

**By Rebecca Harland**

HS859: Research Activity

**Literature Review & Research Proposal**

Registration No: 1005669

MSc Occupational Therapy 2010 cohort

29.06.12

Supervisor: Frances Sheppard

7,954 Words

(Excluding front page, contents page, summary, references, appendices & Acknowledgments)

## Table of Contents

|  |  |
| --- | --- |
| **Chapter 1: Literature Review** | **4** |
| 1.1 Introduction | **5** |
| 1.2 Models: What are the benefits an why do we use them? | **5** |
| 1.3 Search strategy  1.3.1 Inclusion Criteria  1.3.2 Exclusion Criteria | **6** |
| 1.4 Common OT models found within the evidence base:  1.4.1 Model of Human Occupation (MOHO)  1.4.2 Canadian Model of Occupational Performance (CMOP)  1.4.3 KAWA  1.4.4 Vona du Toit Model of Creative Ability (VdT MoCA)  1.4.5 New/Developing models | **8** |
| 1.5 Research topic | **11** |
| 1.6 ABI | **11** |
| 1.7 VdT MOCA; A history and short analysis | **13** |
| 1.8 Critical Appraisal and themes from literature  1.8.1 Motivation as an indicator for success in rehabilitation  1.8.2 Purposeful and meaningful activity; linking in with client centred practice  1.8.3 ABI and lifelong recovery  1.8.4 Terminology | **15** |
| 1.9 Conclusion | **19** |
| **Chapter 2: Proposal** | **20** |
| 2.1 Summary | **21** |
| 2.2 Research question | **22** |
| 2.3 Method  2.3.1 Stage 1  2.3.2 Stage 2  2.3.3 Stage 3  2.3.4 Stage 4 | **22** |
| 2.4 Recruitment  2.4.1 Inclusions  2.4.2 Exclusions  2.4.3 Recruitment selection | **24** |
| 2.5 Proposed location of research | **26** |
| 2.6 Data analysis | **27** |
| 2.7 Ethical Considerations  2.7.1 Obtaining Ethical Approval | **29** |
| 2.8 Proposed Approximate Timescale and plan of work | **32** |
| 2.9 Proposed dissemination methods | **33** |
| 2.10 Future implications for practice and research | **33** |
| References | **34** |
| Appendices | **44** |
| Acknowledgements | **71** |

Chapter 1

**Literature Review**

Investigating the Use of the Vona du Toit Model of Creative Ability (VdT MoCA) by Occupational Therapists (OTs) in Acquired Brain Injury (ABI)

**1.1 Introduction**

The aim of this paper is to investigate the use of the Vona du Toit Model of Creative Ability (VdT MoCA) by Occupational Therapists (OTs) in Acquired Brain Injury (ABI). By way of a detailed literature search and review, the use of models in Occupational Therapy (OT) amongst different client groups will be investigated, in order to get a broad picture of the topic and generate a thorough understanding. Various models and client groups will be discussed, before a proposed research area/question will be formed and a number of pertinent articles to the proposed research of VdT MoCA and ABI, are critically appraised.

* 1. **Models: what are the benefits and why do we use them?**

There has been an increasing drive since the late 1980’s to examine clinical effectiveness of health care services in the UK and to provide a strong evidence base to practice (DOH 1998, DOH 2010). This has been reiterated with various National Service Frameworks (NSFs); including the NSF for Mental Health and NSF for long term Neurological conditions (DOH 1999, DOH 2007).

Conceptual models within OT, which help to evidence and support the constructs and value of OT practice, have only really been prevalent since the 1980’s. Models of practice are said to be a bridge between theory and practice; with knowledge sharing in both directions (Fieldhouse 2008). However, there has been some resistance to the use of models, with therapists stating that the demands and constraints of their practice setting are barriers to implementing theory into practice (Wimpenny et al 2010). It is no surprise then; that from the literature searches carried out across 3 databases (see appendices A and B), evidence for the use of models in practice is still relatively minimal. Certainly within some client groups, such as mental health; the use of models has been shown to provide a sound evidence base for identifying occupational needs of clients and relating them to Payment by Results clusters (Lee et al 2011); which ensures funding during a difficult economic climate. The use of evidence-based practice to secure funding could prove very important with regards the future of the profession, within various client groups, in order that the profession is promoted and most importantly; survives.

The use of models has also shown to produce more sophisticated clinical reasoning (Melton et al 2010). Use of theory has been shown to increase professional confidence and in one study was said to give OTs a common language which helps reinforce feelings of ‘belonging’ to the profession (Pepin et al 2008); particularly important when considering the need for awareness and cohesiveness of the profession’s identity in general.

* 1. **Search strategy**

A literature search of CINAHL, PUBMED and OTSeeker was carried out, with search items as shown in appendix A. Due to some previous knowledge of VdT MoCA and the awareness that there were more research articles relating to the model than those coming up in searches; manual searches were also carried out based on an up to date resources list available through the Model of Creative Ability Interest Group (MCAIG).

It was important to narrow search parameters by way of inclusion and exclusion criteria below in order that the search be valid and relevant to the research topic.

There was an initial consideration to only search the last 10 years to increase validity; however, due to the lack of research in ABI, this would have meant excluding some papers which demonstrated some important findings. Therefore there was no date criteria set.

***1.3.1 Inclusion Criteria***

* Adult settings only\*
* Must discuss an OT specific model which guides the therapists clinical reasoning, treatment and overall practice; a process and/or content driven model\*

*\*Adults were chosen as an age group due to the desire to focus on adult rehabilitation rather than child rehabilitation; the recovery process of children with ABI is different to that of adults due to the development stages of the nervous system, and so different models are needed to guide these two age groups (Finger & Stein 1982)\**

*\*The majority of articles which spoke of models were actually referring to approaches, assessments or models that are specific to certain areas and not OT practice; i.e. a model to guide analysis of quantitative data, a model to assess validity of assessments etc.\**

***1.3.2 Exclusion Criteria:***

* Non-OT related models
* Papers with a focus on another topic (i.e. assessments) which only briefly mention the use of a model
* For those searches looking at a specific client group i.e. mental health, ABI; papers which look at a variety of client groups are excluded.\*
* Duplicate papers across multiple searches.

\**There were a large amount of articles screened out due to them looking at mixed client groups. The purpose of the literature review was to examine the use of a specific model (VdT MoCA) with a specific client group (ABI) and so the search strategy needed to reflect this with the other searches*.\*

24 articles were screened in using the criteria above; which gives an overview of models used in various client groups according to the research (See Appendix B). This overview is discussed in the sections below. Following the review process of all 24 articles, 11 articles were screened in for critical appraisal. These were articles most pertinent to the decided area of research. For both reviews of the 24 articles and critical appraisal of the 11 chosen articles, the Critical Appraisal Skills Programme (CASP) was used to inform the critiques (Solutions for Public Health 2006 a, 2006b).

* 1. **Common OT models found within the evidence base:**

On the whole, models of practice appear to be under-represented within the literature and evidence base; as can be seen from the search results (Appendix A&B). Although models of practice may be mentioned frequently in research, there appears to be a lack of research looking into the use of these models actually in practice; many just mention them in passing or use the models as a way to interpret research rather than investigating the use of them. In addition, more than half of the articles reviewed looked at the use of these models outside of the UK. With this in mind it appears that research on the use of OT models in practice is urgently needed in the UK.

***(Please See Appendix C for a brief overview of MOHO, CMOP, KAWA AND VdT MoCA)***

* + 1. ***Model of Human Occupation (MOHO)***

Of the most frequented OT models; MOHO has the largest evidence base (Heasman & Morley 2011). From the search conducted, 7/13 screened in articles, relating to mental health, used MOHO as their guiding model of practice. A recent study looking at the perceptions of 429 OTs using MOHO, stated that the use of the model increases professional stature and identity for therapists (Lee et al 2012). This could be said to be quite a significant result as the participant number is so high.

Within stroke there was just one article screened in which used MOHO (Mentrup et al 1998). This article gave a very good insight into one case study which highlighted the significance of looking at MOHO’s aspects of volition and habituation when using the model with disabled workers. However, it should be highlighted that the use of MOHO within stroke has not been thoroughly investigated by the use of just this one case study.

There have been new models proposed to use with Traumatic Brain Injury (TBI) clients which are based on the concepts of MOHO (Depoy 1990); however there is no published evidence as to the use of MOHO directly on TBI.

In essence it appears that most of the evidence-base for the use of MOHO is within mental health.

* + 1. ***CMOP***

Of the 13 mental health articles screened in for further examination, 2 looked at the use of CMOP within this client group. One amalgamated concepts of VdT MoCA with the CMOP (Samsonraj et al 2012), however there was more of a focus on the use of the assessment (COPM) which is based on CMOP, rather than any in-depth look at the use of both of these models of practice in mental health. The other article looked at CMOP alone and OTs perception of the use of it by way of assessment using the COPM (Warren 2002). This study found that linking environmental aspects as well as performance components from CMOP into an assessment combined with the already established COPM, resulted in a successful assessment base for OTs (Warren 2002). It should be noted however, that the participants were already conversant with the model and so this may reflect some bias.

There was no evidence of the use of CMOP in other client groups; including ABI. However, Similar to Depoy (1990), Lee et al (2001) proposed a new model for use in cognitive rehabilitation in TBI which was based upon CMOP principles.

* + 1. ***KAWA***

Similarly to CMOP, and surprisingly so as CMOP is some 30 years older than KAWA, there were just two articles from the search reviewing the use of this model; both within a mental health setting. These two articles (Richardson et al 2010, Fieldhouse 2008) are both practice reports; looking at reflections of experiences in using Kawa in mental health. They are insightful articles, using reflectivity in order to analyse the practicalities of the model. Both come to the conclusion that it is a very client-centred model in which the clients are very much engaged in the OT process.

It is clear that this model needs further investigation, but this is understandable considering it has only really been used since the late 2000’s following it’s official publication in 2006 (Turpin & Iwama 2011)

* + 1. ***VdT MoCA***

From the 24 articles screened in, 6 of those were relating to VdT MoCA. It should be noted however, that 3 of those articles were not found through database searches and were discovered through manual searches based on a list of current resources on the model available through the Interest Group (MCAIG 2012). In addition, two of these articles do not match the inclusion and exclusion criteria. One looks at a mixture of client groups and has yet to be published (Chinembiri 2011), however, due to the relevance and currency of data, an exception was made. The other article (De Witt 2003), again does not meet the criteria as it is looks at a certain aspect of the model rather than applying it to any specific client group, but again was included due to its relevance to the research topic.

Out of the articles based on VdT MoCA, two speak of application in ABI/TBI; however neither of these directly look at if it is an appropriate OT model of practice to use across ABI settings as a whole. One of the studies is more of a discussion piece regarding the use of the model in vocational rehabilitation; with one case study as an example (De Witt 2003), whilst the other is a comparison of the model with traditional medical tests to establish neurobiological status (Turnbull et al 2002). It was found that VdT MoCA has a high level of correlation to traditional assessments such as the Glasgow Coma Scale. Turnbull et al’s study was seen as a preliminary investigation and is discussed in more detail below (1.8 critical appraisal); however it proves to be a good starting point for promoting the use of VdT MoCA within an acute ABI setting. It must be noted however, that both of these studies are some 10 years old and so it appears their preliminary investigations have not been broadened with further studies in the field.

