

How Occupational Therapy Staff Spend their Work Time

by

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This article summarises the main findings from a survey of the treatment and treatment-related activities used during one working week by 157 occupational therapy staff working in Southampton and South West Hants Health Authority. Forty eight per cent of overall work time was spent in direct treatment, while 32% was spent in treatment-related work and 20% in other work activities. Treatment was carried out predominantly by technical and helper staff, while occupational therapists spent more time in treatment-related activities. The most extensively used treatment category was Personal Activities of Daily Living which took up 6.80% of work time, while the most extensively recorded treatment-related category was Verbal Communication which took up 7.88% of work time. Very little home visiting was carried out, except by occupational therapists working in physical medicine.

INTRODUCTION

The repertoire of activities used in occupational therapy is wide and continues to increase as new ideas and techniques are developed. While such developments have increased the scope of occupational therapy, they have also made it more complex and sometimes confusing. The need to establish priorities in treatment and identify areas of work which can be relinquished has long been recognised,¹ although there is still a lack of agreement among occupational therapists about the types of treatment which they should be involved in and even about what constitutes a therapeutic activity. Such conflict is partly due to inadequate knowledge about the activities actually being used in practice, with discussions based largely upon assumptions about what therapists think they do, rather than upon known facts.

Of the few studies reported in the literature related to the range of clinical activities used in occupational therapy, most have been carried out for management or educational purposes. Management studies^{2,3} have concentrated on the proportion of time spent in broad categories of activity, such as treatment, consultation, training and administration, but have revealed nothing about the actual content of treatment. Educational studies,^{4,5} prompted by the need to identify training requirements, have been more informative about the broad types of treatment used, but data related to specific activities are still relatively superficial.

The need to fill the knowledge gap prompted a survey of occupational therapy practice in Southampton carried out in 1984-1985. The main aim of the study was to identify the full range of occupational therapy activities used in the health district and to ascertain the extent of their use within different clinical areas and within the various groups of staff. This would then form a valuable data base for further research into specific aspects of treatment.

OCCUPATIONAL THERAPY SERVICES IN SOUTHAMPTON

Southampton and South West Hampshire Health Authority is one of 10 district authorities in the Wessex Region and services a population of 410,000. At the time the survey was carried out in 1984, the staff establishment for all occupational therapy personnel except administrative staff was 139.94 whole-time equivalents. This figure represented 177 full-time and part-time staff, of whom 165 were in post.

The district occupational therapy service is divided into 7 units of management, reflecting a mixture of geographical location and clinical specialty. These units of management have developed in recent years to provide a comprehensive occupational therapy service in all broad clinical areas, that is, physical medicine, geriatric medicine, psychogeriatric medicine, psychiatry and mental handicap. While most departments are hospital based, providing a service to inpatients, outpatients and day patients, there are also several community-based day hospitals and centres which have a strong occupational therapy input. These have developed primarily in the fields of psychiatry and mental handicap, while day centres for physically handicapped people remain within the sphere of social services occupational therapists.

METHOD

All occupational therapy staff in Southampton and South West Hants Health Authority who had clinical contact with patients were surveyed. They included recreational and industrial therapy staff who came under occupational therapy management and excluded the District Occupational Therapist whose post was entirely administrative.

A number of possible methods of data collection were considered and it was decided that the most practical for the participants would be a self-reporting method, using a check list similar to that described by Huxley.⁶ It was realised that a check list method of data collection would have its limitations so, to supplement and give more meaning to the quantitative data, some descriptive data were collected during the survey by means of a brief departmental diary kept by heads of department.

