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Creating the evidence

Research priorities for VdT Model of Creative Ability informed occupational therapy

Foreword by Dr Jennifer Creek

VdTMoCA FOUNDATION (UK)

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Foreword

Jennifer Creek

This timely report describes a study carried out in the UK to identify what practitioners think should be the priorities for research into the Vona du Toit Model of Creative Ability (VdTMoCA). It presents in detail the four priorities identified by participants for research into this distinctive occupational therapy model.

The theory of creative ability, developed in the 1960s and 1970s by Vona du Toit, first came to my attention via a chapter in a South African occupational therapy textbook (de Witt 1992). During the apartheid era in South Africa, the work of occupational therapists was not widely disseminated outside that country so, to a UK practitioner, this theory was entirely fresh, original and exciting. I was eager to learn more about it and find out if it could support my thinking in practice.

Over the next few years, I found opportunities to read more about creative ability and discuss it with South African occupational therapists, such as Pat de Witt who wrote the chapter mentioned above. Du Toit developed her theory at the same time as Mary Reilly was working on the theory of occupational behaviour in the United States. Both theories have their roots in developmental theory, neurophysiology and behavioural science, and both focus attention on how occupation can be used to promote healthy development and adaptation (van Deusen 1988; du Toit 1991; Cole & Tufano 2008).

Occupational therapists around the world have now been using and writing about creative ability and occupational behaviour for over 30 years, so that both theories continue to evolve and remain relevant to emerging health needs and current ways of working. Much occupational therapy practice in the twenty-first century is based on published models, approaches and procedures, making it less dependent on the experience and reasoning skills of the individual therapist. The use of clearly defined and well-researched models for practice ensures that clients in different geographical locations receive similar care and that the outcomes of intervention can be compared across services. In the 1980s, Reilly's theory of occupational behaviour gave rise to the Model of Human Occupation (Miller 1988) and du Toit's theory of creative ability evolved into the Model of Creative Ability (de Witt 1992), now called the VdTMoCA, so they remain available and appropriate for present day students and practitioners.

An aspect of du Toit's theory that I have found especially useful in my practice is the explicit guidance on how to engage clients actively in the occupational therapy process. As noted by some of the participants in this study, the VdTMoCA is of particular use when working with people whose energy levels are very low, such as those experiencing severe depression or negative psychotic symptoms. It is gratifying to

see that occupational therapists are interested, as I was, in the potential of the model to support their clinical reasoning when working with hard-to-engage clients, as well as seeking hard evidence of its effectiveness.

This study has set out a realistic research agenda for occupational therapists interested in further developing the VdTMoCA and extending its use by the profession. It is a welcome addition to the occupational therapy body of knowledge.

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1. INTRODUCTION

The Vona du Toit Model of Creative Ability Foundation (UK) is a Community Interest Company that primarily serves UK occupational therapists and support workers. The Vona du Toit Model of Creative Ability Foundation (UK) acts on all matters regarding the use and development of the VdT Model of Creative Ability, particularly in the UK. It also collaborates internationally with the Vona & Marie du Toit Foundation in South Africa.

The VdTMoCA Foundation (UK) [VdTMoCAF (UK)] has a strategic role in supporting occupational therapists and support workers to deliver Vona du Toit Model of Creative Ability (VdTMoCA) informed occupational therapy that is effective, high quality and informed by literature and research. Freely accessible information on the model is shared on the VdTMoCAF (UK) website. A wide range of resources, including research presentations and literature is shared with its members in its on-line resource area and forum. The VdTMoCAF (UK) has two Centres of Excellence in the UK that actively share information on best practice, plus a bi-annual publication *'Participation'*, in which practice reports are published.

The need to identify priorities for VdTMoCA occupational therapy research has become a pressing concern in recent years as the adoption of the model has become increasingly widespread. Over its 12 year history in the UK, the VdTMoCA has gained favour in many fields, particularly in learning disabilities, mental health and forensic occupational therapy practice. This is despite the fact that there is a paucity of published research. This problem has been commented upon by several writers on the model e.g. de Witt (2005, 2014); Casteleijn & de Vos (2007).

Prior to the establishment of the VdTMoCAF (UK), occupational therapists were encouraged to engage in researching the model by the forerunner to the VdTMoCA Foundation (UK), the Model of Creative Ability Interest Group (MCAIG). In 2006, the Sherwood Grant for Research and the MCAIG Travel Bursary for the exploration of the model abroad were established to encourage enquiry.

The First National Model of Creative Ability Occupational Therapy Conference entitled *'Transformation',* took place in London in 2009. To enable the sharing of information, knowledge and experiences, abstracts were welcomed on any aspect of the model and not restricted to research. Many presenters anecdotally shared how their practice had been positively transformed by the model, but there were no research papers. The conference Chair commented on the need for research activity and encouraged the VdTMoCA community to start this work. As a follow-on from this, the theme for the 2010 International Model of Creative Ability conference was *'Building Capacity'*. This conference sought abstracts on how the model contributed to building client, therapist and service capacity, but also how therapists were building research capacity regarding the model. This conference saw the first research presentations - two from South Africa and one from the UK. During the conference delegates were invited

to contribute to a 'Research priority and interest' board, to state their priority research questions and rate the generated list of questions according to priority. The results were shared with MCAIG members in their on-line resource area and forum.