* + 1. ***New/Developing models***

Of the 24 articles screened in, 6 of them propose a new or developing model. Out of these 6, 4 are relating to ABI or TBI. This seems to indicate that the field of ABI is very much a developing one with regards to the use of OT models of practice.

* 1. **Research topic**

As can be seen from the above overview of models used in different clinical areas; there is very little evidence for the use of established OT models in ABI.There is also very little evidence for the use of VdT MoCA across all client groups; but even more noticeable is the observation that some researchers have attempted to look at the use of VdT MoCA within ABI but without much success in terms of scale and breadth. For this reason articles pertinent to the use of models in ABI and the use of VdT MoCA in general will be examined more closely, in order to generate themes within the literature and help formulate a research proposal. An overview of ABI and VdT MoCA will be given below; before critically appraising the 11 articles which relate specifically to these two areas.

* 1. **ABI**

Acquired brain injury can be defined as any head injury, traumatic or non traumatic, acquired after birth (Headway 2012); this inclusive category covers brain injuries of any cause, including:

* Trauma (road traffic accidents, surgical damage etc)
* Vascular incident (stroke/subarachnoid haemorrhage)
* Cerebral anoxia
* Toxic or metabolic insult (e.g. hypoglycaemia)
* Infection (meningitis, encephalitis) or other inflammation (vasculitis)

Acquired brain injuries with a variety of aetiology, as listed above, are increasingly treated within the same rehabilitation services (RCP&BSRM 2003). It is for this reason that the research topic will look at ABI as a whole and not specifically TBI . There are various types of ABI rehabilitation, including:

* **Inpatient rehabilitation:** Intensive specialist rehabilitation for those who are not yet ready to return home after discharge from hospital; may include structured day programmes.
* **Outpatient rehabilitation:** For clients who are functioning at a level high enough to return home and receive further treatment as an outpatient; at a hospital or rehabilitation centre.
* **Community rehabilitation:** Either a residential transitional living unit where independent living skills can continue to be developed or within the client’s own home; with a community rehabilitation team or outreach team helping them to make further progress. (Headway 2012)

10-15 people out of 100,000 of the population are estimated to suffer a severe head injury, with males being two to three times more likely than females to sustain a head injury (Powell 2003) Head injuries can cause significant emotional, physical and cognitive deficits (Koeler et al 2011) and advances in medicine have meant that there are more people surviving and living with the consequences (Lee et al 2001).

The degree of heterogeneity of the resulting brain damage depends upon a number of factors including; if the injury is diffuse or focal (widespread damage or a specific location); if the injury is closed or penetrating; and the severity of the injury (Koeler et al 2011). Severity can be indicative of long term disability and is usually graded upon the Glasgow Coma Scale (GSC). Used since the 1970’s this is a 15 point scale which looks at eye opening, verbal and motor behaviour; 13-15 being mild, 9-12 moderate, and 3-8 severe.

The physical, cognitive and behavioural effects of brain injury can pose highly complex challenges for suitable rehabilitation pathways, with many specialist settings lacking resources to deal with challenging behaviour and complex cognitive difficulties (BSRM 2008).

The role of the OT in ABI rehabilitation includes maximising the client’s function, via remediation or compensatory techniques (Conti 2012). Examples of OT sessions may cover such areas as

* Fatigue management
* Development of memory and planning systems
* Social participation
* Brain injury education
* Mood management
* Communication skills (Wilson et al 2009)

It has been found that there is a large body of evidence for the use of OT within the field of stroke, but unfortunately this is not true of most other neurological fields (COT 2004); this includes ABI from other sources including TBI.

* 1. **VdT MOCA; A history and short analysis**

When looking back through the history of VdT MoCA; it is evident that the model as we know it today is a result of collaborative efforts. The Model itself is based upon the Theory of Creative Ability developed by Vona du Toit in the early 1970’s, which was later presented as a model by DeWitt (2005). Following a variety of names being used for the model over the years, it was officially named the Vona du Toit Model of Creative Ability in 2010 following criticism over the lack of agreement in name (Sherwood 2011).

The model aims to understand the process of engagement; important to any OT intervention. Unfortunately it is poorly documented and researched, however it is widely used in South Africa (De Witt 2003, Sherwood 2011). The fundamental concept of the model is volition, taking into consideration two intrinsically linked component parts; motivation and action. It is assumed that action is seen through the conversion of motivation into occupational behaviour (De Witt 2003, De Witt 2005).

In the model, motivation and action are divided into different levels within a sequence. Please see Appendix C for the creative ability table which applies to this; often used as the recording for assessment.

When looking at the creative ability assessment, one could criticise the model for not being client centred, as the focus is on levelling the clients rather than them levelling and assessing themselves, and the assessment is based upon a grid of boxes within which the OT is expected to ‘place’ the client. It could be questioned as to if we are really viewing people as individuals if we are placing them in boxes. However, it would be important to consider that the model is based upon motivation theory, and that there is emphasis on the OT understanding the person and their entire world (Sherwood 2011). Here it could be said that the OTs core skill of therapeutic use of self and understanding of the models concepts are the driving force behind client-centeredness.

VdT MoCA has gained interest over recent years within the UK; with South East Essex Partnership Trust being the first trust to implement it across their services in 2002/2003 (Sherwood 2010), followed by many other services particularly in mental health (Harvey & Fuller 2009, Wilson & White 2011); some of which are using the model in conjunction with others like MOHO (Harvey & Fuller 2009). Many of these practice features provide anecdotes that the move to VdT MoCA has been a positive one; with areas such as professional confidence, definition of OT role, increased motivation from staff and increased engagement from clients as benefits to name but a few.

There are also now some 114 members of the UK specialist interest group (MCAIG 2012) which gives the opportunity for professionals to share knowledge about the model and network, as well as stimulate critical evaluation of the model, develop ideas for research and CPD opportunities (Sherwood 2009). It should be noted however, that although there are many such resources like those named above, a strong evidence base is lacking with regards VdT MoCA (ibid) as can be seen within the literature search and review of the model below. It is important, from an evidence-based point of view, to ensure that resources such as practice features, opinion pieces, and blogs on the MCAIG, although very valuable, are taken at face value. It has also been noted by experts in the field that the model is in urgent need of a text dedicated to it (rather than just a chapter; De Witt 2005), as well as the Creative ability assessment to be published (Sherwood 2011).

* 1. **Critical Appraisal and themes from literature**

Among the literature chosen for appraisal and literature available on Vdt MoCA, there is only one paper which looks at the effectiveness of the application of the model; this being a study looking into the effectiveness of the model in comparison to traditionally offered intervention (Jansen & Casteleijn 2009). There were only 10 participants in the end due to drop outs and defaults on treatment; so even though the results were positive towards the intervention based on VdT MoCA, the size of the group meant that the results were too small for any significance to be drawn from it.

Unfortunately, due to the limited research carried out on VdT MoCA, one could say that the research on the topic is somewhat lacking in vigour. Due to this lack of research, some grey literature sources were used; data that professionals may question the validity of its’ data (Aveyard 2010). However it has also been found that grey literature is important to include in order to fully reflect the existing evidence base (Conn et al 2003). For this reason, and due to the overwhelming relevance to the research proposal, some grey literature, including unpublished works (Chinembiri 2011), were important to include in the critical appraisal.

Below details the common themes identified within the 11 VdT MoCA and ABI specific articles, screened in to critique.

* + 1. ***Motivation as an indicator for success in rehabilitation***

Motivation as an indicator for success in rehabilitation has been identified in various papers (Jansen & Casteleijn 2009, Casteleijn & Smit 2002, Casteleijn & de Vos 2007); and it has been noted that MOHO and VdT MoCA are the only models with a focus on motivation as key to client success in OT. It is also not uncommon for those working with VdT MoCA to additionally use MOHO theory and tools (MCAIG 2011).

Motivation was seen as a key theme and strength of VdT MoCA in a recent survey of those using the model in the UK (Chinembiri 2011). VdT MoCA is also said to be the only model which enables client motivation to be measureable (Casteljein & De Vos 2007).

***1.8.2*** **Purposeful and meaningful activity; linking in with client centred practice**

There has been an ongoing emphasis from the government to ensure health professionals involve clients in their treatment (DOH 2002). Client centred practice is one of the underlying tenets of OT practice (Sumsion 2006), but how prevalent was this concept within the appraised literature on VdT MoCA and ABI?

In her investigation into the constructs of task concept, De Witt (2003) found from her survey of 18 OTs using VdT MoCA, that in order for task concept to develop within the parameters of the model; the activity of choice must be one within the range of interests to the client. Turnbull et al (2002) reiterated this and ensured that the 3 activities used as interventions with their participants were within natural contexts and addressed culture. In contrast, Casteleijn & Smit’s (2002) investigation in to the creative participation assessment (based on VdT MoCA), introduced 2 activities for the clients to engage in which appear to be designed for the purposes of the study rather than any mention of them being purposeful and meaningful to the individual. All three of these studies are based upon the VdT MoCA and so it would be interesting to see what OT’s perceptions are on the usability of the model in aiming for client-centred practice, using purposeful and meaningful activities. Indeed Chinembiri’s (2011) survey found that 29/31 OT’s said the model is client-centred, but further exploration into this and in-depth perceptions as to how this is achieved would be beneficial.

All of the papers reviewed which propose new models to working within ABI and TBI highlight the importance of assessing and providing intervention within the clients own environment (DePoy 1990, Lee et al 2001, Dodson 2010, Shwartz 1994). DePoy (1990) highlighted in her proposed model for TBI clients, that meaningful intervention must move outside the walls of the institution and OTs should be considering the unique life of each client; the model itself has the individual at the centre of person/environment interactions.

It appears from the literature that the OTs working within ABI and those using VdT MoCA achieve client-centeredness, often through the use of purposeful and meaningful activity. It has been said that achieving client centeredness when working with cognitively impaired clients can prove a challenge, but is not impossible (Sumsion 2006); this could be the very reason why it appears that none of the ABI articles appraised speak of the client self-assessing, and instead strive to achieve an individual, client centred approach through other means.

***1.8.3 ABI and lifelong recovery***

Turnbull et al (2002) is the only paper out of 11 which seems to elude to complete recovery whereas all the other 10 articles are very clear that ABI involves lifelong recovery. On-going support, which is highlighted as crucial for survivors of ABI, is described as one of the factors influencing return to work and vocational rehabilitation (Sterigou et al 2009, Dodson et al 2010, Lee et al 2001).

