PERSPECTIVES ON OCCUPATIONAL THERAPY LEADERSHIP FUNCTIONS IN CLINICAL PRACTICE

by

MOUSSA K ABU MOSTAFA

Assignment presented in partial fulfilment
of the requirements for the degree of
Master of Occupational Therapy
at Stellenbosch University

Study leaders: Mrs S Beukes
Miss R Kemp

March 2007

DECLARATION

I, the undersigned, hereby declare that the work contained in this assignment is my own original work and that I have not previously, in its entirety or in part, submitted it at any university for a degree.

Signature: …… Date: ……

Moussa K Abu Mostafa

ABSTRACT

Objectives: The study aimed to identify the functions that occupational therapy leaders perform in clinical settings in the Metropole District of the Provincial Administration of the Western Cape (PAWC) and determine the influence of these functions on clinical practice.

Methodology: The researcher used a descriptive design and a non-standardised questionnaire which was compiled to collect the data for the study. The questionnaire was piloted with a group of occupational therapy leaders from the Boland Overberg Region. Feedback was used to refine the final study questionnaire. Thirty-five study questionnaires were mailed or handed to the participants in the study and the researcher received 25 completed questionnaires; therefore, the response rate was 71.4%. The data were analysed using the Statistical Package for the Social Sciences (SPSS 10.0) for all the questions. Descriptive statistics were used to report the data. Inter-observer reliability was checked by using the split-half method. The results revealed that the study questionnaire was reliable as Cronbach's Alfa was calculated at 0.90, correlation coefficient Pearson's r was calculated at 0.51, and Spearman-Brown was calculated at 0.67.

Results: The results were presented in relation to the respondents' number (**N** = 25). The participants identified 57 leadership functions, grouped as managerial, ethics-related, education, research, and consultation functions. The participants reported to have high performance in both direct and indirect occupational therapy services. Performance in the direct occupational therapy services functions was higher than the performance in the indirect occupational therapy services. Minimal performance in occupational therapy leadership functions was reported for consultation, ethics related, and research functions which need to be addressed by in-service training. The indirect occupational therapy services enabled the participants in the study to perform on a more optimum level regarding the direct occupational therapy services. The occupational therapy leaders had many empowering factors in their work place such as subordinates, supervisors, and top management.

Conclusion: The 57 leadership functions identified in the study culminated in an occupational therapy leadership functions framework (OTLFF) which represents the managerial activities of the occupational therapy leaders in the PAWC. These study findings are useful guidelines for occupational therapy professionals and students as guidelines for leadership training, participant facilities to compile job descriptions, and educational facilities to set educational curricula.

Recommendations: The study had many shortcomings; therefore, generalisation of results can't be done. The researcher recommends replication of the study using a larger and more representative sample.

ABSTRAK

Doelwitte: Die studie het ten doel gehad om die funksies wat arbeidsterapie leiers in die kliniese opset in die Provinsiale Administrasie van die Wes-Kaap (PAWK) vervul, te identifiseer, en die invloed van die funksies op kliniese praktyk te bepaal.

Metodologie: Die navorser het 'n beskrywende ontwerp en 'n nie-gestandaardiseerde vraelys gebruik wat saamgestel is vir die data-insameling van die studie. Die vraelys is geloods met 'n groep arbeidsterapie leiers van die Boland Overberg Area. Terugvoer is gebruik om die finale studievraelys te verfyn. Vyf-en-dertig studie vraelyste is aan deelnemers gepos of uitgedeel en die navorser het 25 voltooide vraelyste teruggekry. Die responskoers was dus 71.4%. Die data is geanaliseer met behulp van die "Statistical Package for the Social Sciences (SPSS 10.0)". Beskrywende statistiek is gebruik om die data weer te gee. Daar is vir inter-waarnemer betroubaarheid gekontroleer deur gebruik van die "split-half" metode. Die resultate het getoon dat die studievraelys betroubaar was, gebaseer op 'n berekende Cronbach Alfa waarde van 0.90, 'n korrelasie koëffisiënt (Pearson r) waarde van 0.51 en Spearman-Brown waarde van 0.67.

Resultate: Die resultate is voorgestel in terme van die respondent getalle (**N** = 25). Die deelnemers het 57 leierskapsfunksies geïdentifiseer. Die funksies het bestuurs-, eties-verwante, opleidings-, navorsings- en konsultasie funksies ingesluit. Die deelnemers het hoë vlakke van funksionering getoon in beide direkte en indirekte arbeidsterapie dienste. Funksionering in die direkte arbeidsterapie dienste was hoër as die funksionering in die direkte arbeidsterapie dienste. Minimale funksionering is getoon in die arbeidsterapie leierskapsfunksies soos konsultasie, eties-verwante en navosingsfunksies. Dit behoort aangespreek te word in opleiding. Die indirekte arbeidsterapie funksies het deelnemers aan die studie bemagtig om beter te funksioneer in die direkte arbeidsterapie dienste. Die arbeidsterapie leiers het verskeie bemagtigende faktore in hul werkplek gehad, byvoorbeeld ondergeskiktes, toesighouers en topbestuur.

Gevolgtrekking: Die 57 leierskapsfunksies wat in die studie geïdentifiseer is, is gebruik om ‘n arbeidsterapie leierskap funksies raamwerk (OTLFF) te ontwikkel, wat die bestuursaktiwiteite van die arbeidsterapie leiers van PAWK vervat. Die bevindinge van die studie bied bruikbare riglyne vir arbeidterapeute en studente insake leierskapsopleiding, deelnemerfasiliteite om werksomskrywings moontlik te maak en om opvoedkundige fasiliteite en kurrikula daar te stel.

Aanbevelings: Die studie het vele tekortkominge gehad en daarom is veralgemening van resultate nie moontlik nie. Die navorser beveel aan dat die studie herhaal word met ‘n groter en meer verteenwoordigende steekproef.

ACKNOWLEDGEMENTS

The researcher wishes to thank the Occupational Therapy Department at the Faculty of Health Sciences, Stellenbosch University and the study leaders, Mrs. Susan Beukes and Miss René Kemp. He also wishes to thank the participants, the Department of Biostatistics at Stellenbosch University, specifically Dr. Martin Kidd, and colleagues, Meryl Rybnikar, Corneli Strydom and Charlyn Goliath. The researcher acknowledges the valuable support from all friends and colleagues. The researcher wishes to deeply thank and appreciate Mr.Saeed Al-Sisee for his constant endeavours of reviewing and correcting the language of the research.

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CHAPTER 1

INTRODUCTION AND MOTIVATION FOR THE STUDY

INTRODUCTION 1.1

There are only a few studies that investigate occupational therapy leadership. The most important three are those conducted by Brollier (1985), Burke and DePoy (1991) and Dillon (2001). All three stress the importance of research in the area of occupational therapy leadership and clinical practice. They recommend that such studies be replicated in different circumstances and populations, and using different research methodologies in order to gain a wider spectrum of knowledge about changes in occupational therapy leadership functions.

Occupational therapy leaders need to have knowledge, skills and attitudes to meet the continuing challenges and changes in the workplace environment and to achieve best practice procedures. Change occurs both within occupational therapy functions and at the level of performance. Recent changes in occupational therapy leadership functions have had a positive influence on clinical practice insofar as they have led to greater certainty and better leadership practices.

Consequently, it is worthwhile to conduct a scientific exploration of the functions performed by occupational therapy leaders within a clinical setting so as to determine the influence of these functions on clinical practice. This research is an analytical descriptive study, that uses a convenience sample from amongst the occupational therapists employed by the Provincial Government of the Western Cape (PAWC) in South Africa, as well as a self-administered questionnaire, developed specifically for the study. Study findings are of significance for occupational therapists as leaders and as professionals.

1.2 MOTIVATION FOR THE STUDY

Few studies have evaluated the role of occupational therapy leadership (Brollier, 1985; Dillon, 2001). Yet, there are increasing concerns about a more scientific practice of occupational therapy leadership. Recent studies have brought these concerns into focus (Brollier, 1985: 649–654; Burke and DePoy, 1991: 1027–1032;

Fawcett and Strickland, 1998: 737–743; Baptiste, 2000: 81–85; Dillon, 2001: 441–448; Rappolt, Mitra and Murphy, 2002: 293–302). Therefore, this study endeavours to generate scientific evidence on which occupational therapy leaders could base their leadership functioning.

Occupational therapy aims to promote health and wellness and to prevent disease and disability (Moyers, 1999: 251; Brownson and Scaffa, 2001: 656–660). Baptiste (2000: 81–85) points out that ongoing social, economic and political changes have necessitated transformation and innovative development within the profession of occupational therapy. This would ensure sustainability of the profession and the quality of service delivery. Baptiste (2000: 81–85) maintains that occupational therapy typically develops in terms of knowledge, skills, behaviours, evidence-based practice and research. Development in these areas are facilitated by means of indirect occupational therapy services.

Reed and Sanderson (1980: 75) define indirect occupational therapy services as management, education, supervision, consultation, co-operation with other professionals, completing records and reports and research. Various studies have highlighted the importance of indirect occupational therapy services as a context for the direct occupational therapy service (Reed and Sanderson, 1980: 75–78; Johnson, 1996: 301–305).

It is essential for occupational therapy facilities to establish supervision and performance appraisals based on clear criteria, for example, well-defined functions. Determining the performance level in each function is essential for occupational therapy management. Determining and understanding individual and group functions would ensure the optimum contribution and the maximum participation of leaders across all levels and functions (Maslin, 1991: 91–92, 206–208).

Different functions are performed by occupational therapy leaders in indirect occupational therapy service (Reed and Sanderson, 1980; Brollier, 1985; Maslin, 1991; Dillon, 2001). These studies raise challenging questions about the functions that occupational therapy leaders perform. Therefore, this research explores occupational therapy service functions. The researcher is of the opinion that occupational therapy leaders are a valuable resource for research information

(referred to in the study as occupational therapy leadership functions). The study is conducted within an occupational therapy clinical setting that provides valuable information regarding the influence of leadership functions on clinical practice.

Occupational therapy leaders are usually the ones to decide on the main activities within a clinical setting. They have in-depth knowledge about leadership functions and their influence on clinical practice (Heinemann and Zeiss, 2002: 8–13). Their knowledge, position, feeling of responsibility, skills and experience make them a valuable resource for research. This research stresses that occupational therapy leaders should perform their functions based on a collective understanding and scientific evidence in order to have a positive effect on occupational therapy practice.

The researcher believes that sharing the experiences of others yields a collective understanding of crucial professional issues, such as occupational therapy leadership. The scientific framework of research creates the potential for occupational therapy leaders to practise their leadership functions, for educational facilities set an educational curriculum, and for governing bodies to set standards for the management of occupational therapy services based on scientific evidence. Moreover, the results of this study encourages further research in the area of occupational therapy leadership.

This research regards occupational therapy leaders as unique individuals within a clinical setting. Occupational therapy leaders need to have a specific job description based on a collective understanding of and the actual performance of occupational therapy leadership functions.

Miller (2003: 348–351) states that empowerment is fundamental to occupational therapy as it contributes towards obtaining and using the resources necessary to achieve personal, professional and organisational goals. Identifying empowering and disempowering factors for occupational therapy is essential for establishing a supportive and motivating occupational therapy leadership environment.

1.2.1 AIMS OF STUDY

The study aims to identify the functions of occupational therapy leaders within a clinical setting and to determine the influence of these functions on clinical practice.

The study seeks to rate the level of performance for each leadership function and to rank performance in occupational therapy leadership functions, thus creating the opportunity for performance appraisals and development. The study findings, which seek to establish scientific evidence, are a useful guideline for occupational therapy leaders to base the performance of their functions on. The study provides occupational therapy leaders with the information needed to understand and to successfully implement their functions within a clinical setting. Moreover, the study findings could be useful for developing a framework of leadership functions that act as a guide to occupational therapy leaders and that help them to understand and expand their job description.

The study attempts to screen some organisational activities. It investigates the ways in which occupational therapists reach a leadership position. Study findings could prove to be useful for participant facilities to set up and align organisational structures and the process of appointing occupational therapists to leadership positions, where they perform tasks, such as supervision, delegation and the appraisal of personnel. The study could also help with risk management by identifying shortcomings in how occupational therapists reach leadership positions and by suggesting solutions to reduce risks.

The study investigates leadership training and identifies its gaps. It assesses future training needs from the perspective of study participants. The study conclusions could be useful guidelines for employing facilities to provide appropriate leadership training and for educational facilities when they set up the curriculum and raise awareness of occupational therapy amongst lecturers and students. Furthermore, emerging and future leaders would find the study findings, conclusions and recommendations a useful guideline when training and development essential skills.

The study findings also provide useful guidelines for effective team building, organisational collaboration, giving job descriptions, job enrichment and job enlargement. The conclusions could be useful to governing bodies when they set standards for occupational therapy management. The study findings are helpful for describing the framework for occupational therapy leadership functions.

Empowerment of self and others is a vital issue for the health disciplines (Spreitzer and Quinn, 2001: 22, 175; Miller, 2003: 348–351). This study attempts to identify empowering and disempowering factors for occupational therapy leaders. It rates and ranks the degree of empowerment gained from different team members, such as supervisors and subordinates. The study findings are a useful guidelines for occupational therapy leaders to create an empowering organisational context that supports and motivates occupational therapy leaders and that promotes occupational therapy leadership.

The study outcomes provide guidance to occupational therapy leaders in the health field. They endeavour to set a basis for further research in the area of occupational therapy leadership and clinical practice. The study is an example of how to evaluate leadership functions using an analytical descriptive design. The study can be replicated to assess change in the performance of occupational therapy leaders in relation to their functions. Moreover, the study could also be replicated in the field of nursing and physiotherapy for comparison.

The researcher hopes that the study findings will be a new contribution to the occupational therapy profession in the area of indirect occupational therapy service. Part of the study investigates developing arenas in occupational therapy, such as consultation and research functions. The study findings are an objective step forward towards assessing and ranking occupational therapy leadership functions at a national and international level. Further research may form the basis for international ranking and the standards of occupational therapy leadership practice.

1.3 OBJECTIVES OF THE STUDY

The purpose of the study is to investigate the functions of occupational therapy leaders within a clinical setting and to determine the influence of these functions on clinical practice from the perspective of the occupational therapy leader.

The specific objectives of the study proceed from the perspective of the occupational therapy leaders. They objectives aim to:

1. to identify which functions occupational therapy leaders perform in clinical settings;
2. to estimate the level of performance in these functions;

3. to describe the influence of these functions on clinical practice functions;
4. to investigate occupational therapy leadership training;
5. to determine how occupational therapists reach leadership positions; and
6. to identify empowering and disempowering factors for occupational therapy leaders.

1.4 STATEMENT OF THE PROBLEM

This research regards occupational therapy leaders as distinctive individuals within a clinical setting who perform important functions, occupy vital positions and who are a valuable resource for research. Few studies have investigated occupational therapy leadership functions. Yet, there are increasing concerns about identifying and measuring these leadership functions, investigating occupational therapy leadership training, identifying empowering and disempowering factors for occupational therapy leaders to practise occupational therapy leadership functions based on scientific evidence. Data for this study were collected from the occupational therapy leaders themselves. From a research point of view, the analytical descriptive design complies with this form of data collection. The descriptive study describes occupational therapy leadership in terms of the leaders characteristics, such as age, gender, post, training and experience. In addition, it investigates and measures occupational therapy leadership functions. The descriptive study presents information collected about empowering and disempowering factors for occupational therapy leaders. It looks at how resources are organised and allocated, for example, time, staff and budget to provide a basis for planning. A hypotheses is generated for further studies, such as a comparison of the different profiles of leadership functions amongst different health professions or different countries. The descriptive study investigates challenging issues for occupational therapy leaders and the methods used in management (Mausner and Bahn, 1985: 119–150; Katzenellenbogen, Joubert and Yach, 1991: 31). The researcher is of the opinion that a descriptive design is the optimum framework within which to carry out the study and answer the research questions. The research problem is stated in six questions as outlined below.

1.4.1 RESEARCH QUESTIONS

Six research questions are investigated:

1. What are the functions that occupational therapy leaders, from their own perspective, perform in clinical settings in the Provincial Administration of the Western Cape (PAWC)?
2. What is the level of performance in each of these functions from the perspective of the occupational therapy leader?
3. From the perspective of the occupational therapy leader, what influence do leadership functions have on clinical practice in the respective PAWC settings?
4 What training do occupational therapy leaders have?
5. How do occupational therapists reach leadership positions?
6. What are the empowering and disempowering factors for occupational therapy leaders?

1.5 TERMINOLOGY USED IN THE STUDY

The researcher uses different terms in the study, such as direct and indirect occupational therapy services, management, consultation, leadership, empowerment, psychosocial dysfunction, mental illness and maladaptive behaviour. These terms are explained below.

1.5.1 DIRECT AND INDIRECT OCCUPATIONAL THERAPY SERVICES

Direct occupational therapy service refers to clinical practice functions where the occupational therapist comes into direct contact with the patient to provide occupational therapy service. It involves functions such as referral, assessment and the implementation of an intervention plan.

Indirect occupational therapy service refers to the context in which the direct occupational therapy service is delivered. It involves functions, such as management, supervision and consultation (Reed and Sanderson, 1980: 75).

1.5.2 MANAGEMENT

Management refers to the discipline which aims to obtain resources, such as funds, equipment and human resources and to make them accessible to achieve the agreed organisational goals. Management has financial benefits, assures appropriate quality

of care and encourages active participation of employees. It protects the business and facility against illegal malpractice. Management includes planning, managing, organising, directing, controlling and personnel management (Reed and Sanderson, 1980: 75–78; Maslin, 1991: 73–93; Wendt and Vale, 1999: 169–170).

1.5.3 CONSULTATION

Consultation is an interactive process between the consultant and the consultee. It aims to provide expert or professional advice, to solve problems and to submit plans to the facility to establish or improve services. An occupational therapy consultant helps to establish new occupational therapy programmes and to maintains and develop existing programmes (Reed and Sanderson, 1980: 77; Jaffe, 1992: 15–20; Jaffe and Epstein, 1992: 3–14).

1.5.4 LEADERSHIP

According to Urdang (1991: 242) and Marckwardt, Cassidy and McMillan (1995: 724), the term leadership refers to guidance, management, administration, supervision, command, regulation, control, operation, and/or influence. The term leader refers to chief, head, commander, ruler, supervisor, director, chairperson, principal or boss. In this study, the term leadership refers to management and the term leader refers to chief, head and/or director of the facility. Occupational therapy leaders perform functions. The term function in the study refers to a role, duty, task and responsibility (Urdang, 1991: 169; Marckwardt et al., 1995: 512).

1.5.5 EMPOWERMENT

Miller (2003: 348–351) defines power as the ability to create, get and use resources to achieve one's goal. There are three levels of power: personal, professional and organisational. Personal power refers to the way that an individual perceives power; how others perceive the individual, and the extent to which an individual can influence events. Power to influence others in order to achieve targeted goals can be gained from sources such as qualifications, knowledge, skills, position, authority, respect, responsibility, boundaries, needs, motivations, rewards, connections and information.

1.5.6 PSYCHOSOCIAL DYSFUNCTION

Psychosocial dysfunction refers to interpersonal and intrapersonal skills in the environment, such as antisocial behaviour and social isolation. Individuals with physical or cognitive dysfunction lack the opportunity to interact with others. They may also lack the ability to acquire competent psychosocial performance to achieve social integration and role performance (Foster, 1996: 40). It is arguable that psychosocial symptoms are a direct result of brain lesion or a psychological reaction to the environment (McWilliams, 1996: 469).

1.6 SUMMARY

Occupational therapy leaders in clinical settings are of fundamental importance for health facilities and research. They have knowledge, possess skills, perform certain functions and occupy an essential place in the therapy team and facility. Occupational therapy leaders have a significant influence on the work process and environment. Therefore, it is valuable to explore occupational therapy leadership functions within a clinical setting. The study also aims to determine the influence of occupational therapy leadership functions on clinical practice.

The researcher views indirect occupational therapy service as the context within which direct occupational therapy service functions take place. Chapter 2 discusses the available literature and focuses on the administrative and non-clinical functions in the area of indirect occupational therapy service.

An investigation of occupational therapy leadership functions in a scientifically accountable way has the potential to yield valid and reliable data. The study uses an analytical descriptive design, a self-administered questionnaire and a sample of convenience taken from occupational therapy leaders. The study design is discussed in Chapter 3.

The researcher presents and discusses the results of the study in Chapters 4 and 5. The study findings could prove to be a useful guideline for occupational therapy leaders to practise their functions based on scientific evidence. Moreover, the study findings are useful for developing a framework for occupational therapy leadership functions.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Occupation is a key element of human activity. However, its importance as a therapeutic tool was realised only in the twentieth century. Since then, the field of occupational therapy showed considerable development in terms of theory and practice. This development has been influenced by many factors, such as clinical practice, knowledge, research, models and theories of other disciplines, for example, management and leadership. In fact, these factors contributed significantly towards the development of the foundations and fundamentals of occupational therapy profession (Nelson, 1997: 11−24).

Occupational therapy researchers have highlighted and clearly linked leadership and management to clinical practice (Nelson, 1997: 11−24). Reed and Sanderson (1980: 75) describe two components of occupational therapy services: direct and indirect services. Direct occupational therapy services involve direct contact with the client, while indirect occupational therapy services comprise managerial issues. These in turn establish the context for the direct occupational therapy services. Typically, indirect and direct occupational therapy services (clinical practice) are of equal value as part of service delivery. Yet, most occupational therapy literature focuses on clinical practice. In contrast, the aim of this study is to highlight the importance of indirect occupational therapy services.

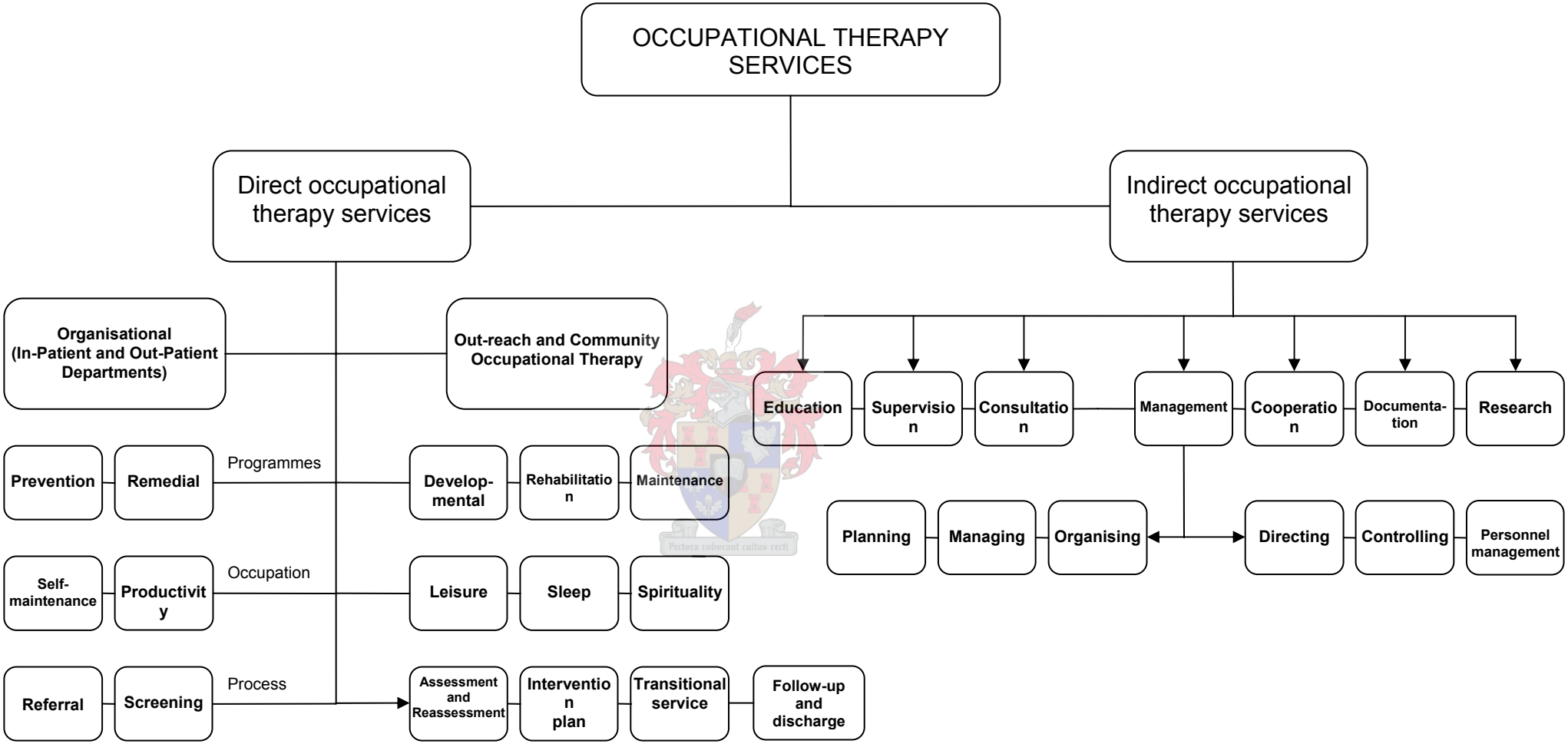


Figure 1: Direct and Indirect Occupational Therapy Services

2.2 DIRECT OCCUPATIONAL THERAPY SERVICES

Direct occupational therapy service or clinical practice is the first concern of occupational therapists as health practitioners and professionals (Georgopoulos, 1986: 74−149; Holtan, 1990: 53; Johnson, 1996: 99−103). Johnson (1996: 99−103) points out that the quality of occupational therapy services, as well as the outcomes (occupational performance) are determined by core skills, namely, managerial, interactive and therapeutic. The therapeutic core skills are the first concern of occupational therapists in clinical practice. Georgopoulos (1986: 74−149) and Holtan (1990: 53) observe that clinical practice reflects the client care decisions that are made to meet the client's needs in terms of therapeutic plans and interventions.

Appropriate case diagnosis and management are decisive for the client's overall health and ability to function independently. Initially, the occupational therapist assesses the client's functional abilities in activities of daily living and his or her higher cognitive functions so as to identify the client's strengths, weaknesses and degree of dysfunction. Thereafter, the occupational therapist determines and appropriate management strategy in terms of interventions and recommendations (Holtan, 1990: 53−58).

Researchers use different approaches to describe the process of direct occupational therapy service or occupational therapy clinical practice. However, they agree on four principle areas, namely, referral, evaluation, intervention and discharge. The four areas where their theories diverge are planning for intervention, the occupational therapy model employed, the number of stages of clinical practice, and the degree of involvement and autonomy of choice provided to the client. This study approaches occupational therapy clinical practice by way of an eight stage model (see Figure 1 in Chapter 2) that reflects the most prominent stages found in occupational therapy literature, namely, referral, screening, assessment, an intervention plan, intervention, transition services, the follow-up and discharge (Reed and Sanderson, 1980: 7; Harwood and Wenzl, 1990: 80; Holtan, 1990: 53−58; Finlay, 1993: 196−203; Fearing, Law and Clark, 1997: 7−15; Moyers, 1999: 294−295; Sumsion, 1999: 15−18). These eight stages and their characteristics are discussed in the literature review.