The International VdT Model of Creative Ability conference, *'Contribution through waves of change'* in 2013 included three research presentations, two of which were by UK researchers. The use of outcome measurement to justify occupational therapy in acute mental health practice (Carter 2013), was a landmark piece of research for the UK. The use of outcome measurement was also reported by other presenters, but not as research. Sue Griffiths MSc from the University of Northampton, fulfilled the role of 'critical friend' at this conference, commenting that there is a need to focus on small areas of research in order to develop robust evidence. In response to this, a pause from conference delivery in 2014 gave occupational therapists the opportunity to engage in writing for publication and carrying out research. In 2015, the VdTMoCAF (UK) sponsored the International VdT Model of Creative Ability conference for which 50% of abstracts were research based, although the vast majority of research was conducted in South Africa.

The task of developing a research evidence-base for the use of the model is a long-term, but achievable challenge. A start has already been made as evidenced by the aforementioned conference activities of occupational therapists. Furthermore, there has been a strong VdTMoCA presence at the College of Occupational Therapists Annual Conferences in recent years. Research on the model is known to have been included in the programme in 2006, and the earliest known practice-based presentation at a College of Occupational Therapists Specialist Section conference, was in 2005. Research has also been reported since 2011 at Symposiums on the model in South Africa, which were inspired by the work undertaken on the model in the UK. A full list of known conference presentations and posters is available at http://www.vdtmocaf-uk.com or http://modelofcreativeability.com.

Occupational therapists are responsible for basing their practice on current research and the best available evidence (College of Occupational Therapists 2010). There is therefore, a need to undertake and publish research. This is in addition to audits and the sharing of anecdotal practice experience and service user verbal reports on practice. Research needs to be done for the benefit of the service users, carers, services and therapists. It is important to recognise that the undertaking of VdTMoCA research can be extremely disparate due to the fact that there is such a lack of research i.e., there is a need to research every aspect of the model across an increasingly broad range of occupational therapy practice. Priority-setting provides a clear indication of gaps in the knowledge base of the profession and the research that is most urgently needed.

'Creating the evidence: Research priorities for VdT Model of Creative Ability informed occupational therapy' describes a research priority-setting study, the results from which have identified the top priorities to focus occupational therapists' research into the VdT Model of Creative Ability. This is set within the context of other research priority agendas for the occupational therapy profession. To date, there has been no

research agenda for occupational therapists using the VdTMoCA, therefore this publication of research priorities is a major development for the profession.

2. National survey of occupational therapists

In 2014-2015, the VdTMoCAF (UK) undertook a survey of occupational therapists for the primary purpose of creating a prioritised list of topic areas to guide and support research activity in the VdTMoCA in health and social care. A five stage process was undertaken to achieve this aim:

stage 1: Perspectives gathering
stage 2: Survey design
stage 3: National survey
stage 4: Data analysis
stage 5: Research priority setting

2.1 Perspectives gathering

In the course of its work, the VdT Model of Creative Ability Foundation (UK) has become aware of occupational therapists' research interests and need for evidence. This has been communicated in emails, general discussions and on a 'research interest and priorities' board at the 2010 conference. These were reviewed in order to identify any commonality in topics and questions; this informed part of the survey design. The literature on occupational therapy research strategies and priorities in the UK was reviewed, in order to understand the context for VdTMoCA research and how research priority setting may contribute to the broader research agenda for the profession:

- Priorities in Mental Health Research: the Results of a Live Research Project (Fowler Davis & Bannigan 2000)
- Occupational Therapy Research Priorities in Mental Health (Bissett et al., 2001)
- 2001 College of Occupational Therapists' Research and Development Strategic Vision and Action Plan (Ilott & White 2001)
- Research Priorities in Forensic Occupational Therapy (Duncan et al., 2003)
- College of Occupational Therapists' Research and Development Strategic Vision and Action Plan: 5-year Review (White & Creek 2007)
- Research Priorities of the Profession (Gutman 2008)
- Building the evidence for occupational therapy (College of Occupational Therapists 2011)

2.2 Survey design

Informed by previous research priority studies and literature, the survey was designed by the project lead to survey occupational therapists' opinions regarding research priorities in the VdTMoCA. Ethical approval was not required.

The survey had four sections:

1) The first section sought respondents' demographic data.

2) The second section asked respondents to state their own top three priority questions for research. Respondents were encouraged to state a question starting with words such as: does/what/is/how/do……? If relevant to their question, they were also asked to state the client group that their question was specific to, or field of practice in which they wanted the question answered e.g., "Does.....for adults with mild learning disabilities living in the community?"

For each question stated, respondents had the opportunity to state reasons why the question was important to investigate.

3) The third section of the survey listed research questions that had been previously communicated to the VdTMoCAF (UK). Respondents were asked to rate each question in degree of priority, considering its importance for developing a robust evidence base for the model rather than considering it in relation to their personal interest alone. The rating scale provided was: Very high priority, High priority, Somewhat of a priority, Not at all.

