problems with bath. No reply.
- 3.00 Visit to Mr. and Mrs. W.
- 4.30 Travelling back to area office.
- 5.00 Phone call to client`s GP re. wheelchair - no reply.
Phone call to Technical Officer at ALAC re. special lightweight chair - no reply.
- 5.20 Go home.

DAILY RECORD SHEET 6

(Intrinsic full time)

Wednesday

Time

- 8.45 Start from home travel 16 miles to first visit.
- 9.30 First visit.
- 10.10 Leave and look for next address. Road numbers run out at 78 no other houses on the road - new development. Go to client`s daughter`s address - no-one at home. Go to corner shop to enquire. Extension of road now half a mile away across a new main road in area re-named a separate village! Locate house 10 mins. late for appt. time. No-one at home. This is a home assessment client being brought from convalescent home by Medical Social Worker.
- 10.45 District nurse arrives also to see same patient!
- 11.05 I write this up. Nurse does another visit meantime. Left a note on back door and go to find a telephone box!!
- 11.25 Found telephone. Phone office, discover message left at 10.30

- that client and MSW wouldn't be coming. Returned to client's address left note on door for nurse and returned to office - 21 miles.
- 11.55 Met a client's wife going through a village on the way spent 20 mins. talking to her re. her problems.
- 12.30 Arrive office. Collect messages, post etc.
Reported client's problems to SW.
- 1.00 Lunch break.
- 2.00 Allocation meeting. Office notices. Give team info. re. client referrals for S. Workers.
- 2.20 Phone call, private matter.
- 2.30 Trying to sign letters for post, etc. In-tray, paperwork.
- 3.00 Tea break. S. Workers give me information re, clients.
- 3.15 Return to desk. Phone call from OT Hospital re. aids for client. Second call from OT Hospital re. info. concerning above.
- 3.25 Husband called, private business.
- 3.30 Carry on with paperwork.
- 3.50 Office cleaner asks query about her handicapped brother, give her advice to pass on.
- 4.00 Phone call from client re. wheelchair for parent.
- 4.10 Start report for Area Director about problems this morning.
Phone call from client re. Mum's wheelchair, can I contact another client re. private purchase?
Contact S. Worker re. tel. no. for wheelchair for Mum. Report to her re. first visit this morning, her client also.
Return to desk and continue report for Area Director.
- 5.45 Finish report, start Adaptations form for 1st visit this morning.
- 6.15 Clear up and go home.

CLIENT VISIT RECORD 1

(Extrinsic part-time)

1. Initials of client : S.MCW. 2. Age: 34 3. Sex: F
4. Diagnosis: Multiple sclerosis
5. A current case.

Reason for visit: Major adaptation in progress - visit to check
and to check plans for additional project.

6. Description of visit

- 1) Building work to provide extension for bedroom, shower, and wc facilities and egress from rear of property, well in hand.
Should be completed in a few days.
- 2) Discussed with builder and client's husband position of rail for wc and simulated transfer tried with client.
- 3) Inspected plans for further work to be carried out in the kitchen - to provide improved levels of work tops and cupboards, also split level cooker. Finance approved by social services and grant aid from environmental health.
- 4) Discussed with client and her husband procedure for final process of obtaining grant(s) for kitchen.
- 5) Agreed to arrange for delivery of shower chair as shower will soon be ready for use.

(Duration of visit - 45 mins)

7. Action resulting from visit

- 1) To photocopy plans of proposed alterations to kitchen for record purposes.
- 2) To write to environmental health officer confirming that plans are suited to client's needs before they agree to grant aid.

CLIENT VISIT RECORD 2

(Extrinsic full time)

1. Initials of client: R.T. 2. Age: 76 3. Sex: F
4. Diagnosis: Rheumatoid arthritis.
5. A current case.

Reason for visit: I am returning following my first visit when I assessed for aids.

6. Description of visit

Client was up and dressed and busy in the house - albeit a relatively early call.

She had just returned from holiday and expressed the feeling of anti-climax at coming home to an empty house. Client had been widowed early this year and was still very lonely and often depressed.

I asked if she would like to consider attending any of the clubs in the area and if she would like a social worker to call. She said she would.