2.2.1 REFERRAL

Referral determines the context of the initial interview with the client. It forms a shared vision between the client and the occupational therapist with regards to referral reasons and expectations. Therefore, the occupational therapist must ensure that a proper referral process takes place in terms of a correct and complete diagnosis, indications and contra-indications (Reed and Sanderson, 1980: 7; Harwood and Wenzl, 1990: 80; Holtan, 1990: 54; Fearing et al., 1997: 8; Moyers, 1999: 263−264; Sumsion, 1999: 16−18).

2.2.2 SCREENING

An occupational therapist performs screening to enable the clinician and client to identify potential issues and priorities that are important to both of them (Reed and Sanderson, 1980: 7; Moyers, 1999: 263, 294). Screening includes recording the client's data and prioritising occupational performance problems or issues.

2.2.3 ASSESSMENT

The assessment starts with client and family interviews to collect information. The next step is to assess the client's occupational performance or occupation. An assessment of a client must result in collecting information relevant to the area of assessment. It is then followed by goal setting. To this end, the occupational therapist uses observation, interviews and specific assessment tools to perform an assessment. Assessment tools may be standardised or non-standardised assessments. An assessment tool aims to assess occupational performance or occupational components within the environmental context that is contributing towards the client's problem(s). During assessment, the client and the occupational therapist collaborate to identify the client's strengths, skills and any resources that can assist in resolving the current dysfunction in occupational performance or occupation. Re-assessment includes plan reviewing and monitoring progress (Reed and Sanderson, 1980: 7; Harwood and Wenzl, 1990: 80; Holtan, 1990: 57; Finlay, 1993: 197; Fearing et al., 1997: 8; Moyers, 1999: 263−264; Sumsion, 1999: 16).

2.2.4 INTERVENTION PLAN

An intervention plan includes information analysis, goal setting and a consideration of the media, methods, occupation and environment (Reed and Sanderson, 1980: 7; Holtan, 1990: 57; Finlay, 1993: 198; Fearing et al., 1997: 8; Moyers, 1999: 263, 295; Sumsion, 1999: 16−17). Furthermore, it includes choosing an appropriate model and a frame of reference on which to base the intervention. The theoretical model enables the occupational therapist to work effectively with the client. Consequently, the occupational therapist should have adequate knowledge and experience in a variety of models and not restrict himself or herself to any particular model.

2.2.5 INTERVENTION

Finlay (1993: 90−92) rightly points out that occupational therapy intervention should ensure the values of purposeful and meaningful activity or occupation. Furthermore, occupational therapy intervention should be structured according to professional guidelines and organisational policies in order to motivate and guide the client and to monitor his or her progress (Reed and Sanderson, 1980: 7; Harwood and Wenzl, 1990: 80; Holtan, 1990: 57; Finlay, 1993: 198; Fearing et al., 1997: 8−9; Moyers, 1999: 263, 295; Sumsion, 1999: 15−16). The process of continuous evaluation ensures that the implementation of treatment occurs according to the prescribed intervention, that progress is monitored and that the intervention plan is adapted and updated. The programme of occupational therapy may continue until it is quite obvious that the client will gain nothing further from the programme.

During programme implementation, specified treatments for various conditions are applied. Therefore, the occupational therapist takes on various roles, such as educator, learner, facilitator, monitor and leader, according to the intervention model used. The client should understand and actively participate in the occupational therapy programme (Reed and Sanderson, 1980: 7; Harwood and Wenzl, 1990: 80; Holtan, 1990: 57; Finlay, 1993: 198; Fearing et al., 1997: 8−9; Moyers, 1999: 263, 295; Sumsion, 1999: 15−16).

During intervention, the occupational therapist encourages and promotes the client to develop expectations that connect the current situation with the desired outcomes. Therefore, the occupational therapist must ensure that the client is adequately and

effectively aware of all the information pertinent to making a decision relevant to intervention. Furthermore, the client should understand that hem or she is the one who owns the goals and who will benefit directly from achieving those goals. As the client and the occupational therapist establish meaningful and purposeful occupational interventions, they will be motivated to implement their plans and achieve the intervention goals (Reed and Sanderson, 1980: 7; Holtan, 1990: 57; Finlay, 1993: 198; Fearing et al., 1997: 8; Moyers, 1999: 263, 295; Sumsion, 1999: 16−17).

The researcher is of the opinion that the clinical facility needs to be adapted in order to be perceived positively as a bridge that connects the current situation of the client to the community. The occupational therapist must enable the client to develop meanings and values in relation to balanced occupation, marked by self-maintenance, productivity, leisure, rest and/or sleep and spirituality (Reed and Sanderson, 1980: 7; Harwood and Wenzl, 1990: 80; Holtan, 1990: 57; Finlay, 1993: 198; Fearing et al., 1997: 8−9; Moyers, 1999: 263, 295; Sumsion, 1999: 15−16).

2.2.6 TRANSITION SERVICES

The occupational therapist participates in planning for discharge with the aim of facilitating the discharge process, continuing care and following up (Reed and Sanderson, 1980: 7; Harwood and Wenzl, 1990: 80; Holtan, 1990: 58; Finlay, 1993: 199−200; Moyers, 1999: 263, 295; Sumsion, 1999: 18). The occupational therapist needs to provide adequate and effective information about the client's current situation to the client and his or her caregiver. In addition, the occupational therapist must ensure that the post-discharge care and follow-up are be conducted adequately and effectively. Before the client is discharged from the occupational therapy programme, proper client and caregiver training must take place. Hence, the occupational therapist co-operates with other health professionals to ensure that an effective and appropriate follow-up and discharge process occurs. A summative evaluation of outcomes will determine whether changes should be made to the programme and to prepare the client for discharge.

2.2.7 FOLLOW-UP

The researcher believes that the follow-up plan is of high importance to sustain the achieved goals by occupational therapy intervention. During follow-up, the occupational therapist must ensure that the client adheres to the guidelines and instructions given. The follow-up plan must be effective and goal-oriented. It must prepare the client for discharge from the occupational therapy treatment programme and for discontinuation of occupational therapy care (Reed and Sanderson, 1980: 7; Harwood and Wenzl, 1990: 80; Holtan, 1990: 58; Finlay, 1993: 200−201; Fearing et al., 1997: 9; Moyers, 1999: 263, 295; Sumsion, 1999: 16−18).

2.2.8 DISCHARGE

Following admission to the occupational therapy programme, an effective intervention strategy should prepare the client for discharge. Plans for discharge must take into account the transitional stage, the use of community aftercare resources and non-treatment home settings. Finally a report must be written and made available to the client and kept on file in the record system (Reed and Sanderson, 1980: 7; Harwood and Wenzl, 1990: 80; Holtan, 1990: 58; Finlay, 1993: 202; Fearing et al., 1997: 10; Moyers, 1999: 263, 295; Sumsion, 1999: 16).

2.3 INDIRECT OCCUPATIONAL THERAPY SERVICES

The aim of indirect occupational therapy services is to ensure the quality of direct services (Reed and Sanderson, 1980: 75). Indirect occupational therapy services refer to the context in which the direct occupational therapy services are delivered. Reed and Sanderson (1980: 75) identify seven components of indirect occupational therapy services, namely, management, education, supervision, consultation, co-operation with other health professionals, completion of reports, and research. Read and Sanderson (1980) note that indirect occupational therapy services do not include any clinical intervention (see Figure 1 in Chapter 2).

2.3.1 MANAGEMENT

Effective management has financial benefits, assures appropriate quality of care, and encourages the active participation of employees (Reed and Sanderson, 1980: 75−78; Maslin, 1991: 73−93; Wendt and Vale, 1999: 169−170). The aim of management is to obtain resources, such as funds, equipment and human resources and to make these accessible to achieve the agreed organisational goals. Furthermore, the onus is on management to protect the business and facility in case of legal malpractice. Occupational therapy management includes planning, managing, organising, directing, controlling and personnel management.

2.3.1.1 Planning

Planning is important in occupational therapy management (Maslin, 1991: 95−110; Steven, 1999: 66−67; Wendt and Vale, 1999: 169−170). These studies highlight the way in which planning reduces uncertainty by anticipating and predicting future developments that influence how the work is carried out. These developments may influence the occupational therapy department in particular. Therefore, the aims of planning are:

- to identify needs or problems in the occupational therapy service area or facility,
- to gather relevant data,
- to establish goals and objectives,
- to identify appropriate strategies, and
- to indicate methods of evaluation of planning outcomes.

Maslin (1991: 95−115) links planning, organising, directing and leadership. She states that the planning function create an organizational context that fosters successful leadership. The planning function enhances the positive change of employees and organizations. It directs efforts towards estimating the future technological, economical and social situations of facility. Planning is linked to the organizing and directing functions because it contributes to cost reduction, production increase, reducing of risk of malpractice, increasing the effectiveness of resource management through resource organizing and needs prioritising. Planning is a core issue of occupational therapy management.

2.3.1.2 Managing

Maslin (1991: 73−93) regards managing as a component of management (see Figure 1 in Chapter 2). She believes that managing ensures the effective and proper handling of work issues, such as care, information, resolving conflict, time, budget, risk, resources and diversity. Managing includes functions, such as managing care, collecting information and conducting meetings with personnel and managers.

Managing care refers to functions, such as quality assurance and daily client rounds. Quality assurance can be either a managing or a controlling function. For the purposes of this study, it is viewed as managing function. Quality assurance focuses on the clinical aspects of the care provided. Methods of quality assurance include chart review or auditing which can be conducted using the active and/or discharge records. Qualified health professionals should randomly select and review charts. In an internal audit, staff members from the same facility where the records were generated should examine the data. Besides, an appropriate audit tool which contains specific criteria based on standards of care, should be applied to each chart being reviewed (Valadez and Otto, 1999: 31; Wendt and Vale, 1999: 181).

Collecting information is achieved by using appropriate tools, such as meetings, interviews, observations and document reviews. Effective communication is a key factor for effective information collection. Conflict managing ensures the proper handling of possible disagreement arising from the occupational therapy service. Budget managing includes functions, such as preparing the annual budget and approving and handling the budget appropriately. The budget function is linked to planning as it entails functions, such as a needs assessment and problem prioritizing. Resource managing aims to ensure the proper use of working hours, human energy, budget and apparatus (Maslin, 1991: 73−93, 142−210; Bleich, 1999: 9−12; Valadez and Otto, 1999: 29−31).

It cannot be emphasized enough that time is wasted when professionals try to do too much, when they are unable to say no, when they procrastinate, complain, are too perfectionistic, are interrupted, disorganised and weighed down by information overload (Reed and Pettigrew, 1999: 195−204). Time management includes three levels of technique, namely, primary, secondary and tertiary.

- Primary time management techniques promote efficiency and productivity.

- Secondary techniques focus on goal achievement and using the right tools for planning and preparation.
- Tertiary techniques help the individual to say no, to gain control and to use information appropriately.

Risk management attempts to analyse problems and minimise loss when a client care error occurs. Risk management includes dealing with financial losses which result from malpractice or absorbing the costs arising from of an extended stay for the client, negative public relations or employee dissatisfaction (Wendt and Vale, 1999: 181−182). Gathering and analysing information, while protecting it from improper disclosure, is essential to managing risk and achieving loss reduction (Hudec, 1998: 89−99). Accurate incident reporting significantly increases the efficiency of risk management. The incident report is a confidential and legal document, but it is not part of the medical record and must not be mentioned therein.

Culture can be defined as the way of life that is developed and communicated by a particular group of people (Lowenstein, 1998: 101−120; Bleich, 1999: 12−15; Otto and Valadez, 1999: 123−136). Culture includes ideas, habits, attitudes, customs and traditions. Although culture is characterised by its development over time and its responsiveness to change, it is difficult to change culture quickly. Culture is learnt and shared by its members. Culture is a necessary survival tool and contributes towards the individual's acceptance within a group.

Cultural diversity refers to a wide range of cultural differences amongst people who are different from each other. It includes layers, such as the composition of the workforce, the cultural representation of the workforce and team structure. A new member of staff may or may not accept, or may take time to accept the cultural values of the established team.

Managing cultural diversity has to do with change and transformation. It aims to prevent conflicts, maintain a competitive level of service and have a positive influence on staff involvement and performance. Therefore, it requires commitment to change, as well as passion, persistence and understanding. Leaders must have the knowledge and skills required to recognise and manage the cultural differences of staff and clients. They may employ a variety of approaches, such as effective communication to make sure that messages about client care are received and

understood correctly. Other helpful approaches are the establishment of mentoring programmes, whereby mentors and the people being mentored are paired off from different ethnic backgrounds. Continuing education programmes to increase knowledge and skills are also useful. Appropriate leadership behaviour, openness, trust, commitment, clarity and caring about others are important. They must fit in with the other approaches. Organisational change may be necessary to reduce conflict due to cultural diversity (Lowenstein, 1998: 101−120; Bleich, 1999: 12−15; Kowalski, 1999: 279−299; Otto and Valadez, 1999: 123−136).

2.3.1.3 Directing

Maslin (1991: 131−140) and Rooch (1999: 265−278) explain the importance of directing as a component of management. Directing ensures the fulfilment of functions by every team member according to functions and agreed goals. Therefore, directing includes delegation, motivation, building trust, communication and staff appraisal. Although motivation, delegation and staff appraisal may be functions of either directing or personnel management, for the purposes of this study, they are viewed as directing functions.

The views of Maslin (1991: 132−133) and Hagedorn (1995: 163−166) are worthy of support. They state that motivation helps individuals to fit into a facility and a specific team. It helps them to perform to their highest levels in an empowered and self-determined manner. Motivation is essential for creating the appropriate work circumstances where people feel that the job provides them with the right amount of stimulation, reward and challenge.

Delegation provides individuals with opportunities for creativity, innovation, growth and leadership (Maslin, 1991: 116; Hagedorn, 1995: 274; Yoder-Wise, 1999: 300−317). Research shows that delegation reduces the workload and complexity of care by enabling other personnel to participate in running the facility. In delegating tasks, the manager or leader is still accountable for the work of the team. People who perform delegated tasks (delegated individuals) must be given authority to implement the tasks. Delegation should include adequate information about task goals, functions, scope of responsibility, reporting lines, regulations, required skills, control procedure and timeframes. It is important to note that a delegated task will not be

performed if it is not delegated properly, for example, if the delegated individual lacks information or training about the delegated task, he or she cannot perform the task.

Effective resource management, personnel, time and finance are essential for a service to achieve and maintain the highest quality of care. Therefore, supervisors should appraise staff performance. Staff appraisal could take the form of a dialogue to discover the strengths and weaknesses of the staff member and to provide feedback. Performance appraisal assesses present work, commitment, communication, clinical performance, interpersonal relationships, adaptability and flexibility. Staff appraisal can be related to job satisfaction (Maslin, 1991: 206−208).

The frequency of appraisal varies from facility to facility. For instance, performance appraisals could take place regularly, once or twice a year. Evaluations are conducted on an ongoing basis, not at the conclusion of a predetermined period. Brief notes which describe either favourable or unfavourable occurrences are entered into the employee's file. The aim is to assist the supervisor or the leader with information throughout the entire rating period. The accumulated notes provide a more accurate cumulative appraisal in a concise manner. Furthermore, relevant documents and reports can be used to provide a more conclusive appraisal (Rooch, 1999: 270−276).

Maslin (1991: 206−208) and Rooch (1999: 270−276) rightly maintain that staff appraisal should be done in a responsible manner, approached positively and acknowledged. The environment in which the appraisal interview takes place is important. The interview should be positive, professional, comfortable and effective in terms of communication and the expected outcome. Trust and respect are essential for an effective appraisal. The outcomes of staff appraisals must be regarded as important by the facility and must contribute to staff motivation, career promotion and job satisfaction. At the end of the appraisal, an action plan must be drafted for implementation in the next review period. Staff appraisal is a core issue, specifically of directing, and generally of management. Staff appraisal must be performed in a motivating manner and have a curative effect on personnel who underperform. They should embrace corrective actions for eliminating poor performance. Barriers that hinder staff appraisal must be removed in order to facilitate this vital and crucial function.

2.3.1.4 Controlling

Controlling aims to improve the quality of occupational therapy services and includes such functions as measuring, monitoring and benchmarking occupational therapy service outcomes (Maslin, 1991: 168−181; Finlay, 1993: 196−203). Controlling requires effective documentation and an appropriate record system. Occupational therapists evaluate processes and outcomes in order to monitor and control practice. Monitoring the client's progress and evaluating the overall intervention outcomes assist in the planning and improvement of services. Evaluation is a continuous process. Initially, evaluation takes place in the planning phase to establish methods, tasks, rating scales and criteria for participation. The process continues during the intervention phases where the plan of treatment is monitored and adapted. Pre-discharge evaluation is conducted to measure and document progress.

2.3.1.5 Organising

Organising functions must ensure appropriate and comprehensive service delivery (Maslin, 1991: 113−128; Brooks, 1999: 137−150). According to Maslin (1991: 113−128), organising functions include setting rules and protocols, collaboration with other health professionals, creating a healthy and friendly work atmosphere, staff orientation, allocation of resources to reach organisational goals, and staff promotion to acquire further knowledge and skills. Brooks (1999: 137−150) links organisational structure and organising functions. The organisational structure, by its vision statement, mission, philosophy, characteristics, type, and focus, determines organising functions. An effective organisational structure allows participatory management.

2.3.1.6 Personnel management

In the health care arena, personnel management aims to build and develop an effective health team that is capable of achieving organisational goals, such as providing the highest quality health care at an affordable price and assisting individuals to establish clear expectations and positive attitudes (Maslin, 1991: 198−210; Rooch, 1999: 265−278). Personnel management includes functions, such as identifying department and facility needs of new personnel and guiding effective recruitment and selection processes, as well as placement. Personnel management

includes participation in setting job descriptions and identifying the needs of new personnel for training and induction (Maslin, 1991: 198−210). Personnel management also includes supervision and team building, whereby human capital is regarded as the real asset of an organisation (Rooch, 1999: 265−278). The strategy of personnel management must be based on improving recruitment and selection practices, training and development, as well as developing increased awareness (Maslin, 1991: 198−210; Rooch, 1999: 265−278). Personnel management is a core issue for health management. It aims to select the best person for a particular position.

The value of team building is that it enhances any one or all of the leadership processes, namely, goal and priority setting, allocation of work and the manner in which a group performs (Maslin, 1991: 132−133; Hagedorn, 1995: 163−166; Kowalski, 1999: 279−299; Heinemann and Zeiss, 2002: 8−13). Team building presupposes a basis of mutual respect and friendship, as well as a sense of belonging to the team. Fundamental issues for team building are effective leadership, teamwork, effective communication, partnership, shared power and managing cultural diversity. Team members should be regarded as significant persons. Their rights and achievements must be acknowledged and sustained. For their part, team members should show commitment, continuous development, growth and high standards of performance. A sense of meaning and accomplishment, autonomy, as well as financial incentives go a long way towards increasing team effectiveness, especially if these incentives are nurtured with great care (Statt, 1994: 276−277).

In a team, it is the supervisor who leads and manages occupational therapy personnel, such as the practitioners, students and volunteers (Reed and Sanderson, 1980: 76−77; Maslin, 1991: 91−139). Good supervision ensures the provision of an efficient and effective service that meets the client expectations. Therefore, the people in management positions must ensure that effective supervision is provided in order to maintain morale, motivate staff and to indicate when work needs corrective actions. Staff supervision is a vital responsibility. This responsibility may be hard to balance when the manager or leader is not viewed as such by colleagues because he or she has been appointed from inside the team. Effective supervision must be goal-directed because it should sustain the energy of team members and help employees attain professional growth.

The degree of supervision required varies according to the setting, the clients and the service provided. Supervision may be either close or general. Close supervision is direct, on site, and takes place during daily contact. General supervision, on the other hand, may be provided through frequent meetings and regular communication. Supervision includes three components, namely, administrative, educational and supportive or mentoring. Administrative supervision aims to achieve and accomplish work tasks. Educational supervision aims to accomplish present educational tasks and future needs. Supportive or mentoring supervision enables staff to solve their own problems effectively by appropriate addressing these problems, for example, ways of getting financial support (Punwar, 1994: 64−65).

There are five conditions necessary to make supervision work (Maslin, 1991: 91−92).

1. Adequate time should be allocated for regular and frequent supervision sessions.
2. The venue should ensure privacy.
3. The size of the group should allow for effective supervision, both on an individual basis (one on one) or on a group basis.
4. A climate of trust, confidence, respect and a belief in growth and change should underpin the supervision sessions.
5. Finally, a positive and optimistic note must be present.

To summarise, occupational therapy management refers to collecting and managing the resources required for providing, maintaining and developing the occupational therapy service. Occupational therapy management aims to maintain and develop the department of occupational therapy. Therefore, the resources should be used strictly for the benefit of the client, community, personnel and the facility. These resources include human capital, finance capital, assets and equipment. Many skills are required to run a business or a facility, particularly clinical, managerial, communication and leadership skills. Therefore, occupational therapy managers should be able to understand the synthesis of the overall facility and see how occupational therapy service fits into the totality of facility (Maslin, 1991: 75−93).

2.3.2 COMPLETION OF RECORDS AND REPORTS

The use of an effective record system is crucial for treatment decisions since it establishes an important legal document that can be accepted in legal procedures (Reed and Sanderson, 1980: 76; Barter and Furmidge, 1998: 61−77; Finlay, 1993: 185−203). Therefore, occupational therapists must be oriented towards and comply with maintaining professional standards and regulations, as well as the use of an effective record system. A document issued from the occupational therapy service is the main means of recording what has been done and/or what must be done. Thus occupational therapists have to complete all client records and reports in order to document client care and progress. In addition, occupational therapists should know how to complete records and reports pertinent to departmental needs, facility statistics, developmental projects and health insurance.

Recording could be seen as a debriefing opportunity for occupational therapists to refine their thoughts, express their feelings and reflect on practice (Finlay 1993: 185−187). Recording gives occupational therapists the opportunity to improve their understanding in relation to professional growth and to develop professional skills (Finlay, 1993: 185−187). Recording is essential for monitoring client progress and to review performance and the intervention process. Recording forms part of the re-evaluation process. It also generates research data. Notes should be written immediately after intervention because a delay in writing could distort the information as the therapist may forget some of the details and events.

Reporting provides the client with a legal document as evidence of participating and involvement in the team processes and functions of intervention (Finlay, 1993: 191−195). It provides feedback and helps to avoid conflict and confusion. Moreover, reporting provides data for administrative and financial needs, as well as for referral letters. In addition to written reports, verbal reports allow for discussion and the exchange of client information.

2.3.3 EDUCATION

Education transmits knowledge, skills and attitudes. It is highly important that educational activities involve family members, occupational therapy students, professional colleagues, educating the public, continuing education and orientation (Reed and Sanderson, 1980: 75−76).

2.3.3.1 Family members

Family and caregiver education and training are extremely important. Occupational therapy staff should devote adequate time to teaching and training family members, caregivers and clients. Education covers issues of intervention, follow-up and post-discharge care. It reviews problems, goals, objectives, limitations, precautions, as well as the home programmes (Reed and Sanderson, 1980: 75); Punwar, 1994: 185−193).

2.3.3.2 Occupational therapy students

The occupational therapy educational programme, for example, clinical teaching, should enable students to deliver the required services and meet professional expectations. Target groups and the needs of students should be defined, so that the educational programme is built up around students' needs (Reed and Sanderson, 1980: 75; Punwar, 1994: 185−193).

2.3.3.3 Professional colleagues

The education of professional colleagues comes as in-service training and outside training services (Reed and Sanderson, 1980: 75; Punwar, 1994: 185−193). The employer undertakes in-service training to meet organisational, clinical, managerial and developmental needs. Outside training services are undertaken by the employee and caters for personal and professional development needs. Sometimes, in-service and outside training services meet more comprehensive goals when they develop the facility, the professionals and the actual services delivered.

Therapy personnel have to keep their knowledge and skills up to date (Johnson, 1996: 316). Professionals who stand in line for ongoing education include the nursing staff, physiotherapists, doctors, rehabilitation workers, speech therapists, social

workers, psychologists and management staff (Reed and Sanderson, 1980: 75; Punwar, 1994: 185−193; Johnson, 1996: 316). The education of professional workers can take the form of lectures, conferences, conventions and workshops.

2.3.3.4 Continuing education

Continuing education is a core issue for the education of occupational therapists as health professionals. Not only does continuing education broaden and update knowledge, it also increases experience (Reed and Sanderson, 1980: 76; Punwar, 1994: 185−193). Continuing education could come in the form of lectures and workshops. Continuing education supports research programmes.

2.3.3.5 Educating the public

Educating the public could help community members to maintaining or restore health and to prevent disability. In addition, it aims to protect the public from unethical practices (Reed and Sanderson, 1980: 76; Punwar, 1994: 185−193). Educating the public may take the form of lectures and workshops.

2.3.3.6 Orientation

Orientation familiarises new staff, visitors and students with ongoing occupational therapy services. It involves issues, such as organisational vision, clientèle, services, resources, educational programmes, new trends and methods of practice. Examples of these are assessments, models, teamwork and consultation. Orientation provides opportunities for networking and enables occupational therapists to broaden their roles (Reed and Sanderson, 1980: 76; Punwar, 1994: 185−193).

2.3.4 CO−OPERATION WITH OTHER HEALTH PROFESSIONS

The aim of co-operation with other health professionals is to share resources and to make mutual decisions for the common good of employees, the people, clients, the facility and the community (Reed and Sanderson, 1980: 77−78; Hurff, Lowe, Ho and Hoffman, 1999: 424−430). Co-operation comes in three forms: individual client care, client service co-ordination and programme service planning. The collaboration of health care team members is required to develop and achieve a comprehensive health care plan. Co-ordination of services for clients involves planning and scheduling services. Effective follow-up and discharge, linking and communicating

with community resources are addressed for the benefit of the client. Programme service planning relates to participation in and the establishment of legal bodies, such as occupational therapy associations. These bodies set the standards of occupational therapy practice and service for occupational therapists and their assistants.

2.3.5 CONSULTATION

Health care delivery systems are changing rapidly. For example, there is the move towards health for all. The role of the occupational therapist has expanded from the traditional clinical field to the wider health care environment, such as community and outreach occupational therapy (Reed and Sanderson, 1980: 77; Jaffe, 1992: 15−20; Jaffe and Epstein, 1992: 3−14. These studies show how change has created a greater need for occupational therapy services that contribute towards effective problem solving and planning. Many occupational therapists now find themselves consulted about such matters (Jaffe, 1992: 15−20; Jaffe and Epstein, 1992: 3−14). Consultation is an interactive process between the consultant and consultee. A consultant could be an employee or outsider. The occupational therapy consultant provides expert or professional advice, solves problems and submits plans to the facility to establish or improve services. He or she helps to establish new occupational therapy programmes and maintains and develops existing ones.

The need for consultation was realised in the early 1900s. Since then, it has continued to develop (Jaffe, 1992: 15−20; Jaffe and Epstein, 1992: 3−14). Consultation services are indirect, because the consultant does not come into direct contact with clients. Consultation includes resource identification, analysis, problem solving, counselling, provision of support and advocacy, as well as assistance in and clarification of the roles of occupational therapy. Consultation rarely includes functions, such as treatment, management or supervision. Consultation may encompass a broader arena, such as the entire organisational structure and the external environment, for example, the economic and social system.

Jaffe (1992: 15−20) outlines seven basic steps that are found in consultation.