This exercise was positioned at this point in the survey so that the listed questions would not influence respondents' thinking for self-stated questions Section 2.

4) The final section asked respondents to consider a list of broad areas for research and rate them according to priority (Appendix I).

3 National survey

An on-line survey tool was used to collect data. The survey was open to all qualified occupational therapists practising in the UK. An invitation to participate in the survey was sent to the VdTMoCAF (UK) and International Creative Ability Network e-mail distribution lists. The survey was promoted on the VdTMoCAF (UK) website.

3.1 Demographics

The first section of the survey gained respondents' demographic data on: the fields of practice in which the model is used; respondents' training in the model; amount of their experience with the model, and role e.g., clinician, manager, academic.

In the sample that completed this section (n=100), 79% had been formally trained of which 79% were clinicians, 23% were managers and 2% were academics. The amount of experience of using the VdTMoCA in practice is displayed in Box 1. Respondents without formal training comprised 21% of the sample, of which 16% were clinicians, 2% were managers and 2% were academics.

The respondents' fields of practice are displayed in Box 2. More than one field of practice could be selected, therefore the response percentages total more than 100%. Nearly a third of respondents worked in acute mental health and over 25% worked in adult forensic mental health. The next largest group was 'older people mental health inpatient' (11%).

Box 1. Experience of using the VdTMoCA in practice	
Answer Options	Response Percent
Less than 12 months	46%
1-2 years	15%
2-3 years	15%
3-4 years	8%
4-5 years	8%
5-6 years	1%
6-10 years	3%
more than 10 years	4%

Box 2. Respondents' fields of practice	
Answer Options	Response Percent
Acute mental health	30%
PICU	3%
Community mental health	6.6%
Older people mental health-inpatient	11%
Older people mental health-community	5%
Recovery service-mental health	8%
Vocational rehab mental health	2%
Personality disorders	2%
Eating disorders service	1%
Forensic mental health-adults	27%
Forensic mental health-adolescents	2%
Forensic learning disabilities-adults	7%
Forensic learning disabilities-adolescents	1%
Community learning disabilities	4%
Inpatient learning disabilities	3%
Brain injury	1%
Paediatrics (neuro)	6%
Paediatrics (cognitive impairment)	5%
Adult neurological conditions	1%
Education	6%
Autism spectrum	7%
Other (please specify)	
Older people care homes	
Aspergers, personality disorder	
Community forensic	
Mental Health Rehab Services	

3.2 Research priorities

Out of the 100 respondents that entered the survey, 62 fully completed the survey and answered questions on research priorities.

The priorities were identified from analysis of the top 3 priority questions that respondents were asked to state in Section 2. These were also compared to the questions that were provided for respondents to rate in degree of priority (Sections 3 and 4); the top ratings of which was predominantly congruent with respondents' self-stated priority questions.

Respondents' research priorities predominantly reflected their clinical or managerial focus in their fields of practice but the main concern was for establishing evidence of the effectiveness of the VdTMoCA. The research priorities of the survey respondents are displayed in Box 3.

Box 3. Research priorities from survey sample (n=62)

1. Effectiveness
2. Clinical application – the "how?" of practice
3. Outcome measurement
4. Occupational therapists' experience of the VdTMoCA

There now follows an outline of the research priorities that have been identified from the data. In relation to each priority, a sample of the questions stated by respondents is provided, plus common rationales for those questions.

An individual respondent's rationale for the sample question is provided when it represents well the rationales given by other respondents for similar questions. When a research question was stated by a single respondent only, the accompanying rationale is identified as a single respondent rationale. When respondents stated varying reasons for the type of research question, a summary of their reasons is provided.

EFFECTIVENESS

Respondents stated questions regarding the effectiveness of the VdTMoCA with respect to several aspects of practice.

Effectiveness as a multidisciplinary (MDT) approach

- How effective is an MDT approach to mental health care provision that is based primarily on the VdTMoCA levels of creative ability?

Rationale: "The framework that the VdTMoCA provides has proven to be successful in improving the quality and effectiveness of OT intervention, but this is used mostly just by OT services and not by other professionals, meaning measuring its effectiveness is very difficult to do as there are so many different variables at play".

Effectiveness in comparison with other models

- What is the effectiveness of the model compared with the Model of Human Occupation or how do they complement each other?
- How effective is the model in acute mental health compared to using the Model of Human Occupation?
- How does the VdTMoCA perform against other OT models?

Rationale: Further to a desire for research into these questions in order to provide evidence, occupational therapists stated that this evidence is needed to establish that the VdTMoCA is as valuable as the Model of Human Occupation (MOHO) (Kielhofner 2008). A need was also expressed to establish *"what it takes for a model to be effective as a treatment modality".*

Effectiveness in comparison with occupational therapy that is not informed by the VdTMoCA

- What is the effectiveness of VdTMoCA informed interventions against non-VdTMoCA informed interventions?
- Is an OT programme of intervention based on the VdTMoCA levels of creative ability more effective than an OT programme of intervention that is not based on a single approach/model or incorporates an eclectic use of approaches/interventions/theory?
- How effective is the model with people on Self-differentiation compared with usual treatment?