We chatted about the holiday and then went up to the bathroom where I fitted the bath aids and she tried them out. They were OK so I left them. I then showed her how to use the kitchen aids ('Strongboy' jar opener and Dycem grip mat) and departed.

(Duration of visit - half an hour)

7. Action resulting from visit

I will be investigating clubs, volunteer visitor and then closing the case.

CLIENT VISIT RECORD 3

(Intrinsic part-time)

1. Initials of client: E.G. 2. Age: (not given) 3. Sex: F
4. Diagnosis: Multiple sclerosis
5. A new referral

Reason for visit: Assess for walking frame.

6. Description of visit

Client took long time answering door but was pleased to have a small folding walking frame which she knew how to use. A small one had been requested as there are several narrow doorways in the house. Paperwork done and handling charge received.

(Duration of visit - 15 mins).

7. Action resulting from visit

Complete paperwork.

CLIENT VISIT RECORD 4

(Intrinsic full time)

1. Initials of client: E.S.W. 2. Age: 92 3. Sex: F
4. Diagnosis: Heart condition/ arthritis of hip and knee/deaf
5. A current case

Reason for visit: To explain that the provision of a stairlift in her case is impossible either by social services or charities due to her age and medical condition.

6. Description of visit

Interview with 65 year old daughter who is caring for her mother. She does not want a home help or a district nurse to help her as she prefers to have the privilege of looking after her mother herself. The previous evening her mother had decided that she was unable to sleep downstairs any longer even with her daughter on the floor in the same room. So despite her medical condition she climbed the stairs and a neighbour helped to take the bed upstairs. Net result

is that she is not very well today.

Explanation to daughter why it was not feasible to have a stairlift and enormous cost etc. Daughter still very disappointed but enjoyed talking to me and explaining the problems she has with her deaf mother and no other family that bother. Her friends still visit her from work which is a break and she admitted to missing work as she did not retire until last year. Despite her apparent loneliness and isolation she will not let neighbours or volunteers look after her mother for an afternoon and she will not leave her for longer than a couple of hours.

Did not speak to mother as she was asleep upstairs. GP does not know that she has climbed stairs against his instructions.

(Duration of visit - 50 mins)

7. Action resulting from visit

No further action to be taken unless client phones dept.

Follow-up will be made in one month`s time.

APPENDIX III

OCCUPATIONAL THERAPISTS' LIAISON WITH OTHER PERSONNEL

TABLES

Table 3:1 Proportion of respondents in each area having contact concerning own clients with these personnel

Personnel	Intrinsic				Extrinsic					
	% B n-7	% E n-11	% H n-12	% K n-5	% A n-8	% C n-5	% D n-22	% F n-9	% G n-1	% J n-10
S.Workers	100	100	100	100	100	100	95	89	100	90
SW Assistants	86	100	100	100	88	100	73	89	100	100
Princ. SWS	14	82	50	100	100	80	73	56	-	50
Home helps	100	73	75	100	88	80	86	67	100	80
Ho. help org.	100	100	67	100	100	100	91	100	100	100
Off. blind	86	91	92	100	86	100	82	44	-	80
Off. deaf	86	36	75	100	86	80	73	55	-	60
Dis. nurse	100	91	100	100	86	100	86	89	100	100
Sen.nur.off.	23	82	67	50	63	80	45	44	-	50
Gen.practit.	100	91	100	75	100	80	95	100	-	80
Comm.physic.	57	64	42	75	25	20	45	33	-	40
Comm.physio.	14	55	100	100	50	20	77	33	100	60
H.visitors	100	100	100	100	100	80	82	100	100	90
Day cen.org.	100	100	92	100	75	60	77	67	-	80
Day cen.staff	71	91	75	100	75	60	50	44	-	60
Res.estab.sup.	100	64	58	100	25	60	41	78	-	70
Res.estab.staff	71	27	58	100	38	20	14	44	-	50
Playgroup org.	-	27	8	25	-	20	14	22	-	10
Head spec.sch.	43	55	67	75	25	-	59	56	-	30
Staff spec.sch.	71	36	67	75	86	20	59	56	-	30
Comm.worker	100	64	42	75	50	20	55	33	-	30
Hosp.staff										
Consultant	29	91	42	75	75	60	59	78	-	40
OTs	100	100	100	100	100	100	91	100	100	100
Physios	86	82	100	100	86	60	91	100	100	80
Soc.worker	100	91	100	100	100	80	95	100	100	100