One of DePoy’s (1990) 3 assumptions to her proposed TBIIM model is life-long recovery. The model for TBI clients was designed at a time when there was a shift in view regarding TBI rehabilitation; when people were starting to see the value in community orientated rehabilitation rather than institutional. DePoy Suggests OTs should be involved for as long as is needed in TBI, and that yearly assessment of role and function until a balance has been achieved within the role functions and environments of the client, is ideal. She could be criticised here for not being realistic with regards OT budget and resources, is it that the TBIIM model is slightly idealistic? However DePoy herself defends this critique by highlighting that having an OT in a life-long consultancy role would reduce the long term cost of traditional OT intervention. Although this article is some 20 years old, this is still a pertinent issue in today’s climate; The National Service Framework (NSF) for Long-term Neurological Conditionsrequires rehabilitation resources to be available at all stages, in both community and hospital settings (DOH 2007). One of the Key guidelines for rehabilitation following ABI is that “Patients with significant ABI should have long-term access to an individual or team with experience in management of ABI” (RCP&BSRM 2003 p.52). The British Society of Rehabilitation Medicine has identified that neurological rehabilitation is a much more lengthy process than is accounted for in a standard medical outpatient service model (BSRM 2008). It would therefore appear that ABI clients need a managed, graded pathway of care in order to provide success in their rehabilitation and reduce costs to Health and Social care as well as the individual.

Lifelong recovery in ABI appears to be in line with the VdT MoCA as it is a developmental model which will allow for sensitive changes. In Jansen & Casteleijn’s 2009 study of diabetic foot patients, it was found that there was not only progression within the Creative ability assessment based on VdT MoCA but also maintenance/consolidation (5/10 patients did not progress within the levels during the research time). This is in keeping with the underpinning philosophy of the model; which highlights that development can entail progression, consolidation and even regression.

* + 1. ***Terminology***

It has recently been found that some OTs find the language used within VdT MoCA to be complicated to use and negative towards clients (Chinembiri 2011). It should be noted however, that this was based on quite a small sample size of 38 OTs and that it was only 15 OTs who were said to have a view relating to the difficult nature of the language as a whole; this may not be statistically significant, however is a good starting point to consider when looking at the model and its’ use.

Similarly, De Witt (2003) found that even when surveying 18 OTs whom were conversant with the model, there was still some confusion surrounding terminology relating to task concept. This was even with 71% of respondents having worked with the model for 10 years or more. De Witt makes an observation that it would have been helpful to send out clarification of terminology and to not assume that as the OTs were working with the model that they were clear on what the terms referred to. It is important to note therefore that, any future research on the model consider these aspects and that the participants are given training to ensure they are clear with the terminology.

Following the outcome of her study, De Witt suggests that more precise definitions of occupation and occupational performance need to be developed following further research. Sherwood (2011) echoes this, saying recently that concepts that are not clearly defined within VdT MoCA need to be addressed, proposing that a full articulation of the model needs to be a priority.

* 1. **Conclusion**

It would appear from the themes identified between the ABI and VdT MoCA papers that some parallels can be made between the two in relation to core concepts; such as life-long recovery, client-centred practice, and purposeful and meaningful activity. However, although these parallels are evident they have yet to be explored fully within the research in order to ascertain if VdT MoCA is an appropriate model of practice for OTs to use in a variety of ABI settings.

Chapter 2

**Research Proposal**

“Occupational Therapists’ perceptions of the use of the Vona du Toit Model of Creative Ability (VdT MoCA) in Acquired Brain injury (ABI) settings; a focus group”

**2.1 Summary**

Acquired Brain Injury (ABI) has complex and often life-long consequences for the individual and their loved ones to manage. Occupational Therapists (OTs) work in a variety of settings with this client group, but there is a lack of evidence for the use of which models of practice are used, most suitable and favoured. Following a thorough literature search and review, it would appear that VdT MoCA is also under-researched but that there are possible correlations between the model and ABI; therefore a gap in the literature has been identified within two pools of knowledge.

There is a real drive from The College of Occupational Therapists (COT) to become more involved in research; in 2007 they stated they were continuing to strive towards achieving 1% of OTs registered with the HPC as being research leaders (White & Creek 2007). Each specialist section of the COT has their own Research and Development plans; this includes the COT Specialist Section (COT SS) Neurological Practice. This COT SS has stated various objectives which aim to promote and encourage further research in the field of Neurology; they do not limit this to the field of stroke, and include other causes of brain injury under their umbrella as being equally as important a field for future research (COT 2004). It has been identified that there is a need to create a similar evidence-base to that of stroke, for those working in other areas of neurological practice (COT 2007).

Furthermore, and more specific to the proposed research question, following a survey regarding research needs at the International MoCA conference in 2010; one of the delegates has suggested that the application of VdT MoCA in ABI be investigated (Sherwood 2010a). Sherwood (2011) has also identified that further research is needed into head injury and VdT MoCA off the back of Turnbull et al’s investigation (2002). As the research in this area is so limited, as is the supposed application of the model in ABI in the UK; it will first be integral to introduce and educate OTs working in ABI on VdT MoCA.

**2.2 Research question**

***“What are OTs perceptions of VdT MoCA and the potential use of the model within their practice in ABI; following training on the model and participation in a focus group?***

Aims of the research:

1. Gather participants’ level of knowledge and understanding as well as perceptions of VdT MoCA prior to training
2. Increase participants’ knowledge and understanding of VdT MoCA by way of official training
3. Gather participants’ perceptions of VdT MoCA as a model of practice and perceptions of using it in their ABI settings; by way of a focus group (A small group of between 6-12 people who come together to discuss a particular issue (Green & Thorogood 2009)).

**2.3 Method**

The validity of using quantitative methods with OT as a whole has been challenged, due to the fact that many of the items for focus in OT research are based on motivation, thoughts, emotions and relationships; items which are difficult to quantify (Finlay 1998). Based on this, a qualitative research method will be used as perceptions of OTs would be best explored through these means.

.

As the OTs perceptions relate to their lived experience, an interpretivist approach is most suited here (Carpenter & Suto 2008). Although the main part of research will be based around a focus group, the individual perspectives will be very important to ascertain; as they may experience what is called multiple realities which are all as valid as each other (ibid). A phenomenological approach will mean that the participants’ descriptions of their experience are valued as being their perceptions (Finlay 1998).

***2.3.1 Stage 1:*** *Initial questionnaire (Appendix D)*

Initial questionnaires will be given to the participants prior to attending the training, for the purposes of gathering socio-demographic information. This initial questionnaire will also find out if they have heard of VdT MoCA and if so, what they feel they know about the model. The socio-demographic information will help to identify trends as well as allowing for the possibility of looking at if the sample is representative of the wider OT population working within ABI. The questions on VdT MoCA will also allow the researcher to put the individual participants’ learning of the model into context following the focus group.

***2.3.2 Stage 2****: VdT MoCA training (Appendix E)*

The participants all attend the level 1 VdT MoCA training for; 3 days (ICAN 2012)

***2.3.3 Stage 3****: Focus group (Appendix F)*

This would be classed as a formal group interview as this is the most beneficial set up for research (Green & Thorogood 2009); with the discussion being tape recorded. However, although there would be structure with the trigger topics set for the facilitator to ask, the informal nature of some of the resultant discussion will be of benefit as this reflects the way that healthcare decisions are often made in everyday life (ibid). There would be a facilitator who would have a list of topics with open ended questions to deliver to the group. Open ended questions will allow the group to focus on specific, relevant questions and allow the individual participants freedom to express thoughts and feelings on these issues. The list of topics and open ended questions will be based upon themes that became evident from the literature review as well as being based on the learning outcomes from the ICAN training. The focus group would last approximately one and a half hours and would be held on the last day of the training. Ideally there would be more than one focus group over a period of time in order to provide triangulation, however this would not be practical based on; the time participants would need to take off from work and cost implications for the research.

*Advantages to Focus Groups:*

* Less time consuming than individual interviews
* Provides rich data and information
* Taking part in a focus group can elaborate and clarify participant’s views (ibid); very much a positive aspect when you consider the nature of research being undertaken and the lack of knowledge and use of VdT MoCA in the UK currently.

*Disadvantages to Focus Groups:*

* The participants may adapt their behaviour and views due to being aware that what they are saying will be interpreted as ‘data’ (ibid)
* It will therefore be important to ensure that the facilitator creates a relaxed environment, and takes time for the participants to feel comfortable with each other so as to minimise this risk. The participants will have had the chance to be involved in icebreakers and to get to know each other during the VdT MoCA training, which should aid in this process.

***2.3.4 Stage 4:*** *Exit questionnaires* (Appendix G)

At the end of the last focus group sessions, individual questionnaires are given out once more to review what people have learnt about the model, ascertain if they would consider using it in practice, and discover implications for future research; if they would consider using the model as a trial in their own practice in the future.

**2.4 Recruitment:**

The researcher would plan to recruit 6 participants from London and the South East. The reason for this particular geographical area is due to the practical and cost implications of sampling a wide geographical area. The sampling would be purposive and would conform to the following criteria:

* + 1. ***Inclusions***
* Must be registered with the HPC and currently practicing as an OT in the field of ABI
* Must be available for, and able to commit to, a period of 3 days for the research; 3 consecutive days training on the model, followed by a focus group meeting on the last day.
  + 1. ***Exclusions***
* Those already using VdT MoCA in their practice (in order to avoid bias). However, if the participants have used it in their past with different client groups, they will not be excluded, as they will provide a richer understanding of the transferability of the model to ABI
* OTs from within the same team

The reason for the goal of 6 participants is due to the fact 6-12 is an advisable number for a focus group (Green & Thorogood 2009). Although a larger number of participants would provide richer data, the practical and cost implications of getting 12 participants from a specialist field such as ABI would be too great; especially with this research being the first of its kind within the UK.

***2.4.3 Recruitment selection*** *could come from a number of sources:*

1. *COT SS Neurological Practice* whom currently have over 900 members (COT 2012). They provide a specific forum for brain injury by which links could be made with other members within the field. It should be noted however that a large proportion of their members work in stroke specific settings (The Stroke Association 2012). In addition it is down to the individual chair of the specialist section if they become involved with research requests and how much help they can give (COT 2011) so recruitment of participants may also need to come from either of the following two resources.
2. *United Kingdom Acquired Brain Injury Forum*; currently 106 members classed as ABI care providers (would need to ascertain how many of these settings provide OT). There are also 2 members listed as independent OTs (UKABIF 2012). UKABIF also provides details of regional Brain Injury forums on their website; including Essex, Suffolk, East of England and London.
3. *The Brain Injury Social Work Group;* although referred to as a social work group, any professionals working within the field of ABI can become a member and offer and receive knowledge, education and skills (BISWG 2012).

The group of participants should consist of people whom do not know each other and are from different backgrounds (Green & Thorogood 2009). However, this could prove difficult with the target group being OTs working in ABI, as this sector is relatively small and there is every possibility that some of the OTs will have met each other at networking events such as conferences before; especially as the selection of participants would be gathered from organisations such as those listed above. There would however be an emphasis, to try and get participants from a diverse range of services involved; i.e. NHS and Private, hospital and community. However, if it turns out to be impossible to gather a group whom have not met beforehand due to the origin of participants, they would be termed a natural group; known to create maximum participation between members (ibid), which could be beneficial for in-depth conversation and in turn; in depth results.