The check list

A check list of the full range of treatment and treatment-related activities used by occupational therapy staff in the district was formulated through extensive discussions with various members of staff from all departments. The identified activities were then grouped into broad categories and incorporated in a data sheet for recording purposes. Following pilot work, the final check list comprised 28 treatment categories and 8 treatment-related categories. 'Activities Guidelines' were given to each participant to ensure exclusivity of each category and avoid confusion amongst staff, thereby increasing

reliability in the recording. Other definitions were also provided, as follows:

'Direct treatment': The 'process of carrying out a treatment activity with a patient or group of patients, to include any discussion or explanation of an activity to a patient; participating with a patient in an activity; teaching an activity to a patient; supervising the patient in an activity; carrying out a treatment procedure on a patient; modifying the treatment according to patient response'.

'Treatment-related categories': 'Those activities which are necessary for treatment to take place or for the overall care of the patient. They might concern work related to specific treatment sessions or overall treatment plans.'

Any work activity such as administration was not required to be recorded.

Implementation of the survey

The study was carried out for one working week, during which participants recorded all their treatment and treatment-related activities. Domiciliary activities were recorded on separate forms to departmental ones. Activities were tabulated to the nearest quarter of an hour, as shown in Table 1. When staff were involved in more than one activity at once, they were required to mark two or more squares at the same time of day. This could occur, for example, when working with a patient whose treatment covered more than one activity category at the same time or when supervising a number of patients whose activities fell into separate categories. Any quarter-hour units which represented activities which did not come under the broad definitions of 'Treatment' or 'Treatment-related' work were left blank.

Table 1. Section from a partially completed record form

Activity category	Time units		
	9 am	10 am	11 am
SECTION 'A' DIRECT TREATMENT			
1. Personal Activities of Daily Living		X X X X X	
2. Domestic Activities of Daily Living			X X
3. Aids/Adaptations/Appliances		X	
4. Community Orientation			
5. Beauty Therapy			
6. Relaxation Training			
7. Counselling		X	
8. Psychotherapy			
SECTION 'B' TREATMENT-RELATED ACTIVITY			
30. Activity Planning	X		
31. Activity Preparation	X		

Three weeks prior to the survey, participants were individually sent a 'Survey Package' comprising data sheets, instructions, and Activities Guidelines containing all the category definitions. In addition, each head of department was provided with a 'diary' in which to record his or her department's main events during the survey. Immediately before the arranged week of recording, every department was visited so that the written instructions could be backed up by full verbal explanations. Each department was visited again on its first day of recording so that any difficulties could be ironed out and, thereafter, staff were encouraged to contact the investigator should any further problems arise.

RESULTS

Although the study included all 165 occupational therapy staff in the district, the analysis was based on 157 participants because 3 failed to participate and the data of 5 had to be eliminated due to incorrect recording.

Staffing distributions

The overall proportion of participants in each staff grade is given in Fig.1, which shows that approximately one third of the staff were occupational therapists. The ratio of technical and helper staff to occupational therapists was relatively high compared with a sample of 12 other district occupational therapy services who were contacted for information about their staffing distributions.

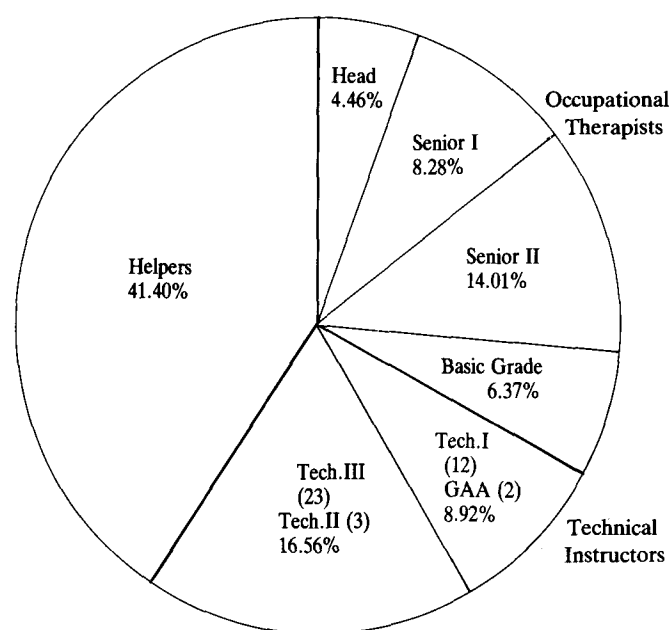
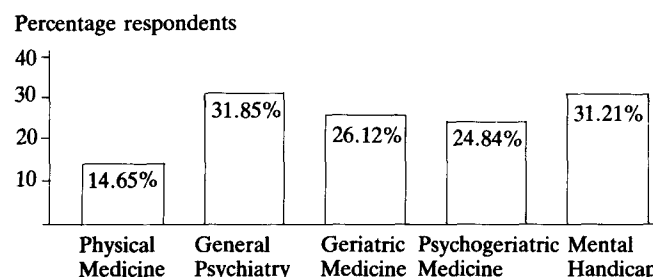


