A colleague and I were recently discussing the frustrations of a student who had completed a Level II fieldwork in a community mental health center that is consumer directed (i.e., the service recipients choose the services and activities in which they will participate rather than having them prescribed via a treatment plan). The student was frustrated because despite the many occupational therapy services she was capable of providing, the consumers often chose not to take advantage of them. From this conversation, I was struck with the realization that the medical models of service delivery to which most educators socialize students have traditionally given health care professionals extensive latitude in making decisions for consumers rather than asking them what issues they want to address.

Through my conversations with consumers, observations shared by students on fieldwork assignments, and my own observations of occupational therapy practice, I have found only limited consumer involvement in decision making. Too often, collaboration with consumers (which is required by the American Occupational Therapy Association's [AOTA, 1994] code of ethics) is interpreted to have been achieved if the therapist asks during the evaluation process what the consumer's goals are or what he or she would like to be able to do before leaving the hospital. During treatment, the therapist may reintroduce the topic of goal setting for additional input. Even if the consumer provides this information, rarely does a therapist use the consumer's stated desires as the sole (or even primary) basis for determining treatment goals. Instead, the therapist continues, albeit beneficently, to create a treatment plan that is predominately his or her own.

I believe that not only should there be collaboration between the therapist and consumer, but also that no occupational therapy service should be performed without obtaining consent from the consumer. I further believe that because the consumer is paying for the services, either directly or indirectly through insurance or government assistance with limited health care dollars, he or she has the right to choose which occupational therapy services to participate in, much like he or she would choose any other professional services (e.g., dental care, legal advice). As Shapiro (1994) put it, "No one—not even doctors or therapists—knew more about the needs of disabled people than disabled people themselves" (p. 73).
CAOT, 1983) and revised them in 1991 (CAOT, 1991). It is unclear, though, to what extent Canadian therapists use these guidelines in their own practices by involving consumers in the treatment planning process (Blain & Townsend, 1993). Reflecting on the impact of the guidelines 10 years after their initial release, Sunson (1993) stated that therapists were now more familiar with the client-centered model of practice, but the extent to which therapists were incorporating the client at the center of their work, or what that meant to practice, had yet to be evaluated.

The occupational therapy literature in the United States provides little evidence of therapist–consumer collaboration in treatment planning. Neistadt’s (1995) survey of 269 occupational therapy directors in adult physical rehabilitation facilities reported that 99% routinely identified clients’ priorities for treatment upon admission, yet only 56% indicated that the clients’ stated priorities were specific enough to suggest specific treatment activities. Neistadt concluded that “occupational therapists in physical disability settings are not effectively collaborating with their clients regarding goal setting and treatment planning” (p. 435).

A study that evaluated the extent to which occupational therapists involved adult rehabilitation clients in goal setting (through audiotapes of initial evaluations and review of corresponding documentation) revealed that only 10% of the 30 participants discussed with the client the possibility of collaboration. None of the participants specifically explored the client’s concerns, asked the client to prioritize concerns, nor confirmed the client’s major concerns. Sixty-three percent of the participants reported collaborating with consumers to establish goals, but the extent was not clearly described (Northen, Rust, Nelson, & Watts, 1995).

AOTA’s Position Regarding Consumer-Based Practice

Although the AOTA has not taken a stance with regard to consumer-based practice, Principle 2. A. of the Occupational Therapy Code of Ethics states, “Occupational therapy personnel shall collaborate with service recipients or their surrogate(s) in determining goals and priorities throughout the intervention process” (AOTA, 1994, p. 2). This standard of practice is based on the ethical principle of autonomy: the right to be independent and self-governing. Although therapist–consumer collaboration is currently required by the code of ethics, I propose the adoption of a consumer-based model for service delivery to ensure that the consumer is autonomous in establishing treatment plans and goals.

A Proposed Consumer-Based Model

In a consumer-based model, the person (potential consumer) referred to occupational therapy services is interviewed so that the therapist can facilitate the identification of specific goals and a description of the contexts in which activities or tasks are performed. Two instruments are available for use in the interview. Payton, Nelson, and Ozer (1990) developed a manual that provides specific questions therapists can ask to help consumers identify their concerns, goals, desired outcomes, and the means to obtain the goals. Law et al. (1991) developed a similar, yet more detailed, instrument called the Canadian Occupational Performance Measure (COPM) to involve consumers in determining occupational therapy intervention. The COPM parallels the Guidelines for the Client-Centered Practice of Occupational Therapy (Department of National Health and Welfare & CAOT, 1983).

After the interview, the therapist, using traditional evaluation techniques, evaluates only those areas of concern identified by the consumer. At the same time, the therapist remains aware of the environment (the context) in which the consumer performs activities to evaluate the compatibility of the environment to the person.