Table 3:2 Proportion of respondents in each area who advise these personnel on their cases or other aspects of work

<u>Personnel</u>	Intrinsic				Extrinsic					
	%	%	%	%	%	%	%	%	%	%
	B n-7	E n-11	H n-12	K n-5	A n-8	C n-5	D n-22	F n-9	G n-1	J n-10
S.Workers	71	73	83	100	100	80	77	100	-	90
SW Assts.	43	64	83	100	63	40	59	100	-	70
Princ.SWs	14	64	67	60	75	60	32	67	100	20
Home helps	29	36	50	100	50	40	41	67	-	50
Ho.help org.	57	64	50	75	88	40	41	78	-	80
Off.blind	57	64	33	100	38	60	55	33	-	20
Off.deaf	57	9	33	100	25	40	36	11	-	10
Dis.nurse	57	55	75	100	38	80	59	89	-	70
Sen.nur.off.	-	27	42	-	13	20	27	33	-	30
Gen.practit.	29	55	50	75	63	40	41	67	100	40
Comm.physic.	29	18	17	50	-	-	18	11	-	10
Comm.physio.	14	36	58	100	34	-	27	-	-	20
H.visitors	71	45	75	100	63	20	45	78	-	60
Day cen.org.	29	55	58	75	50	-	32	67	-	30
Day cen.staff	14	45	42	75	25	20	27	33	-	20
Res.estab.sup.	57	36	42	50	13	20	32	89	-	20
Res.estab.staff	14	27	25	50	13	-	14	78	-	10
Playgroup org.	-	9	-	25	-	-	14	-	-	20
Head spec.sch.	14	27	25	50	13	-	32	11	100	20
Staff spec.sch.	14	27	42	50	25	-	27	22	100	10
Comm.worker	57	36	58	50	25	20	41	33	-	30
Hosp.staff										
Consultant	14	45	17	50	13	20	5	11	-	10
OTs	43	55	67	50	75	60	45	89	-	50
Physios	23	45	33	75	63	20	23	67	-	40
S.workers	43	45	50	75	63	20	50	78	-	50

Table 3:3 Proportion of respondents in each area who became involved in joint ventures with these personnel

Personnel	Intrinsic				Extrinsic					
	% B n-7	% E n-11	% H n-12	% K n-5	% A n-8	% C n-5	% D n-22	% F n-9	% G n-1	% J n-10
S.workers	43	27	25	25	75	60	45	56	-	30
SW assts.	14	27	8	25	50	40	36	56	-	10
Princ. SWS	29	18	25	25	50	20	18	44	-	10
Home helps	-	18	-	-	-	-	-	-	-	-
Ho.help org.	14	27	-	-	25	40	9	11	-	20
Off.blind	14	27	8	50	-	20	14	-	-	10
Off.deaf	14	-	8	25	-	-	5	11	-	-
Dis.nurse	14	36	17	-	-	60	5	33	-	10
Sen.nur.off.	-	18	-	-	-	40	5	33	-	-
Gen.practit.	-	18	8	-	-	-	-	-	-	-
Comm.physic.	-	9	-	-	-	-	5	-	-	10
Comm.physio.	-	-	25	25	13	-	23	-	-	10
H.visitors	-	27	17	25	-	60	5	33	-	10
Day cen.org.	-	18	8	25	-	-	9	22	-	20
Day cen.staff	-	9	17	25	-	-	5	-	-	10
Res.estab.sup.	-	9	-	-	-	20	5	11	-	10
Res.estab.staff	-	-	-	-	-	-	-	-	-	-
Playgroup org.	-	-	-	25	-	-	-	-	-	-
Head spec.sch.	-	9	-	-	-	-	-	-	-	10
Staff spec.sch.	-	-	17	-	-	-	9	-	-	-
Comm.worker	29	27	8	-	25	-	14	22	-	10
Hosp.staff										
Consultant	-	-	-	-	-	20	-	-	-	-
OTs	43	18	33	25	-	60	36	44	-	10
Physios	14	18	17	25	-	60	9	11	-	-
S.workers	14	18	25	25	-	20	27	11	-	10