Fig.1. Proportion of respondents in each staff grade.

The proportion of staff working in each of five broad clinical areas is shown in Fig.2. In comparison with the sample of other district occupational therapy services, the proportion of staff working in physical medicine was low while the proportion of staff working in mental handicap was high. Physical medicine had the highest proportion of occupational therapists and the lowest proportion of technical and helper staff, while mental handicap had the lowest proportion of occupational therapists and the highest proportion of technical and helper staff. This skill mix was the same as that found by Alaszewski et al⁷ in their study of management, deployment and morale of National Health Service remedial therapists.



NB. The summation of percentages is greater than 100% because some respondents worked in more than one broad clinical area.

Fig.2. Percentage of respondents working in each broad clinical area.

Evaluation of departmental diaries

Thirty-five irregular or unusual occurrences were reported in the departmental diaries. Only six of these were rated as being sufficiently out of the ordinary to have affected activities in a way which was not typical for the department concerned. To give an example, the heavy workshop of a psychiatric department had suffered an overnight break-in and an immediate stock check had to be made of tools and equipment,

resulting in cancellation of normal treatment activities in that area for half a day.

Balance of work time

Fig. 3 shows that just under half the total work time was spent in direct treatment and just under a third in treatment-related work. Domiciliary work, which included home visit travel, took up only 3.53% of total work time.

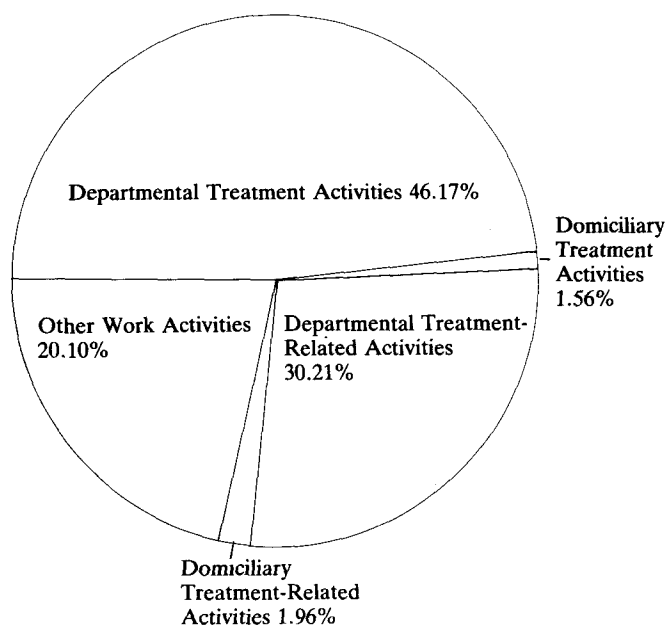


Fig. 3. Gross breakdown of work time for all respondents.

There were some marked differences in the balance of work time among the different staff grades (Fig. 4). The amount of time spent on treatment was highest among technical II/III instructors and helpers. Treatment time decreased as level of staff grade increased.