Rationale: Respondents expressed interest in randomised controlled trials to address these questions, in order to *"provide higher quality research evidence".* There was particular interest in research on the use of the model with people on the levels of Tone and Self-differentiation because for some respondents, this is a client group that they were previously unable to provide occupational therapy for:

"Because these levels would have been viewed as too unwell for OT in the past".

"Provides opportunity to enlarge OT role that no other model does and treats very unwell patients that really need OT".

Effectiveness for people with particular diagnoses/in particular fields

The range of client groups, fields of practice and services for which questions were stated, is represented by the questions below. Respondents stated questions that

were specific to their work practice; therefore many of the questions were stated by individual respondents only.

- Does the VdTMoCA demonstrate positive outcomes for patients with chronic schizophrenia?

Rationale: Respondents stated a need to establish the VdTMoCA as a model that enables the development of occupational therapy specific skills that can facilitate improvement in occupational performance in clients with schizophrenia or psychosis. Associated with this was a need to better assess risk in relation to hospital discharge and to better understand how to bring about positive change in social functioning. The latter was identified as particularly challenging for occupational therapists with this client group.

- Does the use of VdTMoCA in acute mental health have positive outcome for service users with short admissions (2-3 weeks)?

Rationale (single): To establish that the guidance for intervention provided by the VdTMoCA enables therapists to bring about change in a short period of time.

- How effective is the VdTMoCA as a model of practice with those with personality disorders in a forensic setting?

Rationale (single): The effectiveness of the VdTMoCA needs to be established in order to *"convince service managers to allow a change of model"* from MOHO, which respondents perceived to be widely used in forensic services.

- Does the VdTMoCA make a difference in occupational performance in older adults with dementia?

Rationale: Respondents expressed strong feelings regarding the need to maintain clients' skills and enhance their quality of life, particularly for those on the first levels of creative ability. Some respondents perceived that society views these clients as: *"just a shell - the person is not there"*. Respondents were keen to establish evidence that the VdTMoCA enables therapists to identify meaningful, therapeutic activities for these clients. It was suggested that through the model, engagement could be facilitated in group work in care homes to enhance their quality of life, maintain skills and/or support the maintenance of clients at home.

- Is the VdTMoCA an effective tool in aiding OTs to reduce incidences of dementia clients' behaviour that challenges staff in a care home care setting?
- Is the VdTMoCA effective in aiding care home staff to increase activity levels for older people with dementia?

Rationale: "Increased activity levels are key in improving quality life for people with dementia".

- What impact does the model have for adults with autism?

Rationale (single): "I know intuitively and through qualitative feedback that the treatment principles are improving the service users functioning, but it would be great to have that formal evidence".

Effectiveness for enabling service user engagement:

- Does this model improve patient engagement in mental health services?

Rationale: "I have witnessed the model being used by an MDT as directed by OT, having a positive effect on patient engagement - and therefore progress. Evidence around this would really support the use of the model".

- Do the handling principles improve engagement of patients presenting at Self-differentiation?

Rationale: The VdTMoCA was perceived to be the only model that provides detailed guidance on how to 'do' occupational therapy that enables client engagement, particularly at the Self-differentiation level. An evidence base of its effectiveness in this respect is needed.

- How effective is using the model in engaging patients in an acute mental health hospital?

Rationale: "In order to encourage more OTs and other MDT members to use it".

CLINICAL APPLICATION – the "how?" of practice

There were a large number of questions to do with seeking understanding of the use of the VdTMoCA in practice. The rationales for questions were therefore similar i.e. wanting to know how the VdTMoCA is used or could be used in a range of settings with people with a range of diagnoses, occupational performance problems and levels of ability. Respondents wanted to know what occupational therapists do / how they carry out the OT process through use of the model in differing practice contexts. Some respondents also stated that research may encourage occupational therapists to consider using the model as an effective alternative to 'traditional practices'. Other reasons for the questions are identified below as 'single' rationale.

The client groups that were described in these questions are listed in Table 1. This is followed by examples of questions that illustrate the respondents' research interest.

Table 1.
Client groups described in stated research questions

Populations
Forensic mental health
Forensic learning disabilities
Paediatrics - ASD
Dementia
Brain injury
Working individuals experiencing stress, depression and mental health conditions in corporate and public sector
Children with severe Autistic Spectrum Disorders
Personality disorder
Paediatrics - neurological disabilities

Examples of client groups in questions

- How can the VdTMoCA be implemented across an MDT?
- How does the VdTMoCA support the development of group protocols?
- How can the VdTMoCA be implemented within forensic services where institutionalisation is a factor and loss of roles?
- Applying the VdTMoCA in a forensic setting: a case study / demonstration
- What is the relevance of the VdTMoCA in the area of forensic adult learning disabilities?
- How can the model be applied to a paediatric OT setting?
- How does the model inform OTs working with dementia patients who wish to return home from hospital?
- How is the VdTMoCA used with people who have challenging behaviour resulting from brain injury?
- How is the model used within medium secure forensic hospitals with service users with learning disabilities and mental health disorders?