The researcher would aim to get potential participants interested and onboard with the research by offering the VdT MoCA training, as well as a networking dinner on the final evening following the focus group session. Ideally, there would be standby participants identified from the sampling strategy so that if any one of the 6 participants drops out, there is scope for the focus group to still have 6 participants.

**2.5 Proposed location of research**

Due to the nature of the main aspect of this research (focus group); it is not possible to provide a natural context which would create credibility of data (Carpenter & Suto 2008), for example; the OTs using the model in practice. This could be a consideration for future research. Having said this, there would still be a need for a neutral location in which the focus group to take place; no media or advertising within the room which may create any form of bias and no affiliation with anyone working within VdT MoCA. For ease of location and to reduce costs, it would be beneficial if the focus group was held close by to the ICAN training. Previous locations for training have been in Devon, Northampton, and Derby, so once research has been agreed by ethics and a date set, booking of the training would need to take place ASAP, followed by booking of a community hall/small office space somewhere close to the where the training is being held. An example of potential costings and practical considerations is detailed in appendix H.

**2.6 Data analysis**

Data analysis is said to be a complex and time consuming task (Carpenter & Suto 2008), and so a strategy is very much a necessity. Analysis of qualitative data appears less definitive than that of quantitative, and the basic analytic approach is said to be flexible in order to fit the research questions and data (ibid). An interpretive thematic analytic approach would be used for this research with the following stages:

1. *Modification of design* during the data acquisition stage; for example: there are 5 topics which can be discussed during the focus group; with the aim of addressing 3 topics within 1.5 hours. However, the groups’ natural progression will impact on what and how many topics are discussed.
2. Chart the socio-demographic information from the initial questionnaire.
3. *Data Reduction* of initial questionnaire regarding the participant’s understanding of VdT MoCA; repeatedly read, in order to analyse and group under themes.
4. *Data Display* of initial questionnaire regarding the participant’s understanding of VdT MoCA; creating visual and physical displays such as graphs, diagrams, mind maps; these will allow for synthesis and deciphering which themes are most prevalent to allow for the initial formation of tentative conclusions.
5. *Conclusion Drawing and Verification;* by making use of critical questioning of the themes and inductive reasoning. Here a second researcher may be useful (see below).
6. Repeat steps 3-5 for the recordings form the focus group; this would form the main part of data analysis and be the most time consuming.

Within Data Analysis it is important to look at the concept of trustworthiness, which in this case would refer to the extent to which the findings are a true reflection of the personal or lived experiences of the OTs taking part in the VdT MoCA training and focus group.

An OT student conversant with VdT MoCA would be beneficial in order that interpreting the data would be possible due to specific terminology used within the model. Some may argue that having a researcher whom is aware of the model, as the facilitator to the focus group, could result in bias; indeed, Finlay (1998) reflects on how it was impossible for her to be an objective researcher having knowledge in the field, and how she realised through reflexivity that her behaviour influenced the findings of her research by affecting the participants’ responses. However, she then goes on to argue that through reflexive analysis, one can even increase trustworthiness of research; as long as it is done overtly, is open to public scrutiny, and is used as primary evidence (Finlay 1998). Curtin & Fossey (2007) have also cited reflexivity as one of the key considerations when deciding on the trustworthiness of a piece of qualitative research. Therefore, it would be important when coming to analyse the data from the focus groups and questionnaires, that the researcher uses reflexive analysis. The process of reflexivity will be made easier as the focus group will be tape recorded; which can be repeatedly analysed to ensure all behaviours and potential influencing of data are acknowledged.

It will be an important part of data analysis to allow for triangulation; another aspect Curtin and Fossey (2007) identify as a consideration when looking at trustworthiness. Researcher triangulation could be considered by way of having another researcher analyse the data; however this could be difficult if reflexivity is a focus; as the other researcher whom did not facilitate the focus group will be unable to reflexively analyse.

**2.7 Ethical Considerations**

There have been 6 ethical principles identified under research governance:

* The rights and safety of research participants must be paramount
* Independent scrutiny of research plans
* Participants must be fully cognisant of risks before agreeing to participate- the principle of informed consent
* Information about participants must be treated confidentially
* As far as possible, participants should be involved in the design of the research
* Risks should be kept to a minimum

(Montgomery 2003 p 348)

Below are some ethical considerations relating to the proposed research:

|  |  |
| --- | --- |
| **Possible Ethical Problems** | **How these will be addressed** |
| **Confidentiality & Data Protection** | Participants given a number at the beginning of the research rather than having to use their own names  Make sure that all data is stored securely (Carpenter & Suto 2008), e.g. a locked cabinet for materials, password protected computer for documents etc.  Assured of confidentiality and data protection principles within Information sheet (Appendix I). |
| **How the individual approaches of the OTs may change following the research and if this could have an impact on the clients they are working with or the establishment** | Upon first meeting the participants, make them aware that although the training may inform their practice, it is for research purposes only and they will need to use their judgement as to the appropriateness of introducing anything they have learnt during the research, into their practice.  Advise the participants to liaise with their line managers following the training and focus group to have a debrief and disseminate information.  Remind participant that it is their individual responsibility to abide by their own professional code of ethics (COT 2010) and that these considerations are being made when the give their consent to be part of the research. |
| **How the organisations the participants work within may view the OTs involvement.** | As above. As well as:  Provide information to the participant’s organisation on the research and seek  permission/consent from these services (COT 2011). A similar information letter will be sent out to each participant’s organisation to the participant information letter in Appendix I. |

It will be important that the researcher spends time going through the information sheet and consent with each participant with time for questions after (NRES 2011). In the case of this research proposal this would be in the form of a telephone conversation between participant and researcher, due to the cost and practical constraints. There is also a consent form template which can be used for the purposes of this research available through the National Research Ethics Service (NRES 2011)

***2.7.1 Obtaining Ethical Approval***

The 2011 GAfREC (Governance arrangements for research ethics committees) states that ethics committee approval via a Research Ethics Service (RES) is not needed when the research involves staff from health and social care recruited by virtue of their professional role. However, these type of proposals still need to undergo some sort of ethical review (COT 2011a).

Due to the nature of the research proposed here, it would appear that RES approval is not needed, however some form of ethical review is. In this instance it would be beneficial to apply though the Integrated Research Application System (IRAS) for ethical review as they are a single point system for capturing information needed for the relevant approvals from various review bodies (IRAS 2012).

**2.8 Proposed Approximate Timescale and plan of work**

NB: The above final timescale is based upon adding a couple of weeks of additional contingency time to each stage.

**2.9 Proposed dissemination methods**

If participants were recruited through the COT SS neurological Practice, it is said to be good practice for the researcher to develop dissemination plans that include the specialist section; whom may wish to include the article in their newsletter or an abstract submitted for a conference or study day (COT 2011).

If this study formed part of a dissertation; it could be donated to the COT library’s thesis collection, which would be acknowledged through publication of the abstract in the British Journal of Occupational Therapy (BJOT) (ibid). Other options which could be explored include:

* Approaching the Model of creative ability Interest Group to see if they would be interested in sharing the study within the MCAIG, at VdT MoCA conferences and education days.
* Approach BJOT directly
* Approaching client group specific, peer reviewed journals such as: “*Brain Injury*”

**2.10 Future implications for practice and research**

If this research were to go ahead and proved successful in completion, this would be the first UK study on VdT MoCA of its kind. It could have implications for future wider use and understanding of the model and would add to the small evidence base that the model currently has. If participants were to agree to future research; there could be scope to extend into another study looking at the implementation of VdT MoCA within the participant’s settings. Of course this would involve much consideration with regards to practicalities and ethics, but if managed effectively; could provide a further evidence base for the use of the model as a whole in the UK, and more specifically for a specialist field (ABI) which is under-evidenced within the literature itself.

References

Aveyard H (2010) Doing a Literature Review in Health and Social Care: A practical Guide, Berkshire:Open University Press

Brain Injury Social Work Group (BISWG) (2012) About Us, accessed on 10.6.12 from: <http://www.biswg.co.uk/html/about_us.html>

British Society of Rehabilitative Medicine (BSRM) (2008), NEUROLOGICAL REHABILITATION A Briefing Paper for Commissioners of Clinical Neurosciences, London: Royal College of Physicians

Carpenter C & Suto M Qualitative Research for Occupational and Physical Therapists, Oxford: Blackwell Publishing

Canadian Association of Occupational Therapists(CAOT) (2002) Enabling occupation : an occupational therapy perspective. Ottowa: Canadian Association of Occupational Therapists

Casteljein D & De Vos H (2007) The Model of Creative Ability in Vocational Rehabiltation, Work 29 55-61

Casteljein D & Smit C (2002)The Psychometric Properties of the Creative Participation Assessment 32(1) 6-11

Chinembiri O (2011) A Survey on the use of the model of creative ability for Occupational Therapy in the united Kingdom, *Unpublished Research*, accessed on 1.2.12 from: <http://modelofcreativeability.com/phpBB2/viewtopic.php?t=305> via: <https://www.box.com/shared/pt3irugtra0bpd934uls>

College of Occupational Therapists (COT) (2004) Research and Development strategic vision and action plan for neurological occupational therapy, London: COT

College of Occupational Therapists (COT) (2007) Building the evidence base for occupational therapy: Priorities for research, Accessed on 22.6.12 from: <http://www.cot.co.uk/publication/books-z-listing/building-evidence-occupational-therapy-priorities-research>

College of occupational Therapists (COT) (2010) Code of Ethics and Professional Conduct. London: College of Occupational Therapists

College of Occupational Therapists (COT) (2011) Briefing 88: Responding to research enquiries: Information for specialist sections, accessed on 22.6.12 from: <http://www.cot.co.uk/system/files/privatedownloads/briefings/briefing-88.pdf>

College of Occupational Therapists (COT) (2011a) Briefing 82:Applying for ethics approval for research, accessed on 22.6.12 from: <http://www.cot.co.uk/research-governance/obtaining-ethics-approval-your-research>

College of Occupational Therapists (COT) (2012) COT SS Neurological Practice, Accessed on 10.6.12 from: <http://www.cot.co.uk/cotss-neurological-practice/cot-ss-neurological-practice>

College of Occupational Therapists (COT) (2012a) UKOTRF research priorities Accessed on 20.6.12 from: <http://www.cot.co.uk/uk-ot-research-foundation-ukotrf/ukotrf-research-priorities>

Conn V, Valentine J, Cooper C, Harris M, Rantz M (2003) Grey Literature in Meta-analyses, Nursing Research 52 (4) 256-261

Conti G (2012) *Acquired Brain Injury* in Atchison B & Dirette D (2012) Conditions in Occupational Therapy, Philadelphia: Lippincott Williams