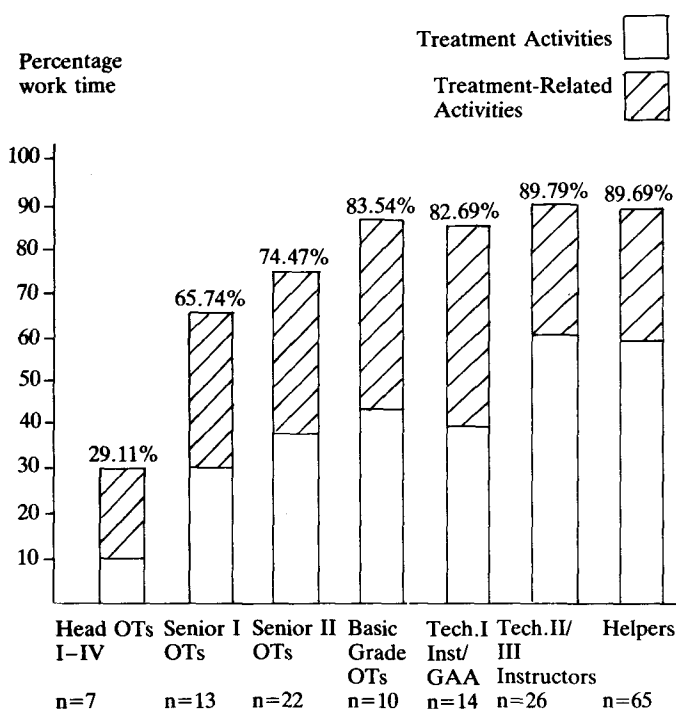


Fig. 4. Gross analysis of treatment and treatment-related time according to staff grade.

One-fifth of the respondents carried out home visits, the majority of whom were senior occupational therapists working in physical medicine. Domiciliary activities took up 15.03% of this group's overall work time while, in contrast, they took up only 0.42% of overall work time in the mental handicap group. Over half the occupational therapists carried out a home visit while less than 10% of technical and helper staff did so.

Analysis of treatment activities

The percentage of work time spent on each treatment category throughout the district is given in Table 2. Since it is impossible to provide full definitions of all the treatment categories within the limitations of an article, some examples of the types of activity included within them are listed (in brackets) with those categories which are not self-explanatory. Table 2 also shows the prime user of each activity category according to broad clinical area and according to staff grade. There were 14 categories which took up at least 1% of work time of which only one, Personal Activities of Daily Living, took up more than 5% of work time. The 16 categories which took up less than 1% of work time accounted for only 6.51% between them. Apart from Personal Activities of Daily Living, which took up almost twice as much time as any other treatment category, Creative/Expressive Activities, Counselling and Light Work Activities took up the most treatment time. The majority of the categories which were used for at least 1% of work time were those of a general nature, while those taking up less than 1% of work time tended to be of a more specific nature. Psychodrama was the only treatment category which was not used at all.

Only six treatment categories were used in domiciliary work, as indicated by asterisks in Table 2. Most home visit treatment time was spent on Counselling, followed by Personal Activities of Daily Living and Aids/Adaptations/Appliances.

Table 3 shows the three most used treatment categories in each broad clinical area. The percentage figures are representative of the total work time of each group. The predominance of Personal Activities of Daily Living in both physical and geriatric medicine is clearly indicated. Counselling rated in the top three for all clinical groups except mental handicap. Light Work Activities were the top ranking category in general psychiatry and mental handicap, mainly because industrial therapy staff at two hospitals in the district were included in the survey. These staff recorded Light Work Activities almost exclusively, while the majority of other respondents recorded a wide variety of treatment categories.

The treatment activities most extensively used by the trained staff groups were all similar (Table 4) and included Personal Activities of Daily Living, Aids/Adaptations/Appliances, Counselling and Creative/Expressive Activities. Heavy activities predominated among technical instructors. Printing was recorded almost exclusively by technical I instructors while Craft Activities were recorded mostly by helpers.