1. Initially, consultancy is an opportunity for the consultant to experience consultation, that is, entry into the system.
2. Then, the consultant negotiates a contract and focuses on the consultation functions.
3. He or she establishes trust by developing mutual understanding and respect.
4. Problem identification, goal setting, strategies and implementation take place in the maintenance phase.
5. The occupational therapist consultant then evaluates the outcomes by using appropriate assessment and feedback from the consultee.
6. Termination of consultation takes place in the conclusion of consultation functions and feedback within an agreed period.
7. There is a possibility for renegotiation, extension or revision of the contract for further consultations.

2.3.6 RESEARCH

It is important for occupational therapists to participate in research. The aim of research is to improve the quality of health care in terms of facility, professionals and expected outcomes (Reed and Sanderson, 1980: 78). A study by Taylor and Mitchell at the Occupational Therapy Division of the University of North Carolina that included 270 occupational therapy clinicians directly involved in patient service showed that there is a strong belief in the importance of research in the profession (Taylor and Mitchell, 1999: 350−355). Although there was minimal involvement in research due to limited time, budget and skills, it was found that collaboration with experienced researchers was rated as highly desirable. Few clinicians indicated no interest in research.

The importance of research in occupational therapy has been widely acknowledged (Baum, Boyle and Edwards, 1984: 267−269); Ottenbacher, Barris and Van Deusen, 1986: 111−116; Von Zweck, 1999: 208−213). The production of valuable research literature establishes a priority in occupational therapy endeavours to achieve significant professional rank amongst health service providers. From the literature reviewed, it would seem that most occupational therapy departments are committed to research. Research is viewed as fundamental in developing an evidence base for

providing quality and cost effective service. Therefore, research established on a scientific basis of practice must be produced and integrated with clinical practice.

The work of the occupational therapist is essential to ensure a good quality of life for individuals with various disabilities and rehabilitation needs, as well as their integration in the community. Most research studies investigate clinical issues, personal, and/or professional identity issues related to occupational performance, as well as socio-cultural, economic and political influences. Effective occupational therapy requires the ability to identify relationships amongst specific disease processes, occupational performance component deficits, deficiencies in occupational performance, and adaptation in occupational roles. Research tends to investigate areas, such as the use of different assessment and treatment modalities (Ottenbacher et al., 1986: 111−116; Von Zweck, 1999: 208−213).

Occupational therapy research strives to increase knowledge and to raise awareness of different issues. such as the prevention of disability programmes, assistive technology, professional ethics and management (Baum et al., 1984: 267−269; Ottenbacher et al., 1986: 111−116). Research may focus on assistive technology principles, practice and the occupational therapist's role on the assistive technology team. Other areas of research focus on the different aspects of occupational therapy management, including planning, organising, directing and controlling.

2.3.7 ETHICAL ISSUES

Ethics is about morality and the individual's system of values. It comprises individual beliefs about truth and acceptable behaviour (Guido, 1999: 49−57). Ethics has to do with motives, attitudes and the relationship of these attitudes to the good of the individual. The increase of ethical dilemmas in client situations and management coincides with the increase in the number of facilities using ethical committees. Some governments, for example, the federal government of the USA, have enacted several laws to assure equal employment opportunities by prohibiting discrimination on the grounds of sex, age, race, religion, handicap, pregnancy and national origin (Barter and Furmidge, 1998: 61−77).

A Code of Ethics is a public statement of the concepts, principles and values used to promote and maintain high standards of behaviour in an ethical manner in

occupational therapy. The Code of Ethics applies to occupational therapy personnel at all levels. It cannot be emphasised enough that any violation of the Code of Ethics is considered to be unethical. Occupational therapy personnel shall provide service in a fair and equal manner (American Occupational Therapy Association, 2000b: 614−616). Accordingly, health personnel and organisations are compelled to prohibit discrimination in treatment based on gender, age, race, handicap or religious differences (Schelly, Sample and Spencer, 1992: 457−460).

The onus is on management and staff leaders to provide guidance in identifying ethical dilemmas (Sliwa, McPeak, Gittler, Bodenheimer, King, Bowen and AAP Medical Education Committee, 2002: 708−717). Management and staff leaders are obliged to monitor how occupational therapists implement ethical principles in their practice. Continuous professional development and in-service training opportunities must be provided to enhance ethical awareness. The Code of Ethics is an important document that managers and leaders can use in order to set rules and regulations for occupational therapy practice. Occupational therapy interventions are obliged to conform with occupational therapy professional ethics. Client confidentiality must be assured, while unethical behaviour must be addressed and managed by the responsible authority.

2.4 LEADERSHIP

Leadership is a core issue of management. Organisations have started to recognise the functions of leaders and acknowledge their achievements in the workplace. Leaders should be perceived as business partners and not merely another tier of management. The big question is: Do we need leaders in the field of occupational therapy? If the answer is Yes (and it is the personal conviction of this researcher that good leadership is essential), then what are the functions of occupational therapy leaders and how do these functions influence clinical practice?

2.4.1 DEFINITION OF LEADERSHIP

Leadership, according to Leach (2003: 167), is a process of interaction and mutual relationship that occurs between the leader, on one hand, and an individual, group, organisation or community, on the other hand. Leadership aims to persuade, influence and guide others, for example, a team within the context of a shared goal

(Marquis and Huston, 2000: 1−20; Leach, 2003: 167). One instrument of leadership is influence. It comprises inspiring and engaging others to participate. The context of leadership is determined by the interactive relationship of the leader, followers and surrounding environment. The environment includes physical, cultural and social dimensions. Leadership requires knowledge and skills. Knowledge is gained through training while skills are developed through experience and training. Skills could be an inherent quality of the leader as well.

The literature review presents many different perspectives of leadership. Stevens (1991: 23−33) and Dillon (2001: 441−448) focus on attributes of occupational therapy leadership, for example, enabling others, creating effective vision and being a decision maker. Reed and Sanderson (1980: 75−78) focus on the managerial aspects of planning, controlling and personnel management. Heinemann and Zeiss (2002: 8−13) describe the way in which leaders reach leadership positions and their influence on the team. Stevens (1991: 23−33), Brody (1993: 3−19) and Marquis and Huston (2000:1−20) demonstrate the need for effective leaders who can influence and guide staff and be accountable for the organisation's performance. These aspects of leadership are relevant to health organisations where there is a need for health services to be developed in different areas, such as management and leadership. Berwick (1989: 53−56), on the other hand, highlights the importance of quality assurance in leadership. For Berwick, good leadership is a driving force for the improvement and growth of health services.

An occupational therapy leader needs to use leadership skills and managerial functions to adapt the environmental context effectively and to foster success and the achievement of goals (Brody, 1999: 3−19); Marquis and Huston, 2000: 1−20). A strategic leader is able to diagnose the current situation and visualise effective time-oriented actions in terms of past, present and future. Strategic leadership are marked by creativity and innovation.

Occupational therapy leadership creates and maintains an effective, comfortable and healthy work atmosphere. It enhances clear vision, shared decision making and effective communication (Kowalski, 1999: 279−299; Welch, 1999: 96−105). The components of effective leadership can be summarised as leadership knowledge, self-awareness, communication, goals and action (Tappen, 1989: 30−50). Effective communication transmits a clear vision and mission and provides skills like active

listening, assertiveness and feedback. In addition, communication provides linking and networking and allows for the effective flow of information. Leadership functions should adhere to professional ethics and behaviour relevant to occupational therapy practice in order to promote and maintain high standards in occupational therapy leadership (Tappen, 1989: 30−50; the American Occupational Therapy Association (2000b: 614−616).

In most clinical health care teams, leaders are appointed from amongst the team members. Sometimes the leader is appointed from outside of the team. The position of leadership may be a formal one within the facility or occupational therapy department (Heinemann and Zeiss, 2002: 9−10). The leadership position is informal when a leader is selected by team members. Thus, a team may have more than one leader. Effective leadership shares responsibility out amongst the team members according to seniority, experience, skills and qualifications.

An effective leader comes from within the team in a formal way. The leader has authority when appointed by the facility, as well as influence from being known to and familiar with other team members. Appointing a leader from the team has the advantage of encouraging other team members to fulfill leadership positions by developing the necessary skills and qualifications. Thus the leader acts as a role model for other team members.

In summary, leadership is fundamental for a healthy and well-functioning health care team. Leadership is either formal or informal. To have a positive influence and to perform leadership functions successfully, an occupational therapy leader must possess the necessary leadership knowledge, skills and leadership tools. Authority and influence are essential leadership tools. Authority is gained from being appointed to a leadership position by the organisation and influence refers to the ability to create a positive change within the team context. The issue of occupational therapy leadership needs to be addressed in a comprehensive way from different perspectives.

2.4.2 LEADERSHIP MOTIVATION

The theory of leadership development has been widely debated. Leadership as a theory evolved at the beginning of the twentieth century and has its origins in researching the influence of different leadership styles and traits on the workforce (Bleich, 1999: 5−7; Marquis and Huston, 2000: 1−20). Since then, the influence of motivational factors has been evaluated in terms of personnel satisfaction and environmental factors, such as organisational structure and whether the hierarchy system encourages or discourages shared achievements. The discipline of leadership studies evolved towards investigating the characteristics, behaviours and functions of leaders who have a successful influence on situations, personnel and organisational activities, as well as the achievement of positive change.

2.4.3 LEADERSHIP FUNCTIONS

A team usually has a leader. Leaders are accountable. They spend time and energy on team building and empowering team members (Reed and Pettigrew, 1999: 193−204). Leadership functions are generally determined by the relationship between the leader's personality and the specific context (Marquis and Huston, 2000: 1−20).

Dillon (2001: 441− 448) identified four attributes of leadership: enabling others, focusing on the greater good, collaborative visioning and leadership through caring and service. A good leader is deemed to be a decision maker, teacher, critical thinker, communicator, buffer, evaluator, advocate, facilitator, visionary, risk taker, forecaster and mentor (Marquis and Huston, 2000: 1−20; Reed and Sanderson, 1980: 78; Stevens, 1991: 23−33; Brody, 1993: 3−19; Dillon, 2001: 441−448). Successful leadership employs the tools of decision making, problem solving and critical thinking.

2.4.4 LEADERSHIP TRAINING

Knowledge, skills and attitudes are key issues for effective occupational therapy leadership. They are gained and sustained by continuous training (Tappen, 1989: 30−50). Gray (1999: 411) points out that leaders should be able to identify and acknowledge their areas of competence and incompetence. Leaders can acquire information through continuing education, experience, workshops, books,

professional journals and electronic sources. The leader, as well as the employing facility should carry out leadership training. The leader stands to gain professional development, motivation, self-confidence and satisfaction, while the employing facility is likely to deliver a better service and achieve its goals.

2.5 EMPOWERMENT

Empowerment embraces aspects of meaning, self-determination, impact and competence (Kelly, 1999: 420−429; Spreitzer and Quinn, 2001:14−20; Nel, 2004).

2.5.1 MEANING

Meaning may be understood as the personal connection and commitment to work. A main issue of meaning is to discover purpose in one's work, for example, in personal growth, a sense of ownership and self-actualisation (Kelly, 1999: 420−429; Spreitzer and Quinn, 2001: 16−17; Nel, 2004: 162−165). Adequate time for reflection, identifying personal talents, effective feedback, as well as guidance make for a truly unique occupational therapy leader.

2.5.2 SELF−DETERMINATION

Self-determination is found in freedom and in discretion, that is, a sense of personal autonomy that requires mutual trust by the occupational therapy leader and supervisor and openness to risk (Kelly, 1999: 420−429; Spreitzer and Quinn, 2001: 14−16; Nel, 2004: 162−165). Increasing self-determination requires creating and celebrating achievements, learning from mistakes, taking the initiative, taking risks, security, authority and testing boundaries. Self-determination also involves delegating decision making within clear boundaries and within a clear scope. It is a process whereby management or leadership develops a clear vision and then communicates specific plans and assignments to the rest of the organisation. Top management provides employees with information and resources that enable them to achieve organisational goals. Employees make the necessary operational and procedural improvements and changes. The result is greater managerial control, increased self-determination, increased classification, job enrichment and a simplification of work.

2.5.3 POSITIVE IMPACT

Positive impact happens when advantageous change takes place within an organisation (Kelly, 1999: 420−429; Spreitzer and Quinn, 2001: 19−20; Nel, 2004: 6−7, 187). Increasing positive impact means coming up with new good ideas from outside of the organisation that are acceptable and applicable.

2.5.4 COMPETENCE

Competence can be defined as confidence regarding abilities, such as knowledge and skills (Kelly, 1999: 420−429; Spreitzer and Quinn, 2001:17−19). Competence requires support, effective feedback, daily practice of skills, continuous updating through disciplined reading and self-expression towards work groups and colleagues.

2.5.5 IMPLICIT STRATEGY FOR EMPOWERMENT

It has been found that empowered people are in turn empowering people through their positive behaviour (Collins, 2001: 21; Spreitzer and Quinn, 2001:27−51). They are involved in creativity, innovation and constructive challenge. On the other hand, disempowered people cannot create an empowering context where others are willing to risk empowering themselves. Disempowered people lack a strong sense of meaning, self-determination, competence and impact. They do not feel comfortable giving up their authority and/or making themselves vulnerable to events and colleagues at work.

Spreitzer and Quinn (2001: 138−142) believe that there are three approaches to empowerment.

1. The system of suggestions encourages employees to solve problems and suggest innovative ideas to the organisation through their managers or leaders. Employees are acknowledged and rewarded if their ideas are implemented. This approach requires adequate openness and trust. The suggestion system moves some authority to the lower level employees. A disadvantage of this system is that managers or leaders still decide which ideas will be implemented.
2. The job involvement approach gives employees more say in their work. They have complete responsibility to handle problems regarding their own job as they see fit. Key issues for a successful job involvement approach are an effective communication and a feedback system.

3. The method of high involvement or commitment gives all employees at all levels of the organisation more control over their own work. Workers are invited to participate in decisions concerning organisational strategies.

It is important to note that whatever approach of empowerment is employed, it must be stressed that employees should have a good understanding of the organisation in order to have an effective influence. Employees must be acknowledged and rewarded for their achievements in order to foster organisational success. Key issues for a successful empowerment programme are continuous vision, challenge, guidance, a secure and supportive environment, empowering boundaries, two-way communication and feedback.

Spreitzer and Quinn (2001:169−178) maintain that the process of achieving empowered behaviour encompasses six steps.

1. It starts at the top by defining the need for change and alignment of the organisation's vision, mission and values.
2. Next, the employees' needs must be evaluated and addressed fairly.
3. The leaders and organisation need to define a model of empowered behaviour for employees.
4. The health care team and professionals must possess and enhance a positive business culture and co-operative behaviour.
5. Tasks, functions and rewards for employees must be clearly defined.
6. The leaders and the organisation must trust people to perform, encourage intelligent risk taking, delegate responsibility and hold people accountable for the results.

2.5.5.1 Continuous vision and challenge

Effective leadership creates an environment that provides opportunities for people to choose to empower themselves and others (Spreitzer and Quinn, 2001: 85−103; Nel, 2004: 11−14). Leaders should start by empowering themselves in order to be a role model for those around them and to encourage others to empower themselves. Vision is fundamental in creating an empowering context. Vision is something we live daily. It is moulded in our hearts, minds and daily actions. Every level of an organisation needs to possess a clear vision that meets the criteria of evoking

passion, challenging employees to grow and providing a sense of legacy, as well as encouraging empowered leadership behaviour.

2.5.5.2 Creating a secure and supportive work environment

A secure and supportive work environment encourages people to take chances and focus on creative ways of actualising the organisational vision (Collins, 2001: 41−45; Spreitzer and Quinn, 2001: 105−123). Creating a secure and supportive work environment can be achieved through a supportive network, resources that meet basic human needs and training that builds skills and abilities. In addition, the organisation must have a fair and effective reward system that promotes initiative and a culture that tolerates mistakes if they create learning opportunities. On the other hand, the biggest obstacles to workplace empowerment are leaders who are not open to sharing information with employees. Those leaders centralise the decision-making at high levels of the organisational hierarchy. They do not trust employees to try to act in the best interest of the organisation. The researcher agrees that encouraging empowerment does not simply mean delegating authority to others, but rather trusting them and sharing responsibility.

2.5.5.3 Continuous guidance

Every system needs order. Otherwise, people experience chaos rather than freedom (Collins, 2001: 71−72; Spreitzer and Quinn, 2001: 147−149). An empowering system is not a place of reckless freedom. We need to balance trust and openness, on one hand, continuous control and guidance on the other. A truly empowering system is quite distinct from one of command and control systems. An empowering system aims to unleash the initiative of employees. It assumes that everyone can exercise leadership. Therefore, it encourages self-management rather than close supervision. It promotes wide authority within boundaries and active participation by employees at all levels of decision-making.

2.5.5.4 Creating empowering boundaries

Boundaries are rules that demarcate limits (Spreitzer and Quinn, 2001:149−151). Boundaries provide guidance to leaders and employees about appropriate decisions and actions. They establish limits to our authority and indicate the negative consequences if we exceed them. Setting boundaries is quite different from

prescribing a specific course of action. Leaders need considerable freedom to determine the best way to carry out their responsibilities while still being clear about the limits of that freedom. Clarity regarding limits includes defining the areas in which leaders can make decisions and the magnitude of the decisions that they are free to make.

Spreitzer and Quinn (2001: 151−155) explain that there are specific considerations to take into account when setting boundaries. Authority should have a clear space. One person's empowerment should not create chaos for others. Only a few critical boundaries should be set that are wide enough to allow significant room for discretion and initiative. Boundaries are established to protect the organisation from intolerable risk to the mission, overall strategy and core values. Employees should understand the reasons for the critical boundaries. Both the organisation and employees participate in setting boundaries.

2.5.5.5 Providing empowering feedback

There is a link between empowering boundaries and empowering feedback. Setting boundaries is essential for any prospective feedback that will enable leaders to advance in self-management (Spreitzer and Quinn, 2001:155−159; Nel, 2004: 264−268. Setting boundaries establishes the range of appropriate action in advance. Constructive feedback is necessary to make leaders aware of how they are exercising their freedom and authority. Feedback provided to/or by leaders should be on a regular basis and should aim to encourage appropriate behaviour. That means providing specific feedback on behaviours, such as taking the initiative, coming up with new ideas, as well as making the organisation's priorities one's own. The provider and recipient should build a feedback system into the job, and consider aspects of content, frequency, place, duration and planning. Effective feedback creates a sense of accountability whereby leaders feel competent and responsible for their results.

2.5.5.6 Creating empowering structures

The organisational structure must provide order and stability and define the formal relationship within the enterprise, both at a vertical and at a horizontal level (Collins, 2001: 125; Spreitzer and Quinn, 2001: 159−165; Nel, 2004: 17−20). There are three

types of organisational structure: flatter hierarchies, wide spans of control and team-based structures.

1. Flatter hierarchies aim to shorten the distance between the work and the final decision makers. Flatter hierarchies are faster in information flow and more responsive than taller or vertical hierarchies. They engage fewer people in decision making and locate them near to the real action.
2. Wide spans of control aim to share control with leaders and employees. There are limits to how wide the span of control can be before the employees feel detached from control. Too wide a span of control leads to a lack of support and security required by leaders and employees.
3. Team-based structures are self-managing. They operate as mini-organisations with authority to make decisions relevant to their work, including hiring, firing, disciplining, budgeting and service development. They require the removal of layers of hierarchy and the absorption of administrative tasks by specialists. People feel that they are senior managers, accountable and responsible for the operation and success of the enterprise. Many organisations today are moving towards the establishment of team-based structures.

It should be mentioned that any change in organisational structure must be done carefully and gradually (by evolution rather than revolution) in order to increase opportunities for success and to avoid failure and chaos, negative reactions and corruption. Any organisational structure of choice should depend on the type and size of the facility, the services provided, the degree of involvement of different departments in service delivery, the interpersonal and inter-departmental co-operation required to achieve intervention and organisational goals, as well as organisational experience. A small rehabilitation hospital, for example, that deals with physical disabilities is more likely to use a flatter hierarchy.

2.6 SUMMARY

Occupational therapy aims to assess the client's overall occupational performance within an environment and to set up and implement an intervention plan in co-operation with the client and other health care professionals. Intervention brings about positive, meaningful, valuable and sustainable change in the client's

occupational performance and environment. Therefore, occupational therapy provides two forms of services: direct and indirect.

In direct occupational therapy service, the clinician comes into direct contact with the client. This does not happen in indirect occupational therapy service. The indirect occupational therapy service refers to managerial type functions in order to establish the context for occupational therapy intervention to take place. Indirect occupational therapy services encompass management, education, research, consultation, co-operation with other health care professionals and record keeping.

Leadership is fundamental to management. It is a key factor for success. Leadership is the process of influencing others positively within a context. It aims to guide the team towards a shared goal. Empowered leaders are empowering people and they are able to create positive change within a team or facility. Ideally, leaders should be perceived as partners and not merely as managers. It is worthwhile using a scientific approach, such as an analytic descriptive study to investigate occupational therapy leadership functions.

Chapter 2 discussed the available information on leadership in occupational therapy literature. During the research process it was found that there was a lack of information relevant to national or international research, statistics and trends in occupational therapy leadership.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

This study was conducted using a descriptive analytical design and a sample of convenience of 35 occupational therapy leaders. The study sample was drawn from a population of occupational therapy leaders employed by the governmental health sector of the Provincial Administration of the Western Cape (PAWC).

In order to collect the required data for the study, the researcher compiled and used a non-standardised questionnaire which comprised 97 questions. This chapter looks at the advantages and disadvantages of using questionnaires. All possible measures to counteract bias in the study were taken so as to increase the validity and reliablity of the questionnaire. The study protocol was approved by the Occupational Therapy Department and then by the Committee for Human Research, Faculty of Health Sciences, Stellenbosch University.

3.2 THE ANALYTICAL DESCRIPTIVE DESIGN

A descriptive study explores a problem or phenomenon and investigates its determinants. It uses available data for this purpose. A descriptive study establishes comparability, for example, occupational therapy leadership in South Africa versus occupational therapy leadership in the USA and allows for a follow-up of dependent variable(s) over time (Beaglehole, Bonita and Kiellstrom, 1993: 31–32). This study uses a descriptive analytical design to investigate occupational therapy leadership in the governmental health sector of PAWC in terms of age, gender, job title (senior, chief or assistant director occupational therapist), functions, facility, experience (clinical and leadership), leadership training, ways of reaching leadership positions by occupational therapy leaders, as well as empowerment factors. In this descriptive study, the researcher used a questionnaire to collect the data from a convenience sample of occupational therapy leaders and the Statistical Package for the Social Sciences (SPSS 10.0) to perform the statistical analysis.

Participants in this study were already been in leadership positions. They did not have to move from their current posts to new posts with new functions which could have entailed inconvenient changes in different aspects of their life and work situations,for example, friends, facilities, work contracts and the types of cases treated. It is widely accepted that people do not easily accept change and that they resist change to varying different degrees. The researcher proceeded from the premise that participants in any study should feel convenient and safe about their health and the information that they impart. The use of available data and a descriptive study avoids exposing the study sample – occupational therapy leaders – to either tentative or permanent inconvenient change in their posts and life situations.

Where the occupational therapy leadership functions under study are relatively stable, it is possible to describe them by collecting information from the performers themselves, for example, functions regarding their planning and clinical practice areas. These functions, however, are vulnerable to change over time by the influence of experience, training and changing organisational needs. Other information is less likely to be stable, for example, the training and number of subordinates reporting to each occupational therapy leader. Experience and leadership training needs are dynamic components and they change over time.

A descriptive study organises and saves resources, like money, time and staff. It forms the basis for effective management, quality assurance and research (Mausner and Bahn, 1985: 119–150; Katzenellenbogen, Joubert and Yach, 1991: 31).

A descriptive study describes and documents a problem rather than manipulating or investigating variables. The relationship between independent and dependent variables is irrelevant (Oyster, Hansen and Llorens, 1987: 90–98). A descriptive study usually focuses on one variable, for example, occupational therapy leadership functions. However, it may also look at two variables, for example, occupational therapy leadership functions and the leaders' perspective of their influence on clinical practice which is one of this study's objectives (Armstrong and Grace, 2000: 16).

Studies by Armstrong and Grace (2000: 16), as well as Norwood (2000: 95) indicate some limitations to descriptive studies. Since descriptive studies usually address only one variable, they are less likely to be published. Bearing that in mind, the researcher, nevertheless believes that an analytical descriptive design is the most

appropriate structure within which to investigate occupational therapy leadership and to describe its functions, as well as estimate the influence of these on clinical practice. Moreover, an analytical descriptive design is a useful way to explore occupational therapy leadership training, to identify future training needs, to evaluate how occupational therapists reach leadership positions and to investigate empowerment factors for occupational therapy leaders.

3.3 POPULATION AND SAMPLING METHOD

The study population consists of occupational therapy leaders employed by the governmental health sector within PAWC. PAWC has four regions: Cape Town Metropole, Boland Overberg, West Coast Winelands and Southern Cape Karoo. In 2004, the Cape Town Metropole included 27 health centres that provide occupational therapy services. The researcher is an international masters student with the Faculty of Health Sciences at Stellenbosch University in the Cape Town Metropole. Consequently the researcher is not familiar with the provinces of South Africa. It should also be noted that the study was sponsored entirely by the researcher alone. For time, cost and convenience factors, the researcher chose a study sample from the Cape Town Metropole since the study sample was within reach and allowed, from the researcher's point of view, for more co-operation from the study participants in terms of using available data and saving time and money. Moreover, volunteers, such as lecturers and students, participated in distributing and collecting study questionnaires. This was an important contribution on their part. Drawing the study sample exclusively from the Cape Town Metropole could render the study sample not quite representative of occupational therapy leaders in either South Africa or the Provincial Administration of the Western Cape (PAWC), thus limiting the generalisation of results. The researcher believes that researchers need to take into account the use of available information, so as to save resources so far as possible, and to avoid disadvantages, such as bias or non-representative sample.

3.3.1 INCLUSION CRITERIA

The following inclusion criteria were set:

1. All participants must be occupational therapists.
2. Participants must hold the title of assistant director, chief or senior occupational therapist.
3. The participant must be employed by a governmental health facility in PAWC.

To allow for a larger sample size and access to a bigger body of information, the length of time in the leadership position was not considered as an inclusion criterion. Therefore, sampling bias could be possible (incidence and/or prevalence bias).

3.3.2 SAMPLING METHOD

In 2004, the governmental health sector of the Cape Town Metropole in PAWC had 27 facilities that provided occupational therapy services. The researcher contacted these facilities between March and April 2004 over a period of four weeks via telephone, fax and email. The aim was to identify the number of occupational therapy leaders in each facility who met the study inclusion criteria and who would agree to participate in the study. Those leaders were assistant directors, as well as chief and senior occupational therapists. Thirteen facilities of the 27 stated that they had occupational therapy leaders who met the study's inclusion criteria and the total number was 35 occupational therapy leaders. The researcher decided to include those 35 individuals, thus creating a convenience sample of 35 individuals.