Curtin M & Fossey E (2007) Apprising the trustworthiness of qualitative studies: Guideline for Occupational Therapists, Australian Journal of Occupational Therapy 54(2) 88-94

Department of Health (DOH) (1998) Our Healthier nation: A contract for health, London: HMSO

Department of Health (DOH) (1999) National Service Framework for Mental Health, London: HMSO

Department of Health (DOH) (2002)Shifting the balance of power: The next steps, London: HMSO

Department of Health (DOH) (2007) National Service Framework for long term conditions, London: HMSO

Department of Health (DOH) (2010) Equity and Excellence; Liberating the NHS White Paper Executive Summary, London: Stationary Office

DePoy E (1990) The TBIIM: An Intervention Model for the treatment of individuals with Traumatic Brain Injury, Occupational Therapy in Healthcare 7(1) 55-67

De Witt (2003) Investigation into the Criteria and Behaviours Used to Assess Task Concept, South African Journal Of Occupational Therapy, 33(1) 1-7

De Witt P (2005) Creative Ability: A model for psychosocial occupational therapy, In: Occupational Therapy in Psychiatry and mental health, 4th ed, Crouch R And Alders V (2005) London: Whurr Publishers

Dodson M (2010) A model to guide the rehabilitation of high-functioning employees after mild brain injury, Work, 36, 449-457

S. Finger and D. G. Stein (1982) Brain Damage and Recovery: Research and Clinical Perspectives, New York: Academic Press

Fieldhouse J (2008) Using the Kawa Model in Practice and in Education, Mental Health Occupational Therapy 13(3) 101-105

Finlay L (1998) Reflexivity and essential component for all research?, Briish Journal of Occupational Therapy 61(10) 453-456

Green J & Thorogood N (2009) Qualitative methods for health research, Los Angeles: Sage

Headfirst (2012) Accessed on 22.6.12 from <http://www.headfirstcharity.co.uk/index.php>

Headway (2012) Rehabilitation after brain injury, accessed on 10.6.12 from:

[**http://www.headway.org.uk/rehabilitation-after-brain-injury.aspx**](http://www.headway.org.uk/rehabilitation-after-brain-injury.aspx)

Harvey H & Fuller K (2009), Changing Practice through MoCA, OT News; December 2009, p41

Heasman D & Morley M (2011) Using the Model of Human Occupation assessment tools to deliver clinical outcomes in mental health, Metal Health Occupational Therapy, 16(1) 3-7

International Creative Ability Network (ICAN) (2012) Training and Workshops, accessed on 1.6.12 from: <http://www.ican-uk.com/vdtmoca.php>

Integrated Research Application System (IRAS), accessed on 22.6.12 from: <https://www.myresearchproject.org.uk/Signin.aspx>

Jansen M & Casteleijn D (2009) Applying the Model of Creative Ability to Patients with Diabetic Foot Problems, South African Journal of Occupational Therapy, 39 (3) 26-33.

Kielhofner G (2008) Model of human Occupation: theory and Application (4th ed) Philadelphia: Lipincott Williams& Wilkins

Koehler R, Wilhelm E, Shoulson I (2011) Cognitive Rehabilitation Therapy for Traumatic Brain Injury : Evaluating the Evidence, Washington: National Academies Press

Kawa model (2010) Concepts and Structure, Accessed on 23.3.12 from: <http://www.kawamodel.com/>

Lee SW. Morley M, Taylor R, Kielhofner G, Garnham M, Heasman D, Forsyth K (2011) The Development of Care pathways and packages in mental health based on the model of human occupation screening tool, British Journal of Occupational Therapy, 74(6) 284-295.

[Lee SS](http://www.ncbi.nlm.nih.gov/pubmed?term=Lee%20SS%5BAuthor%5D&cauthor=true&cauthor_uid=11233687), [Powell NJ](http://www.ncbi.nlm.nih.gov/pubmed?term=Powell%20NJ%5BAuthor%5D&cauthor=true&cauthor_uid=11233687), [Esdaile S](http://www.ncbi.nlm.nih.gov/pubmed?term=Esdaile%20S%5BAuthor%5D&cauthor=true&cauthor_uid=11233687) (2001) A functional model of cognitive rehabilitation in occupational therapy. [Can J Occup Ther.](http://www.ncbi.nlm.nih.gov/pubmed/11233687) 68(1):41-50.

Lee S, Keilhofner G, Morley M, Heasman D, Garnham M, Willis S, Parkinson S, Forsythe K, Melton J, and Taylor R (2012) Impact of using the Model of Human Occupation: A survey of occupational therapy mental health practitioners’ perceptions, Scandinavian Journal of Occupational Therapy

Melton J, Forsythe K, Freeth D (2010) A pratice development programme to promote the use of the model of human occupation: contexts, influential mechanisms and levels of engagement amongst occupational therapists, British Journal of Occupational Therapy, 73(11) 549-558

Mentrup C, Niehaus A & Kielhofner G (1998) Applying the model of human occupation in work-focused rehabilitation: a case illustration, Work, 12 61-70

Model of Creative Ability Interest Group(MCAIG) (2011) Assessment, Accessed on 28.6.11 from: <http://www.modelofcreativeability.com/assessment.html>

Model of Creative Ability Interest Group (MCAIG) (2012) Members list, accessed on 10.6.12 from: <http://modelofcreativeability.com/phpBB2/memberlist.php?mode=joined&order=ASC&start=100>

MOHO Clearing House (2012) Introduction to MOHO, Accessed on 20.6.12 from: <http://www.uic.edu/depts/moho/intro.html>

Montgomery J (2003) Law in Health Care (2nd ed), Oxford:OUP

National Institute for Health Research (NIHR) (2012) Research, Accessed on 24.6.12 from: <http://www.nihr.ac.uk/research/Pages/default.aspx>

National Research Ethics Service (NRES) (2011) Guidance sheets and consent forms: Guidance for researchers and reviewers, accessed on 24.6.12 from: <http://www.nres.nhs.uk/applications/guidance/consent-guidance-and-forms/?1311929_entryid62=67013>

Pepin G, Guerette F, Lefevre B, Jaques P (2008) Canadian Therapist’s experiences while implementing the Model of Human Occupation remotivating process, Occupational Therapy in Healthcare 22(2- 3) 115-124

Powell T (2003) Head Injury: A practical Guide, Nottingham: Headway

Richardson P, Jobson, B Miles S [(](http://0-web.ebscohost.com.serlib0.essex.ac.uk/ehost/viewarticle?data=dGJyMPPp44rp2%2fdV0%2bnjisfk5Ie46bdQr6qwUbOk63nn5Kx95uXxjL6srUmupbBIr6ieSbipsFKurZ5oy5zyit%2fk8Xnh6ueH7N%2fiVa%2bqsEm1prZLrqukhN%2fk5VXj5KR84LPwkuac8nnls79mpNfsVbCmr0i2rbNOtaikfu3o63nys%2bSN6uLyffbq&hid=10)2010) Using the Kawa model: A practice report Mental Health Occupational Therapy, 15 (3): 82-5

Royal College of Physicians and British Society of Rehabilitative Medicine (RCP&BSRM), Turner-Stokes L ed, (2003) Rehabilitation following acquired brain injury; National Clinical Guidelines, London: RCP,BSRM

Samsonraj RS, Loughran MF, Secker J (2012) Work-related mild-moderate traumatic brain injury and the construction industry, Journal of mental health 17

[Schwartz S](javascript:__doLinkPostBack('','ss%7E%7EAR%20%22Schwartz%20SM%22%7C%7Csl%7E%7Erl','');) (1995) Adults with traumatic brain injury: three case studies of cognitive rehabilitation in the home setting. [American Journal of Occupational Therapy](javascript:__doLinkPostBack('','mdb%7E%7Erzh%7C%7Cjdb%7E%7Erzhjnh%7C%7Css%7E%7EJN%20%22American%20Journal%20of%20Occupational%20Therapy%22%7C%7Csl%7E%7Ejh','');) 1995 49(7) 655-67

Sherwood (2009) An emerging community of practitioners, OT News; May 2009, 26-27

Sherwood W (2010) An Electric event, OT News; February 2010, 38-39

Sherwood (2010a) Building Capacity: International Model of Creative Ability Conference 2010, accessed on 10/6/12 from: <http://modelofcreativeability.com/phpBB2/viewtopic.php?t=235> via: <https://www.box.com/shared/9hebdjj7ro>

Sherwood W (2011) An introduction to the Vona du Toit Model of Creative Ability , Accessed on 10.6.12 from: Venter E& Zietsman K (2005) Rehabilitation of the mentally ill in long-terminstiutionalisation. In Crouch R & Alders V (2005) Occupational Therapy in Psychiatry in Mental Health (4th ed) London: Whurr Publishers.

Solutions for Public Health (2006a) Critical Appraisal Skills Programme (CASP) : 10 Questions to Help You Make Sense of Qualitative Research, accessed on 10.5 .12 from: <http://www.sph.nhs.uk/sph-files/casp-appraisaltools/Qualitative%20Appraisal%20Tool.pdf/view>

Solutions for Public Health (2006b) Critical Appraisal Skills Programme (CASP):   
10 questions to help you make sense of randomised controlled trials, accessed on 10.5 .12 from:: <http://www.sph.nhs.uk/sph-files/casp-appraisal-tools/rct%20appraisal%20tool.pdf/view>Sumsion T (2006\_ Client-centred Practice in occupational Therapy: A guide to implementation (2nd ed), London: Churchill Livingstone

[Stergiou-Kita M](javascript:__doLinkPostBack('','ss%7E%7EAR%20%22Stergiou%2DKita%20M%22%7C%7Csl%7E%7Erl','');), [Rappolt S](javascript:__doLinkPostBack('','ss%7E%7EAR%20%22Rappolt%20S%22%7C%7Csl%7E%7Erl','');), [Kirsh B](javascript:__doLinkPostBack('','ss%7E%7EAR%20%22Kirsh%20B%22%7C%7Csl%7E%7Erl','');), [Shaw L](javascript:__doLinkPostBack('','ss%7E%7EAR%20%22Shaw%20L%22%7C%7Csl%7E%7Erl','');) (2009) Evaluating work readiness following acquired brain injury: building a shared understanding, [Canadian Journal of Occupational Therapy](javascript:__doLinkPostBack('','mdb%7E%7Erzh%7C%7Cjdb%7E%7Erzhjnh%7C%7Css%7E%7EJN%20%22Canadian%20Journal%20of%20Occupational%20Therapy%22%7C%7Csl%7E%7Ejh','');) 76(4): 276-84

Sumsion T (2006) Client-Centred Practice in Occupational Therapy a Guide to Implementation, 2nd Ed, Edinburgh: Churchill Livingstone/Elsevier

The Stroke Association (2012) UK Stroke Forum: The College of Occupational Therapists Specialist section: Neurological Practice, accessed on 22.6.12 from: <http://www.ukstrokeforum.org/about_us/coalition_organisations/national.html>

Turnbull A, De Witt P, Concha M (2002) Investigation into the Assessment of Recovery in Head Injured Patients, 32(1) 12-18

Turpin M Iwama M (2011)Using Occupational Therapy Models in Practice: A field guide, London: Churchill Livingstone

United Kingdom Brain Injury Forum (UKABIF) (2012), UKABIF Directory, Accessed on 10.6.12 from: <http://www.ukabif.org.uk/index.php?option=com_comprofiler&task=usersList&Itemid=50&limitstart=0&search=&listid=8&name=&cb_companyname=&cb_city=&cb_county=&email=&cb_membertext=>

Warren A (2002) Using the COPM in mental health... 'An evaluation of the Canadian Model of Occupational Performance and the Canadian Occupational Performance Measure in Mental Health Practice’ British Journal of Occupational Therapy, 65(11) 515-521

White E & Creek J (2007) College of Occupational Therapists’ Research and Development Strategic Vision and Action Plan: 5-year Review, British Journal of Occupational Therapy 70(3) 122-128

Wilson B, Gracey F, Evans J, Bateman Wilson S & White B (2009) Neuropsychological Rehabilitation Cambridge: Cambridge University Press

Wilson S & White B (2011) The journey to service Redesign, OT News; August 2011, 36-37

Wimpenny K, Forsythe K, Jones K, Matheson L and Colley J (2010) British Journal of Occupational Therapy 73(11) 507-516.

