An Occupational Performance Process Model: Fostering client and therapist alliances

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Keywords

Client-centred practice, occupational therapy
Human activities and occupations
Models of practice
Occupational performance

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Abstract

Occupational therapists, known for their ability to coach others through difficult changes, now find themselves in changing environments that include clients' desire for participation in service delivery, and the need for evidence of the outcome of occupational therapy intervention. This paper proposes a process model that is based on core concepts of occupation and client-centred practice, that incorporates theoretical approaches, and can be applied to all clients. The process model coaches the occupational therapist through a client-centred problem-solving process. It represents a description or plan for occupational therapy assessment and intervention that leads to a collaborative approach to client-identified occupational performance issues. Examples of the application of the process to occupational therapy practice are included. This model helps to articulate core concepts and values, and provides guidance for occupational therapy practice within changing environments and expectations.

Résumé

Reconnus pour leur habileté à guider les autres à travers des changements difficiles, les ergothérapeutes sont confrontés aujourd'hui à de nouvelles situations, dont la volonté des clients de participer à la prestation des services ainsi que la nécessité de mettre en évidence les résultats de l'intervention ergothérapique. Cet article propose un modèle de processus qui s'appuie sur les concepts de base de l'occupation et sur la pratique centrée sur le client. Ce modèle, qui incorpore des approches théoriques, peut être appliqué à toutes les clientèles. Le modèle de processus fournit un cadre à l'ergothérapeute pour la résolution de problèmes centrée sur le client. Il constitue un plan d'évaluation et d'intervention en ergothérapie, favorisant une approche coopérative de problèmes liés au rendement occupationnel, identifiés par le client. L'article présente des exemples d'application du processus en ergothérapie. Ce modèle permet de relier des valeurs et des concepts fondamentaux tout en fournissant des directives pour la pratique de l'ergothérapie en fonction des nouvelles réalités et attentes.

Occupational therapists, known for their ability to coach others through difficult changes, now find themselves in changing environments that may include increasing caseloads, shortened lengths of stay, decreasing health dollars, decreasing supervisory support, changing programmes, and expectations. Changing expectations include clients' desire for increased participation in service delivery, and the need for evidence of the outcome of occupational therapy intervention. Long before the current interest in patient-centred or focused care, occupational therapists embraced client-centred practice (DNHW & CAOT, 1983). However, since client-centred practice is not the exclusive domain of occupational therapy, and now that other professions and organizations are adopting a client-centred perspective, occupational therapists need to articulate clearly what client-centred occupational therapy practice looks like on a day to day basis. What are the indicators of a client-centred occupational therapy interaction? How does that differ from any other client-centred interaction? How do occupational therapists collect evidence that occupational therapy makes a difference? Every practicing therapist must be able to answer these questions and to demonstrate on a daily basis core beliefs about client-centred occupational therapy practice.

This paper proposes a process model that is based on core concepts of occupation and client-centred practice, that incorporates theoretical approaches, and can be applied to all clients. The process model coaches the occupational therapist through a complete client-centred problem-solving process. An Occupational Performance Process Model represents a description or plan for occupational therapy assessment and intervention that leads to the collaborative resolution of client-identified occupational performance issues. This model helps to articulate core concepts and values, and provides guidance for occupational therapy practice within changing environments and expectations.

OCCUPATIONAL THERAPY PRACTICE MODELS

It has been recognized that occupational therapy practice should be based on the integration of client-centred values and occupational therapy theory into a model of service delivery (CAOT, 1991; Christiansen & Baum, 1991). Occupational therapists have described a number of theoretical models of practice to guide assessment and intervention. For example, the Occupational Performance Model (CAOT, 1991) illustrates the relationships between an individual, the occupational performance areas of self-care, productivity and leisure, performance components, and environments. Other occupational therapy theoretical perspectives have included the Model of Human Occupation (Kielhofner & Burke, 1980), a Developmental Model of Practice (Llorens, 1976) and an Adaptation Model (Schkade & Shultz, 1992).

With many different theoretical perspectives it becomes difficult for occupational therapists to make decisions about the appropriate perspective(s) to guide an occupational therapy practice or intervention encounter. McColl, Law and Stewart (1993) proposed a system (Figure 1) to enable the classification of different occupational therapy theoretical approaches. In this taxonomy, occupational function or dysfunction can be understood via six theoretical perspectives: (level 2) physical rehabilitative, psycho-emotional, socio-adaptive, neurointegrative, developmental, or environmental. Theoretical ideas about occupation (level 1) are inherent in all six perspectives. Theoretical ideas describing components and conditions for occupation also contribute to our understanding of how occupational function and dysfunction arises and can be resolved (level 3). This taxonomy is a useful tool for organizing ideas about theoretical approaches for use in a process model.