- How is the assessment implemented within a forensic setting?

Rationale (single): "I feel, with working in such a restricted environment, that it would be useful to know how others in the field use the assessment".

- How can the model be developed for use within the corporate and public sector to treat and educate working individuals experiencing stress, depression and mental health conditions?

Rationale (single): "Having worked within the acute mental health sector using VdTMoCA and understanding the accuracy and difference the tool has in the implementation of treatment for recovery (from Tone to Passive Participation), I am interested in how the model works to improve and develop performance (from Passive Participation to Active Participation) for individuals in the work place".

- How do occupational therapists use the VdTMoCA tool to plan and complete treatment sessions within the levels with adults who have learning disabilities?

Rationale (single): "There is little or no research in how learning disability OTs use formal assessment tools, due to there being so few appropriate ones available".

- Does the model apply to children with severe Autistic Spectrum Disorders?
- How does the VdTMoCA apply to a paediatric population with a diagnosis of ASD/ neurological disabilities and how can this be implemented within an educational environment?
- How relevant is the model when used with mainstream children with motor difficulties?

Rationale (single): "I think this model has great potential for children and needs more research in general, however I have found it hard to apply this model to children with social difficulties as they are motivated by different factors".

Rationale (single): "Not many approaches have been researched within the field of ASD and education and most OTs tend to use an eclectic approach to therapy and intervention. It would be good to have a model that fits in both the diagnostic group and the environment of education".

Rationale (single): "I work with kids of all ages (birth - 19 years) with special needs; specifically those with Cerebral Palsy, Sensory Processing Disorder, and Autistic Spectrum Disorder. I would like to see detailed information, or have training in, how to apply the model to this population in a Special School setting".

- How can the model be used effectively with people who have a personality disorder?

Rationale: A significant percentage of this client group was perceived to be people receiving mental health and forensic services, but for whom occupational therapists struggle to provide effective intervention. One respondent stated that s/he was uncertain that the levels of creative ability "translate smoothly" in relation to these clients and another indicated a similar view in the statement: *"Many clients with personality disorder appear to be highly functional, but with certain specific areas of difficulty i.e. social skills and emotional reasoning. They can be leveled at a low level, but the activity structure appears to be too basic for them".*

OCCUPATIONAL THERAPISTS' EXPERIENCES OF THE VdTMoCA

There were questions regarding therapists' experiences of the model and how/whether it contributed to professional practice. Specifically, there was an interest in whether the model aids decision-making and prioritisation of treatment, influences occupational therapists' professional identity and improves teamwork. The rationale for this enquiry was that respondents' experiences had been positive in these respects and there was a desire to establish evidence of this. The extent of the model's use and whether it is used with other models was also of interest. Identifying the barriers to its use was also suggested, to inform occupational therapists of what they need to consider.

- What are the facilitators and barriers of applying the VdTMoCA in a forensic mental health institution?
- Does the use of the VdTMoCA improve MDT working and understanding of occupational therapy interventions?
- How does the VdTMoCA assist the therapist in prioritising treatment?
- How many services use this model only?
- What needs to be in place for the model to be successfully implemented into practice by therapists?
- How useful is the VdTMoCA when making decisions on clinical intervention?
- Is there any other model that therapists use that works well with the VdTMoCA concepts?
- Theories used in services - a national survey of OTs who use VdTMoCA and to what extent
- Does the VdTMoCA's guidance on prescribed treatment have a fundamental role to play in maintaining professional identity and the unique OT role in a particular work setting e.g. acute mental health, community mental health?

- Is the terminology of the model suitable for UK use?

Rationale (single): "Some clinicians identify that they find the model terminology and descriptors at times negative and not client-centred. For the model to be successful, cultural applicability and language should be explored".

OUTCOME MEASUREMENT

In this category, the use of the model's assessment recording tool (Creative Participation Assessment) is referred to as a tool for measuring change. The Activity Participation Outcome Measure (APOM) (Casteleijn & Graham 2012a) is based on the levels of creative ability to measure activity participation. The APOM was specifically developed for use in mental health services.

- How can the creative participation assessment tool be used more effectively to demonstrate change over time and contribute to service evaluation?

Rationale: "Clinicians need to demonstrate outcomes on a 'real time' basis - could the creative participation assessment tool aid this?"

- Is the APOM a reliable tool for measuring functional level of ability for forensic mental health patients?
- Is the model useful as an outcome measure for OT intervention?
  Rationale: Evidence needed

- Would a simplified version of the APOM be a valid assessment tool?
  Rationale (single): "Current tool is lengthy to administer".

- How sensitive is the VdTMoCA in relation to measuring improvement in treatment interventions in comparison with other OT models like the MOHO?

Rationale (single): "Current opinion states that the VdTMoCA is able to detect small changes in client performance levels better than other models but at the moment this is only opinion".

3.3 Discussion

This study generated a small data set but the sample that fully completed the survey (n=62) is estimated to be more than 25% of the VdTMoCA occupational therapist population.