Table 3:4 Proportion of respondents in each area who became involved in the training of these personnel

Personnel	Intrinsic				Extrinsic					
	% B n-7	% E n-11	% H n-12	% K n-5	% A n-8	% C n-5	% D n-22	% F n-9	% G n-1	% J n-10
S.workers	43	36	17	-	38	20	41	56	-	40
SW assts.	14	36	42	-	50	20	41	44	-	10
Princ.SWS	-	-	-	-	25	-	5	22	-	-
Home helps	14	-	-	-	50	20	32	33	-	60
Ho.help org.	-	-	-	-	25	-	5	-	-	20
Off.blind	29	-	8	-	-	-	-	-	-	-
Off.deaf	14	-	-	-	-	-	-	-	-	-
Dis.nurse	57	9	17	-	-	-	18	11	-	40
Sen.nurs.off.	-	-	-	-	-	-	-	-	-	-
Gen.practit.	14	-	8	-	13	-	9	11	-	-
Comm.physic.	-	-	-	-	-	-	-	-	-	-
Comm.physio.	14	-	-	-	-	-	-	-	-	-
H.visitors	43	18	8	-	-	20	14	11	-	20
Day cen.org.	-	9	8	-	13	-	-	11	-	-
Day cen.staff	-	18	8	-	13	-	9	11	-	-
Res.estab.sup.	-	-	-	-	13	-	-	22	-	-
Res.estab.staff	-	-	-	-	-	20	-	33	-	-
Playgroup org.	-	-	-	-	-	-	-	-	-	-
Head spec.sch.	-	-	-	-	-	-	-	-	-	-
Staff spec.sch.	-	-	-	-	-	-	-	11	-	-
Comm.worker	14	-	-	-	-	-	9	11	-	-
Hosp.staff										
Consultant	-	-	-	-	-	-	5	-	-	-
OTS	14	18	8	-	13	-	18	22	-	-
Physios	-	-	-	-	-	-	-	-	-	-
S.workers	-	-	-	-	-	-	5	11	-	-

Table 3:5 Proportion of respondents in each area who had no contact with these personnel.

Personnel	Intrinsic				Extrinsic					
	% B n-7	% E n-11	% H n-12	% K n-5	% A n-8	% C n-5	% D n-22	% F n-9	% G n-1	% J n-10
S.workers	-	-	-	-	-	-	-	-	-	-
SW assts.	14	-	-	-	13	-	9	-	-	-
Princ.SWs	29	9	17	-	-	-	9	-	-	10
Home helps	-	-	8	-	-	-	9	-	-	10
Ho.help org.	-	-	8	-	-	-	-	-	-	-
Off.blind	-	-	-	-	13	-	-	22	100	-
Off.deaf	-	36	-	-	13	20	5	33	100	10
Dis.nurse	-	-	-	-	-	-	5	-	-	-
Sen.nurs.off	14	18	8	-	25	20	23	11	100	20
Gen.practit.	-	-	-	-	-	-	-	-	-	-
Comm.physic.	14	27	50	-	63	40	32	11	-	-
Comm.physio.	71	27	-	-	38	60	9	44	-	10
H.visitors	-	-	-	-	-	-	5	-	-	-
Day cen.org.	-	-	-	-	-	-	5	22	-	10
Day cen.staff	-	9	-	-	25	20	27	44	-	20
Res.estab.sup	-	18	17	-	63	-	32	-	100	10
Res.estab.staff	14	45	17	-	50	-	50	-	100	10
Playgroup org.	86	64	75	50	100	60	45	67	100	50
Head spec.sch.	29	27	25	25	38	100	27	33	-	10
Staff spec.sch.	-	45	25	25	13	60	27	33	-	20
Comm.worker	-	27	17	-	25	40	23	33	-	30
Hosp.staff										
Consultants	14	-	25	25	-	20	14	11	-	10
OTs	-	-	-	-	-	-	-	-	-	-
Physios	-	18	-	-	-	20	-	-	-	-
S.workers	-	-	8	-	-	20	-	-	-	-

Table 3:6 Proportion of respondents in each area having contact concerning own clients with these personnel