A convenience sample has advantages and disadvantages. A the sample of convenience reduces cost, saves time and increases the possibility that individuals who agree to participate in the study will be co-operative (Indrayan and Sarmukaddam, 2001: 75; Blumenthal and Diclemente, 2004: 109). Another advantage is that in convenience sampling, the small sample used is readily available. On the other hand, Leedy (1993: 199–200) shows that in convenience sampling no attempt is made to control sampling bias. Consequently data may be skewed in favour of participants, thus making the sample less representative of the population. Katzenellenbogen et al. (1991: 35) stress the importance of a representative sample to ensure that good quality information is obtained and to reflect the study population and the possibility of generalising sample results to the

whole population. The convenience sample used in this study is not representative of the whole population of occupational therapy leaders in the PAWC.

Fourteen facilities within the Cape Town Metropole did not participate in the study. In six of those facilities, occupational therapists did not meet the study inclusion criteria. Eight other facilities, four community health centres and four hospitals, did not respond at all. The researcher cannot confirm that the non-respondent facilities did not include individuals who met the inclusion criteria. This introduces a possible source of bias to the study sample as the findings from the study sample may not reflect conditions in the non-respondent facilities.

3.4 DESIGN OF DATA COLLECTION INSTRUMENT

A literature review and an Internet search produced no appropriate data collection instrument available for investigating occupational therapy leadership functions. The researcher investigated various functions and compiled the study questionnaire based on available occupational therapy, management and leadership literature (Maslin, 1991; Barter and Furmidge, 1998: 61–77; Bleich, 1999: 5–15). The questionnaire was piloted using a similar sample of 10 occupational therapy leaders from the Boland Overberg Region and then refined to incorporate comments and feedback before being used in the study. Using a questionnaire has many advantages and disadvantages. The researcher took all possible measures to counteract the disadvantages and to increase the questionnaire's validity and the possibility of collecting reliable data.

3.4.1 ADVANTAGES AND DISADVANTAGES OF USING A SELF-ADMINISTERED QUESTIONNAIRE

Studies by both Armstrong and Grace (2000: 64–66), as well as Norwood (2000: 245) reflect on the advantages and disadvantages of using a questionnaire for data collection. Questionnaires present low data collection costs and greater geographic coverage where distance and inaccessibility may be barriers. Questionnaires avoid the bias of an interview, assures anonymity, saves time and has low data processing costs. On the other hand, questionnaires have a high potential for a low response rate. There is lack of control over respondents and the instrument could be liable to

contamination bias. The possibility that questions may be left unanswered is always there. Questionnaires do not provide any opportunity to clear up misunderstandings.

3.4.2 COUNTERACTIVE MEASURES

A covering letter and a separate written anonymous consent form were attached to each questionnaire to decrease its disadvantages (see Appendix C). The covering letter that accompanied the questionnaire briefly described the aims of the study and explained its importance for the participants. It requested participants to complete the questionnaire individually and independently and to return it in the enclosed stamped envelope within six weeks. The covering letter assured freedom of participation and the anonymity of participants and their facilities. It also confirmed the confidentiality of information. The anonymous consent form requested the participant to tick (✓) and sign that he or she agreed to participate in the study. The timeframe for data collection was six weeks. The researcher considered this to be adequate to allow for the completion and return of the questionnaire. The researcher avoided potential barriers, such as holidays and provided an incentive in the form of receiving a summary of the results. On each page of the questionnaire, there was a reminder/request to continue answering each question, to check all the questions on each page before continuing with the questions on the next page (Armstrong and Grace, 2000: 64–66; Norwood, 2000: 245).

3.4.3 STUDY QUESTIONNAIRE

The study questionnaire was made up of 97 questions divided into three parts (Appendix C). The questions were closed-ended, open-ended and mixed (open-ended and closed-ended). Part 1 of the questionnaire had three groups of questions. The first group had five questions (Questions 1 to 5) that collected biographic data in terms of the leader's gender, the dominant gender in the team, age and experience. Questions 1 to 4 were mixed (open-ended and closed-ended). Question 5 was closed. Question 1.4 collected information about leader's experience as a senior and chief occupational therapist and/or assistant director. Question 1.5 collected information about leader's total experience. Therefore, it was easy to estimate clinical experience and leadership experience. The data obtained from Questions 1 to 5 were a combination of quantitative and qualitative. The qualitative data were nominal: gender, leadership training, type of affiliating facility, job title and the targeted clients'

diagnostic categories. The quantitative data were interval and ratio: age, experience and number of leaders in the department. Group 2 of Part 1 of the questionnaire was made up of 57 closed questions (Questions 6 to 62). These questions collected information about planning, managing, organising, personnel management (staffing), directing, controlling and ethics-related functions. The data were quantitative nominal (representing opinion) and ratio (rating viewpoint). The Likert scale used was 1 to 4 (1 = strongly agree, 2 = moderately agree, 3 = moderately disagree and 4 = strongly disagree). Group 3 of Part 1 of the questionnaire had one mixed question (Question 63) that consisted of an open-ended and a closed question. Question 63 collected quantitative nominal data about focus or issues of concern in terms of planning functions.

Part 2 of the questionnaire comprised 14 closed questions (Questions 64 to 77) that collected information concerning clinical practice: referral, screening, evaluation, intervention plan, implementation of plan, transitional service, follow-up and discharge. The data were quantitative nominal (representing opinion) and ratio (rating viewpoint). The Likert scale used was 1 to 4 (1 = strongly agree, 2 = moderately agree, 3 = moderately disagree, and 4 = strongly disagree).

Part 3 of the questionnaire comprised 20 questions (Questions 78 to 97) divided into two groups. The first group had 15 closed questions (Questions 78 to 92) that collected information relevant to empowerment factors of occupational therapy leaders, such as supervising, subordinates and management. The data were quantitative nominal (representing opinion) and ratio (rating viewpoint). The Likert scale used was 1 to 4 (1 = strongly empower, 2 = moderately empower, 3 = moderately disempower and 4 = strongly disempower). The second group had five questions (Questions 93 to 97) that were mixed (open-ended and closed questions). Questions 93 to 97 collected qualitative and quantitative data relevant to convenient and inconvenient functions and future leaders' training needs.

3.4.3.1 Validity

Norwood (2000: 245) defines validity as a concept and measure that describes how closely the observations correspond to the actual state. The questionnaire compiled by the researcher for this study was not standardised before being used in the study. The researcher took all possible measures, such as covering a large range of

leadership functions, gathering data that directly predict the issue under study, choosing suitable wording for the respondents and completion of the same version of the questionnaire by all respondents to increase the questionnaire's validity. Content validity was assured by covering a wide range of leadership functions and clinical practice stages in the questionnaire based on well-researched information in the literature (Reed and Sanderson, 1980: 7, 75–78; Holtan, 1990: 53–58; Maslin, 1991: 73–93; Barter and Furmidge, 1998: 61–77; Moyers, 1999: 294–295; Sumsion, 1999: 15–20). The questionnaire only included questions that measured leadership functions within clinical settings. All questionnaire items pertained to the same issue under study – occupational therapy leadership. The questionnaire gathered biographic information relevant to participant occupational therapy leaders, data pertinent to occupational therapy clinical practice, occupational therapy leadership functions, occupational therapy leadership empowerment factors and leadership training. All the data collected were necessary to conduct and complete the study.

Construct validity was affirmed where measurements, for example, performance in planning, varied according to the presence of other established indicators, such as experience and setting. The questionnaire addresses aspects of occupational therapy functions and differentiates between the theoretical concept of occupational therapy leadership and other concepts.

All the data collected by the questionnaire (for example, managing, directing, referral, assessment and implementing an intervention plan) directly speak to the issue under study, namely, occupational therapy leadership in clinical practice, which established the criterion validity of the questionnaire. The questionnaire reflects current occupational therapy leadership functions and is able to predict the future functions from the current ones (Armstrong and Grace, 2000: 76; Norwood, 2000: 245).

The questionnaire as a whole measures occupational therapy leadership functions thus assuring face validity. Face validity was improved to increase readability by using white A4 paper, justified text and an appropriate font size (Arial 12). The choice of wording (words and word length) is deemed to be suitable for the respondents. The questionnaire is easy to read and understandable. All respondents completed the same version of the questionnaire.

3.4.3.2 Reliability

Studies by both Mark (1996: 285) and Norwood (2000: 245) see reliability as a concept and measure that describes the accuracy of the instrument used. For them reliability is the ability of an instrument to yield the same information when administered repeatedly. The error or difference between observed values and true values must be very small in order to obtain reliable data. The reliability of the questionnaire was assured in different methods, such as inter-observer, intra-observer and internal consistency.

Different methods used to assure inter-observer and intra-observer reliability were using a self-administered questionnaire that was completed independently and individually by participants. The researcher piloted the questionnaire and refined it according to the feedback obtained. The questionnaire covers a wide range of occupational therapy leadership functions. Concise and clear wording was used in order to make questions clear and to avoid misinterpretation (Mark, 1996: 285–286).

All the items in the questionnaire belong to the same conceptual category, namely, occupational therapy leadership. This assures internal consistency. Split half method measures internal consistency and computes reliability coefficient factors or Cronbach's Alfa and the Spearman-Brown (Mark, 1996: 287–288). Split half is calculated by dividing questions into two groups and comparing a subject's score on both halves of the questionnaire (Oyster et al., 1987: 45; Mark, 1996: 287). A reliability coefficient factor – Cronbach's Alfa – takes random samples of items on the test and correlates the scores obtained from the samples with each other to find out the average inter-correlation. A reliability coefficient factor – the Spearman-Brown – estimates what the correlation between the two halves would have been had each half been the length of the whole questionnaire (Mark, 1996: 287–288).

A reliability coefficient factor – the Spearman-Brown – is similar to a regular Pearson correlation coefficient (the Pearson **r**), that is in terms of the proportion of variability accounted for. The Spearman-Brown reliability coefficient factor is computed from ranks. A Spearman-Brown reliability coefficient factor assumes that the variables under consideration were measured on at least an ordinal (rank order) scale; that is, the individual observations (cases) can be ranked into two ordered series (Argyrous,

2000: 86–90; Polgar and Thomas, 2000: 279–282). Incomplete values are substituted by the mean. A reliability coefficient factor (Cronbach's Alfa or Spearman-Brown) or a Pearson correlation coefficient (Pearson **r**) close to 1.0 indicates that the data are reliable (Mark, 1996: 287–288; Argyrous, 2000: 86–90; Polgar and Thomas, 2000: 279–282).

Table 1 Split-half reliability test

Group	Questions	Items number	Chronbach's Alfa value
Group 1	6–48	43	0.80
Group 2	49–92	43	0.88
All questions	6–92	86	0.90

Correlation coefficient (Pearson's **r)** = 0.51

Reliability coefficient factor (Spearman-Brown) = 0.67

The values of Chronbach's Alfa reliability coefficient factors are high and close to the value one (0.80, 0.88 and 0.90) because the error variance is absorbed amongst the large number of questions (see Table 1). There is, however, a good correlation between the two halves. The conclusion is supported by the correlation coefficient Pearson's **r** which was calculated at 0.51 and the reliability coefficient factor Spearman-Brown which was calculated at 0.67. Both coefficients (Pearson's **r** and Spearman-Brown) are close to the value one (1.0). This implies that the questionnaire is a reliable data collection instrument and that consequently the data collected by the questionnaire are reliable and reproducible.

3.4.3.3 Pilot study

The pilot questionnaire comprised 68 questions covering three parts (see Appendix B). All questions were closed except for Questions 7, 8 and 60. These were mixed (open-ended and closed-ended) questions. Part 1 of the pilot questionnaire had two groups of questions. The first group had eight questions (Questions 1 to 8) that collected biographic information, such as gender, experience and leadership training. The data were mixed quantitative nominal and qualitative, for example, training relevant to leadership in terms of courses and periods. The second group had 37 questions (Questions 9 to 45) that collected information about seven areas of

managerial functions: planning, managing, organising, staffing, directing, controlling, and ethical issues. The data were quantitative nominal (representing opinion) and ratio (rating viewpoint). The Likert scale used was 1 to 5 (1 = strongly agree, 2 = moderately agree, 3 = don't know, 4 = moderately disagree and 5 = strongly disagree).

Part 2 of the pilot questionnaire had 14 questions (Questions 46 to 59) that collected information relevant to clinical practice: referral, screening, evaluation, intervention plan and implementation of plan, transitional service, follow-up and discharge. The data were quantitative nominal (representing opinion) and ratio (rating viewpoint). The Likert scale used was 1 to 5 (1 = strongly agree, 2 = moderately agree, 3 = don't know, 4 = moderately disagree and 5 = strongly disagree).

Part 3 of the pilot questionnaire had nine questions (Questions 60 to 68). It collected nominal data relevant to occupational therapy departments, type of facility (Question 60), targeted clients' diagnostic categories (Question 61) and indirect occupational therapy service (Questions 62 to 68), all covering education, consultation, reporting and recordkeeping system, research and co-operation with other health professionals. Questions 62 to 68 collected quantitative nominal data (representing opinion) and ratio (rating viewpoint). The Likert scale used was 1 to 5 (1 = strongly agree, 2 = moderately agree, 3 = don't know, 4 = moderately disagree and 5 = strongly disagree).

A covering letter and a list of nine questions for feedback on the pilot questionnaire were attached to each pilot questionnaire (see Appendix B). The covering letter of the pilot questionnaire invited and encouraged the individuals to participate and complete the pilot questionnaire. It briefly described the aims of the pilot questionnaire and the study. It assured freedom of participation, the anonymity of participants and their facilities, as well as confidentiality of information. The covering letter requested the participants to complete and return the questionnaire in the enclosed stamped envelope within two weeks. Participants were told to feel free to answer the questions and to comment on the questionnaire as well.

The researcher carried out the pilot study in June 2004. The pilot study was performed with a sample of ten occupational therapy leaders who were governmental

sector employees in the Boland Overberg Region. The individuals of the pilot sample were randomly selected from the list of addresses and telephone numbers of the occupational therapists in the Western Cape health sector and they were given code numbers (01 to 12). A colleague randomly selected 10 numbers between 1 and 12. Ten pilot questionnaires were mailed to those ten individuals. Each envelope contained a pilot questionnaire and a stamped envelope in which to return the completed pilot questionnaire. After three days, the researcher telephoned the participants in the pilot study to confirm receipt of the pilot questionnaires and to sort out any problems. The researcher asked the participants in the pilot study to give verbal consent. They were encouraged to return the completed pilot questionnaires as soon as possible. The pilot study continued over two weeks at the end of which the researcher received seven completed pilot questionnaires out of ten. Therefore, the response rate was 70%. The participants in the pilot study gave feedback to the researcher by completing and returning a list of nine questions together with the completed pilot questionnaire (see Table 2). They commented on the pilot questionnaire as well. In addition, two expert lecturers from the Faculty of Health Sciences, Stellenbosch University with about thirty years of experience in occupational therapy management completed two pilot questionnaires. Their feedback was useful and considered only in compiling the study questionnaire. The researcher did not consider the two lecturers' feedback on the list of nine questions to avoid pilot study bias as they were not a part of the pilot study. The researcher used feedback received to revise and finalise the study questionnaire as follows.

There were minor changes to the covering letter. Three respondents (3 out of 7) suggested defining and highlighting in bold font the group targeted by the study. Three respondents (3 out of 7) suggested using only one mark to tick the correct answer **(✓)** throughout the questionnaire. Six respondents (6 out of 7) recommended mentioning the dates for completion and return of the questionnaire. Changes were made accordingly. Information was added to tell the participants in the study about the average time required to complete the questionnaire. The layout of the covering letter for the study questionnaire was improved to increase its face validity.

Table 2 Feedback on the pilot questionnaire (N=7)

Questions	Yes	No
1. Is each of the questions measuring what it is intended to measure?	5	2
2. Are all the words understood?	4	3
3. Do the options apply to the questions? *	5	1
4. Are there any un-interpretable questions? *	2	4
5. Are any of the items reflecting a leading question?	1	6
6. Does any aspect of the questionnaire suggest bias on the part of the researcher? *	0	6
7. Is/are there any irrelevant question(s) that needs to be omitted? **	0	5

* One incomplete answer, **n**=6 ** Two incomplete answers, **n**=5

Table 2 summarises feedback received for the pilot questionnaire. The incomplete answers were excluded (one incomplete answer in each of Questions 3, 4 and 6 and two incomplete answers in Question 7). The respondents in the pilot study recommended changes to the Likert scale used, changes to wording and changes to the structure of some of the questions. The Likert scale used in the pilot questionnaire (1 to 5) allowed the option of not reflecting on the questions by ticking 3 (don't know). At the same time, the value 3 may have significant influence on the means and the standard deviations and it has no statistical meaning. The Likert scale suggested was 1 to 4 (1 = strongly agree, 2 = moderately agree, 3 = moderately disagree and 4 = strongly disagree). Changes in wording (using more appropriate language or words) and changes in structure (dividing questions that have more than one item) were suggested for Questions 7, 8–10, 13, 16, 18–24, 27, 33, 41–54, 57, 59 and 62–64. Another comment recommended highlighting (in bold font) the main issues and focus of requests.

Five respondents (5 out of 7) suggested removing Question 4 (position of leadership in terms of formal or informal). Four respondents (4 out of 7) suggested adding one more question relevant to opportunities provided for the fulfilment of leadership positions in an occupational therapy department, five more questions in ethical issues functions and one more question in planning functions. Three respondents (3

out of 7) suggested shifting two questions from Part 3 to Part 1 (type of facility and client diagnostic categories) and four questions from Part 3 to Part 2 (education, consultation, research, and records). Three respondents (3 out of 7) suggested adding five more questions to each one of managing, organising and staffing functions. In addition, they suggested adding a new group of fifteen questions relevant to empowerment factors of occupational therapy leaders. Two participants (2 out of 7) reported difficulty in reflecting on the questions (whether the answers should indicate what they do now or what should be done). The average time required to complete the pilot questionnaire was 22 minutes. The reliability test (split two halves) was not performed on the pilot study because the number of values was small (seven values).

The Likert scale suggested in the feedback was discussed with the statistician. All the suggestions and viewpoints the pilot study participants were taken into consideration and changes were made accordingly. The layout of the final questionnaire was improved to increase its face validity. The numbering system was adjusted to facilitate data entry, control, peer checking and analysis.

Information about individual agreement to participate in the study and the size of study sample had to be considered before mailing the pilot questionnaire in order to increase the response rate, achieve better feedback quality, to facilitate equal and independent participation, and to counteract bias contamination (Katzenellenbogen et al., 1991: 35; Leedy, 1993: 199–200). Therefore, the researcher examined part of the study population (Cape Town Metropole) before sending out the questionnaires in order to accurately define the study sample in terms of the numbers and the addresses of the occupational therapy leaders who met the inclusion criteria and who agreed to participate in the study. The researcher used telephone, fax, and email to contact the individuals of the study sample. Thereafter each participant received one copy of the study questionnaire. In addition, the covering letter for the study clearly requested participants to complete the questionnaire independently and individually. A consent form on a separate page requesting each participant's agreement to take part in the study was attached to each study questionnaire.

3.5 DATA COLLECTION

Thirty-five copies of the study questionnaire were sent out to the 35 participants of the study sample in 13 facilities of the governmental health sector of the PAWC in July 2004. Twenty questionnaires were mailed. Each envelope included an enclosed stamped envelope to facilitate the return of the completed questionnaires. Two lecturers and a student volunteered to take 15 questionnaires to four facilities (the facilities were on their way to work and included 15 participants). After three days, the researcher contacted all the participants by telephone who confirmed that that they had received the questionnaires. During the telephone conversation, the researcher encouraged participants to carry out the process within the timeframe reserved for data collection (six weeks) and he answered any questions. These questions were relevant to the perspective from which the participants would answer the questions, that is, the occupational therapy leader's perspective.

After six weeks, that is, the timeframe for data collection (July–August 2004), the researcher received 25 completed questionnaires out of 35 (71.4%). Few closed questions (3.7%) were left unanswered while more than the half of the open-ended questions (55.3%) were left unanswered. Ten out of 20 mailed questionnaires were returned by mail. The same volunteers (two lecturers and a student) collected the other 15 completed questionnaires. Two completed questionnaires were lost in the post during the return phase and were regarded as two non-respondents. The other eight questionnaires were not completed and were regarded as non-respondents. Therefore, the total number of the non-respondents in the study was 10 out of 35 (28.6%).

One facility which received eight questionnaires did not distribute them directly. The researcher experienced difficulty in getting hold of the person in charge. Ten days after receiving the questionnaires, the person in charge asked the researcher to submit a summary of the study proposal, a copy of the study approval by the Faculty of Health Sciences, Stellenbosch University Ethical Committee, and a copy of the questionnaire to the ethical committee of the specific facility. All the required documents were submitted within three days and the facility confirmed receiving them. After two weeks, the facility's ethical committee approved the study and agreed to allow its participants to complete the questionnaires. Communication with the

contact person(s) was difficult. Every time the researcher contacted the facility, he was referred to new contact people who were assigned to follow-up, collect and return the questionnaires. After six weeks which was the assigned timeframe for data collection, the researcher completed all data collection and stopped communication with that facility without receiving any feedback or completed questionnaires.

3.6 BIAS

Six potential sources of bias in the study were indicated: bias in the pilot study, sampling bias, contamination bias, measurement bias, statistical bias and literature bias.

3.6.1 BIAS IN THE PILOT STUDY

The researcher did not have accurate information about the number of occupational therapy leaders in each facility in the Boland Overberg and he sent one copy of the pilot questionnaire to each facility. The covering letter of the pilot questionnaire did not clearly request the participants to complete the pilot questionnaire individually and independently. Therefore, one leader together with his or her colleagues who met the study inclusion criteria in one occupational therapy department completed one pilot questionnaire. This established contamination bias in the pilot study. Besides, the researcher contacted the participants in the pilot study by telephone and answered their questions which created the opportunity for unequal information to be received by the participants. The non-respondents in the pilot study were three out of ten (30%). These sources of bias in the pilot reduced the significance of feedback to the pilot questionnaire that refined and finalised the study questionnaire.

3.6.2 SAMPLING BIAS

Sackett (1979: 51–52), as well as Sitthi-amorn and Posthyachinda (1993: 286–288) regard sampling bias as incidence/prevalence (differences in exposure in terms of time: age and experience) and non-respondent bias. Individuals have different clinical, managerial and leadership experiences and skills. Both studies see the matching of individuals in terms of age and experience as a way to avoid the incidence/prevalence bias. Armstrong and Grace (2000: 15–16) and Norwood (2000: 93–94) take a different approach. They see the individuals' matching strategy as downsizing the study sample and thus diminishing the information collected. This

study found it difficult to avoid this type of bias. Relevant data, such as age, clinical, and leadership experiences are measured in terms of average, range and standard deviation (SD). It is left to future studies to search out the influence of age and experience variables on leadership functions and clinical practice.

Armstrong and Grace (2000: 15–16), as well as Norwood (2000: 93–94) found that non-respondent bias influences the significance of a study's findings, data validity and reliability, as well as the generalisation of findings to other populations. The non-respondents in the study were 10 out of 35 (28.6%). A way to decrease non-respondents, is to send out a second copy of questionnaire to the non-respondent. Due to time constraints and to maintain the anonymity of participants and their facilities, the researcher did not consider this strategy of sending out a second round of the study questionnaire to non-respondents. Moreover, the researcher is of the opinion that a second round of study questionnaire could have increased the potential for contamination bias. The researcher resorted to various ways to counteract non-respondent bias, namely, piloting the questionnaire, hand delivery(where possible), giving sufficient time to respond, avoiding holidays and facilitating the questionnaire collection process. The researcher established continuous communication with the participants in the study and answered their questions directly. Participants were motivated by the prospect of receiving a copy of the study results (Sackett, 1979: 51–52; Sitthi-amorn and Posthyachinda, 1993: 286–288).

3.6.3 CONTAMINATION BIAS

Contamination bias was decreased by facilitating and assuring individual participants to complete the questionnaire independently and individually. Each participant in the study received one copy of the questionnaire. The covering letter requested the participants to complete the study questionnaire individually and independently. Besides, the small size of the study sample (25 individuals) and the reasonable time (six weeks) within which to complete the questionnaire both contributed towards limiting contamination bias.

3.6.4 MEASUREMENT BIAS

The researcher took all possible measures to decrease measurement or recall bias. He used clear, specific and subjective questions, piloted the questionnaire and collected information about present practice and functions of occupational therapy leaders (Armstrong and Grace, 2000: 16; Norwood, 2000: 95). There is the potential of bias in terms of giving unequal information to participants during data collection. The researcher, therefore, referred participants to the covering letter and to the questionnaire per se in an attempt to provide the same information for all and to use the same wording.

3.6.5 STATISTICAL BIAS

The strategies used to counteract statistical bias were co-operation with a statistician and peer checking. A peer randomly checked approximately 50% of the data after entry on the computer.

3.6.6 LITERATURE BIAS

Although the researcher conducted an extensive literature search, drawing on 89 references, literature bias could not be excluded. The researcher reviewed the research question from different perspectives and was open to different opinions. The researcher tried to be objective in discussing and accepting or rejecting any point of view. There is the potential of publication bias, where results are less likely to be published.

In summary, one can conclude that no study can ever be entirely bias-free. The researcher took all possible measures to decrease potential bias in the study. If measured against the literature reviewed, the study questionnaire was a reliable data collection instrument and the obtained data were found to be reliable (reliability coefficient factors: Chronbach's Alfa = 0.90, Spearman-Brown = 0.67, and correlation coefficient Pearson's **r** = 0.51).

3.7 ETHICAL CONSIDERATIONS

The researcher initiated the idea of the present study on October 2003. A research plan was developed during two protocol discussions (November 2003 and March 2004) in the Occupational Therapy Department, Faculty of Health Sciences, Stellenbosch University. The study leaders, Mrs. Susan Beukes, Head of the Occupational Therapy Department and Miss René Kemp, Lecturer, accepted the research concept. The researcher, in close co-operation with the study leaders, developed the research protocol which was approved by the Occupational Therapy Department and then submitted to the Committee for Human Research, Stellenbosch University on April 2004. The study project was finally approved on 1 June 2004 (Project Number: N04/04/068).

The researcher was aware that the way of obtaining consent might create an ethical dilemma. All participants were informed about the purpose of the study through the covering letter. Participants who agreed to complete the questionnaire were requested to tick **(✓)** Yes and sign the consent form. The consent form was on a separate page that was attached to the study questionnaire. The names of participants, their identities or facilities were not identified because the signed consent forms were returned separately to the completed questionnaire. The consent forms with the signatures are kept in a secure place in the Occupational Therapy Department, Stellenbosch University.

One respondent ticked **(✓)** Yes on the consent form and completed the questionnaire. However, but he or she did not sign the consent form. The inclusion of that questionnaire in the data was discussed with the statistician, the study leaders, and the researcher and they recommended including it.

Freedom of participation was assured. Individuals were free to participate, refuse or withdraw from the study. Anonymity of participants and the validity of information given were also assured. The study did not establish any direct or indirect risk to the participants.

3.8 SUMMARY

The researcher used a descriptive analytical design to investigate occupational therapy leadership functions in clinical settings. The researcher compiled the study questionnaire after reviewing the relevant literature. The questionnaire was piloted with a sample of 10 occupational therapy leaders and the feedback was used to finalise the study questionnaire. The study questionnaire comprised 97 questions which collected biographic data, information relevant to managerial functions, clinical practice, empowerment and leadership training. It is believed that the questionnaire used for data collection is reliable as indicated by Cronbach's Alfa of 0.9.