In the literature, there have also been several generic occupational therapy processes described to guide practice. The majority of these processes have been described at the level of the individual client, although a few have encompassed a societal and system perspective. For example, the *Occupational Therapy Guidelines for Client-Centred Practice* (CAOT, 1991), include societal influences in a service model description. Law and Baum (1994) have also described societal influences of community resources, knowledge and policy initiatives on occupational therapy practice.

At the level of individual clients, the *Occupational Therapy Guidelines for Client-Centred Practice* (CAOT, 1991) illustrate stages of practice and the occupational therapy process within a systems approach. The stages of practice through which a client moves include referral, assessment, programme planning, intervention, discharge and follow-up. Based on work by Clark (1979), Pratt and Allan (1989) describe a sequential model of the occupational therapy process encompassing elements of assessment and programme development and evaluation followed by discharge or referral. Christiansen and Baum (1991) view the occupational therapy process as a dynamic interaction in which therapists work with clients to meet occupational performance needs, while recognizing environmental influences. They have proposed a problem-solving model of the occupational therapy process with the following steps: referral or case identification, screening and initial assessment, determination of needs, intervention plan, intervention and formative assessment, summative assessment and termination of treatment.

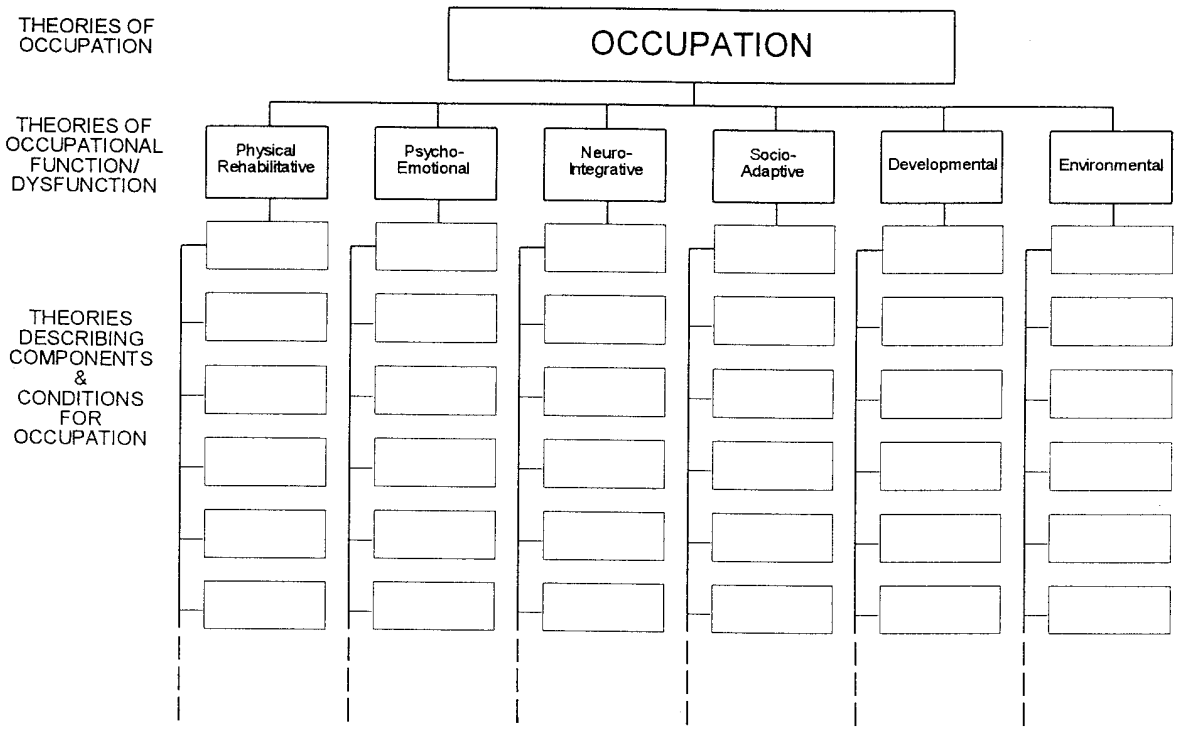
The difficulties posed by these generic occupational therapy processes have been that they do not demonstrate linkages with client-centred practice. There may be no evidence that intervention is based on clients' vision of their occupational functioning. They do not explicitly include consideration of client strengths and resources, theoretical perspectives for practice and the ongoing dynamic nature of occupational performance resolution.