The top priority area for research that was identified in this study, is the effectiveness of the VdTMoCA. The need to establish the effectiveness of occupational therapy has been identified by other priority setting studies in the UK. In 1998, the College of Occupational Therapists found that providing evidence of the effectiveness of interventions was the highest priority for respondents (Ilott and Mountain 1999). Fowler Davis & Banngan (2000) identified the interventions that occupational therapists working in mental health thought most needed research, plus their rationales. Several themes arose from the analysis, including 'effectiveness issues'. Duncan et al., (2003) found effectiveness to be the research priority for forensic occupational therapists and Bannigan et al., (2008) identified effectiveness to be the research priority for the profession as a whole.

In this study, effectiveness was identified as a research priority in relation to several concerns in practice. Regarding effectiveness as an MDT approach, the model suggests that positive service user outcomes are more likely when the treatment principles are consistently applied. Some occupational therapists in the UK are known to share their understanding of how best to respond to and enable service users with their MDT colleagues. Some services have gained inter-disciplinary training in the VdTMoCA for the purpose of enhancing the quality of services and outcomes. Therefore, there is the scope to conduct research into the VdTMoCA as an MDT approach.

Research into effectiveness was also a priority in relation to the impact of VdTMoCA informed occupational therapy on the occupational performance and quality

of life of service users with a range of diagnoses in varying service contexts. It is interesting to note that the majority of respondents' questions concern client groups that are likely to be on the first levels of creative ability (e.g. dementia, acute mental health, chronic schizophrenia), or have complex presentations such as personality disorder or autism. This may reflect the fact that the model is purported to enable occupational therapists to provide therapeutic intervention for people on all levels of creative ability (de Witt 2005); its niche being for enabling therapy with people on the first levels (Casteleijn & de Vos 2007). There may be a link between the client groups in the research questions and respondents' desire for research into the effectiveness of the model for *engaging* service users in occupational therapy, as again, it is clients on the first levels of creative ability that are specifically mentioned in questions about engagement.

Similarly, some respondents wanted research into the effectiveness of VdTMoCA informed occupational therapy versus non-VdTMoCA informed therapy, for people on the first two levels of creative ability. Their rationales were that in their previous practice (without the model), they had not been able to effectively provide occupational therapy for clients on these levels. The VdTMoCA is what is known as a dynamic or practice theory; this type of theory provides theoretical information on how change will occur and specifies the technical details required for therapists to act on the problem to promote change (Walker & Avant 2005; Hinojosa et al., 2010). The problem that occupational therapists commonly seek to address is improving a person's ability for activity participation. Therefore, therapists need dynamic theory to explain and predict how this change will occur (Miller 1993; Kramer & Hinojosa 2010). Because the VdTMoCA is a practice theory, there is potential to establish a causal relationship between graded activity participation informed by the VdTMoCA and changes in occupational performance, health and wellbeing.

Commented [s1]: reference to find

The need to establish effectiveness relates to another priority: outcome measurement. Although a priority, there were far fewer responses regarding outcome measurement compared with the effectiveness category, despite outcome measurement being essential to demonstrating effectiveness.

Some rationales for outcome measurement research were to do with wanting to find out how changes in creative ability can be measured. This need indicates a lack of knowledge of the Creative Participation Assessment tool and the Activity Participation Outcome Measure. Similarly, there were a few questions about whether these tools are valid and reliable, suggesting a lack of awareness of existing published research that addresses this inquiry. Other questions were to do with testing or developing the Creative Participation Assessment tool and the Activity Participation Outcome Measure, with indications that they are used in practice. Some respondents wanted evidence as verification of their own positive experiences of using these measurement tools.

A desire to demonstrate the value of the VdTMoCA that respondents had experienced themselves, featured in many of the respondents' rationales for their stated

research questions. This is a striking contrast to the findings of other research priority studies, which identified that occupational therapists need research in order to *find out* what works in practice. In this study, occupational therapists predominantly wanted resarch to show occupational therapists and other professions that the use of the model *is* effective. That is, for many respondents, using the model has achieved positive outcomes or 'has worked' in relation to varying aspects of practice. Subsequently, they want other occupational therapists and the multi-disciplinary team to realise the effectiveness of occupational therapy that is informed by the model, for the benefit of the service as a whole. This was particularly expressed by respondents working in the field of mental health. This is a far more positive outlook than that of the acute mental health occupational therapists in Fowler Davis & Bannigan's (2000) study, who reported being uncertain whether their intervention is *"useful/helpful for the clients"* (p. 101). The lack of confidence in the effectiveness of their therapy, negatively affected their opinion of themselves and their validity for providing treatment as part of the wider team.

A related issue identified in this study, is that some respondents' rationales refer to the need for research in order to establish that, as per their experience, the model aids clinical reasoning and enhances professional identity amongst other disciplines. Again, this differs to Fowler Davis & Banngan's (2000) study in which occupational therapists expressed a need to find evidence of effectiveness in order to gain improved status within the team or service. Also on this issue, in *'Building the evidence for occupational therapy'*, the College of Occupational Therapists (2011) state that outside of the profession *"there is poor understanding of the occupational therapist's core role, specialist skills and potential contribution to government agendas for health and social care for the UK population in the 21st century"* (p. 2). In contrast, there have been consistent reports that the use of the VdTMoCA enables occupational therapists and assistants to explain and demonstrate the value of occupational therapy in the fast changing, performance measured climate (e.g., Sherwood 2014; Sherwood et al., 2015). However, as indicated by this study, such contribution needs to be researched and documented.