The researcher used a convenience sample of 35 occupational therapy leaders employed in the governmental health sector of the Provincial Government of the Western Cape. During the study, the researcher took the all possible measures to increase the response rate, to counteract bias, to assure the validity and reliability of the study questionnaire and to collect reliable data. Freedom of participation, anonymity of participants and confidentiality of information were assured. Each respondent who agreed to complete and return the study questionnaire was requested to sign an anonymous consent form.

The researcher received 25 completed study questionnaires out of 35, a response rate of 71.4%. All the received questionnaires were used to perform a data analysis (**N**=25). Descriptive statistics were used in statistical analysis. These results are described in Chapter 4. Tables, a bar graph and a circle graph were used to present the data collected.

CHAPTER 4

RESULTS

4.1 INTRODUCTION

This study uses an analytical descriptive design, a non-standardised questionnaire and a convenience sample of 35 occupational therapy leaders for data collection. All possible measures were taken to assure the validity of the study questionnaire and to increase the reliability of the data collected. Twenty-five completed study questionnaires out of 35 were received. These were used for the data analysis (N = 25).

Descriptive statistics and Cronbach's Alfa were used to answer the research questions. The results are summarised in tables, a bar graph and a circle graph. Fifty-seven leadership functions were identified by the respondent leaders in the study: 44 managerial, 10 ethics-related, one education, one research and one consultation.

The study results reveal different levels of performance in the occupational therapy leadership functions under study. The respondents preferred the clinical practice functions to managerial ones. A large majority of the respondents (≥ 87%) performed clinical practice functions. A lesser majority of respondents (≥ 66.7%) performed managerial functions. The work environment provided respondent leaders with empowerment, support and motivation.

4.2 STATISTICAL ANALYSIS

A statistician (Dr Martin Kidd of the Department of Biostatistics at the Faculty of Health Science, Stellenbosch University) created a Microsoft ® Excel 2000 information sheet which was used to enter the data collected. The completed study questionnaires were given code numbers (01 to 25). Then the data were entered and later peer checked. She randomly checked about 50% of the data entered. After completion of the data entry, the file with the data was emailed to the statistician who performed the statistical analysis in co-operation with the researcher. The researcher and the statistician decided to present the data and results using the Statistical Package for the Social Sciences (SPSS 10.0) since the researcher was familiar with

it. Various methods were used to present and summarise the data, namely, tables, a bar graph and a circle graph.

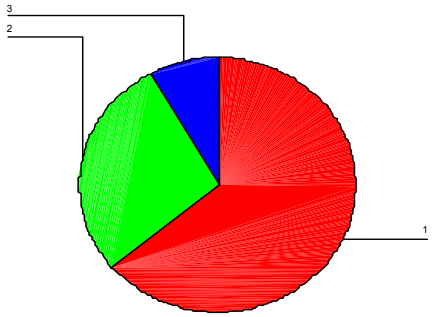
The researcher used descriptive statistics (means, ranges, standard deviation (SD) and frequencies), Cronbach's Alfa, as well as the split-half reliability test to perform a statistical analysis and to answer the research questions. Descriptive statistics are used to describe the sample under study. They illustrate characteristics and quality of data. The mean (**M**) is the most used measure in descriptive statistics. The mean is a particularly informative measure of the central tendency of the variable if it is reported along with its confidence intervals. The width of the confidence interval depends on the sample size and on the variation of data values. The larger the sample size, the more reliable its mean. The larger the variation, the less reliable the mean. The range is found by taking the highest and lowest values in a set of data. Standard deviation (SD) is useful to assess how variable a sample is. Descriptive statistic measures can be calculated using the Excel ® or the SPSS software (Argyrous, 2000: 86−90; Polgar and Thomas, 2000: 279−282). The statistical analysis was performed taking the sample size as 35, the respondents or obtained values number **N** as 25 and the non-respondents as 10.

Questions 3 and 93−97 were open-ended. They collected information about leadership training and performed leadership functions that were not mentioned in the study questionnaire, as well as desired and not desired leadership functions. The researcher grouped the answers and presented the results in the tables presented in this chapter.

4.3 ANALYSIS OF RESULTS

The study explores, by way of six questions, the functions of occupational therapy leaders in clinical settings, the performance level of these functions, the influence of these functions on clinical practice, occupational therapy leadership training, ways of reaching leadership positions by occupational therapists, as well as empowering and disempowering factors for occupational therapy leaders.

4.3.1 BIOGRAPHICAL DATA



1.Chief occupational therapist: 16 leaders (64%);
2.Senior occupational therapist: 7 leaders (28%);
3.Assistant director occupational therapist: 2 leaders (8%)

Figure 2 Sample distribution according to post title (N=25)

Twenty-five occupational therapy leaders out of 35 completed the study questionnaire and returned it to the researcher. Thus, the response rate was 71.4%. The respondents were 24 women (96%) and one man (4%). The majority of respondents (64%) were chief occupational therapists while a minority (8%) were assistant director occupational therapists. The rest (28%) were senior occupational therapists (see Figure 2).

The response rate to the study was high (71.4%). This is a significant indicator for two reasons.

1. The occupational therapy leaders realise the importance of participation in research.
2. The researcher could have had a representative sample if a vigorous sampling strategy had been implemented, for example, stratified or random sampling from all occupational therapy leaders in the Provincial Administration of the Western Cape (PAWC).

As an international masters student the researcher was not familiar with the population of occupational therapy leaders in South Africa. Since the study was sponsored exclusively by the researcher, it was decided to limited the selection of the study sample to the Cape Town Metropole to save on time, costs and for convenience. This had the advantage of saving time and money and using available resources. A disadvantage was the non-representative study sample.

The number of occupational therapy leaders in each occupational therapy department ranged from one to eight leaders and the average was three leaders per department. The result is in agreement with the study by Heinemann and Zeiss (2002: 8−13) that indicates that a team might have more than one leader. The number of subordinates reporting to each leader ranged from one to 24 with an average of six subordinates.

Table 3 Age distribution of participants in years (N=25)

Age in years	Number of participants *	Percentage
25−35	16	66.7%
36−45	3	12.5%
46−55	4	16.7%
58	1	4.1%

* Twenty-four values were included and one incomplete value was excluded

The mean age of the respondents was 35.7 (SD = 8.9) years. The respondents' ages ranged from 25 to 58 years. The majority of respondents (66.7%) were 25 to 35 years old. A minority of respondents (29.2%) were 36 to 55 years old. One respondent (4.1%) was 58 years old. There was one incomplete value that was excluded (see Table 3).

Table 4 Experience of participants in years (N=25)

Total experience			Experience in leadership		
Years	**Response**	**Percentage**	**Years**	**Response***	**Percentage**
3−6	5	20%	1−3	2	9.5%
7−10	9	36%	4−6	12	57.1%
11−14	4	16%	7−9	4	19.1%
15−18	2	8%	10−12	0	0%
19−22	1	4%	13−15	1	4.8%
23−26	2	8%	16−18	0	0%
27−29	2	8%	19−21	0	0%
			22−24	2	9.5%

* Twenty-one values were included and four incomplete values were excluded.

The mean experience of the respondents in the study was 12.2 (SD = 7.2) years. The total experience of the respondents (clinical, managerial and leadership experience) ranged from 3 to 29 years. The majority of respondents (56%) had a total experience (clinical, managerial, and leadership experience) which ranged from three to ten years while one respondent (4%) had total experience of 19 years (see Table 4).

The mean experience in leadership was 6.8 (SD = 6.3) years. The respondents' experience in leadership ranged from one to 24 years. The majority of respondents (76.2%) had experience in leadership which ranged from four to nine years. The respondents had minimum clinical experience of three years before reaching a leadership position. There were four incomplete values which were excluded (see Table 4). The researcher regards three years as an adequate period for an occupational therapist to can gain and develop the knowledge, skills and attitudes required to lead and supervise a team of occupational therapists.

Table 5 Leadership training (N=25)

Training	Response (%)
1. Leaders who received training relevant to leadership	18 (72%)
2. Range of training periods	2−14 days
3. Leaders who received in-service training (by employing facility) relevant to leadership	11 (44%)
4. Leaders who received undergraduate training relevant to leadership	2 (8%)
5. Leaders who received postgraduate training relevant to leadership	4 (16%)
6. Leaders who received community training relevant to leadership	1 (4%)

Question 3 in the study questionnaire was open-ended. It collected information relevant to leadership training. Most of the respondents (72%) received some leadership training ranging from two to 14 days. The rest of respondents (28%) reported that they did not receive any leadership training. Leadership training was conducted during undergraduate study (8%), postgraduate study (16%) and by the employing facility (44%). One respondent (4%) reported having received community training in leadership through the church (see Table 5). The participants in the study pointed out that undergraduate training in leadership focused on management. Postgraduate training in leadership focused on hospital leadership, emerging leadership, management, supervision, health management, human resource management and development. In-service leadership training focused on supervision, diversity management, interviewing skills, leadership development, job training and human resource management. Four respondents (16%) noted that they had attended PAWC courses where the focused was on supervision, diversity management, human resource management, finance management and women in management. Study participants may have had leadership training in more than one area.

Leaders in the study had undergone a four-year undergraduate training and had a minimum of three years' clinical experience before reaching the leadership position. Their leadership training ranged from two to 14 days. The employing facilities seem

to value the importance of leadership training more than the educational facilities as they provided the majority of leadership training for participants in the study.

Occupational therapy leaders in the study had limited exposure to leadership training. Yet, it would seem that to varying degrees occupational therapy leadership training is essential to both leaders and to followers or subordinates for collaboration purposes and to achieve therapeutic, professional and organisational goals. The result (8% of the participants in the study received undergraduate leadership training) indicates that newly graduated occupational therapists face challenges in dealing with leadership and management issues when they start their occupational therapy career. Occupational therapy leaders, therefore, need access to more structured leadership training. Employing facilities and educational institutions have to address the issue of leadership training more effectively, including the undergraduate and postgraduate programmes offered to current and emerging leaders.

Table 6 Ways of achieving leadership positions by participants (N=25)

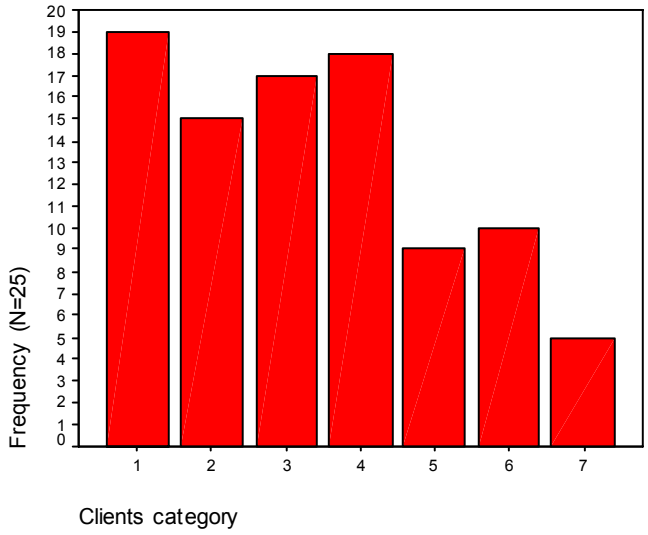
Way of achieving leadership position	Number of OT leaders (%)
1. By appointment	13 (52%)
2. Seniority	10 (40%)
3. Experience	8 (32%)
4. Qualifications	6 (24%)
5. Departmental selection	2 (8%)
6. By virtue of discipline	1 (4%)

The majority of respondents reached leadership positions by appointment (52%) and/or seniority (40%). The department selection (8%) had minimal significance in achieving leadership positions. Although qualifications (24%) and experience (32%) are important, they are not determinants for leadership positions. Eight participants (32%) reported more than one way of achieving leadership positions (see Table 6). This result does not concur with the study by Heinemann and Zeiss (2002: 8−13) who found that effective leadership takes into account qualifications, seniority and experience.

The results indicate that the criteria for achieving a leadership position could be disappointing and discourage some or many occupational therapists who are willing to develop themselves and fulfil occupational therapy leadership positions. On the other hand, 24 respondents (96%) pointed out that they provided opportunities for staff to reach/fulfil leadership positions. One respondent (4%) reported that he/she did not perform this function. The participants in the study recognize the importance of providing opportunities for growth and development whereby occupational therapists achieve leadership positions. This is a motivating result and it contributes towards counteracting the weakness in the criteria for achieving leadership positions as perceived by the study participants.

Although the respondent leaders had experience ranging from three to 29 years, their experience was not a determinant in reaching leadership positions. The results of this study seem to indicate that this has to do with low motivations to fulfil leadership positions, very limited leadership training and the existing organisational structures. Effective leadership, organisational structure, qualifications, experience, seniority and department selection must be considered equally to reach/fulfil a leadership position (Heinemann and Zeiss, 2002: 8−13).

It would seem that organisational structure must evoke understanding, co-operation, and support from all management levels – top, middle and line management − as well as stakeholders. Knowledge and skills are essential for an appropriate performance of leadership functions. These are gained by training and they are developed by experience. Seniority has a positive influence on team members and department selection assures cohesion of team and the co-operation of team members. The result is the appointment of acceptable occupational therapists to leadership positions and successful implementation of occupational therapy leadership functions.



1. Physical disability, 2. Cognitive disability, 3. Psychosocial dysfunction, 4. Mental illness, 5. Developmental or learning disorders, 6. Maladaptive behaviour, 7. Other disorders or conditions

Figure 3 Targeted clients' main diagnostic categories of work (N=25)

All the respondents were employed by the governmental health sector PAWC. Twenty-four respondents (96%) were employed full-time while one respondent (4%) was employed part-time.

The targeted clients' main diagnostic categories of work were physical disability (76%), mental illness (72%), psychosocial dysfunction (68%) and cognitive disability (60%). The participants in the study may have worked more than one area and they covered a wide spectrum of clinical diagnosis that occupational therapists see in different health facilities (see Figure 3).

It is important to cover a wide spectrum of the diagnoses that occupational therapy entails, including the different experiences and backgrounds of the study participants. This would increase the significance the information collected. Sharing their rich experiences and knowledge in a scientific framework with other colleagues is valuable and essential for occupational therapy education. It is a step forward towards achieving a collective understanding of new trends and towards exploring unknown facets of occupational therapy.

4.3.2 INVOLVEMENT IN AND FULFILMENT OF LEADERSHIP FUNCTIONS

The respondent leaders identified 57 leadership functions. Effective implementation of occupational therapy leadership functions assumes that occupational therapy leaders will perform on a more optimum level regarding managerial, ethics related, education and clinical practice functions.

4.3.2.1 Planning functions

Good performance in planning enables occupational therapy leaders to identify and meet future service and facility needs and to reduce uncertainty in the occupational therapy department/facility (Maslin, 1991: 95−110; Steven, 1999: 66−67; Wendt and Vale, 1999: 169−170).

Table 7 Leadership functions attributed to planning
(Likert scale 1−4: 1 and 2 = agree; 3 and 4 = disagree) (N=25)

Planning functions	Function fulfilment			
	Agree (%)	Disagree (%)	M	SD
1. Participates in reducing uncertainty as much as possible by anticipating and predicting future developments which will affect the operations of workplace	22 (88%)	3 (12%)	1.5	0.82
2. Identifies needs or problems in occupational therapy service area	24 (96%)	1 (4%)	1.3	0.56
3. Gathers data related to meeting needs in occupational therapy service area (*)	22 (91.6%)	2 (8.4%)	1.5	0.77
4. Establishes goals and objectives related to needs in occupational therapy service area	23 (92%)	2 (8%)	1.3	0.70
5. Identifies possible courses of action and decides on the most appropriate strategy	23 (92%)	2 (8%)	1.4	0.65
6. Indicates methods of evaluating the success of the planning in occupational therapy area (*)	22 (91.6%)	2 (8.4%)	1.7	0.75

* One incomplete value which was excluded, **n** = 24 occupational therapy leaders

The majority of respondents (88−96%) performed planning functions: collecting information about problems and needs in the occupational therapy service area, identifying possible intervention and indicating the optimum implementation and evaluation methods. A minority of the respondents (4−12%) did not perform planning

functions. The mean performance in planning functions ranged from 1.3 to 1.7. There was one incomplete value in two questions which was excluded in each of them (see Table 7).

The participants in the study carried out a wide range of planning functions. They are aware of the importance of implementing planning in occupational therapy to reduce uncertainty, increase organisational structural stability, appropriately allocate resources and achieve positive change for the organisation and personnel. The research results indicate that appropriate resource allocation and management is a vital issue for effective occupational therapy leadership. Moreover, it could offer significant input that could contribute towards high performance in many occupational therapy leadership functions such as directing, controlling and research functions.

The planning functions of occupational therapy leaders revolved around direct occupational therapy service (100%), personnel (84%), education and training (76%), quality control (60%) and resources (60%). While planning for other areas are important, the respondent leaders perceived that they had less to do with these: socio-cultural environment (32%), budgeting (32%), research (24%) and information technology (20%). Participants in the study may have had more than one planning area (see Table 8).

Table 8 Planning functions focus issues (N=25)

Planning functions focus issues	Frequency (%)
1. Direct occupational therapy service	25 (100%)
2. Personnel	21 (84%)
3. Education and training	19 (76%)
4. Quality control	15 (60%)
5. Resources	15 (60%)
6. Time issues	12 (48%)
7. Occupational therapy physical facility	9 (36%)
8. Budget	8 (32%)
9. Socio-cultural environment	8 (32%)

The study participants saw the importance of planning for direct occupational therapy services, education and training, personnel, quality control and resources. The study findings showed that occupational therapy leaders perceive that they have low performance in the planning for research, budget, occupational therapy physical facility, information technology, socio-cultural environment and time issues. Marquis and Huston (2000: 1−20), as well as Leach (2003: 167) stress the importance of the socio-cultural environment in creating an appropriate context that fosters successful participatory occupational therapy leadership. Low performance in the area of socio-cultural environment (32%) might contribute towards poor handling of conflict due to cultural diversity, inferior general performance and low participation in leadership functions. Recommendations regarding this will be discussed in Chapter 5.

About half of the respondent leaders (48%) were involved with planning for time issues. The study results agree with Maslin's work (1991: 22) where it was found that time management is a problem area for occupational therapists. The results indicate that Maslin (1991: 22) rightly found the need for time management to be directed so as to provide occupational therapy services and to develop self, other colleagues, the occupational therapy profession and the facility.

Many facilities manage the budget at the level of finance management within the administration section/department. Therefore, occupational therapy leaders are less involved in budgeting. Budget is an important resource for managing work issues and occupational therapy service delivery. The results support other research indicating that occupational therapy leaders must manage resources in the best interests of clients, staff, the facility and the nation (Reed and Sanderson, 1980: 75−78; Maslin, 1991: 73−93; Wendt and Vale, 1999: 169−170). Low interest in planning for time and budget could have negative consequences for the occupational therapy profession and facilities with adverse implications, such as poor resource management, increased costs, a decrease in production and malpractice (Maslin, 1991: 95−115).

For more effective planning, that predicts future developments and reduces uncertainty in the occupational therapy department, occupational therapy leaders need to take an active interest in planning for research, information technology, the socio-cultural environment and resource management. Planning for these areas should identify problems and needs, establish goals and objectives and identify appropriate strategies to diminish uncertainty in occupational therapy department

(Maslin, 1991: 95−110). The relevant recommendations will be discussed in Chapter 5.

4.3.2.2 Managing functions

Table 9 Leadership functions attributed to managing (Likert scale 1−4: 1 and 2 = agree; 3 and 4 = disagree) (N=25)

Managing functions	Function fulfilment			
	Agree (%)	Disagree (%)	M	SD
1. Participates in and ensures effective and proper handling of possible disagreement or conflicts relevant to occupational therapy service	21 (84%)	4 (16%)	1.6	0.87
2. Manages risks and liabilities by analysing problems and minimising losses in client care (*)	20 (83.3%)	4 (16.7%)	1.8	0.70
3. Manages budgets allocated to the department (*)	17 (81%)	4 (19%)	1.8	0.87
4. Participates in and ensures proper daily clients' rounds take place (*)	18 (90%)	2 (10%)	1.7	0.66
5. Ensures that working hours in occupational therapy department are properly justified and effectively used	23 (92%)	2 (8%)	1.5	0.77
6. Decides to call in extra help when needed in occupational therapy department (*)	14 (63.6%)	8 (36.4%)	2.1	0.95
7. Attends and participates in management meetings (*)	21 (91.3%)	2 (8.7%)	1.5	0.67
8. Conducts meetings with own staff to ensure smooth and effective workflow	24 (96%)	1 (4%)	1.2	0.52
9. Participates in quality assurance, designing studies, collecting data and preparing reports (*)	23 (95.8%)	1 (4.2%)	1.5	0.59
10. Ensures effective use of energy and maximum participation of all occupational therapy staff	22 (88%)	3 (12%)	1.7	0.98

* Incomplete values which were excluded, **n** < 25 occupational therapy leaders

The majority of participants (81−96%) in the study were involved in a wide spectrum of managing functions: staff meetings, quality assurance, time and energy managing, daily rounds of clients, budgeting, conflict management and risk management. The mean performance in managing functions ranged from 1.2 to 1.8. About two thirds of the respondent leaders (63.6%) performed workload management functions and the

mean performance was 2.1. There were one to five incomplete values in six questions which were excluded (see Table 9).

The participants in the study perceive the significance of implementing and having high performance in managing functions. These results are consistent with Maslin (1991: 73−93, 142−210), Bleich (1999: 9−12), as well as Valadez and Otto (1999: 29−31) who found that the occupational therapy leaders' performance in managing functions reduced problems in the work environment, enhanced effective resource management, ensured smooth and effective workflow and improved service quality. On the other hand, eight respondents (36.4%) did not perform workload management functions (see Table 9). Maslin (1991: 73−93, 142−210) states that low performance in workload functions may have a negative impact on service flow, time management and the occupational therapy care quality. Recommendations will be discussed in Chapter 5.

4.3.2.3 Organising functions

Table 10 Leadership functions attributed to organising

(Likert scale 1−4: 1 and 2 = agree; 3 and 4 = disagree) (N=25)

Organising functions	Function fulfilment			
	Agree (%)	Disagree (%)	M	SD
1. Uses his/her authority to set rules and protocols that facilitate and ensure appropriate flow of comprehensive occupational therapy service in terms of quality, time and effectiveness	19 (76%)	6 (24%)	2.0	1.0
2. Collaborates with other services to the good of clients and organisation	23 (92%)	2 (8%)	1.4	0.65
3. Shares responsibility with others when work/business is at risk	22 (88%)	3 (12%)	1.6	0.92
4. Ensures that resources are spent to reach agreed targets (*)	22 (91.6%)	2 (8.4%)	1.7	0.76
5. Attends and participates in relevant committees'/teams' meetings in organisation	23 (92%)	2 (8%)	1.5	0.77
6. Creates healthy work atmosphere in terms of respect, concern and team spirit	23 (92%)	2 (8%)	1.4	0.64
7. Orientates staff to agreed goals and objectives	24 (96%)	1 (4%)	1.3	0.56
8. Promotes occupational therapy staff to acquire further knowledge and skills	22 (88%)	3 (12%)	1.4	0.71

* One incomplete value which was excluded, **n** = 24 occupational therapy leaders

According to Maslin (1991: 73−93, 113−128), organising and managing are both components of management. Organising includes setting rules and protocols, collaboration with other health professionals, creating a healthy work atmosphere, staff orientation, resources allocation to reach organisational goals and staff promotion to acquire further knowledge and skills. Managing includes issues, such as care, information, resolving conflict, time management, budget, risk, resources and diversity.

The majority of respondents (76−96%) performed organising functions: staff orientation and promotion, collaboration with other services, sharing responsibility, facilitating appropriate flow of occupational therapy service and participation in team meetings. Four to twenty-four percent of the respondents did not perform any organising functions. The mean performance in organising functions ranged from 1.3 to 2.0. There was one incomplete value in one question which was excluded (see table 10).

The participants in the study value the importance of implementing organising functions in the area of occupational therapy leadership. These results are in agreement with Maslin (1991: 113−128) who found that occupational therapy leaders' performance in organising functions motivated staff, increased team effectiveness, increased co-operation with other services, ensured comprehensive occupational therapy service delivery, achieved organisational goals and increased customer satisfaction. These results also agree with the findings of Baptiste (2000: 81−85) where occupational therapy leadership has assured the co-ordination function, a key element for professional development. Recommendations are discussed in Chapter 5.

Twenty-four percent of the participants have different views regarding what they perceive to be low performance for using authority to set rules and protocols that facilitate and ensure the appropriate flow of comprehensive occupational therapy service in terms of quality, time and effectiveness. This view of a low use of authority can be attributed to the limiting organisational structure, unco-operative and unsupportive management and unmotivated occupational therapy leaders. Recommendations will be discussed in Chapter 5.

4.3.2.4 Personnel management functions

Table 11 Leadership functions attributed to personnel management (Likert scale 1−4: 1 and 2 = agree; 3 and 4 = disagree) (N=25)

Personnel management functions	Function fulfilment			
	Agree (%)	Disagree (%)	M	SD
1. Participates in building and development of the team	23 (92%)	2 (8%)	1.4	0.65
2. Identifies department's needs for staff	21 (84%)	4 (16%)	1.6	0.87
3. Gives guidance to facilitate appropriate recruitment (for example, preparing of announcement) (*)	16 (76.2%)	5 (23.8%)	1.8	1.0
4. Participates in the process of personnel selection (*)	16 (76.2%)	5 (23.8%)	1.7	1.2
5. Identifies and plans for training needs of new personnel (*)	17 (81%)	4 (19%)	1.7	1.0
6. Ensures appropriate and effective placement of new personnel (*)	15 (79%)	4 (21%)	1.7	1.1
7. Participates in setting job description (*)	19 (82.6%)	4 (17.4%)	1.6	0.99
8. Participates in implementing effective measurements to reduce staff turnover (*)	15 (71.4%)	6 (28.6%)	2.0	1.1

* Incomplete values which were excluded, **n** < 25 occupational therapy leaders

The majority of respondents (71.6−92%) performed personnel management functions: identifying staff needs, team building and developing, recruitment, selection, training and induction of new personnel. Fewer respondents (71.4%) implemented effective measurements to motivate staff and reduce staff turnover. Thus, talented people may have resigned. It is important to note that talented people are an important human capital component and a real asset to any facility. Failure to retain talented people can have negative consequences for the facility and the occupational therapy profession. For the facility, this could mean inferior performance, poor service quality and financial loss. It could also mean low customer and clientèle satisfaction. For the occupational therapy profession it could mean losing trust with customers and clientèle and suffering the prevention of service

delivery in aspects of both direct and indirect occupational therapy services, for example, research and evidence-based practice. The low performance in the staff turnover management function might indirectly contribute to low performance in other occupational therapy leadership functions, such as consultation, research, time management and budget management. Eight to 28.6% of the respondents reported that they did not perform personnel management functions. The mean performance in personnel management functions ranged from 1.4 to 2.0. There were two to six incomplete values in six questions which were excluded (see Table 11).

Occupational therapy departments may have less experienced staff members due to inappropriate staff recruitment, selection and lack of inservice training opportunities. The results of this study indicate that it is imperative for service delivery to get rid of incompetent people and to replace them with competent or talented people. In order to achieve that, contracts, remuneration, promotions, incentives and annual appraisals must be effective and based on individual performance. In this way, competent and talented people are recruited, selected and inducted at work while incompetent individuals leave the workplace. Therefore, occupational therapy leaders must effectively participate in the staff turnover management function.