In 1993, Fearing proposed guidelines for documentation using a problem-solving process that guides the therapist through the stages required to identify and address occupational performance problems from a client-centred stance (Fearing, 1993). This process was then related to the health record. Fearing's model has been further developed in this paper as a basis for the integration of the theoretical ideas of occupation and of client-centred practice into a client-centred practice process.

CLIENT-CENTRED PRACTICE

Client-centred occupational therapy practice is an alliance formed between client and therapist to use their combined skills and strengths to work towards client goals related to occupational performance. Occupational therapy clients may be individuals, or groups/systems

FIGURE 1
THEORIES OF OCCUPATION



From McColl, Law & Stewart, 1993: reproduced with permission of SLACK Inc.

such as families, caregivers, businesses, organizations, communities, and governments.

THE CLIENT AS EXPERT

People usually continue to develop, change, and adapt their abilities to perform self-care, productive and leisure activities throughout their life spans. Performance depends on the relationship between their stage of development, ability to perform, individual values and resources, and environmental demands and resources. This development results not only in a growing store of experience but also in the confidence to continue exploring. The quality of this experience and the ability to continue to grow is dependent upon relative success during the developmental process. As people move along the developmental continuum they gain life experience and, because the developmental continuum is not always a straight path, people also gain expertise in problem solving within their own environments.

A cross-section of the core tube representing occupational performance (Figure 2a) indicates the inter-relationship of the physical, social, mental and spiritual components with the three areas of occupational performance: leisure, productivity and self-care. When problems occur, individuals usually draw on their own experiences and environmental supports to solve these problems satisfactorily. Occasionally, unresolved problems or issues, no matter what the causes, begin to draw momentum away from meaningful occupational experience and development (Figure 2b). Clients are the experts in identifying the nature of these problems and issues within the context of their own lives and whether or not they want assistance in understanding and addressing them.

THE OCCUPATIONAL THERAPIST AS EXPERT

In the client-centred occupational therapy process, the therapist assists the client to problem solve so that lost momentum can be redirected into continuing satisfactory experience and development (Figure 3). This apparently simple process requires a complex combination of knowledge and skills to enable the client to move through the stages required to complete problem resolution or to undertake new directions. This process, initially identified by Fearing (1993), has been further developed in this paper as a seven stage process (Figure 4).

AN OCCUPATIONAL PERFORMANCE PROCESS MODEL

The seven-stage Occupational Performance Process Model is a problem solving model designed to be used as a guideline for practice, rather than a rule book. Although completion of the process should result in the resolution of problems, or new directions, the process itself is dynamic. Therapists and clients may choose to combine stages

FIGURE 2A
Relationship between occupations and components

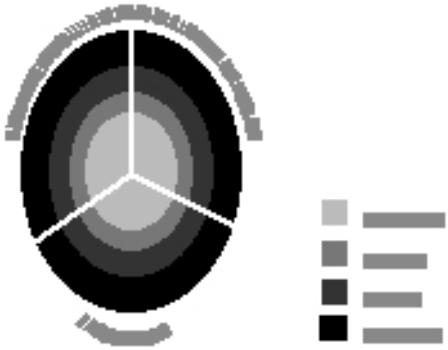
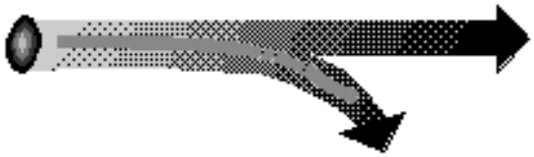


FIGURE 2B
Losing momentum due to unresolved occupational performance problem



or alter their order, depending on the client. Since it is client-centred, this process may be used by an interprofessional team to resolve client performance problems although resolution of occupational performance problems is the expertise of occupational therapists.

1. Name, validate, and prioritize occupational performance problems/issues

To name occupational performance problems, information must be gathered about occupational performance. The occupational therapist enables clients to identify self-care, productivity and leisure problems or potential issues that are important to them. The Canadian Occupational Performance Measure (COPM) (Law et al, 1994) is an excellent assessment to use in identifying client perception of problems and their importance in the client's life. The COPM is an individualized measure administered in an interview between therapist and client with information obtained through client story telling rather than responding to a checklist. The results of the COPM provide information about client-identified occupational performance issues and clients' perceptions of their performance and satisfaction with these issues. If the client has no occupational performance problems that are perceived as important, the process is stopped. In the event that the client is seen to be at substantial but unacknowledged risk to self or others, the therapist acts to protect those involved. It is important to differentiate between substantial risk and reasonable risk. It is not the therapist's role to tell a client if something seems unrealistic unless it is a safety or ethical issue. Wherever possible, the therapist discusses substantial safety issues with the client and, with client permission, others who may be affected. When others are seen to be at risk, it is not uncommon for them to become a primary client involved in the seven stage process. For example, when an individual performs a transfer from wheelchair to toilet in such a way that it puts others at risk, but the individual does not acknowledge that this is a problem, those at risk need to work on the problem and may become the primary client. The potential for caregiver injury while assisting a family member with toiletting is an occupational performance problem that can be addressed.