Although many respondents indicated that they have found the model to be useful in practice, the need to research its clinical application – the 'how?' of practice, strongly suggests that there are many occupational therapists that are unsure about how the model is applied in varying fields of practice. Many respondents stated research questions that were to do with seeking understanding of the use of the VdTMoCA in a range of settings for people with a range of diagnoses, occupational performance problems and levels of ability. Respondents wanted to know how occupational therapists carry out the occupational therapy process in differing practice contexts. This need links with the research priority of 'Occupational therapists' experiences of the VdTMoCA', for gaining insight into the use of the model. Both of these categories reflect how relatively new to practice the model is in the UK. A large number of conference presentations and several publications in the UK to date have reported on use of the model in mental health, forensic and learning disabilities services. However, the survey respondents' fields of practice indicate that the model is of interest to a broader population of occupational therapist; these are seeking other

VdTMoCA occupational therapists that are willing to share their knowledge and experiences through research and publication.

Although not in the top list of priorities, other aspects of practice are worthy of mention and discussion in relation to research. Section 3 of the survey listed research questions for respondents to rate in degrees of priority. Analysis of responses identified that 'service user experiences and the VdTMoCA' was fourth in the ranking of topics viewed as a 'very high' priority; 'clientcentredness and the VdTMoCA' was the top 'very high' priority. These concerns did not, however, appear in any of the respondents' own stated priority questions in Section 2. Thus, these concerns did not feature frequently enough in the analysis to be established as one of the highest priority categories. Section 3 of the survey did not provide an opportunity for respondents to state reasons for how they ranked the questions therein. However, the VdTMoCA Foundation is aware that due to the prescriptive characteristics of the model, occupational therapists tend to have questions about the voice of the service user. It is encouraging that occupational therapists express a desire to establish the client-centred use of the model and how VdTMoCA informed therapy is experienced by those that it serves.

There were several questions about the reliability and validity of the model. The questions were not about whether the assessment or outcome measure tools are valid and reliable, but about whether the theory is valid. That is, whether the levels of creative ability exist and/or are 'correct' i.e. reliable. The rationales given were that evidence was needed to justify the use of the VdTMoCA and so that the model can withstand the "scrutiny" of other disciplines. Recently, Casteleijn (2015) reported on a study that sought to answer the question: "What evidence do we have that there are different levels of creative ability and that they follow a linear and hierarchical pattern?" A Rasch analysis of three instruments that measure the levels of creative ability showed perfect threshold ordering of categories of the scales, indicating that the levels of creative ability indeed exist.

4. The current health and social care context

Therapists currently face challenges posed by significant reforms in health and social care that focus on cost efficiency, clinical effectiveness, evidence-based practice and quality. For example, the government stated that there would be a 'relentless focus on clinical outcomes' (Department of Health 2010a), while the new Health and Social Care Act (2012), has transformed funding of services by developing clinical commissioning structures that determine which services are commissioned or decommissioned. Subsequently healthcare professions and service providers openly compete for business. Depending on success or failure to deliver effective health and financial outcomes, commissioning structures pose opportunities for those services that can flexibly adapt to meet changing population needs and demonstrate both clinical outcomes and cost effectiveness. Equally, a threat is posed to those who are unable innovate and adapt. In this context occupational therapists must develop skills in entrepreneurship and innovation, demonstrate cost effectiveness and use standardised

outcomes measures in recognition of the need to produce 'credible and reliable justification for the intervention that is delivered' (College of Occupational Therapists 2013).

A challenge for occupational therapists is to collaborate with and inform commissioners and service managers of the vital role that occupational therapists play in service users' rehabilitation and recovery by clearly articulating their purpose, demonstrating outcomes, marketing their economic value and shaping OT provision in a flexible and integrated manner. Occupational therapists must also act to improve others' understanding of their important contribution to delivering outcomes for service users as well as preventing admissions or reducing length of stay in hospital (Department of Health 2010b; Morley and Rennison 2011).

In 2006 the College of Occupational Therapist set out a ten-year vision for occupational therapy in mental health to reassert the unique contribution of occupational therapists against the backdrop of the government's agenda. Whilst this document focused on mental health, the messages are the same for occupational therapists in all clinical fields. The document detailed five key areas for practitioners, educators and managers to develop and strengthen:

- Valuing occupation
- Marketing the added value of OT
- Leadership
- Education and training
- Workforce development

Recommendations to occupational therapists included:

- Implement new ways of working focusing on enhancing occupations and participation for service users;
- Provide service users and commissioners with information and build pathways of care that highlight what is expected from OT intervention;
- Use outcome measures and provide clear evidence to organisations on the cost effectiveness of OT.