More than eighty percent (80.3%) of the respondents perceive that they achieve high performance in the personnel management functions versus 19.7% who responded that they have low performance levels in the same functions. The implementation of occupational therapy leaders personnel management functions can build and develop effective and motivated health care teams, maintain competitive levels of service delivery and provide opportunities for growth and leadership. These results are consistent with other research findings that indicate that effective personnel management is a key issue for team building, development and promoting competitive occupational therapy service delivery (Reed and Sanderson, 1980:76−77; Maslin, 1991: 91−210; Statt, 1994: 276−277; Hagedorn, 1995: 163−274; Lowenstein, 1998: 101−120; Bleich, 1999: 12−15; Otto and Valadez, 1999: 123−136; Kowalski, 1999: 279−299; Rooch, 1999: 265−278).

4.3.2.5 Directing functions

Table 12 Leadership functions attributed to directing (Likert scale 1−4: 1 and 2 = agree; 3 and 4 = disagree) (N=25)

Directing functions	Function fulfilment			
	Agree (%)	Disagree (%)	M	SD
8. Allows for professional differences (*)	23 (95.8%)	1 (4.2%)	1.4	0.71
9. Provides proper and effective handling of clients' compliance (*)	21 (91.3%)	2 (8.7%)	1.5	0.67
10. Accepts accountability for decisions	24 (96%)	1 (4%)	1.3	0.54
11. Uses two way communication (*)	23 (95.8%)	1 (4.2%)	1.2	0.51
12. Delegates tasks to others when necessary to facilitate occupational therapy service delivery	24 (96%)	1 (4%)	1.3	0.56
13. Motivates and enables occupational therapy staff to perform tasks according to intervention goals	23 (92%)	2 (8%)	1.5	0.77
14. Establishes and sustains trust and commitment	24 (96%)	1 (4%)	1.4	0.58
15. Ensures regular staff appraisals take place	23 (92%)	2 (8%)	1.5	0.77

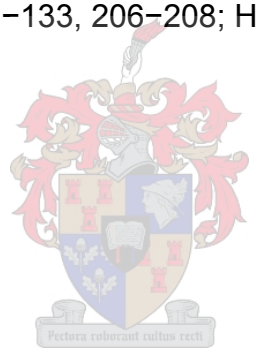
* Incomplete values which were excluded, **n** < 25 occupational therapy leaders

The majority of respondents (91.3−96%) implemented directing functions, such as motivation, enabling others, staff appraisals, compliance handling, building trust and commitment assurance and delegation. Twenty-four respondents (96%) noted that they accept accountability for the decisions that they make. There were one or two incomplete values in three questions which were excluded (see Table 12).

The results are consistent with other research findings where leadership is seen as behaviour that demonstrates accountability (Fawcett and Strickland, 1998:737−243; Kowalski, 1999: 279−299; Welch, 1999: 96−105). Accountability is a concept familiar to occupational therapy leaders since it is necessary to protect the public (Baptist, 2000: 81−85). Twenty-three respondents (95.8%) said that they use two-way communication. These results are consistent with the findings of Kowalski (1999: 279−299) and Welch (1999: 96−105) who report out that leadership embraces effective communication. One or two respondents (4−8.4%) reported that they did not implement directing functions. The mean performance in directing functions ranged from 1.2 to 1.5. More than 94.4% of the respondents replied that the have high performance levels in directing functions versus 5.6% who indicated that they have low performance levels in the same functions. These results are consistent with the findings of Maslin (1991: 131−140) and Rooch (1999: 265−278) who found that the

directing performance of occupational therapy leaders creates a healthy work atmosphere, motivates staff, increases employee participation and satisfaction, contributes towards effective resource management, enhances occupational therapy service delivery, and achieves organisational goals.

High performance in directing functions makes a valuable contribution and has a positive influence on facilities and the occupational therapy profession. It enables every team member in a facility to fulfill functions according to agreed organisational goals and to perform at to the best of his or her ability in an empowered and self-determined manner. This important contribution of directing functions creates positive work circumstances where people feel that the job provides them with reward, challenge, opportunities for creativity, innovation, growth and leadership. These factors contribute towards more competent personnel in the facility, effective occupational therapy leadership and high quality occupational therapy service delivery (Maslin, 1991: 116, 132−133, 206−208; Hagedorn, 1995: 163−166, 274; Yoder-Wise, 1999: 300−317).



4.3.2.6 Controlling functions

Table 13 Leadership functions attributed to controlling (Likert scale 1−4: 1 and 2 = agree; 3 and 4 = disagree) (N=25)

Controlling functions	Function fulfilment			
	Agree (%)	Disagree (%)	M	SD
1. Participates in and ensures that measuring of occupational therapy outcomes take place regularly (*)	18 (75%)	6 (25%)	2.0	0.96
2. Monitors quality of occupational therapy service delivered	22 (88%)	3 (12%)	1.7	0.80
3. Participates in benchmarking of current occupational therapy service against the standards in South Africa (*)	15 (71.4%)	6 (28.6%)	2.1	0.97
4. Ensure effective documentation – clear, brief and effective	24 (96%)	1 (4%)	1.5	0.71

* Incomplete values which were excluded, **n** < 25 occupational therapy leaders

The majority of the respondents (88−96%) indicated that they performed quality control and documentation functions. A smaller majority (71.4−75%) measured occupational therapy service outcomes and benchmarked service against standards which may have hindered or delayed research and occupational therapy based evidence practice. One to six respondents (4−28.6%) reported that they did not conduct controlling functions. The mean performance in controlling functions ranged from 1.5 to 2.1. The low performance in controlling functions could have negative consequences, such as a low quality of occupational therapy services and a low ranking of the occupational therapy profession amongst other health care professionals. There was one incomplete value in Question 1 and four incomplete values in Question 3 which were excluded (see Table 13). More than 82.6% of the respondents indicated that they have a high performance level in the controlling function versus 17.4% who indicated that they have a low performance level, for example, measuring and benchmarking occupational therapy services. It is important to note that high performance in controlling functions develops professional skills, provides research data and develops occupational therapy evidence- based practice (Maslin, 1991: 168−181). Quality assurance includes professional development, motivation and reaching leadership positions (Gray, 1999: 411). Therefore, quality

assurance offers an indirect improvement in occupational therapy leadership functions.

Controlling functions establish a feedback system about the quality of occupational therapy service delivery by way of continuous measuring, monitoring and benchmarking. Some controlling functions are perceived as bureaucratic, autocratic and limiting. Consequently, occupational therapy leaders may have low performance in these functions (Maslin, 1991: 168−169). The low contribution of occupational therapy leaders in measuring, monitoring and benchmarking occupational therapy services might contribute to a low participation of occupational therapy leaders in research and other leadership functions. Maslin (1991: 184) rightly points out that controlling functions must allow for an easy flow of work processes and service delivery by avoiding bureaucratic and/or autocratic behaviour and enhancing co-operation at all organisational levels.

4.3.2.7 Ethics related functions

Table 14 Leadership functions attributed to occupational therapy ethics (Likert scale 1−4: 1 and 2 = agree; 3 and 4 = disagree) (N=25)

Ethics-related functions	Function fulfilment			
	Agree (%)	Disagree (%)	M	SD
1. Assists staff to identify ethical dilemmas	23 (92%)	2 (8%)	1.5	0.65
2. Provides guidance with decision making regarding ethical dilemmas	22 (88%)	3 (12%)	1.6	0.81
3. Monitors the execution of ethical principles by clinicians (*)	20 (83.3%)	4 (16.7%)	1.8	0.85
4. Reports unethical behaviour to authorities (*)	17 (81%)	4 (19%)	1.7	0.91
5. Provides in-service training regarding ethics (*)	15 (68.2%)	7 (31.8%)	2.0	0.82
6. Provides continuing professional development opportunities pertaining to ethics (*)	16 (72.2%)	6 (27.8%)	2.1	0.92
7. Participates in setting the rules and regulations of occupational therapy practice in accordance with the Code of Ethics (*)	16 (72.2%)	6 (27.8%)	1.8	1.1
8. Ensures that interventions take place within structures of the occupational therapy profession (*)	20 (83.3%)	4 (16.7%)	1.8	0.74
9. Ensures confidentiality of clients (*)	24 (100%)	0 (0%)	1.3	0.46
10. Provides foundations for autonomous occupational therapy practitioners (*)	16 (80%)	4 (20%)	1.7	0.93

* Incomplete values which were excluded, **n** < 25 occupational therapy leaders

The majority of respondents (68.2−100%) performed ethics-related functions. Twenty to twenty-three respondents (83.3−92%) performed staff awareness functions and monitoring relevant to ethical dilemmas. They monitored the practice of ethical principles by occupational therapists. Fifteen to seventeen respondents (68.2−81%) reported unethical behaviour, provided training relevant to ethics and participated in setting rules and regulations for occupational therapy practice in accordance with the Code of Ethics. There were one to five incomplete values in eight questions which were excluded (see Table 14). These results are inconsistent with the findings of Sliwa, McPeak, Gittler, Bodenheimer, King, Bowen and AAP Medical Education

Committee (2002: 708−217) who highlight the importance of referring unethical behaviour to the responsible authority. Twenty-four respondents (100%) reported that they assured client confidentiality. Two to seven respondents (8–31.8%) reported that they did not conduct ethics-related functions (except for function No 9 – Ensures confidentiality of clients). The mean performance in ethics-related functions ranged from 1.3 to 2.1.

Eighty two percent of the respondents indicated high performance in ethics-related functions versus twenty percent who indicated low performance in the same functions, for example, providing in-service training and continuing professional development opportunities regarding ethics and participating in setting the rules and regulations of occupational therapy practice in accordance with the Code of Ethics. Low performance in ethics-related functions could have severely negative consequences for patients, facilities and the occupational therapy profession. Unmanageable and unethical behaviour could result. The occupational therapy interventions might not adhere to occupational therapy professional ethics and client confidentiality may not be maintained.

Sliwa et al. (2002: 708−217) rightly maintain that high performance in ethics-related functions guide occupational therapists towards providing health care in accordance with the Code of Ethics and increases customer satisfaction. It is also important to note that all occupational therapy personnel, including occupational therapy leaders, must adhere to strict ethical behaviour and the standards of the occupational therapy profession (American Occupational Therapy Association, 2000a: 617−621). Occupational therapy leaders are responsible for implementing ethics-related functions and for taking the necessary corrective action where the Code of Ethics is violated, for example, reporting unethical behaviour to responsible authorities. Therefore, the use of authority and the implementation of ethics-related functions by occupational therapy leaders is strongly advocated, since these are essential for implementing ethics-related functions and taking corrective action to prevent malpractice or corruption.

4.3.2.8 Education, research and consultation functions

Table 15 Leadership functions: education, research and consultation (Likert scale 1−4: 1 and 2 = agree; 3 and 4 = disagree) (N=25)

Education, research and consultation functions	Function fulfilment			
	Agree (%)	Disagree (%)	M	SD
1. Provides internal occupational therapy consultation to his/her organisation (*)	18 (78.3%)	5 (21.7%)	1.6	0.84
2. Participates in research (*)	16 (66.7%)	8 (33.3%)	2.1	0.95
3. Participates in continuing education programmes	24 (96%)	1 (4%)	1.5	0.59

* Incomplete values which were excluded, **n** < 25 occupational therapy leaders

Eighteen respondents (78.3%) indicated that they provided consultation functions while five respondents (21.7%) reported that they did not do so. The mean performance in consultation was calculated at 1.6. There were two incomplete values in Question 1 which were excluded (see Table 15). These results concur with other findings that show the demand for occupational therapy consultation can be increased through service marketing (Reed and Sanderson, 1980: 77; Jaffe, 1992: 15−20; Jaffe and Epstein, 1992: 3−14). Low performance in the consultation function could hinder the valuable service provision in occupational therapy.

Twenty-four respondents (96%) participated in continuing education function while one respondent (4%) reported that he/she did not conduct this function. The mean performance in continuing education was calculated at 1.5. Taylor and Mitchell (1999: 350−355) report a similar result. The high performance of occupational therapy leaders in continuing education keeps them updated with the latest information in the field.

Sixteen respondents (66.7%) indicated that they participate in research while eight respondents (33.3%) reported no involvement in research. The mean performance in the research function was calculated at 2.1. There was one incomplete value in Question 2 which was excluded (see Table 15).

Low participation and limited input in occupational therapy research by occupational therapy leaders hinder the exploration and understanding of various unknown facets and new trends in occupational therapy. Consequently, the occupational therapy profession could lag behind other health professions in aspects of evidence-based practice and client-centred practice (Maslin, 1991: 12). It is important for occupational therapy leaders to allocate adequate resources, such as time and budget in order to increase their participation in research. At the same time, they should have adequate access to resources, such as the library and the Internet. Occupational therapy leaders need to refine their research skills and collaborate with experienced researchers. Their participation in research could be increased through mutual experiences and continuing education (Reed and Sanderson, 1980: 75−78; Punwar, 1994: 185−193; Taylor and Mitchell, 1999: 350−355).

It is important for occupational therapy research and consultation to acquire more of the knowledge and skills that respondents in the study indicated they lacked in their training and work environment. Future occupational therapy leadership training must take into account the research and consultation functions.

Questions 94, 95 and 96 were open-ended. They collected information about convenient and inconvenient leadership functions. Twelve respondents (48%) pointed out that they performed unwelcome leadership functions: budget management, conflict management, time management, staff management and directing. In staff management, they mentioned the recruitment of new personnel. In directing, they mentioned disciplining issues, such as having to wear a uniform. Another 12 respondents (48%) reported that they conducted all the functions included in the study questionnaire. The majority of respondents (72%) did not suggest any new leadership functions. The fact that occupational therapy leaders performed unwelcome functions might have contributed to their low performance in these functions, for example, budget and time management. Furthermore, low performance in other occupational therapy leadership functions, such as research can be attributed to low performance in resource management (time and budget). Decreased interest in resource management, such as time and budget might have negative consequences on occupational therapy profession and facility, for example, poor resource management, cost increase, production decrease and malpractice (Maslin, 1991: 95 – 115).

This study supports the findings of Marquis and Huston (2000: 1−20), as well as Leach (2003: 167) that indicate inconvenient issues needing to be approached appropriately and addressed effectively to achieve maximum participation of all occupational therapy leaders in all leadership functions. Using an effective social environment as an appropriate approach might be an effective entry point to manage inconvenient issues in occupational therapy leadership functions. In addition, effective communication, as well as delegation and training are essential tools for handling unwelcome occupational therapy leadership functions.

Question 93 in the questionnaire was open-ended. It requested participants to give information about any leadership function that they performed but that was not included in the questionnaire. The majority of respondents (68%) pointed out that the study questionnaire covered all the leadership functions that they perform. A minority of the respondents (20%) pointed out that they performed other leadership functions that are not included in the study questionnaire. These are: representing the department and facility in the community (4%), supervision of occupational therapy students (12%), and providing counselling to colleagues (4%). Twelve percent of the respondents did not answer Question 93. This indicates a disadvantage in using a questionnaire for data collection. It is also one of the disadvantages of using open-ended questions. Besides, the questionnaire was lengthy. This may have contributed to some degree in unanswered questions (Armstrong and Grace, 2000: 64−66; Norwood, 2000: 245).

4.3.3 CLINICAL PRACTICE

Table 16 Leadership functions attributed to clinical practice functions (Likert scale 1−4: 1 and 2 = agree; 3 and 4 = disagree) (N=25)

Clinical practice functions	Function fulfilment			
	Agree (%)	Disagree (%)	M	SD
1. Ensures proper referral process in terms of correct and complete diagnosis, including indications and contraindications, takes place	24 (96%)	1 (4%)	1.3	0.56
2. Ensures client's proper and smooth entry to occupational therapy department takes place	24 (96%)	1 (4%)	1.4	0.57
3. Ensures proper screening procedures available for each client	24 (96%)	1 (4%)	1.4	0.57
4. Ensures proper assessment/evaluation for each client (*)	23 (95.8%)	1 (4.2%)	1.3	0.57
5. Ensures proper planning for intervention for each client takes place	24 (96%)	1 (4%)	1.3	0.56
6. Ensures the proper intervention process takes place for each client (*)	23 (95.8%)	1 (4.2%)	1.4	0.58
7. Ensures proper preparation for client's discharge takes place (*)	23 (95.8%)	1 (4.2%)	1.4	0.58
8. Ensures proper follow-up plans for client are drawn up and ensures execution of the follow-up plan	22 (88%)	3(12%)	1.5	0.71
9. Ensures proper discontinuation of services takes place with a final report made available (*)	21 (87.5%)	3 (12.5%)	1.5	0.72
10. Ensures that staff are caring about clients (*)	23 (95.8%)	1 (4.2%)	1.4	0.58
11. Ensures specified treatments for various conditions take place (*)	21 (91.3%)	2 (8.7%)	1.5	0.73
12. Ensures implementing of treatment according to prescribed intervention (*)	22 (91.6%)	2 (8.4%)	1.4	0.65
13. Ensures proper teaching of care, continuity and post-care for client	24 (96%)	1 (4%)	1.4	0.58
14. Ensures proper, effective practice and documentation is available (*)	24 (100%)	0 (0%)	1.3	0.46

* Incomplete values which were excluded, **n** < 25 occupational therapy leaders

More than 87.5% of the respondents reported that they conducted clinical practice functions. The mean performance in clinical practice functions ranged from 1.3 to 1.5.

There were one or two incomplete values in eight questions which were excluded (see Table 16). The respondents promoted the development of intervention programmes based on clearly identified client needs. Leadership functions contributed to identifying client needs, establishing treatment goals and developing and implementing intervention programmes. Furthermore, they promoted the co-ordination and integration of intervention programmes. They also provided a systemic review of the client's progress. The respondents established a point of contact for client, family, caregiver, society and community agencies. One to three respondents (4−12.5%) pointed out that they did not perform clinical practice functions. Those respondents could have been occupational therapy leaders who were not involved in direct occupational therapy services, such as assistant directors. Two respondents (8.7%) reported that they did not ensure that specified treatments for various conditions took place. Two respondents (8.4%) reported that they did not ensure the implementation of treatment according to prescribed intervention. Three respondents (12%) reported that they were not involved in follow-up plans which could imply that the patient was not adhering to the guidelines and instructions given and that he/she is prone to complications. This could be of great disadvantage to the patient, facility and occupational therapy profession. The patient will not benefit from occupational therapy intervention, occupational therapy outcomes, as well as customer satisfaction will be low. This could also entail great financial loss in health services and poor benchmarking of the occupational therapy profession amongst other health care professionals (Reed and Sanderson, 1980: 7; Harwood and Wenzl, 1990: 80; Holtan, 1990: 58; Finlay, 1993: 200−201; Fearing, Law and Clark, 1997: 9; Moyers, 1999: 263, 295; Sumsion, 1999: 16−18). Three respondents (12.5%) reported that they were not involved in discontinuation of services. More than 94.4% of the respondents indicated that high performance of the clinical practice functions versus 5.6% who indicated a low performance, for example, ensuring that proper follow-up plans for client are drawn up, the execution of the follow-up plan and that a proper discontinuation of services takes place together with a final report. These results back up other research findings that show how high performance in leadership functions enables occupational therapists to perform clinical practice functions at a more optimum level (Berwick, 1989: 53−56; Bleich, 1999: 5−7; Marquis and Huston, 2000: 1−20).

Occupational therapy leaders were more concerned with the direct occupational therapy service or clinical practice functions than with managerial functions. More than 87.5% of the respondents performed all clinical practice functions while 66.7–96% of the respondents performed managerial leadership functions. These findings support those of Georgopoulos (1986: 74−149), as well as Holtan (1990: 53−58) who maintain that clinical practice is the first concern of occupational therapist. It would seem that the performance of occupational therapy leaders in managerial functions (management, ethics related functions, continuing education, research and consultation) improves their own performance, as well as that of their subordinates in clinical practice.

The study shows that participants realize the importance of motivation, commitment and accountability as occupational therapy leadership tools for increasing their performance in both direct and indirect occupational therapy service delivery.

4.3.4 FUTURE TRAINING NEEDS RELEVANT TO LEADERSHIP

Table 17 Respondents' suggestions for future training (N=25)

Suggestions	Respondents (%)
1. Respondents who expressed their need for further training in leadership	22 (88%)
2. Respondents who suggested that both undergraduate programmes and work facilities should provide leadership training	10 (40%)
3. Respondents who suggested that undergraduate programmes should provide leadership training	10 (40%)
4. Respondents who suggested that work facilities should provide leadership training	17 (68%)

Question 97 in the questionnaire was open-ended. It collected information about future leadership training. The majority of respondents (88%) pointed out that they need further training about occupational therapy leadership functions. Ten

respondents (40%) reported that both undergraduate programmes and work facilities should provide leadership training for supervision, staffing, management, budgeting, operational management, human resource management and strategic planning. Ten respondents (40%) indicated that undergraduate programmes should provide leadership training about conflict management, health personnel management, teamwork and co-operation, management, leadership skills, quality assurance, supervision, diversity management and the Code of Ethics. Seventeen respondents (68%) suggested that work facilities should provide leadership training about management, teamwork, co-operation, national health policies, leadership styles, supervision, Code of Ethics, career development and promotion, research and cultural diversity. Under management, they suggested issues, such as budgeting, diversity, financial management, health personnel management and human resource management (see Table 17). The participants in the study indicated a weakness in the different areas of occupational therapy leadership training and suggested appropriate solutions to meet their identified training needs. These results show the need for both educational and work facilities to collaborate to meet the participants' needs in terms of future leadership training. Recommendations will be discussed in Chapter 5.

The results obtained reflect a great need for further leadership training of occupational therapy leaders. Competence areas were clinical practice, planning, directing, controlling, managing, organising, personnel management and continuing education functions. Incompetence areas were ethics related functions, consultation and research. These results support the findings of Taylor and Mitchell (1999: 350−355) who indicate that occupational therapists have limited involvement in research due to limited resources, such as time and budget, as well as inadequate training relevant to research.

To summarise, occupational therapy leadership training is mainly performed by employing facilities to meet organisational needs. Undergraduate and postgraduate training have less input in occupational therapy leadership training. Therefore, there are areas of weakness in occupational therapy leadership functions, such as research, consultation and ethics-related functions. Performance in occupational therapy leadership functions can be increased through training, increased involvement in continuing education, providing opportunities and motivating

occupational therapists to reach/fulfill leadership positions, commitment of occupational therapy leaders to leadership functions and conducting research about occupational therapy leadership. Undergraduate training and postgraduate training must give greater input and more involvement in leadership training.

4.3.5 EMPOWERMENT

Table 18 Factors of occupational therapy leadership empowerment

(Likert scale 1−4: 1 and 2 = empower; 3 and 4 = disempowered) (N=25)

Empowerment factors	Empowering (%)	Disempowering (%)	M	SD
1. Existing team support	23 (92%)	2 (8%)	1.6	0.76
2. Accountability to authorities (*)	21 (87.5%)	3 (12.5%)	1.8	0.78
3. Sharing leadership functions with the team	21 (84%)	4 (16%)	1.6	0.76
4. Organisational vision available	23 (92%)	2 (8%)	1.6	0.77
5. Clients interaction with occupational therapy staff (*)	22 (91.7%)	2 (8.3%)	1.5	0.59
6. Supervisor's attitude	21 (84%)	4 (16%)	1.7	0.74
7. Subordinates' attitude (*)	23 (95.8%)	1 (4.2%)	1.5	0.59
8. Predominant gender within the team (*)	18 (90%)	2 (10%)	1.9	0.55
9. Existing top management support	19 (76%)	6 (24%)	1.9	0.95
10. Existing people management process (*)	18 (81.8%)	4 (18.2%)	1.8	0.75
11. Existing line management support (*)	19 (79.2%)	5 (20.8%)	1.8	0.78
12. Available resources in relation to clinical facility (*)	20 (83.3%)	4 (16.7%)	1.9	0.90
13. Available organogram, team working according to it (*)	14 (66.7%)	7 (33.3%)	2.0	0.90
14. Diversity of background amongst colleagues (*)	19 (82.6%)	4 (17.4%)	1.7	0.78
15. The policy of the National Health System (*)	19 (79.2%)	5 (20.8%)	2.0	0.88

* Incomplete values which were excluded, **n** < 25 occupational therapy leaders

The work environment of participants in the study presented many empowering factors for occupational therapy leaders. The most empowering factors, as indicated

by the respondents, were existing teams in terms of support (92%), sharing leadership (84%) and predominant gender − female − (90%), supervisors (84%), subordinates (95.8%), accountability to authorities (87.5%), organisational vision (92%) and interaction with clients (91.7%). One to four respondents (4.2−16%) noted that these factors were disempowering. The majority of respondents (92%) pointed out that the dominant gender in occupational therapy departments is female.

There were other factors which were seen as less empowering factors by the respondents, such as supportive management, including top management (76%), people management (81.8%), line management (79.2%), available resources (83.3%), available organisational structure (66.7%), diversity (82.6%) and the policy of the National Health System (79.2%). One to seven respondents (4.2−33.3%) indicated that these were disempowering factors. There were one to five incomplete values in ten questions which were excluded (see Table 18).

Occupational therapy leaders perceived clients, colleagues, subordinates and supervisors as highly empowering factors. This indicates strong professional and interpersonal relationships. The direct daily contact between occupational therapy leaders, on one hand, and clients, colleagues, subordinates and supervisors, on the other hand, could have played an important role in the way occupational therapy leaders perceive the empowering factors. The researcher believes that the occupational therapy leaders have lesser daily contact with the personnel management which in turn could be interpreted as low co-operation. Moreover, personnel management might be viewed as bureaucratic and limiting people. Therefore, occupational therapy leaders perceive them as less empowering factors. This inference might account for the low co-operation between occupational therapy leaders and personnel management. There could be a sense of competition between the two as occupational therapists are now more involved in different managerial functions (Maslin, 1991). The notion of competition could be interpreted in a negative, disempowering way. Whatever the inferred reasons for a sense of disempowerment, disempowering factors have negative consequences, such as lack of co-operation and poor trust.

More than 84.7% of the respondents perceive the current context in their facilities as an empowering milieu versus 13.3% who regard the same context as

disempowering. The research results indicate that more work, such as aligning the organisational structure needs to be done in terms of empowerment, so that occupational therapy leaders perceive their work context as more empowering.

4.4 CONCLUSION

Table 19 Reliability coefficient factors Cronbach's Alfa values for occupational therapy leadership functions

Occupational therapy leadership functions	Cronbach's Alfa values
Planning functions	0.91
Managing functions	0.93
Organising functions	0.89
Personnel management functions	0.97
Directing functions	0.92
Controlling functions	0.82
Ethics-related functions	0.94
Education, research and consultation functions	0.71

The response rate to the study was high and rated at 71.4%. The majority of respondents were chief or senior female occupational therapists in full-time employment of the governmental health sector of PAWC. The average number of occupational therapy leaders in each department was three and the average number of subordinates reporting to each leader was six. The respondents had long clinical experience (M = 12.2 years, SD = 7.2) and leadership experience (M = 6.8 years, SD = 6.3). The majority of respondents reached leadership position by appointment (52%) and/or seniority (40%). Departmental selection, qualifications and experience had minimal significance in achieving leadership positions. The appointment of individuals to leadership positions took into account organisational structure, seniority, department selection, qualifications, training and experience. Unfair criteria of appointing occupational therapists to leadership positions could have negative consequences, such as low performance in occupational therapy leadership

functions, low motivation to develop self and others and to fulfill leadership positions and a low ranking of occupational therapy amongst other health care professions.