Analysis of treatment-related activities

The percentage of work time spent on each treatment-related activity throughout the district is given in Table 5. This again shows the prime user of each activity category according to broad clinical area and staff grade. The most extensively used treatment-related activity was Verbal Communication followed by Activity Preparation and Patient Welfare. These three categories were predominant in all clinical areas. The pattern among staff grades was different, however. Verbal Communication, Written Communication and Activity Planning predominated among occupational therapists, while technical and helper staff mostly recorded Activity Preparation, Patient Welfare and Verbal Communication. The only exception was technical I instructors whose top ranking treatment-related activity was Activity Planning.

Shared activities

Consideration was given in the analysis to activities recorded at the same time. Although the overall time was generally very

Table 2. Analysis of treatment activities used during one working week

Activity category	Total work time (%)	Ranking	Prime users (broad clinical area)	Prime users (staff grade)
Personal ADL*	6.80	1	Geriatric Medicine	Helpers
Creative/Expressive Activities (eg art, drama, music)	3.95	2	Mental Handicap	Helpers
Counselling*	3.83	3	Psychogeriatric Medicine	Senior II OTs
Light Work Activities	3.78	4	Mental Handicap	Helpers
Verbalising Activities (eg word games, discussions)	3.52	5	General Psychiatry	Tech. III instructors
Craft Activities	3.34	6	General Psychiatry	Helpers
Sport & Physical Exercise	3.00	7	Mental Handicap	Tech. III instructors
Domestic ADL*	2.90	8	Mental Handicap	Tech. III instructors
Heavy Work Activities	2.05	9	General Psychiatry	Tech. I instructors
Community Orientation* (eg shopping, use of public transport)	2.03	10	General Psychiatry	Senior II OTs
Social Activities (eg films, tea parties)	1.96	11	Psychogeriatric Medicine	Tech. I instructors
Gardening	1.92	12	Mental Handicap	Tech. III instructors
Table Games	1.10	13	Psychogeriatric Medicine	Helpers
Aids/Adaptations/Appliances*	1.05	14	Physical Medicine	Basic Grade OTs
Printing	0.94	15	General Psychiatry	Tech. I instructors
Relaxation Training*	0.80	16	Mental Handicap	Senior II OTs
Remedial Teaching (basic educational activities)	0.63	17	Mental Handicap	Tech. I instructors
Remedial Games & Exercises (eg adapted games, remedial bicycle)	0.55	18	Physical Medicine	Basic Grade OTs
Communication (eg Bliss, Makaton)	0.54	19	Mental Handicap	Tech. III instructors
Beauty Therapy	0.46	20	General Psychiatry	Basic Grade OTs
Recall & Reminiscence Therapy	0.45	21	Psychogeriatric Medicine	Helpers
Reality Orientation	0.42	22	Psychogeriatric Medicine	Senior II OTs
Specific Assessment Tests	0.40	23	Geriatric Medicine	Senior II OTs
Personal Physical Contact (Communication by Touch)	0.38	24	Mental Handicap	Helpers
Social Skills Training	0.31	25	Mental Handicap	Tech. III instructors
Computer Work	0.21	26	Physical Medicine	Senior I OTs
Typing	0.17	27	General Psychiatry	Tech. I instructors
Befriending (chatting with patients)	0.13	28	Geriatric Medicine	Head OTs
Psychotherapy	0.11	29	Psychogeriatric Medicine	Senior I OTs
Psychodrama	0.00	30	-	-

* Treatment categories used in domiciliary work.