Appendix A: Database Searches

**CINAHL**

Nb:

Occupational Therap\* used in order that other suffixes could be considered; e.g. therapists, therapy etc.

Abstracts that were screened in following inclusion and exclusion criteria; were sought through interlibrary loans, COT library, and other sources.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Search No | Search Term(s) | Results | Excluded | Screen in |
| 1 | Occupational Therap\* *AND* model | 1335 | N/A | N/A |
| 2 | Occupational Therap\* *AND* model *AND* Physical | 292 | N/A | N/A |
| 3 | Occupational Therap\* *AND* model *AND* mental health | 103 | 93 | 10 |
| 4 | Occupational Therap\* *AND*  model *AND* Stroke | 55 | 54 | 1 |
| 5 | Occupational Therap\* *AND*  model *AND* Neurological | 22 | 22 | 0 |
| 6 | Occupational Therap\* *AND*  model *AND* Acquired brain injury(ABI) | 4 | 2 | 2 |
| 7 | Occupational Therap\* *AND*  model *AND* traumatic brain injury (TBI) | 15 | 13 | 1 |
| 8 | Model of Creative Ability | 3 | 0 | 3 |

**PUBMED**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Search No | Search Term(s) | Results | Excluded | Included |
| 1 | Occupational Therap\* *AND* model | 908 | N/A | N/A |
| 2 | Occupational Therap\* *AND* model *AND* Physical | 277 | N/A | N/A |
| 3 | Occupational Therap\* *AND* model *AND* mental health | 69 | 67 | 2 |
| 4 | Occupational Therap\* *AND*  model *AND* Stroke | 76 | 76 | 0 |
| 5 | Occupational Therap\* *AND*  model *AND* Neurological | 25 | 25 | 0 |
| 6 | Occupational Therap\* *AND*  model *AND* Acquired brain injury(ABI) | 31 | 30 | 1 |
| 7 | Occupational Therap\* *AND*  model *AND* traumatic brain injury (TBI) | 25 | 24 | 1 |
| 8 | Model of creative ability | 36 | 36 | 0 |

**OTSeeker**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Search No | Search Term(s) | Results | Excluded | Included |
| 1 | Occupational Therap\* *AND* model | 16 | 16 | 0 |
| 2 | Occupational Therap\* *AND* model *AND* Physical | 4 | 4 | 0 |
| 3 | Occupational Therap\* *AND* model *AND* mental health | 0 | N/A | N/A |
| 4 | Occupational Therap\* *AND*  model *AND* Stroke | 5 | 5 | 0 |
| 5 | Occupational Therap\* *AND*  model *AND* Neurological | 0 (precise search failed) | N/A | N/A |
| 6 | Occupational Therap\* *AND*  model *AND* Acquired brain injury(ABI) | 0(precise search failed) | N/A | N/A |
| 7 | Occupational Therap\* *AND*  model *AND* traumatic brain injury (TBI) | 0 (precise search failed) | N/A | N/A |
| 8 | Model of creative ability | 0 (precise search failed) | N/A | N/A |

Appendix B: Overview of Screened in Papers

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Authors | Database/ Source | Year | Country | Type of paper & methodology | Client group | Model used |
| 1 | Wimpenny et al | CINAHL | 2010 | UK | Qualitative over 2 years; group reflective supervisions | MH | MOHO |
| 2 | Lee et al | CINAHL | 2011 | UK | Mixed methods. Existing data from 625 service users | MH | MOHO |
| 3 | Warren | CINAHL | 2002 | UK | Qualitative; 7 OTs working in MH | MH | CMOP |
| 4 | Melton | CINAHL | 2010 | UK | Qualitative 74 OTs; self-report survey | MH | MOHO |
| 5 | Robeiro & Cook | CINAHL | 1999 | Cana-da | Qualitative; 8 female clients with MH; their experience of occupational engagement | MH | Occupational Spin off (proposed- new from results). Developmental. |
| 6 | Richardson et al | CINAHL | 2010 | UK | Practice report; 3 OTs | MH | Kawa |
| 7 | Heasman & Morley | CINAHL | 2011 | UK | Mixed methodology, impact of a practice development programme. | MH | MOHO |
| 8 | Pepin G, Guerette F, Lefevre B, Jaques P | CINAHL | 2008 | Canada | Qualitative; 4 OTs self report narratives over 2 years | MH | MOHO |
| 9 | Fieldhouse | CINAHL | 2008 | UK | Practice report- reflection on own practice | MH | Kawa |
| 10 | Melton et al | CINAHL | 2008 | UK | Reflective piece on how MOHO helped guide programme redesign. | MH (acute inpatient) | MOHO |
| 11 | Mentrup et al | CINAHL | 1998 | Germ-any | Discussion; 1 case study | Stroke (long term rehab) | MOHO |
| 12 | Smaonraj et al | PUBMED | 2012 | UK | Quantitative – looking at if OT intervention increases function | MH (acute inpatient) | Vdt MOCA and CMOP |
| 13 | Lee et al | PUBMED | 2012 | UK | Quantitative – 429 OTs | MH | MOHO |
| 14 | Sterigou-Kita et al | CINAHL | 2009 | Canada | Qualitative; 10 OTs | ABI (vocational Rehab) | Work readiness evaluation model |
| 15 | shwartz | CINAHL | 1994 | USA | 3 case studies | ABI (Cog rehab in home setting) | Decision-making model |
| 16 | DePoy | CINAHL | 1990 |  | Discussion; 1 case study | TBI (life-long intervention; various settings) | TBIIM (using concepts from MOHO) |
| 17 | Casteleijn & de VOS | CINAHL | 2007 | South Africa | Discussion & case study | ABI | VdT MoCA |
| 18 | Jansen & Casteleijn | CINAHL | 2009 | South Africa | Quantitative | Physical (diabetic feet) | VdT MoCA |
| 19 | De Witt | CINAHL | 2003 | South Africa | Qualitative; 18 OTs questionnaire | ALL | VdT MoCA |
| 20 | Dodson | PUBMED | 2010 | USA | Discussion only | ABI (mild)(vocational rehab) | EMPLOYEE ENABLERS & WORKPLACE ECOLOGY |
| 21 | Lee et al | PUBMED | 2001 | Canada | Discussion only | TBI (cognitive rehab) | Functional model of cognitive rehabilitation (based on CMOP) |
| 22 | Turnbull et al | MCAIG | 2002 | South Africa | Quantitative | TBI | VdT MoCA |
| 23 | Chinembiri | MCAIG | 2010 | UK | Quantitative | ALL | VdT MoCA |
| 24 | Casteleijn & Smit | MCAIG | 2002 | South africa | Quantitative | MH (Schizophrenia) | VdT MoCA |

\*highlighted green: articles chosen for critical appraisal\*

Appendix C: Overview of models

**MOHO**

One of the first OT models of practice to be devised; first published in 1980, MOHO seeks to explain how occupation is motivated, patterned, and performed. The model states that people are made up of three interrelated components: volition, habituation, and performance capacity.

Volition: the motivation for occupation

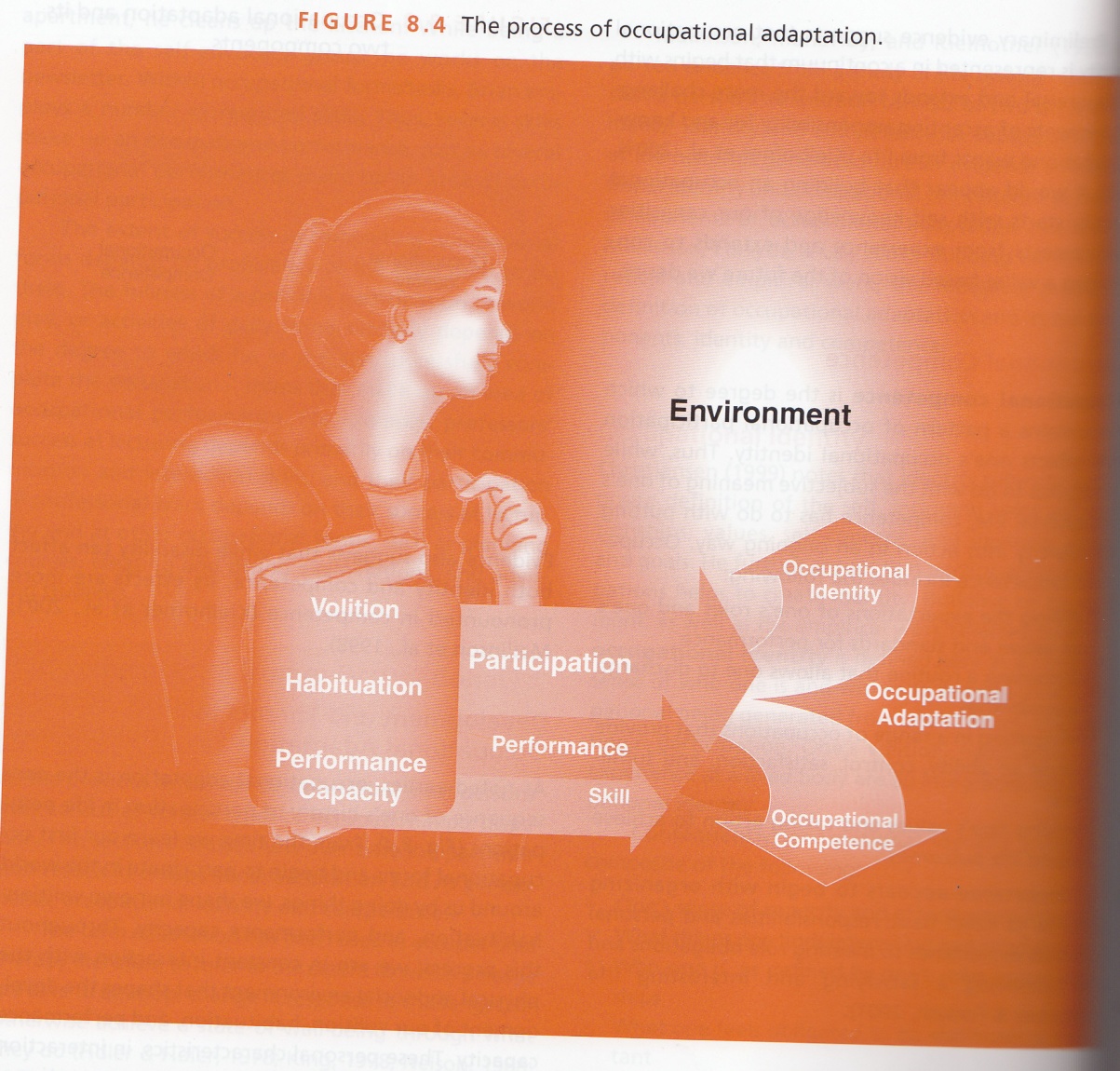
Habituation: the process by which occupation is organized into patterns or routines,

Performance capacity: the physical and mental abilities that underlie skilled occupational performance.