Once problems are named, clients then identify order of importance. This process is facilitated by using the importance score on the COPM. The outcome of the first stage of the process is client and therapist agreement on one or more named occupational performance problems and the priority in which they will be addressed in that particular setting. Other issues may be carried forward to another setting or addressed later. When the therapist hears the client's story within the context of a personal environment, the intervention is individualized, resulting in a plan for intervention that has meaning for the client and is therefore client-centred.

2. Select potential intervention models

In order for occupational therapists to work effectively with clients to address occupational performance problems, it is necessary to draw on a broad range of theoretical approaches. Using a theoretical perspective is similar to selecting a lens through which to look. It is a viewpoint, a way to see the world of the client and the reasons why occupational performance problems are occurring. The structural model as identified by McColl, Law and Stewart (1993) clearly outlines potential theoretical approaches which are used to address occupational function and dysfunction (Figure 1). Theories of occupation and occupational performance provide a general viewpoint. Before assessing to identify components and environmental conditions contributing

FIGURE 3
Redirecting momentum due to the Occupational Performacence Process

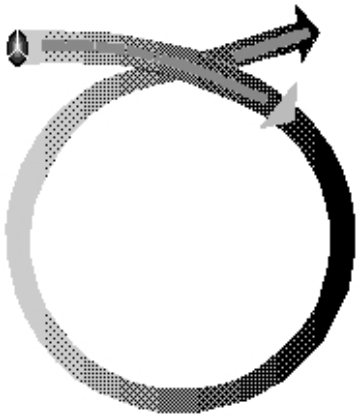
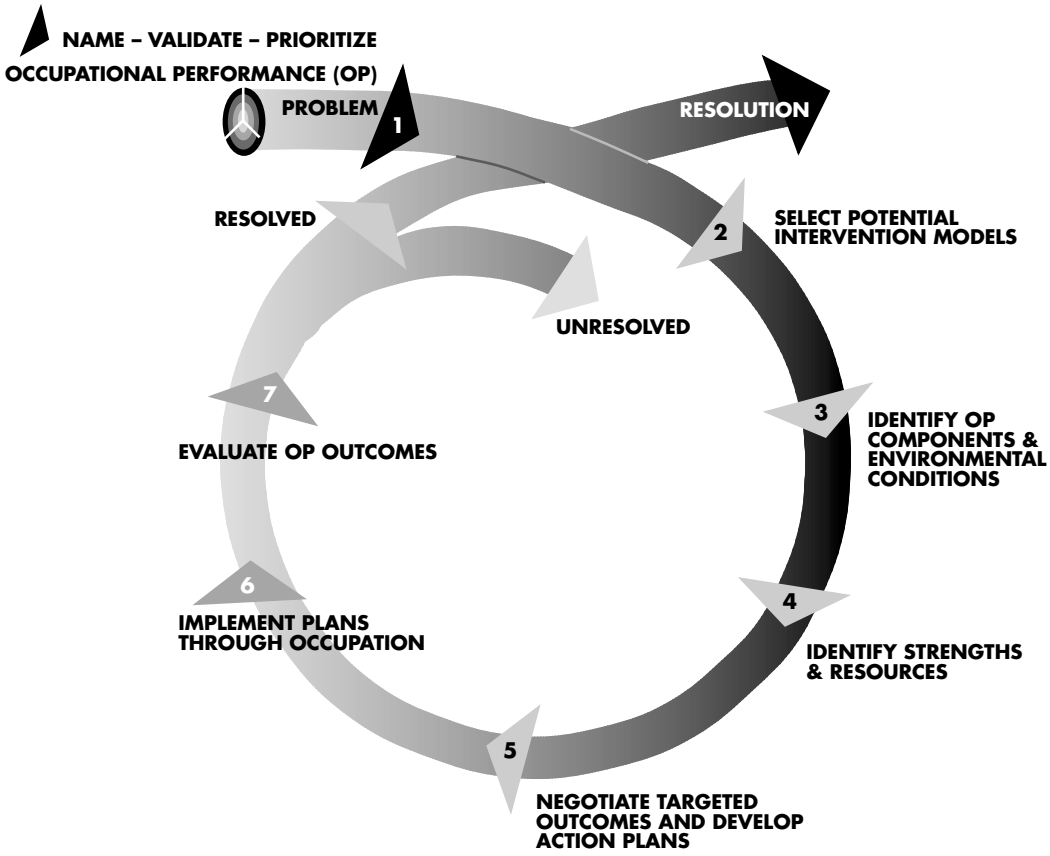


