Using the Occupational Performance Model (Australia) to guide practice and research

Judy Ranka and Christine Chapparo

Judy Ranka, BSc, MA, OTR, is a Lecturer in the School of Occupational Therapy, The University of Sydney

Christine Chapparo, MA, DipOT, OTR, FAOTA, is a Senior Lecturer in the School of Occupational Therapy, The University of Sydney.

Originally prepared in 1998 for dissemination in Tromso, Norway. Based on a 1993 paper presented at the NSWAOT State Conference, Mudgee.

INTRODUCTION

A test of a model is how well it guides decision-making in practice and research. The remainder of this paper demonstrates how the OPM(Australia) can be used to explain occupational therapy and structure occupational therapy practice and research.

Uniqueness of Occupational Therapy

> *How does the Occupational Performance Model (Australia) identify the uniqueness of occupational therapy?*

The primary tenet of the OPM is that occupational therapists are concerned with the occupational nature of humans. It recognises that a person's ability to identify, select and perform roles, routines, tasks and sub-tasks to the satisfaction of self and/or others is essential to health. This occupational dimension to humans can be challenged by disease or disability or by the environment. When people are unable to adapt to these challenges or overcome them in a manner that is acceptable to themselves or others, an occupational need arises. Although occupational therapists claim to have an holistic view of clients (Hubbard, 1991; Jenkins, 1993), the relationship between constructs outlined in this model demonstrates that occupational therapists do not treat the 'whole' person:

> *Occupational therapists address the occupational need of their clients.*
>
> *Occupational therapists aim for their clients to be satisfied with their occupational existence.*
>
> *Occupational therapists use strategies to enhance their clients' occupational performance.*
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> *Occupational performance is the ability to perform (including 'doing', 'knowing' and 'being' dimensions) the occupations (roles, activities and tasks) s/he (or they) wants to do, needs to do and is capable of doing.*

Some therapists assert that this model uses too much jargon, that clients and others will have difficulty understanding references made to 'occupation'. We maintain that 'occupation' is a part of the professional language of Occupational Therapy. The OPM(A) provides therapists with a means for explaining the complexity of this construct and for describing the

unique concerns of occupational therapy.

The configuration of the OPM(A) demonstrates that occupational therapy is unique in that practice revolves around enhancing occupational role performance. If this does not occur, occupational therapy may become indistinguishable from other professionals such as nurses, physiotherapists, social workers, psychologists, etc.

> *The configuration of the OPM(Australia) demonstrates that therapy provided which is not related to occupational role performance is NOT occupational therapy.*

Professional Cohesion in Occupational Therapy

> *How does Occupational Performance contribute to establishing professional cohesion?*

Occupational therapists using the Occupational Performance Model (Australia) address their client's occupational need.

- *Occupational need becomes the focus of occupational therapy regardless of the*

- *practice setting* (eg. psychiatry, rehabilitation, community, acute care, hospice, industry),
- *population receiving services* (physically handicapped, 'well' population, Aids-related dementia, corporate managers)
- *severity of dysfunction* (chronic pain, acute stress related disorders, multiple handicap, deteriorating conditions)
- *'technical' orientation* of individual therapists (preference for sensory integration techniques, psychodynamic techniques, biomechanical techniques, compensation techniques).

For example, an occupational therapist working in the community or in hospice care environments may focus on addressing the occupational needs of clients at the level of occupational performance roles (self-maintainer, player), occupational routines, tasks and sub-tasks (cooking, resting, taking medication, playing cards) and the environment (accessibility, social support) by utilising compensation techniques (home modification, adapted equipment) but still must consider other levels of the model and their effect on occupational performance such as a change in body systems function (core element).

Another occupational therapist working in acute psychiatry or an acute brain injury unit focuses on the core elements of performance (effects of medication, contracture) and the components of occupational performance (intrapersonal, biomechanical). This therapist may use psychodynamic techniques (intrapersonal component) or upper limb orthotics (biomechanical technique) and considers the impact of the acute care environment (amount of stimulation, location of furniture) on behaviour in order to address the occupational need of a client. This therapist ensures that intervention for acute component problems is designed with consideration of the client's occupational roles and eventual community environment.