Seventy-two percent of the respondents received relevant leadership training which ranged from two to 14 days. Employing facilities (44%) mainly conducted training to meet organisational needs and focused on supervision, diversity management, leadership development, human resource management and finance management. The majority of respondents (88%) suggested that both educational and work facilities should provide leadership training for supervision, health management, budgeting, human resource management, research, consultation, continuing education and the Code of Ethics.

High performance in occupational therapy leadership functions enabled occupational therapy leaders to plan effectively, deliver quality care, develop occupational therapy evidence-based practice, maintain a healthy and motivating work environment and to increase team effectiveness. In addition, it increased employees' participation and satisfaction, promoted occupational therapy service delivery in accordance with the Code of Ethics, enhanced effective resource management and achieved organisational goals.

The respondents in the study identified 57 leadership functions: 44 managerial, 10 ethics-related, one education, one research and one consultation. These leadership functions propose a frame of reference for occupational therapy leaders in PAWC. The majority of respondents performed planning functions (88−96%), managing functions (81−96%), organising functions (76−96%), personnel management functions (71.6−92%), directing functions (91.3−96%), controlling functions (71.4−96%), ethics related functions (68.2−100%), consultation (78.3%), research (66.7%) and continuing education (96%). A minority of respondents (≤ 33.3%) reported that they did not conduct occupational therapy leadership functions. The mean performance in the identified leadership functions ranged from 1.2 to 2.1. Occupational therapy leaders have different levels of fulfilling of occupational therapy leadership functions. Their performance in some leadership functions ranked highly while other functions reflected poor performance. The reliability coefficient factors, Cronbach's Alfa values, for the identified leadership functions ranged from 0.71 to 0.97.

While both direct and indirect occupational therapy services are important to provide occupational therapy care, there was more concern for direct occupational therapy service or clinical practice than indirect service. Indirect occupational therapy service promoted the majority of respondents (≥ 88%) to have high performance in direct occupational therapy service or clinical practice (mean performance in clinical practice functions ranged from 1.3 to 1.5). Cronbach's Alfa reliability coefficient factor for clinical practice was calculated at 0.97.

These results were reached in an empowering work environment. Empowerment factors comprised existing team, supervisors, subordinates, clients, organisational vision, management and available resources. Alignment, partnership and cultural change are also necessary factors for empowering leaders at the core of the facility. The reliability coefficient factor, Cronbach's Alfa for empowerment was calculated at 0.92.

Half of the respondents (48%) performed unwelcome leadership functions: budgeting, conflict management, time management, health personnel management and directing. The majority of respondents appeared unmotivated to change the situation and did not suggest any solution or alternative.

Time and people are important resources when providing occupational therapy care. However, about half of the respondents managed time and about two thirds of them managed workload and implemented effective measurements to motivate staff and reduce staff turnover. The mean performance in time management was rated at 2.1. The respondents in the study had inadequate input and low involvement in resource management which could mean a negative impact on patient, personnel, facility and the occupational therapy profession. There could be poor quality occupational therapy service which might not meet clientèle needs and expectations and result in low customer satisfaction. Resources are important for meeting personnel needs, such as salaries, incentives and training. Harmful results could be poor performance, malpractice, decrease in production, increase in costs and financial loss. Resources are basic to the development of the occupational therapy profession. Time and money are necessary for research and to explore unknown facets of the profession. More training is strongly recommended to improve occupational therapy leaders' performance in resource management.

Research is very important to develop occupational therapy evidence-based practice. Two thirds of the respondents participated in the research function. The mean performance in research function was rated at 2.1. Occupational therapy leaders must possess necessary skills and allocate the adequate resources to increase participation in research.

These study results could be useful for occupational therapy students and practitioners to incorporate into their training and practice. Leaders need to continuously expand their skills and knowledge in order to cope with and develop their leadership functions. Performance in occupational therapy leadership functions can be increased through training, participation in continuing education and research, providing opportunities and motivation to reach leadership positions, as well as the commitment of occupational therapy leaders to perform leadership functions. Effective communication is necessary to establish a useful, convenient and operational work environment.

The study sample was small and the group of respondents even smaller (16 chief, 7 senior and 2 assistant director occupational therapists). Therefore, there was not significance in analysing the different ranks of the leaders and correlate the groups separately, for example, senior occupational therapists versus chief occupational therapists.

4.5 SUMMARY

This study answered all the research questions. Fifty-seven leadership functions were identified. An accurate description of leadership functions, as well as the level of performance of each function were presented in the study results. Areas of competence and incompetence of occupational therapy leadership functions for the study group were identified. The respondent leaders and the researcher made suggestions to address areas of incompetence in occupational therapy leadership.

The majority of occupational therapy leaders performed the clinical practice functions while a smaller majority performed the managerial leadership functions. The respondents were more concerned with clinical practice functions than managerial ones. The identified leadership functions show a strong link to each other and they establish a framework for occupational therapy leadership functions. Occupational therapy leaders realise the importance of having high performance in direct and indirect occupational therapy services in order to deliver occupational therapy service quality, develop occupational therapy personnel, the facility and the profession, and to achieve organisational goals.

There is weakness in the way the occupational therapists reach a leadership position. It is strongly recommended that organisational structure, qualifications, seniority, experience and department selection be taken into account when appointing occupational therapists to leadership positions. Recommendations to these results are discussed in Chapter 5.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The study investigated the application of occupational therapy leadership functions within clinical settings. The study builds on previous research projects by Reed and Sanderson (1980: 75−78) and Maslin (1991: 73−93). At the same time, it brings additional information to the table in the form of the Occupational Therapy Leadership Functions Framework (OTLFF) that was developed as a result of this investigation into occupational therapy leadership functions within clinical settings. Occupational therapy leadership functions were researched in a collective way and the study findings were used to compile the OTLFF that will be discussed in detail in this chapter.

The research findings indicate a higher performance of occupational therapy leaders in direct occupational therapy service than in indirect service. The findings suggest the use of different applications, such as the occupational therapy management tool to improve the quality of direct services and to facilitate performance and participation of occupational therapy leaders in leadership functions.

The results of the study indicate that the respondents used influence rather than authority in the workplace to perform their leadership functions. They appropriated the supporting work environment to overcome barriers. The respondents expressed less involvement in resource management and conflict management functions and they suggested a need for more training in these leadership functions.

It is strongly recommended that the study be replicated using a larger, more representative sample of occupational therapy leaders. Moreover, it would be worthwhile to standardise the questionnaire in order to generalise the results to other populations of occupational therapy leaders.

5.2 DISCUSSION

The data collected show that occupational therapy leaders performed 57 leadership functions that enabled them to deliver a quality health care in satisfactory circumstances and to achieve organisational goals. The performance of occupational therapy leaders in managerial functions (means ranged from 1.2 to 2.1) was higher than in research, consultation and ethics-related functions (means ranged from 1.3 to 2.1). These functions require more knowledge, skills, authority and influence which were lacking in the training and work environment of the respondents. The respondents indicated that these functions should be given priority for future training needs.

This research supports the work of Reed and Sanderson (1980: 75−78), Georgopoulos (1986: 74−149) and Holtan (1990: 53−58) that indicate no clear distinction between direct and indirect occupational therapy services in practice. Occupational therapy leaders in the study were more involved with direct occupational therapy services or clinical practice than indirect services. More than 88% of the respondents performed direct occupational therapy service functions and their mean performance ranged from 1.3 to 1.5. More than 66% of them performed indirect occupational therapy service functions and their mean performance ranged from 1.2 to 2.1. All the respondents (100%) participated in planning for direct occupational therapy service functions while 47.2% of them participated in planning for indirect functions. This seems to be a clear indication that occupational therapy leaders need to be sufficiently involved with both direct and indirect occupational therapy services and to devote equal attention to issues pertaining to each area in order to achieve occupational therapy goals, such as health and wellness promotion, as well as disease and disability prevention. In addition, equal and high participation in both direct and indirect occupational therapy services is necessary to achieve employee goals, such as self-actualisation and growth, as well as organisational goals, such as partnership, cost reduction and accreditation. The occupational therapy profession has much to gain from the development of research and evidence-based practice and could stand to rank highly amongst other health professionals (Reed and Sanderson, 1980: 75−78; Maslin, 1991: 1−211; Moyers, 1999: 251−289).

The research findings support the work of Maslin (1991: 1−17) who found that the main area of activity for occupational therapists as health professionals is direct occupational therapy service. Therefore, occupational therapy training focuses on clinical practice. However, occupational therapy leaders are obliged to address and implement both clinical and managerial functions. The study findings show that about 12% of the respondents received information relevant to occupational therapy leadership during their undergraduate or postgraduate training and that the timeframe of such training ranged from two to 14 days. This is considered to be inadequate training for them to effectively perform occupational therapy leadership functions and to address clinical and managerial functions.

The majority of occupational therapy leaders (≥ 66.7%) in the study had high performance levels in leadership functions due to motivating factors, such as supportive subordinates and supervisors. They seem to realise the importance of high performance and participation in leadership functions for the sake of patients, occupational therapy personnel, the facilities and the occupational therapy profession.

Fifty-two percent of the respondents said they felt comfortable with the functions they were performing. Forty-eight percent of the respondents felt uncomfortable in performing budgeting, conflict management, time management and health personnel management functions. At the same time, 82.3% of the respondents have performed budgeting, conflict management, time management and health personnel management functions and their mean performance was 1.7. These research findings concur with those of Maslin (1991: 131−140), Hagedorn (1995: 163−166) and Rooch (1999: 265−278) who report that motivation increases participation in leadership functions and strengthens links between leaders, team members and the facility. Motivation creates leaders who are committed to the workplace and who are accountable for the decisions that they make. It would seem that by increasing performance in leadership functions, opportunities for growth and development as motivating factors are developed. Moreover, high performance in occupational therapy leadership functions contributes towards creating a knowledge database, which is necessary for research and which has a positive impact on the quality of occupational therapy health care (Reed and Sanderson, 1980: 75−78).

The results of the study show that resource management − time, budget and human capital − is perceived as a burden where half of the respondents indicated that they found having to conduct these functions an inconvenience. Nearly half of the respondents (48%) have performed unwelcome leadership functions, such as budgeting, conflict management and time management. None of the respondent leaders had any suggestions for addressing the situation, for example, removing those functions from their agenda that they do not favour. It would appear that the respondents see the importance of good performance in those inconvenient functions since they form part of indirect occupational therapy service. They understand how essential it is to manage conflict, time and budgets in the occupational therapy department. Their participation and input in these functions contribute significantly towards achieving occupational therapy service delivery and organisational goals. Occupational therapy leaders highlighted different strategies that they use to manage unwelcome leadership functions. They resort to training, delegation and communication. Seventy-two percent of the respondent leaders have received training relevant to the leadership functions (including the inconvenient functions, for example, budgeting and conflict management). Eighty-eight percent expressed the need for further training in different leadership areas, such as managing and planning. The majority of respondent leaders (96%) use delegation in the workplace. Moreover, 95.8% of the respondents use two-way communication. This is in line with the Maslin's study (1991:116) that showed how relevant training in leadership functions, the appropriate use of delegation and effective two-way communication could go a long way towards effectively managing work-related issues and reducing the workload and as such the expressed inconvenience of certain leadership functions.

The balance between managerial and clinical functions is a big challenge for occupational therapy leaders because it means taking on more responsibility for occupational therapy personnel management, client assessment, planning for intervention, implementation of intervention and documentation. This could increase the burden that occupational therapy leaders already have to bear.

The study findings show poor engagement with the socio-cultural environment in planning areas (32%). These results are in contrast to those of Marquis and Huston (2000: 1−20), as well as Leach (2003: 167) who stress the importance of the socio-

cultural environment in creating a motivating milieu for participatory occupational therapy leadership. Low performance in the socio-cultural environment could be a strong reason for low performance and low participation in certain leadership functions which require co-operation, for example, conflict management, time management and research. It is highly important to address the socio-cultural environment effectively in order to increase motivation and co-operation in occupational therapy service areas and in the performance of occupational therapy leadership functions.

Table 20 Summary of the Occupational Therapy Leadership Functions Framework

1. Planning area 9. Identifying needs or problems in occupational therapy service area 10. Gathering data related to needs 11. Establishing goals and objectives related to needs	**2. Managing area** 5. Participating in and ensuring of proper handling of conflicts 6. Managing risks and liabilities 7. Managing budgets
3. Organising area 4. Using authority to set rules and protocols 5. Collaboration with other services 6. Sharing responsibility with others	**4. Personnel management area** 5. Participation in team building 6. Identifying departmental staff needs 7. Guiding appropriate recruitment
5. Directing area 7. Allowing for professional differences 8. Providing proper handling of client compliance 9. Accepting accountability 10. Using two-way communication	**6. Controlling area** 7. Participating in and ensuring that evaluation of occupational therapy outcomes takes place regularly 8. Monitoring the quality of occupational therapy service
7. Ethical issues area 11. Assisting staff in identifying ethical dilemmas 12. Providing guidance with decision making regarding ethical dilemmas	**8. Others** 13. Providing internal occupational therapy consultation 16. Participation in research

The respondents in the study identified 57 occupational therapy leadership functions which reflect the perspectives of the majority of the study participants. The researcher tried to present these functions in a useful way by reworking the 57

occupational therapy leadership functions from the study questionnaire and compiling the Occupational Therapy Leadership Functions Framework (OTLFF). The OTLFF was produced as a result of this study. It is a useful occupational therapy management tool and comprises eight areas, namely: planning, managing, organising, personnel management, directing, controlling, ethical issues and others.

A summary of the OTLFF which includes the 22 functions is presented in Table 20. The complete version of the OTLFF with the 57 occupational therapy leadership functions can be found in Appendix A. Planning areas in the OTLFF includes six functions, namely, identifying needs or problems, gathering relevant data and indicating methods of evaluating the success of planning in the occupational therapy area. The managing area includes ten functions, such as managing risk, time and budget and appropriate handling of staff conflicts The organising area includes eight functions, such as sharing responsibility with others when work/business is at risk, ensuring that resources are used to reach agreed targets and staff orientation to achieve agreed goals and objectives. The personnel management area includes eight functions, such as participation in building and development of the team, identifying departmental staff needs and participation in job descriptions setting The directing area includes eight functions, such as using two-way communication, task delegation and staff appraisals The controlling area includes four functions, namely, measuring, monitoring, benchmarking occupational therapy services and documentation. The ethical issues area includes ten functions, such as assisting staff to identify ethical dilemmas, monitoring the implementation of ethical principles by clinicians and reporting unethical behaviour to authorities The area classified as “others” includes three different functions: providing internal occupational therapy consultation to one’s own facility, participation in research and participation in continuing education programmes.

Unlike existing occupational therapy literature or health management literature, for example, Maslin (1991) and Guido (1999), the OTLFF is a management tool. It can be used by occupational therapy managers and leaders for different purposes, such as setting job descriptions, performing accountability and leadership appraisals. The appraisals of occupational therapy leaders are generally performed once or twice a year. Researchers, lecturers and occupational therapists could also use the OTLFF as a research tool to compare leadership functions performed by clinical staff. As an

educational tool it could help to upgrade the occupational therapy curriculum and raise awareness about the performance of leadership functions based on scientific evidence. In the area of policy design the OTLFF is an implementation tool that sets standards and regulates the practice of occupational therapy leadership functions. The OTLFF reflects the perspectives of the majority of respondent leaders in the study.

The study findings showed that study participants covered a wide spectrum of planning areas. There was a high performance in planning functions (91.9%). Occupational therapy leaders acknowledge the importance of planning in occupational therapy in order to create a stable organisational structure that fosters high performance in relevant leadership functions, such as organising, managing and directing. These findings are supported by Maslin (1991: 95−115) who links planning, on one the hand, with organising, managing and directing, on the other hand. This link is supported by the the study findings which showed that the performance in occupational therapy leadership functions is related to performance in planning functions, for example, high performance in planning for the direct occupational therapy service (100%) coincided with high performance in clinical practice functions (94.4%); and low performance in planning for research (24%) coincided with low performance in research functions (66.7%).

The study findings indicated that study participants had a high performance in management functions: directing (94.4%), organising (89.5%), controlling (82.6%), personnel management (80.7%) and managing (78.2%). Occupational therapy leaders seem to acknowledge the importance of these functions in delivering quality service for occupational therapy and for achieving employee and organisational goals. These results are consistent with other studies (Maslin, 1991: 1−221; Bleich, 1999: 9−12; Valadez and Otto, 1999: 29−31) who state that performance of occupational therapy leaders in management functions aims to attain and effectively use resources that are necessary to meet both patient and customer needs and to achieve employee and organisational goals.

About half of the participants (48%) in the study indicated a low interest in resource management: time, budget and human capital. This result contrasts with those of other studies (Reed and Sanderson, 1980: 75−78; Maslin, 1991: 73−93; Wendt and

Vale, 1999: 169−170) that maintain occupational therapy leaders must manage resources for the well-being of the client, staff, facility, profession and nation. On the other hand, these results partly agree with those of Maslin (1991: 184) who found that finance management may be an unwelcome function to a number of occupational therapists due to the fact that occupational therapists see themselves as health personnel and not business workers. The researcher agrees with Maslin (1991: 20−31, 73−93, 184) that occupational therapy leaders must participate effectively in resource management in order to make wise use of resources with the ultimate view of providing good quality occupational therapy services.

Research is very important for exploring unknown facets of occupational therapy and to evaluate new occupational therapy trends, such as evidence-based practice, client centred practice and consultation (Maslin, 1991: 12). The study findings showed that the participants in the study had low performance in occupational therapy research (66.7%) and occupational therapy consultation (78.3%). It is important to note that research requires knowledge, experience and adequate resources; while consultation requires more knowledge and skills which the respondent leaders perceive as a lack in their training and work environment. Future occupational therapy leadership training must take into account a consideration of research and consultation functions.

Occupational therapy leaders in the study used influence and authority as management tools to implement their leadership functions. Ninety-five percent of the respondents used influence while 81% of them used authority. Ninety-six percent of the respondents make allowance for professional differences, accept accountability for the decisions that they make and used two-way communication. Eighty percent of the respondents provide a basis for autonomous occupational therapy practice. Ninety-two percent of the respondents assist staff in identifying ethical dilemmas and 88% provided guidance in decision making regarding ethical dilemmas; while 81% reported unethical behaviour to authorities. Ninety-two percent of the respondent leaders gained power from the existing team and 95.8% from the attitudes of subordinate; while 84% have gained power from the attitudes of supervisors. The respondents acknowledge the importance of authority. However, they did not request more control. For example, a small majority (76%) of the respondents used their leadership authority to set rules and protocols that facilitate and ensure an

appropriate flow of comprehensive occupational therapy service in terms of quality, time and effectiveness.

It is important to note that the limited use of authority was characteristic of occupational therapy leadership (and leadership of other health professionals as well). Less than thirty-four percent of the respondents reported that they did not perform the leadership functions mentioned in the study. Spreitzer and Quinn (2001: 62−69) report the same findings, whereby health leaders use influence rather than authority. Occupational therapy leaders must make adequate and effective use of both leadership tools, that is, influence and authority, in order to perform all the functions mentioned in the OTLFF and to improve the quality of leadership functions performed.

The respondent leaders appeared to be familiar with the terminology used in the study, for example, consultation, influence, authority, empowerment, commitment and accountability. Commitment and accountability are leadership terms. Leaders in the study were accountable for decisions that they make and for their loyalty to their work facilities. Work facilities and the culture of the respondents encourage both commitment and accountability. The researcher believes that commitment and accountability are key factors for motivated, creative, talented and innovative leaders in the workplace.

The researcher agrees with Maslin (1991: 208) and Nel (2004) who point out that for career promotion in occupational therapy further training in functions, such as resource and conflict management may be required. Career promotion enables the occupational therapist to reach a new position with new functions and to have greater responsibility, authority and accountability at a higher post, for example, assistant director.

The majority of occupational therapy leaders in the study reached their leadership positions by appointment (52%) and/or seniority (40%). This suggests that the organisational promotion system is a main determinant for reaching a leadership position. According to Spreitzer and Quinn (2001: 159−167), promotion and selection criteria must be fair and familiar to each individual to allow for equal opportunities for growth and development and to fulfill a leadership position according to

organisational structure, seniority, qualifications, departmental selection, personnel wishes and expectations. Any leadership promotion or selection that does not adequately consider these six criteria may have negative consequences, for example, staff conflict and inferior performance in leadership functions. An unfair or biased system demoralises leaders, degenerates commitment links and increases personnel turnover. Therefore, it is worthwhile for each health facility to review its own leadership promotion system and to implement these six criteria, namely: organisational structure, seniority, qualifications, department selection, personnel wishes and expectations.

Although occupational therapy leaders and subordinates form a team, the opinion of subordinates, as eight percent of the respondents indicated, has minimal significance in the appointment of occupational therapists in leadership position. On the other hand, the majority of respondent leaders (95.8%) valued the influence of subordinates and considered them to be a highly empowering factor (mean empowerment = 1.5) rather than that of the organisational structure (66.7%, mean empowerment = 2.0). The organisational structure was a determinant in the appointment of individuals to leadership positions – as indicated by 46% of the respondents. The researcher strongly agrees with Heinemann and Zeiss (2002: 8−13) that the opinion of subordinates must be taken into account regarding the appointment of individuals to positions of leadership in order to maintain team cohesion and effectiveness.

The study supports the findings of Georgopoulos (1986: 74−149) showing how reliable data on leadership functions are preferably collected from acting leaders. Investigating occupational therapy leadership functions within a clinical setting requires a large and representative sample of occupational therapy leaders and a reliable or standardised questionnaire in order to gain a wide spectrum of occupational therapy leadership and detailed information about the performance of leadership functions. The researcher used an analytical descriptive design to conduct the study and a non-standardised questionnaire to collect the required data. The questionnaire was piloted and refined before being used in the study. The data obtained in the study from the respondent leaders were reliable and useful to assess the performance of leadership functions in the study population (occupational therapy

leaders working for PAWC). The reliability coefficient factor Cronbach's Alfa values ranged from 0.71 to 0.97.

5.3 CONCLUSIONS

The researcher achieved the objectives and aims of the study. Occupational therapy leaders perform the 57 leadership functions, that make up the OTLFF, in an empowering work environment. The OTLFF reflects the perspectives of the majority (≥ 66.7%) of respondent group and it includes managerial, ethical-related and other leadership functions. The study identified different levels of performance of occupational therapy leadership functions. Occupational therapy leaders and researchers are invited to make use of the study findings. They should strive to increase their performance in areas that need attention, such as consultation, resource management and research.

Occupational therapy leadership is characterised by focusing on direct occupational therapy service rather than indirect services, providing opportunities for occupational therapists to grow and develop, as well as using influence rather than authority. Occupational therapy leaders used delegation, communication and training to manage inconvenient leadership functions. These characteristics are attributed to motivation and the main area of occupational therapy training, that is, direct service. Undergraduate, postgraduate and in-service training programmes must be reviewed for development and for updating based on organisational, National Health, and individual needs. These needs must be guided by research.

It is preferable for occupational therapy leaders to be appointed from within a team by promotion criteria which are fair and effective, such as qualifications, seniority, experience, organisational structure and departmental selection.

5.4 STUDY LIMITATIONS

People tend to see situations from their own perspective. There is a tendency by individuals to evaluate the significance of data according to their duties, responsibilities, and personal attention (Heinemann and Zeiss, 2002: 86−87). The researcher believes that generalising the study results to other populations requires reliable, complete and detailed data, a large and representative sample, as well as a

standardised data collection instrument. Shortcomings in the study were skewed data in favour of participants, incomplete answers, non-respondents (10 individuals out of 35 or 28.6%), lack of rigour, the relatively small and unrepresentative sample, as well as the non-standardised questionnaire used for the study. Incomplete answers and non-respondents are disadvantages of using a questionnaire for data collection (Armstrong and Grace, 2000: 64−66; Norwood, 2000: 245). The study sample represents only the Cape Town Metropole which is but one of four regions in PAWC. Taking the high response rate to the study (71.4%), the researcher could have obtained a larger and representative sample had he used a more rigorous sampling method, such as a stratified sample from a large population, like the whole of PAWC.

The researcher is hesitant to generalise the study findings to all other populations. The study lacked a descriptive setting, for example, total number of occupational therapy leaders and types and numbers of facilities providing occupational therapy services in PAWC. It is important that the description of the study setting should include adequate information about customer and patient profiles, as well as the National Health System. More information is required about existing grading structures in national health and occupational therapy services, career promotion structures and job descriptions for senior, chief and assistant directors. The study has to give information relevant to challenges facing the National Health System in general and occupational therapy services in particular in terms of resources, limitations, accreditation system, continuous professional development and a profile of occupational therapy qualification.

The study results are aligned with the settings of the participating facilities and as such skewed in favour of the study sample. Therefore, the study results only reflect the perspectives of the study participants and their facilities in the Cape Town Metropole and not the entire population of occupational therapy leaders in PAWC. The sampling strategy (convenience sampling) is not rigorous and the study sample is not representative of the whole study population, namely, all occupational therapy leaders in PAWC.

The study questionnaire was lengthy in order to collect the in-depth data. Consequently, few closed ended questions (3.7%) and more than half of the open-ended questions (55.3%) were left unanswered. The researcher received 15

completed questionnaires of the 15 that were delivered by hand and only 10 completed questionnaire of the 20 that were sent by post to the study participants. The non-respondents were 28.6% (non-respondents bias). The questionnaires delivered by hand were completed more thoroughly than the mailed ones. Incomplete answers decrease the importance of the data collected because the collected information is skewed in favour of respondents. In some cases, there were queries and the possibility for misinterpretation. Incomplete answers and non-respondent bias decreases the significance of the study results and thus restricts its generalisation to other populations of occupational therapy leaders.

One facility had to go through ethical clearance which hindered the process of receiving and completing eight study questionnaires. The researcher strongly recommends prior inquire about ethical procedures and timeframes required in each clinical setting before conducting any study in order to take this information in account when defining the timeframe for the data collection.

Norwood (2000: 233) points out that the size of the sample adds power to descriptive studies. In order to estimate and document population means, she classifies the size of a sample into three groups.

1. A small sample consists of 20 individuals.
2. A medium sample consists of 50 individuals.
3. A large sample consists of 80 or more individuals.

The study sample included thirty-five occupational therapy leaders and the respondents were twenty-five. Therefore, the study sample is relatively small. The study sample can be increased in order to collect information from a wider spectrum of occupational therapy leadership functions and to generalise the study results to other populations.

The data collection tool is a non-standardised questionnaire. The researcher compiled and piloted the study questionnaire using a sample of ten occupational therapy leaders which is regarded a small pilot sample. In the pilot study, the researcher received seven completed questionnaires out of 10 (70%). The pilot study sample was not informed about the study on receiving the pilot questionnaire. They were requested to give verbal consent when they received the pilot questionnaire (pilot study bias). The participants in the pilot study gave limited feedback which was

used to refine and finalise the study questionnaire. Limited feedback in a pilot study may decrease the reliability of the data collection tool. On the other hand, appropriate and honest feedback in the pilot study is important to increase the reliability of the data collection tool.

