OTs Overcoming Barriers to Implementing Constraint-Induced Movement Therapy: A Cross-Sectional Qualitative Study

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PURPOSE: The purpose of this study was to investigate therapist generated solutions to barriers of implementing CIMT in occupational therapy (OT) practice settings and to determine if there were any additional barriers not previously identified in the literature. CIMT is an evidence-based intervention with significant research support to improve functional movement in the upper extremity of stroke survivors (Borges et al., 2018). Unfortunately, research has found that there are barriers to the use of CIMT in clinical settings (Viana & Teasell, 2012). Barriers include knowledge, program implementation, poor client tolerance, and lack of time (Reiss et al., 2012). The purpose of this study was to seek real world solutions to bridge the knowledge to practice gap with regards to CIMT use in OT practice for clients following stroke.

DESIGN: A cross-sectional survey design with open ended questions was used. Inclusion criteria was occupational therapist or occupational therapist assistant, over 21 years of age, English speaking, and at least one year of experience utilizing CIMT in clinical practice.

METHOD: A online survey with six opened questions about occupational therapists' experiences with barriers to implementing CIMT and ideas for solutions was developed. The survey was distributed through social media and AOTA's CommunOT group. Thematic analysis was used to analyze the data and develop themes. The categories, themes, and subthemes were developed from the participant's responses to the six open-ended questions.

RESULTS: There were 20 participants. The majority of the participants were female (95%) and practiced in urban settings (72.22%). Participants ages ranged from 26 to over 46 years old and education levels ranged from bachelors in OT to post-professional OTD, along with one OTA. There were three subthemes that arose from the questions about solutions: education, research, and advocacy. Therapists felt that entry-level and post-professional educational opportunities were needed to overcome barriers. Education should include practical ways to implement CIMT in a variety of practice settings. There also were knowledge to practice solutions proposed, one was that there should be more research to support CIMT in practice and the other was that there should be better dissemination of current research to clinicians. Finally, with regards to advocacy, therapists thought that advocacy was needed for better education about CIMT, which aligned with the education theme, and that occupational therapists needed to do their part to increase public awareness to support client/family buy in.

CONCLUSION: This study offers therapist generated solutions to known barriers to implementing CIMT in clinical settings. Though the sample size was limited the thematic analysis process was robust. These findings support the development of protocols for a multitude of clinical settings, with corresponding education and research to support these practices. In addition to therapist centered practice solutions, advocacy to increase awareness and client/family willingness to engage in CIMT is needed.

IMPACT STATEMENT: This research offers solutions generated from therapists working in clinical settings giving us important insight to the needs of therapists and helping bridge the research to practice gap.

References

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