Personnel	Intrinsic				Extrinsic					
	%	%	%	%	%	%	%	%	%	%
	B n-7	E n-11	H n-12	K n-5	A n-8	C n-5	D n-22	F n-9	G n-1	J n-10
Sen.arch.	14	45	25	100	25	40	41	11	-	50
Staff arch.	43	64	58	100	63	100	77	56	-	90
Priv.arch.	71	55	25	75	25	40	59	33	-	60
Sen.hous.off.	71	100	58	100	50	80	91	67	-	60
Staff hous.off.	100	100	75	100	86	100	86	89	100	90
Sen.env.h.off.	43	55	33	55	25	20	50	56	-	50
Staff env.h.	71	55	42	75	38	20	73	67	100	80
Sen.off.plan.	14	45	-	75	-	40	23	11	-	20
Staff planning	29	55	8	75	-	-	32	22	100	30
Sen.off.works	86	64	33	75	-	-	36	11	-	50
Staff works	86	27	42	75	-	40	50	22	-	70
Sen.off.educ.	14	-	17	25	13	-	18	11	-	30
Sen.off.recr.	57	-	-	50	-	-	5	11	-	10
Res.& develop.	14	9	-	50	-	20	-	-	-	10
Training off.	-	9	-	25	-	-	-	-	-	30
LA councillors	57	55	17	75	38	80	45	44	-	40
LA comm.chair.	14	9	-	25	13	60	-	11	-	-
Vol.org.org.	100	100	67	100	63	80	73	78	-	80
Vol.org.staff	100	64	83	100	63	60	56	78	-	90
Housing assoc.	100	73	50	100	75	80	77	22	-	40

Table 3:7 Proportion of respondents in each area who advised these personnel on their cases or other aspects of work

Personnel	Intrinsic				Extrinsic					
	%	%	%	%	%	%	%	%	%	%
	B n-7	E n-11	H n-12	K n-5	A n-8	C n-5	D n-22	F n-9	G n-1	J n-10
Sen.arch.	14	45	25	100	25	40	41	11	-	50
Staff arch.	29	27	50	50	38	60	50	22	-	50
Priv.arch.	29	45	8	25	-	20	36	33	-	30
Sen.hous.off.	43	55	25	50	50	20	23	33	-	30
Staff hous.off.	57	45	25	25	38	80	55	44	-	30
Sen.env.h.off.	14	36	25	25	-	40	14	33	-	20
Staff env.h.	29	27	25	25	-	40	55	44	-	40
Sen.off plan.	-	27	-	25	25	40	9	22	-	10
Staff planning	-	27	-	50	13	20	9	22	-	10
Sen.off.works	43	27	17	50	13	40	18	22	-	20
Staff works	43	9	8	50	-	40	18	11	-	40
Sen.off.educ.	-	-	8	-	-	-	-	-	-	-
Sen.off.recr.	29	9	-	-	-	-	5	22	-	-
Res.& develop.	29	9	-	-	-	-	5	22	-	-
Training off.	14	9	17	-	13	20	5	22	-	40
LA coucillors	14	45	25	-	13	-	23	33	-	-
LA comm.chair.	-	-	-	-	13	-	-	33	-	-
Vol.org.org.	57	55	50	25	25	40	55	56	-	40
Vol.org.staff	43	36	50	25	38	20	50	67	-	10
Housing assocs.	43	36	17	-	38	20	45	22	-	-

Table 3:8 Proportion of respondents in each area who became involved in joint ventures with these personnel

Personnel	Intrinsic				Extrinsic					
	% B	% E	% H	% K	% A	% C	% D	% F	% G	% K
	n-7	n-11	n-12	n-5	n-8	n-5	n-22	n-9	n-1	n-10
Sen.arch.	-	18	-	25	13	40	14	33	-	40
Staff arch.	14	27	8	50	13	60	41	22	-	40
Priv.arch.	14	9	-	25	13	60	23	11	-	10
Sen.hous.off.	-	27	-	-	25	40	18	22	-	20
Staff hous.off.	29	27	8	-	25	20	32	11	-	-
Sen.env.h.off.	-	9	8	-	-	20	9	22	-	10
Staff env.h.	-	27	8	-	-	20	36	22	-	20
Sen.off.plan.	-	9	-	-	13	-	14	-	-	20
Staff planning	-	-	-	-	13	-	32	-	-	20
Sen.off.works	-	18	8	-	13	20	14	-	-	20
Staff works	-	9	8	-	13	20	23	-	-	-
Sen.off.educ.	-	-	-	-	-	-	5	11	-	-
Sen.off.recr.	29	-	-	-	-	-	9	-	-	-
Res. & develop.	29	9	8	-	13	20	5	33	-	-
Training off.	43	-	17	50	25	40	27	11	-	40
LA councillors	-	18	-	-	-	-	5	-	-	-
LA comm.chair.	-	-	-	-	-	-	-	-	-	-
Vol.org.org.	29	18	-	-	13	20	9	56	-	10
Vol.org.staff	29	18	-	-	13	20	5	56	-	-
Housing assocs.	14	9	-	-	13	40	9	11	-	10