Table 3. The three most extensively used treatment categories in each broad clinical area

Clinical Area	First category	Second category	Third category
Physical Medicine (n=23)	Personal ADL (11.55%)	Counselling (5.29%)	Aids/Adaptations/ Appliances (5.01%)
General Psychiatry (n=50)	Light Work Activities (9.03%)	Counselling (5.49%)	Verbalising Activities (4.68%)
Geriatric Medicine (n=41)	Personal ADL (16.46%)	Craft Activities (2.92%)	Counselling (2.78%)
Psychogeriatric Medicine (n=39)	Counselling (5.67%)	Personal ADL (4.76%)	Craft Activities (3.38%)
Mental Handicap (n=49)	Light Work Activities (9.85%)	Creative/Expressive Activities (7.37%)	Sport/Physical Exercise (4.47%)

Table 4. The three most extensively used treatment categories in each staff grade

Staff Grade	First category	Second category	Third category
Head OTs (n=7)	Counselling (2.75%)	Aids/Adaptations/ Appliances (1.65%)	Personal ADL (1.37%)
Senior I OTs (n=13)	Personal ADL (4.86%)	Counselling (4.29%)	Creative/Expressive Activities (2.42%)
Senior II OTs (n=22)	Counselling (6.61%)	Creative/Expressive Activities (4.63%)	Verbalising Activities (4.60%)
Basic Grade OTs (n=10)	Personal ADL (9.92%)	Aids/Adaptations/ Appliances (4.36%)	Counselling (3.93%)
Tech. I Instructors (n=14)	Heavy Work Activities (8.39%)	Printing (6.13%)	Light Work Activities (3.80%)
Tech. II/III Instructors (n=26)	Gardening (7.90%)	Heavy Work Activities (6.76%)	Counselling (5.14%)
Helpers (n=65)	Personal ADL (12.39%)	Craft Activities (7.20%)	Light Work Activities (7.00%)

Table 5. Analysis of treatment-related activities used in one working week

Activity category	Total work time (%)	Ranking	Prime users (broad clinical area)	Prime users (staff grade)
Verbal Communication	7.88	1	Physical Medicine	Basic Grade OTs
Activity Preparation	5.92	2	Psychogeriatric Medicine	Tech. I instructors
Patient Welfare	5.12	3	Geriatric Medicine	Helpers
Activity Planning	4.21	4	Mental Handicap	Tech. I instructors
Written Communication	2.99	5	Physical Medicine	Senior I OTs
Activity Completion	2.98	6	Mental Handicap	Tech. I instructors
Activity Evaluation	1.52	7	Mental Handicap	Senior II OTs
Patient Cafeteria Service	0.79	8	Psychogeriatric Medicine	Tech. I instructors
Home Visit Travel	0.76	9	Physical Medicine	Head OTs

low, the possibility that certain activities might regularly be shared together was investigated. In spite of the diversity of shared activities which could have occurred in view of the 1,400 possible combinations, a definite pattern of shared activity emerged. Three pairs of activity categories were recorded together regularly. Verbal Communication and Written Communication were most often carried out in unison, paired 188 times and accounting for approximately 1% of total work time. They were closely followed by Personal Activities of Daily Living paired 180 times with Counselling, and Personal Activities of Daily Living paired 161 times with Patient Welfare.

DISCUSSION

In spite of the fact that occupational therapy is a treatment-orientated discipline, barely 50% of overall work time throughout the district was actually spent on direct treatment. These findings were, in fact, similar to those of other studies^{2,5,8} which attempted to measure time spent on treatment, suggesting that occupational therapy staff in Southampton are fairly typical in this respect. The only evidence⁹ found in the literature of occupational therapists spending more time in direct treatment was based on estimated times, a method of data collection which is often considered to be unreliable.

The results show that there was a considerable difference between the time spent on treatment and treatment-related work between different staff grades. While senior occupational therapists, for example, divided their time almost equally between treatment, treatment-related activities and other work, technical III instructors and helpers spent two thirds of their time in treatment alone. The most likely cause of these differences was the number of professional duties, other than those directly related to treatment, which staff were required to carry out. While the responsibilities of most technical III instructors and helper staff were concerned with the implementation of planned treatment programmes, trained staff had many additional duties including the planning and organisation of services, involvement in student training, supervision of staff and general administration. Concern that the increase in demands made upon therapists severely limits the time available for practising clinical skills has been expressed in other studies. Edwards⁵ describes the frustrations of occupational therapists in having to compromise between the ideal and the practical, while Florian et al⁸ refer to 'professional burnout' caused by conflict between numerous professional duties.