5. Summary and key messages

The findings of this study are encouraging in terms of indications that occupational therapists are finding the model useful and effective for engaging clients and enhancing participation, with positive outcomes. That this appears to be the case in therapy for people on the first levels of creative ability and therefore most impaired, is of significant interest. There is however, an urgent need to conduct research into how effective VdTMoCA informed occupational therapy is and how outcomes can be measured across fields of practice. Particular fields of practice to focus on are: acute mental health, older people mental health, forensic mental health, people with acute psychosis and chronic schizophrenia, dementia, autism and personality disorder.

Due to the model's specific grading of intervention for specific levels of creative ability, randomised control trials (RCT) could be carried out for the purpose of demonstrating effectiveness. Given the lack of RCTs in occupational therapy, such research is worthy of consideration whilst understanding that RCTs are not necessarily the best method to employ.

Key messages:

- Focus on providing evidence of a causal relationship between graded activity participation informed by the VdTMoCA, changes in occupational performance and health and wellbeing
- Focus on establishing the validity and reliability of the Creative Participation Assessment tool and the Activity Participation Outcome Measure with a range of diagnostic populations
- Focus on measuring outcomes of VdTMoCA informed occupational therapy using the Creative Participation Assessment tool and/or the Activity Participation Outcome Measure

Findings of the study also indicate that occupational therapists need to gain insight into the application of the model in terms of carrying out the occupational therapy process as well as therapists' experiences of using the model in differing service contexts. In relation to the latter, there are resources available that can contribute to meeting these needs. These include contributions by therapists that have used the model for several years and are no longer novice practitioners. Networking with those therapists can be a valuable contribution to one's professional development. Furthermore, in recent years there has been a significant increase in the number of articles published in peer reviewed journals, as well as text-based examples of the use of the model in practice. These are in addition to the VdTMoCAF (UK) *'Participation'* publication; its forum of resources such as conference presentations and Centre of Excellence Open Days. There is a freely accessible, comprehensive list of published and unpublished resources, many of which are available via the Foundation. Whilst use of these resources does not negate the need for research into the use of the model, it is essential that occupational therapists actively seek, create and engage in opportunities that enable their own growth.

Key messages:

- Focus on providing evidence of how the VdTMoCA is applied in varying fields of practice and services, including how it may inform a whole MDT or service approach
- Focus on researching the utility of the VdTMoCA in varying fields of practice and services

Although not making the list of top priorities, 'service user experiences and the VdTMoCA' and 'client-centredness and the VdTMoCA' are important topics to include here. The items measured by the Activity Participation Outcome Measure were established through service user consultation regarding what they perceived to be important outcomes (Casteleijn & Graham 2012b). Therefore, continuation of this collaborative approach to improving practice is strongly encouraged. Furthermore, the

undertaking of research in which service users are actively involved in the research process, can enhance the quality of a study and bring perspectives which would otherwise be missed (College of Occupational Therapists 2013).

Key messages:

- Focus on gaining insight into the service user experience e.g., their perspectives and evaluation of VdTMoCA informed occupational therapy and services
- Focus on actively involving service users in the research process

In Fowler Davis & Bannigan's (2000) study, occupational therapists that participated in the study received criticism for wanting research to raise the profile of the occupational therapy in MDTs, perhaps as a greater focus than improving patient outcomes. In the current health and social care climate, it can be argued that both are essential and inter-related. In this study, respondents' rationales for research into the model suggest that it could demonstrate how use of the model improves the quality of care provided by occupational therapists and subsequently inform MDT or service wide practice for the benefit of service users. In the process, the value of occupational therapy can also be clearly articulated, demonstrated and established. This is an exciting prospect.

This is the first study into the areas of research that occupational therapists with interest in or using the VdTMoCA, consider to be priorities. Journal publications and presentations at occupational therapy conferences in the UK over the past few years indicate that there are an increasing number of occupational therapists that are engaging in and sharing their research. The image for the cover of this document was chosen to represent the start of investigation into the VdTMoCA in the UK, and for which it is important to develop momentum.

It is hoped that this study inspires occupational therapists to create evidence through research activity; the process of which may enable personal and professional growth whilst contributing to the development and growth of VdTMoCA informed occupational therapy in many fields of practice.

This research priority setting study will inform a VdTMoCAF (UK) research strategy for the next five years to direct and support occupational therapists in this endeavor..

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Appendices

Appendix I

Survey, Section 4. Broad areas for research to rate according to priority

Consider the following broad areas for research and rate according to priority
The VdTMoCA assessment form / tool validity and reliability
Developing the VdTMoCA assessment form / tool
Developing standardised activities for use as a task assessment
The APOM (Activity Participation Outcome Measure) in use with the model
Service user experiences and the VdTMoCA
Client centredness and the VdTMoCA
Using the VdTMoCA with other models and theories e.g. the Pool Activity Levels, MOHO, CMOP-E, sensory integration, Allen's cognitive levels
Occupational science: the contribution of the VdTMoCA to people achieving developmental milestones, health and well-being
VdTMoCA informed activity and occupation focused intervention
VdTMoCA informed service innovation, developing services
The efficiency or economic evaluation of VdTMoCA informed services