Also pertinent to the model is the understanding of the physical and social environments in which occupation takes place.

(MOHO Clearing House 2012)

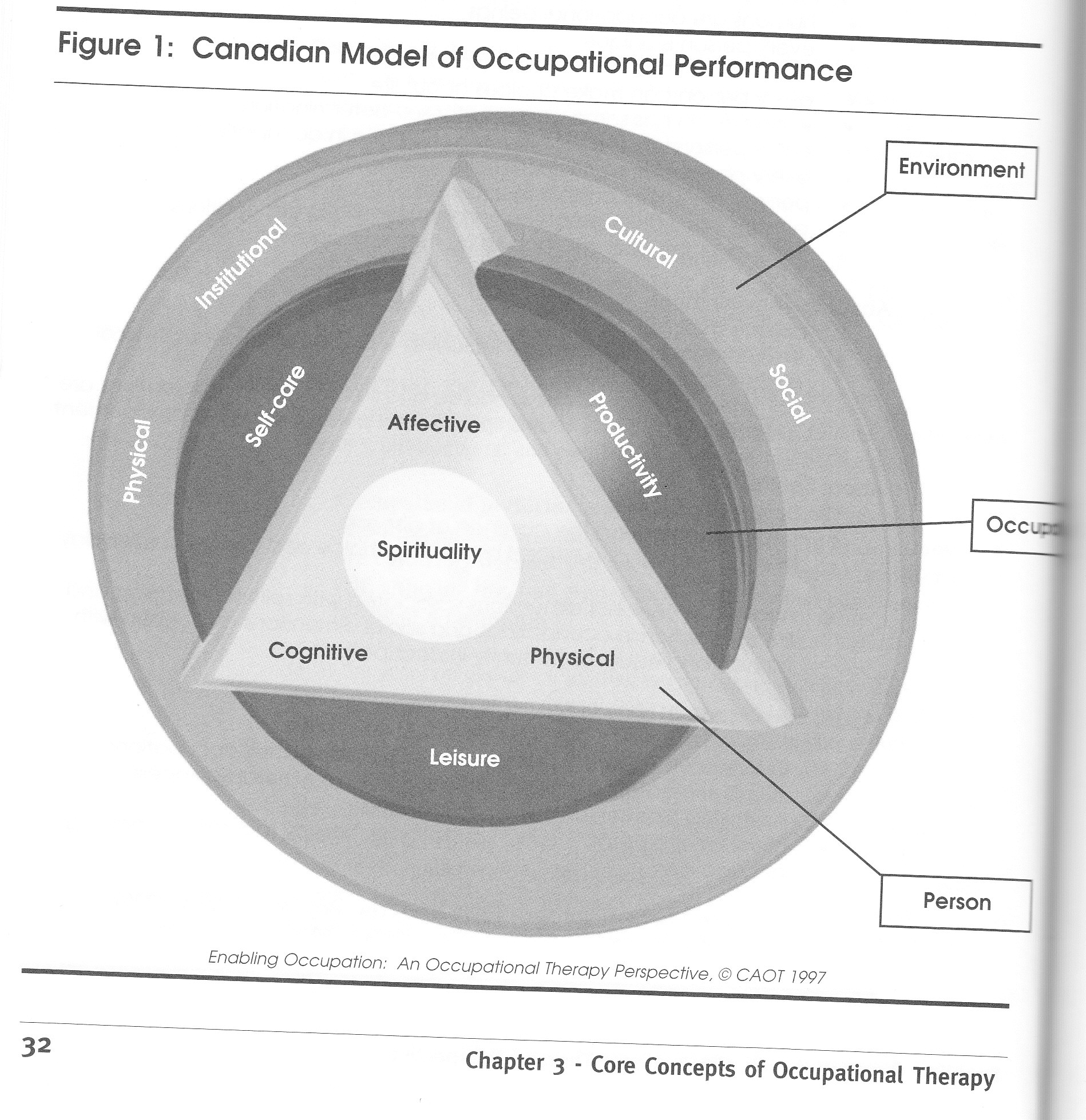
**The process of Occupational Adaptation; MOHO**



*Kielhofner (2008) p.108*

**CMOP**

The CMOP emphasises the importance of the relationship between person, environment and occupation; with occupation being the bridge to the other two components (Turpin & Iwama 2011). It is client centred as the person’s individual components including spirituality, affective, physical and cognitive self are at the centre of the model.

****

*CAOT 2002 p. 32*

**Kawa Model**

The model uses a metaphor of a river and its’ elements pertaining to the client’s life energy or flow; the purpose being that OT to helps to facilitate flow along the person’s river and create a harmonious balance between all elements (Turpin & Iwama 2011).

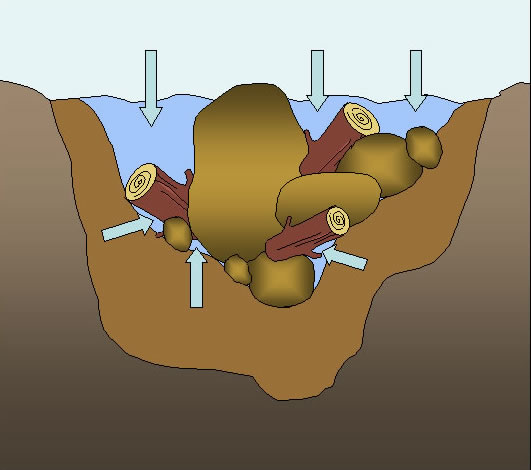
**Water:** life flow; all elements of the river have an effect on the form and flow of the client’s life

**River’s sides and bottom:** environment, social and physical contexts

**Rocks:** life circumstances perceived by the client to be problematic and difficult to remove

**Driftwood:** personal attributes and resources

**Example of a client’s river:**



*Adapted from Kawa Model 2010, fig.4*

Not being able to share a bed with my wife following ABI

Loss of social networks following ABI

Good IT skills

Motivated to recover

Fatigue

Problems with information processing

**VdT MoCA**

The fundamental concept of VdT MoCA is volition, taking into consideration two intrinsically linked component parts; motivation and action. It is assumed that action is seen through the conversion of motivation into occupational behaviour (De Witt 2003, De Witt 2005).

It is receptive to change as it makes motivation of the client measureable (Casteljein & De Vos 2007). A developmental model, the categorisation of the client’s occupational performance into levels of creative ability, allows the therapist to offer the correct intervention at the correct time (De Witt 2005); which again allows for sensitivity. De Witt’s (2005) seminal work sets out principles of assessment, treatment, grading as well as the levels being able to be used as an outcome measure.

Du Toit defined creative ability as the potential in a person which has been realised; it allows them to be engaged in activities and present themselves freely (De Witt 2003).

The model depicts 3 steps which help to assess the client’s level of creative ability:

1. Evaluate skills and behaviour in the four occupational performance areas via interview and observation.
2. Establish level of action in each of the four occupational performance areas/area of concern
3. Presume level of motivation from level of action recorded

(De Witt 2005)

**VdT MoCA Levels of creative participation**

\*There are 3 groups throughout the levels; **GROUP 1** **(purple):** **Preparation for constructive action:** motivation mainly around physical components, limited occupational performance. **Group 2 (red):Behaviour and skill development for norm compliance:** motivation to develop necessary skills to be productive and live in the community. **Group 3 (green): Behaviour and skill development for self-actualisation:** developing skills for leadership and originality; related to self-actualisation (MCAIG 2011).

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **1.Tone** | **2.Self-differentiation** | **3.Self- presentation** | **4.Passive participation** | **5.Imitative participation** | **6.Active participation** | **7.Competitive action** |
| **Action** | Undirected and unplanned | Incidentally constructive or destructive (1-2 step task) | Explorative (3-4 step task) | Product centred (5-7 step task) | Product centred (7-10 step task) | With originality- transcends norm expectations | Product centred |
| **Volition** | Egocentric to maintain existence | Egocentric to differentiate self from others | Seems willing to try to present self- unsure | Robust. Directed to attainment of skill | Directed to product, a good product, acceptable behaviour | Directed to improvement of product, procedures, etc | Directed to participation with others, compare& evaluate self in relation to others |
| **Handle tools and material** | Not evident | Only simple tools (e.g spoon) | Basic tools for activity participation-poor handling | Appropriate skill | Good | With initiative | Very good |
| **Relate to people** | No awareness | Fleeting awareness | Identification selection, makes contact, tries to communicate, superficial | Communicate | Communicate/ interact | Close interpersonal relationships, can assist others, adapt, shows consideration | Close interpersonal relationships, can assist others, adapt, make allowance, shows consideration |
| **Handle situations** | No awareness of different situations | No awareness or ability | Stereotypical handling makes effort but unsure or timid | Follower, variety of situations, participates in a passive way | Manages a variety of situations. Appropriate behaviour | Can evaluate adapt, adjust according to need, can deal with problems. | Can evaluate adapt, adjust according to need, can deal with problems. |
| **Task concept** | No task concept, basic concept | No task concept, basic & elementary concept | Partial task concept, compound concepts | Total task concept , extended compound (abstract element) | Comprehensive task concept, integrated abstract concepts | Abstract reasoning | Abstract reasoning |
| **Product** | None | None | Simple- familiar activities, poor quality product | Product of fair quality (aware of expectations\_ | Product good quality (according to expectations) | quality, adapt, modify, evaluate, upgrade, exceeds expectations | quality, can adapt, modify, evaluate, upgrade, exceeds expectations |
| **Assistance or supervision needed** | Total assistance and supervision (24 hour) | Physical assistance and constant supervision | Constant supervision needed for task completion | Regular supervision | Guidance, supervision, regular for new activities, occasional for known activities | Guidance, formal training- (own responsibility) help to supervise others | Guidance, formal training- (own responsibility) help to supervise others |
| **Behaviour** | Bizarre, disorientation | Bizarre, little reaction disorientation | At times strange behaviour, hesitant, unsure | Follower but will participate passively- occasionally strange | Socially acceptable behaviour, generally controlled | Acceptable, shows originality may decide to act contrary to norm | Socially acceptable/correct, variety situations acceptable, adaptable, plan action behaviour |
| **Norm awarness** | None noted | None noted | Starts to be aware of norms | Norm awareness (aware of expectations) | Norm compliance (Do as expected required standard) | Norm transcendence (Do better or more than norm) and to adapt effectively, graded from activities to situations to variety of situations | Norm transcendence (Do better or more than norm) and to adapt effectively, graded from activities to situations to variety of situations |
| **Anxiety and emotional responses** | Limited responses | Limited uncontrolled basic emotions. Comfort and discomfort are easily evident. | Varied, usually low self-esteem & anxiety, poor control. | Full range of emotions, mostly controlled, makes effort | Subtle differences compassion and self awareness, anxiety used | New situations- anxiety, normal emotional responses (anxiety motivator) |  |
| **Initiative & effort** | None noted | Fleeting, minimal | Effort inconsistent, non sustained, not maintained, decreased on frustration tolerance | Varied | A expected, required sustained | Consistent and original | Consistent and original |