Table 3:9 Proportion of respondents in each area who became involved in the training of these personnel

Personnel	Intrinsic				Extrinsic					
	%	%	%	%	%	%	%	%	%	%
	B n-7	E n-11	H n-12	K n-5	A n-8	C n-5	D n-22	F n-9	G n-1	J n-10
Sen.arch.	-	-	-	-	-	-	-	-	-	20
Staff arch.	-	-	-	-	-	-	-	-	-	20
Priv.arch.	-	-	-	-	-	-	-	-	-	-
Sen.hous.off.	-	-	-	-	-	-	-	-	-	10
Staff hous.off.	-	-	-	-	-	-	5	11	-	10
Sen.env.h.off.	-	-	-	-	-	-	-	-	-	-
Staff env.h.	-	-	-	-	-	-	5	11	-	10
Sen.off.plan.	-	-	-	-	-	-	-	-	-	-
Staff planning	-	-	-	-	-	-	-	-	-	-
Sen.off.works	-	-	-	-	-	-	-	-	-	-
Staff works	-	-	-	-	-	-	-	-	-	-
Sen.off.educ.	-	-	-	-	-	-	-	11	-	-
Sen.off.recr.	-	-	-	-	-	-	-	-	-	-
Res. & develop.	-	-	-	-	-	-	-	-	-	10
Training off.	43	-	17	50	25	40	27	11	-	40
LA councillors	-	-	-	-	-	-	-	-	-	-
LA comm.chair.	-	-	-	-	-	-	-	-	-	-
Vol.org.org.	-	-	8	-	13	-	5	22	-	10
Vol.org.staff	-	-	8	-	13	-	5	22	-	-
Housing assocs.	-	-	-	-	-	-	5	-	-	-

Table 3:10 Proportions of respondents in each area who had no contact with these personnel

Personnel	Intrinsic				Extrinsic					
	% B	% E	% H	% K	% A	% C	% D	% F	% G	% J
	n-7	n-11	n-12	n-5	n-8	n-5	n-22	n-9	n-1	n-10
Sen.arch.	71	27	58	-	38	40	27	56	100	20
Staff arch.	14	18	25	-	25	-	5	22	-	-
Priv.arch.	29	36	67	25	63	40	14	44	100	20
Sen.hous.off.	14	-	8	-	13	20	-	11	100	10
Staff hous.off.	-	-	17	-	13	-	-	-	-	-
Sen.env.h.off.	14	36	50	50	63	60	23	22	100	30
Staff env.h.	43	45	42	25	63	60	9	33	-	10
Sen.off.plan.	86	55	92	25	63	40	45	67	100	40
Staff planning	71	45	75	25	75	60	23	67	-	50
Sen.off.works	14	36	58	25	75	40	45	67	100	40
Staff works	14	64	58	25	75	60	41	78	-	10
Sen.off.educ.	57	82	83	75	88	100	55	67	100	60
Sen.off.recr.	14	82	12	50	100	100	68	67	100	80
Res. & develop.	43	82	83	50	50	40	15	56	100	50
Training off.	29	73	58	25	25	40	32	56	100	30
LA councillors	29	18	50	25	50	20	27	44	100	60
LA comm.chair.	71	91	83	75	75	40	77	56	100	100
Vol.org.org.	-	-	8	-	38	20	-	11	100	10
Vol.org.staff	-	36	8	-	25	20	5	22	100	10
Housing assocs.	-	18	33	-	25	20	-	33	-	40

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