After the evaluation, the therapist meets with the consumer (or his or her surrogate[s]); explains, in lay terms, the evaluation results; and describes alternatives for addressing the consumer’s goals. A mutual education process, between therapist and consumer, is required so that the consumer can make informed decisions and identify realistic and achievable goals. The consumer and therapist collaborate on developing a treatment plan, with the consumer choosing and prioritizing treatment goals (ideally the consumer and therapist discuss their motivations and rationales in the decision-making process). While the therapist is presenting the treatment options, the consumer has the opportunity to provide input, choose the services he or she will use, and prioritize his or her own goals. If the consumer requests a treatment option that the therapist believes would not be beneficial (or would be potentially harmful), the therapist has a moral and ethical obligation to decline provision of such an option, explaining to the consumer why the treatment would not be included or perhaps even contraindicated. Consumers have the right to change the priority of treatment goals as they deem necessary throughout the treatment process. Consumers also have the option of choosing or changing therapists if the therapist is not doing what the consumer deems necessary or if the consumer prefers to work with another therapist.

Implications of Using a Consumer-Based Model

The consumer-based service delivery model has the potential of investing the consumer in the treatment process and subsequently requiring the consumer to take more responsibility for his or her health care. The model also assumes that consumers are comfortable in challenging the recommendations of a health care professional. Whether all consumers can reasonably assume the role of directing their own treatment, especially when under the duress of a medical (and perhaps life-threatening) emergency, could be questioned. When evaluating the consumer comments after completion of the COPM, Law et al. (1994) found that “it was difficult for some clients to
discuss problems which seemed overwhelming to them in the early stages of disability [but that] many clients commented that they enjoyed the process of identifying priorities, and found it challenging" (p. 196). If needed, the consumer could initially waive this right of assuming responsibility for his or her health care and later reassert that right when ready, designating a surrogate to act as the responsible party in the interim. Furthermore, if a person does not have the ability to make decisions (e.g., persons who are comatose, persons who have severe mental retardation) and where state or federal legislation do not supersede, the consumer's surrogate would make decisions regarding care.

Law et al. (1994) found that some therapists were uncomfortable with the client-centered approach and with allowing the client to identify problems and treatment goals. Additionally, according to Law et al., some clients had difficulty with a client-centered approach, expecting that "the therapist, as an expert, should be able to identify the problems that required intervention" (p. 196). Yet, through their evaluation of the COPM, it became evident that the treatment priorities of the client were often different from those anticipated by the therapist. Another potential problem with the consumer-based model is that the therapist could limit the parameters of treatment options he or she offers. Additionally, the therapist and consumer (or surrogate[s]) may not agree on what needs to be done. The therapist must evaluate what he or she can offer ethically. If the offered services do not meet the consumer's wishes, the consumer can refuse them, thus still retaining the right to make the final determination.

Another concern is whether occupational therapists and third-party payers are amenable to the concept of consumers delaying treatment. For example, what if a consumer who has had a stroke says that he or she would like to wait and see how much improvement occurs spontaneously or wants to see the results from other therapies before participating in occupational therapy? What if a hospitalized consumer delays occupational therapy treatments until he or she is an outpatient or receiving home services? I believe that consumers should be provided with information about various plans of action and then be allowed to make an educated decision. Furthermore, what if treatment goals were not reached to the consumer's satisfaction? Routinely informing consumers about potential outcomes would make therapists accountable for the services provided as well as allow the consumer to weigh the cost-benefit ratio of the treatment before making his or her decision. Considering that therapy services are usually revenue generators, some organizations providing health care, as well as third-party payers, may be reluctant to entertain a consumer-based model because treatment revenues may decrease, as therapists would only address consumer concerns, not all treatment possibilities.

A consumer-based model may require more time during the interview phase, which may result in increased initial costs. In the long run, these costs may be offset by a reduction in the total treatment time (Chiou & Burnett, 1985). However, as indicated in the nursing literature, length of stay is shorter (Shendell-Falik, 1990) and progress toward goal achievement was notably better (Czar, 1987) in units where the health care team worked cooperatively with consumers and their families to establish care plans and goals. Neistadt (1995) corroborated these findings in summarizing two of her studies of independent living skills programs (Neistadt, 1987; Neistadt & Marques, 1984): "clients in long-term settings who collaborated on their treatment goals made statistically and clinically significant gains in their ability to perform or direct self-care and community living skills" (p. 428). Hence, the research (albeit limited) indicates that consumer-based models lead to shorter lengths of stay and better outcomes, which are goals that we all share.

Conclusion

Adopting a consumer-based model for occupational therapy practice would require a shift in decision-making power from the therapist to the consumer. A necessary first step is a thorough discussion of the model and its implications on practice, which would help ensure that, if adopted, it is understood and used. Adoption of a consumer-based service delivery model would allow consumers to choose our services based on their sense of worth of what we have to offer. ▲

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