(adapted from De Witt 2005, p.58-60)

**Within each Level of Creative Ability, the client be at one of 3 stages:**

|  |  |
| --- | --- |
| Therapist directed | Demonstration of skills and aspects of both the current and previous level. Without support from someone providing structure and encouragement the client may regress to the previous level. |
| Patient Directed | Skills and performance is consistent with the current level. The client is able to maintain this occupational behaviour and performance mostly independently. |
| Transitional | The client is showing some signs of occupational performance and behaviour of the next level, but this is not consistent enough for them to be placed within this next level as yet. |

Adapted from De Witt 2005

**Task concept is one of the important aspects to deciphering a client’s creative ability level as it is integral to being able to perform activities independently; it tends to emerge within the explorative level (De Witt 2003). It can be viewed as having the following components:**

**Adapted from De Witt 2003 p.5**

Appendix D: Initial Questionnaire

|  |  |
| --- | --- |
| Participant number |  |
| Gender | M/F |
| Age |  |
| How long have you been qualified as an OT? |  |
| How long have you been working in ABI? |  |
| What town/city do you currently work in? |  |
| What type of setting do you work in?  e.g. NHS hospital, private/independent hospital, outreach/community team, residential rehabilitation, transitional living unit. PLEASE SPECIFY IF NHS OR PRIVATELY RUN. |  |
| Do you use a model of practice currently, if so which one? |  |
| Had you heard of Vdt MoCA prior to being approached for this training and research? |  |
| What do you currently know about Vdt MoCA? Please include as much information as you can, i.e. concepts, terminology, where it is used, how the model guides practice, assessments etc. |  |

Appendix E: VdT MoCA Training

ICAN offers foundation training in VdT MoCA plus a range of workshops, consultation and supportive post training/workshop initiatives. The training scheme is in line with professional development as it offers levels if training in the model from from novice to advanced practitioner, from level 0 – level 3.

**Level 1** **Vona du Toit Model of Creative Ability (VdT MoCA)**

* The first of three levels which focus training on the VdT MoCA.
* Suitable for OTs and OT support workers that are supervised by an OT.
* Provides knowledge required to use the model in practice and to be permitted to use and reproduce the Creative Participation Assessment tool.

**Aims**

* Provide detailed information on key concepts of the VdT MoCA that explain motivation and occupational performance, how a person’s level of ability is assessed; how intervention is selected, graded and facilitated for therapeutic benefit.
* Understand the principles of the theory of creative ability
* Relate levels of creative ability to their clients and relate recommendations for intervention to their daily work.

**Learning outcomes**

At the end of the course participants will:

* have a good understanding of creative ability
* understand how to assess creative ability, interpret findings, identify the assessment methods that are the most relevant and practical for their practice, explain how assessment findings may be recorded and reported
* be familiar with the concept of phases of performance within levels of creative ability
* be able to explain how to select activities for intervention and how they may be graded on an individual and group basis
* understand how to structure and present activity in order to meet the needs of clients and achieve therapy aims
* be able to demonstrate application of the treatment principles to a role play treatment session and self-evaluate his/her clinical reasoning.

CPD certificates are provided.   
  
**Cost** £230 per person from 01.05.12 for the 3 day course.

Appendix F: Topics for Focus Group

1. **Life-long recovery from ABI/ developmental approach**

* What are your experiences of length of time required for recovery/rehabilitation within ABI
* Do you feel the levels of creative ability apply to stages of recovery in ABI? If so, how?

1. **Motivation**

* What is your understanding of motivation within VdT MoCA?
* How do you feel it applies within ABI settings?

1. **Client-centred practice**

* Discuss your views on the client-centeredness of VdT MoCA
* How could you achieve this within your setting?

1. **Terminology**

* Discuss your views on the terminology used in VdT MoCA
* What is your understanding of creative ability?
* How do you feel the terminology used in the model would fit in with your ABI setting?

1. **Meaningful and Purposeful Activity; assessment and intervention**

* What type of assessments do you already use with your clients?
* Do you feel they would differ or stay the same if you used Vdt MoCA as your guiding model of practice?

Appendix G: Exit Questionnaire

|  |  |
| --- | --- |
| **Participant number** |  |
| **Following the VdT MoCA training, do you feel it is an appropriate model to use in ABI?** |  |
| **If yes, what aspects of the model do you feel are relevant?** |  |
| **Have you come away from the training with any ideas for your own practice?** |  |
| **Would you consider using the model in your own practice?** |  |
| **Would you consider being involved in future research involving VdT MoCA?** |  |
| **Would you consider being involved in future research involving a trial of the model in your setting?** |  |

***Thank you so much for your time. We hope you have enjoyed the VdT MoCA training, focus group and networking event which followed. Your input will have been invaluable to the growing body of research on the model.***

Appendix H: Funding, Costings and Practical Considerations

**Proposed possible funding streams**

* [UK Occupational Therapy Research Foundation (UKOTRF)](http://www.cot.co.uk/uk-ot-research-foundation-ukotrf/uk-ot-research-foundation-ukotrf-0) who identify research priorities within the field of OT and provide grants to successful applicants (COT 2012a)
* Headfirst, a charity whose sole aim is to fund and promote research into head injuries, stroke and associated brain damage (Headfirst 2012)
* National Institute for Health Research who’s role is to develop research evidence to support decision making by professionals (NIHR 2012); which ties in with the underlying premise to this research proposal.

**Approximate Costs of the research (including resources needed)**

|  |  |
| --- | --- |
| ICAN Training | **£1,380** (6 participants at £230 each) |
| Hire of room for the focus group & questionnaires | **£75** (based on 3 hours at £25/hour: 1.5 hour focus group plus 1.5 hour total for initial and exit questionnaire completion) |
| Networking dinner | **£180** (6 people at£30 per head) |
| Digital Voice recorder | **£30** |
| TOTAL | **£1, 665** |

Appendix I: Participant Information Sheet

(Contact details of Researcher)

(Date)

**RE: Participant Information Sheet**

***“Occupational Therapists’ perceptions of the use of the Vona du Toit Model of Creative Ability (Vdt MoCA) in Acquired Brain injury (ABI) settings; a focus group”***

Dear Participant,

Following our preliminary contact with you, we would like to invite you to take part in our research study titled above. We would like to give you a fuller understanding of the purpose of the research and what it will mean for you to be involved, before you decide whether to take part. We have sent a similar letter out to your employer. We will make a telephone call to you within one week of the date of this letter; please feel free to read this information leaflet before-hand and discuss with your employer and relevant peers. **Please ask any questions along the way during the telephone consultation, if there is anything you are unclear on.**

The purpose of this study is to ascertain your views on the potential use of VdT MoCA in ABI. You have been asked to take part as you are an Occupational Therapist currently working in the specified field whom is not currently using the model. If you decide to join us in the study, you will be one of 6 participants.

Your participation in this study will be entirely voluntary and you are free to withdraw at any point. If, after going through the information sheet, you wish to proceed with taking part in the research you will be asked to sign the consent from sending a copy to the researcher in the stamped addressed envelope provided, and bringing the original with you to our initial meeting on the first day of the VdT MoCA training.

If you decide to take part in the research, you will be expected to be available for 3 full days which will include:

* Initial meeting with the researcher and other participants on the morning of the1st day to fill out an initial questionnaire and get to know your research peers
* Official VdT MoCA training (level 1 provided by ICAN) free of charge (3 days)
* Involvement in a focus group of one and a half hours on day 3 (this will be audio-taped)
* Filling out an exit questionnaire
* Followed by a networking dinner free of charge.

It is a requirement of the research that all of the above components are attended, in order for you to be eligible for the free training being offered. If you decide not to take part in the focus group and questionnaire following the training, your organisation will be asked to pay for your training which is at a cost of £230. Your data would also not be used if you did decide to withdraw from the study.

Participants should be aware that this training is being given for research purposes only. What you take with you from the training will be your own opinions and perceptions of the model and the researcher is by no means inferring that VdT MoCA should or should not be used within your individual settings and practice.

Following this study you will receive not only a training certificate from ICAN, but also athere may be the opportunity to be involved in future research, of which the researcher will keep you informed of if you so wish and if you have given consent to be contacted in the future.

Ethical and legal practices will be followed and your details will be handled in confidence. Your data will be kept secure with only authorised persons having access. It will be retained for use in future studies if there is scope and REC approval for future research. Your data will be retained for the next 15 years after which time it will be disposed of securely.

It is intended and hoped that the results of this study be published within an academic journal such as the British Journal Of Occupational Therapy and/or discussed at the Model of Creative Ability Interest Group Conferences. The results will be made available to all participants. You, as a participant, will not be identified in any report/publication unless you have given your consent.

This study has been reviewed and given favourable opinion by \_\_\_\_\_\_\_\_\_\_\_\_\_\_Research Ethics Committee and will be funded by \_\_\_\_\_\_\_\_\_\_\_\_.

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions [contact number]. If you remain unhappy and wish to complain formally, you can do this via [insert details].

As stated previously, a researcher will be in telephone contact within the next week; at which point if you decide to be involved in the study, and have been given consent by your employer/organisation, we would ask that you fill in your consent form following the telephone conversation and return in the stamped addressed envelope provided.

We hope to soon welcome you on board for this exciting research opportunity.

Yours Sincerely,

[Researcher’s name].

Acknowledgements

**I would like to thank Owen Chinembiri for introducing me to VdT MoCA in my second practice placement and for all of his guidance and support regarding this dissertation.**

**I would also like to thank Wendy Sherwood for all of her professional advice and guidance; without the Model of Creative Ability Interest Group and its’ resources this would not have been possible.**

**Finally I would like to give special thanks to my Supervisor; France Sheppard, whom has supported and encouraged me through this process**