The differences found in the balance of work time raise an important question in relation to the quality of service delivered to patients. In all clinical areas except physical medicine, most treatment was actually carried out by technical and helper staff, due both to the high proportion of such staff and to the extent of their patient-contact time. The findings also showed that the types of treatment activity in which they were involved were not necessarily restricted to those of a routine and practical nature, which indicates that adequate support and supervision of technical and helper staff is of paramount importance. In situations where occupational ther-

apists are not available for advice, technical and helper staff may carry out routine activities and tasks without appreciating their therapeutic purpose or, more seriously, undertake work which they are neither qualified for nor capable of doing. In view of the implications for practice, the question of whether there is adequate supervision and support for technical and helper staff should be investigated further.

The proportion of work time spent on domiciliary visits was not as high as expected from comments made during the pre-survey departmental visits. Physical medicine was the only clinical area in which a substantial number of home visits were carried out in the space of a week. The treatment activities used were extremely limited, consisting primarily of those related to self-care, including the provision of aids. Most therapists also indicated that most home visits were carried out for pre-discharge assessments, rather than for treatment, or to deal with urgent requests for aids. These findings suggest that the main gaps in domiciliary work were the lack of treatment in its purest sense and the scarcity of home visits to mentally ill and mentally handicapped people. It is not known, however, whether these gaps represented unmet needs or whether they existed because the needs of the client groups were adequately provided for in other ways. Further investigation is needed to establish what changes in practice, if any, would be desirable. Future research should be concerned both with the overall service provision in the community by therapists based in social services and in hospital, and with evaluation of home-based treatment programmes.

In broad terms, the results indicate that, in Southampton, the more traditional, task-orientated treatment activities still predominated at the time of the survey. Those activities which involved the use of specialised techniques were certainly in evidence but appeared to have been used in addition to traditional activities. The findings confirm the concern expressed by occupational therapists in the district that the range of activities used in treatment has expanded over the years but that little has been relinquished.

The large proportion of overall treatment time taken up by Activities of Daily Living is in agreement with other studies.^{4,9} These activities, which have long been accepted as standard practice, tend to be among those whose efficacy is no longer questioned as rigorously as it should be. Most studies that have involved the use of daily living activities have tended to use them as outcome measures for other treatments or have included them as part of a broader rehabilitation programme. Since these activities consume a very large proportion of therapy time, it is suggested that more detailed evaluative work is carried out on the actual retraining and teaching of new skills in this area, rather than on assessment alone.

With the exception of mental handicap, the amount of time spent on Relaxation Training was surprisingly low, even allowing for the fact that relaxation sessions are generally carried out for short periods of time. Literature on relaxation techniques is extensive, although little has been documented by occupational therapists, and it is possible that specific referrals for relaxation are made more frequently to departments other than occupational therapy.

The findings for Counselling need to be interpreted cautiously. For the purposes of the Activities Guidelines, it was the most difficult term to define in a way that would ensure consistent interpretation. The definition was deliberately left relatively broad to allow for on-the-spot counselling as well as specific counselling sessions but was consequently laid open to wider applications. Notwithstanding this circumspection, Counselling was recorded extensively by staff of all grades working in all clinical areas. The implications for occupational therapy staff involvement in such a sensitive area of work are such that further research eliciting more detailed information ought to be a priority. The results support the idea that there is something 'special' about the atmosphere in an occupational therapy department and/or the therapeutic relationship evolved through the medium of activity which encourages some patients to discuss their problems more freely. The fact that Counselling was recorded for a large proportion of the time in conjunction with other activities indicates that it was mostly counselling of the spontaneous kind rather than involvement in formal sessions. While counselling is something that many occupational therapists feel ill-prepared for, the evidence of this study is that technical and helper staff also find themselves in a counselling role, whether or not it is the policy of that department or whether they feel sufficiently experienced.