FIGURE 4
Occupational Performance Process Model



to occupational performance problems, it is necessary for the therapist to identify the theoretical perspective(s) that will be used in assessment. This viewpoint could be described as the magnifying lens through which the therapist examines components of occupation. For example, the therapist working with a person having difficulty transferring may chose a physical-rehabilitative, environmental and/or psycho-emotional perspective. A person with a physical impairment who experiences panic attacks when riding the bus may require a psycho-emotional and physical-rehabilitative perspective. One of the results of assessment may be the selection of a different theoretical perspective in intervention. The choice of perspective(s), or lack of it, influences the methods and tools used in both assessment and intervention. The therapist who restricts practice to one theoretical perspective such as a physical-rehabilitative or psycho-emotional approach runs the risk to the client of missing important components contributing to the problem.

3. Identify occupational performance components and environmental conditions

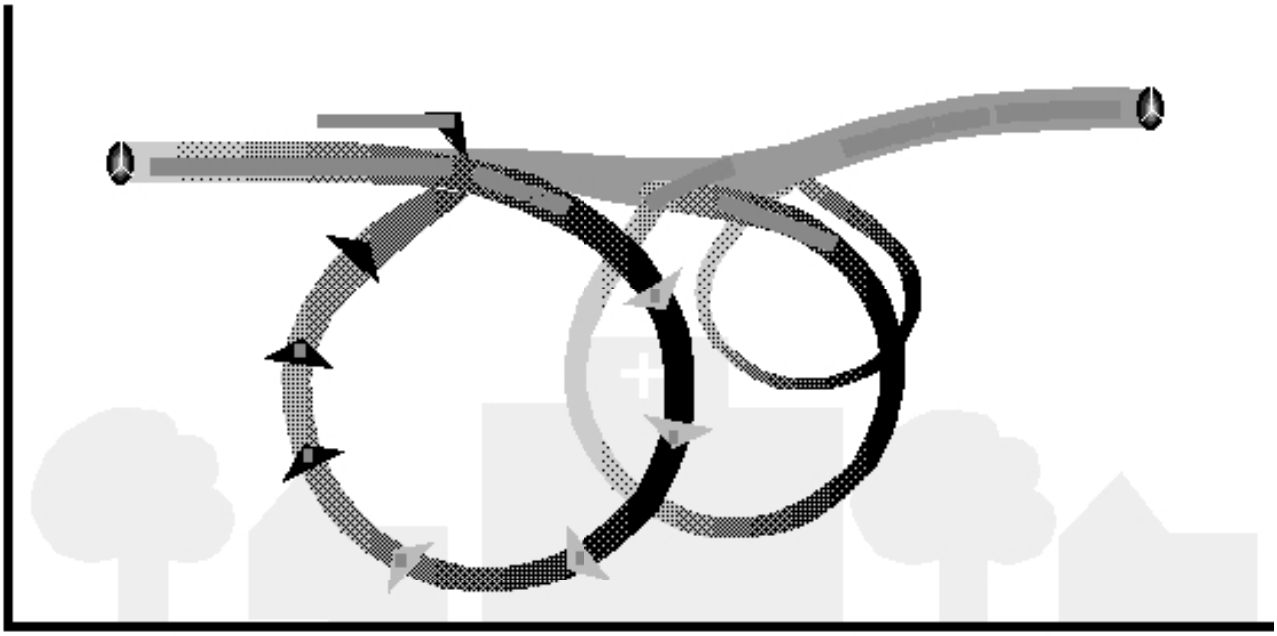
Once potential theoretical perspectives have been chosen, the therapist selects an assessment in keeping with that theory. This assessment is used to identify components and environmental conditions contributing to the identified occupational performance problems (Fearing, 1993).

The therapist who has chosen a psycho-emotional perspective might select a cognitive therapy assessment, perhaps the Beck Depression Inventory, for a person who reports that various occupations are affected by low mood and fatigue. The resulting information makes explicit what *low mood* and *fatigue* look like in this particular situation. An environmental perspective and the selection of a home visit might result in identification of conditions such as lack of money to buy nutritious food, or three flights of stairs between ground floor and apartment.