A third occupational therapist working in health promotion considers specific aspects of the model at all levels. For example, providing clients with

knowledge (cognitive component) about the effects of smoking (risky rest task) or high fat diet (risky self-maintenance or leisure routine) on one's body (core element) and passive smoking on other people (social dimension of the environment). This therapist may also provide clients with knowledge about the long-term effects of smoking and diet on health (time and space) so that they can make informed choices about occupational role behaviour (occupational roles).

Another occupational therapist working with children considers all constructs in the model relative to their contribution to occupational role development (time and space).
These examples demonstrate that:

> *The OPM (Australia) provides occupational therapists with a common structure for designing and delivering occupational therapy services regardless of practice domain.*

> *The OPM (Australia) ensures that occupational therapists consider all aspects of human function that contribute to occupational performance.*

Guidance for Practice and Research

> *How does the OPM (Australia) provide a guide for practice and research?*

The usefulness of a model for practice is ultimately determined by how well it offers guidance in terms of assessment, problems identified, type of goals formulated, and intervention.

When the OPM (Australia) is used, the focus of occupational therapy is on addressing clients' occupational needs. Therapy involves providing opportunities for choice and participation in role (Occupational Performance Role), routine, and task performance (Occupational Performance Areas).

Occupational therapists then design programs that attempt to alter or compensate for underlying biomechanical, sensory-motor, cognitive, intrapersonal or interpersonal problems (Components of Occupational Performance), their link with the Core Elements and any physical-sensory-socio-cultural and political-economic environmental (Environment) barriers to performance through the primary use of goal-directed activities and tasks.

> *The structure of occupational therapy programs is determined by a client's needed or desired occupational roles.*

At this point in the development of occupational performance, therapists can use the following questions to guide practice:

> *What occupational roles are desired or needed?* (Eg. What does the client need or want to 'do'? What does their family, partners or other significant people require them to 'do'?, What are they capable of 'doing'?).

> *What occupational routines, tasks and sub-tasks from the occupational areas are required to enable role performance?* (Eg. brushing teeth; conducting a meeting - 'doing'; instructing others to transfer - 'knowing', be comfortably seated and positioned - 'being').

What performance components or environmental factors are causing difficulty in task performance? (Eg. weakness, lack of confidence, inadequate knowledge, inaccessible bathroom, absence of the tools of one's culture, socially shunned, room is too dark and hot, lack of finances).

Are core element functions damaged, at risk and/or healthy? (Eg. fractures, systemic illness, mental processing, will to live and sense of hope)

What is this person's time and space fit? Are things 'in place' to support occupational performance? (Eg. environmental supports, personal preparedness)

What is my preferred approach to intervention? (Eg. biomechanical, neurodevelopmental, sensory integrative, behavioural, psychodynamic or interpersonal techniques).

How can I apply the techniques I prefer to use to enhance a client's role, routine, task or sub-task accomplishment? (Eg. use techniques within the context of a task or relevant performance environment).

Answers to these questions guide clinical decisions. For example, a physiotherapist may decide that a 4 y/o child with right hemiparesis needs to work on right fine motor skills only. The occupational therapist recognises that this child will soon assume the occupational performance role of a student. A task required by this role is handwriting. This therapist chooses to focus on left hand activity for pencil use. The intervention provided by these two therapists might look similar but the purpose directing it is different -- it is an 'occupational' one.

Alternately, therapists working with clients with severe cognitive or psychosocial disturbances may query whether these clients even have an occupational role. This touches on a fundamental view concerning the value of life. Client's such as these are members of a family or community group. They have a right to be able to participate in family or community events with as much ease as possible. In this instance, seating and transportation equipment or safety measures put in place to enable participation, may be the occupational need or priority.

The OPM (Australia) guides the provision of occupational therapy services by providing a focus to occupational therapy practice. This practice begins with the identification of client occupational roles.

SUMMARY:

In summary, the Occupational Performance Model (Australia) is a professional and practice model developed to unite occupational therapy and to direct occupational therapy practice. Therapists have the option to use preferred methods of intervention and other practice models but within a common view of occupational therapy.

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