Not surprisingly, the Remedial Games and Exercises category was recorded almost exclusively in physical medicine but its use in this field was not as extensive as expected. The use of adapted equipment as a means of exercising a specific group of muscles or improving range of movement, for example, is an aspect of treatment for which occupational therapists receive in-depth training at pre-registration level. It would appear from this study that such skills are being under-utilised. One possible reason is that staff resources in physical medicine were limited, with the result that therapists may have been under pressure to restrict much of their treatment to activities such as daily living which would enable patients to return home. Secondly, the limited understanding by other disciplines of the occupational therapist's role, as found by Correia,¹¹ may have been a contributory factor to this result. The general unawareness of the scope of occupational therapy may also partly explain the low time recordings in other specialised treatment activities.

Although many occupational therapists would like to get away from the old-fashioned craft image, the results show that craft activities are still very much in evidence, particularly in psychiatric occupational therapy departments. In agreement with the findings of Williams et al,¹² the results also show that helpers were mainly responsible for carrying out Craft Activities with patients.

Printing was one traditional occupational therapy activity which was used less than expected. The study showed that it was used almost entirely by technical instructors working in psychiatry, while its adapted use as a remedial tool in physical medicine was very limited. It would appear that the main purpose to which the practical printing skills of occupational therapists are put is for the teaching of technical instructors.

When the survey was carried out in late 1984, computers were only just beginning to be used in occupational therapy in Southampton. At the time, only two departments actually owned a computer, so the amount of time recorded on this category was, understandably, very low. Since then, every departmental base has acquired at least one computer for use in treatment, with six or seven being used in mental handicap alone. It is therefore reasonable to expect that the time spent on computer work with patients has increased, although it would be interesting to test this out.

Without the inclusion of industrial therapy staff in the survey, the amount of work time spent on Light Work Activities would have been negligible. Similarly, Heavy Work Activities were used almost exclusively by technical I instructors. The minimal involvement of occupational therapists in work activities is in agreement with the findings of Bayliss et al.⁴ This trend would imply that this is an area of rehabilitation in which occupational therapists have relinquished some of their involvement, particularly as specialist instructors invariably

have superior practical skills in many work-related activities. However, it may be argued that instructors do not have the theoretical knowledge base to apply their practical skills therapeutically without the guidance of an occupational therapist. Since the survey, changes at one hospital in the district have resulted in the abolition of industrial therapy as such and the introduction of a broader range of work experiences in which occupational therapists are actively involved. It would be useful to make a comparison of the therapeutic outcome in work-related areas where an occupational therapist is actively involved and those where indirect supervision only is given.

In view of the large proportion of time spent on some treatment-related activities, particularly by occupational therapists and technical I instructors, some attention should be paid towards finding ways of reducing the time taken up by this whole area of work. It is the responsibility of both managers and individual staff to look at the non-treatment activities which consume the most work time and to examine why they do so.

CONCLUSION

This study shows that a wide range of activities was used in occupational therapy at the time of the survey, but that most treatment time was taken up with traditional task-orientated activities. Specific treatment techniques such as Relaxation Training, Remedial Games and Exercises, Social Skills Training and Reality Orientation were shown to be additional, complementary activities. To assist decisions regarding changes in clinical practice, it is important to have more evaluative work in established, traditional areas of treatment such as activities of daily living, as well as in newer, more fashionable techniques. Few home visits were carried out except by senior staff working in physical medicine. It is suggested that further research should be undertaken to establish the adequacy of occupational therapy provision to patients living in the community, particularly in the fields of general psychiatry and mental handicap.

The study found that most treatment was carried out by technical III instructors and helper staff while occupational therapists spent more time in treatment-related work. The limited time spent on treatment has been attributed partly to the numerous professional duties required of them, although individual management of time has also been questioned. The findings raise the question of whether the supervision and support of technical instructors and occupational therapy helpers is adequate for the work which is required of them.

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The full report is available on loan from the Education Department.