4. Identify strengths and resources

Clients seldom come to occupational therapy with no history of problem solving within the context of their own lives. Many clients are adept at problem-solving and there is much to learn from them. As well, clients have individual, social, familial and community supports that are long-standing, and whether or not they appear to be ideal, they may work very well. In client-centred practice, the therapist and client together identify client strengths, skills and resources that can assist in resolving occupational performance problems. As well, the therapist's skills and resources must be considered in relation to the identified problems, components and environmental conditions. The therapist may also consider engaging the assistance or advice of others within the community to contribute to the resources available for the client's problem.

Figure 5
Occupational performance process in different settings



5. Negotiate targeted outcomes and develop action plans

Occupational therapists excel at assisting clients to see and connect with their future. Mattingly and Fleming (1994) report that "...the clinician's thinking primarily focused not so much on the disability and the present treatment, as on the possibilities for the person's functioning in the future" (p.337). This ability to coach people from a present problem to a possible future requires a shared vision with a destination that is achievable. Once the destination, or outcome, is identified and agreed upon, and this is usually the resolution of occupational performance problems and components, an action plan to reach that destination can be made. Without agreement, the therapist and client may work toward different outcomes. When therapist and client expectations of the targeted outcomes differ, the problem solving process is off track. Therapists working from a client-centred stance create a shared vision for the future, with shorter term, achievable objectives identified to reach that outcome. An important reason for identifying targeted outcomes that are clear is that the method for arriving at that destination can vary day to day as the conditions change.

6. Implement plans through occupation

Just as clients value resolving problems that they have identified as important, they also value interventions that have meaning for them. Mattingly and Fleming (1994) report that "Occupational therapists have long claimed that purposeful activity is more therapeutic than are processes, such as repetitive exercise, that are not directed toward an immediate external objective or, as they say, a goal" (p.102-103), and that "... everyday activities are significant and meaningful" (p.105). The art of occupational therapy includes the ability to create healthy environments where clients can grow and change while remaining firmly grounded within the context of their own lives. Plans address resolution of the components and environmental conditions contributing to that individual's identified occupational performance problems in a manner that has meaning to the client. For example, a client with a shoulder injury might put groceries away in the cupboard, if that has meaning to the client, rather than stacking cones.

7. Evaluate occupational performance outcomes

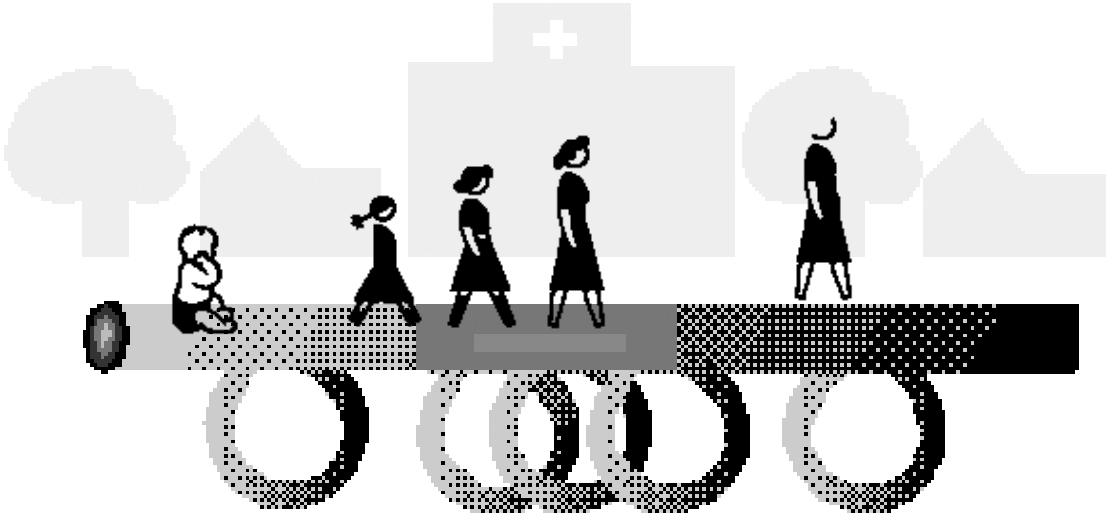
An important step of the process is to evaluate the effectiveness of the intervention. Since the intervention addresses occupational performance problems, one way to evaluate outcomes is to ask the question "Were occupational performance problems resolved?" Another way to evaluate outcome is to compare the data collected about client perception of performance and satisfaction with important occupational performance problems through use of the COPM in stage 1 and again in stage 7 of the process (Figure 4). Evaluating occupational performance outcomes is of value to clients because it helps them gain insight into the degree of change that has occurred and to identify focus for further change. Sometimes, achieving targeted outcomes signals the end of intervention as the person integrates learning into daily occupational patterns.