5.5 THE CLINICAL VALUE OF THE STUDY

The study investigates the knowledge and practice of occupational therapy leaders about the functions that they perform in clinical settings. Part of the study findings, such as planning and managing functions, is in agreement with the existing occupational therapy literature. Other parts present new and innovative work in the field of occupational therapy, such as empowerment factors for occupational therapy leaders in clinical settings. These study findings are an important contribution to the body of research knowledge about occupational therapy leadership, participant facilities and individuals, the occupational therapy profession and personnel, educational facilities and legislative bodies. The study findings are applicable in different clinical situations. They are a useful guideline for curriculum design and for raising awareness about occupational therapy leadership functions and training. They can be used in research to compare and benchmark occupational therapy leadership functions in different occupational therapy settings. The study can be replicated in the same population for follow-up, re-evaluation and comparison. It can be replicated in different populations and disciplines for benchmarking and comparison. The results of replication, however, are debatable, insofar as the original results can be specific for that original method and population.

Replication of the study allows for the elimination or decrease of bias and an increase of reliability. Study replication using different methods is critical to determine whether results are rigorous with respect to methodology used. Results that have been replicated are considered more likely to be generalised. The stronger the design, the stronger the inferences that can be made from any study replication. Therefore, the most feasible design should be used. It is advantageous to measure more variables that are relevant to the study (Maxwell and Delaney, 2004: 1−2, 88; Ranganathan and Foster, 2005; Yearly, 2005: 100−102).

The study findings summarised the performance of occupational therapy leaders in different occupational therapy leadership functions. These study findings are useful

as occupational therapy management guidelines to increase participation, eliminate or remove barriers, facilitate and increase performance in occupational therapy leadership functions. They provide an opportunity for occupational therapy leaders to practise their leadership functions based on scientific evidence. The study findings set user-friendly guidelines for the leadership functions of occupational therapy leaders.

The study assessed the performance of occupational therapy leaders in different occupational therapy leadership functions. Thus it reflected the value of each occupational therapy leadership function from the occupational therapy leader's perspective. The study findings highlighted the performance of occupational therapy leaders in some challenging issues for occupational therapy practice, such as resource management, research, consultation and implementing the Code of Ethics. The study suggested solutions to increase performance in leadership functions through training and participation in research.

The study findings highlighted the ways in which occupational therapy leaders reached leadership positions. The study findings can be used as a guideline for setting or aligning organisational structure. The study highlights the importance of organisational structure, seniority, departmental selection, qualifications, training and experience in reaching leadership positions.

The study findings are important for new staff recruitment and selection. Occupational therapy leaders and managers can use the OTLFF to set job descriptions and to perform staff appraisals. Furthermore, these findings establish guidelines for job enrichment, job enlargement and task delegation.

The study encourages the provision of support for occupational therapy leadership functions. It highlighted the term empowerment from the perspective of occupational therapy leadership. It investigated how occupational therapy leaders rate different factors in the work environment in terms of empowerment. It can be used as an appropriate guideline to support and empower occupational therapy leaders.

The study findings are useful for policy design and the implementation of guidelines to set and regulate occupational therapy leadership functions. Occupational therapy legislative bodies can use the study findings to set rules and regulations, such as

management policy documents. The study findings can be helpful in advocacy and in raising awareness amongst occupational therapists.

5.6 RECOMMENDATIONS

The researcher believes that occupational therapy leadership tools, such as motivation, authority and accountability are key elements for successfully implementing the study recommendations and to bring about the desired positive change. Occupational therapy leaders are recommended to increase motivating factors in occupational therapy service areas in particular, and in health facilities in general. Occupational therapy leaders must be motivated and be able to motivate other occupational therapists to develop self and others, to acquire further knowledge and skills and to implement occupational therapy leadership functions with high performance. In order to increase motivation in the occupational therapy service area, occupational therapy leaders are encouraged to address the socio-cultural environment effectively in their planning functions and in the inconvenient functions, to use collaboration and training as appropriate and effective approaches, to increase their participation in research, to provide opportunities for growth, to development of other occupational therapists and to participate in implementing fair career promotion criteria.

Authority, influence, motivation, communication, delegation and accountability are important tools for occupational therapy leadership. Appropriate use of these tools enables occupational therapy leaders to increase their performance in both direct and indirect occupational therapy services.

Occupational therapy leaders are encouraged to maintain their current high performance in direct occupational therapy services and management functions, planning, directing, controlling, managing, organising and personnel management functions, in order to achieve collective and individual organizational goals, to meet community health care needs and to establish a healthy work environment. Occupational therapy personnel and other employees must feel satisfied, confident and willing to perform to the best of their ability. When implementing occupational therapy leadership functions, occupational therapy leaders must collaborate with occupational therapy colleagues, other health care professionals and management

personnel to reduce problems in the work environment, to enhance effective resource management, to ensure a smooth and effective workflow, to improve service quality, to promote the occupational therapy profession and to achieve organisational goals.

The researcher recommends that both educational and work facilities must collaborate to meet occupational therapy leadership needs in terms of future leadership training. Training is an appropriate and effective way to increase motivation, knowledge, skills and performance in different occupational therapy leadership functions. Occupational therapy training should appropriately and effectively address leadership training at undergraduate and postgraduate levels.

Alongside motivation and training, inconvenience issues must be addressed effectively to decrease or remove barriers in the occupational therapy service area. The high performance in resource management – time, budget and human capital – is necessary to deliver occupational therapy service quality, to achieve employee and organisational goals and to develop important areas in the occupational therapy profession, for example, research. Occupational therapy leaders are encouraged to review and positively change attitudes related to the inconvenience issues. The attitudes and practice of occupational therapy leaders must ensure a maximum involvement in occupational therapy leadership functions. The appropriate social environment could be an effective entry to decrease the inconvenience of some occupational therapy leadership functions.

Occupational therapy leaders must provide equal opportunities for the growth and development of occupational therapists. At the same time, facilities must apply fair and familiar promotion criteria based on qualifications, experience, seniority, organizational structure and departmental selection. The researcher proposes that employing facilities consider the minimum experience as three years before occupational therapists can fill a leadership position. Moreover, he suggests that the organizational structure be aligned to provide more a empowering environment for occupational therapy leaders.

Occupational therapy leaders are recommended to increase co-operation in the occupational therapy service area, to adhere to the occupational therapy Code of

Ethics and to avoid bureaucratic, autocratic and limiting behaviours. In addition, they are encouraged to increase their co-operation with management personnel and to regard them as business partners.

The study findings illustrate low performance in areas of occupational therapy leadership functions. Occupational therapy leaders must give adequate attention to both direct and indirect occupational therapy services and should address them equally. The study in the study are encouraged to increase their performance in these functions: consultation, workload, research, budget management, using authority, personnel selection and reducing staff turnover. They are urged to improve their performance in measuring, monitoring and benchmarking occupational therapy services, reporting unethical behavior to responsible authorities, ensuring proper follow-up plans for client care, seeing that the follow-up plan is implemented, and that proper discontinuation of services takes place with a final report made available. Occupational therapy leaders are encouraged to give the socio-cultural environment and resource management a place in their planning and training priorities. Planning for these areas includes identifying problems and needs, establishing goals and objectives, and identifying appropriate strategies to diminish uncertainty in the occupational therapy department.

Increasing performance and participation of occupational therapy leaders in research, consultation and ethics-related functions could be achieved by co-operation with expert researchers, as well as collaboration with colleagues, training, experience and adequate resource allocation, such as time and budget. Occupational therapy leaders are strongly recommended to actively participate in research so as to develop different aspects of the occupational therapy profession, to contribute to a scientifically-based occupational therapy practice and to maintain a high ranking of occupational therapy amongst the other health professions. At the same time, they should have adequate access to useful resources, such as the library and the Internet. Occupational therapy leaders must develop their research skills and collaborate with experienced researchers.

It is recommended that researchers use the study findings as a research tool to compare leadership functions performed by clinical staff. Educational facilities can use the OTLFF as a tool to upgrade the occupational therapy curriculum. Legislative

bodies can use the study findings as a tool for policy design and standards formation. Occupational therapy leaders and managers can use the OTLFF as an occupational therapy management tool to benchmark and align their performance in leadership functions. Occupational therapy students and practitioners are invited to incorporate the study findings in their training and practice.

Maxwell and Delaney (2004: 1−2, 88) encourage researchers to replicate studies using the same methods as were used in the original studies and different methods that counteract possible bias and increase data reliability. They add that if different results are obtained in a replicated study, this suggests that the initial results may be attributed to chance or hidden variables. Obtaining the same results when using the same methods allows for the possibility that the results were either specific to the method or a general truth statement. Study replication using different methods is important to determine whether results are rigorous with respect to methodology and not an artifact of the methods used. When the same results are obtained with different methods, they are considered rigorous with respect to the methods used. Results that have been replicated are considered more likely to be generalized to other populations.

The researcher, however, recommends replication of the study using the same method, an analytical descriptive design, as well as taking into account necessary measures to avoid its shortcomings, such as the small convenience sample (N = 25), non-respondents (28.6%) and incomplete answers (3.7% for closed-ended questions and 55.3% for open-ended questions). Therefore, he recommends using a medium to large representative sample (for example, stratified sample of 50–80 occupational therapy leaders from all the PAWC regions). In addition, the researcher recommends providing a longer timeframe of data collection, for example, three months, in order to facilitate the completion of the questionnaire and its return to the researcher. It is recommended that the researcher inquires after ethical procedures used by each facility to meet the ethical requirements which may save time and increase the response rate.

The researcher recommends replication of the study to follow-up occupational therapy leaders' performance for leadership functions. Such a study may investigate changes in performed occupational therapy leadership functions over time.

Advantages of comparative studies are the possibility to compare groups and to identify risk factors. Disadvantages of comparative studies are that you can never be sure which occurred first: the disease or the exposure (Katzenellenbogen, Joubert and Yach, 1991: 31−34; Beaglehole, Bonita and Kiellstrom, 1993: 31−45). The researcher recommends a replication of the study to compare the profiles of different occupational therapy leaders, for example, male versus female, or leaders' perspectives versus subordinates' perspectives. Researchers may compare different leadership function profiles between different countries, for example, the United Kingdom versus the United States of America or different disciplines, for example, occupational therapy versus physiotherapy.

According to Marchall and Rossman (1989: 146), Krefting (1991:214−222) and Polgar and Thomas (1991: 105−106), qualitative research describes a phenomenon or experience. It aims to produce accurate data based on the face-to-face knowledge of individuals. Its situation is made up of a particular researcher in a particular interaction with particular informants. The qualitative study is conducted in a naturalistic setting with few controlled variables. Due to a weakness in this method, the results of qualitative research are less likely to be generalised to other populations and its applicability is limited to the original study. The researcher recommends replication of the study using a qualitative method and comparing the obtained results with the current study findings.

Further research may investigate the impact of other variables on the performance of leadership functions, for example, age, gender, social factors, economic factors, geographical factors and cultural factors. The researcher recommends a study to investigate occupational therapy leadership functions which create inconvenience and burden. Furthermore, research may investigate the area of emerging leaders, challenging issues (leadership training, research and consultation) and resources used by leaders to perform their functions, for example, books, journals, the Internet, lectures, workshops and conferences. The availability and accessibility of resources may be investigated as well.

The researcher recommends standardizing the study questionnaire. There is a need for the study to investigate competence indicators of occupational therapy leaders, such as the degree of autonomy that occupational therapy leaders have when

performing occupational therapy leadership functions. Research could investigate the effectiveness of leadership training programmes in both undergraduate and postgraduate educational programmes, as well as in-service training programmes. Research could also investigate the impact and outcomes of such studies on the occupational therapy profession, practice, staff, team, client, facility and the quality of occupational therapy interventions. There is a need for a study to investigate the perspective of employing facilities relevant to implemented criteria for the promotion of occupational therapists to leadership positions.

To summarize, the researcher agrees with Maxwell and Delaney (2004: 1−2, 88) who write that a study benefits from replication rendering it less at risk of yielding misleading conclusions. Study replication allows the researcher to consider and eliminate bias in the original study. The stronger the study design, the stronger the inferences made from study replication. The most feasible design should be chosen, for example, an analytical descriptive design, qualitative and comparative studies. Besides, it is advantageous to measure more variables that are relevant to the study. Future studies should involve different occupational therapy sectors, such as governmental, non-governmental and clinic-based community services. The researcher recommends addressing leadership training more effectively by occupational therapists, educational institutions and employing facilities.

5.7 SUMMARY

Direct and indirect occupational therapy services are two interwoven aspects of the occupational therapy profession. The researcher used an analytical descriptive design and a non-standardised questionnaire, compiled by the researcher, to investigate occupational therapy leadership functions within a clinical setting. The study aims and objectives were achieved. The main findings were used to compile the Occupational Therapy Leadership Functions Framework (OTLFF). Although occupational therapy leaders were more concerned about the direct occupational therapy service, they have showed high performance in both the direct and the indirect occupational therapy services. Direct and indirect occupational therapy services must be addressed equally in training and practice to decrease incompetence in the occupational therapy leadership functions.

Motivation, leadership training, communication, organisational structure and a supportive work environment positively influence the implementation of occupational therapy leadership functions. Occupational therapy leadership functions influence the direct occupational therapy service or clinical practice.

The study findings reflect the perspectives of the respondent leaders. Resource management, research and consultation were challenging issues; occupational therapy leaders in the study were obligated to perform leadership functions even though they lacked the necessary skills and training. These study findings are useful guidelines for occupational therapy professionals and students, participant facilities, educational facilities, legislative bodies and researchers. Generalisation of the study results to other populations cannot be done because the study has many limitations. It is recommended that a replication of the study in better circumstances where bias can be avoided or reduced be carried out.

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APPENDIX A

1. OCCUPATIONAL THERAPY LEADERSHIP FUNCTIONS FRAMEWORK (OTLFF)

1.1 PLANNING AREA

- Participation in reducing uncertainty as much as possible by anticipating and predicting future developments which will affect the operations of workplace
- Identifying needs or problems in occupational therapy service area
- Gathering data related to meeting needs in occupational therapy service area
- Establishing goals and objectives related to needs in occupational therapy service area
- Identifying possible courses of action and deciding the most appropriate strategy
- Indicating methods of evaluating the success of the planning in occupational therapy area

1.2 MANAGING AREA

- Participating in and ensuring effective and proper handling of possible disagreement or conflicts relevant to occupational therapy service
- Managing risks and liabilities by analysing problems and minimising losses in client's care
- Managing budgets allocated to the department
- Participating in and ensuring proper daily clients' rounds take place
- Ensuring that working hours in occupational therapy department are properly justified and effectively used
- Deciding to call in extra help when needed in occupational therapy department

- Attending and participating in management meetings
- Conducting of meetings with own staff to ensure effective and smooth workflow
- Participation in quality assurance “designing studies, collecting data, and preparing reports
- Ensuring effective energy-use and maximum participation of all occupational therapy staff

1.3 ORGANISING AREA

- Using of allowed authorities to set rules and protocols that facilitate and ensure appropriate flow of comprehensive occupational therapy service in terms of quality, time and effectiveness
- Collaborating with other services to the benefit of clients and organisation
- Sharing responsibility with others when work/business is in risk
- Ensuring that resources are spent to reach agreed targets
- Attending and participating in relevant committees’/teams’ meetings in organisation
- Creating healthy work atmosphere in terms of respect, concern and team spirit
- Staff orientation to agreed goals and objectives
- Promoting of occupational therapy staff to acquire further knowledge and skills

1.4 PERSONNEL MANAGEMENT AREA

- Participation in building and development of the team
- Identifying department’s needs for staff

- Giving guidance to facilitate appropriate recruitment (e.g. announcement preparing)
- Participation in the process of personnel's selection
- Identifying and planning for training needs of new personnel
- Ensuring appropriate and effective placement of new personnel
- Participation in job description setting
- Participation in implementing of effective measurements to reduce staff turnover

1.5 DIRECTING AREA

- Allowing for professional differences
- Providing proper and effective handling of clients' compliance
- Accepting accountability for decisions
- Using two way communication
- Task delegation to others when necessary to facilitate occupational therapy service delivery
- Motivating and enabling occupational therapy staff to perform the tasks according to intervention goals
- Establishing and sustaining trust and commitment
- Ensuring regular staff appraisals take place

1.6 CONTROLLING AREA

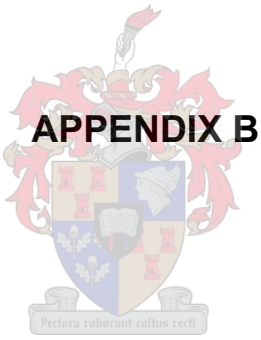
- Participating in and ensuring that occupational therapy outcomes measures take place regularly
- Monitoring of occupational therapy service quality
- Participation in benchmarking current occupational therapy service against the standards in South Africa
- Ensuring effective documentation "clear, brief and effective"

1.7 ETHICAL ISSUES AREA

- Assisting staff to identify ethical dilemmas
- Providing guidance with decision regarding ethical dilemmas
- Monitoring of the implementation of ethical principles by clinicians
- Reporting unethical behavior to authorities
- Providing in service training regarding ethics
- Providing of continuing professional development opportunities pertaining to ethics
- Participation in setting the rules and regulations of occupational therapy practice in accordance with the Code of Ethics
- Ensuring that interventions take place within structures of occupational therapy profession
- Ensuring confidentiality of clients
- Providing foundations for autonomous occupational therapy practitioners

1.8 OTHERS

- Providing internal occupational therapy consultation to one's own facility
- Participation in research
- Participation in continuing education programs



APPENDIX B

1. PILOT QUESTIONNAIRE COVERING LETTER

Moussa Abu Mostafa
Department of Occupational Therapy
Faculty of Health Science
University of Stellenbosch
P.O. Box 19063
TYGERBERG
7505

20-03-2004

Dear Sir/Madam,

Thank you for your time for completion of the questionnaire and your willingness to participate in the pilot study. The purpose of the questionnaire is to identify the perspective of occupational therapy leadership roles in clinical practice.

Your honest opinion and expertise are appreciated. The questionnaire will be anonymous. Once you have completed the questionnaire, could you please answer the questions at the end. Please feel free to comment on or rectify any of the questions in the questionnaire. By completing the questionnaire, it would assist in making it possible for use in the actual study. **Please time yourself when completing the questionnaire.**

Please return the completed questionnaire in the stamped enclosed envelope.

Thank you for your co-operation.

Yours truly

Mr Moussa Abu Mostafa
Master student in Occupational Therapy

2. PILOT QUESTIONNAIRE

PART ONE: LEADERSHIP ROLES

Please make sure that you complete all the questions.

You are invited as a leader to comment on your roles and reflect your viewpoint.

Please complete the following questions by (/) the appropriate answer:

1. Your gender	Male	Female
2. Your present age in years:		
3. Your job title		Experience in years
a) Assistant director		
b) Chief occupational therapist		
c) Senior occupational therapist		
Your total experience in years		
4. Position of leadership in terms of:	Formal *	Informal **
5. Employment	Part-time	Full-time
6. Number of leaders in your department:		

* Formal leadership: the leader is appointed in the post by the organisation.
** Informal leadership: the leader is appointed in the team.

7. Please indicate the way you reached the leadership position:

Vote	
Seniority	
Qualifications	
Experience	
By appointment	
By virtue of discipline	
Departmental selection	
Other (please specify):	

8. Have you received any training relevant to leadership?

YES	
NO	

If yes, please specify: ……

Please choose (✓) the most applicable number that is true to your leadership roles under each of the following items:

1-Strongly agree
2-Moderately agree
3-Don't know
4-Moderately disagree
5-Strongly disagree

Planning	**1**	**2**	**3**	**4**	**5**
9. Participates in alignment process					
10. Establishes the source of a vision of the staff					
11. Participates in setting policies					
12. Serves as strategic planner					
12. Is a change agent					
Managing					
13. Uses manager's authorities					
14. Manages conflicts					
15. Manages time					
16. Manages finance					
17. Manages risks and liabilities					
Organising					
18. Participates in setting the rules and protocols of occupational therapy department					
19. Promotes providing a comprehensive occupational therapy service					
20. Provides supervision					

Staffing					
21. Builds the team					
22. Identifies followers' needs					
23. Schedules staffing needs					
24. Promotes team's development					
Directing					
25. Facilitates the vision of subordinates					
26. Allows for professional differences					
27. Manages clients' compliance					
28. Accepts accountability for decisions					
29. Is open to feedback/criticism from team members					
30. Uses two ways communication channels					
31. Delegates tasks to others					
32. Provides staff with feedback					
33. Uses reinforcement					
34. Serves as a mentor					
35. Enables others to act					
36. Establishes and maintains trust					
Controlling					
37. Assesses outcomes					
38. Monitors quality					
39. Promotes occupational therapy service development					
40. Evaluates team's performance					

Ethical issues					
41. Serves as an ethical stand and bearer for the staff					
42. Works to integrate both the leadership roles and managerial skills					
43. Advocates clients					
44. Participates in setting the rules and regulations of occupational therapy practice					
45. Participates in career development					

PART TWO: CLINICAL PRACTICE

Please make sure that you complete all the questions.

You are invited as an occupational therapy leader to comment on the influence of leadership on the occupational therapy clinical practice.

Please choose (✓) the most applicable number that is true to the perceived influence of leadership on clinical practice under of each of the following items:

1-Strongly agree
2-Moderately agree
3-Don't know
4-Moderately disagree
5-Strongly disagree

Leadership facilitates	**1**	**2**	**3**	**4**	**5**
46. Client's referral					
47. Client's entry to occupational therapy department (admission rules)					
48. Client's screening					
49. Client's evaluation/assessment					
50. Planning for intervention					
51. Intervention process					
52. Client preparation for discharge					
53. Discontinuation					
Leadership promotes					
54. Staff being sensitive towards clients					
55. Specified treatments for various conditions					
56. Implementing treatment according to prescribed intervention					
57. Provision for client's teaching care continuity and post-care					
58. The use of relevant quantifiable measures/assessment					
59. Effectiveness of disposition in terms of requirements such as report, splints					

PART THREE: DEPARTMENT

Please make sure that you complete all the questions. (✓) the appropriate answer.

You are invited as a leader to comment on your department and reflect your point view about it from your perspective.

60. Type of organisation in terms of delivered service:

a) Health organisation	
b) Educational organisation	
c) Others	

61. Tick (✓) where appropriate.

Occupational therapy service (in your organisation) is directed to those who possess or who are at risk for:

a)	Physical disability	
b)	Cognitive disability	
c)	Psychosocial dysfunction	
d)	Mental illness	
e)	Developmental or learning disorders	
f)	Maladaptive behaviour	
g)	Other disorder or conditions	

Please choose (✓) the most applicable number that is true to your department practices under of each of the following items:

1-Strongly agree
2-Moderately agree
3-Don't know
4-Moderately disagree
5-Strongly disagree

Leadership promotes	**1**	**2**	**3**	**4**	**5**
62. Involvement in continuing education programs					
63. Using occupational therapy consultation					
64. Using effective record system					
65. Participation in research					
66. Co-operation with the other health professionals in terms of planning					
67. Writing records and reports in outcome based fashion					
68. Regular staff meetings					

Please use the place for additional comments:

……

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END

3. LIST OF QUESTIONS FOR FEEDBACK ON PILOT QUESTIONNAIRE

ANSWERING OF THE QUESTIONNAIRE

After completion of the questionnaire, please answer the following questions.

Mark the appropriate answer with (/).

1. Is each of the questions measuring what it is intended to measure?

YES	
NO	

If no, specify:

……

……

……

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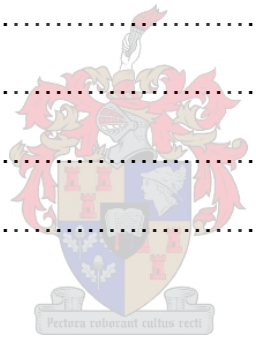

2. Are all the words understood?

YES	
NO	

If no, specify:

……

……

……

……

3. Do the options apply to the questions?

YES	
NO	

If no, specify:

……..……..……..

……..……..……..

……..……..……..

……..……..……..

4. Are there any un-interpretable questions?

YES	
NO	

If no, specify:

……..……..……..

……..……..……..

……..……..……..

……..……..……..

5. Are any of the items reflecting a leading question?

YES	
NO	

If no, specify:

……..……..……..

……..……..……..

……..……..……..

……..……..……..

6. Does any aspect of the questionnaire suggest bias on the part of the researcher?

YES	
NO	

If no, specify:

……

……

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7. How long did it take to complete the questionnaire?

Hours Minutes

	:	

Comments:

……

……

……

……

8. Is/are their any irrelevant question(s) that needs to be omitted?

YES	
NO	

If no, specify:

……

……

……

9. Any other additional comments or recommendations:

……

……

……

……

……

Thank you for your co-operation.

APPENDIX C

1. CONSENT FORM

RESEARCH PROJECT TO IDENTIFY THE PERSPECTIVE OF OCCUPATIONAL THERAPY LEADERSHIP ROLES IN CLINICAL PRACTICE

I am willing to participate in the research project and complete the questionnaire.

YES	
NO	

SIGNATURE: _____

DATE: -----/-----/2004

THANK YOU FOR PARTICIPATING AND COMPLETING THE QUESTIONNAIRE

MOUSSA ABU MOSTAFA
MASTER STUDENT IN OCCUPATIONAL THERAPY
TYGERBERG CAMPUS-STELLENBOSCH UNIVERSITY
TEL: 021 938 9308

E-MAIL: 14278820@sun.ac.za or mosa181@hotmail.com

2. COVERING LETTER OF STUDY QUESTIONNAIRE

Moussa Abu Mostafa
Department of Occupational Therapy
Faculty of Health Science
University of Stellenbosch
P.O. Box 19063
TYGERBERG
7505

17 May 2004

Dear Sir/Madam,

MASTER RESEARCH IN OCCUPATIONAL THERAPY

Thank you for your time, for completion of the questionnaire and your willingness to participate in the study. The purpose of the questionnaire is to identify the **perspective of occupational therapy leadership roles/functions in clinical practice**.

By completing the questionnaire, you are assisting me to identify the perspective of occupational therapists regarding occupational therapy leadership roles/functions in clinical practice. I am particularly interested in obtaining your viewpoint. Your knowledge and experience in the field will contribute significantly in enriching and enlarging available data.

The questionnaire has been tested and revised with a similar sample of occupational therapists. The average required time for its completion was 22 minutes.

Your answers will be handled confidentially since the questionnaire is completed anonymously. The questionnaire must be completed by occupational therapy leaders "**assistant director, chief or senior occupational therapists**". I request you to complete the questionnaire individually and independently and reflect your own perspective about the study issue.

Please **tick (✓)** the responses, which genuinely reflect the most appropriate answer according to your opinion. A summary of the questionnaire results will be made available to you on request and will be published in an occupational therapy journal. **It will be highly appreciated if you complete the questionnaire in two days and return it to the researcher.** Please return the completed questionnaire in the stamped enclosed envelope. Thank you for your cooperation.

Yours truly,

Mr Moussa Abu Mostafa
Master student in Occupational Therapy

Pectora roborant cultus recti