However, solving one problem may cause other issues to be identified. Different problems or stages of one problem may be addressed in different environments. Addressing components of a problem may be done in one setting, with resolution of the occupational performance problem occurring in another setting (Figure 5).

Lifespan development within a unique environment

Figure 6 is a visual representation of one person's development within a specific environment. The core tube represents continuing devel-

Figure 6
Life span development within a unique environment



opment in self-care, productivity and leisure skills and abilities. Through the life span, different emphasis is given to self-care, productivity and leisure skill development and activities depending on the needs of the person at a given time. The external tube represents a person's environments over the life span. The closed loops represent the return of momentum to use through successful problem solving whether or not function remains the same as it was before the problem occurred. Components are unique to each individual and depend on a person's abilities. Environmental conditions are cultural, economic, institutional, physical or social factors outside the individual. Environmental conditions are important not only because they influence performance, and our understanding of that performance, but also because they have the potential to become resources rather than barriers. An occupational performance problem identified by the client, for example, at risk for losing a valued job, would require identification of components and environmental conditions contributing to that problem. The components might include the inability to access public transportation, the inability to access necessary equipment at work, lack of ability to see the work clearly, or drifting of attention.

The Caregiver and Significant Others

In client-centred occupational therapy practice, the client is viewed within the context of unique environments. These environments often involve others whose lives are affected by the primary client's problems. As one person goes through the problem solving process, it affects those in the related environment. The client who learns enough self-care skills to go home but not enough to be independent may contribute to actual or potential problems for others at home (Figure 7). The caregiver who experiences loss of occupational performance momentum as a result of primary client problems may become the exhausted caregiver with potential inability to continue caring for self as well as the primary client. Problem solving is often a tandem or related effort within environments so that problems are not shifted from one person to another. Occupational therapists work closely with clients and others within their environments to promote problem-solving behaviour, maintain momentum, enrich daily living, and prevent dysfunction.

Applications

The occupational performance process prompts occupational therapists to interact with consumers in a client-centred and holistic manner. This process can be applied across all age, cultural, and gender groups, as well as all practices and types of clients. In some cases, the client may be a family member, a group or a community. Examples of the clinical application of this process with a variety of clients who are experiencing occupational performance problems are shown in Table 1.

Discussion

Occupational therapists who use this model will find that their practice changes. Perhaps the biggest change is being able to put client-centred practice into operation in an organized fashion. As therapists became comfortable with the concept of the client as expert, they re-evaluate their usual methods of practice. Because the process itself is client-centred, therapists will practice from a holistic point of view, rather than an individual specialty point of view. Instead of assigning clients to established programmes, therapists will consider the best venue for achieving specific client outcomes. This may change the nature and use of group interventions since group outcomes will need to reflect the individual outcomes toward which each member of the group is working.

Table 1
Occupational Performance Process in Practice

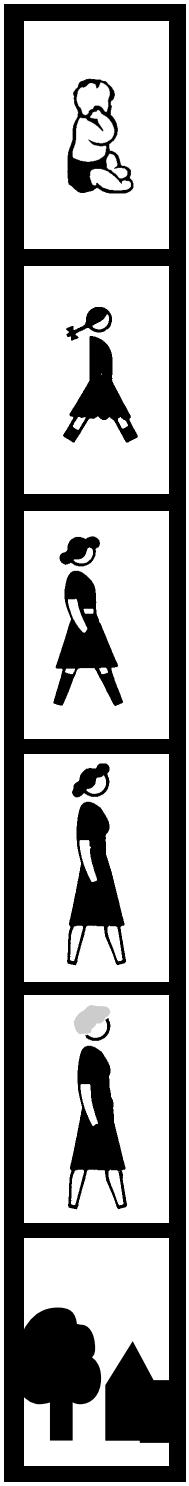
Developmental Age Group	Name Occupational Performance Problem	Select Intervention Models	Identify Components & Environmental Facts	Identify Resources	Negotiate Outcomes and Plan in Partnership	Implement Plans Through Purposeful Occupation	Evaluate Outcome
	Unable to sustain independent feeding/sucking (breast or bottle)	• Neuro-integrative • Developmental • Environmental • Socio-adaptive	• Poor arousal control • Decreased muscle tone • Unable to coordinate breath, suck, swallow	• Parents/caregivers all following same program • Caregivers dedicated	Bottle or breast feed with only occasional tube feeds for supplements (i.e., no more than twice/week). OT will demonstrate techniques - parents will practise until comfortable	• Positioning • Lip closure assistance • Timing of feedings • Sensory stimulation for state control	• Number of feelings per day (# of breast or bottle & # of tubes) • Performance & satisfaction of caregivers & child
	Unable to participate in previously valued activities (i.e. video games) with other children	• Psychosocial • Rehabilitation • Environmental	• Pain • Burn area/ hypertrophic scarring which limits range of motion bilaterally in hands	• Family supportive • Child is optimistic & motivated • Financial backing for adaptive aids	Child will tolerate 1 video game (duration 10 minutes) in sitting position, through the use of adaptive aids	• Fabrication of splints & adaptive aids • Fitting of pressure garments • Teach techniques to deal with pain • Child to practise daily	Changes in ROM • # of video games played/day & duration of same • Child's reassessed performance & satisfaction
	Lack of vocational plans & confusion regarding vocational options	• Environmental • Psycho-emotional • Socio-adaptive • Developmental	• Lack of belief in skills • Lack of knowledge about options • Discouragement with current job market • Dysfunctional peer group (substance abuse)	• Family support • Lives in an area with numerous resource for youths	Client will have identified at least 1 area of interest & linked to at least 1 community resource to pursue involvement in same	• Role playing • Vocational interest batteries • Further assess (i.e. Vineland) • Explore resources • LInk up to appropriate resource	# of possibilities to pursue # of resources linked with • Client's reassessed performance & satisfaction
	Unable to use public transit, does not leave immediate neighbourhood	• Psycho-emotional • Socio-adaptive • Environmental	• Fear • Irrational thoughts - feels others on the bus are looking at her or talking about her	• Client has strong sense of personal commitment • Client communicates clearly when feeling overwhelmed	Client will complete two bus trips of 30 minutes duration, independently & free of panic attacks	• Relaxation training • Cognitive therapy • Graded trials on bus using techniques	• # of bus trips client able to complete & duration • # of panic attacks • Client's reassessed performance & satisfaction
	Unable to climb stairs in home & gain access to bathroom, currently crawling upstairs	• Environmental • Physical Rehabilitation	• Poor standing tolerance/ balance • Trunk rigidity (Parkinson's) • Postural hypotension • 85 years ot age • No bathroom facilities on main floor	• Husband is elderly but remains in good health • Daughter able to help on occasion • Homecare aide comes in 3 times/week	Discharge home to husband. Able to toilet self with only minimal assistance	• Home visit • Ideas for renovations, alterations, use of commode, etc. • Refer to physio to work on stair climbing	• Client able to d/c to home? • Client's & caregiver's performance & satisfaction with toileting
	Need to improve access and inclusion to community recreation services	• Environmental	• Poor physical accessibility • Lack of staff training • Poor provision of information to consumers	Community is supportive of making changes to increase access. Community information service is available	Increase participation of people with disabilities in community recreation programs.	• Will develop and implement staff training programs. • Will complete physical accessibility evaluations and take steps to improve access. • Develop new methods of providing consumer information	# of people with disabilities participating in programs • Changes in accessibility to facilities • Number of people using community information system

Figure 7
Occupational performance impacts on others

Therapists will re-evaluate their assessments to ensure that needed occupational performance information is collected. For example, instead of assessing everyone on a large caseload but not having time for intervention, therapists and clients can identify occupational performance problems and complete the problem solving cycle for priority problems, resulting in improved occupational performance for those who receive service (Rackow, Medcalf, Fearing, Jordon & Pearson, 1996). The focus on occupational performance outcomes will give both therapists and clients a target, resulting in not only a greater understanding of when to start and stop interventions, but also increased adherence to recommendations by clients.

The occupational performance process is dynamic and does not presume to return clients to previous conditions or states of normality, but rather to address problems or issues so that clients can maintain or regain momentum in daily living. As therapists gain a better understanding of the impact of client problems on others within their environments they are expanding their definition of client to include them. Completing the occupational performance process can be a powerful tool in advocacy for both the client and the profession of occupational therapy. Occupational therapists using this method will find themselves providing leadership in clinical settings because they are practicing from a client centred stance and can demonstrate evidence of the results of that practice.

Acknowledgments

The authors thank Mary Clark Green for the graphics and acknowledge all those who have contributed to our thinking including the occupational therapists at Vancouver Hospital and Health Sciences Centre, UBC Pavilions, Sue Stanton, and authors of the Canadian Occupational Performance Measure, Sue Baptiste, Anne Carswell, Mary Ann McColl, Helen Polatajko and Nancy Pollock. Parts of this paper were presented at the CAOT Conference in Edmonton, Alberta, 1995.

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